



REPUBLIC OF KENYA

MENTAL HEALTH AND WELLBEING TOWARDS HAPPINESS & NATIONAL PROSPERITY

A report by the Taskforce on Mental Health in Kenya

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ACRONYMS/ABBREVIATIONS

ADHD	Attention-deficit/hyperactivity disorder
ASD	Autism spectrum disorder
BBI	Building Bridges Initiative
CRPD	Convention on the Rights of Persons with Disabilities
GBV	Gender Based Violence
KEMSA	Kenya Medical Supplies Authority
KMHYC	Kenya Mental Health Youth Coalition
KNCHR	Kenya National Commission on Human Rights
KPA	Kenya Psychiatric Association
LGBT	Lesbian, Gay, Bisexual and Transgender
MOH	Ministry of Health
MNS	Mental, neurological and Substance use disorders
NACADA	National Authority for the Campaign Against Drug and Alcohol Abuse
NHIF	National Hospital Insurance Fund
OAG	Office of the Auditor General
PTSD	Post-Traumatic Stress Disorders
SDMH	Social Determinants of Mental Health
SUD	Substance Use Disorders
UHC	Universal Health Coverage
WHO	World Health Organization

THE PREAMBLE

In his Madaraka Day speech in June 2019, H.E President Uhuru Kenyatta spoke profound words depicting a husband, father and grandfather. He said:

“Depression has today become a common phenomenon and it affects persons from all walks of life and ages. I urge employers and institutions of learning to invest more time and resources in monitoring and facilitating the mental Wellbeing of their charges. I, therefore, direct the Ministry of Health in consultation with County Governments, Ministries of Education, Labour & Social Protection and Public Service, Youth & Gender Affairs, to formulate an appropriate policy response...”

In so doing, he gave a voice to millions of Kenyans whose silent suffering in the face of challenges of poor mental health had reached unacceptable levels. On that day, there was celebration within the mental health fraternity; they saw a dawn of a new Kenya, characterised by a national and personal sense of hope. The cries of the people had reached the highest office in the land.

In a Cabinet directive in November the same year, mental health was given a further boost with the decision to form a Taskforce to, among other things, study the causes of the increasing burden due to mental disorders. This, to our knowledge was the first time that discussion on mental health had taken place at this level. This fact alone signified both the severity and urgency of the problem.

In a different forum Kenyans spoke with a loud and clear voice when they addressed the Building Bridges Initiative (BBI) Taskforce. One of the key recommendations of the BBI is the creation of a body to monitor and report (to Parliament) the state of the mental health and wellbeing of the people of Kenya. This Taskforce is in full support of this proposal by the BBI. A key building block of our nation is the family unit. Mental ill health is tearing families apart, as spouses turn against each other, as terrified offspring witness the violence, which they will in turn visit on their spouses and children in the next generation. Family and school based interventions are proposed in this report.

This report further details the findings and recommendations as were established during the period of its mandate. Some findings were surprising, while others were shocking and brought tears to members of the Taskforce. In this regard, the state of our mental health facilities stood out in some cases as a century old monuments of national shame. The physical facilities in some sections of Mathari Referral Hospital as well as Port Reitz Hospital in Mombasa are the source of great shame to all Kenyans. No citizen of our country should live in those dehumanising conditions. Beyond being unhygienic and lacking the most basic items like toilets, Kenyans are housed in unsafe buildings that would be condemned as unfit for human habitation if inspected by Public Health Authorities.

The extent and consequence of the stigma and discrimination found in all sectors of Kenyan society appeared to be systematic and deeply entrenched. Many examples were cited by the public, and are described in the body of the report. They range from the negligible budgetary provision by Treasury (see report by the Office of Auditor General, Dec. 2017) to the derogatory language in some statutes, and media reports on mental health issues, in particular suicide. Many Kenyans who told stories of exclusion from society because they, or a relative, suffered from mental illness.

It was clear that Kenyans are hurting and are crying for answers and solutions. Frequent mention was made of the President's directive as the evidence that their petitions had at last reached the right place. Many Kenyans came forward and for the first time spoke openly and loudly about the difficulties they faced, on account of suffering from mental disorders. Repeatedly, they spoke about lack of services, and medications, but also spoke of discrimination in schools and work places. They were glad that the government at last seemed aware of the devastating problems before them and they wanted immediate and effective solutions.

As the Taskforce retreated to write the report, it became clear that the years of neglect of mental health services have at last come to haunt us as a nation. The monster that has grown out of poor public financing and policy demanded urgent attention if national development was to be achieved. It is clear that poor mental health is a threat to national development. It was also clear that the only way available to slay the monster was by way of new, innovative and appropriate approaches that spoke to the magnitude of the problem. The Taskforce noted that Kenya has had a similar health crisis and has a history of success, when appropriate action is put in place.

When Kenya declared HIV AIDS to be a national disaster in 1999, the response that was put in place enabled the Government to mobilise national and international resources that in the end saved the lives of millions of Kenyans. This report details the burden of disease due to mental disorders and through the evidence presented, it is clear that this silent epidemic is a threat to the wellbeing of the people of Kenya. Many are dying while millions of mostly young people fail to achieve their full potential due to treatable mental disorders. Poverty and unemployment were at the top of the concerns of the youth. We recommend a similar response to the HIV epidemic in part because of its overwhelming success. We annex to this report draft legislation to give effect to such a response.

The recommendations detailed in the report fall into three broad categories. Some are purely administrative and can be effected with great ease immediately and without additional expenditure. An example is the supply of drugs as is already a Government policy. There were many mentions of Kenya Medical Supplies Authority (KEMSA) and the non-availability of psychotropic medications already on the essential drugs list. During our visit to Mathari Hospital on 14th February 2020, there was not a single injectable emergency drug available in the hospital. Psychotic patients in need of emergency care received none. This deplorable state of affairs borders on culpable dereliction of duty. The streamlining of KEMSA would lead to much needed relief for Kenyans. Urgent action by the Ministry of Health will save Kenyans much suffering and indignity.

The next group of measures is equally painless and includes the proposed set of legislative changes. We have annexed to this report the Acts of Parliament that cry out for urgent attention. Our interaction with Parliament confirmed it is able and willing to give urgent effect to our proposals.

The third group of recommendations are by their very nature painful and sadly will be the true test of our commitment to the service of a most vulnerable group of Kenyans. This category of proposals includes changes in the Criminal Justice System, as well as the provision of adequate budgetary allocations to eliminate the dehumanising facilities we found in a number of hospitals. Our attention was drawn to the proposed National Neuropsychiatric Institute and if built and operationalised, would resolve some of the problems we witnessed. Mathari Referral Hospital is, in our opinion beyond repair in some areas which should be brought down to build in their place, a hospital where Kenyans can receive care in a humane environment.

We conclude that the present system of financing will not deal with the challenges identified whose roots go back many generations. It is estimated (by the World Health Organization – WHO) that for every shilling invested in mental health, the return is five shillings. Treasury and the private sector should act on this self-evident reality. This report proposes a number of financing mechanisms, including the adherence to the WHO guidelines which take account of the burden of disease caused by mental disorders. We also propose raising funds for mental health through additional taxation for those sectors that contribute to the increase of the burden including alcohol manufacturers, as well as the gambling industry. The proposed Mental Health and Wellbeing Commission would manage these additional funds for the promotion of mental wellbeing, through greater awareness, and strategies to reduce the stigma associated with mental illness. Much as one obtains credit carbons for the use of green energy, we propose tax credits for organisations' that run approved mental health promotional programmes.

A declaration of mental ill health as a national emergency of epidemic proportions (or similar proclamation) would lead to the release of Kenya's collective might to steer all of us into a journey of good mental health and wellbeing. It is our view that such a declaration would faithfully reflect the magnitude of the problem as described in this report, and would justify the involvement of all sectors of the community, including the private sector and our development partners, as well as local and international bodies interested in mental health.

In conclusion, I would like to thank the Government and the people of Kenya for the opportunity to serve. The call to duty in this once in a lifetime assignment has left all members of the Taskforce with a heavy debt of gratitude. We as a Taskforce remain cognisant of the privileged position we occupy in the transformation of this and future generations.

The support and encouragement from the Cabinet Secretary Hon. Sicily Kariuki has ensured that we have had a smooth sail in the duration of our mandate. My Co-chair and Principal Secretary for Health; Susan N. Mochache's continuous contribution and support made the taskforce accomplish the tasks. The Secretariat consisting of staff from the Ministry of Health is clear testimony of the existence of very able men and women we are proud to call our sons and daughters.

“Mental Health and wellbeing: Towards happiness and national prosperity”.



Dr. Frank Njenga
Co-chair Mental Health Taskforce

EXECUTIVE SUMMARY

On June 1st, 2019, President Uhuru Kenyatta indicated in his official Madaraka Day speech that the country was facing a mental health crisis, and ordered the Ministry of Health to implement programmes and policies to address the problem. A Cabinet meeting held on 21st November, 2019, went further and directed the formation of a Mental Health Taskforce to address the mental health concerns of Kenyans and help guide the government on resource allocation for mental health. On December 11th, the Taskforce was inaugurated and given 80 days in which to complete the work.

The Taskforce, in the conduct of its duties, reviewed existing literature on mental health in Kenya and in the global context, and in addition received memoranda and met Kenyans across the country to listen to what they thought are the priority mental health problems in the country and provide ideas on the potential solutions. We visited facilities and held hearings in Mombasa, Nairobi, Eldoret, Nakuru, Meru, Garissa, Makueni, Kakamega, Kisumu, and Nyeri and also held sector-specific meetings with the youth, security sector, education sector, professional societies, religious sector, government departments, politicians, and people with lived experience of mental ill health, among others. In total, the Taskforce met and held discussions with 1,569 Kenyans, received 206 memoranda (submitted 121 on emails, 73 hard copies and 12 on Taskforce website).

The findings and recommendations of this Taskforce are here presented in ten thematic areas:

- Mental Health and Wellbeing,
- Burden of mental illness,
- Mental health in special populations,
- Determinants of mental health,
- Stigma and discrimination,
- Policy and legislative framework,
- Leadership and governance,
- Mental health services and systems,
- Mental health financing and universal health coverage, and
- Mental health data and research.

Mental health and wellbeing

Our findings reiterate the fact that good health is central to human happiness and Wellbeing and makes an important contribution to economic progress and a healthy population. However, many Kenyans are unable to distinguish between Mental Health, Mental Wellbeing, and Mental Illness. Many thought that mental health was synonymous with mental illness, and everywhere we went it was clear that Kenyans do not have sufficient information on the signs and symptoms of mental illness, and the accompanying change in individual behaviour is interpreted incorrectly. The majority of Kenyans who spoke to the Taskforce indicated that mental illness is a big challenge in our society, with the widespread concern that they were affected by high levels of stress citing lack of jobs, the constant negative politics, fear of violent and divisive elections.

Concerning Mental Health and Wellbeing, the Taskforce recommends as follows:

- A Presidential declaration of mental ill health as a national public health emergency.
- That National and County governments establish amenities and facilities to provide recreational activities to the public.
- All employers to ensure healthy working spaces, and fully-fledged wellness centres in learning institutions staffed with psychologists.
- Mental Health Literacy is incorporated in curricula at all levels of education from schools, colleges and universities, and similar programmes be designed and implemented in the community.
- Promote mental health and wellness in families and communities through community health and wellbeing programmes.

The burden of mental illness

The research and what the Taskforce was told by Kenyans as we traversed the country shows that mental and neurological disorders are common and widespread. It was clear that at least 25% of outpatients and 40% of inpatients in different health facilities had a mental illness, and an estimated prevalence of psychosis stated as 1% of the general population. The common mental illnesses in Kenya are depression and suicide, substance use disorder, bipolar disorder, schizophrenia and other psychoses. Kenyans in all hearings attributed distress to the divisive nature of our politics especially around election time, which perpetuate fear and distress in them and cause trauma and post traumatic stress disorder among others.

The Taskforce therefore recommends:

- The Government, through research institutions and universities, conducts a national mental health survey to better define the mental illness burden in the country.
- We again reiterate that mental health be declared a national public health emergency because the high burden of mental illness is a threat to national development, and that the government reduces the mental illness burden by providing funds for promotive, preventive and curative interventions.
- Parliament to move fast to decriminalise suicide attempts in order to reduce stigma and discrimination and encourage help-seeking among people that are feeling suicidal.
- Specific to suicide, the Taskforce recommends restricting access to means for example, access to firearms; educating the media on responsible reporting of suicide; implementing programmes among young people to build life skills that enable them to cope with life stresses.

Mental health and special populations

Special populations are groups whose needs may not be fully addressed by primary health care service providers. They include children and youth, women, refugees, prisoners, disciplined forces, sexual minorities, the boy child, people living with chronic physical illnesses, persons with disability, and survivors of gender-based violence.

The Taskforce recommends:

- That National and County governments design inclusive mental health care services to cater for all ages and demographic groups, including the youth and the elderly.
- National and county health ministries and departments to ensure integration of mental health services with ante-natal and post-natal care.
- The Government to increase the number of mental health care providers at correctional facilities, and ensure screening of inmates for mental health conditions and provision of adequate treatment.
- Judiciary to streamline proceedings to ensure cases are disposed of in an expeditious manner in order to decongest the system and reduce stresses due to slow judicial processes.
- Disciplined forces to ensure availability of psychological services, and regular staff debriefing on mental health at all workplaces.
- All sectors to adopt recommendations from the National Gender and Equality Commission, including affirmative action, programmes and interventions that support empowering of both girls and boys.
- The Government to institute appropriate programmes to address mental health needs of refugees, the LGBT population, people living with chronic physical conditions, survivors of sexual and gender-based violence, and persons living with disability.
- Seek the services of youth counsellors to primary schools to provide counselling services for this vulnerable group in schools. School nurses be required to undertake classes on youth and adolescent health in order to better meet the needs of adolescents.
- The Taskforce fully supports youth empowerment, creation of jobs and building of skills to the youth for self-employment and further creation of more jobs.

Social and other determinants of mental ill health

Mental wellbeing and most mental ill health is shaped to a great extent by the social, economic, and physical environments in which people live. Poverty and social deprivation affects people in low-income areas/ neighbourhoods and manifests through psychotic disorders and depression in the population. Natural or industrial disasters, war or armed conflict, terrorism, forced migration/displacement, human trafficking, torture, trauma, distress, bullying, discrimination, language differences, an increased population of those bearing refugee status, climate change and its concomitants – droughts or flooding are all environmental events, and are associated with mental illness, especially PTSD. Individuals who experience these negative events and survive them also suffer from higher levels of anxiety and “*survivor guilt*”. People live in fear of crimes of all types from within and externally. The COVID-19 pandemic (which was ongoing at the time the Taskforce was concluding its work) caused by the SARS-CoV-2 virus is a prime example of the traumatic experiences caused by changes in the interaction between humans and the environment, and the mental health consequences are expected to be enormous.

The Taskforce recommends:

- Government to ensure mental health impact assessment for all new policies aimed at reducing the risk factors associated with social determinants of mental health where they already exist, and to develop new policies for this as appropriate. The Taskforce has identified some of the policies and laws under Chapter 7 of this report.
- The socio-economic and cultural determinants of mental ill health are cross cutting and interrelated. The Taskforce recommends for the implementation of anti-poverty and social protection programmes to address these factors.

Stigma and discrimination

Stigma is one of the areas Kenyans talked so much about during the Taskforce meetings. It was clear that people with mental illness were facing stigma and discrimination in various areas of their lives. As defined by WHO, stigma is a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against and excluded from participating in a number of different areas in a society. Stigma is a result of lack of knowledge, prejudicial attitudes, and discriminatory behaviours. Stigma and discrimination lead to marginalisation of users of mental health services, underfunding of the sector leading to poor service delivery. “*The physical infrastructure of most mental health institutions is in itself a key driver of stigma....*”, as observed by Kenyans.

The Taskforce makes the following recommendations:

- Government to ensure training of staff on human rights violations and the rights of people with mental health conditions.
- Ministry of Health to design anti-stigma programmes, and support people with lived experience to lead the anti-stigma campaigns, and to identify and engage mental health champions in communities.
- Use of less stigmatising words to refer to mental illnesses. Words such as “wazimu” should never be used to refer to a person with mental illness. This can be done through public awareness and social marketing programmes.

Policy and legislative framework

A number of issues raised in hearings and review of the literature call for the implementation of the Mental Health Policy (2015-2030) and amending and/or repealing some laws to strengthen the systems to address mental health challenges. Majority of Kenyans highlighted the lack of a Mental Health Action Plan as a major hindrance to the operationalisation of the policy. Kenyans were specific on the laws, indicating that we must “*amend the law to decriminalise suicide*” and “*decriminalise substance use and abuse*” in order to facilitate care.

The Taskforce therefore recommends:

- Ministry of Health to disseminate the National Mental Health Policy and then develop an action plan to fast track the implementation of the policy across all sectors and levels of government.
- Parliament to ensure all laws affecting mental health conform with the Constitution of Kenya 2010, Health Act and the CRPD, and amend or repeal laws including the Penal Code (e.g., Section 226 that criminalises attempted suicide), Marriage Act 2014, and Persons with Disabilities Act 2003.
- Government to implement and enforce existing laws that have not been implemented specifically of clauses touching on mental health, including the Mental Health Act, Counsellors and Psychologists Act 2014, The Health Act 2017 (Section 73), Insurance Act (Section 82), Betting, Lotteries and Gambling Act, and The Children’s Act.
- Parliament to harmonise substance use-related laws including the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) Act 2012, The Alcoholic Drinks Control Act 2012 (2010), The Narcotic Drugs and Psychotropic Substance (Control) Act 2012, and The Tobacco Control Act 2012.

Leadership and governance

The Taskforce identified the absence of a unified leadership and governance structure in the mental health field in the country. At County level each county we visited was implementing a different model, with varying degrees of success.

The Taskforce therefore recommends:

- Government to establish the National Mental Health and Happiness Commission which will have the overall mental health authority.
- Ministry of Health to establish the directorate of mental health and substance use to coordinate implementation of policies on mental health.

Access to mental health services

Access to mental health services encompasses the ability to use good infrastructure, good services, adequate human resource, required health products, equipment and technologies. Currently, 75% of Kenyans are NOT able to access mental health care despite the heavy burden of mental ill health in the country. The only National Referral Mental Hospital, Mathari Hospital, was built in 1910 and, shockingly, most of the infrastructure is 110 years old and dilapidated, and lacks basic infrastructure to deliver modern evidence-informed psychiatric care.

The Taskforce recommends:

- The Ministry of Health to rebuild Mathari Teaching and Referral Mental Hospital.
- National and County governments to implement community mental health services; and ensure a decentralised and integrated mental health services are accessible to communities.
- The Ministry of Health to set aside resources for training, recruitment and deployment of adequate multidisciplinary mental health service providers. We further emphasise that the ministry ensures training and recruitment of mental health professionals to shift the gap in human resources per population ratio.
- KEMSA to provide the requisite range of medications for psychiatric conditions that are modern and evidence-informed and to fulfil its mandate of adoption and procurement of products recommended in the Kenya essential drugs list.

Mental health financing and universal health care

Kenya is among the 28% of WHO member states that do not have a separate budget for mental health, and government expenditure on mental health is 0.01% of the total expenditure. Consequently, people with mental health disorders have to pay out-of-pocket for treatment. Private medical insurance covers are discriminatory, and most insurance companies do not cover for mental health care.

The Taskforce recommends:

- Parliament to amend the Mental Health Act to provide for a Mental Health Fund.
- Government to increase equitable funding for mental health services and expand the scope of financed mental health services, including opening up NHIF cover for mental health outpatients.
- Treasury to provide for tax exemption for people living with mental illness and tax incentives for organisations and individuals that run approved mental health programmes.

Mental health data and research

The Kenya Health Act, 2017 and Health Information Policy 2014-2030 provide for a National Health Information System that is responsive to the needs of the population. However, the current health information system does not address specific mental health conditions and monitoring of mental health interventions.

The Taskforce recommends:

- The Government, through the National Mental Health and Happiness Commission, ensures the integration of a mental health information sub-system within the general health and other information systems, as well as to ensure regular National Mental Health Surveys are conducted.
- The Government, through the National Mental Health and Happiness Commission, ensures inclusion of epidemiological data. Though costly, epidemiological surveys in conjunction with other data on service utilisation can allow service planners to monitor the requirements for care in terms of budget allocation for services, medication and human resource.

SUMMARY OF KEY RECOMMENDATIONS

1. Set up a Mental Wellness and Happiness Commission, to monitor the state of mental health and happiness among Kenyans.
2. Declare mental illness a **National Emergency** of epidemic proportions.
3. Carry out a National Mental Health survey.
4. Fast track the creation of Mathari Teaching and Referral Hospital as a semi-autonomous Government Agency for specialized referral services, teaching and research in mental health
5. Implement a multisectoral approach to Mental Health challenges, (similar to that adopted in 1999 against HIV/AIDS).
6. Provide adequate financing for mental Health, in line with international best practices (Kshs. 250 per capita per annum).
7. Regulate and license all institutions offering healthcare (including rehabilitation centres) through the Kenya Medical Practitioners and Dentists Council.
8. Amend and/or repeal specified legal provisions that offend the Constitution, and Acts of Parliament.
9. Gazette the second week of October as the National Mental Health Awareness Week in Kenya.
10. Develop Mental Health literacy materials for use across all sectors as a means of dealing with stigma and discrimination.
11. Support the Senate initiative on the Mental Health (amendment) Bill 2018 (subject to a number of proposed amendments).
12. Involve Carers and Users of mental health services at all levels of legal and policy development.
13. Decentralize mental health services to the primary health care level.
14. Train and recruit mental health professionals to bridge the gap in human resources per population ratio.
15. On the COVID-19 Pandemic, we observe that the implementation of the taskforce recommendations will be an important strategy in the COVID-19 pandemic response and long term recovery.



CHAPTER ONE

INTRODUCTION AND BACKGROUND: SITTING ON A TIME BOMB

Kenya's mental health and wellbeing has been neglected for decades as we spent most of the available energy and resources on trying to fix our economy and with equal vigour, the challenging politics of our country. We have had a measure of success in dealing with both, but in the last few years, it has become clear that a good economy without commensurate mental health will not be enough.

When the BBI team went round the country recently, their primary mandate was to fix the politics of Kenya. What they consistently heard was to seek ways of dealing with the mental state of the people, even as they found ways of fixing politics and the economy.

Images of young men loitering the streets of urban centres in states of advanced intoxication with drugs and alcohol continue to prick our collective conscience. The situation in rural areas is no better as evidenced by images of chiefs making gallant but futile attempts to deal with what is commonly referred to as the alcohol and drug menace.

In the last few years, Kenyan society has witnessed unprecedented numbers of people and families adversely affected by poor mental health. Newspaper headlines and other media reports are replete with images of families engulfed in grief either because a family member has died by suicide or some other act of domestic violence has occurred against the presumed background of a mental disorder. This is the ticking time bomb that Kenyans are sitting on.

Less visible but equally devastating are the millions of children who go to school daily and do not, on account of mental illness benefit from the teaching by their teachers. It is estimated that 50% of all mental disorders start by the age of 14 years! Put another way, the best place to start picking out mental illness in any society is in primary school! It is further estimated that by the age of 24 years, 75% of all mental disorders have made themselves manifest.

These numbers dictate that any efforts at prevention and promotion of mental disorders must start with young children. It is here that teachers and parents will play a critical role. It is recognised that early identification and treatment of mental disorders is both more effective and costs much less than treatment when the full blown illness becomes established and a source of anguish and social dysfunction.

There is also the economic burden of mental illness. Depressed farmers produce fewer crops. Factory workers who are depressed are less productive. Thousands of teachers, police officers and other civil servants are the subject of disciplinary action simply because they offend the code of conduct in the context of a depressive or other mental illness.

A Muslim Cleric asked the Taskforce to recommend that a mental health specialist be made available prior to the declaration of a divorce. This cleric was supported by Christian leaders who had identified mental disorders, including drug and alcohol abuse as sources of divorce and much suffering in the family unit.

The link between illicit drug supply chains and national security and crime are well documented. Less often acknowledged is the fact that the Criminal Justice System is clogged up by petty offenders who find their way into the system, as they seek ways to feed their drug habits.

Beyond the arrests made for possession of drugs, thousands of Kenyans find their way into remand prisons because of theft. In a dramatic confession, a young man addicted to heroin explained how he started by stealing money from his mother's handbag, later stole and sold the television set before finally selling the very *sufuria* his mother used to cook his *ugali* in. Such people belong to a system that gets them into treatment for the addiction. It is indeed estimated that up to 60% of all persons in remand suffer from one form or another of mental disorder. There was overwhelming support for the establishment of a special Magistrates Court with the support of experts in mental health whose specific brief would be decongesting the Criminal Justice System.

Two reports describe in graphic detail, the state of the mental health facilities in Kenya. They are easily available and make for a wakeup call. They emphasise that what Kenya now needs is an action plan to tackle the challenge. The first report is dated 2011 and is a publication of the Kenya National Commission on Human Rights (KNCHR) titled 'Silenced Minds: The systemic neglect of the mental health system in Kenya'. It makes numerous observations on all aspects of the mental health landscape and in essence concludes that the state of our mental health facilities is an affront to the human rights of Kenyans. The other equally disturbing report is from the office of the Auditor General and is, in its detail a disturbing read and provides more than adequate reason to wake up all Kenyans into some form of action (Office of the Auditor General, Dec. 2017).

The statistics now available call for urgent and decisive action. For every shilling invested in mental health, the country gets five shillings back in benefit. Of the entire burden of disease in Kenya, 13% is due to mental illness. The corresponding budgetary allocation to mental health is less than 0.1%.

There is no escape from mental disorders, either at a personal or family level. No single family can claim immunity from the effects of some form of mental disorders. Indeed, mental afflictions are equally and democratically distributed in the entire country transcending status, gender and politics.

Every fifth Kenyan will, at one point or another suffer from a mental illness in their lifetime. This means that on average, in a family of five, one member will be afflicted. Millions of Kenyans are directly and indirectly living with a mental disorder, leading to much family and domestic strife, often accompanied by reduced productivity at school and at work. In its rather silent way, depression as an illness drives alcohol and other substance dependence and, abuse, poor performance at school and work, and domestic violence.

In Chapter 2 of this report, a referenced study of a rural district of Kenya shows that, up to 11% of seemingly healthy Kenyans were found to have a diagnosable mental disorder. Up to 30% of the people seen in any outpatient health facility in Kenya will have a diagnosable mental disorder. That the diagnosis is not made is evidence of the poor investment in mental health knowledge and technology. Studies confirm that many man hours are wasted in health facilities as patients undergo useless tests, in futile attempts to diagnose non-existent physical disorders such as malaria, typhoid fever, or brucellosis. Many studies have shown the cost effectiveness of training clinical officers on the recognition and treatment of common mental disorders.

By its very nature, suicide is a subject that continues to receive much media attention. It is estimated that globally one person dies by suicide every forty seconds. That attempted suicide remains in our statutes books as a criminal offence, means that Kenyans who suffer the severe pain inflicted by depression suffer the additional trauma of being viewed as criminals. One of the key recommendations in this report is to repeal this provision in law. This will lead to persons with depression seeking early treatment while data on suicide is also likely to be more accurately kept.

Official records suggest that in 2016, the national crude suicide mortality rate was 3.2 per 100,000 of a population. Experts believe that the true figures are much higher. Whatever the truth, Kenyans have the duty to care for their countrymen who reach, by reason of mental disorder depths of despair that lead to suicide.

This picture is adequate to enable us to conclude that Kenya can no longer keep burying its head in the sand as the people continue to cry out for help. It is also clear that a great deal is known about what the problem is, and the only decision we must now make is what to do, when and how.

When a task is enormous, Kenyans respond by adapting learned helplessness. We act as though no matter what we do, nothing can fix the issue at hand. In this report we argue that we can be more positive and strategic as a nation, dividing the challenge into smaller manageable components, and allowing each stakeholder to play their part, and within realistic timeframes. All the evidence we gathered gives the Taskforce reason to believe that the solutions are within our reach.

There is more than ample evidence that the darkest hour for mental health is over, that a new dawn is in sight. The following section shows commitment and collective evidence that we can deliver a people in full enjoyment of good mental health and wellbeing.

The President

In his Madaraka Day speech on 1st June 2019, the President drew a red line to slay the dragon afflicting mental health. He directed that the entire Government Machinery adopt a multisectoral approach to address the rising cases of depression, suicides and femicides. He encouraged Kenyans who felt depressed, hopeless and suicidal to “*Speak out*” because they are not alone! By speaking as a Head of State, a husband, father and grandfather, he enabled millions to feel understood. The highest office in the land had spoken, now, it is time for action.

In 1999, President Moi made a similar pronouncement when it became clear that the people of Kenya were dying under the weight of HIV infection. No family in Kenya was spared from death and suffering. Decisive action was necessary. As a consequence, the weight of the Government Machinery led to the release of local and international human and financial resources. In twenty years, the prevalence of HIV in our population came down from a high of 13.5% to the current 4.6%. Without being a doctor, the President saved the lives of millions of Kenyans. The mental health crisis today calls for similar decisive action.

The Cabinet

In response to the concerns expressed by the President, the Cabinet formed this Taskforce. This is the first time in the history of our Country that mental health has reached the high table of Cabinet for discussion. This, for Kenyans, is another sign that a new dawn in mental health is nigh. There is justifiable reason to be optimistic in the action by the Government following the recommendations of this report.

County Governments

In the discharge of its mandate, the Taskforce was encouraged by the response it received from County Governments. It was clear that all counties were suffering from the challenges posed by mental disorders. Governors and the First Ladies that we met were articulate and clear-minded that Kenyans had an opportunity to act together to resolve the challenge. Some spoke of their first hand contact with mental disorders including Substance Use Disorder (SUD).

It also became clear that the County Government of Makeni was all the evidence that was required to prove that even without adequate resources much can be achieved. Specialised mental health services have been made available at the sub-county level and though not perfect, provide a clear silver lining to the effectiveness of their model. The Taskforce was encouraged by the bold steps that the county is taking to respond to the challenge. Senior county officers were loud and confident messengers of hope as they described their own experiences of mental disorder. Such testimonies are great tools for dealing with stigma. Kenyans are no longer shy to speak out about their pain and suffering.

Government agencies

We received testimonies from many government departments and were impressed by their level of knowledge and preparedness. It is written in the Bible that “*My people die for lack of knowledge.*” The people of Kenya are dying in spite of great knowledge.

A few examples will make the point.

- The already referenced report of the Office of the Auditor General (December 2017) is the evidence that some parts of our system are working well. The OAG has done his job. All we need to do is to implement their recommendations.
- The Ministry of Labour and Social Protection has already received international acclaim for its policies on the family. This masterpiece is within the knowledge of Government and if implemented will lead to the creation of a sound building block for Kenya, which is the family.
- The Ministry of Education has very sound and clear guidelines which if implemented would have far-reaching impact on the wellbeing of children in schools.
- Ministry of Public Services: the existing policies within this Ministry are adequate and cry out for implementation.

In confirming that we have systems in Government that work well, the officers who presented from the different departments were all confident, highly motivated and had clear ideas on how to move their departments forward with respect to the improvement of Mental Health Services. The Kenyan people have done most of the work. This report proposes how the policies already in place can be implemented.

The Universities

Between the University of Nairobi and Moi University, Kenya is producing large numbers of Psychiatrists that are unequalled in Africa. In the last 5 years the study of psychiatry has proved one of the most popular at university, a great step forward from the days when a class had 2 or 3 students of psychiatry. More than one hundred Psychiatrists will graduate in the next 3 years! (2020-2023).

They are producing high quality actors in other aspects of mental health, including psychologists, counsellors and other cadres. In terms of the human resource response, the public and private universities are doing a good job. These gigantic steps must be celebrated and encouraged.

Research

A great deal of data is available in the field of mental health, and a lot more research is going on under the radar. This however requires greater coordination, and in Chapter 10 of this report the Taskforce proposes methods of capturing more accurate data to enable Kenya plan better, for the utilisation of the available resources. It is also obvious that more resources need to be continuously channeled towards research in mental health in order to guide policy and programmes.

Professionals

The Taskforce engaged the various Stakeholders in mental health and received memoranda from psychiatrists, psychologists, counsellors, teachers, doctors, nurses and security officers, among others. It was pointed out that a register of mental health professionals does not exist. Such a register would come in handy for patients seeking health, as well as at times of national need or emergency.

A presentation by the Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPDU) was most moving as the doctors described their own pain and suffering as they attended to the pain of fellow Kenyans. They described their own mental health needs giving meaning to the saying “*Physician Heal Thyself*”.

Parliament

Of its own motion, Parliament is considering a bill on mental health which has already gone through the Senate and is at the time of writing, before the House of the National Assembly. All the Members of Parliament that the Taskforce engaged during this process spoke about the need to sort ourselves as a country if we are to save future generations. Parliament has proved to be an able and willing partner in the efforts to deal with mental disorders. The Taskforce met members of the relevant Parliamentary Committees who received our views favourably. We are confident that this process will see completion shortly.

Building Bridges Initiative (BBI) report

This report provides a potential mechanism for the monitoring of the mental wellbeing of Kenyans. It proposes the setting up of a mental health and wellbeing body tasked with reporting on the wellbeing of Kenyans. In the view of the Taskforce, such a body would coordinate all the stakeholders mentioned in this report and would report annually to Parliament through the President. This view is well articulated in the BBI report. The Taskforce was impressed by the magnitude of the recognition of the centrality of mental health and wellbeing by BBI the members. We met the BBI team and were able to present our draft views, which in respect to mental health resonated well. We concluded that the mental health of Kenyans had found yet another credible voice of support.

Mathari National Referral Hospital

Contrary to the pictures drawn by others before us, Mathari Referral Hospital is the evidence of the resilience of Kenyans. Under the extremely deplorable conditions that we witnessed and that have been similarly described by others who appeared before the Taskforce, we found men and women working well. It is difficult to believe that people can work cheerfully and in a dedicated manner in the dilapidated and dehumanising environment that we found.

All the staff we met seemed to believe that a brighter future is coming and all they have to do is to trust and wait. The doctors, nurses and other staff seemed to care deeply about their work and had the welfare of their patients at heart. These are the true heroes of Kenya.

They demonstrated to the Taskforce that given resources, they have the capacity to deliver world class services. The “*Methadone Clinic*” that caters for Kenyans with the problem of addiction to heroin sees up to 700 people per day. It is a world class facility that is fully automated with digital identification of patients, as well as fully automated dispensing machines. We were proud to be associated with this success in Mathari.

The dental facility at Mathari is the other clear evidence that given resources, the Kenyan system can work. The unit was clean and efficient and serves both in and outpatients. A mother and child unit is also in operation. These and other little known facts led us to believe that all is not lost.

The recent decision by Cabinet to give Mathari Referral Hospital a semi-autonomous status will be a big first step in realising the dream of a clean and dignified hospital for the care of some of the most vulnerable Kenyans. The Taskforce recommends the fast tracking of this landmark decision.

Professional bodies

The Kenya Psychiatric Association (KPA) with its partners has set aside the month of May as a National Mental Health month. Through a myriad of activities, the association stands tall in its advocacy programmes, stigma reduction being a key agenda. Psychologists and counsellors were clear on the need to urgently operationalise the Act of Parliament that regulates their practice. A number of problems were identified in the Act and we make specific recommendations on its amendments which in full operation, the Act would regulate who may practice as a professional in this field.

First responders as well as armed forces made their presentations and it was clear that they have specific needs that arise from the nature of their work.

Carers and consumers of services

Many groups gave their view in the public hearings while others gave written memoranda. All groups viewed this as the time for action. They were willing to stand up and be counted in providing the response in the approach supported by the WHO.

Other stakeholders

The media, employers and the NGO Community all expressed urgency and assured the Taskforce of their availability in the task ahead. They recognised the need to educate themselves on the early recognition of mental disorders. The Mental Health Policy document was cited as an excellent starting point.

Faith based organisations

Christians, Muslims and Hindu Communities asked experts to urgently draw up a curriculum for the training of their staff in mental health. The Muslim community was specific in its request for mental health experts in Kadhis Courts dealing with divorce and related family matters.

Central Bank of Kenya

The Taskforce learned that the Central Bank of Kenya (CBK) has put in place urgent measures to legislate the Micro Lending Sector. This was in response to increasing cases of suicide related to unmanageable debt. Other cases of suicide have been linked to debt arising from gambling. The Taskforce supports all efforts to regulate and manage personal debt, a position well supported by scientific literature.

CONCLUSION

For the first time in Kenyan history, all the stakeholders involved are singing from the same hymn book. All they want is a coordinated response to the well-articulated challenge posed by mental disorders. The Taskforce holds the view that if implemented, the incremental steps will lead to the achievement of improved mental health and wellbeing for the people of Kenya.



CHAPTER TWO

MENTAL HEALTH AND WELLBEING

Good health is central to human happiness and Wellbeing. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more. In this context, “health” means a state of complete physical, mental and social Wellbeing and not merely the absence of disease or infirmity (WHO Constitution, 1948). Consequently, the United Nations Sustainable Development Goals cannot be fully achieved unless mental health is addressed.

On the other hand, mental illness can have severe economic impact that leads the affected population to abject poverty. The Taskforce focused on mental health, mental wellbeing and mental illness, terms that are often misunderstood.

Mental Health is a state of Wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2005). On the other hand, **Mental Wellbeing** is an active or dynamic process of becoming aware and making choices towards a healthy and fulfilling life in different dimensions. It can be understood as how people feel and how they function, both on a personal and on a social level, and how they evaluate their lives as a whole.

Happiness is a mental or emotional state of Wellbeing defined by positive or pleasant emotions ranging from contentment to intense joy. Happy mental states may also reflect judgments by a person about their overall Wellbeing (Faltin, 2011). **The Happiness Index** is a development philosophy as well as an index which is used to measure the collective happiness in a nation (Musikanski et al., 2017). It was first used in the Kingdom of Bhutan in 1979. The World Happiness Report is a measure of happiness published by the United Nations Sustainable Development Solutions Network. In July 2011, the UN General Assembly passed a resolution inviting member countries to measure the happiness of their people and to use this to help guide their public policies. The United Nations declared 20th March the International Day of Happiness to recognise the relevance of happiness and Wellbeing as universal goals. According to the World Happiness Report which ranked 156 countries in the 2016-2018 period, Finland was rated as the happiest country in the World, while Kenya ranked 121st (Walker et al., 2017).

Finally, **Mental Illness**, also known as mental disorders, refers to a wide range of mental conditions that affect one’s mood, thinking and behaviour. Some examples of mental illness include schizophrenia, depression, intellectual disabilities, and disorders due to drug abuse. Within all definitions of health, it is clear that **there is no health without mental health.**

THE ECONOMIC COST OF MENTAL ILLNESS

At least 10% of the world’s population is affected by one or more mental disorders. Through a combination of its health effects, injuries, and suicide, mental disorders are also a major killer. It is documented that people with severe mental disorders die 10 to 20 years earlier than the general population (WHO, 2014). Mental disorders are also the leading cause of years lived with disability globally. Evidence also indicates that they are on the rise: A 2015 Lancet study found that the prevalence of anxiety disorders increased by 42% and depressive disorders by 54% between 1990 and 2013. Because mental disorders greatly increase the risk of a person developing another chronic disease, and vice versa, it is clear that mental disorders affect both a significant portion of the population and disproportionate numbers of the vulnerable and the underserved (World Bank Group, 2016).

There is also significant evidence showing that social conditions associated with poverty create stress and trigger mental disorders, and that the labour insecurity and the health care costs associated with mental disorders in turn move many into poverty. This circular relationship between mental disorders and poverty creates a cycle that leads to ever-rising rates for both. Several recent studies in high-income countries have found that the total costs associated with mental disorders total between 2.3% and 4.4% of GDP (World Bank Group, 2016), as shown in Table 1.

Table 1: Direct and indirect costs of mental disorders: Results from selected studies

Country	Year	Direct Cost (Billions)	Indirect Cost (Billions)	Total Cost (Billions)	% of GDP
Canada	2011	CAD 42.3	CAD 6.3	CAD 48.6	4.4
England	2009/10	GBP 21.3	GBP 30.3	GBP 51.6	4.1
France	2007	EUR 22.8	EUR 21.3	EUR 44.1	2.3
Global	2010	USD 823	USD 1,670	USD 2,493	4.0

Source: World Bank Group, 2016

Just as mental disorders generate large economic and social costs, treating or preventing them can generate substantial health and economic gains. As well as the direct impact of interventions on health, effective treatment also leads to increased participation in the workforce, reduced rates of absenteeism, and substantially improved functioning while at work. The value erupts when those receiving treatment are better able to form and maintain relationships; to study, work or pursue leisure interests; and to make decisions in everyday life. A 2007 paper focused on Nigeria found that a package of selected mental health interventions generated an additional year of healthy life at a cost below that country’s average per capita income (World Bank Group, 2016).

WHAT KENYANS SAID

The Taskforce found out that a significant proportion of Kenyans lack sufficient information on signs and symptoms of mental illness, and the accompanying change in individual behaviour is interpreted incorrectly. This means that care for those in need is only sought after the illness worsens and as a result, the healthcare system mainly handles patients who present in crisis and severe psychiatric emergencies.

Kenyans on the whole, cannot distinguish the difference between the different mental states. Below are some of the views that they expressed to the Taskforce as significant contributors to their adverse mental status:

- Kenyans thought that the term mental health was synonymous with mental illness; they did not know the difference between mental health and mental illness.
- Kenyans said they were affected by high levels of stress citing lack of jobs in particular, while those who were gainfully employed said that their managers imposed a lot of stress on them.
- Kenyans said that the constant emphasis on politics by the print and electronic media increased their levels of stress.
- Kenyans suggested the urgent need to promote mental health in schools and families, and to advocate for good parenting. Those in employment emphasised that their bosses need training on mental health and mental health issues.
- Mental health services are hardly accessible. The country has very few healthcare facilities and providers that offer specialised mental health care and interventions for those affected. In addition, the medication and psychosocial follow-up is too expensive for the majority of Kenyans who live on less than a dollar a day (KNBS, 2016). This hinders post treatment follow-up, affecting the eventual outcome of treatment leading to many relapses, treatment failures, and precipitates even more severe illness.

TASKFORCE RECOMMENDATIONS

The Taskforce notes that the Constitution of Kenya 2010 guarantees every citizen access to the highest attainable health to guarantee their physical, mental and social Wellbeing, and that includes mental healthcare. Further, the United Nations, in the Sustainable Development Goals (SDGs) 4.3 advocate for the reduction of premature mortality from non-communicable diseases and promotion of mental health and wellbeing through prevention and treatment (UN, 2015). These SDGs, to which Kenya is a signatory were adopted by member states in 2015.

Despite these provisions, it is apparent that most of the emphasis in our domestic health system focuses more on physical illnesses, delegating mental health and Wellbeing to the periphery. Treatment and care for the persons with mental illness has traditionally involved isolating them from the general public and society at large, whether in homes or institutions. This has led to widespread incarceration of persons with mental illness, further entrenched stigma and contributes to the high prevalence of mental disorders in the country (KNCHR, 2011). Evidence shows that mental health can be affected by non-health policies and practices, for example in housing, education, and childcare (WHO, 2003). This accentuates the need to assess the effectiveness of policy and practice interventions in diverse health and non-health areas.

Though there are uncertainties and gaps in the evidence, there is sufficient information and knowledge in global literature on the links between social experience and mental health to make a compelling case to apply and evaluate locally appropriate policy and practice interventions to promote mental health in Kenya. The Taskforce makes the following recommendations:

Declare mental health an emergency of epidemic proportions

This will require an interagency approach in dealing with mental health in the country, and the immediate formation of Mental Health and Happiness Commission that will coordinate the management of mental health issues. They will generate an annual national happiness index that will be included in the Presidential Annual Report along with Article 132(c)(i). The country should also recognise and observe 20th March, the International Day of Happiness in keeping with the UN declaration.

Establish amenities and facilities to provide recreational activities for the public

The Government to provide and maintain within the counties, parks and other such facilities with green spaces where citizens can relax and unwind, exercise and interact.

Ensure healthy working spaces

Institutions to develop and implement policies and programmes that create a working environment that is healthy. Every working place should provide avenues of seeking help for their staff and have a medical cover that provides access to a mental health practitioner or provider for professional care. This is to be facilitated through health insurance covers for mental healthcare.

Develop fully fledged wellness centres in learning institutions with psychologists

The Ministry of Health and the Ministry of Education together should ensure that all learning institutions in Kenya have fully fledged wellness centres with psychologists working in linkage with other supportive services. Children in schools should have access to School centred professional mental healthcare on demand just like the institution based nurses.

Promote mental health and wellness in families

The Government, through the Nyumba Kumi Initiative to work with families to promote all-inclusive parenting that includes mental health and wellness. Nyumba Kumi Initiative officers to work with local healthcare professionals and community structures like CHVs and religious organisations to develop messages to promote mental Wellbeing at the community level.

Encourage and promote physical fitness in communities, workplaces and schools

Physical activity is key to mental Wellbeing. Regular and adequate levels of physical activity reduce risk of non-communicable diseases including the risk of depression. The Taskforce recommends the active promotion of physical fitness in schools and workplaces by the relevant officials, and building and staffing of community sports centres in all the counties.

Mental health is everybody's business

Promote mental health in our individual capacities. Every able individual or organisation should strive in whatever manner, slight or big, to make an effort to promote mental health in their individual capacities. Particularly important are the decision-makers in governments at local and national levels whose actions affect mental health in ways that they may not realise. All senior managers in different levels of government should attend a basic mental health literacy course to be offered by officials from the Department of Mental Health at the Ministry of Health in conjunction with the Kenya School of Government

Carry out an annual Happiness Index Survey

Happiness can be measured by assessing an individual's emotional wellbeing as well as their global life satisfaction. This includes their capacity to attain their goals and maintain healthy relationships. Happiness survey can promote mental wellbeing through public policy. The collected data can be used to identify best happiness practices of government, businesses, schools, city planning, health systems, and other institutions in society.

Everyone requires good mental health. There is no health without mental health. Good mental health contributes to the economic prosperity of a nation while poor mental health stunts its progress. The voice of the people demands for urgent and immediate interventions to promote mental wellness.

CHAPTER THREE

THE BURDEN OF MENTAL ILLNESS

In Chapter 2 we discussed mental health, mental wellbeing and mental illness. In this Chapter, we focus in detail on the mental illness; who is affected and to what extent. In its hearings, the Taskforce heard about the high burden of mental illness among different groups of Kenyans. There exist high levels of depression and suicidal behaviour, high levels of mental distress and substance use. Suicide was repeatedly talked of by the general public, with the increasing trend of the younger age group in taking their own lives.

The impact of this health problem on the population can be measured using a variety of indicators such as the number of persons who die from the illness, the number of persons who suffer from the illness or the financial cost of the illness, to mention but a few. Unlike other illnesses, the greatest impact of mental ill health does not lie solely in the number of persons who die from the disease but mainly from the number of years of life lived with the disability following onset of the mental illness. The impact of mental ill health on individuals, families and communities is large. Individuals suffer the distressing symptoms of mental illness which often is chronic in nature. They also suffer because they are frequently unable to participate in work and leisure activities, often as a result of discrimination. They may worry about not being able to shoulder their responsibilities towards family and friends, and are fearful of being a burden for others. Families are not spared, they are expected not only to provide physical and emotional support, but also to bear the negative impact of stigma and discrimination. The financial impact is also substantive. Expenses for the treatment of mental illness often are borne by the family either because insurance is unavailable or because mental disorders are not fully covered by insurance.

It is critical to measure the burden of mental ill health in order to prioritise preventive and curative interventions in health and the environment, to identify high risk populations and to set priorities in health research.

The term mental illness is frequently used interchangeably with mental disorders and includes common conditions such as depression and anxiety, those due to abuse of alcohol and other substances, schizophrenia and bipolar disorder. Mental disorders often coexist with other neurological disorders such as epilepsy and dementia. Hence, lately these illnesses are commonly classified together as mental, neurological and substance use disorders (MNS).

Mental and neurological disorders are common and widespread with estimates showing that 1 in every 4 persons globally is likely to suffer from a form of mental health condition at some point in their life. Recent WHO estimates have found about 450 million people globally; currently suffer from mental disorders (WHO, 2013). This places these conditions among the leading causes of ill health and disability worldwide. The burden of mental illness in Kenya mirrors the high global rates reported. Indeed, it is for this very reason that the President on June 1st 2019 declared an urgent need to address the high media reports of depression, suicide and substance abuse in the country.

In the *Kenya Mental Health Policy 2015-2030*, the National Government estimates that the burden of mental illness is 25% among outpatients and 40% among inpatients in different health facilities, with an estimated prevalence of psychosis stated as 1% of the general population (Ministry of Health, 2015). Given the Kenya population of 47,564,296 as per the 2019 census, this means that 475,633 Kenyans are suffering from severe mental illnesses. The most common mental conditions in Kenya are depression, substance use disorder, bipolar mood disorder, schizophrenia and anxiety.

Lifetime prevalence of mental disorders in Western Kenya, Nandi County

■ Anxiety disorders

■ Major Depression disorders

■ Alcohol & substance use disorders

■ Suicide behaviour disorder

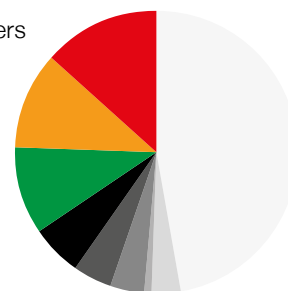
■ Bipolar mood disorder

■ PTSD

■ Psychotic disorders

■ Others

■ No mental disorder



In Kenya, a household survey conducted in 2013 in Western Kenya, Kisumu County found 1 in every 10 persons at the time had a common mental disorder (Jenkins R, Othieno C, Onger L, Sifuna P, Ongecha M, Kingora J, et al, 2015). More recently in 2016 another study conducted in Nandi County found close to half of the population had suffered at least one mental disorder in their lifetime with rates highest for depression and anxiety disorders (Kwobah E, Epstein S, Mwangi A, Litzelman D, Atwoli L, 2017), as summarised in the figure above. Estimates from general patients attending outpatient facilities for care revealed that 1 in every 4 persons has a mental illness while 4 in every 10 patients admitted in these facilities were suffering from a mental disorder (KNCHR 2011).



Depression

Depending on the number and severity of symptoms, a depressive episode can be categorised as mild, moderate or severe. A key distinction is also made between depression in people who have or do not have a history of manic episodes. Both types of depression can be chronic (i.e. over an extended period) with relapses, especially if they go untreated.

Depression is a leading cause of disability worldwide (GBD 2016). An estimated 264 million people are affected by depression globally. Depression is more common among females (5.1%) than males (3.6%). Prevalence varies by age, peaking in older adulthood (above 7.5% among females aged 55-74 years, and above 5.5% among males). Depression also occurs in children and adolescents below the age of 15 years, but at a lower level than older age groups.

Kenya was ranked 4th in Africa having an estimated 1.9 million people with the condition. What this means is that Kenyans are amongst the most depressed Africans. A number of local studies have found depression to be the most frequently diagnosed mental illness. At its worst, depression can lead to suicide. Depressive disorders and schizophrenia are responsible for 60% of all suicides.

Suicide

Suicide is defined as death caused by self-directed injurious act with intent to die. A suicide attempt is a non-fatal, self-directed, potentially injurious act with intent to die. A suicide attempt might not result in injury. Suicidal ideation refers to thinking about, considering, or planning suicide.

Suicide is an extreme but not uncommon outcome for people with untreated mental disorders. Suicide accounts for approximately 1.4% of deaths globally and is the 15th leading cause of death overall and the second leading cause of death among 15-19 year olds. Close to 800,000 people die globally due to suicide every year, this translates to one person every 40 seconds. Of note is 79% of these reported suicides occur in low and middle income countries.

WHO statistics (GHO, 2016) estimates an annual global age-standardised suicide rate of 10.5 per 100,000 populations. Suicide rates are under-reported both globally and locally due to a number of factors including the illegality of suicidal behaviour leading to fear of stigma and persecution and lack of a formal data collection mechanism for suicide data. In 2014, Kenya's mortality rate due to suicide ranked 29th worldwide with an estimate of 5.6 per 100,000 deaths (WHO 2015).

The Kenya National Bureau of Statistics indicates that 421 deaths in 2018 were as a result of suicide. Local estimates of suicide from verbal autopsy data collected in Kilifi between 2008-2016 found the mean annual incidence rate of suicide was 4.61 per 100,000, male suicide rate was 3 times more than in females (Bitta MA, Bakolis I, Kariuki SM, Nyutu G, Mochama G, Thornicroft G, et al, 2018).

For every adult who has died by suicide there have been more than 20 others attempting suicide (WHO, 2018). A household survey in Western Kenya found 1.9% of the study population had attempted suicide in their lifetime (Jenkins R, Othieno C, Omollo R, Ongeru L, Sifuna P, Ongecha M, et al, 2015). Studies done among hospital patients groups have found significantly higher reports of suicidal attempts. One study at the coast found 4% of outpatients had had a suicidal attempt in the past one month and 17% had attempted suicide over their lifetime (Ongeru L, McCulloch CE, Neylan TC, Bukusi E, Macfarlane SB, Othieno C, et al, 2018). Similar findings were also seen in a study in Western Kenya that found a 16% lifetime diagnosis of suicidal attempts (Kwobah E, Epstein S, Mwangi A, Litzelman D, Atwoli L).

Substance use

Substance use disorder describes the wide range of disorders from a mild form to a severe state of chronically relapsing, compulsive drug taking. It includes both aspects of harmful use and addictive syndrome. Harmful use is defined by a pattern of substance use that is causing damage to health while addictive syndrome describes a cluster of physiological, Behavioural, and cognitive symptoms in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.

Substance use disorders are associated with a significant disease burden and the highest mortality among all mental and Behavioural disorders. For example, the mortality ratio, compared to the general population, is about 5 times higher for alcohol use disorders (Chesney E, Goodwin GM, Fazel S, 2014). Alcohol and illicit drug use account for 5.4% of the world's annual disease burden, with tobacco responsible for 3.7%. Many more people suffer from alcohol use disorders compared to drug use disorders, and both types are more common in men than women. Alcohol causes the highest demand for treatment of substance use disorders. Alcohol kills every year 35 people while illicit drugs kill four people per every 100,000 people. (WHO | ATLAS 2010: 2010).

In Kenya and globally substance use contributes significantly to mental illness and current surveys indicate that the trends are rising. The STEPWISE survey done by Ministry of Health in 2015 found a worryingly high prevalence of Heavy Episodic Drinking (HED) in Kenya at 12.6% (Kendagor A, Gathecha G, Ntakuka MW, Nyakundi P, Gathere S, Kiptui D, et al, 2015). HED is defined as consumption of 60 or more grams of pure alcohol (6+ standard drinks in most countries) on at least one single occasion per month. Even more troubling was that the highest proportion of HED was reported in the 18-29 year age group (35.5%). These are youth expected to be at their peak productivity.

Substance use among college and university students predicts substance related problems in later life. A study that assessed substance use among this population groups in 4 tertiary learning institutions in Kenya found the lifetime prevalence of any substance use was 69.8%, specifically lifetime prevalence of alcohol use was 51.9%, and 97.6% of alcohol users had consumed alcohol in the week prior to the study (Atwoli L, Mungla PA, Ndung'u MN, Kinoti KC, Ogot EM, 2011).

Recent data from a survey on Drugs and Substance Abuse among Primary School Pupils in Kenya¹ indicates that at least 17% of pupils in primary schools are abusing drugs. Worryingly, the NACADA, 2019 report indicates the problem is increasing among younger age groups – as low as 4 years, while the average was 8 years less than a decade ago. Data from the survey shows 7.2% were currently using prescription drugs; 3.2% were using tobacco, 2.6% were using alcohol, 2.3% *miraa*/muguka, 1.2% were using inhalants and 1.2% heroin. The report shows 20.2% of primary school pupils have used at least one drug in their lifetime.

At secondary school level the data shows that 9.3% use alcohol, 6.8% prescription drugs, 5.9% use *khat*/*miraa*, tobacco 5.2%, *bhang* at 3.7%, inhalants at 0.8% while heroin and cocaine both at 0.4%.

Despite the relatively lower prevalence of heroin and other opioid use in Kenya their use is accompanied by severe health, psychological, economic, legal, and social consequences (Strathdee SA, Stockman JK, 2010). Injecting drug users (IDUs) have a markedly high risk of acquiring HIV and other blood-borne pathogens as a result of sharing contaminated syringes and other injecting equipment as well as from unprotected sex (Degenhardt L, Peacock A, Colledge S, Leung J, Grebely J, Vickerman P, et al, 2017). Injecting drug use accounts for nearly 10% of HIV infections globally (Mathers BM, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee SA, et al, 2008).

Maternal Depression

Maternal depression refers to a depressive episode that ranges from mild to major severity in the antepartum or postpartum period. It is a key contributor of pregnancy-related morbidity. Maternal depression has been linked to adverse outcomes, including psychological and developmental disturbances in infants, children, and adolescents.

Despite its enormous burden, maternal depression in low-income and middle-income countries remains under-recognised and undertreated. Prevalence estimates of postpartum depression are higher in low and middle income countries at 20% compared to high income countries at 10% (Gelaye B, Rondon MB, Araya R, Williams MA, 2016). In Kenya, a high prevalence of postpartum depression has been reported at 18.7% (Ongeri L, Wanga V, Otieno P, Mbui J, Juma E, Stoep A Vander, et al, 2018) among women attending maternal and child health clinics in Nairobi.

Mental health problems in children and adolescents

Mental health problems in children and adolescents are of concern because of their high prevalence and the accompanying disabilities. A subset of these mental health conditions referred to as neurodevelopmental disorders manifest early in development bringing about deficits in the child. These include autism, intellectual disability, attention deficit and hyperactivity disorders among others. In Sub-Saharan Africa, child mental health problems occur in about 14.3% of this population. The most commonly identified mental health disorders are emotional problems (including depression), anxiety disorders, conduct, disruptive, and reactive behaviour disorders; and post traumatic stress disorder (Cortina MA, Sodha A, Fazel M, Ramchandani PG, 2012).

A community survey at the coast of Kenya for preschool children found that 13% of this population group had Behavioural and emotional problems (Kariuki SM, Abubakar A, Kombe M, Kazungu M, Odhiambo R, Stein A, et al 2017). Another study focused on school going children found an even higher prevalence (37.7%) of mental disorders. Somatic complaints were the most prevalent (29.6%) followed by mood disorders (14.1%) and conduct disorder (12.5%) (Ndeti DM, Mutiso V, Musyimi C, Mokaya AG, Anderson KK, McKenzie K, et al, 2016).

A survey among 166 patients and their guardians in an adolescent mental health clinic at a tertiary referral hospital (KNH youth clinic) found substance use disorders to be most prevalent (30.1%) followed by depressive disorders (13.9%). Most referrals to the clinic were made by medical practitioners and teachers. The mean time to access care following symptom onset was >1yr (16.6 mo), emphasising the need for timely child and adolescent mental health service delivery and involvement of various stakeholders including the education sector (Kamau JW, Omigbodun OO, Bella-Awusah T, Adedokun B, 2017).

¹ <http://www.nacada.go.ke/documents-and-resources/category/8-statistics-research-survey-findings?download=40:rapid-assessment-of-alcohol-and-drug-abuse-situation-in-kenya-2012>. Accessed 29 Jan 2016

Trauma and PTSD

Kenya is a traumatised nation. This is evidenced by the trans generational exposure to trauma its citizens have experienced. Spanning from historical atrocities committed during the colonial era, massacres, extra judicial killings, sexual violence and displacement during post-election violence as well as the recurring terror attacks and general pervasive disasters and insecurity in the country. Of critical importance is the cyclical nature of trauma. Trauma perpetuates trauma. Research evidence shows that persons who experience trauma are at a high risk of inflicting trauma. It's imperative that this cycle is broken for restoration of Kenya's mental health.

An estimated 3.6% of the world's population has suffered from post-traumatic stress disorder (PTSD) in the previous year (https://www.who.int/mediacentre/news/releases/2013/trauma_mental_health_20130806/en/). Post-traumatic stress disorder refers to a syndrome resulting from exposure to real or threatened serious injury or sexual assault. It commonly manifests with three main types of symptoms: Re-experiencing the trauma through intrusive distressing recollections of the event, flashbacks, and nightmares. Emotional numbness and avoidance of places, people, and activities that are reminders of the trauma. Increased arousal such as difficulty sleeping and concentrating, feeling jumpy, and being easily irritated and angered.

In Kenya a number of studies have been undertaken on trauma and post-traumatic stress disorder. A household survey in Western Kenya found 48% of the study population had experienced a traumatic event and 10.6% had probable post-traumatic stress disorder (Jenkins R, Othieno C, Omollo R, Ongeri L, Sifuna P, Mboroki JK, et al, 2015) Trauma and PTSD is not only limited to adults but also occurs in children and adolescents. A Kenyan study that assessed children aged between 11 and 17 years found a high proportion of school children had witnessed people being shot at, beaten up or killed (46.9%) or had heard about the violent death or serious injury of a loved one (42.0%). Over one quarter (26.8%) had PTSD (Mbwayo AW, Mathai M, Harder VS, Nicodimos S, Vander Stoep A, 2019).

A different study examined PTSD rates among Mau Mau survivors and found 65% of these survivors had this diagnosis 50 years after the traumatic event (Atwoli L, Kathuku DM, Ndeti DM, 2006). A study that focused on the internally displaced following the 2007 post-election violence found equally high rates at 62.1% (Musau J, Munene A, Khasakhala L, 2017).

Terrorism is a constant reality in Kenya. Since the August 7th 1998 terror attack on the American Embassy in Nairobi, Kenyans have witnessed attacks in Garissa, Westgate Mall and most recently at Dusit D2. Many people continue to carry psychological wounds sustained in these acts of terror. In a naturalistic study following the bombing in Nairobi (Njenga et al (2004). Njenga et al found a prevalence of 35% in 2883 Kenyans, 1-3 months after the bombing. Those who witnessed the blast, as well as those injured were at the highest risk of symptoms. Acts of terror continue to be a real threat and must be viewed as a contributor to mental ill health in Kenya.

Not only does exposure to trauma and PTSD have a strong link with substance use disorders, violence, depression and suicide they additionally impact on physical health and Wellbeing. This and the fact that historical and cultural traumas have been shown to affect survivors' children for generations to come underscores the need for immediate action.

Table 2: Summary of the global and national rates of mental disorders

Mental Health Condition	Global	Kenya
Mental Illness	1 in every 4	1 in every 2 ²
Depression	4.5% of world population in 2015 ³	12.6% of 420 persons in a community survey ⁴
Anxiety	3.6% of world population in 2015 ⁵	15.7% of 420 persons in a community survey ⁴
Suicide	10.5 per 100,000 persons ⁴	4.61 per 100,000 persons ⁵
Heavy episodic alcohol use	16% of drinkers in the world population ⁶	12.6% of Kenyan drinkers engage in Heavy episodic drinking ⁷
PTSD	3.6% ⁸	4.5% ⁴

Despite this high prevalence, routine diagnosis of psychiatric morbidity is poor; most mental health conditions go unnoticed, resulting in a high burden of undiagnosed mental illnesses in the country. A study done in a rural district in the country concluded that mental disorders are common in Kenya and rates are elevated among people who are older, and those in poor health. (Jenkins et al., 2012). A notable outcome of this state is the frequent reports in the print and electronic media of suicides by both the young and the old members of society, homicides, domestic violence and other signs of mental turmoil in different parts of the nation.

- 2 Kwobah E, Epstein S, Mwangi A, Litzelman D, Atwoli L. PREVALENCE of psychiatric morbidity in a community sample in Western Kenya. *BMC Psychiatry*. 2017;17:30. doi:10.1186/s12888-017-1202-9.
- 3 WHO-MSD-MER-2017.2
- 4 https://www.who.int/gho/mental_health/suicide_rates/en/
- 5 Bitta MA, Bakolis I, Kariuki SM, Nyutu G, Mochama G, Thornicroft G, et al. Suicide in a rural area of coastal Kenya. *BMC Psychiatry*. 2018;18:267. doi:10.1186/s12888-018-1855-8. . 8. Kendagor A, Gathecha G, Ntakuka MW, Nyakundi P, Gathere S, Kiptui D, et al. Prevalence and determinants of heavy episodic drinking among adults in Kenya: analysis of the STEPwise survey, 2015. *BMC Public Health*. 2018;18:1216. doi:10.1186/s12889-018-6057-6.
- 6 https://www.who.int/substance_abuse/facts/alcohol/en/
- 7 Kendagor A, Gathecha G, Ntakuka MW, Nyakundi P, Gathere S, Kiptui D, et al. Prevalence and determinants of heavy episodic drinking among adults in Kenya: analysis of the STEPwise survey, 2015. *BMC Public Health*. 2018;18:1216. doi:10.1186/s12889-018-6057-6.
- 8 https://www.who.int/mediacentre/news/releases/2013/trauma_mental_health_20130806/en/

WHAT KENYANS SAID

- The Kenyan public in hearings across the country reiterated the global views mentioned above. The Taskforce heard of **high levels of depression and suicidal behaviour** among specific groups. These include students who suffer from examination stress and health professionals with burnout. Persons with substance use disorders were mentioned as having higher rates of depression and suicide.
- Kenyans in all hearings attributed the **high level of mental distress** to the divisive nature of our politics especially around election time. They said that elections in the country perpetuate fear and distress in them and re-traumatised persons who had prior exposure to post election related violence, *“suicides are due to land issues and..., post-election violence and trauma”*.
- **Substance use** was a priority issue in all counties visited. Substance use was especially highlighted at the coast region with specific concern raised for heroin and khat use. In Garissa, there was a public outcry on khat use and its negative impact on the residents. In all other counties visited the greatest concern was for **alcohol abuse**. The disquieted voices of women and the youth were particularly distinct in their distress about the adverse effects of heavy alcohol use in their community. Women said that the pervasive use of alcohol by their men was a catalyst for family disintegration, violence, depression and suicide.
- **Teenage and youth depression** was of great concern. On a repeated basis, the current high rate of suicide was raised by the general public. They expressed concern at the increasing trend of the younger age group taking their own lives. One comment from a participant was *“suicide has increasingly become an option for the teenager when it should not”*.
- **Maternal depression** was of special concern for women in Garissa and Nairobi. The women echoed the desk review findings that postpartum depression though common was often missed and many mothers went untreated. In Nairobi, women linked postpartum depression with the high rates of gender based violence. In Garissa, they said it was complicated by traumatic deliveries secondary to female genital mutilation.

TASKFORCE RECOMMENDATIONS

The high burden of mental ill health found from both the review of existing studies as well as from the public hearings, emphasises an urgent need to increase access to mental health care services from the community level to the tertiary level facilities. Besides facility based care, provision of psychological care at all workplaces and learning institution offers both a preventive, promotive and care solution to tackling this problem. Specifically, the Taskforce recommends that;

A national mental health survey be conducted in the country

Though a substantial number of studies have been conducted examining the burden of mental illness, majority have been region and population specific and hence may not be easily generalised to the entire country. Due to this limitation, the Taskforce recommends that the government conducts a national mental health survey to better define the burden of mental illness in the country.

Declare mental health a National Public Health Emergency

The high burden of mental illness is a threat to national development and necessitates the President to declare mental health a National Public Health Emergency. This will imply calling for an interagency approach to deal with mental health in the country and the establishment of mental health and happiness commission to coordinate, including generating an annual national happiness index that will be included in the Presidential Annual Report along with Article 132(c)(i).

Urgently avail funds to implement promotive, preventive and curative interventions to reduce the burden of mental illness

Funds geared towards research and setting up of structures that allow for systematic data collection to monitor trends in mental ill health disease burden are crucial and will go a long way in addressing this high burden.

Decriminalise suicide

This will help to reduce stigma and discrimination and in turn encourage early identification, management and follow-up of people at risk of suicide. There should be restriction to the means used for example access to firearms. The Taskforce recommends educating the media on responsible reporting of suicide; implementing programmes among young people to build life skills that enable them to cope with the stresses of life.

CHAPTER FOUR

MENTAL HEALTH AND SPECIAL POPULATIONS

Special populations are groups whose needs require special consideration and attention and may not be fully addressed by primary health care service providers. These groups may require specialised care either structurally or functionally. Structural characteristics are defined by age and gender. Functional characteristics are social, clinical or legal conditions shared by a certain group such as coexisting mental illness, being in prison settings or having a similar occupation. Special populations are therefore defined by age, occupation, biological, psychological and social characteristics (Ministry of Health, 2017).

Mental illnesses are not easily identified in these key vulnerable populations that include young children, adolescents, the youth, the senior citizens, gender based violence survivors, people living with chronic physical illnesses, people living with HIV/AIDS, refugees, security personnel, persons with physical disability, Lesbian, Gay, Bisexual and Transgender (LGBT) community and the boy child. In these groups, the burden of mental conditions could even be higher than that of the general public. This chapter presents a discussion on mental health and special populations, their experiences and what these groups told the task force.

4.1 CHILDREN BELOW 10 YEARS AND MENTAL HEALTH

Children can develop the same mental health conditions as adults, but their symptoms may be different. Mental illness in children can be hard for parents to identify. As a result, many children who could benefit from treatment do not get the help they need. Young children exhibit mental illness in vague and dramatic ways such as bed-wetting and school phobia that evade clinicians when they are taken for treatment. Even if you know the red flags, it can be difficult to distinguish signs of a problem from normal childhood behaviour. You might reason that every child displays some of these signs at some point. Children often lack the vocabulary or developmental ability to explain their concerns. Concerns about the stigma associated with mental illness, the use of certain medications, and the cost or logistical challenges of treatment might also prevent parents from seeking care for a child who has a suspected mental illness.

Children with depression will often show more irritability than depressed adults who more typically show sadness. They can experience a range of mental health conditions, including:

Anxiety disorders

Children who have mental conditions such as obsessive-compulsive disorder, post-traumatic stress disorder, social phobia and generalised anxiety disorder, experience anxiety as a persistent problem that interferes with their daily activities. Unfortunately, anxiety could be a normal part of every child's experience, often changing from one developmental stage to the next. However, when worry or stress makes it hard for a child to function normally, an anxiety disorder should be considered;

Attention-deficit/hyperactivity disorder (ADHD)

This condition typically includes symptoms in difficulty paying attention, hyperactivity and impulsive behaviour. Some children with ADHD have symptoms in all of these categories, while others might have symptoms in only one;

Autism spectrum disorder (ASD)

Autism spectrum disorder is a serious developmental disorder that appears in early childhood — usually before the age 3. Though symptoms and severity vary, ASD always affects a child's ability to communicate and interact with others;

Eating disorders

Eating disorders — such as anorexia nervosa, bulimia nervosa and binge-eating disorder — are serious, even life-threatening, conditions. Children can become so preoccupied with food and weight that they focus on little else; and

Mood dysregulation

Mood dysregulation conditions — such as depression and bipolar disorder — can cause a child to experience persistent feelings of sadness or extreme mood swings much more severe than the normal mood swings common in many people.

PTSD

PTSD has also been reported in children.



Warning signs that a child might have a mental illness include:

- **Mood changes.** Look for feelings of sadness or withdrawal that last at least two weeks or severe mood swings that cause problems in relationships at home or school;
- **Intense feelings.** Be aware of feelings of overwhelming fear for no reason sometimes with a racing heart or fast breathing or worries or fears intense enough to interfere with daily activities;
- **Behaviour changes.** These include drastic changes in behaviour or personality, as well as dangerous or out-of-control behaviour. Fighting frequently, using weapons and expressing a desire to badly hurt others also are warning signs;
- **Difficulty concentrating.** Look out for signs of trouble focusing or sitting still, both of which might lead to poor performance in school;
- **Unexplained weight loss.** A sudden loss of appetite, frequent vomiting or use of laxatives might indicate an eating disorder;
- **Physical symptoms.** Compared with adults, children with a mental health condition might develop headaches and stomach aches rather than sadness or anxiety;
- **Physical harm.** Sometimes a mental health condition leads to self-injury, also called self-harm. This is the act of deliberately harming your own body, such as cutting or burning yourself. Children with a mental health condition also might develop suicidal thoughts or attempt suicide; and
- **Substance abuse.** Some children use drugs or alcohol to try to cope with their feelings. Mental illnesses in children can be diagnosed and treated based on the signs and symptoms presenting and on how the condition affects a child's daily life. The child will require closer than usual parental/guardian support when unwell. In Kenya, the average median age of onset of at least one drug or substance of abuse was 11 years while the lowest reported age of onset to drugs and substances of abuse was 4 years (NACADA/KIPPRA, 2019).

WHAT KENYANS SAID

During the public hearings, the Taskforce heard that;

- Children who suffer from mental illness are tied up and hidden away from the public. They do not attend school and are stigmatised and discriminated against.
- According to NACADA findings, children as young as 4 years old are using substances of abuse. The same concern was also raised by members of the public.

TASKFORCE RECOMMENDATIONS

- The Taskforce recommends that Parents/guardians be very observant in order to be able to detect signs of mental illness. It also recommends family education sessions on children and mental health for those with mentally ill children through the *Nyumba Kumi Initiative*, working closely with community health volunteers.
- The government, through the Health Ministry should establish inclusive mental health care services to cater for all ages. The primary healthcare ecosystem should be well staffed with competent professionals in mental health diagnosis and treatment so that it's able to cater to the needs of children with mental health conditions.

4.2 ADOLESCENTS AND MENTAL HEALTH

Adolescence refers to the period marking the transition from childhood to adulthood. Historically, this typically spans from 12 to 18 years of age. It is a unique and formative time (Jaworska & Macqueen, 2015). Adolescence is a crucial period for developing and maintaining social and emotional habits important for mental Wellbeing. These include adopting healthy sleep patterns; taking regular exercises; developing coping, problem-solving, and interpersonal skills; and learning to manage emotions. Supportive environments in the family, at school and in the wider community are also important.

An estimated 10–20% of adolescents globally experience mental health conditions, yet these remain underdiagnosed and undertreated (WHO, 2014). Globally, depression is the fourth leading cause of illness and disability among adolescents aged 15-19 years and fifteenth for those aged 10-14 years. Anxiety is the ninth leading cause for adolescents aged 15-19 years and sixth for those aged 10-14 years.

Emotional disorders can profoundly affect areas like schoolwork and school attendance. Social withdrawal can lead to isolation and loneliness. At its worst, depression can lead to suicide (KESSLER et al., 2007). Adolescents undergo significant distress during this important transitional period. In a study on PTSD in Kenyan and South African youth, it was established that 80% of the subjects reported exposure to severe trauma either as victims or as witnesses. Kenyan adolescents, compared with South African, had significantly higher rates of exposure to witnessing violence (69% v. 58%), physical assault by a family member (27% v. 14%) and sexual assault (18% v. 14%) (Seedat, et al, 2004).

WHAT KENYANS SAID

Key contributors to adverse mental health conditions among adolescents were expressed as;

- Absentee parenting and experimentation with drugs and other substances of abuse leading to significant mental health challenges.
- Youth unemployment.

TASKFORCE RECOMMENDATIONS

Psychosocial services should be made available to adolescents

Youth counsellors should be employed in primary schools to provide counselling services. School nurses should be required to undertake training on youth and adolescent health in order to better meet the needs of adolescents.

Build capacity for teachers to identify and help the affected children in schools

School teachers should be trained in child psychology and development to better assess their students and intervene whenever they notice any changes that denote mental health conditions in this age category.

4.3 THE YOUTH AND MENTAL HEALTH

Youth is best understood as a period of transition from the dependence of childhood to adulthood's independence. Several UN entities, instruments and regional organisations have somewhat different definitions of youth. However, the definition used in this document is 15-24 age cohort because it serves its statistical purposes for assessing the needs of the young people and providing guidelines for youth development (United Nations, 2014).

A report by the Kenya Mental Health Youth Coalition (KMHYC), states that Kenyan adolescents and youth face several challenges leading to mental health conditions. With youth unemployment at about 40% and increased pressure for adolescents to perform in school and new media exposures, mental health for this cohort is bound to worsen as the socio-economic fabric of the society weakens. Poverty, gender inequity and human rights violations are shown to increase the incidence of mental health problems, and vice versa.

Mental health conditions also correspond to the decreased ability to make rational choices and increase the probability of risky sexual behaviour and substance abuse. This can lead to more unintended pregnancies, STIs-including HIV-and a higher risk of being either the victim or perpetrator of GBV. Among adolescents and youth, the problems they face include relationship and social pressures, prenatal depression and suicide; the mental and psychological consequences of miscarriage, abortion or complications stemming from pregnancy and childbirth, lack of support following childbirth, gender-based violence (GBV) and HIV/AIDS.

The youth raised grave concerns on the state of their mental health. They were emphatic that the prevention and treatment of mental health problems is not only critical to their general Wellbeing, but also necessary to prevent problems relating to sexual and reproductive health.

WHAT THE YOUTH SAID

- The youth urged the Taskforce to provide mechanisms to safeguard them from elements that affect their mental health and that of their peers. They were particularly emphatic on three themes:
- **Loans from the Higher Education Loans Board (HELB)** – They said that despite the benefit accorded to them by HELB loans to pursue their education, the loan should be interest free. They also decried the listing of defaulters on social media and newspapers and asked that it stops with immediate effect.
 - » **That gambling and sports betting should be strictly regulated** and measures taken by gaming operators to assist those who are addicted and suffering from problem gambling as a result of addiction.
 - » **The marketing of alcohol, cigarettes and substances of abuse should be strictly regulated.** Drinking hours should be limited citing the case of Botswana where alcohol is not sold in retail stores after 6pm, and all establishments that sell alcohol be closed by 10pm.
- They wanted to be involved in policy making and implementation so that they can have peer led interventions that are non-discriminatory and relevant to them.
- They also lamented that joblessness is on the rise and many of them were languishing in poverty despite having educational qualifications. They asked that employee internship programmes in state and non-state agencies be offered to graduates and that the Ministry of Public Service, Youth and Gender coordinate the activity.

TASKFORCE RECOMMENDATION

The Taskforce fully supports youth empowerment and recommends the implementation of the above by the relevant ministries and government bodies.

4.4 MATERNAL MENTAL HEALTH

Worldwide, about 10% of pregnant women and 13% of women who have just given birth, experience a mental disorder, primarily depression (postpartum depression). In developing countries this is even higher, i.e. 15.6% during pregnancy and 19.8% after childbirth. Maternal mental disorders negatively affect the growth and development of their children. Maternal mental disorders are treatable and there are effective interventions that can be delivered even by well-trained non-specialist health providers. **Kenyans told the Taskforce that general health care-givers do not easily recognise postpartum depression.**

TASKFORCE RECOMMENDATIONS

Integrate mental health services with antenatal and postnatal care

Women should be educated on the potential to develop mental health conditions during pregnancy and in the immediate postpartum period. They should also be taught how to recognise signs and symptoms and early for self-care during ANC visits by trained personnel. They should also be counselled on the potential outcome of the pregnancy to prepare them should a child develop neurodevelopmental conditions.

Build capacity for general health care providers to identify and manage postpartum depression

General medical personnel in primary healthcare facilities e.g. dispensaries should be trained in mental health and the management of maternal mental health conditions for early treatment and referral.

4.5 SENIOR CITIZENS AND MENTAL HEALTH

Senior citizens are older adults, defined as those aged 60 years and above. While most senior citizens have good mental health, many are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis that will affect their mental health status.

Mental and neurological disorders among senior citizens account for 6.6% of the total disability (DALYs) for this age group and approximately 15% of adults aged 60 and over suffer from a mental disorder. The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed (Yasamy, Dua, Harper, & Saxena, 2013).

TASKFORCE RECOMMENDATIONS

The Taskforce heard a very clear voice from the senior citizens who noted that their mental health needs are neglected.

- Mental health services should be mainstreamed in all sectors and be cognisant of mental health of senior citizens including those in the pre-retirement age.
- Accessible senior citizens' healthcare programmes should be implemented for them and measures taken to reduce long stays and queues and provide specialised geriatric attention at the health facilities in the country.
- Initiate senior citizens' social groups and include senior citizens in community activities to keep the dignity and love alive as their memories are affected.

4.6 REFUGEES AND MENTAL HEALTH

Traditionally, the refugee experience is divided into three stages: pre-flight, flight, and resettlement. The pre-flight phase may include, for example, losses of family members, livelihoods, and belongings, paired with possible physical and emotional trauma to the individual or family, the experience of witnessing extreme violence, and social upheaval. Adolescents may also have participated in violence, voluntarily or not, as child soldiers or militants (Nicholson, 2016).

The flight phase involves an uncertain journey from the home area to the resettlement site and may involve arduous travel, refugee camps, and/or detention centres, often including further losses and traumatic stressors. Children and adolescents are often separated from their families and at the mercy of others for care and protection.

The resettlement process includes challenges such as the loss of culture, community, and language, as well as the need to adapt to a new and foreign environment. Children often straddle the old and new cultures, as they learn new languages and cultural norms more quickly than their elders. All of these experiences may play a role in the acquisition of, or protection from, mental health conditions in each individual within a refugee population (Nicholson, 2016).

The more common mental health diagnoses associated with refugee populations are depressive and anxiety disorders, including PTSD, generalised anxiety, panic attacks, adjustment disorder, and somatisation. The incidence of disorders varies with different populations and their experiences. Researchers studying settled refugees have found rates of PTSD and major depression of 5-15% or 10-40%, depending on the study. Children and adolescents from refugee camps often have higher prevalence, with various investigations revealing rates of PTSD from 50-90% and major depression from 6-40%. Risk factors for the development of mental health problems among refugees include the trauma experienced, delayed asylum application process, detention, and loss of culture and support systems.

WHAT KENYANS SAID

Kenyans said:

- Refugees have no socioeconomic opportunities.
- They undergo trauma, torture and documentation challenges.
- They are anxious of their security in their host country.

TASKFORCE RECOMMENDATION

The government and the relevant bodies **provide a supportive environment where affected populations can access basic needs**, maintain or form new social connections and relationships, and be supported in pursuing educational and economic opportunities.

4.7 PRISONERS AND MENTAL HEALTH

Mental health issues are common in prisons. The disproportionately high rate of mental disorders in prisons is related to several factors. These include:

- Widespread misconception that all people with mental disorders are a danger to the public;
- General intolerance of many societies to difficult or disturbing behaviour;
- Failure to promote treatment, care and rehabilitation; and
- Lack of, or poor access to, mental health services in many countries.

Many of these disorders may be present before admission to prison, and may be further exacerbated by the stress of imprisonment. However, mental disorders may also develop during imprisonment itself due to the prevailing harsh conditions and possibly due to torture or other human rights violations (Challenge, 2005). Evidence shows that the criminal justice system deals with mental illness in a profoundly broken way, leading to tremendous anguish and suffering among mentally ill people locked away behind bars, as well as to high rates of re-offense once prisoners go back into the community. This compounds social and economic costs of untreated mental illness and substance-use disorders (World Bank Group, 2018).

When persons with mental illness end up in the criminal justice system, their health tends to worsen more than others and are susceptible to medical neglect and abuse. This is hardly surprising because ultimately the mission of jails and prisons is punishment, not medical care.

On the other hand, not all the effects occur inside the criminal justice system; many people with mental illness cycle back and forth between jail or prison and living in the community. They have an elevated risk of all-cause mortality, including suicide, both while in custody and soon after release. Data from different countries shows that as many as half the people in jails and prisons have a mental disorder (World Bank Group, 2018).

Mathari National Teaching and Referral Hospital Forensic Unit

Mathari Hospital is the national referral and teaching hospital. Its official capacity is 750. There are two wings: the civil wing for routine mental healthcare and a maximum security unit for mentally ill offenders and for other persons with mental illness referred for assessment and treatment within the criminal justice system (Njenga, 2002).

What the Taskforce found out

The forensic unit where patients are reviewed for capability to answer charges in court is grossly overcrowded and some patients had been there for a very long period of time. The effectiveness of the unit to meet its original intent was found to be wanting and the members of the Taskforce were unanimous in the decision that it urgently requires a complete overhaul.

- At the prisons service, the Taskforce held discussions with both prison service providers and the users (prisoners). It was clear that the flaws and delays in the criminal justice system process in admission and discharge of mentally ill offenders to the forensic psychiatric unit denied the patients fair administration of justice and access to mental healthcare.
- Mental health care services are inadequate at the institutions in the country; and prisons service providers need to undergo regular psychological counselling for their own mental wellbeing.
- Many convicted persons on petty offenses were people with undiagnosed and untreated mental health conditions whom may have benefited from mental health screening in the criminal justice system.

TASKFORCE RECOMMENDATIONS

- The Government should increase the number of mental health care providers at prison institutions in the country.
- The delay in the conclusion of inmates' cases was a significant stressor. The judiciary should be streamlined to act upon inmate cases in a judicious manner and dispense with them rapidly.
- The Kenya Prisons Service should adopt prison system reforms that include effective mental health treatment, care, and rehabilitation programmes that focus on the whole person.
- Adopt effective service pathways. For the healthcare providers working in forensic psychiatric units and criminal justice system, effective service pathways will include:
 - » Screening for mental illness and substance-use disorders to ensure case identification at reception and at other critical times;
 - » Referral to specialised facilities for offenders with serious mental illness; and
 - » Release planning to ensure continuity of care across health care and social services providers in the community. This requires a concerted effort to overcome the criminalisation of mental illness by offering comprehensive physical and mental health services during incarceration and to support transition to community life after prisoners are released.

4.8 SECURITY OFFICERS AND MENTAL HEALTH

An officer's mental state affects his or her behaviour. It can influence decision-making and judgment. The daily realities of the job can also affect the officers' health and wellness. They face a constant need to be vigilant, long hours and shift work, exposure to the daily tragedies of life and regular interaction with people who are in crisis or hostile toward them. Disciplined officers experience mental health challenges in a number of ways, including:

- **Army Officers** – they are often deployed to the frontlines where they experience extreme violence and endure the possibility of their own mortality. They also have to follow orders and they too cause the mortality of opposing forces. PTSD and depression are prevalent among army officers.
- **Security personnel** usually offer the first response in emergencies and often experience catastrophic scenes such as injuries and mangled bodies at accident scenes. Sometimes they get involved in shootouts where people die of bullet wounds. Each day in their work day, they stare death in the face. In spite of this, they lack systematic access to treatment and counselling because their training emphasises physicality with little to no emotional preparation for the unsettling circumstances they face on the job. As a result, they suffer significant rates of depression and Post-Traumatic Stress Disorder (PTSD).
- **Prison service officers** encounter verbal abuse and physical assault from prisoners.
- Stress and childhood traumas have been identified as possible risk factors for mental health problems among **security guards**.
- Traumatic law enforcement work has been shown to increase officers' risk of developing Post-Traumatic Stress disorder (PTSD) symptoms. PTSD is associated with major depression, panic attacks, phobias, mania, substance abuse, and increased risk of suicide.

WHAT THE OFFICERS SAID

- Members of the disciplined forces experience mental health challenges in their different lines of duty. They are normally called to assist at accident and incident scenes (murder, accidents, war and insurgencies to mention but a few), where they see and retrieve bodies from horrifying scenes. This leads to immense psychological trauma from among their ranks.
- Officers stay long days away from family, they are regularly transferred and are posted far from their families and homes. As a result, their marriages are affected and they do not get to understand nor bond well with their children.

TASKFORCE RECOMMENDATIONS

- The different security service institutions must **provide psychological services** for both managers and staff at disciplined institutions.
- The institutions should **establish regular staff support sessions on mental health in workplaces for the officers**.
- The government through the Ministry of Health should **mainstream mental health in all sectors** including the disciplined forces.

4.9 THE LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) POPULATIONS

The lesbian, gay, bisexual and transgender (LGBT) populations also have unique health needs including an increased risk of mental health problems. Every day in every country, individuals are persecuted, vilified or violently assaulted, and even killed, because of their sexual orientation and gender identity. Violence against them causes enormous suffering that is often masked in a veil of silence and endured in isolation causing mental distress.

TASKFORCE RECOMMENDATION

Accessibility of mental health services

The LGBT people should access mental health services including psychosocial support as described in Chapter 8.

Train health care workers on non-discriminatory care services

Training of health care workers to include non-discriminatory care services to these key populations.

Provide psychosocial support services

The government and other agencies should provide psychosocial support services to these key population groups.

4.10 THE BOY CHILD

The advent of the female liberation movement and the resultant campaign to empower women has gained momentum over the last few years, to the exclusion of their male counterparts in many social endeavours. As a result, young boys in Kenya have been left out of programmes and their welfare has not been sufficiently mainstreamed. Many young men have low self-esteem and have lost the confidence and drive necessary for success (National Gender and Equality Commission, 2015). Recent trends in Kenyan society have led to increased perceptions that in the spirit of empowering women and girls, boys and men are being marginalised. Research carried out by the National Gender and Equality Commission established that the boy is lagging behind because there has been excessive focus in many instances on the girl child by the Government and NGOs in terms of programmes and interventions to empower the girl child (National Gender and Equality Commission, 2015).

TASKFORCE RECOMMENDATIONS

The recommendations on the boy child are adopted from the National Gender and Equality Commission 2015 report as they had major similarities. They are:

- **Affirmative action initiatives** by government should be based on consideration of sex–disaggregated data to identify beneficiaries and differential impact on boys and girls;
- There should be **regular reviews to find out whether it is the boy or girl who needs an intervention** based on varying cultural, economic and regional considerations;
- The programmes and intervention that **support empowering of women and girls must engage men and boys** as well;
- **Poverty reduction strategies should be focused on the needy**, especially to ensure children are not the ones earning income for the parents. Such strategies should address parental capacity to retain children in school;
- Use of existing structures including “*nyumba kumi*” initiatives to **monitor the boy child activities** and ensure they are going to school;
- Strengthen enforcement of laws at the lowest levels and empowering chiefs and other law enforcers to **monitor enrolment and retention in schools** and to give regular reports;
- Enforce implementation of relevant laws and policies that **protect the rights of the child and monitor to identify specific challenges likely to impact negatively on boys schooling** and develop localised strategies to address them;
- Ensure the Cabinet Secretary for Education holds Head Teachers responsible for school dropouts as provided for in the *Basic Education Act, 2013*;
- **Strengthen Guidance and Counselling and teaching of life skills in schools**; develop and implement specific programmes focused on enhancing boys schooling especially in areas most affected by boy drop-out;
- Work with communities, religious organisations and relevant Civil Society Organisations to **strengthen the family unit as the right environment to nurture children**; and
- Amend the Sexual Offences Act to **avoid apparent discrimination of the boy** in instances of “*consensual*” sex by minors.

4.11 PEOPLE LIVING WITH CHRONIC PHYSICAL ILLNESSES SUCH AS CANCER, HEART DISEASE, DIABETES AND HIV/AIDS

Chronic diseases are mainly health conditions that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely (CDC, 2012). They cause 7 out of 10 deaths each year and are among the most preventable and treatable of all health problems. Arthritis, as a chronic condition, and depression, as a mental health illness, are both leading causes of disability worldwide. The relationship between mental health, chronic disease and injury is significant. Many examples exist of individuals with a chronic condition or risk factor and an increased risk for mental illness such as the risk for tobacco use is about twice as high for those with mental illness compared to the general population.

People living with chronic physical illnesses face a number of challenges. They have a higher prevalence of comorbid mental illness than do other patients; Depression is found to co-occur in 17% of cardiovascular cases, 23% of cerebrovascular cases, and with 27% of diabetes patients and more than 40% of individuals with cancer (CDC, 2012); and Depression is also common among people who have chronic illnesses such as Cancer, Coronary heart disease, Diabetes, Epilepsy, Multiple sclerosis, Stroke, Alzheimer's disease, HIV/AIDS, Parkinson's disease, Systemic lupus erythematosus, Rheumatoid arthritis (National Institute of Mental Health, 2018).

WHAT THE PEOPLE SAID

That people living with chronic physical illnesses are treated for the physical conditions without usually providing mental health services.

TASKFORCE RECOMMENDATION

The government should put in place **programmes that offer psychological support to those persons with chronic health conditions**. It should be a requirement that upon diagnosis, referral be made for follow up in psychiatry units where psychotherapy can be offered on a long-term basis.

4.12 GENDER BASED VIOLENCE (GBV) SURVIVORS

The mental health challenges faced by GBV survivors should not be overlooked. There is a lot of secrecy about their experiences and they are likely to suffer from depression among other psychiatric illnesses. Violence against women is a serious violation of human rights, yet women across the globe experience violence in private and public domains. Women are disproportionately affected by gender-based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank as well as unremitting responsibility for the care of others (World Bank, 2009).

Violence has been identified as the leading cause of injury and harm against women and as the most common and exemplary cause for depression in women (Chowdhary & Patel, 2012). According to UNDP, gender-based violence is a silent health toll yet, so often, mental health services are not available for survivors of violence, and, where available, they are rarely integrated into the primary health care system. Providing women with comprehensive and gender-sensitive mental health services can allow them to take back control of their bodies, sexuality, and lives.

TASKFORCE RECOMMENDATION

The government should **make mental health care services accessible to GBV survivors** to reduce chances of them developing PTSD as a result of exacerbation of symptoms.

4.13 PERSONS WITH DISABILITIES

The World Report on Disability – published in 2011 by the World Bank and WHO – estimates that there are more than one billion people globally living with disabilities. This includes approximately 93 million children aged 0–14 years living with “moderate or severe disability” (5%) of whom 13 million (0.7%) experience severe difficulties (Kuper et al., 2014). Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors). Disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others (World Health Organization, 2011).

Physical Disability

Persons with physical disability undergo mental stress as a result of discrimination by the society. They do not have equal opportunities to those who are physically without disability and sometimes undergo mockery, and suffer a disadvantaged social life. They are more vulnerable to mental illnesses.

Mental, neurological and substance use (MNS) disorders and disability

Mental, neurological and substance use (MNS) disorders are highly prevalent, accounting for a large burden of disease and disability globally. MNS disorders interfere, in substantial ways, with the ability of children to learn. It also interferes with the ability of adults to function in families, at work, and in society at large. These priority conditions include depression, psychoses, self-harm/suicide, epilepsy, dementia, disorders due to substance use and mental and behavioural disorders in children and adolescents. Priority conditions were identified based on the criteria that they represented a high burden (in terms of mortality, morbidity and disability), resulted in large economic costs or were associated with violations of human rights. (WHO, 2016).

Children with disability

The scarce data that exists shows that children with disabilities face barriers to participation in many activities. Children with disabilities are less likely to start school, have lower rates of school attendance and lower transition rates to higher levels of education. The gap in school attendance associated with disability observed at the primary level widens further at the secondary level. Furthermore, the overall quality of the educational experiences of disabled children is often inadequate where they do attend school.

Children with disabilities may also have poorer access to health services, while experiencing higher health care needs (Kuper et al., 2014). Mental health disorders in childhood generally have larger impacts than childhood physical health problems in terms of adult health, years of schooling, participation in the labour force, marital status, and family income. There is a high prevalence of childhood mental illness and neurodevelopmental disorders in educational settings as documented by several researchers (McLanahan et al., 2012).

The Lancet Global Health for the Global Burden of Diseases, Injuries, and Risk Factors Study 2016 (GBD 2016) estimated the prevalence and years lived with disability (YLDs) for six developmental disabilities among children younger than 5 years. These are epilepsy, intellectual disability, vision loss, hearing loss, autism spectrum disorder, and attention deficit hyperactivity disorder (ADHD). Neurodevelopmental disabilities such as ADHD do not necessarily include medical comorbidities and are often undiagnosed before age 5 years. ADHD has traditionally been diagnosed during school age when the inattention, distractibility, and other behaviours indicative of ADHD come into conflict with the demands of primary school.

All Persons with disabilities face challenges, including:

- **Being disadvantaged in their opportunities.** People with functional limitations or bodily impairments are generally disadvantaged in their opportunities to participate in social life. These restrictions not only contradict basic human rights, but may also affect people’s health and wellbeing (Tough, Siegrist, & Fekete, 2017).
- **Having limited access to opportunities.** Many people with disabilities do not have equal access to health care, education, and employment opportunities, do not receive the disability-related services that they require, and experience exclusion from everyday life activities.

WHAT KENYANS SAID

- That almost every human being will be temporarily or permanently impaired at some point in life by disease or infirmity, and those who survive to old age will experience increasing difficulties in functioning. In that regard, the provision of mental health services tailored to these unique circumstances is important and urgent.
- Kenyans wanted special attention given to children with developmental and intellectual disabilities e.g. (cerebral palsy and downs syndrome) noting the lack of adequate facilities to cater for their needs and that of their parents as well who were equally affected.

TASKFORCE RECOMMENDATIONS

- **Adoption of community and educational inclusivity.** The government should adopt international policy which has now shifted towards community and educational inclusion instead of solutions that segregate people with special needs, such as residential institutions and special schools (World Health Organization, 2011).
- The Ministry of Education should **include policies on supporting children with physical and psychosocial, intellectual and cognitive disabilities** to learn in the same schools as those who are inherently normal in the new Competency Based Curriculum.
- That Medical associations should **hold continuous medical education for medical professionals in Obstetrics and Paediatrics** on the latest improvements in obstetric and neonatal care to reduce brain injuries from birth complications.
- **Provide psychosocial support for parents with children with disabilities.** They can be referred to higher level health facilities with access to mental health practitioners for counselling and management.
- Reforms to the education and employment model to provide reasonable accommodation to persons with disabilities.
- Legal reforms to support legal capacity and fulfil the human rights and fundamental freedoms of persons with disabilities.
- Review of social protection package to people with psychosocial, intellectual and cognitive disabilities to be fully aligned to CRPD.
- Close monitoring and evaluation to ensure access to services upholding to WHO QualityRights mental health initiative.

The foregoing suggests that special populations are persons with greater than average need for mental health services. This spans mental health promotion, prevention, treatment, rehabilitation and community integration. They require an array of quality mental healthcare services delivered with a human rights approach at all levels of the service delivery pyramid. The main service delivery recommendations are to integrate mental health services into general health care systems; develop formal and informal community mental health services; and promote and implement deinstitutionalisation once alternative services are in place (WHO 2003).

This, therefore, calls for the urgent establishment of relevant policies and programmes to address the unique mental health needs of special populations. The recommendations that have been made attempt to bridge the gaps that were noted during the Taskforce hearings and provide a first step towards the critical measures that should be developed and enacted by the different state and non-state actors to actualise good mental health status for the people of Kenya.



CHAPTER FIVE

SOCIAL AND OTHER DETERMINANTS OF MENTAL ILL HEALTH

Available evidence shows that mental wellbeing and most mental ill health are shaped to a great extent by the social, economic, and physical environments in which people live. The course of an individual's life further influences their mental state. The Taskforce in the course of its engagements came across worrying situations that can directly be attributable to these determinants. Factors, such as adverse childhood experiences, poor education, food insecurity, poor housing quality, unemployment, and discrimination, climate change and environmental degradation, all contribute to ill health and early demise. Better health and mental health can be achieved by understanding and responding to these determinants.

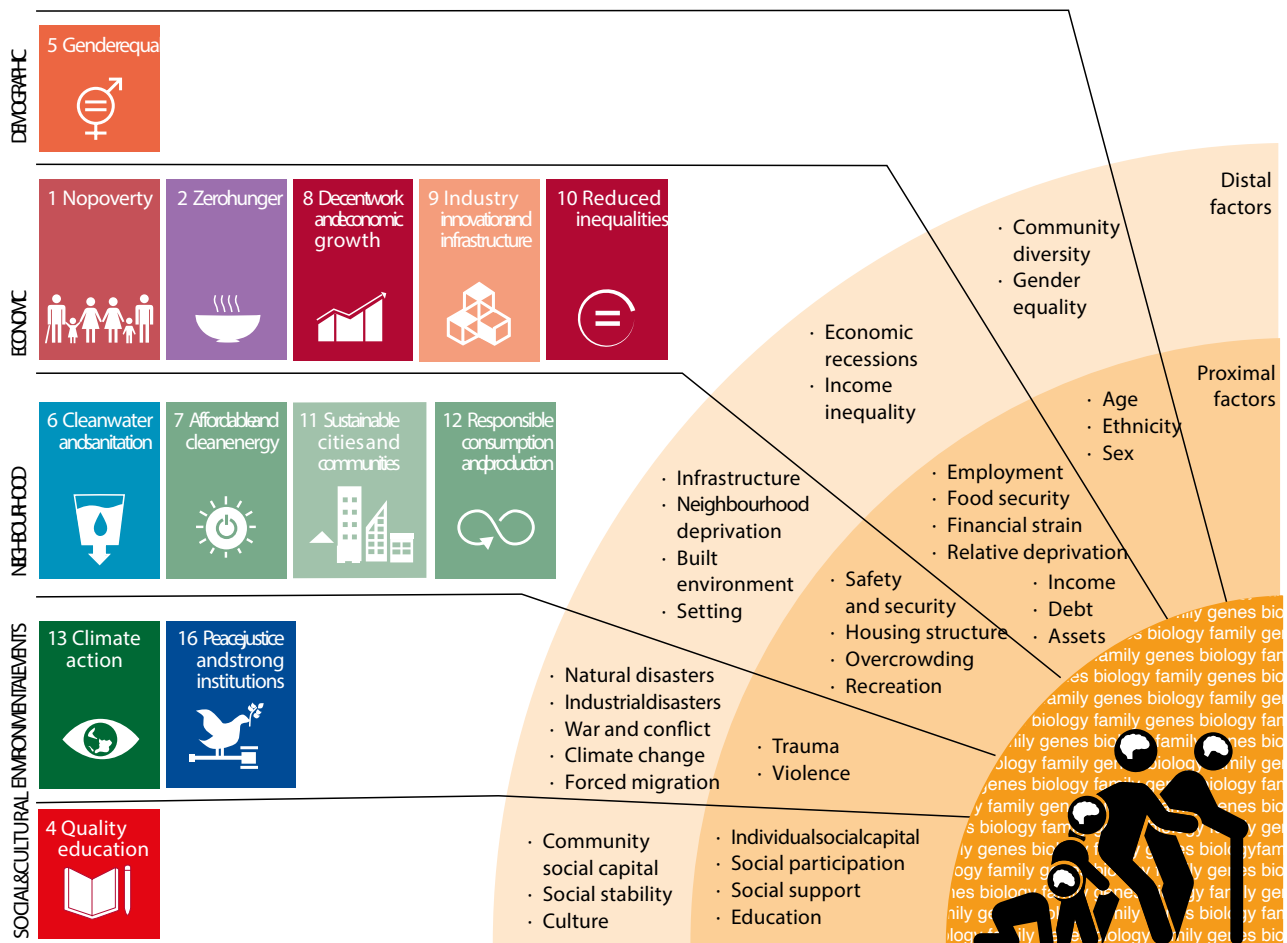
The UN-General Assembly Resolution A/RES/70/1 (UNGA, 2015) reported that 90% of health determinants have a basis in the social and physical environments. This is clearly demonstrated in Chapter 4 where it is shown that special populations are significantly influenced by various social determinants. In this chapter, we consider the key determinants of mental ill health, including demographic, socio-political/, economic/cultural, and physical environments in which people live and work.

Social determinants are defined as “circumstances in which people are born, grow, live, work and age; and the systems in place to assist those affected with illness – shaped by social, economic and political factors and by access to resources like safe environments, education and health [care]” (WHO, 2008). These determinants are further delineated into individual and environmental or contextual elements; emphasising their proximal and external nature, especially in respect to mental ill health (Silva et al. (2016) and (Lund et al. (2018).

These social determinants were well reflected in the public hearings in which the Taskforce heard of social disadvantages or stressors cutting across demographic, economic, neighbourhood, environmental and socio-cultural domains. Figure 1 shows how these factors affect and are manifested in different groups in the society.

Understanding how these factors are linked to mental health, how they interact, and their impact is vital for the development of appropriate interventions to improve and maintain the mental health wellbeing of all Kenyans.

Figure 1: Socio-economic and cultural determinants of mental health



Adapted from: Lund et al., Lancet Psychiatry 2018; 5:357- 69

Demographic Domain

The key factors associated with mental ill health in this domain include: age, gender, ethnicity, life-expectancy, longevity and minority status – of any type including race, tribe, religion, migrant and/or refugee status among others. Literature indicates that the female gender is associated with major depressive disorders at different life stages, beginning in adolescence, as well as anxiety issues and girls are reported to have a preponderance of self-harm and eating disorders. The male gender on the other hand is associated with substance use disorders and an increased probability of dying by suicide in a wide range of settings (Lund et al. 2018).

With regard to age, most mental disorders start early in life – first years and/or decades of life – when adverse social experiences are said to negatively impact cognitive, emotional and Behavioural development (ibid). Increasing age is also associated with a fair share of mental disorders – with young adults being more prone to anxiety disorders and the elderly being prone to dementia and depression. Minority status of any nature, e.g., racial, ethnic, religious, migrants, refugees to mention but a few predisposes individuals and whole communities to mental health disorders. This observation may be a consequence of experiences of discrimination and exclusion affecting all age groups.

To contextualise the above data, the population of Kenya today is estimated to be 48 million (2019 census), with a GDP 5.7% (in Kenya Economic Survey, 2019). While the GDP shows an upward trend, the growth does not reflect the reality of people's lives at the household level. The demographics indicate that slightly under half of 40% of all Kenyans are under the age of 15 years. The population is characterised by early marriages, early childbearing, high fertility and birth rates – 2.8 children born per woman and 22.6 births/1000 population respectively (CIA – Theodora.com [updated on February 08, 2019] – KDHS and national census or KNBS data.

This persistent and rapid population growth not only strains social services, but also the labour market. It increases pressure on land (for humans and animals), and decreases food security. In turn this increases pressure on the political front, inevitably leading to stressors that may trigger mental illness. There are also large numbers of working-age individuals who are not productively employed which will continue to increase as indicated by the “*Youth Bulge*” age structure of Kenya's population (AfDB/OECD, 2004). No significant changes to this structure are expected for the next 20-30 years with all its ramifications for mental health in this age group. However, it is expected that a large population of elderly individuals with its own mental health issues will emerge in coming years.

Economic Domain

Poverty and its consequences including lack or low income, high debt, financial strain, unemployment, food insecurity, poor housing and homelessness, poor/chronic physical health and limited access to health care all increase the risk of mental ill health. Poverty is a key variable associated with increased mental disorders such as depression and anxiety amongst adults. Its effects are more visible among women (during their adolescent and perinatal stages), as well as among individuals with chronic diseases. Poverty is also associated with suicidal ideation and suicidal behaviour for all age groups but with a higher prevalence amongst school-aged children and adolescents. For the elderly, poverty is associated with increased dementia.

It is important to note that poverty and mental disorders have a complex bidirectional association – poverty puts individuals at risk of mental illness, and mental illness puts people at increased risk of poverty. Unemployment, which exacerbates poverty, is associated with severity of symptoms and poor quality of life for individuals with schizophrenia and bipolar disorders. Food insecurity is highly associated with mental disorders in adults (Lund et al. 2018); and with disorders in children due to inadequate and/or under nutrition. This affects their cognitive, motor and social/emotional development. Debt, fuelled by poverty and/or bad life choices such as gambling and betting among others is associated with higher rates of depression and suicidal ideation.

The Kenyan economy is characterised by slow growth, a huge domestic debt and rising inflation; and disturbing political/governance. This has led to social changes and upheavals at all levels of society especially high levels of poverty and all its concomitants – including mental illness. Currently, about a third (35.6%) of Kenya's population falls below the poverty line, living below the global threshold of KES190 (\$1.90) per day (World Bank, 2018). The declining income per head in the formal and informal sectors is aggravated by unemployment, retrenchments and redundancies.

Kenya has the highest unemployment rate (currently standing almost at 10%) in East Africa (UNDP, 2017), with the most affected being youth. The country also has a large number of people living with HIV/AIDS and other chronic diseases. Others are at high risk of water and vector borne, as well as animal contact diseases. These groups have low access to health care. This is a likely platform for high levels of poverty and related mental ill health consequences. Further, a dependency on the agricultural sector which is perpetually under threat from vagaries of the climate – including droughts, floods, pestilence among others, stagnate or keep households in cyclical seasonal poverty, which is particularly severe in rural areas and Arid and Semi-Arid Lands (ASAL).

Area/Neighbourhood Domain

Poverty is a key driver of the neighbourhood that individuals find themselves in. Factors including insecurity, poor housing, overcrowding, urban or rural residence, lack of recreation, slum dwelling with over built settings, workplace issues and some geographical issues are risk factors for mental ill health. Social deprivation affects people in low-income areas/neighbourhoods and manifests through psychotic disorders and depression in adolescents and young adults, and reduced cognitive function in older adults (Wu et al., 2015). In some instances, people with mental illness drift to deprived areas due to abandonment or other reasons.

Urbanised living has its fair share of problems for mental health due to overbuilt spaces, lack of recreation, violence, unemployment and anonymity among other factors, which lead to lack of social support. Slum dwelling which is characterised by high population density, over-crowdedness, family composition, unhappiness among others creates crime-related violence, which in turn creates fear among the people and acts as triggers to mental illness including substances abuse, post-traumatic stress disorder (PTSD), depression and anxiety among others (Lund et al., 2018).

About a third of Kenya's population lives in an urban setting. Although there's a growing middle-class, the majority of these people live in socially deprived, low-income slum areas. These environments are highly congested – such as Nairobi and Mombasa with 4.3 and 1.2million people respectively (CIA-Theodora.com, 2018), with its ramifications for mental health.

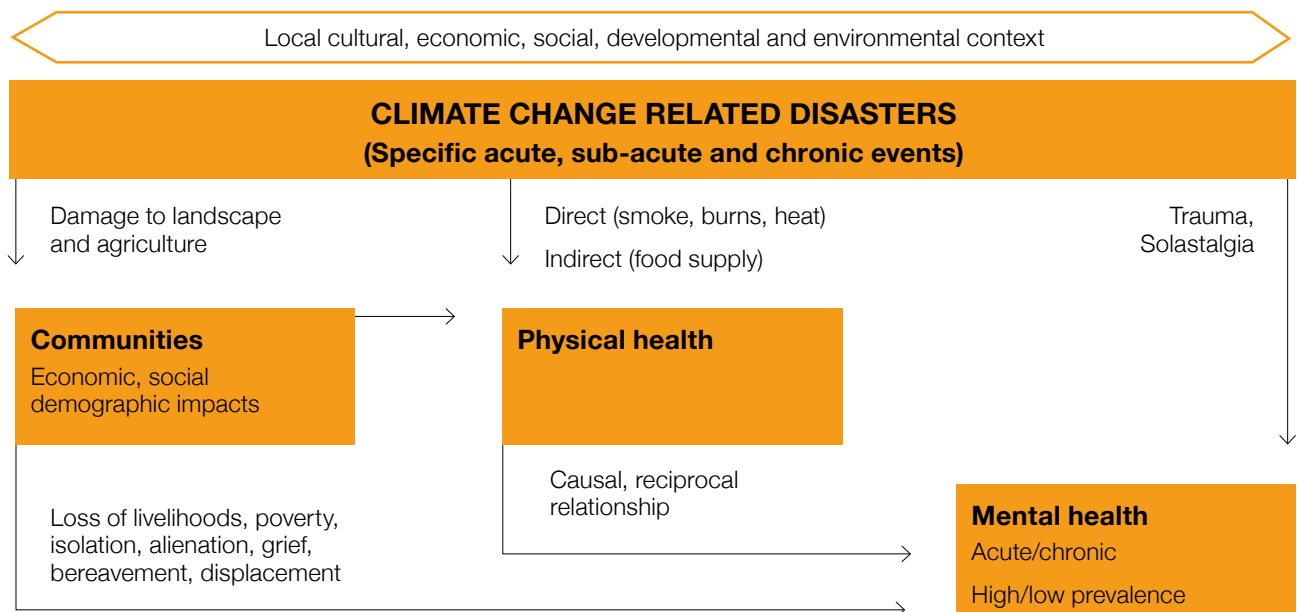
Other high population density areas include western Kenya along the shores of Lake Victoria and the Southeast along the Indian Ocean. While urbanisation may enhance livelihoods for the population, it also exacerbates disparities and negatively affects those who live in disadvantaged areas such as slums and fringes of cities. These and other folks in rural areas are the poorest of the poor with even lower access to social services such as education and health, including mental health – yet they are the most at risk. The two thirds of Kenyans who live in rural areas have their unique problems driven mostly by poverty and all its consequences.

Environmental events/situations

Natural or industrial disasters, war or armed conflict, terrorism, forced migration/displacement, human trafficking, torture, trauma, distress, bullying, discrimination, language differences, refugee status, increased population, climate change and its concomitants – droughts or flooding are all associated with mental ill health, particularly PTSD. Individuals who experience these negative events and survive them may additionally suffer from higher levels of anxiety and “*survivors' guilt*”. The ongoing COVID-19 pandemic, caused by the SARS-CoV-2 virus, is a prime example of the kinds of potentially traumatic events that may arise from the interaction between humans and the environment. It is expected that among the negative health outcomes that will emerge from this pandemic, mental ill health will play a huge role.

While all age groups are affected by these environmental events or situations, the female gender, being single, very young or elderly and poor increases the risk of developing mental disorders. With migration, displacement and post-war/conflict situations, poor living conditions, coupled with loss of status, discrimination and minority status are the stressors that lead to mental health issues. Figure 2 puts into perspective the effects of climatic change on mental health.

Figure 2: The effects of climatic change on mental health



Kenya has had its fair share of these environmental effects over the years; starting with colonisation, war for independence, recurrent ethnic skirmishes related to land or other resources resulting in long-term displacement, frequent and sustained terrorist events across the country and especially in some border areas, cyclical politically instigated conflict, collapsing of structurally unsound buildings resulting in high fatalities, frequent grisly/fatal traffic accidents, landslides during flooding among others. These stressors are known to precipitate mental disorders.

Socio-cultural Domain

There is need for a holistic response driven by strong political will to manage and equalise the social factors that have been described as the initiators and maintainers of mental ill health (Nebhinani and Basu, 2019). Strong and supportive social relationships especially at the household level are critical for mental Wellbeing. The review by Lund et al., (2018) reports that partner abuse during pregnancy is strongly linked to increased risk for depression, anxiety and postpartum depression in women in the postnatal period.

Lack of social support from partner and others increases the risk of suicide in these women. Other risk factors include lack of social and cultural stability, harmful cultural practices, poor social networks, peer and family relationships, loneliness, bereavement/widowhood, critical life events – including abuse of any type – physical, mental and increasingly cyber bullying, lack of attachment to a religion, and discrimination of any nature, among others.

At a glance the education sector seems to be doing well with a literacy rate (persons aged 15+ who can read and write) currently standing at 81.5%. The reality is that high enrolment at primary level does not translate to secondary and tertiary level institutions. With an underlying belief among most Kenyans that education is the key to success in life, individuals, families and communities become frustrated due to the lack of access to education. Unfortunately, even for those who manage to get an education, the absorptive capacity of the labour market, even of university graduates is not guaranteed. Parents who also have a high stake in the education of their children are exposed to stressors that could lead to mental disorders.

Empirical evidence indicates that there are high levels of divorce and broken homes (BBI 2019) in Kenya, which affect child parenting and may lead to mental disorders. Families are also characterised by gender-based violence across board.

WHAT KENYANS SAID

Right across the country, the socio-economic and environmental determinants were very vivid.

- Poverty is caused by poor political leadership and governance and high-level corruption. This in turn leads to high unemployment especially amongst the youth and is the key driver of substance abuse and other vices such as prostitution. The citizens believe poverty and the lure for easy money leads people especially men of all ages to gambling and debt, leading to stress and possibly to mental illness and suicide.
- The high rate of youth unemployment is deplorable. It creates idleness which leads to stressors that in turn lead to antisocial behaviours including substance abuse and crime. Young people become targets for recruitment into criminal and/or terrorist gangs, leading to stress to their families and the society. Corruption was heavily linked to high unemployment with Kenyan's stressing that corruption at all levels particularly in public institutions is a constant source of stress for those unable to raise bribes.
- With respect to education, a participant in Nairobi said, *"many of us have degrees but no work. 'Tarmacking' leads to despondency, which may lead to the lack of mental wellbeing and related consequences such as suicide, substance abuse, crime and recruitment into terrorist cells for young adults"*.
- Insecurity and a lack of general law enforcement are big problems for residents regardless of their place of residence. People live in fear of crimes of all types from within and externally.
- Issues of poor governance and toxic politics that lead to ethnic clashes and civil upheaval before and during electioneering periods cause serious anxiety amongst the people.
- Frequent 'bad news' from the media about insecurity, contaminated foods – sugar, cereals (aflatoxin), ethnic clashes, serious accidents, homicides and suicides among others, were also reported to be stressors that lead to mental ill health.
- The social cohesion and the moral fibre of the society has broken down severely. The erosion of traditional cultural practices has led to poor parenting and socialisation of children as well as poor interpersonal relations. Consequently, children lack direction from parents who are busy working to make ends meet. These children, without supervision end up spending too much time watching television, on social media, or on the streets where they learn negative behaviours from peers.
- While Kenyans would like some cultural practices to be retained for instance those that promote family and societal cohesion; they cited early marriages and Female Genital Mutilation (FGM), as possible triggers for postpartum depression and thus should be ended.
- Religious (all faiths) fanaticism rampant in the country was also identified as a factor that likely aggravates mental ill health.

- Participants in the armed forces wanted decriminalisation of suicide, policy changes within the forces and more attention paid to mental health awareness. They expressed concern about the high number of persons with mental health conditions in their midst due to the nature of their work. The Taskforce heard that officers who die by suicide are discharged dishonourably and hence their families do not get any compensation thus suffering twice.
- Kenyans are also concerned with socio-cultural practices that continue to restrict the male gender from expressing themselves emotionally. The expectation that boys and men should be strong and should not express fear – perceived as failure – was said to put a lot of pressure on men leading to mental conditions.
- The people of Meru and Garissa were at a loss about cultural practices gone mad. This included the chewing of *miraa*, which has in recent years become problematic. They called for an education of the population while others called for reduction of the *miraa* growing in Kenya and for the growers to be provided with alternative cash crops. In Garissa, a participant said that *“in the past people chewed miraa and they were fine, but there must be a different type of miraa from the one of before, or it is because the chewers are mixing it with other substances”*.
- Kenyans want economic and skills empowerment of individuals and communities aimed at reducing unemployment, poverty and other social inequalities. Participants in the Coast and North Eastern regions of Kenya implored the government to deal with insecurity too and expressed concern that although they are victims of terror, they are victimised by the state security apparatus by being perceived as perpetrators of terror – as one Garissa participant said *“just being a youth and Muslim in this area is a crime. You are guilty until proven innocent”*.
- Kenyans suggested a holistic approach to the interventions that address mental health, requiring the Ministry of Health to collaborate with other ministries and all stakeholders to undertake educational awareness campaigns aimed at sensitising communities and families about mental wellness. They suggested that school-based interventions be instituted for both teachers and learners. Workplaces were also seen as centres to reinforce the public campaigns for mental health awareness and to enact programmes to sensitise parents and communities as well as special groups such as political, religious and traditional leaders.

In a telling quote, a participant at a public hearing in Nairobi said, *“The family is the taste of freedom – when we don’t fix it we produce sick professionals”*. Kenyans thus want integrated development of strategies and policies to strengthen the family unit, interpersonal relationships and workplace wellbeing to increase happiness and reduce stressors that lead to mental health.

TASKFORCE RECOMMENDATIONS

A wide range of issues were raised in these public hearings, which indicate the need for multi-pronged interventions at different levels of the governing and health systems as well as by different stakeholders. The Taskforce therefore makes the following recommendations:

Relevant policies

At the political and governance levels, policies that will reduce the risk factors described above must be improved and accelerated where they already exist, developed and enacted where they do not exist and enforced where they should – to drive better outcomes for mental health for Kenyans.

Anti-poverty and social protection programmes

These domains are cross cutting and interrelated. They need interventions to broadly address:

- **Economics** – through acceleration/implementation of reforms to buffer the economy by scaling up of anti-poverty and social protection programmes for the indigent to reduce inequities, create opportunities and additional jobs for productive employment especially for youth, and escalate the fight against corruption at all levels of government and institutions.
- **Neighbourhoods** – by improving housing and safe spaces in urban and rural areas, encouraging community cohesion and increasing recreational facilities especially for youth. The government must pay particular attention to slum dwelling and proper planning in urban areas.
- **Environmental Events** – through reduction of violence and related fear, enforcement of regulations and laws that protect citizens, e.g., traffic and building laws, enhancement of good governance practices to avoid cyclic political conflict and related ethnic clashes – with attendant loss of life and property and improve Kenya’s preparedness for early and rapid response to environmental/climate change events of every nature, whether natural or man-made.
- **Socio-cultural** – by improving education which will produce a population that is not only informed about mental health, but also skilled and/or employable; empowered communities based on strong family relationships and social support networks for individuals for all stages of the life course; thus creating a holistic buffer against mental illnesses for all Kenyans.



CHAPTER SIX

STIGMA AND DISCRIMINATION

From the engagements the Taskforce had with Kenyans at different levels, it was clear that people with mental illness were facing stigma and discrimination in various areas of their lives. They were being stigmatised by their relatives, at work and in the community. Kenyans even expressed disappointment that the government which was supposed to embrace its people still discriminated them in policy making, legislature, underfunding of the sector and poor infrastructure.

Stigma as defined by WHO is a mark of shame, disgrace or disapproval which results in an individual being rejected discriminated against and excluded from participating in a number of different areas in a society. Stigma greatly limits access to care and decreases quality of life for individuals and families with mental health conditions.

Norman Sartorius, renowned authority on Stigma, with his colleagues in their seminal work for the World Psychiatric Association in 2010, define stigma in the area of mental health broadly, to encompass various negative stereotypes as well as prejudicial beliefs that people may hold, which usually will result in discriminatory or inequitable practices. They further posit that *“stigma and discrimination may occur at the level of the individual, through interpersonal interactions, as well as at the level of social structures by virtue of unfair policies, practices, and laws.”*

Brohan and Thornicroft (2010) present a framework for understanding these phenomena and articulately conceptualise stigma as comprised of the three problems of: knowledge (ignorance or misinformation), attitudes (prejudice) and behaviour (discrimination). These three problems will naturally feed into each other, leading to a deeper entrenchment of stigmatisation and discrimination of people suffering from mental ill health.

Mental health is one of the most neglected sectors in the country's health industry. KNHCR (2011) established the prevalence of low awareness of mental health and discrimination of people with mental illness in the country.

WHAT KENYANS SAID

- **People with mental health conditions are widely neglected by families**, friends, and relatives in the community. To avoid discrimination, families seek medical care in facilities far off from their homes in order to hide their sick relatives. Some even abandon their relatives in these facilities for long as seen in Kisumu County Hospital and the mental unit at Kakamega hospital both of which have patients who have called the hospital home for more than 10 years now.
- **Patients with mental illnesses are hidden and some even tied in shackles** as the family members are ashamed of them. They see the patients as a burden and believe they give the family a negative social image. In Garissa, women who had mental illness were locked up in rooms and some have died from neglect and malnutrition.
- **Cultural beliefs lead to negative attitudes toward people with mental illness and/or substance abuse.** Cultural beliefs about causes of mental illnesses that include curses are prevalent. These beliefs lead to alienation of the people suffering from mental illness and their families. Some would rather take the patient to a faith healer than to a medical facility. A resident of Mombasa said; *“Mad men were always associated with bad omen...”*. Some families were stigmatised and people were not even allowed to marry from such families especially if they had a history of mental illness. The society considered such families cursed and sidelined them in community services and ceremonies.
- Persons with mental disorders, caregivers and mental health providers face **hurdles in the realisation of the right to quality health services**. This leads to marginalisation of users of mental health services and underfunding of the sector resulting in poor service delivery. *“The physical infrastructure of most mental health institutions is in itself a key driver of stigma...”*. This was said by users and service providers in Mombasa and echoed across the 10 regions visited. The mental units in the country consist of old and dilapidated structures. The people serving there as well as their patients felt neglected by the government, as if they were an afterthought secluded in units located at a distance from the general health care facilities. The uniforms worn by patients were also similar to the uniforms worn by prisoners, some were short and ill-fitting leading to most of the patients wearing additional clothes not part of the uniform as evidenced in Mathari female wards.
- People with mental health conditions are **disempowered and undergo extensive restrictions to some of their basic rights**. The community denies them several basic rights and opportunities like their choices in life, marriage, family life, employment, and education. The society holds an assumption that people with mental health issues do not have the capacity to assume responsibility, make decisions, and manage their own affairs. The patients expressed their frustrations that even in the family, their opinions were not sought because everyone assumed that they did not understand and could not make sound meaningful decisions. For example, legally, mental illness is grounds for marriage dissolution!

- **Mental illnesses are assumed to be non-fatal and therefore of little priority** as compared to other medical conditions.
- **Stigmatisation also plays a role in the medical training facilities.** Psychiatry as a unit is not emphasised as a course in most of the cadres in medical training and this leads to little interest amongst students to pursue the subject. Even those who pursue it and become service providers are perceived to have a mental illness as narrated by one service provider.
- **Prejudiced social norms and expectations** have led to discrimination against those who have different sexual orientation e.g. the LGBTQ populations. They shared their stigma related experiences both by the society and the legal system stressing that they suffer mental issues due to discrimination and lack of access to mental health care.
- **Lack of empathy.** Patients with substance use disorders are perceived to be suffering from their own choices and therefore fail to get the empathy accorded to patients. They are also viewed as dangerous, inadequate, unlawful, unpredictable and unable to live fulfilling lives.
- **Low socioeconomic status.** People experiencing mental illnesses are turned down for jobs due to their state of health. They also stop themselves from seeking jobs for fear that they will be discriminated against. This leads to low socioeconomic status amongst patients and families with chronic mental illnesses as they do not have jobs or are given low paying jobs because of their mental disorders.
- **Stigma at the workplace** is another priority issue in our local population.
 - » Some employers suspend their workers' salary before sending them to the counselling departments when symptoms of mental illness are identified. This is discriminatory as persons with other illnesses stay on payroll even when seeking treatment. Case in point is teachers under the Teachers Service Commission who are seen to exhibit substance use disorder symptoms.
 - » Patients who had substance use disorders or other mental illnesses were ridiculed when they eventually return to their work stations as mentioned by a police officer 'Once designated 'mike papa' by fellow police officers, it's impossible to work in the police force comfortably' .
 - » Kenyans told us that most employers do not provide for flexi hours. Patients with mental illness require time off monthly for regular clinic visitations yet this is not covered in the workplace.
 - » Some work environments provide counselling units for their employees. However, in some of these units, the workers don't go to the counselling department for fear of stigmatisation. They believe that when seen in those offices, people will tease them as being mad. This in turn hinders their health seeking behaviour and leads to late diagnosis and chronicity of illness.
- **Lack of legislative, programmatic, budgetary, and policy steps.** The government neglects people with mental health conditions through lack of legislative, programmatic, budgetary, and policy steps which could lead to the attainment of the highest standards of mental health. There is unavailability and inaccessibility of basic mental health facilities. Mental health is also not integrated into primary and community health care compared to physical health.

TASKFORCE RECOMMENDATIONS

From the above observations, the Taskforce makes the following recommendations:

- **Implementation of the QualityRights mental health initiative.** This can be used as a tool to reduce stigma, discrimination and human rights violations. This project aims to unite and empower people to improve the quality of care and promote human rights in mental health and social care facilities. This mental health initiative will not only provide training for health care workers and mental health service users to improve services, but will also leave a lasting legacy of respect for human rights. Being treated with dignity not only reduces stigma but also promotes recovery. The Taskforce recommends that the QualityRights mental health initiative be included in the continuous medical education programme for health workers and non-medical staff working on mental health facilities and be regulated by the national mental health and happiness commission. The QualityRights mental health themes drawn from the Convention on the Rights of Persons with Disabilities (CRPD) include:
 - » The right to an adequate standard of living and social protection (Article 28 of the CRPD).
 - » The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD).
 - » The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD).
 - » Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD).
 - » The right to live independently and be included in the community (Article 19 of the CRPD).
- **Anti-stigma programmes/campaigns.** People with lived experience must be encouraged to take charge of anti-stigma programmes and campaigns. This process signifies a change in direction for various programmes. The service providers and family members are key advocates for people with serious mental illnesses and as advocates, they have in the past stepped up to assert various community rights for people in their care. The modern-day environment is such that anti-stigma and anti-prejudice efforts should be led by those harmed by discrimination and prejudice.
- **Mental health champions in the community.** These individuals could be anyone with a passion for mental health in the community. This could be a focal person in areas of employment, the judiciary system, media to mention but a few. Corrigan 2018 also concluded that participants with lower self-stigma identify the harm brought by stigma and thus endorse rights and self-worth as priority areas in managing stigma amongst the person with a mental illness.

- **Educate communities on mental wellness.** Lack of mental health literacy seems to fuel the stigmatisation of mental illness. Kenyans need to be educated on mental wellness and its importance, mental illness and management. This will increase early recognition of symptoms and reduce the severity of most of the illnesses. Some of the ways proposed include mental health literacy programmes targeted at community leaders, religious leaders and traditional leaders to allow for early identification and referral of the mentally ill to mental units and normalisation of mental illness in the community. The government should lead support programmes to increase mental health literacy.
- **Use of less stigmatising words to refer to mental illnesses.** For example, a person with mental illness “*anayeugua ugonjwa wa kiakili*” as opposed to “*wazimu*”. This can be done through public awareness, social marketing amongst others.
- **Develop modern infrastructure for care.** We recommend new infrastructure to enable patients of mental illness to access care in modern and safe environments in their communities. This would also facilitate the medical providers working in the units provide quality service delivery.
- Develop community based mental health services which are evidence based, people centred, and recovery oriented with a human rights approach.
- Inclusion of people with lived experience in policy, education and all aspects of socioeconomic development in the country.
- Institute legal reforms and enforcement of laws to ensure the human rights and fundamental freedoms of people with mental health conditions are fulfilled.

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CHAPTER SEVEN

POLICY, LEGISLATION, LEADERSHIP AND GOVERNANCE

7.1 POLICY AND LEGISLATION

In reviewing the policy and legislative framework and listening to Kenyans, it became clear that it is time to implement the Mental Health Policy (2015-2030) as well as amend or repeal some laws in order to address mental health challenges. Kenyans wondered why the policy remains unimplemented and why discriminatory and derogatory laws still exist. They stressed that, “we must amend the law to decriminalise suicide” and “decriminalise substance use and abuse” in order to facilitate the care of persons with mental illness.

This Chapter is dedicated to examining the policies, legislation, leadership & governance structures relevant to mental health in Kenya. The Taskforce began by assessing the *Kenya Mental Health Policy 2015-2030*, *Mental Health Act 1989* (1991) followed by the Constitution of Kenya and other legislations relevant to mental health. The Taskforce also looked at international legal obligations which Kenya has ratified which include the Convention on the Rights of Persons with Disabilities (CRPD).

KENYA MENTAL HEALTH POLICY (2015-2030)

The Taskforce reviewed the *Kenya Mental Health Policy 2015-2030*, which is a good policy, developed based on high-level approval from the Minister of Health. It was based on a needs assessment that included extensive consultation with stakeholders. The development process incorporated other national and international documents such as the Constitution of Kenya 2010; Kenya Health Policy (2014-2030); Kenya Vision 2030; WHO’s comprehensive Mental Health Action Plan (2013-2020). All these key documents call for an efficient and high-quality health care system in the country with the best standards. The vital role of the county governments in the implementation of this policy has been described clearly in Part 3.2 (b) of the policy and this will be done ‘through five-year Mental Health Strategic Plans’.

WHAT KENYANS SAID ABOUT THE KENYA MENTAL HEALTH POLICY

- Kenyans were not aware of the existence of the Kenya Mental Health Policy; the Taskforce attributed this to the lack of dissemination of the policy after its development in 2015.
- Those who knew of the existence of the policy highlighted the lack of a mental health implementation plan as a major hindrance to the operationalisation of the policy. Kenyans also highlighted the lack of a leadership structure or focal person for mental health in most counties as a major contributor to the inadequate dissemination of national mental health policies/ plans and leading to the overall poor coordination of mental health activities at the county level.
- Some stakeholders including the police service, prison service, media companies and county governments felt it is essential to customise/ adapt the Kenya Mental Health Policy to address their unique needs.

TASKFORCE RECOMMENDATIONS

The Taskforce makes the following recommendations as regards to the Kenya Mental Health Policy:

- There is urgent need to disseminate the Kenya Mental Health Policy to the counties and the public.
- The government should fast track implementation of Kenya Mental Health Policy through the development and dissemination of a national mental health plan.
- Mainstreaming the implementation of the policy across sectors.
- Creation of structures at county level to lead and coordinate implementation of policy.
- Development of guidelines and monitoring and evaluation tools to guide the implementation.

LEGISLATIVE FRAMEWORK

While reviewing legislation touching on mental health in Kenya, the Taskforce is cognisant of the fact that there may be laws that touch on the issue, albeit in a peripheral manner. The laws included in this section, are those that either, touch on mental health or have an impact on how mental health issues are administered in Kenya.

WHAT KENYANS SAID ABOUT THE LEGISLATION RELEVANT TO MENTAL HEALTH

- There is urgent need to amend the mental health act to align to the constitution of Kenya, international human rights standards (CRPD) and address emerging issues.
- Kenyans want the completion and enactment of the Mental Health Bill, 2018, taking into consideration further amendments as raised by stakeholders during the public participation process (as provided for in the law).
- Kenyans called for an amendment of the law to decriminalise suicide.
- Kenyans demanded the amendment of the law to decriminalise persons with substance use problems.
- Kenyans said: amend laws on the criminal justice system regarding persons who are mentally ill offenders; abolition of offensive pieces of law including demeaning references to persons with mental conditions and denial of legal capacity in relation to mental health treatment, upholding rights in relation to property, marriage and decriminalising symptoms of mental health conditions.
- Implement the Counsellors and Psychologists Act.
- Regulate gambling & gaming.
- Enforcement and implementation of laws to prevent and control alcohol and substance abuse.
- Amend discriminatory laws and those with derogatory language in reference to people with mental conditions.
- Enact law to cater to the mental health and psychosocial needs of veterans.
- Implement the provision of the Constitution of Kenya and health act as regard mental health and wellbeing.

SPECIFIC LAWS REQUIRING REVIEW AND AMENDMENTS

Mental Health Act 1989 (1991)

Kenya has had an evolving legislative framework on mental health dating pre-colonial time from the lunacy act of 1910, to the treatment act of 1949 which was repealed by the Mental Health Act of 1989 (7). This act was legislated in 1989 which brought forth many changes. However, the act requires amendment to align with the constitutional dispensation, the provisions of the health act, the CRPD and address other emerging issues including human rights and the protection of vulnerable groups. A significant provision of the mental health act was not implemented or enforced, these include; the Kenya Board of Mental Health, the District Mental Health Councils and equitable access to health insurance for people with mental health conditions.

There have been several initiatives to amend the Mental Health Act. The latest Mental Health (Amendment) Bill, 2018 is currently in the National Assembly.

TASKFORCE RECOMMENDATIONS

- A detailed review and analysis of the Mental Health Act and its implementation to date to inform the process of mental health legislation in conformity with Constitution of Kenya, Mental Health Policy, Health Act, the Convention of the Rights of Persons with Disability (CRPD) and emerging issues.
- The Taskforce recommends further amendments to the Mental Health Bill, taking into consideration stakeholders input, ensuring its alignment to the constitution of Kenya, Health Act and CRPD.

Discriminatory laws and laws which use derogatory language

The Taskforce noted that there are laws that are discriminatory and use derogatory language in reference to aspects of mental ill health. They include:

- Penal Code 2009 (11). Section 226 says that, any person who attempts to kill himself is guilty of a misdemeanour. Section 146 further says, any person who, knowing a person to be an idiot or imbecile, has or attempts to have unlawful carnal connection with him or her under circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the person was an idiot or imbecile, is guilty of a felony and is liable to imprisonment with hard labour for fourteen years.

The Taskforce recommends amendment of section 146 to remove the derogatory words and repeal the entire Section 226

- Marriage Act 2014 (12) Repeal sections 66 and 73 of the act. These provisions violate the constitution.
- Persons with Disabilities Act 2003 [2012] (13) The definition of disability should be expanded to include persons suffering from psychosocial, intellectual and cognitive disabilities.
- Children Act 2012 (22) makes exception to the provision for the appointment of a guardian to end upon the child attaining the age of eighteen years.
- Constitution of Kenya; Sections 83(1) b, 99(2) e and 193(2) d; limit political rights for persons of 'unsound' mind. Article 83(1) b qualifies Article 38 by providing that a person qualifies for registration as a voter at elections or referenda if the person is not declared to be of unsound mind. Article 99(2) e disqualifies persons of 'unsound mind' from being elected a member of Parliament. Article 193(2) d disqualifies persons of 'unsound mind' from being elected a member of a county assembly.
- The Elections Act disqualifies a person of unsound mind from being nominated as a Member of Parliament, county assembly, and other public offices. See sections: 9; 24(2)(e); 25(2)(d).

Enforcement and implementation action of existing laws

- The Counsellors and Psychologists Act 2014 (14). Operationalise this act, by immediately constituting the Counsellors and Psychologists Board. This will ensure the regulation of counsellors and psychologists as provided in the act.
- The Health Act 2017 (15). Enact provision of section 73 on mental health.
- Insurance Act (16). Section 82 states, “*Effect of suicide or capital punishment on policy – A policy of life assurance shall not be voided merely on the ground that the person whose life is assured died by his own hand or act, sane or insane, or suffered capital punishment, if, upon the true construction of the policy, the insurer has thereby agreed to pay the sum assured in the events that have happened.*”
 - » Enforce the Act
 - » Practice by insurance companies is in direct contravention to the act
- Mental Health Act; section 46. (1) Every person in Kenya shall, be entitled, if he wishes, to insurance providing for his treatment as a person suffering from mental disorder and no insurance company shall make any insurance policy providing insurance against sickness, which excludes or restricts the treatment of persons suffering from mental disorder: (2) An insurance company which makes any insurance policy which expressly excludes or puts restrictions on the treatment of any person suffering from mental disorder shall be guilty of an offence.
- Betting, Lotteries and Gambling Act 2012 (1991) (17). The act needs to be reviewed with necessary amendments enacted and enforced.

Harmonise laws related to control of substance use

The Taskforce observed that these laws impacted on the burden of disease in Kenya with regards to control of alcohol, substance use and addiction. The implementation of these laws across sectors needed to be well harmonised and therefore the call for amendments of sections in conflicts or provisions with no clear mandate on implementation and regulations.

- National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) Act 2012 (18)
- Alcoholic Drinks Control Act 2012 (2010) (19)
- Narcotic Drugs and Psychotropic Substance (Control) Act 2012 (20)
- Tobacco Control Act 2012 (21)

The Taskforce observed as follows:

- Regulation of treatment and rehabilitation centres to be under the health regulatory laws.
- The Taskforce proposes the introduction of a RETI Tax, which will be a tax for Research, Education, Treatment and Infrastructure, dealing with alcohol and substance use and addictions.

The Constitution of Kenya 2010

In reviewing the Constitution, the following sections stood out as being pertinent in speaking to matters of Mental Health in Kenya:

- Article 28 states, “*Every person has inherent dignity and the right to have that dignity respected and protected.*” This directly addresses the fundamental right to human dignity for all persons, including those affected by and living with mental ill health.
- Article 43 1(a) provides that, “*every person has the right to the highest attainable standard of health, which includes the right to healthcare services.*” According to the Taskforce, health in this context includes mental health, as defined by the WHO.
- Article 46 1(c) states that, all Kenyans have a right to “*the protection of their health, safety, and economic interests.*” This addresses the issue of the quality of services offered to Kenyans, including those dealing with Mental Health.
- Article 53 speaks to the rights of children in Kenya. It addresses the fact that all children are entitled to receiving the highest level of care, including, but not limited to health care.
- Article 54 talks about the rights of persons with disabilities in Kenya. This article is clear on how such persons will be treated, with dignity and respect like all other Kenyans. It also addresses matters of their access to all services equally and recognises them as fully participating members of the Kenyan society.
- Article 55 focuses on youth and their contribution to society. It expressly says that the youth must be included in all spheres of Kenyan life, including in decision making, elective positions, and access to employment among others.
- Article 57 deals with older members of society and guarantees the protection of their rights to fully participate in all aspects of the Kenyan society, also protecting them from exploitation and abuse.

TASKFORCE RECOMMENDATIONS

The Taskforce recommends both transformative legislative and administrative reforms:

All laws in Kenya must align with the constitution with respect to mental health in Kenya. This will ensure the success of the mental health agenda.

7.2 LEADERSHIP AND GOVERNANCE IN MENTAL HEALTH

Although the mental health act provides for the establishment and functions of the Kenya Board of Mental Health with an office of the director of mental health as the Chief Executive Officer, this remains a pipe dream. The perceived district mental health councils, have unfortunately, to date, not been implemented.

The constitution of Kenya (2010) brought devolution of health services. However, the county governments lack a leadership & governance structure. Mental health is a cross-cutting issue which requires main streaming across all sectors, and a well-coordinated and harmonised approach. The constitution of the leadership structure should bring inclusivity with representation from different sectors and foster participation of people with lived experience. In the spirit of the 65th World Health Assembly resolution 65.4 calls for 'a comprehensive and coordinated response from health and other social sectors at country level' to address the growing burden of mental health conditions. This will require a partnership between public and private sector to enable significant gains in the efforts to reform the mental health system in Kenya.

WHAT KENYANS SAID

Kenyans expressed the lack of political will as a major barrier towards reforming mental healthcare in the country. They cited:

- Lack of a well-coordinated response within various sectors and departments in government.
- Lack of prioritisation of mental health at national level, county level and at household level.
- Lack of role models among political leaders.
- Lack of the desire among citizens to talk about mental health and/or lack of knowledge about what to do about it.
- Fragmentation of the social fabric and family unit in Kenya and hence, the need to take mental health governance to the family unit at grass root level using already existing structures like the Nyumba Kumi initiative.
- There is exclusion of people with lived experience and their caregivers at the level of decision making for mental health.

TASKFORCE RECOMMENDATIONS

- Establishment of a **Mental Health and Happiness Commission (MHHC)** as explained in Annex 5 of this report. The functions of the Commission shall be to:
 - » Advise the National and County Governments on the state of mental health and happiness in Kenya.
 - » Conduct periodic surveys of mental health and happiness in Kenya.
 - » Ensure continuous surveillance of the state of mental health and happiness.
 - » Supervise the delivery of mental health services in Kenya.
 - » Provide advisories on the effect of guidelines, policies, legislation, and any acts by state organs on mental health and happiness.
 - » Perform such other functions as the Commission shall deem necessary for the enhancement of mental health and happiness.
- Establish the Directorate of Mental Health & Substance use at the Ministry of Health in line with schedule 6 of the constitution and executive orders on health functions including; formulation of health policies, health regulations, guidelines and quality assurance, capacity building, and technical assistance to counties.
- Include mental health and wellness across all ministries and government entities as part of their performance contract.
- Establish county mental health councils and appoint county mental health coordinators.
- Appoint sub county mental health focal persons.
- Establish village mental health committees.
- Strengthen users and caregivers' organisations and support groups.
- Promote leadership for youth peer groups led interventions in mental health.
- Sensitisation of policy makers and political leaders on their role in promotion and prevention of mental health condition.



CHAPTER EIGHT

ACCESS TO MENTAL HEALTH SERVICES

“The physical infrastructure of most mental health institutions is in itself a key driver of stigma”

Mental Health Service User

The Taskforce visited hospitals, psychiatric units and clinics, both public and private, community programmes, alcohol and drug treatment centres (rehabilitation centres) and also had focus group discussions with caregivers and users of mental health services.

The Taskforce found dehumanising infrastructure, lack of trained personnel, coupled with barriers due to stigma and affordability, prevented Kenyans from accessing the few existing mental health facilities. The services lack preventive and promotive interventions and strategies and indeed, only 25% of the Kenyan population can access mental health care.

Kenyans from every region and group visited, urged the Taskforce to inform the government that urgent measures need to be put in place to ensure mental health services can be accessed at all levels.

Mental Health Services consists of a full spectrum of comprehensive services which include promotive and preventive interventions and strategies, curative and rehabilitation services, continuum of care and recovery management as well as palliative services. A key point to note is that the continuum of care ensures promotion of mental health, recovery, independent living, community inclusion and quality of life. Community mental health systems must be empowered in such a way that they are able to respond to the needs of the population at every level of the continuum. The people with lived experience must be central in planning policies and services which ensure their wills and preferences in treatment and recovery management are respected.

The access to mental health services encompasses having mental health systems and structures to enable effective delivery of comprehensive, quality, people centred, recovery oriented care with a human rights approach. The systems for effective mental health services require investment in the following key pillars of health:

- Policy and a legislative framework,
- Leadership and governance,
- Infrastructure with recommended norms and standards,
- Adequate human resource,
- Required health products, equipment and technologies,
- Equitable health care financing mechanism with a provision of universal health care.

Access to mental health care is therefore, measured not only by adequacy of supply but also its affordability, physical accessibility and acceptability of services that are also relevant and effective for the population, delivered by a capable qualified workforce to ensure satisfactory health outcomes.

Due to the limitations and barriers outlined, 75% of Kenya's population is unable to access mental health care.

THE MENTAL HEALTH POLICY AND ACCESS TO MENTAL HEALTH SERVICES

The Mental Health Policy (2015 – 2030) provides five directions that should apply in regard to mental health service delivery:

- The government shall ensure that the mental health system for service delivery is affordable, equitable, accessible, sustainable and of good quality.
- The mental health system shall be responsive so that the performance of the system shall meet the populations' expectation in dignity and respect.
- The organisation of mental health services shall adopt the WHO model of service organisation pyramid for an optimal mix of services for mental health (see Figure 3).
- Comprehensive mental health services shall comprise promotion of good mental health, prevention of MNS disorders, treatment and rehabilitation of MNS disorders at all health care levels.
- To strengthen the referral system to ensure effectiveness, efficiency and cost-effectiveness in service delivery.

The policy also adopts strategic and evidence-based approaches to address substance use prevention, treatment and the rehabilitation of persons with substance use disorders with the following key priority actions:

- National strategic programme on substance use prevention, treatment, care and rehabilitation
- Investment plans to improve access to effective substance use treatment and care.
- Capacity building and quality assurance to meet the guidelines and standards for evidence-based and best practices in substance use treatment and care.
- To integrate substance use treatment and care in the health care system and social welfare system in the comprehensive continuum of care.

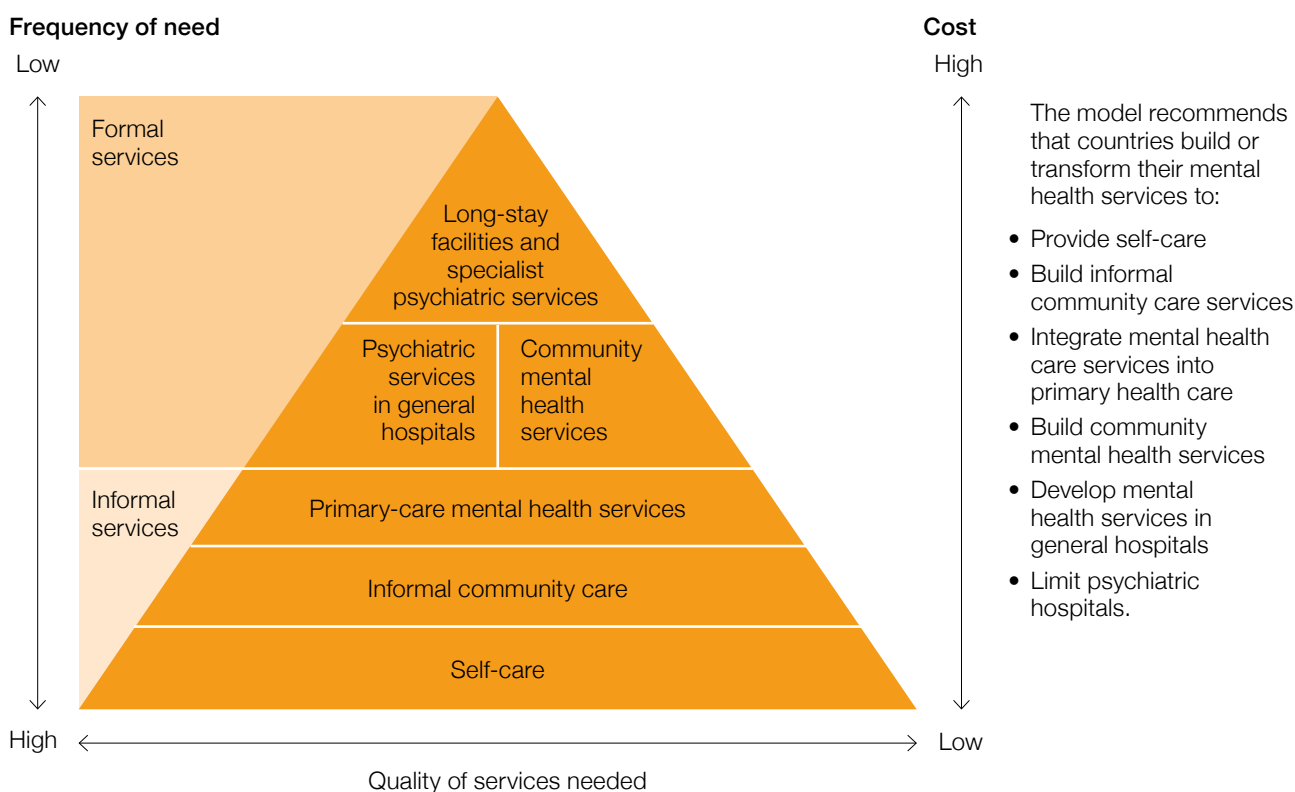
MENTAL HEALTH SERVICES ORGANISATIONAL MODEL

The optimal mix of services for mental health is described in the WHO's Service Organisation Pyramid (Figure 3). Primary care for mental health, as defined in the WHO model, is fundamental but must be supported by other levels of care to meet the full spectrum of needs of the population. The pyramid provides six levels namely; (1) Self-care (2) Informal community care, (3) Integration into primary care mental health services, (4) Community mental health services, (5) Psychiatric services in general hospitals, and (6) Limited long-stay facilities.

Self-care

Most people can manage their mental health problems themselves, or with support from family or friends. Self-care should be supported by formal health services. Kenyans need to be educated on how to deal more effectively with stress, the importance of physical activity in staying mentally well, effective ways of dealing with relationships and conflict management, and the dangers of hazardous alcohol and drug use.

Figure 3: WHO Organization Pyramid for Optimal Mix of Services for Mental Health



Source: WHO Organization of Services for Mental Health

Informal community care

Informal community care comprises services provided in the community that are not part of the formal health and welfare system. Examples include traditional healers, professionals in other sectors such as teachers, religious leaders and police, services provided by non-governmental organisations, user and family associations, and lay people. This level of care can help in prevention, promotion and aftercare support to prevent relapses among people who have been discharged from hospitals. Informal services are usually accessible and acceptable because they are an integral part of the community. Informal community care should not form the core of mental health service provision, but complement and form useful alliances to formal services while primary health care and integrated general hospital and specialised hospital care should support the informal community care.

Primary care mental health services

Essential services at this level include early identification and treatment of mental disorders, management of stable psychiatric patients, counselling for common mental disorders, referral to other levels where required, and mental health promotion and prevention activities. General practitioners, nurses or other health workers may provide these assessments, treatment and referral services. Services at the primary health care level are generally the most accessible, affordable and acceptable for communities and they integrate treatment of physical conditions as well.

Community mental health services

Community mental health services include day centres, outreach services, rehabilitation services, hospital diversion programmes, mobile crisis teams, therapeutic and residential supervised services, group homes, home help, assistance to families, and other support services. To maximise effectiveness, strong links are needed with other services up and down the pyramid of care.

Psychiatric services in general hospitals

The nature of certain mental disorders may require hospitalisation during an acute phase. Sub-county hospitals provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute worsening of mental disorders, in the same way that these facilities manage acute presentations of physical health disorders. Mental health services provided in sub-county referral hospitals also enable 24-hour access to services for any physical health problems that might arise during the course of inpatient stays.

Specialist services

For a small minority of people with mental conditions, specialist care is required beyond that which can be provided in general hospitals. Treatment-resistant or complex presentations need to be referred to specialised centres for further evaluation and treatment. Some conditions require ongoing care in residential facilities due to their very severe mental disorders or intellectual disabilities and lack of family support. Forensic psychiatry is another type of specialist service that falls into this category.

Quality Improvement for Mental Health

Quality improvement helps ensure that scarce resources for mental health are used effectively and efficiently. This is a continual process, which requires the active participation of all stakeholders on an ongoing basis. The Kenya Government is currently implementing the WHO Quality Rights Initiative where quality mental health care services with a human rights approach is emphasised.

For effective mental health services and the implementation of mental health policies to reach all, there has to be a multi-sectoral and multidisciplinary approach as indicated.

GAPS IN INFRASTRUCTURE

- There are about 3,956 government-owned health facilities in Kenya of which 284 are Level 4 hospitals. Mental health care services are only provided in a paltry 29 of these level 4 hospitals representing only 0.7% of the facilities. Psychiatric units are only available in 15 of the 47 counties in Kenya. Patients seeking mental health care in the remaining 32 counties are most often forced to travel to Mathari National Teaching and Referral Hospital (MNTRH) in Nairobi, the only national referral hospital for mental health. Even with the few mental health units that exist, the public is not fully aware where they are located as there is no existing database for reference: In addition, patients have to pay for the treatment and sometimes have no money to pay for emergency services hence they are turned away.
- The Mathari Hospital was built in 1910 and, disturbingly, most of the infrastructure being utilised to date was established at that time meaning, it is 110 years old. Some of the buildings have even been condemned by the Ministry of Works as inhabitable. It lacks basic infrastructure to deliver modern evidence-informed psychiatric care.
- At that time, mentally ill patients were deemed to be “*lunatics*” hence these inpatient psychiatric units were termed ‘lunatic asylums’ hence ‘hidden’ and isolated from the rest of the hospital services further leading to their neglect, rendering them dangerous to both patients and service providers. To date these institutions lack necessary diagnostic and treatment equipment for quality mental health service provision.
- The Taskforce visited some of the few psychiatric units that exist, and found them to be in a deplorable state. They were described as inhumane for both patients and staff. Indeed, users of mental health services said that the poor state of the infrastructure of the psychiatric units in itself is a key driver of stigma, with the majority of Kenyans shying away from being associated with these facilities.
- Despite the growing population, these units have not expanded in their physical capacity and hence most are severely overcrowded, many have more than double the occupancy. Many patients are also abandoned in the hospital; the Taskforce members were shocked when they met an 80-year-old patient who had been abandoned in Gilgil hospital for 60 years.
- There is only one forensic psychiatry inpatient unit located in Mathari Hospital and it serves the entire country. The unit is old, overcrowded, understaffed and lacks in providing an environment for treating the illness as well as the rehabilitation of behaviour of those admitted. The prisons suggested having a psychiatric facility in regional stations to address the concern of the lack of mental health facilities within prisons. Service provision for mentally ill offenders should include resources for rehabilitation and resettlement services.
- Treatment and rehabilitation facilities for persons with substance use disorders in the public health are very few. There are only two government owned inpatient rehabilitation centres which in total have a capacity of less than 70. A majority of private rehabilitation centres are poorly regulated. Despite the fact that these institutions offer medical care as part of rehabilitative care, many are not approved or regulated by the Medical Practitioners and Dentists Council.
- Related to human resources, there is poor coordination of care among communities, traditional healers, faith-based healers, and primary, secondary, and tertiary care health workers.



Open drainage along the ward (Kakamega.)



Bathroom for patients in Kakamega



Toilet for patients and health workers in Kakamega

Taskforce members at MSU



WHAT KENYANS SAID ABOUT ACCESS TO MENTAL HEALTH SERVICES

Kenyans are unable to access mental health care due to poor infrastructure, unaffordability, and lack of trained personnel in communities and health care facilities. There is a stigma attached to psychiatric facilities due to their poor condition, location and reputation. Kenyans said, medication was frequently missing and when available they found it to be too expensive and at times of a poor standard. Majority of Kenyans mostly depend on outdated but affordable first generation medication. Due to the high level of stigma and lack of community support, there are high incidents of abandoned patients in hospitals. Counselling though deemed to be important was scarcely offered in public facilities and expensive in the private sector.

Users and caregivers opinions are integral to these Task Force findings and recommendations, as their viewpoint emanates from first-hand experience an experience which is invaluable in gaining insight into the current situation regarding mental health in Kenya. One such person so candidly stated:

“Persons with mental conditions face several challenges in accessing healthcare services due to lack of effective prevention, early diagnosis and intervention, referral and treatment services. Many suffer from increased mental and physical health complications due to delayed diagnosis and interventions, with some being handled unprofessionally or against their basic rights. Many cannot afford public health insurance cover, which provides mostly for inpatient services without provisions for much needed outpatient services. Those with private insurance are discriminated from treatment through some retrogressive policy clauses. Due to these reasons many patients with mental conditions lack access to treatment including emergency care. Public facilities lack availability of medicines which are mostly first generation drugs with adverse side effects. Improved quality second generation drugs are expensive, beyond reach for many patients.”
(Refer to Users and Caregiver Presentation in Annex 6).

- Kenyans said there is a need to make services accessible by decentralising them to the community level and making rehabilitation centres affordable. Establishment of emergency counselling services and a helpline for psychiatric emergencies should be made an urgent priority.
- Between 10 – 20% of women suffer mental disorders after pregnancy and child birth, these are missed due to lack of aftercare support systems and a lack of integration of mental health services in other health services.
- Lack of mental health experts during screening of other major health conditions combined with lack of outreach-services leads to mushrooming of unregulated counselling centres.

- Most hospitals lack mental health departments / units for inpatient care. Newer psychiatric medications with fewer side effects are unavailable and where offered are financially out of reach of the majority leading to poor compliance. Caregivers gave moving testimonies of the economic and emotional burden they are forced to carry with little or no support from care providers, the government and the community at large.
- Kenyans further observed that most schools lacked trained and qualified school counsellors – (psychologist or Counsellor deployed with no teaching duties).
- Mental health care service provision was deemed to be under-resourced at all levels of the health system. This puts a large strain on the limited trained mental health care providers and hence impacting on quality of care. In addition, Kenyans reiterated the scarcity of counsellors and psychologists in the public service and pointed out that, though a number of nurses received specialised training in mental health nursing or psychology they were often redeployed to other disciplines of health.
- Kenyans pointed out that politicians were nationalising anxiety and that bureaucracy in the government structures derailed training and deployment of mental health workers. The training of disciplined forces is mainly focused on combat paramilitary/ military training; “*You come out physically strong but emotionally broken*”, they said.
- Kenyans also highlighted the importance of spirituality on mental health and the delivery of this care at the informal level. They quoted the following scriptures:
 - » Ephesians 4:23: Be renewed in the spirit of your mind
 - » Book 76, Hadith 1: There is no disease that Allah has created, except that He also has not created its treatment.
 - » Bhagavad Gita Chapter 2 Verse 66: The individual whose mind and senses are not controlled cannot have a focused intellect, without a focused intellect he cannot meditate, and without meditation there is no peace. How can there be happiness without peace?

Users and caregivers stated that:

- We advocate for the provision of highest attainable standards of mental health services that are accessible, high quality and cost effective, while upholding the right to emergency medical treatment according to Article 43 of the Constitution of Kenya. These include prevention, promotion, early diagnosis, intervention, treatment and management with adequate access to equipment, medication, occupational and psychological therapy. In line with universal health care, there is need to provide free and quality medication for mental health conditions in public facilities and cost regulation for drugs in private facilities.
- Advocate for integration of mental health services in primary healthcare systems for all health services, with a focus on community based services.
- Recommend free or subsidised NHIF inpatient and outpatient cover for persons with mental conditions and the review of retrogressive private insurance clauses that discriminate persons with mental conditions.
- Recommend the facilitation of support group psychotherapy for users of mental health services and caregivers in primary health centres to promote community healthcare models of care and support. After hospitalisation, persons with mental conditions should be supported with socioeconomic and support services for smooth reintegration into the community and to ensure seamless continuity of care.
- Recommend close monitoring to ensure that the various WHO Quality Rights are upheld in the care of patients within health facilities and in their communities.
- Special disability registration systems to ensure access to social protection for persons who are homeless and with severe mental conditions and the provision of specialised facilities for shelter, food, clothing, healthcare, rehabilitative and resettlement services. Additionally, socio-economic disability support packages are required for persons with chronic mental conditions and for caregivers to reduce the barriers of access to livelihoods, education and employment.

TASKFORCE RECOMMENDATIONS

Re-build Mathari Hospital

There is urgent need to re-build Mathari Hospital, restructure and improve counties mental health units as part of the general health care service provision.

Adopt Community Mental Health Services approach

The gold standard for delivery of mental health care in the world today is through community mental health teams. This underscores the importance of rolling out mental services to all levels of health care including the community countrywide. The efficacy of existing (though very limited) community-based provision was witnessed by the Task Force. To increase this service will require:

- Training and supervising service providers located at primary care facilities. These are the first entry points for patients and form a critical component of the health system.
- Engage, train and supervise informal providers such as traditional and faith healers in providing psychosocial support.
- Ensure that mental health services are provided at the community level through accessible and affordable outreach and counselling services.
- Address the needs of adolescents and youths and devise responsive interventions.
- Use technology to reach the hard-to-reach and provide interventions from a central place.
- Train and capacity build people on prevention and management of Adverse Childhood Experiences (ACEs).

No Kenyan seeking mental health services should be left behind

- Mental health services must be available at all levels of health care provision especially at the community level.
- Mental health services must be integrated with other health care services.
- Renovating existing mental health facilities as well as building modern facilities.
- Every county should have outpatient services at all levels
- Inpatient mental health wards must be available in all counties at least in their referral hospital.
- Ensuring that services are accessible, evidence-informed and adhere to the quality rights approach.
- The mental health treatment gap can be narrowed by the use of technology for example by supporting use of telemedicine for hard-to-reach areas.
- There is a need to establish half-way homes for the abandoned patients and those requiring rehabilitation in order to decongest hospitals as they await reintegration into society.

Human resources for mental health services

Human resources are the most valuable asset of a mental health service. A mental health service relies on the competence and motivation of its personnel to promote mental health, prevent disorders and provide care for people with mental condition. Human resources for mental health comprise a multidisciplinary workforce that works collaboratively to ensure efficient services at different levels of care from promotion, prevention, treatment, rehabilitation and aftercare.

Gaps identified in Human Resource

- Limited human resources for mental health in all specialties at all levels of the health system with most health facilities lacking mental health professionals. The few that exist are strained and over-worked, thus unable to offer efficient and quality services. For instance, the entire Mombasa County is served by one psychiatrist who is retired and working on contract. There are no psychologists even in the Mathari Hospital, the national teaching and referral institution for mental health. Medical social workers are limited to a few referral hospitals.
- Gaps in training of health care workers. The training curriculum for health professionals such as nurses and clinical officers lacks a component of mental health yet they form the largest workforce that interacts with the majority of patients especially at the primary health care level.
- No ongoing mentorship and on-the-job training on best practices in mental health.
- Health care workers who are trained in mental health are underutilised; for instance, mental health nurses are deployed to work in areas such as antenatal clinics.
- Lack of motivation of the mental health workers due to poor working environment, lack of risk allowances, lack of support supervision leading to poor retention and low uptake of courses related to mental health.
- The cost of training a general nurse to become a mental health nurse is prohibitive, and this cost is borne by the nurses themselves.
- The Public Service does not have psychologists and counsellors employed as part of the health workforce.

RECOMMENDATIONS ON HUMAN RESOURCE

- Provide adequate multidisciplinary mental health service providers to ensure efficient services that take care of all aspects that influence mental wellness. This includes hiring and deployment of counsellors and psychologists through the Public Service Commission.
- Establish and strengthen the county mental health secretariat, committee and multi-disciplinary thematic working groups (TWGs).
- Review the curriculum used in training health care workers and mandate all training institutions to embed an examinable component of mental health training at all levels including rotation in mental health units, as well as experience in a community setting.
- Develop or adopt an existing training course on mental health that is certifiable that can be used to upskill existing health workers.
- Orientate and train outsourced staff including security personnel in all facilities and offer continuous in-service quality rights training to all staff.
- Train and recruit community health workers and medical social workers to work in the community especially on prevention, promotion, screening, referral and after care.
- Train and supervise service providers at primary care facilities as they are entry points for patients and form a critical component of the health system.
- Motivate the mental health care workers in order to improve the uptake of the profession and retain them by improving their work environment, providing regular support supervision and risk allowances.
- Provide government funding for training mental health workers.

Mental Health Products, Equipment and Technologies.

Provide for the requisite range of medications for psychiatric conditions that are modern and evidence-informed by compelling KEMSA to fulfil its mandate of adoption and procurement of products recommended in the Kenya essential drugs list.

Develop mental health service provision for mentally ill offenders.

Under universal health coverage, we strongly suggest that mentally ill offenders should be categorised as special patients requiring special treatment. We suggest that every patient should receive an NHIF card funded by the state. So far Mathari Hospital does not receive any funding for mentally ill offenders which translates to very constrained services offered to them and this clientele being a huge burden to the Mathari Teaching and Referral Hospital since they account for 30% of the in-patient bed capacity at any one time.

RECOMMENDATION ON SUBSTANCE PREVENTION AND TREATMENT

- That all outpatient and inpatient substance use disorder treatment facilities be regulated by the Medical Practitioners and Dentists Council.
- Establish a national strategic programme on substance use prevention, treatment, care and rehabilitation.
- Establish investment plans to improve access to effective substance use treatment and care.
- Enhance capacity building and quality assurance to meet the guidelines and standards for evidence-based and best practices in substance use treatment and care.
- Integrate substance use treatment and care in the health care system and social welfare system in the comprehensive continuum of care.

Ensure minimum standards of mental health services

Ensure minimum standards of mental health services; by developing norms and standards as well as evidence based guidelines on best practices of mental healthcare with well-defined care pathways and referral strategy. A rights-based approach to community services for persons with mental illnesses should be adopted. Provision of care should be accessible and affordable to every person. Community-based provision is effective and sustainable in the long run in preventing stigma and discrimination. A holistic approach to recovery in mental health which has proven to work therefore should be implemented in all counties in Kenya.



CHAPTER NINE

MENTAL HEALTH FINANCING AND UNIVERSAL HEALTH CARE

“Cost of treatment for mental health illnesses is very high”.

This is what Kenyans told the Taskforce. Health care and treatment for mental health conditions are often excluded from essential packages of care or insurance schemes. People with mental health conditions and their families face a difficult choice: that of pay out-of-pocket for treatment.

The underfunding of mental health in Kenya forces most of those suffering from mental illness to seek private treatment at very high cost. If they cannot afford to seek treatment, they continue to suffer quietly in their homes.

HEALTH CARE FINANCING

Health financing falls under four categories; out of pocket, government budgetary allocation, NHIF and private insurance. With the devolved system of government (2013) the provision and management of healthcare in Kenya falls under both the national government and county governments. Under this system, an analysis of public healthcare financing must be done at both the national and county levels. In 2010/11, health, which was then entirely a national function, accounted for about 5.9% of total government budgets, increasing in 2011/12, but it has since remained stagnant between 7% to 8% (Kenya Health Financing System Assessment, 2018).

Health as a percentage of the government budget has remained below the 15% target set by Africa heads of states in Abuja in 2000, of which Kenya is a signatory. For the period between 2010 and 2015, the Kenya government general health expenditure averaged at 1.78% of the GDP (ibid). With devolution, there is wide variation in the prioritisation of health needs, though the overall trend, comparing FY 2015/16 to FY 2016/17 is upward in terms of the share allocated to health (ibid). However, the county health sectors have inherited the national-level spending pattern in which the budget for recurrent expenditures far exceeds development.

HEALTH INSURANCE IN KENYA

Affordable health care is one of Kenya’s “*Big Four Agenda*” under the flagship of Universal Health Coverage (UHC). This is meant to ensure that all people resident in Kenya have access to health services that are of good quality and that work, whenever they need them, without encountering financial hardship. According to the Universal Health Coverage strategy (2018–2022), Kenya intends to achieve universal coverage through a Social Health Insurance Fund (SHIF) as a single-payer by 2022. Currently NHIF coverage by most measures is less than one-fifth of the population. In 2018, about 18% of individuals had some form of health insurance, an increase from 17% in the 2013 (MOH, 2018)⁹.

A Universal Health Coverage Health Benefits Package Advisory Panel (in the MOH) report on implementation of the Presidential health coverage agenda has one of the key deliverables to develop the UHC – Essential Benefits Package of services. The Package is explicit on Mental Health services (see box). However, the costing for service package which is estimated to be between \$130-\$170 per household is not broken down by disease category.

MENTAL HEALTH FINANCING

Globally, mental health is generally underfunded. Kenya is among the 28% of WHO member states that lack a separate budget for mental health. The global median mental health expenditure per capita is US\$ 2.5 (KES250). Based on the WHO Global Health Expenditure, the global average of domestic general government health expenditure per capita in 2015 was US\$ 141 (KES14,100), thus making governments mental health expenditures less than 2% of global average (government) health expenditure.

There is a large variation between regions; for example, mental health expenditure per capita in European region is more than 20 times higher compared to African and South East Asian Region. Government expenditure in mental health in developing countries remains very low and most of it goes towards mental health hospitals with very little going to preventive and community-based services.

In Kenya, government expenditure on mental health is 0.01% of the total expenditure on health (Office of the Auditor General, Dec. 2017). The report shows that; Mathari Referral Hospital is not allocated financial resources that are commensurate to its status. In 2015/2016 the hospital had a recurrent expenditure shortfall of 82% (Office of Auditor General, Dec. 2017). Yet, mental health conditions pose several service and financial access challenges to the households.

9 Facility-Based Services: Basic and Specialised Essential Health Services benefit package

1. Reproductive, Maternal, Newborn, Child and Adolescent Health Services
2. Management of Major Infectious Diseases: Malaria, TB and HIV/AIDS
3. Management of Non-Communicable Diseases
4. Management of Other Medical and Surgical conditions
5. Mental Health Services

Kenya Household Health Expenditure and Utilisation Survey, 2018

First, persons with these conditions are too often subjected to discrimination and stigmatisation, which can reduce their willingness to seek care. Second, individuals may be unaware of their condition and not seek or know about appropriate treatment. Third, mental health conditions are typically chronic and require ongoing treatment. Furthermore, health care and treatment for mental health conditions are often excluded from essential packages of care or insurance schemes. Without such coverage, people with mental health conditions and their families face a difficult choice: that of pay out-of-pocket for treatment.

The goal of UHC is to ensure that people have access to the required services without falling into poverty as a result of health expenditure. The out-of-pocket expense represents a regressive form of health financing by placing the burden of payment on those with the least capacity to bear the costs. The progress towards UHC therefore seeks to achieve three goals of increasing:

- The proportion of the population covered by some form of financial protection;
- The proportion of total costs covered by some form of prepayment, such as health insurance; and
- The depth of coverage (the range of services or interventions available to insured persons) (WHO 2010a). In increasing the depth of coverage, it is crucial to include an essential package of mental health services as guided by need and extended cost effectiveness analysis.

The reduction or elimination of out-of-pocket spending for the care and treatment of mental health conditions can represent major savings for affected households. Public financing provides financial risk protection (FRP) benefits and shields many households from impoverishment. (Verguet and others 2015).

A case study on Universal Public Financing of Mental Health Services in India and Ethiopia shows that enhanced coverage of effective treatment leads to significant improvements in population health. This works out to 1,500 healthy life-years per one million populations in Ethiopia and 3,000 India, when the three disorders are considered together. This can be achieved at a very reasonable cost (US\$1.21 per capita in Ethiopia and US\$1.37 in India). Furthermore, a Universal Public Financing policy can lead to a more equitable allocation of public health resources across income groups and benefit the lowest-income groups mostly in terms of the value of insurance, used here as a measure of financial protection: the poorest 40% of households receive over 50% of the combined value of insurance in India, and 76% in Ethiopia.

Private expenditures on complementary or traditional remedies would not be covered by such public financing, thus this might continue to be a significant drain on the resources of some household groups. It is critical that increased financial protection goes hand in hand with enhanced coverage of an essential package of care. Improved service access without commensurate financial protection will lead to inequitable rates of service uptake and outcomes but improved financial protection without appropriate service scale-up will bring little improvement if any.

WHAT KENYANS SAID

- That the NHIF only partially covers substance abuse treatment and rehabilitation programme and only in a few hospitals. Many private medical insurers do not cover mental health care at all. A few have an extremely limited cover which is inadequate even for complete treatment in a single hospital admission. It also fails to cover patients admitted with attempted suicide or for treatment and rehabilitation of substance use disorders. Even with the NHIF card, most 2nd generation medicines were not available in hospitals and patients end up buying from chemists.
- Kenyans reported that there were no dedicated budgets toward mental health services in County Government Departments of Health and County health facilities.
- There is insufficient allocation of resources for mental health, both at national and county levels. This is coupled with inadequate provision for insurance cover for mental health, and tax discrimination for people living with mental health conditions. Although NHIF for inpatients in facilities like Mathari Referral Hospital covers the admission and treatment, the outpatients will require extra monies to buy drugs.

TASKFORCE RECOMMENDATIONS

The Taskforce echoes the Universal Access to Mental Health Services Kenya approach and recommendations, that is:

- Amend the Mental Health Act. Amend the Act to provide for mental health fund which will include revenue raised from sin taxes to be managed by the commission on mental health and happiness.
- Increase equitable funding for mental health services: Urgently reduce reliance on out of pocket payments for mental health services by increasing public funding (budgetary allocation) for mental health from general government revenues to closely match the international average mental health financing of \$2.5 (KES250) per capita per year.
- Expand the scope of financed mental health services: With increased funding, additional funding can go towards community based and preventive mental health enhancing services. This would ease pressure on referral hospitals like Mathari.
- Risk pooling for mental health: Ensure that the existing health insurance programmes especially NHIF provide a comprehensive coverage for mental health including community based mental health services at the primary healthcare level.
- Tax exemption for people living with mental illness: Just like persons with disability, the Taskforce recommends tax exemptions for persons with mental illnesses.
- Include mental health package in medical insurance: The Taskforce recommends that insurance companies should include mental health in their packages.
- Open NHIF cover for mental health outpatients. Currently NHIF coverage is restricted to a health facility chosen by an individual. If that health facility does not have a mental health unit, the individual will not get the services. The Taskforce recommends that for cases of mental health, a patient should be treated in any hospital outside his/her choice so long as it has a mental health unit. Further, NHIF should cover outpatients.
- Levy sin tax to manufacturers of commodities with known effect on mental health. Commodities such as alcohol and tobacco are known to cause mental health illnesses. Manufacturers of such commodities should be compelled to pay sin tax.
- Tax incentives. Provide tax incentives for organisations and individuals that run approved mental health programmes.
- Private sector incentives. Recognise and encourage the private sector corporate social responsibility.





CHAPTER TEN

MENTAL HEALTH DATA AND RESEARCH

Since the 1990s, Kenya has made efforts to develop and implement a Health Information System. *The Kenya Health Act, 2017* and *Health Information Policy 2014-2030* provide for a National Health Information System that is responsive to the needs of the population.

The current health information system however, does not address specific mental health conditions and monitoring of mental health interventions. For example, at facility level only a single diagnosis defined as mental disorder is used to capture any diagnosis of the various types of mental illnesses and conditions managed. Further, many smaller non-generalisable studies on mental health research in Kenya have been carried out over time. These studies need to be harmonised and approaches standardised for them to inform policies and programming around mental health.

A mental health information system (MHIS) will be a sub-system of national health information system. It supports the collection, processing, analysing, disseminating and using information about a mental health service and the mental health needs of the population it serves. The MHIS will aim to improve the effectiveness and efficiency as well as the decision making of the mental health services. As a result of it, managers and service providers will be able to make more informed decisions for improving the quality of care.

WHAT KENYANS SAID

- Kenyan health care workers observed the **glaring gap in the health information system data capture at facility level**. At present only one indicator captures all mental disorders in the existing health information system. This means that health care workers are forced to record substance use disorders, suicide attempts, schizophrenia, depression simply as **mental disorders**. This indicator is completely insufficient in monitoring specific disease burden from mental illness. This in turn translates to poor planning and prioritisation of mental illnesses. Kenyans restated that the health information system must include specific mental health conditions not only to better understand and address this disease burden but also to ensure health care workers are identifying and managing these conditions in patients.
- Kenyans further reiterated the **paucity of mental health research particularly due to limited government funding**. Kenyans recommended a national mental health survey as well as funding for research studies examining curative and preventive research interventions that are appropriate and locally relevant.
- Kenyans emphasised the **need to monitor and evaluate different mental health aspects**, including facility based data, existing infrastructure both human and physical, and research conducted. This collated information is critical for prioritising, planning and implementing preventive and curative mental health related interventions. It is advisable that an agency be established to manage these functions.

TASKFORCE RECOMMENDATIONS

The Taskforce recommends the establishment of a Mental Health Data and Research function to be managed by the proposed Mental Health Commission to carry out the following tasks:

Ensure integration of mental health information sub-system within the general health information system.

There is need to put in place a well-coordinated and structured mental health information system that is integrated within the existing general health information system data capture.

- One subsystem should focus on routine service reporting from the basic health services at primary health care level, formal community mental health services, psychiatric services in general hospitals and specialist mental health services. Key indicators in this system are the mental health conditions. A minimum data set of at least 8 mental health conditions including depression, substance use disorder, anxiety disorder, bipolar mood disorder, schizophrenia, neurodevelopmental disorder, suicidal attempt and dementia need to be captured. This will not only serve to better define disease burden but will improve identification and management of these conditions by front line health care workers.
- A second subsystem shall focus on administrative systems. This includes human resource information, drug and logistic systems, and financial information.
- A third subsystem can include non-routine data collection for specific initiatives as special programme reporting for example a suicide prevention initiative or a mental health promotion programme in schools.

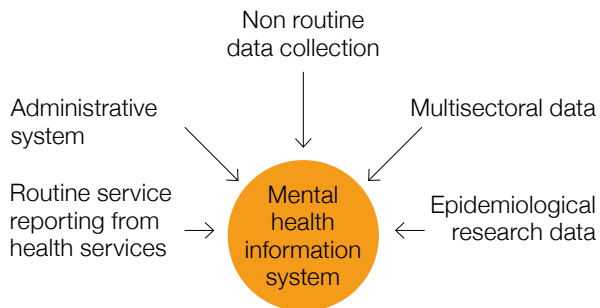
Ensure mental health information system is integrated within information systems of other sectors.

This refers to information system outside the health sector. Mental health touches on various other sectors. These include social services, education, criminal justice, labour and other sectors like the non-governmental organisations (NGOs). This inter sectoral coordination shall ensure resources are planned and distributed adequately depending on mental health needs of the sector. In order to capture this information and ensure integration, suicide prevention as an indicator (in line with SDGs) as well as substance abuse prevention needs to be captured in all government and non-government performance contract reporting.

Inclusion of epidemiological data.

Though costly epidemiological surveys in conjunction with other data on service utilisation can allow service planners to monitor the requirements for care in terms of budget allocation for services, medication and human resource.

The figure below is a summary of the proposed national mental health information system:



The proposed Mental Health Commission will design the mechanisms to ensure Mental Health Information System Data and Research is implemented throughout the implementation of this report.



CHAPTER ELEVEN

IMPLEMENTATION PLAN

11.1 TASKS AND RESPONSIBILITIES

Through an intensive reflection process, The Taskforce analysed the causes of the increased cases of mental health issues in the country, and carefully considered the recommendations given in each chapter of this report. Subsequently, the Taskforce now recommends that to ensure the long term mental wellbeing outcomes, it is important to have an effective implementation, monitoring and evaluation framework of this report. This calls for collaboration of both public and private sectors.

The Taskforce therefore proposes an appropriate institutional framework that utilises existing departments and institutions to implement recommendations specified in this report ensuring active participation of communities. If other capacity gaps will be identified in the course of implementation, additional support will be mobilised by the Ministry of Health.

The implementation of this report is anchored on the Mental Health Policy (2015-2030), and dully informed by Constitution of Kenya 2010; Kenya Health Policy (2014-2030); Kenya Vision 2030; the World Health Organizations (WHO's) comprehensive Mental Health Action Plan (2013-2020), and the Convention on the Rights of Persons with Disabilities. These remain reference documents throughout the implementation.

The implementation matrix has been derived from the preceding Chapters, carefully taking into account financial, human and institutional resource constraints. Different actors will be involved in the implementation. Their roles are discussed below.

MINISTRY OF HEALTH

The Ministry will have an overall coordination of the implementation of this report as well as monitoring and evaluation. The Ministry of Health will work with all government ministries, state departments, agencies and counties to ensure the implementation of these recommendations. The Ministry of Health will formulate policies, initiate programmes and develop technical guidelines and standards to support the implementation of Taskforce recommendations.

THE NATION MENTAL HEALTH AND WELLNESS COMMISSION

The Taskforce has recommended for the creation of a National Mental Health and Wellness Commission to advise the National and County Governments on the state of mental health and happiness in Kenya. This Commission will conduct periodic surveys of mental health and happiness in Kenya, ensure continuous surveillance of the state of mental health and happiness, supervise the delivery of mental health services in Kenya, and provide advisories on the effect of guidelines, policies, legislation, and any acts by State Organs on mental health and happiness, among other functions.

THE COUNTY GOVERNMENTS

As per the Mental Health Policy {3.2 (b)}, the counties are required to;

- Include mental health in the County Integrated Development Plans, Strategic Plans and Annual Implementation Plans.
- Mobilise resources and carry, monitoring and evaluation of mental health programmes; and
- Build capacity and provide and technical assistance for effective implementation of the policy.

The county governments will therefore design inclusive mental health care services to cater for all ages and demographic groups, including the youth and the elderly. The county governments will also implement community mental health services; and ensure decentralised and integrated mental health services are accessible to communities.

MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

The Taskforce recommends restructuring and improvement of Mathari National Teaching and Referral Hospital as a semi-autonomous government agency serving as an institute of neuropsychiatry and mental health. This will enable the institution to be a centre of excellence providing referral specialised neuropsychiatric services, training and research in mental health in collaboration with regional training facilities/hospitals and international Universities and research Organisations'.

THE COMMUNITY MENTAL HEALTH SERVICES

The Taskforce has recommended the adoption of **Community based Mental Health Services approach**. The services should be people centred; recovery oriented and with a human rights approach delivered through community mental health teams. This underscores the importance of decentralising and integrating mental health services to the primary care and community level. This will require support systems to primary care facilities, Communities mental health outreach and counselling services, users and caregivers support organisations, adolescents and youth participation and tracing of hard-to-reach groups. The community strategies through community health units and existing community structures such as the Nyumba Kumi Initiative, peer and empowerment groups will offer a good platform to involve communities in primary mental health care.



11.2 MONITORING AND EVALUATION

Monitoring the extent to which recommendations in this report are implemented is critical for the Government. The Ministry of Health and Mental Health and Wellness Commission (at its establishment) will be responsible for monitoring the implementation of these recommendations and reporting to the National Assembly. Each MDA and Counties will implement mental health as part of their performance contracting; and will be required to mainstream mental health programmes in their annual plans. To ensure this happens, Ministry of Health will work with each of these agencies during the negotiation of performance contracts so that specific mental health indicators are included in their contracts.

Monitoring and evaluation will take place at three levels: national; county; and at community levels. The Ministry of Health will identify and define specific targets and indicators, integrate them in a matrix that will be disseminated up to the lowest implementing levels. The same indicators will be made available through the **Community Mental Health Services** to assist the communities to participate in the monitoring and evaluation.

Mental health data and research (as discussed in Chapter 10) will support M&E in data collection, processing, analysing, disseminating and using information about a mental health service and the mental health needs of the population it serves.



Thematic area	Key Findings	Key Recommendations	Actors
Burden of Mental illness	<ul style="list-style-type: none"> Kenya has a high burden of mental illness. This is measured based on numbers of years lost due to ill health, disability and premature mortality with huge gaps in access to care. Many cases of depression, suicide and substance use were reported in various epidemiological studies as well as reporting by the media. 	<ul style="list-style-type: none"> Declare mental ill health a National Public Health Emergency. Institute a national suicide prevention programme. 	<p>Cabinet</p> <p>Commission on Mental Health and Happiness</p> <p>Ministry of Health</p>
Mental health and special population	<ul style="list-style-type: none"> Some populations are more vulnerable to the burden of mental ill health with a vicious cycle leading to high impact on quality of life. The key vulnerable and special populations identified by the Taskforce were: the youth, elderly, prisoners, disciplined forces, and the boy child. 	<ul style="list-style-type: none"> Develop and implement guidelines, screening tools and user friendly care and support pathways for special populations in prisons, schools, displaced populations, trauma survivors, veterans. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Health</p> <p>Ministry of Education</p> <p>MDA and Counties</p> <p>Users and Caregivers</p> <p>NGOs and Private sector</p>
Mental health and wellbeing	<ul style="list-style-type: none"> Kenyans have a poor understanding of mental health. They thought that mental health was synonymous with mental illness. Negative narrative on mental illness leading to low focus on the importance and benefits of mental wellbeing and wellbeing. 	<ul style="list-style-type: none"> The Taskforce recommends promotion of mental health and wellness programmes at all levels of society. Cabinet to approve and gazette the National Mental Health Awareness week to be observed every 2nd week of October. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Health</p> <p>Ministry of Public services and Gender Affairs</p> <p>MDA and Counties</p> <p>Users and Caregivers</p> <p>NGOs and Private sector</p>
Social determinants and other factors contributing to ill mental health	<ul style="list-style-type: none"> Kenyans are a traumatised population. They have had many experiences and exposures leading to increased vulnerability to mental ill health with far reaching impact on their health and quality of life. 	<ul style="list-style-type: none"> An annual measure of happiness index with focus on population mental wellbeing. Family Affairs and Social protection policy to have a focus on mental health and psychosocial support services for vulnerable populations. Establish a surveillance mechanism on mental health to measure determinants of mental health. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Labour and Social protection</p>
Stigma and discrimination	<ul style="list-style-type: none"> In Kenya, stigma plays a significant role on how mental health is addressed. Stigma and discrimination lead to social exclusion, marginalisation of users of mental health services and underfunding of the sector leading to poor service delivery. 	<ul style="list-style-type: none"> Have multi-sectoral programmes against stigma and discrimination. Launch countrywide sustained anti-stigma and mental health education campaigns through public barazas, sport, media, art and cultural festivals. Empowerment and inclusion of people with mental health conditions through reasonable accommodation in Education, Employment, Skills training and Policies development. QualityRights initiative implementation to improve quality of care, to protect, respect and fulfil the human rights of people with mental health conditions, psychosocial, intellectual and cognitive disabilities. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Health,</p> <p>MDA and Counties</p> <p>NGOs and Private sector</p> <p>Users and Caregivers</p>

Thematic area	Key Findings	Key Recommendations	Actors
Policy and legislative framework	<ul style="list-style-type: none"> • Lack of prioritisation of the implementation of mental health policy at National, County and Community levels. • Mental Health Act enacted 1989 requires amendment. • Other legislations were found to have clauses which negatively impact on people with mental health conditions, psychosocial, intellectual and cognitive disabilities. 	<ul style="list-style-type: none"> • Disseminate the Mental Health Policy to all MDAs, counties and the private sector to implement mental health as part of their performance contracting. • Develop a Mental Health Action Plan with prioritised resources to fast track the implementation of the policy. • Amend mental health act to align to the constitution of Kenya, Health Act, International laws and address emerging issues. • Decriminalise suicide and amend other laws which are discriminatory and use derogatory language. • Amend law relating to criminal justice system to ensure people with mental health conditions are not discriminated by criminalisation of symptoms of mental illness and get fair administration of justice. • Implement and enforce existing mental health related laws including the Counsellors and Psychologists Act. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Health</p> <p>State Law Office and department of Justice</p> <p>Kenya Law Reform Commission</p> <p>Parliament</p> <p>Judiciary</p>
Leadership and Governance	<ul style="list-style-type: none"> • Lack of national and county mental health leadership structures and systems left mental health unattended to. • The Kenya Board of Mental Health was not constituted as provided for by the law. 	<ul style="list-style-type: none"> • Establish a Commission for Mental Health and Happiness. • Establish the Directorate of Mental Health & Substance Use at the Ministry of Health. • Establish mandatory requirement for performance contracting by all Ministerial Departments and Agencies (MDAs) and counties to mainstream mental health programmes. • Establish county mental health council and county mental health coordinators. • Establish sub county mental health focal point and ward mental health committees. • Strengthen users and caregivers' organisations and support groups. • Promote leadership for youth peers groups lead interventions in mental health. 	<p>Ministry of Health</p> <p>Ministry of Interior and Coordination of National Government</p> <p>County Governments</p> <p>NGO Council</p> <p>Ministry of ICT and Youth</p> <p>Users and Caregivers</p> <p>Youth Organisations</p>

Thematic area	Key Findings	Key Recommendations	Actors
Access to mental health services	<ul style="list-style-type: none"> Mental health services are generally not available to the population at the county, and community levels. Where they existed they are in dehumanising conditions, poor infrastructure with inadequate resources to deliver quality services. 	<ul style="list-style-type: none"> Decentralise and integrate mental health services accessible by communities, user friendly, people centred, recovery oriented and with a human rights approach. Take urgent administrative measures to ensure availability of emergency drugs in mental health facilities. Mathari National Teaching & Referral Hospital to be gazetted and operationalised as a semi-autonomous Institute of Neuropsychiatry and Mental Health. Establish an affirmative action fund to train and recruit critical threshold of mental health professionals in accordance to the multidisciplinary staff establishment at different levels of service across sectors. Support implementation of psychosocial rehabilitation and aftercare services. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of health</p> <p>County Governments</p> <p>NGOs and Private sector</p> <p>Users and Caregivers</p> <p>Youth Organisations and Groups</p>
Mental health financing	<ul style="list-style-type: none"> Only 0.01% of the national health budget is allocated to mental health. Kenyans have been forced into poverty due to payment for mental healthcare through out-of-pocket. The recommended amount of money that ought to be spent on mental health is KES 250 per capita but Kenya is spending 15 cents. NHIF cover is not comprehensive and private insurance policies are discriminatory. 	<ul style="list-style-type: none"> Urgently reduce out of pocket payment for mental health services by increasing public funding under Universal Health Care. Increase general government revenue to closely match the international median health financing of KES 250 per capita per year. Insurance healthcare financing by NHIF to provide comprehensive coverage of outpatient and inpatient mental health care package. Amend Mental Health Act to provide for mental health fund to address disparities which will include revenue raised from sin taxes to be managed by the commission on mental health and happiness. Tax incentives for organisations that promote and support implementation of approved mental health programmes to service users and caregivers. 	<p>Commission on Mental Health and Happiness</p> <p>Parliament</p> <p>Ministry of Health</p> <p>National Treasury and Planning</p> <p>Kenya Revenue Authority</p> <p>NHIF</p>
Mental health data and research	<ul style="list-style-type: none"> The current health information system is inadequate in not addressing specific mental health conditions. Inadequate research data on mental health in Kenya. 	<ul style="list-style-type: none"> Carry out a national mental health survey to establish the burden, determinants and impact of mental ill health. Additional funding to Mathari hospital to build research capacity in mental health working in collaboration with KEMRI and other partners. 	<p>Commission on Mental Health and Happiness</p> <p>Ministry of Health, Mathari Institute of Mental Health and Neuropsychiatry and KEMRI</p> <p>Universities and Research institutions</p>



POSTSCRIPT: THE COVID-19 MENTAL HEALTH PANDEMIC

Subsequent to the completion of its mandate, but prior to the publication of its findings, the Taskforce met and discussed the events that had changed the world in a few months. The world had been changed by a virus, the SARS-CoV-2 that causes the respiratory illness called COVID-19, in ways that defied the imagination. This post script captures the views of the Taskforce in the timeframe since the onset of the pandemic and describes the views of the team subsequent to the declaration of the pandemic. It is a postscript in the true sense in that it does not in any way purport to change the report as it was prior to the declaration of the pandemic. It does however seek to point out its relevance and applicability as we move into the post covid-19 era.

After initial reports at the end of 2019, COVID-19 rapidly spread to all corners of the world, and was declared a pandemic in mid-march 2020. By mid-May hundreds of Kenyans had been confirmed to have the infection, and dozens had died. As the pandemic established community spread in Kenya, the Taskforce met and decided to comment on its effects on the mental health of Kenyans. We hold the view that this report would be incomplete if it were to be published without comment on this, perhaps the most life changing single event for this and many generations past and future.

It is self-evident that the world has undergone a fundamental change in a way not witnessed before in human history. The global extent of the pandemic is new. The entire world has gone through events that have led to the reshaping of the way humans understand their world and the way they relate to each other. Social disruption of a magnitude never seen before has led to novel experiences of life that are likely to lead to an increase in mental disorders. Indeed, there are published reports of significant increases in anxiety and depression among frontline medical workers and other vulnerable groups. Now, more than ever before, Kenya must act with haste and clarity of purpose to implement strategies that will promote mental wellbeing. The Taskforce report is a good starting point.

The Covid-19 pandemic has highlighted the need for Kenya to be prepared for this type of emergency. It has brought to the fore, the imperative of having in place a National body whose mandate includes ensuring focused leadership in mental health. Such a body would avail the critical thought leadership during and after any crisis. Indeed, in the report we suggest that mental ill health is now itself a National public health emergency of epidemic proportion and we recommend such a declaration by the appropriate authority.

There were many different reactions to the prevailing situation. At the population level, there was what has been called psychic contagion that is characterised by extreme level of communal anxiety. For many it was the fear of catching the virus, while for others it was the fear that a loved one could be infected and possibly die. For many others, fear was fuelled by the consumption of copious amounts of information that was pumped through all the media houses and driven by social media outlets. Inaccurate information via formal and informal outlets did not help things in particular in the early stages of the pandemic.

The public health measures put in place to contain the pandemic seemed to be both necessary and painful, a situation that created a level of ambiguity that led to more stress to the population. A clear such example is the fact that the curfew regulations in the early stages of the pandemic were implemented by security agents with a great deal of vigour not matched by sensitivity. Many of the messages sent out were diametrically opposed to the normal mental health messages people are accustomed to. People were for example told to keep away from each other while at the same time told not to go to places of worship and, most seriously for Africans, not to bury their dead in the customary way! Added to this was the requirements that people stay at home, not go to work, and for many therefore face starvation. Those on daily wages and earnings were unable to begin to comprehend what was worse, death from COVID-19 or death from starvation. This unprecedented dichotomy from the pandemic led to levels of societal anxiety never seen before. It was clear that both the message and the messenger needed to be acutely sensitive to the novelty of the situation.

There was evidence of a trust deficit in the authorities that, for some, seemed insensitive and distant from the needs of the people. Some members of society said that the disease was for those who travelled by aeroplane and that therefore it did not affect them. Acts of disobedience of lawful authority were on this account and led to greater levels of anxiety.

For the individual there came some unusual difficulties. Long hours spent in confinement and in close proximity to family members led to reports of domestic abuse. Children and the elderly suffered a great deal on account of massive disruption of routine that is often provided in the case of children by going to school. Frontline health care workers were reported in many countries including Kenya to be suffering from high level of stress and many developed clinically significant depression and anxiety. Many reported sleep disorders. The very people we depended on were in danger. Other groups to have reported increased levels of risk for mental disorder were those already in care. For some it was because of lack of continuity of care while for others it was on account of the stress and disruption occasioned by the virus and its consequences.

The economic hardship due to the pandemic is likely to drive the prevalence of mental disorders higher. The link between poverty and depression and suicide in particular is well articulated in the body of this report. Whatever measures Kenya takes to deal with economic consequences of the pandemic, we must be acutely aware of the mental health consequences. In this regard, the pandemic is not only a health concern because it hits at the economy, disrupts social order and cohesion which in turn affects the mental health and wellbeing of the people.

The pandemic has brought into sharp focus some observations made in this report. The first and most obvious is our insufficient investment in mental health. This will come to haunt us as we face increased demand for care. Other areas that leave Kenya exposed are the field of human resources addressed in some detail in this report. The report further describes in detail the inadequacy of the infrastructure in place for mental health. It also points to the need to increase mental health financing.

All predictions we have seen indicate a dramatic increase in demand for mental health services in the post-covid-19 era. **We hold the view that the urgent implementation of our recommendations will assist Kenya in the recovery phase.**

The section on the administrative reforms that are required is worth focussing on as these are mostly painless and inexpensive measures that have great and immediate benefit.

Two medium and longer term interventions are worth mentioning as they would be helpful in preparation for the future. The first is the declaration of mental ill health as an emergency of epidemic proportion. The other is the proposed Mental Health and Happiness Commission. These two interventions would ensure greater readiness for the future.

This pandemic comes with challenges and opportunities. The practice of medicine will almost certainly not be the same again. New opportunities in fields such as telemedicine call for a new legal and regulatory framework. They also offer avenues for novel methods of healthcare delivery and education.

The fact of the high penetration of mobile telephony as well as the availability of internet connectivity in Kenya, provide great opportunities for care. These existing investments are available for exploitation in the field of mental health. Basic tools such as short text messages (sms), email and even a phone call can complement the more modern tools of trade such as telemedicine and telepsychiatry.

It is true that the pandemic will change the world in ways not imaginable before. It is also true that the very fact of change demands a response that ensures the delivery of timely, quality and affordable care to all Kenyans, using the strategies and resources currently at our disposal. Immediate steps to adopt and begin implementing the recommendations we make in this report will potentially mitigate some of the more devastating mental health consequences of this pandemic.

To sum up, members of the task force observed; that the mental health of Kenyans must be considered in the government's pandemic response. That psychosocial support intervention need be integrated within this response. That excess gaps in mental health systems and access to services were worsened especially by restrictions of movement and resulted in most people in particular ones residing in rural communities being cut off from services. That the people with pre-existing mental health conditions were experiencing exacerbation of ill health and challenges in accessing continuity of care. We as a taskforce therefore recommend fast tracking of the implementation of this report and specifically the setting up of a mental health commission that can oversee the improvement of the level of national preparedness and readiness to provide mental health and psychosocial support during emergencies and humanitarian situations.

We wish to take this opportunity to sincerely thank the Cabinet Secretary for Health Hon. Sen. Mutahi Kagwe, for the work he is doing in the National response to the COVID-19 Pandemic. In the midst of all the challenges caused by the pandemic, he has found time to offer leadership to us and his interest in this report has been self-evident and gives us hope that in his watch the report will find full implementation.



ANNEX 1

TASKFORCE MEMBERS AND TERMS OF REFERENCE

TASKFORCE MEMBERS

The Taskforce on Mental Health was formed pursuant to a Cabinet resolution and officially commissioned by the Cabinet Secretary for Health on the 11th December 2019 to study the causes of the increased cases of mental health issues and recommend solutions to tackle the emerging epidemic.

The Taskforce comprised of the following persons:

MEMBERS



Prof. Lukoye Atwoli
Associate Professor of Psychiatry at Moi University School of Medicine, R&D Director at citiesRISE, and Vice President Kenya Medical Association



Dr. Joyce Nato
Programme manager, Prevention and Control of NCDs, Mental Health, Disabilities, Violence and Injuries, WHO, Kenya Country Office



Mrs. Melanie Blake
MBE, KRPN, Founder and Programme Director of Kamili Organisation



Susan N. Mochache
CBS (Co-Chairperson)
Principal Secretary Health



Dr Frank Njenga
(Co-chairperson)
Founder, Chiromo Mental Health Hospital



Dr. Oscar Githua
Forensic Psychologist, Assistant Professor of Psychology – USIU-Africa, Chair, Kenya Psychological Association



Dr. Benard Olayo
Senior Health Specialist – World Bank



Dr. Linnet Ongeru
Senior Clinical Research Scientist, Kenya Medical Research Institute; Centre for Clinical Research



Mr. Raymond O. Ochieng
Secretary Youth Affairs, Ministry of ICT, Innovation & Youth



Dr. Halima Abdalla Mwenesi
PhD, – Public Health and Social Scientist, Director, RAMWE Consultancy & Development Services, Nairobi, Kenya/ Ann Arbor, Michigan USA



Charity Muturi
(Co-opted Member) – Representative of Users of mental health services and Caregivers, trained in community health & development, Chairperson of Tunawiri CBO – mental health and community reintegration with focus on criminal justice system

Secretariat



Dr. Wekesa Masasabi



Dr. Simon Njuguna



Dr. Catherine Syengo Mutisya



Dr. Mercy Karanja



Ms. Jacqueline Aloo



Dr. Priscilla Makau



SECRETARIAT SUPPORT

- Dr. Nasri Omar
- Dr. Alfred Gitonga Miriti
- Jane Gichuru
- Joy Muhia
- Maureen Njeri
- Aphlyne Turfy
- Matilda Mghoi

THE TERMS OF REFERENCE

- Assess the prevailing mental health status in Kenya, the social determinants and other factors contributing to adverse mental health status in the country.
- Assess the mental health systems in the country and outline the policy and administrative reform proposals for each challenge identified for the transformation of mental health systems for improved mental health and the quality of life.
- Review the Mental Health Policy 2015-2030, its instruments and its institutional framework and assess its capacity to deliver improvements in access, experience and outcomes throughout the mental health pathway, across the life-course and make recommendations where necessary.
- Propose long term strategies to accelerate the implementation of Mental Health Policy across all the sectors.
- Recommend strategic interventions including resource mobilisation approaches for the effective implementation of the interventions identified.
- Identify and review for synergy, the existing enabler legislations and policies for the effective implementation of the interventions identified.
- Propose a framework for effective and efficient collaboration, monitoring, evaluation and review of progress made in the implementation of the identified interventions.

DELIVERABLES

- A report on the prevailing mental health status in Kenya, the mental health systems gaps including the legal and policy framework environment, the social determinants and other contributing factors to the adverse Mental Health status.
- A report on the proposed legal, policy and administration reforms to address the challenges limiting the transformation of mental health systems for improved mental health and quality life of Kenyans.
- A report on the adequacy or otherwise of the Mental Health Policy 2015-2030 with clear recommendations for practical approaches towards prevention and control of mental ill health across all sectors.
- An Action Plan with strategic programmes, interventions and resource mobilisation strategies for effective implementation driven by equity and human rights approaches.
- A proposed framework for collaboration and coordination among all the key sectors and stakeholders.
- A proposed framework for monitoring, evaluation and feedback on the implementation of the recommended action plan.

MODE OF OPERATION

In the performance of its functions, the Taskforce shall:

- Regulate its own procedures and while working within the confines of the Constitution, form technical working groups and collaborate across and beyond its constituent membership to deliver on its mandate where necessary.
- Submit a work plan at commencement to facilitate the preparation to hold such number of meetings in such places and in such times as the Taskforce shall consider necessary for the proper discharge of its functions in consultation with the Ministry of Health.
- Conduct public participation forums as appropriate, receive and consider memoranda or information from all relevant stakeholders and including from persons with experience on mental ill health, their families and care givers.

REPORTING

- The Taskforce shall report to the Cabinet Secretary.
- The Taskforce shall present reports fortnightly to the Cabinet Secretary.

DURATION

The Taskforce shall submit its comprehensive report within 80 days from the date of its inauguration.

ANNEX 2

METHODOLOGY AND PUBLIC PARTICIPATION

The Mental Health Taskforce was established pursuant to the cabinet directive to transform mental health systems and improve the mental wellbeing of Kenyans. The Taskforce was mandated to report on the prevailing mental health status in Kenya, the mental health systems gaps including the legal and policy framework environment, the social determinants and other contributing factors to the adverse mental health status.

The TOR contained a general methodology, including:

- Review of existing administrative processes, procedures, and systems that impact on mental health.
- Review of legislative documents, procedures and related documentation including best practices.
- Consultative meetings with the stakeholders including focus group discussions with service providers at all levels of the mental health fraternity, administration, citizens, civil society organisations, NGOs, and other sectoral representatives.

The Taskforce included desk reviews, public hearings/ engagement, visits to counties, received oral and written submissions, and engaged with various stakeholders including experts in different fields of health and outside. They met with young and old, women and men, professionals, mental health services providers, policy makers, Members of Parliament, MCAs, Governors, First Ladies, persons with lived experiences and patients currently undergoing treatment.

The Taskforce employed the media as a tool for public awareness and engagement through various platforms which included; mental health Taskforce twitter account, Ministry of Health Facebook page and media briefs.

The outputs from these activities were consolidated into nine themes that formed the chapters of the Taskforce report. They include:

- Mental health and wellbeing,
- The Burden of Mental illness,
- Mental health in special populations,
- Determinants of mental health,
- Stigma and Discrimination,
- Policy and, Legislation, Leadership and Governance,
- Mental health services and systems,
- Mental health financing and universal health coverage, and
- Mental health data and research.

Desk review

The Taskforce reviewed empirical literature (studies) globally and in the country, best practices, legislative documents, administrative procedures and related documentation relevant to the nine themes, ensuring the encompassing of activities set out in the terms of reference.

Public hearings/engagements

The Taskforce visited 10 counties between 13th of January to the 27th of January 2020. During these visits, public hearings were conducted, focus group discussions and consultative meetings were held and written memorandum from organisations and individuals were received. In total, the Taskforce held discussions with a total of 1,569 Kenyans, received 184 memoranda (111 emails and 73 submissions).

The ten (10) counties visited were:

• Meru	13/01/2020
• Makueni	14/01/2020
• Eldoret	15/01/2020
• Nakuru	16/01/2020
• Mombasa	16/01/2020
• Kakamega	17/01/2020
• Kisumu	20/01/2020
• Nyeri	21/01/2020
• Garissa	22/01/2020
• Nairobi	27/01/2020

Written Submissions

The Taskforce received 184 written submissions/ memoranda from individuals and organisations. Some were received online and others during the public hearings.

Focus Group Discussions

The Taskforce conducted focus group discussions between 28th of January to the 31st January 2020. The following focus group discussions took place in Nairobi:

- Youth and Education sector forum (28/01/2020)
- NGOs, Religious groups, users and caregivers (29/01/2020)
- Mental health professionals, Health regulatory bodies, Medical training institutions and service providers including alternative medicine (29/01/2020)
- Workplace mental health, Media and Insurance industry (30/01/2020)
- Security, Justice and Law sector (31/01/2020)
- State actors; Ministries, State Departments and commissions (31/01/2020)



Consultative Meetings

The Taskforce conducted consultative meetings and fact-finding visits in Nairobi between 5th February and 04th March 2020:

- County First Ladies (5/02/2020)
- Senate Health Committee (13/02/2020)
- Taskforce member attendance to National Assembly Public hearing on the mental health bill
- Mathari National Teaching & Referral Hospital (14/02/2020)
- Nairobi Remand & Allocation Prisons (18/02/2020)
- Kenya Medical Supplies Authority (KEMSA) (18/02/2020)
- Kenya Medical Practitioners and Dentists' Council (19/02/2020)
- National Committee on Criminal Justice Reform (NCCJR) (19/02/2020)
- Developmental Partners for Health in Kenya (25/02/2020)
- Asumbi Treatment Center (25/02/2020)
- Nairobi West Hospital (25/02/2020)
- Chiromo Lane Medical Center, Bustani Branch (25/02/2020)
- Consultative meeting with NCD Alliance Kenya (27/02/2020)
- Consultative meeting with AMREF Health Africa (28/02/2020)
- Nairobi place – a private treatment and rehabilitation centre (04/03/2020)
- Kamili Organisation; Kangemi Outreach Clinic (04/04/2020)
- Consultative meeting with National Council for Persons with Disability (05/03/20)
- Consultative meeting with KMTC Mathari campus (05/03/20)
- Taskforce presentation to the steering committee on the implementation of BBI Report (10/03/2020)

Public participation

The Mental Health Taskforce has submitted this report after extensive public consultations with Kenyans across ten regions¹⁰; meeting with young and old, women and men, professionals, mental health services providers, policy makers, Members of Parliament, MCAs, Governors, First Ladies, persons with lived experiences and patients currently undergoing treatment. In total, the Taskforce met and held discussions with 1,569 Kenyans, received 206 memoranda (121 emails, 73 hard copies and 12 uploaded on the website).

¹⁰ Meru, Makueni, Eldoret, Mombasa, Nakuru, Kakamega, Nyeri, Kisumu, Garissa and Nairobi

ANNEX 3

DETAILED KEY FINDINGS AND RECOMMENDATIONS

Thematic area	Key findings	Key Recommendations
Mental Health & Wellbeing	<ul style="list-style-type: none"> • Kenyans felt distressed with many circumstances in their lives and did not know how to deal with it. • Kenyans were unable to differentiate between mental wellbeing and its importance. They instead thought that mental health was synonymous with mental illness. • Across sectors, communities, private sector; there was no prioritised focus on the importance and benefits of population mental health and wellbeing. • There is lack of specific interventions, investments and programmes to address population mental health and wellbeing. 	<ul style="list-style-type: none"> • Cabinet to approve and gazette the national mental health awareness week on every 2nd week of October. • Establish workplace wellness programmes as a mandatory target in all public and private sector annual performance contracting and reporting. • Set up county mental health friendly spaces and amenities to promote mental wellbeing and build resilience through sport, art, music & cultural festivals. • Implement mental health literacy curriculum for public education and awareness creation through communities' baraza, empowerment and peer groups, schools and colleges. • Establish school psychology, learning support and development services with full time school counsellors and psychologists working together with other relevant sectors.
Burden of mental illness	<ul style="list-style-type: none"> • Kenya has a high prevalence of mental illness translating to a high burden of mental illness considering the numbers of years lost due to ill health, disability and premature mortality. • Treatment gap, stigma and discrimination worsen the burden of mental illness. 	<ul style="list-style-type: none"> • Declare mental ill health a National Public Health Emergency. • Establish a national suicide prevention programme to restrict means, enhance surveillance, education, access to treatment. Other gains will include decriminalisation, responsible reporting, helplines and crisis interventions. • Establish community based services with focus on primary mental health care.
Mental health in special population	<ul style="list-style-type: none"> • Some populations are more affected by the burden of ill mental health with a vicious cycle leading to a high impact on quality of life. • Among the key vulnerable and special populations identified by the Taskforce were: the youth, elderly, prisoners, disciplined forces, and the boy child. • Other special populations include: young children, adolescents, survivors of gender based violence, people living with chronic physical illnesses, elderly, people living with HIV / AIDS, refugees, persons with physical disability and the LGBT community. 	<ul style="list-style-type: none"> • Develop and implement guidelines, screening tools and user friendly care and support pathways for special populations in prisons, schools, displaced populations, trauma survivors, veterans to mention but a few.
Determinants of mental health	<ul style="list-style-type: none"> • Kenyans are a traumatised population with various experiences and exposures leading to increased vulnerability to mental ill health with far reaching impact on their health and quality of life. • Mental health and many common mental conditions are shaped to a great extent by the social, economic, and physical environments in which people live. • Factors such as unemployment, poverty, insecurity, gender based violence, low literacy levels, deprivation and homelessness, poor working conditions and other social inequality and disparities contribute significantly to the mental ill health of Kenyans. 	<ul style="list-style-type: none"> • Establish a commission which will monitor and evaluate and give advisory on measures to mitigate risks (socioeconomic, sociocultural, demographic, environmental, neighbourhood); strategies to promote mental health and wellbeing. • The happiness of Kenyans and their wellness should be monitored through a surveillance mechanism to conduct continuous monitoring and evaluation of mental health determinants and report on happiness index. • Family affairs and social protection policy – with targeted mental health and psychosocial support services to vulnerable populations as well as promote family skills and unity.

Thematic area	Key findings	Key Recommendations
Stigma and discrimination	<ul style="list-style-type: none"> In Kenya, stigma plays a significant role on how mental health is addressed. Stigma and discrimination lead to social exclusion, marginalisation of users of mental health services and underfunding of the sector leading to poor service delivery. There is criminalisation of signs and symptoms of mental illness coupled with discriminative legal provisions leading to many petty offenses being attributed to mental illness and substance use related and addictive disorders. 	<ul style="list-style-type: none"> Have multisectoral programmes against stigma and discrimination. Launch anti-stigma and mental health promotion campaign through sport and media. Empower and include people with mental health conditions through reasonable accommodation in education, skills development and employment. Inclusion of people with mental conditions in policy development, decision making and programme as a strategy of dealing with stigma and discrimination. Implement quality rights mental health initiative to educate the public on mental health and human rights aimed at changing narrative and attitudes and practices; transform services and reform policies and legislative framework. Social marketing to bring social and behaviour change: package of services, modern infrastructure, champions advocates and branding.
Policy and legislative framework	<ul style="list-style-type: none"> Lack of prioritisation of the implementation of mental health policy at national, county and community levels. Mental Health Act enacted 1989 requires amendment to align with the constitutional dispensation, the provisions of the health act and international laws (CRPD) and address emerging issues. Other legislations were found to have clauses which negatively impacted on people with mental health conditions, psychosocial, intellectual and cognitive disabilities. 	<ul style="list-style-type: none"> Develop and disseminate the mental health plan to fast track implementation of mental health policy across sectors as a mandatory target under the performance contract. Amend the Mental Health Act to align it to national and international laws (e.g. CRPD). Amendments of discriminatory laws which negatively affect people with mental health conditions such as decriminalise suicide and people with substance use disorders. Enforcement of law to ensure no discrimination by insurance companies on comprehensive medical coverage for treatment of mental illnesses. Harmonise laws and regulations on substance use prevention and control for effective implementation of strategies to control substance abuse and facilitate treatment and rehabilitation services as a health and human right issue. Amend law relating to criminal justice system to ensure people with mental health conditions are not discriminated, by criminalisation of symptoms of mental illness and get fair administration of justice.
Leadership & Governance	<ul style="list-style-type: none"> Lack of National and County mental health leadership structures and systems left mental health unattended as a priority public health and socioeconomic agenda. The provided leadership and Governance structures in the Mental Health Act including the Kenya Board of Mental Health and District Mental Health Council were not operational or were not implemented. The lack of structures, systems and prioritisation of mental health at community and household levels was a major barrier in achieving any gains in mental health in Kenya. 	<ul style="list-style-type: none"> Establish a Commission for Mental Health and Happiness. Establish county mental health councils with mental health coordinators, with leadership structure up to the community through sub county focal persons and ward mental health committees to coordinate implementation of mental health programmes at county level. Directorate of mental health and substance use at the national level. To lead policy formulation of policies on mental health and substance use prevention, treatment and rehabilitation Strengthen Users and Caregivers organisations and support groups. To promote leadership for Youth Peers groups lead interventions in mental health.

Thematic area	Key findings	Key Recommendations
Mental health services and system	<ul style="list-style-type: none"> • The current status is that many Kenyans have no access to mental healthcare despite the heavy burden in existence. • Dehumanising infrastructures in mental health facilities across different parts of the country. • There were insufficient promotive and preventive services. • KEMSA stock out and lack of supply of essential medicines to mental health facilities in Kenya. • The multidisciplinary team of mental health professionals was in low ratio to the service need and some trained and qualified professionals were unemployed. • The treatment and rehabilitation services for substance use disorders were mainly in private facilities which were not licensed or regulated by healthy regulatory bodies. • The system of forensic psychiatric services is dysfunctional with many people with mental health conditions not accessing healthcare services, fair administration of justice and fulfilment of their human rights. 	<ul style="list-style-type: none"> • Decentralise and integrate mental health services in general health facilities with community outreach programme; which are people centred, recovery oriented with a human rights approach. • Establish counselling and psychosocial services centres at service delivery point at sub county level and Huduma centres. • Every licensed health facilities in the country should provide mental health services as a part of the essential package of care. • Mathari NTRH to be gazetted and operationalised as a semi-autonomous Institute of Neuropsychiatry and Mental Health. • Restructure existing and design new comprehensive services that meet norms and standards for an environment with respect and dignity that ensure quality of care and promote recovery. • KEMSA to provide mental healthcare products and equipment including variety of second generation medicines. • An affirmative action fund to train and recruit critical threshold of mental health professionals in accordance to the staff establishment at different levels of service across sectors. • Government to absorb the already existing mental health professionals including psychologists and counsellors. • Treatment and rehabilitation of substance use disorders to be regulated under health regulatory framework as a health and a human rights issue. • Establish and support implementation of psychosocial rehabilitation and aftercare services.
Mental health financing	<ul style="list-style-type: none"> • There is insignificant financing for mental health both at the national and county levels. • Only 0.01% of the national health budget is allocated to mental health. • Most of government expenditure in mental health goes towards facility based services with very little going to preventive and promotive community-based services. • The recommended budget for mental health is KES 250 per capita but Kenya is spending 15 cents. • Kenyans have been forced into poverty due to out of pocket payment for mental healthcare. • NHIF cover is not comprehensive and private insurance policies are discriminatory. 	<ul style="list-style-type: none"> • Urgently reduce out of pocket payment for mental health services. Increasing public funding for mental health from general government revenue to closely match the international median health financing of KES 250 per capita per year. • At least 5% of National health budget to be incrementally allocated to mental health as determined by the report on annual happiness index. • All MDAs and counties to establish mental health vote to fund mental health mainstreaming and community mental health programmes. • Mental Health Act amendments to provide for mental health fund which will include revenue raised from sin taxes to be managed by the Commission on Mental Health and Happiness. • Tax incentives for private and other organisations that promote mental health programmes to users and caregivers. • Comprehensive mental healthcare services under UHC health benefit package. • Insurance healthcare financing by NHIF to provide comprehensive coverage of outpatient and inpatient mental health care package. • Insurance Regulatory Authority (IRA) to ensure all insurance companies are compliant with the law in respect to issuance of equitable medical cover for all mental health conditions including substance use disorders and suicide attempts. • Develop public private partnerships to include as part of corporate social responsibility financing mental health. • Social security and protection to people with psychosocial, intellectual and cognitive disabilities.
Mental health data and research	<ul style="list-style-type: none"> • The current health information system is inadequate and fails to address specific mental health conditions. • Inadequate research data on mental health in Kenya. 	<ul style="list-style-type: none"> • Carry out a national mental health survey to establish the burden, determinants and impact of mental ill health. • Mental health data collection from community and health facilities through integrated health information systems. • Additional funding to support research at the institute of mental health and neuropsychiatry working in collaboration with other research organisations to promote and conduct research on mental health.

ANNEX 4

ESTABLISHMENT OF THE NATIONAL MENTAL HEALTH AND HAPPINESS COMMISSION

The Presidential Taskforce on Mental Health in Kenya, having considered all the evidence and consulted Kenyans of all walks of life across the Republic, proposes the declaration of the mental ill health in Kenya as a National Emergency of Epidemic Proportions, and the formation of a National Mental Health and Happiness Commission. The formation of this Commission will be accomplished through the introduction of a Bill to Parliament by the Leader of the Majority, or any other member, under Article 256 of the Constitution of Kenya that provides for amendment by Parliamentary initiative. Further, the passage of this Bill will NOT require a referendum since it does not relate to any of the matters listed in Article 255(1) of the Constitution.

The functions of the Commission shall be to:

- Advise the National and County Governments on the state of mental health and happiness in Kenya.
- Conduct periodic surveys of mental health and happiness in Kenya.
- Ensure continuous surveillance of the state of mental health and happiness.
- Supervise the delivery of mental health services in Kenya.
- Provide advisories on the effect of guidelines, policies, legislation, and any acts by State Organs on mental health and happiness.
- Perform such other functions as the Commission shall deem necessary for the enhancement of mental health and happiness.

The Commission consists of:

- A chairperson who shall be a mental health expert with at least 15 years of distinguished service in the field.
- One person who shall be a person living with mental illness or a caregiver of a person living with mental illness.
- Seven other persons with expertise in mental health and happiness.

The Commission shall:

- Prepare the Annual National Mental Health and Happiness Report that shall be presented to Parliament by the President under Article 132(1)(b), and to the nation under Article 132(1)(c)(i) [in addressing Article 10(2)(b)].
- Develop guidelines on the delivery of services that enhance mental health and happiness.
- Develop tools for continuous surveillance of the state of mental health and happiness.
- Ensure the integration of services that enhance mental health and happiness in all state departments and activities.
- Continuously monitor adherence to constitutional and legal provisions on mental health.
- Liaise, where necessary, with other persons or agencies in order to fulfil its mandate.

The draft Bill to accomplish this amendment follows.

A Proposed Draft Bill of the Constitution of Kenya (Amendment), 2020

(Amendment by Parliamentary Initiative in accordance with Article 256 of the Constitution of Kenya)

ENACTED by the Parliament of Kenya, as follows-

Short title

This Act may be cited as the Constitution of Kenya (Amendment) Act, 2020

Insertion of Part 4, Article 237A in Chapter 13 of the Constitution.

The Constitution is amended-

- By inserting the following new Part immediately after Article 237-
- Part 4- National Mental Health and Happiness Commission
- By inserting the following new Article 237A under this part-
- 237A (1) There is established the National Mental Health and Happiness Commission

The Commission consists of:

- A chairperson who shall be a mental health expert with at least 15 years of distinguished service in the field
- One person who shall be a person living with mental illness or a caregiver of a person living with mental illness
- Seven other persons with expertise in mental health and happiness

The functions of the Commission shall be to:

- Advise the National and County Governments on the state of mental health and happiness in Kenya
- Conduct periodic surveys of mental health and happiness in Kenya
- Ensure continuous surveillance of the state of mental health and happiness
- Supervise the delivery of mental health services in Kenya
- Provide advisories on the effect of guidelines, policies, legislation, and any acts by State Organs on mental health and happiness
- Perform such other functions as the Commission shall deem necessary for the enhancement of mental health and happiness

The Commission shall:

- Prepare the Annual National Mental Health and Happiness Report that shall be presented to Parliament by the President under Article 132(1)(b), and to the nation under Article 132(1)(c)(i) to address matters under Article 10(2)(b)
- Develop guidelines on the delivery of services that enhance mental health and happiness
- Develop tools for continuous surveillance of the state of mental health and happiness
- Ensure the integration of services that enhance mental health and happiness in all state departments and activities
- Continuously monitor adherence to constitutional provisions on mental health
- Liaise, where necessary, with other persons or agencies in order to fulfil its mandate

Amendment of Article 248 of the Constitution

Article 248 (2) is amended

- In paragraph (i), by deleting the word “and” immediately after the semi-colon
- In paragraph (j), by replacing the full stop with a semi-colon, followed immediately by the word “and”
- By inserting the following new paragraph immediately after paragraph (j)-
- The National Mental Health and Happiness Commission

Implementation provisions.

Subject to the provisions of the Constitution, the President shall take the necessary steps to ensure that this Act is fully implemented within six months of enactment of this Act.

MEMORANDUM OF OBJECTS AND REASONS

The Bill aims at providing for a National Mental Health and Happiness Commission to manage the State of Mental Health and Happiness in Kenya, after mental ill health was declared a crisis and a national emergency of epidemic proportions. It is envisaged that this Bill will be introduced to Parliament by the Leader of the Majority, or any other member, under Article 256 of the Constitution of Kenya that provides for amendment by Parliamentary initiative. Further, the passage of this Bill will not require a referendum since it does not relate to any of the matters listed in Article 255(1) of the Constitution.

The Bill proposes to introduce a new Part 4 in chapter 13 of the Constitution, to provide for the National Mental Health and Happiness Commission. Under this part, the new proposed Article 237A provides for the composition, functions and powers of the National Mental Health and Happiness Commission.

The Bill also proposes to amend Article 248 of the Constitution by including the National Mental Health and Happiness Commission in clause 2 of this Article. This will ensure that the National Mental Health and Happiness Commission will be considered as one of the Constitutional Commissions, governed and regulated by the relevant provisions in the Constitution.

Finally, the Bill proposes to set a time-frame for full implementation of the proposed amendments by providing that the President shall ensure that the Commission is fully functional within six months of the enactment of the Act. This is in keeping with the spirit of the Constitution of Kenya, 2010, which provided a timeline for all legislation and actions provided for in the Constitution.

The enactment of this Act shall occasion additional expenditure of public funds, which shall be provided for in the estimates.

ANNEX 5

RECOMMENDED ADMINISTRATIVE ACTIONS

Taskforce on Mental Health Recommended Administrative actions

No.	Actions	Responsible party/ Actors	Outcome
POLICY AND ADVOCACY REFORMS FOR MENTAL HEALTH			
1	Declare mental illness as a national public health emergency of epidemic proportions	Secretary to the cabinet	Reduction of the burden of mental ill health and its impact on health and socio-economic development (Happiness Index and GDP). Good mental health contributes to the achievement of universal health coverage.
2	Directive by Cabinet for Establishment of a National Mental Health and Happiness Commission	Secretary to the cabinet	Overall improvement in the happiness of Kenyans as measured by the annual happiness index
3	Development of a national suicide prevention programme	Cabinet Secretary for Health	Reduction of suicide mortality rate
4	Implementation of the Mental Health policy through mental health plans at national and county governments level	National: Cabinet Secretary for Health County: Chairman, The Council of Governors	Achieve the objectives of the mental health policy
5	Mainstreaming mental health programme across all government ministries, state departments and counties as part of the mandatory performance contract in public and private sector	Secretary to the cabinet	Establishment and operationalisation of workplace mental health and wellness programmes in all sectors
6	Establishment of county mental health councils	Chairman, The Council of Governors	Functioning county mental health leadership and governance structures in place
7	Declaration and Gazettment of the 2nd week of October as a National mental health awareness week	Cabinet Secretary for Interior	Public education and awareness creation eventually leading to a reduction in stigma
HEALTH FINANCING REFORMS FOR MENTAL HEALTH			
8	Increase budgetary allocation for mental health to KES 250 per capita at both national and county governments level	Cabinet Secretary for National Treasury and Planning	Strengthening of the mental health system
9	NHIF to provide free cover for both inpatient and outpatient mental health services to all people diagnosed with mental health conditions paid for by the state as previously done in schemes like Linda mama and school cover	Cabinet Secretary for Health	Reduction in out of pocket expenditure for mental health services Improve access to mental health care
10	Insurance Regulatory Authority to enforce Section (46) of the mental health act with respect to exclusion of people with mental health conditions from insurance policies	Cabinet Secretary for National Treasury and Planning	Increase in insurance coverage for mental health services
11	Tax incentives to promote financing of mental health & wellness programmes by faith based and private sector organisations	Cabinet Secretary for National Treasury and Planning	Increased public-private partnership support for mental health & wellness programmes
12	Empowerment of people with mental health conditions and disabilities through their inclusion in social protection schemes including Cash transfers, employment quotas and grants for socio-economic development (education bursaries, skills training)	Cabinet Secretary for Labour and social protection	Community inclusion and independent living for persons with mental health conditions and disabilities

No.	Actions	Responsible party/ Actors	Outcome
IMPROVING ACCESS TO QUALITY MENTAL HEALTH SERVICES IN KENYA			
13	Streamline KEMSA to ensure accessibility of essential second-generation medicines and equipment to enable the provision of quality mental health care at all levels	Cabinet Secretary for Health	Zero-stock out of mental health products and equipment at all levels of care
14	Gazettment and operationalisation of Mathari hospital as a semi-autonomous institution	Cabinet Secretary for Health	A national centre of excellence in specialised care, training and research in mental health
15	Coordination across sectors on the regulation of treatment and rehabilitation services for substance use disorders by the Kenya medical practitioners & dentists council	Cabinet Secretary for Health	Improve access to quality treatment and rehabilitation services for substance use disorders
16	Primary health care services should include mental health services with requisite human resource for mental health	Cabinet Secretary for Health	Decentralisation of mental health services
17	Establish community preventive and promotive mental health programmes through training of existing community health workers, community and peer-groups	Chairman, The Council of Governors	Early diagnosis and management of mental health conditions
18	Directive to Kenya Medical Training Colleges (KMTCs) to include examinable mental health training curriculum in the training of all healthcare professionals	Cabinet Secretary for Health	Increase number of human resource for mental health
19	Directive to all public and private university medical colleges to include examinable mental health training curriculum in the training of all healthcare professionals	Cabinet Secretary for Education	Increase number of human resource for mental health
20	Inclusion of mental health curriculum in the school learning programme	Cabinet Secretary for Education	Improved mental wellbeing and learning outcomes for school-going children
21	Provision of counselling and psychological services through the deployment of counsellors/ psychologists in schools and other sectors	Cabinet Secretary for Public Service & Gender Affairs	Increased mental wellbeing and productivity for the population
CROSS SECTORAL MENTAL HEALTH REFORMS			
22	Establishment of mental health courts in collaboration with mental health professionals to screen and link to care special needs offenders with mental health conditions	Chief Justice	Fair administration of justice and decongestion of prisons
23	Development and implementation of mental health literacy curriculum for the national police service, prison service and defence forces	Cabinet Secretary for Interior	Improved mental wellbeing among the security forces
24	Develop and implement curriculum for the training of media practitioners on mental health advocacy and reporting	Cabinet Secretary for ICT & Youth	Increase Public education and awareness creation on mental health

ANNEX 6

PROPOSED REVIEW OF THE EXISTING LEGISLATION/LAWS GOVERNING THE MENTAL HEALTH SYSTEMS IN KENYA

Law	Section	Gaps	Recommendations
CONSTITUTION OF KENYA 2010	<p>Article 43. (1a) provides that “every person has the right to the highest attainable standard of health, which includes the right to healthcare services”. Health in this context includes mental health, as defined by the WHO definition of Health.</p> <p>*Article 28 – Human Dignity</p> <p>*Article 46 1(c) – Consumer Rights</p> <p>*Article 53 – Children</p> <p>*Article 54 – Persons with Disabilities</p> <p>*Article 55 – Youth</p> <p>*Article 57 – Older members of Society</p>	While this is stated explicitly in the Constitution, various laws as are inconsistent with the letter and spirit of the Constitution.	All laws in Kenya must align with the Constitution with respect to provision of Mental Health services.
HEALTH ACT 2017	<p>Section 73.</p> <p>There shall be established by an Act of Parliament, legislation to:</p> <ol style="list-style-type: none"> protect the rights of any individual suffering from any mental disorder or condition; ensure the custody of such persons and the management of their estates as necessary; establish, manage and control mental hospitals having sufficient capacity to serve all parts of the country at the national and county levels; advance the implementation of other measures introduced by specific legislation in. the field of mental health; and ensure research is conducted to identify the factors associated with mental health. 	Full implementation of the law.	Need to revise the Mental Health Act to conform to the Constitution of Kenya, the Health Act and CRPD.
MENTAL HEALTH ACT 1989		Not aligned to Constitution of Kenya, Health act and Convention on the Rights of Persons with Disabilities (CRPD).	Fast track further amendment of the bill to become an act of parliament.
MENTAL HEALTH (AMENDMENT) BILL 2018			
THE PENAL CODE 2009	<p>Section 226. Any person who attempts to kill himself is guilty of a misdemeanor.</p> <p>Section 146. Any person who, knowing a person to be an idiot or imbecile, has or attempts to have unlawful carnal connection with him or her under circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the person was an idiot or imbecile, is guilty of a felony and is liable to imprisonment with hard labour for fourteen years.</p>	<p>Criminalisation of mental health symptoms.</p> <p>Use of derogatory terminology to describe vulnerable groups, including persons with disabilities, mental or otherwise.</p>	<p>Delete the section from the penal code</p> <p>Change the language in Section 146 to “Persons with severe mental illness”</p>

Law	Section	Gaps	Recommendations
COUNSELORS AND PSYCHOLOGISTS ACT 2014	This is the law that provides the legal basis for the professions of counseling and psychologist in Kenya. It covers registration, regulation as well as professional conduct.	Lack of implementation has led to poor standards of practice and lack of adherence to boundaries of competence.	Operationalise the Law, and establish the Counselors and Psychologists Board.
NACADA ACT 2012		Implementation of some stipulated functions needs comprehensive services from the Ministry of Health.	Review of the NACADA act to align it to the Constitution of Kenya. Treatment and rehabilitation as Health Function to be regulated under Health regulatory laws, Health Act and Kenya Medical Practitioners and Dentist Council Act. To move the agency to Ministry of Health.
ALCOHOLIC DRINKS CONTROL ACT 2012 (2010)		Counties collect revenue meant for Rehabilitation and use it for other issues they may find as priorities. Gaps in the implementation of the Law and regulations e.g. to strictly enforce the control of production, advertisements, use and protect the health of Kenyans.	Harmonise all the laws that deal with Substance Distribution, Acquisition, Use, Abuse, and Treatment etc.
BETTING, LOTTERIES AND GAMING ACT 2012 (1991)			Taskforce in agreement with the BBI Recommendation on Betting. In addition, review A vice tax – industry players contribute to kitty that goes into research and treatment managed by independent bodies – mental health commission.
NHIF ACT 2012 (1998)	This law establishes the National Insurer. It is actually a good law because it does not discriminate in either letter or spirit against anyone with any ailment, Mental or otherwise.	The practice with regards to provision of Mental Health cover under NHIF is discriminatory, while it is not explicit under the law on the insurance cover. Current practices do not cover for outpatient services; comprehensive cover for treatment and rehabilitation of substance use disorders nor promote prevention as well as continued care for mental illnesses.	All Mental Health services are Health services, therefore should be covered to the same extent as other conditions.
INSURANCE ACT 2017 (2016)	82. Effect of suicide or capital punishment on policy. A policy of life assurance shall not be avoided merely on the ground that the person whose life is assured died by his own hand or act, sane or insane, or suffered capital punishment, if, upon the true construction of the policy, the insurer has thereby agreed to pay the sum assured in the events that have happened.	Practice and implementation by Insurance Companies is in direct contravention with the Law.	Implement the act e.g., Section 82 death by suicide does not lead to nullification of payment of the entitlement. The language

Law	Section	Gaps	Recommendations
THE NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES (CONTROL) ACT 2012 (1994)		The laws not fully implemented especially part V section 51 – 58.	Full implementation of this law; for example part of this law deals with rehabilitation.
PHARMACY AND POISONS ACT		Diversion and abuse of prescription only medicines.	Enforcement of the Law and regulations.
TOBACCO CONTROL ACT 2012 (2007)		Fully implementation of the law in line with Framework on Tobacco Control Convention.	Implementation of the law and regulations.
THE MARRIAGE ACT 2014	Section 66 (6) A marriage has irretrievably broken down if – (g) “spouse suffers from incurable insanity, where two doctors, at least one of whom is qualified or experienced in psychiatry, have certified that the insanity is incurable or that recovery is improbable during the life time of the respondent in the light of existing medical knowledge;” Section 73. (1) A party to a marriage may petition the court to annul the marriage on the ground that – (g) “at the time of the marriage and without the knowledge of the petitioner, the other party suffers recurrent bouts of insanity.”	Section 66.	These provisions violate the Constitution. They should be repealed.
Criminal laws and Provision on Forensic Psychiatric service for Special needs offenders CRIMINAL PROCEDURE CODE ACT PRISON ACT POWER OF MERCY ACT PROBATION OF OFFENDERS ACT	Prison Act section 38 and 39.	Forensic psychiatric services in Mathari Hospital congested with long stay of patients. Ineffective administration of justice for offenders with mental health conditions. Congestion of Prisons with people with mental health conditions.	Amend the criminal laws.
THE ELECTIONS ACT	Disqualifies a person of unsound mind from being nominated as a Member of Parliament, county assembly, and other public offices. See sections: 9; 24(2)(e); 25(2)(d).		Amend the Act.

ANNEX 7

USERS AND CAREGIVERS PRESENTATION

Mental conditions present in different ways due to peoples developmental, neurological, intellectual, psychosocial, substance use and cognitive challenges. Affected people require various forms of support to thrive in their communities. Some conditions present in children at birth and in the first formative years of life. Others tend to exhibit as young adults or later in life.

According to WHO MNS Intervention Guide, priority conditions for low and middle income countries include depression, psychoses, epilepsy, child & adolescent mental & behavioural disorders, dementia, disorders due to substance use and suicide. In some cases, a combination of conditions exists as comorbidities requiring diverse health services beyond mental health.

In the Kenyan cultural context, people living with mental conditions face societal stereotypes based on ignorance, religious bias, deep rooted traditional and cultural beliefs. These include beliefs that they are being punished, are bewitched, cursed, mad, dangerous and lacking the capacity to make decisions. In many cases they are isolated, locked up and chained to poles with denial of dignity, some enduring ritual beatings 'to rid' them of evil. These beliefs and practices lead to stigmatisation by self or others and exclusion in socio-cultural, economic, political decision making processes and opportunities.

Current legal frameworks further discriminate persons with mental conditions through demeaning language, denial of various rights and criminalisation of symptoms of mental conditions including petty offenses and suicide attempts. It additionally fuels discrimination from rights to vote, marry, start and keep a family, own property and access justice. Many experience sexual and other forms of violence and are unable to defend themselves or advocate for justice.

Persons with mental conditions face several challenges in accessing healthcare services due to lack of effective prevention, early diagnosis and intervention, referral and treatment services. Many suffer from increased mental and physical health complications due to delayed diagnosis and interventions. Others are handled unprofessionally or against their basic rights. Many cannot afford public health insurance cover, which provides mostly for inpatient services without provisions for much needed outpatient services.

Those with private insurance are discriminated from treatment through some retrogressive policy clauses. Due to these reasons many patients with mental conditions lack access to treatment including emergency care. Public facilities lack availability of medicines which are mostly first generation drugs with adverse side effects. Improved quality second generation drugs in private facilities are beyond the reach for many patients. Without appropriate systems in schools to identify, provide psychological first aid and refer for mental health assessment, children with mental conditions are often assumed to be slow to understand or deviant. Persons with mental conditions experience challenges with discrimination, lack of access and accommodation in education and employment to help them find and stay in school or hold jobs.

Lack of support systems in education and employment lead to loss of economic productivity resulting in social and economic burden to caregivers and their families. Sometimes, the caregivers are forced to sacrifice job opportunities to take care of persons with mental conditions. This further fuels poverty, lost productivity and dysfunctional households, mostly led by single parents/guardians struggling to balance care and economic needs. Families with children and persons with mental conditions are assumed to know how to care for them and many have to grope in the dark without guidance and support.

Lack of awareness, effective referral systems and social protection facilities for persons with mental conditions lead to homelessness, being dumped in psychiatric facilities or rotating in prisons. Though persons with mental conditions qualify for disability protection, current disability benefits are more suited to physical disabilities and lack caregiver packages yet many with the conditions require a minder. Some beneficiaries are left out of disability registration due to challenges in access or loss of identity cards lost through seasons of illness or incarceration. Those who are registered struggle to get state support for years due to delayed registration systems, meager support for groups and unfulfilled promises. Persons with mental conditions revolve around spiritual leaders, traditional healers and in the criminal justice system for many years before finally ending up at a psychiatric facility when the condition is severe.

According to WHO there is a widely shared but false notion that all mental health interventions are complex and can only be delivered by highly skilled staff. However, in many cases, the capacity of community members can be built to improve prevention, care and management of mental health conditions. Mental health awareness and training for key gate keepers in local administration, religious leaders, traditional healers, community health workers, teachers and human resource personnel will greatly help improve early detection, intervention, treatment and management with a community mental health focus.

Unfortunately, persons with lived experience of mental conditions are not consulted in the provision of mental health services to provide feedback and valuable input to address multifaceted psychological, social and economic barriers to enhance responsive services.

RECOMMENDATIONS

Inclusion of patients & caregivers in mental health programmes and in the community:

- According to the WHO Quality Rights Initiative (WHO, 2020), social inclusion is a human right for all people, including people with mental conditions. Persons with lived experience of mental conditions and their caregivers have valuable experiences which can add valuable insight to the development of evidence based and context specific programmes and interventions on mental health. As such:
- We call for their inclusion in all decision making and decision shaping tables on matters pertaining to mental health prevention, promotion, treatment and aftercare management of mental conditions.
- The inclusion should cut across various levels of policy, legislation, advocacy and service provision by government, civil society organisations and community programmes at national, county and village level.
- Inclusion in these programmes should involve all programme levels of strategy, planning, implementation, monitoring and evaluation. We value the co-option of a representative of users of mental health services & caregiver representative in the Task Force on Mental Health and advocate for similar representation in all multi-level processes impacting decisions on mental health wellbeing service delivery. We recommend that these representatives are selected in consultation with formal associations of users of mental health services and caregivers.

Access to Services

We advocate for the provision of the highest attainable standards of mental health services that are accessible, high quality and cost effective, while upholding the right to emergency medical treatment according to Article 43 of the Constitution of Kenya. These include prevention, promotion, early diagnosis, intervention, treatment and management with adequate access to equipment, medication, occupational and psychological therapy.

In line with universal health care, there is need to provide free and quality medication for mental health conditions in public facilities and cost regulation for drugs in private facilities. We advocate for integration of mental health services in primary healthcare systems for all health services, with a focus on community based services. There should be free or subsidised NHIF inpatient and outpatient cover for persons with mental conditions and review of retrogressive private insurance clauses that discriminate persons with mental conditions. Finally, there should be facilitation of support group psychotherapy for users of mental health services and caregivers in primary health centres to promote community healthcare models of care and support.

After hospitalisation, persons with mental conditions should be supported with psychosocial and economic support through social protection services for smooth reintegration into the community and to ensure seamless continuity of care. Caregivers should be provided with mental health education to enhance care, while developing the capacity building of communities through local administration and gate keepers to improve promotion, prevention, care and management of mental health conditions to complement healthcare. We also recommend close monitoring to ensure the various WHO Quality Rights are upheld in the care of patients within health facilities and in their communities.

Legal reforms

We advocate for the abolition of offensive pieces of law. These include demeaning references to persons with mental conditions, denial of legal capacity in relation to mental health treatment, supported decision making, upholding the rights to marriage, having a family, property, voting, sexual offense protection among others.

We recommend that the law adopts Article 12 of the CRPD recognising the right to equal recognition before the law. This adopts supported decision making and advance directives instead of guardianship in all matters pertaining to property and inclusion in the community. In addition, it promotes the protection of users of mental health services from manipulation and abandonment through psychiatric facilities. Persons with mental conditions should remain central to decisions regarding their lives, including treatment and communication of their informed choices must only be through their trusted persons.

We call for the decriminalisation of symptoms of mental conditions including petty offenses and suicide attempts. The removal of suicide as a cause of death in death certificates should be sped up because it leads to prolonged stigma for families. It is important to provide access to justice for persons with mental conditions including provision of legal aid. There should also be provision of mental health and referral training for personnel within the criminal justice system to enhance referral of symptoms of mental conditions for treatment.

We call for legislation to enhance inclusion of users of mental health services and caregivers in all decision making and decision shaping tables on matters pertaining to prevention and management of mental conditions and issues impacting mental health and wellbeing in policy, legislation, advocacy and service provision by government, civil society organisations and community programmes at national, county and community level. The legislation of the inclusion of persons with mental conditions in the provision and monitoring of disability protection will be necessary.

We recommend that a human rights and legal committee looks further into the various laws and make legislative recommendations with reference to persons with developmental, intellectual, cognitive, mental, neurological and substance use disorders/conditions.

Educational and Employment

We call for the provision of access to education and employment for persons with mental conditions. This will be achieved by awareness creation to address stigma and discrimination in the education system and workplaces. Reforms of education and employment models will be necessary to provide reasonable accommodation to persons with mental conditions. These include flexible hours, additional exam time and evaluation on performance and the inclusion of ICT based programmes customised to support varied special needs.

Educational facilities within integrated learning systems need to be adopted to stop the segregated learning of children and persons with mental conditions. Focus on practical vocational, socio-economic and transitional support programmes will help to exit school systems and enhance self-reliance to thrive in their communities.

The Ministry of EAC, Labour & Social Protection National Plan of Action (based on Article 24 of the CRPD), emphasises the transition for children with mental conditions and disabilities from segregated to inclusive quality education. This would include reasonable accommodation and ensure that budgetary, technical and personal resources are available to complete the process of the inclusive education system. We also recommend inclusion of mental health in the school curriculum with basic knowledge on promotion of mental health, understanding of mental condition, stigma reduction, psychological first aid and referral systems.

Inclusive employment is a human right, according to the United Nations' CRPD. However, the discrimination of people with mental conditions has an effect on the decision to disclose mental health status especially in employment. A study in Kenya showed that about 56% of the people with mental conditions had a challenge in both finding a job and keeping it (Ebuenyi et al., 2019). Stigma and competitive routine-based labour market structure does not accommodate persons with mental conditions.

There is need to develop and implement policies which enhance inclusive education and employment; effective enforcement mechanisms and sanctions for discrimination in education and employment, both in the public and the private sectors. The Ministry of EAC Labour & Social Protection National Plan of Action (based on Article 27), recommends adoption of measures to foster compliance with the positive measure of quotas for persons with disabilities in employment. This should include design work and employment programmes in the open labour market specifically with reasonable accommodations and development of skills to undergo competitive selection processes to access jobs, entrepreneurship and business start-up support for self-employment.

Social Protection

Article 28 of the CRPD requires, among other things, that people with disabilities are provided with an adequate standard of living, including adequate food, clothing, clean water, devices and other assistance for disabilities and continuous improvement of their living conditions. The Persons with Disabilities Act includes persons with mental impairments which impact adversely on social, economic and environmental participation.

We advocate for the urgent review of disability packages to include favourable terms for persons with mental conditions by the Ministry of Labour & Social Protection as current provisions are focused on physical disability. Persons with mental disability are the users or consumers of mental health services; survivors of psychiatry or people experiencing mental health problems, issues or crises (USP Kenya, 2017). Special disability registration systems are necessary to ensure access to social protection for persons who are homeless and with severe mental conditions and the provision of specialised facilities for shelter, food, clothing, healthcare, rehabilitative and resettlement services.

Additionally, socio-economic disability support packages are required for persons with chronic mental conditions and for caregivers to reduce the barriers of access to livelihoods, education and employment. This includes provision income tax relief for persons with mental conditions and caregivers to help cushion economic challenges of living with mental conditions. Besides this, the zero-rated tax of equipment and materials supporting the interventions and support of persons with mental conditions e.g. diapers for persons with severe mental conditions, vocational training resources, occupational and psychotherapy resources is necessary.

Steps should be taken to urgently extend the coverage of social protection schemes beyond persons with 'severe' disabilities to ensure an adequate standard of living to all persons with chronic mental conditions who are not currently eligible for social protection schemes. There is need to:

- Ensure that support services and social assistance for persons with mental conditions and primary caregivers are distributed on a regular basis, reach the grassroots throughout the country and that progress in the living conditions of persons with mental conditions is monitored.
- Adopt as a matter of priority, a strategy to combat stereotypes against children and persons with mental conditions within families and in society and
- Implement an early warning mechanism to prevent the abandonment of such children and persons in urban and rural areas.

To address elimination of institutionalisation, we recommend community based services and appropriate support structures for children and persons with mental conditions. We recommend for a special committee to look further into social protection packages for children and persons with developmental, intellectual, cognitive, mental, neurological and substance use disorders and conditions with a focus to provide provisions more favourable to reducing their existing social, economic and environmental barriers due to their impairments.

ANNEX 8

KENYA ADOLESCENTS & YOUTH MENTAL HEALTH COALITION:

OUR MENTAL HEALTH; OUR SHARED OWNERSHIP; OUR RESPONSIBILITY

INTRODUCTION

We are a coalition of Kenyan youth, youth workers and youth serving organisations, concerned about grave mental health issues and challenges among adolescents and youth in Kenya. We have come together to engage the Mental Health Taskforce set up by the President and develop programmes to address the issue. This was a follow up of first ever National Mental Health Conference organised by the Ministry of Health in December, 2020.

Our concern is fear of addressing symptoms of mental health outcomes among adolescents and youth (the present and future of Kenya) instead of the real issues facing our society and nation.

PREAMBLE

We recognise;

The Global and National Efforts

Target 3.4 of the Sustainable Development Goals states: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and Wellbeing

Although the international community has pledged to address mental health problems, too many people still suffer their deleterious effects. Among adolescents and youth, the problems they face include relationships and social pressures, prenatal depression and suicide; the mental and psychological consequences of miscarriage, abortion or complications stemming from pregnancy and childbirth, lack of support following childbirth, gender-based violence (GBV) and HIV/AIDS.

Kenya is currently piloting Universal Health Coverage in Kisumu, Nyeri, Isiolo and Machakos counties; of the four, only Nyeri County, is focusing in Non-Communicable Diseases setting.

The High Burden of Mental Health Problems

Mental and Behavioural disorders are estimated to account for 12 per cent of the Global Burden of Disease (GBD). Depression ranks fourth worldwide in GBD and is projected to move up to second place by the end of 2020. One million people commit suicide every year which translates to one person every 40 seconds. In 2017, a WHO report ranked Kenya as the sixth African country with the highest levels of depression with at least 1.9 million diagnosed Kenyans suffering from depression. According to the World Health Organization (WHO), about 800,000 people die from suicide each year (that is one person every 40 seconds), majority of them aged 15-29, in which age-group suicide is the second leading cause of death. In Kenya, WHO data estimates that 1408 people commit suicide yearly, or simply put, four deaths daily, a number that is higher by far, than what the Kenya National Bureau of Statistics reported for 2018: 421 deaths. For the seven (7) minutes it will take you to read this article, eleven (11) people would have committed or attempted to commit suicide around the globe.

We caution against dealing with symptoms

Kenyan adolescents and youth face several challenges leading to mental health challenges. With youth unemployment hitting about 40% and increased pressure for adolescents to perform in school coupled with uncontrolled exposure to new media, mental health for this cohort is bound to worsen as socio-economic fabrics of the society weaken.

Poverty, gender inequity and human rights violations are shown to increase the incidence of mental health problems, and vice versa. Mental health problems also correspond to the decreased ability to make rational choices and increase the probability of risky sexual behaviour and substance abuse. This can lead to more unintended pregnancies, STIs – including HIV – and a higher risk of being either the victim or perpetrator, of GBV.

We understand that

The rates of depression, homicide and suicide incidences among young people are alarmingly escalating. Prevention, Treatment and Care Screening can detect mental health problems. Mental, physical health and social conditions are three vital strands of human life that are deeply interdependent and interconnected. The prevention and treatment of mental health problems is not only critical to general Wellbeing, but also necessary to prevent problems relating to sexual and reproductive health. In Kenya, we have policy and programme fragmentations and that tend to isolate mental health concerns and interventions.

Medication and psychological interventions, most of them deliverable through primary health care services, can prevent these problems. Family, partner and peer support are effective; community involvement also plays an important role-as does the social environment.

OUR REQUESTS AND RECOMMENDATIONS

Strengthen the Legal and Policy Framework;

- Review the *Kenya Mental Health Policy 2015-2030* so as to capture adolescents' and youth relevant situation needs and devise responsive interventions at the National level.
- Adopt a human rights based approach to the development and implementation of law, policy, guidelines, plans and programmes on mental health that provide meaningful and active participation of people with mental disorders and their caregivers.
- Fast-track development and approval of a clear roadmap for mental health at county and national levels including the review of Mental Health Act, finalising the Mental Health Policy, development and financing of a costed Mental Health Strategy with guidelines.
- Development and operationalising of mental health work place policies in all Government, private offices and institutions of higher learning.
- Develop mental health treatment protocols that will guide the treatment and referral mechanism for youth presenting in hospitals with mental health issues.
- Ministries of Labour and Education and State Department of Youth to develop robust and mandatory programmes for integration and transition of fresh graduates into the job market through voluntary, internship and actual employment to match the growing pressure and attention given to TVET graduates.
- Make HELB loan interest free, do away with penalties and job clearance certificates until one is employed.

Strengthen Mental Health Governance, Management and Coordination

- Establish and strengthen County Mental Health Secretariat, committee and Technical Working Groups at both sub-county and ward levels.
- Ensure that county health management and mental health secretariat teams have the capacity to effectively implement mental health services into their plans and budgets.
- Strengthen mental health collaboration and networking forums targeting policy makers and officers in healthcare from national and county governments, civil society organisations, local media, private and public institutions. This is with a view to improvement of services to persons with mental disorders and their families in line with the CRPD and to drive forward the policy development agenda.
- Support youth serving organisations and educational institutions to carry out mental health preventative programmes in youth work through social skills, life skills and self-awareness trainings.

Strengthen Mental Health Service Delivery and Primary Health Care Integration Through Community Strategy

- County Governments to develop and implement mentorship and psychosocial programmes from household to facility level specifically targeting adolescents and youth in and out of school. These programmes should be responsive to the current, emerging and future determinants of health and Wellbeing. Special attention should be given to collaborative, life influencing decision making, technology, audit of functionality of existing interventions.
- Enhance the referral system between county level facilities and level 4 and 5 facilities. Improve lower level facilities, increase drug supplies and professional staffing at these levels. This referral system should capture the patient from the 1st point of contact all the way to linking them up with a Community Healthcare Worker.
- Build the capacity of mental health service providers and champions (mental health secretariat, sub county health management committees, health care workers, CHVs, champions).
- Provide mental health services at all levels (county, sub county and community) including prevention services, community psychosocial support services, treatment services in health facilities, integration of mental health, SGBV and safe spaces, rehabilitation services, counselling supervision services for mental health service providers, initiate workplace mental health services in every county.
- Promote early preventive interventions within curricula in learning institutions, and strengthen school mental health services. MoH and MoE to collaboratively restructure and strengthen the Guidance and Counselling Departments in primary and secondary schools to respond to emerging issues.
- Integration of mental health in all other health programmes e.g. reproductive health and HIV AIDS programmes.

Reduce Stigma and Discrimination

- Increase access to culturally-sensitive and tailored information about mental health care services by support initiatives to combat stigma and raise awareness about mental disorders at all levels.
- Enhance civil society organisations collaboration to facilitate access to remote or under served areas and also to support community based Mental Health education and awareness creation.
- Establish public education and awareness raising programmes at the community and work place level that promote good mental health and the prevention of mental disorder.
- Provide psycho-social support for caregivers and families on coping with mental disorders.
- Establish sustainable community initiatives and infrastructure that support mental health at the community level, for example community centres and recreational facilities.
- Strengthen existing models of community based mental health programmes that promote the rights, dignity and social inclusion of people with lived experience of mental health problems, so that these models can inform policy and practice at county or national levels.

Expand Mental Health Financing and Human Resources

- Train health workers on youth friendly services and competencies on how to meaningfully relate to diverse adolescents and youth including those with disabilities, to enhance early treatment of mental health problems.
- Provide adequate financial and human resources in psychiatric units across the country and at the Mathari National Mental Health & Referral Hospital. Make the hospital a fully-fledged parastatal.
- Improve mental health infrastructure at the county, sub county and community levels.
- Promote the participation of support groups and civil society, especially organisations of people with lived experience of mental health problems, in mental health policy and related resource allocation. Strengthen mental health budget advocacy at national and county level in order to increase access to community based mental health programmes that promote the rights, dignity and social inclusion of people with lived experience of mental health problem.
- Establish Mental Health Fund to support Community Based Mental Health care, rehabilitation education and service delivery.
- Mark Mental Health Day as a calendar event within the ministry and engage in rigorous campaigns to get people with mental health disabilities identified, screened, registered and linked with relevant bodies.
- NHIF, and private insurance companies to incorporate mental health care within their covers, and mental health care to be prioritised within the UHC package.

Advance Monitoring, Evaluation and Research

- Include all age and sex disaggregated mental health indicators in the Ministry of Health reporting tools.
- Collect and disseminate best practices on awareness raising campaigns and activities conducted by civil society organisations on mental health.
- Improve community reporting systems on mental health.
- Undertake comprehensive scientific research in more vulnerable counties with focus to analysis on mental health management and financing, gaps in mental health service delivery. Identify the human rights claims of rights-holders and the corresponding human rights obligations of duty-bearers as well as the immediate, underlying, and structural causes of the non-realisation of rights by people with experienced living with mental disorders.
- Create a department of mental health at the ministerial level to oversee implementation of policies, and develop a monitoring and evaluation framework for mental health programmes, overseen by a co-youth led national steering committee on mental health.

Mental Health and Reproductive Health Especially at Primary Health Care

- Integrate mental health in sexual and reproductive health policies, strategies, programmes, services, statistics, training and publications.
- National Aids Control Council to revamp its interventions and target young people living with HIV, their partners and families, and care providers who face or have potential to face stigma, and develop mental health strategies from the onset of AIDS related complications for this cohort. Special attention should be paid to vulnerable populations such as women, young people, older persons, migrants, people in conflict situations and those affected by natural disasters as well as persons with disabilities.

OTHER RECOMMENDATIONS TO SUPPORT ADOLESCENT AND YOUTH MENTAL HEALTH

Recommendation 1: Ensure active and direct participation of young people

- Ensure the full and direct participation of young people in the research, design, implementation and practice of mental health policies. *“Nothing about us without us”*.
- Involve and engage young people in the co-production of multi-sectoral mental health policy frameworks that encompass an inclusive rights-based approach. These can cover a range of topics from prevention, early intervention, to mental health rehabilitation during early life stages.
- Work with youth-led advocacy groups to strengthen effective leadership and governance for adolescent mental health.
- Relevant government authorities that run youth and youth related programmes to fund, support and work collaboratively with youth led and serving organisations within communities to expand spaces and opportunities for meaningful adolescents and youth engagement to reduce triggers of mental health issues and to curb violent extremism and radicalisation.

Recommendation 2: Invest in early intervention, adopt a holistic approach

- Actively increase financial investment and redistribution of departmental budgets to provide integrated and responsive mental health and social care services in community-based settings.
- Allocate funding towards integrated community, school and university-based mental health services that focus on skills training, screening for at-risk young people and the education of teachers, primary care physicians and media personnel. Integrated youth programmes or curricula can be packaged as life-skills education, mindfulness and physically active programmes.
- Alongside direct interventions, implement effective social policies that address social factors that influence mental health during developmentally sensitive periods, including poverty, gender discrimination and violence.

Recommendation 3: Improve and support mental health literacy

- Strengthen mental health education and training to young people in schools and universities to promote mental health awareness, reduce stigma and improve help-seeking.
- The Ministry of Health in partnership with youth led and serving organisations to develop a youth friendly mental health toolkit.
- Implement strategies to strengthen information systems for promotion of psychosocial Wellbeing, prevention of mental health problems and promotion of human rights of young people who face mental health challenges.
- Build capacity in caregivers at parental gatherings, schools and universities to promote mental health literacy to assist with motivation and self-efficacy.

ANNEX 9

CASE STUDIES

CASE STUDY 1: SMILES AMID HARDSHIPS

In all the places visited by the Taskforce, the members noted that mental health staff had a passionate and committed attitude towards their work despite the challenges they faced daily. Whether at a government or private establishment, the attitude was right.

This was very apparent at Mathari National, Teaching and Referral Hospital including at the methadone clinic. It was also clear at two (2) facilities successfully providing private services, Nairobi Place – a drug and substance abuse rehabilitation services and Bustani that has a modern facility in a serene environment that enhances patient recovery. They also have established a multi-disciplinary team that provides efficient and adequate care and wholesome patient approach.

Even at the County government level, there was hope. Makueni County led by the first lady who is a trauma psychologist, has a psychologist in every sub county level health facility. Each psychologist is employed and paid for by the government.

At the community level, Kamili Organisation in Kangemi stands out in its response to mental health needs. Kamili provides loans for start-up business by users enabling them access a livelihood. It has also set up a repatriation programme in conjunction with Mathari NTRH whereby abandoned patients (users) are resettled back home. The organisation now provides accessible and free services in 27 of the 47 counties.

On the religious front, the Hindu council has created a support system, which supports mental health in their community.

To deliver a successful mental health programme, on the minimum, the Taskforce recommends:

- That mental health care and training standard is delivered by a comprehensive mental health team comprising of a psychiatrist, psychologist, mental health nurse, social worker, occupational therapist and any other necessary staff.
- That every county should have a functional and effective mental health team. Every sub-county hospital should have a community mental health service (Kamili Organisation model of community care: website link <https://www.kamilimentalhealth.org/>).
- The establishment of a mental health care programme for all medical staff to take care of burnout and related issues. There is need to have every health worker exposed and certified in mental health delivery competences. Currently only medical doctors are examined in psychiatry both in training and in internship.
- That the Nursing council and the clinical officers' council ensure that training of nurses and clinical officers include mental health and psychiatry in the training, examine the subject and ensure exposure and examination during training and log book signing during internship.
- Beyond health care, there should be socio-economic support put in place for users as this will enhance adherence to treatment measures.

CASE STUDY 2: KENYA MEDICAL SUPPLIES AUTHORITY (KEMSA)

Kenya Medical Supplies Authority (KEMSA) is a state corporation under the Ministry of Health established under the KEMSA Act 2013. Its mandate is to provide logistics in medical procurement. This includes:

- Procure, warehouse and distribute drugs and medical supplies for prescribed public health programmes, the national strategic stock reserve, prescribed essential health packages and national referral hospitals.
- Establish a network of storage, packaging and distribution facilities for the provision of drugs and medical supplies to health institutions.
- Enter into partnership with or establish frameworks with County Governments for purposes of providing services in procurement, warehousing, distribution of drugs and medical supplies.
- Collect information and provide regular reports to the national and county governments on the status and cost effectiveness of procurement, the distribution and value of prescribed essential medical supplies delivered to health facilities, stock status and on any other aspects of supply system status and performance which may be required by stakeholders.
- Support County Governments to establish and maintain appropriate supply chain systems for drugs and medical supplies.

The Taskforce met the KEMSA director with his team. The KEMSA team gave a presentation on the processes involved in procurement of medication as well as the current essential drug list for mental health products.

From the current Kenya Essential Medicine List (KEML) shared, the Taskforce observed that majority of the newer psychiatric medications were included. The list appeared to comprehensively and adequately cover a wide range of antidepressants, antipsychotics and sedatives which are very important for mental health treatment.

The KEMSA team also elaborated on the challenges they experience in the discharge of their mandate as follows:

- **Poor consumption data:** Most facilities fail to provide accurate and timely data on their consumption. This means that KEMSA tends to rely more on issuance data rather than consumption data. This may result in stock outs at the facility level because the medicine is not replaced as it gets consumed.
- **Online ordering challenges:** A number of facilities are unable to undertake the online ordering process of medications due to ICT related challenges.
- **Lengthy public procurement processes:** KEMSA is a government entity guided by the public procurement process. Unfortunately, this tends to be a very lengthy and inefficient process where advertising for tenders, evaluation and awarding of the tenders may take up to 5 months. This is unreliable especially for emergency drugs. Sometimes, the selected suppliers may not supply the medication within the agreed upon time frame yet KEMSA is prohibited from sourcing from a different supplier even in the event of this occurring.
- **Pending bills:** KEMSA is not funded by the national treasury. It is dependent on the purchase of medication by the counties through the cash and carry system. With the introduction of Universal Health Care (UHC) counties now have drawing rights to a stated limit. A number of counties owe KEMSA large sums of money, prohibiting them from placing any subsequent orders to the institutions.

Of note is that Mathari Hospital actually has a substantial credit with KEMSA despite missing drugs. For the majority of the missing antipsychotic medication KEMSA was either unaware or was not entirely sure why medication was missing.

RECOMMENDATIONS

In the implementation of UHC, it is critical that medication listed in the comprehensive KEML is the same medication available under UHC. The Taskforce also recommends the following:

- Following the introduction of newer psychiatric drug molecules in the KEML there is an urgent need for training health care workers on the effective administration of these medicines. If this is neglected, then it is likely that the medicines would expire despite the existing need.
- There is need to fast track the procurement process, with the possible exemption of KEMSA from the usual general procurement processes. KEMSA will benefit from direct procurement especially for emergency type medication and allowing for multiple awards.
- Lithium levels test kits, thyroid tests and drug screening tests are essential to mental health. KEMSA must supply these to public facilities that have laboratories. Though incredibly useful these tests are currently inaccessible in public facilities.

CASE STUDY 3: MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL

Mathari National Teaching and Referral Hospital (MNTRH) was founded in 1910 by the British colonial government as a smallpox isolation centre. It was redesigned and became the Nairobi Lunatic Asylum. The facilities were segregated with African patients, who constituted 95% of the patients, being kept in the worst conditions. They lived in very overcrowded bomas, which were the traditional form of housing in Kenya.

The hospital is now Kenya's premier psychiatric hospital, and is the national psychiatric teaching and referral hospital. It has a bed capacity of 600 (a third of which are reserved for females), and mostly admits patients with severe psychiatric disorders. It has a wide catchment area with patients often being referred from as far as North Eastern Kenya. Aside from psychiatric services, the hospital also offers dental, laboratory, radiology, maternal and child health services among others to both the inpatients and the general public. Yet, majority of the buildings constructed at the inception, are still currently in use in spite of being dilapidated.

The Task Force visited selected areas within the facility. This included the outpatient clinic, the dental unit, pharmacy and registration offices, several wards, the Medically Assisted Treatment (MAT) programme and the forensic unit.

CHALLENGES RAISED AND OBSERVATIONS OF THE TASK FORCE

Poor physical infrastructure

Though a few wards have been recently constructed, majority of the physical infrastructure is old and dilapidated. This only works to fuel the stigma and discrimination of the mentally ill. Other observations are:

- The outpatient unit, for example though a relatively newly constructed building, has been poorly designed and does not meet the expected standards. Patients, doctors and nurses are crammed inside a small room with little ventilation, no escape route (in case a patient turns violent) but most importantly, it offers a complete lack of privacy for issues discussed.
- The forensic unit is in complete disrepair with majority of the roofs in the building gaping or leaking.
- Buildings that have been condemned are still standing and thus pose a serious hazard for both workers and patients in the facility.

Lack of medical supplies and dysfunctional equipment

Drug shortages, supplies in the dental unit, laboratory equipment and reagents are all in short supply. Electroconvulsive Therapy a treatment for severe mental illness was also non-operational for the past month prior to the visit by the task force. Shortage of drugs was cited as a perennial problem, affecting even essential emergency psychiatric medication.

Standards of hygiene

These were wanting especially in the forensic unit where both fleas and flies roamed freely. The Taskforce was met by a heavy stench in many of the wards and worst in the forensic unit.

Inadequate human resource

According to the WHO's Mental Health ATLAS 2017, Kenya has a total of 92 mental health professionals serving in both government and non-governmental establishments. This translates to 0.18 psychiatrists for every 100 000 people. Similarly, the nurse to patient ratio falls short of the recommended WHO standard. The quality of care is compromised as the human resource is strained. One of the nurses attested to this "*We are forced to lock people like in the historical times*". Nurses, doctors and even the security team at the forensic unit complained of burn out.

Neglect of the Maximum Security Unit (MSU)

The operations and the mandate of the MSU appear to straddle two ministries; The Ministry of Health under Mathari Hospital and the Ministry of Interior under the prisons department. Arising from this is some confusion and a lack of responsibility in conducting their operations. Both the health care workers and the prison officers stationed at the unit attested to this. The MSU was heavily crowded with a notably strained work force. Contributing to this heavy crowding are two issues.

- The inefficient and protracted processes required in the probation procedures. It was noted that since 2016 there have been no release of these special needs offenders. This not only promotes congestion but also a relapse in some patients.
- A substantial number of these patients admitted here are petty offenders "*imprisoned*" for cutting other people's crops. Their only "*crime*" was having a mental illness.

RECOMMENDATIONS

- The Task Force recommends that the process of making Mathari Hospital a semi-autonomous agency should progress faster. This will help release funds that can address basic and urgent needs of the facilities such as shortages in terms of human resource, equipment and supplies.
- Majority of the buildings are in disrepair. The Task Force recommends demolishing of the existing old dilapidated buildings and rebuilding of a new facility. This will both serve to align to the WHO Quality Rights standards for persons with mental illness as well as go a long way in reducing stigma and discrimination of the mentally ill leading to better clinical outcomes.
- There is an urgent need to fix the probation system at the maximum security unit.
- The role of the prison warden in Mathari should only be to mitigate violence; another option would be to allow Mathari to hire its own security personnel.

CASE STUDY 4: NAIROBI REMAND AND ALLOCATION PRISONS

Kenya Prisons Service (KPS) is a department within the Ministry of Interior and Coordination of National Government established under the Prisons Act Cap 90 and Borstal Institutions Act Cap 92 Laws of Kenya. KPS is a critical component of the Criminal Justice System which ensures the safe custody of all persons who are lawfully committed to prison facilities. It also facilitates the rehabilitation of custodial sentenced offenders for community reintegration.

It comprises 118 institutions of which 115 are for adult offenders whilst three (3) are primarily for youthful offenders. The current prisoners' population stands at 54,000 of whom 48% are pre-trial detainees whilst the remaining ones are sentenced prisoners. Some of these are in need of mental health treatment. The staff establishment stands at approximately 22,000 comprising of uniformed officers and auxiliary staff.

The task force visited the Nairobi Remand and Allocation Prison to understand the conditions in which remandees, prisoners and their minders are exposed to. Nairobi Remand and Allocation Maximum Security Prison was upgraded to a maximum prison about five (5) years ago. It is located in Industrial area along Enterprise Road.

The Taskforce received a warm welcome by the officer in charge stationed at Kamiti B Prison.

CHALLENGES RAISED

Shortage of staff and lack of mental health specialists in the prisons

- Though the institution handles a large number of persons with mental conditions, there are only 2 clinical officers and 3 nurses stationed there, none of whom have had specialised mental health training. Many of the workers suffer from burnout. Many health care workers posted here quit the service after approximately 2 years. Indeed, one officer said: "*we have found ourselves in unfamiliar environment, one is trained as an officer and is forced to handle mentally unstable clients with no additional skills*".
- Due to the lack of specialised training, the in charges admitted that officers would not be able to distinguish who had an underlying mental illness especially among petty offenders and who did not. This distinction is often made in court by the magistrate, hence only limited for seriously ill persons with openly psychotic symptoms (behaving in bizarre manner). "*we go by face value*", said the officer. They further observed that among the youth, there exists a revolving door phenomenon. The youth are released and find their way back into the prisons after a short while. Many of these have underlying common mental illnesses with comorbid substance dependence. Evidence of this was noted during the tour, when the Taskforce had a chat with some of these remandees. Their personal stories captured the same narrative (drug dependence, petty offence [stealing small items, loitering], serving time in remand).

- Due to the high cases of comorbid substance use disorder by inmates, the institution is forced to ferry these remandees on a daily basis for direct observation and treatment in Ngara (MAT programme). They were reported to be more than 40 cases. A chat with a group of them revealed that the MAT programme has helped them tremendously and felt capable to engage in productive occupational activities upon release.

Slow processing and referral of offenders with known mental illness

In some cases, it may take up to 3 years for the offenders to be moved to the forensic unit in Mathari. This is also subject to availability of space. The staff are overwhelmed at the forensic unit. *“Are we running a prison or a hospital”*, one quipped, expressing frustration at the role of a prison warden in Mathari. There is a clash between doctors and guards in terms of rights of the offenders/patients. Three offenders have managed to escape recently resulting in prison wardens losing their jobs.

RECOMMENDATIONS

Address staffing challenges

A low hanging fruit could be to train already existing prison officers in health care and specifically mental health care provision.

Link young petty offenders to care

Removing the young from prison, will decongest the prison wards and increase the quality of care in the institution.

Introduce an efficient filtering process at the point of arrest

This will involve training police officers to identify young petty offenders with underlying mental health related problems and channel them for care rather than jail.

Integrate screening instruments for common mental disorders

These will be used at admission particularly for first time offenders. There is also need for a special wing for seriously mentally ill.

Urgently address the remandees quarters

These are dilapidated and perpetuating mental illness in the inmates.

Empower probation officers

These officers should be able to identify mental health related problems and corroborate with relatives on the previous history of the offenders. Probation officers can be used to filter the numbers that wind up within this system, as they are in contact with the relatives of the offenders.

Strengthen research in the prison system

There is very scarce data related to mental health in this special population. Without research it is impossible to have evidence based disease burden assessments that lead to appropriate interventions.

CASE STUDY 5: KENYA MEDICAL TRAINING COLLEGE (KMTC)

The Kenya Medical Training College (KMTC) headquarters and the main campus, Nairobi, stand on a 20-acre piece of land, opposite Kenyatta National Hospital, along Old Mbagathi Road. The only public middle level health training institution under the Ministry of Medical Services, it was started in 1927 with four students at Kenya Institute of Administration (KIA), Kabete. Today, KMTC enrolls over 41,000 students undertaking 76 medical courses, in 71 constituent campuses across the country. Its graduates account for more than 85% of the hospitals' workforce. It has a staff complement of over 2,200.

The wide range of courses, from certificate, diploma to higher diploma include; diplomas in clinical medicine, registered nursing, mental health and psychiatry as well as a higher diploma in clinical psychiatry.

CHALLENGES RELATED TO MENTAL HEALTH ARE:

- A shortage of practicum training centres where students can acquire practical skills in knowledge acquired. Of the 71 campuses, 54 provide nursing courses. These trainee nurses are required to rotate in mental health units as part of their training. Unfortunately, with a paltry 14 mental health units in the country, the units are overcrowded with these nurses and hence impacting on the quality and standards of the practicum offered.
- Courses in mental health are highly stigmatised, partly attributed to a lack of career progression for nurses and clinical officers who chose to specialise in this area.
- Mental health training in KMTC lacks the seriousness and quality that it deserves. For example, at the end of a 6-week rotation, health care workers are not evaluated in mental health unlike in all other modules. The principal reported that *“the students take this 6-week period as a small holiday as it is the one module with no exams”*.

TASKFORCE RECOMMENDATIONS

- **Increase the number of mental health units in the counties.** Each unit should be run by a minimum staffing of a psychiatrist, a psychiatric nurse, and a social worker. This minimum standard of staffing will ensure adequate supervision is provided to trainee health care workers as well as the population served.
- **Enlist Private and faith based facilities in practicums.** These can support a significant number of KMTC trainees to reduce the over reliance on the few existing government ran facilities.
- **Make the mental health module examinable.** The Nursing Council of Kenya and the Clinical Officer Council should help develop a proper career path for mental health specialists and begin at the very basic level of making the mental health module examinable for all nurses and clinical officers.
- **Define the career progression** for psychiatry nurses and clinical officer in mental health and psychiatry.

ANNEX 10

AN EXAMPLE OF A COMMUNITY MODEL MENTAL HEALTH CLINIC COST ESTIMATE PER YEAR IN KES

Human Resources	Nurse's Salary	80,000	1	12	960,000	Outreach Nurse basic salary + all allowances
	Counsellor's Salary	60,000	1	12	720,000	Counsellor's basic salary + all allowances
	Social Worker's Salary	45,000	1	12	540,000	Social Worker's basic salary + all allowances
	Subtotal				2,220,000	
Fixed Overheads	Filing Cabinet	20,000	1	1	20,000	1 filing cabinet to store patients' files
	Drug Cabinet	20,000	1	1	20,000	1 drug cabinet to store drugs. This might not be necessary where drugs are centrally kept in the pharmacy
	Laptop	40,000	1	1	40,000	Laptop for reporting purposes and surfing
	Tuition & Exam Fees	150,000	1	1	150,000	Fees for upgrading general nurse to psychiatric nurse
	Mentorship on an Existing Model	20,000	1	4	80,000	Nurse/Social Worker/Counsellor/CHV travel and accommodation @20,000Ksh
	Subtotal				310,000	
Variable Costs	Communications; Internet	2,000	1	12	24,000	Data for surfing and reporting purposes
	Communications; Phone Etc.	1,000	4	12	48,000	Airtime for communication, 4 staffs, 1 k each a month
	Spring Files	65	1	500	32,500	Estimate 500 patients in the care each with a spring file to store data
	Photocopy of Patient Forms	500	1	4	2,000	Cost of photocopying patients writing materials, and others
	Printing, Postage & Courier	2,000	1	12	24,000	Photocopy paper, and others
	Drugs (Patient Cost: 1,200Ksh P.A)	1,200	500	1	600,000	Medicines and medical supplies
	Occupational Therapy Interventions	18,900	1	3	56,700	Cost of training patients on technical skills including sewing, beadwork etc. 10 patients at 3 different interventions. Cost of tutor, learning materials
	Group Therapy Interventions	18,900	1	3	56,700	Cost of running 3 groups a year. Cost of stationery, refreshments during the meetings
	Awareness Raising	65,000	1	3	195,000	Awareness during mental health day, UN day against illicit drug trafficking, World suicide day. Cost of pamphlets, stationery, drinks, and others for 300 participants at each occasion
		Subtotal				1,038,900
Outreach Expenses	Fuel/Taxi Expenses	5,000	1	4	20,000	Cost of hiring a taxi to the field 4 times a month
	Outreach Staff Lunches	500	3	4	6,000	Estimated that 3 staff will be going for outreach
	CHW Bus fares	1,000	1	4	4,000	Bus fare reimbursements for a CHW as a motivator
	Airtime For Mobilisation	1,000	1	12	12,000	Airtime for mobilisation @ 1k p.m,
	Home Visits	1,000	3	12	36,000	3 staff traveling to see 1 patient a month
	Subtotal				78,000	
TOTAL					3,646,900	

TASKFORCE RESOURCES LINKS

Combined Report from All Regions as per Thematic Areas

<http://bit.ly/2HZOBN8>

Summary of Attendance and Memoranda Submitted

<http://bit.ly/2wIXaJJ>

Memoranda Highlights

<http://bit.ly/32uiv5y>

Summary of Memoranda Submitted to the Taskforce on Mental Health via Email

<http://bit.ly/2Ppxfxe>

Links to photos on the Mental Health Taskforce Public Hearings

<https://photos.app.goo.gl/v4hkg3N88hwa7JNS6>

<https://photos.app.goo.gl/9VCFfd8fZrDZ7pqq6>

<https://photos.app.goo.gl/pVjtFkGT45q4fkSXA>

<https://photos.app.goo.gl/UDPanM365SgvU8eBA>

<https://photos.app.goo.gl/QwhTZUWMERp81KKG8>

<https://photos.app.goo.gl/PSVvvp8apZubLUk6A>

<https://photos.app.goo.gl/CUdU36eJkT3aEedt7>

<https://photos.app.goo.gl/aaq6iaiQxAdjACv5>

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