The Task Force on Mental Health in Kenya

Improving Access and Effectiveness of Psychological Interventions for Common Mental Health Problems in Kenya

Dr Geoffrey Wango

.

Improving Access and Effectiveness of Psychological Interventions for Common Mental Health Problems in Kenya

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Abstract

Mental health issues are gaining significance worldwide and in Kenya as a result of several concerns such as anxiety disorders, depression and suicide. Government policy interest is evident, what with the setting up of a task force on mental health. However, an improvement in the quality of care for persons with mental health disorders and distress must aim at improved access and effectiveness of psychological interventions. This paper set out to review underlying issues in access to mental health care, the need for a synthesized approach to treatment and the development of a conceptual model of access and treatment. The paper considers the more traditional-cum-contemporary Kenyan society and the implications of various models on both the development and evaluation of various psychosocial interventions for a variety of groups with poor access to mental health care such as the underprivileged poor, people in rural areas, children, persons with special needs and older people.

1.0. Background to Mental Health in Kenya

Although mental health is a considerably neglected area in most developing countries, it is gaining significance worldwide as well as in Kenya (Goldberg & Huxley, 1980, 1992; Henderson et al., 2014; Mascayano, Armijo, & Yang, 2015; Njenga, 2007; Parikh et al., 2019; Patel & Kleinman, 2003; Saraceno et al., 2007; Semrau, Evans-Lacko, Koschorke, Ashenafi, & Thornicroft, 2015; Scott, et al., 2011; World Health Organization, 2018a, 2018b). Increasingly, health centres and institutions are contending with rising cases of mental disorder as a result of a variety of issues such as stress, anxiety disorders, depression and suicidality. Attempts at prevention and treatment of mental health have established the fact that mental disorders tend to coexist with other non-communicable diseases (Patel et al., 2018; World Health Organization, 2013; 2018b). In that case, there are several risk factors. As a result, mental health care aims at general wellbeing are integral processes in order to reduce the global burden of non-communicable diseases (NCDs) and is part of the World Health Organization's mental health

action plan (Scott, et al., 2016; World Health Organization, 2018b). For example, diabetes, cardiovascular diseases, cancer, and respiratory diseases commonly co-occur with both common mental disorders (such as depression and anxiety disorders) and severe mental illnesses such as schizophrenia and bipolar disorder (Stein et al., 2019; Von Korff, Scott, & Gureje, 2009).

The more traditional societies that form the bulk of developing countries are often faced with a myriad of challenges, chief among them political turmoil, poverty, HIV / AIDS and other illnesses (Republic of Kenya, 2005; 2009a; 2009; Wango, 2013; 2015). In health, other issues are more pronounced, such as infectious diseases, malaria as well as maternal and child mortality. Amidst such a background, government policy interest is evident, for example, in the setting up of a task force on mental health in 2019. However, an improvement in the quality of care for persons with mental health disorders and distress must establish the correlates of common mental disorders and thus aim at improved access to and effectiveness of psychosocial interventions (Wahlström, 2017; Wango, 2013; 2015). It must be recognized that mental health in traditional-cum-contemporary societies tends to have a cultural orientation, a social and cultural practice, and thus it is embedded in the more religious-traditions realm rather than, the more modern medical sphere (Nettleton, Watt, O'Malley, & Duffey, 2005; Njenga, 2007; Wango, 2017).

This paper set out to review various underlying issues in access to mental health care, the need for synthesized approaches to treatment and the development of a conceptual model of access and treatment. There are several factors that influence mental health, including historical, cultural and medical contexts (Nettleton et al., 2005; Rogers, & Pilgrim, 2003; Stein et al., 2015). The paper considers the more traditional-cum-contemporary Kenyan society (Wango, 2013) and the implications of various models in both the development and evaluation of psychosocial interventions for a variety of groups with poor access to mental health care such as the underprivileged poor, people in rural areas, children, persons with special needs and older people.

2.0.   Methodology

The paper adopts a narrative review of the available literature on mental health to trace the development of guidance and counselling, as well as mentoring and coaching and mental health,

to identify various concepts underlying mental health care. The narrative is synthesized into a conceptual model to enable evaluation of the complex interventions required to improve access to mental health care (Bleicher, 1980; Gask et al., 2012; Moules, McCaffrey, Field, & Laing, 2015; Schnell, 2010).

3.0. Challenges and Limitations in the current understanding of Mental Health Care in Kenya

The paper commences with a summary of aspects of mental health as relates to Kenya, including a brief narrative of the history of guidance and counselling, psychiatry and mental care. This is evidence of both the overlaps, in a bid to comprehend mental health and attempts at care and treatment.

3.1. Psychiatric Services in Kenya

Psychological counselling and mental health in Kenya has been largely associated with Mathari Mental Hospital, the national referral and teaching hospital for both civil and criminal mental patients. The history of the hospital dates back to the 19th Century when smallpox was prevalent in Kenya. Victims spotted in Nairobi area were collected together and tucked away in a bushy isolated place four miles to the north of the town centre; known then as the 'Smallpox Isolation Centre'. The centre closed down in April 1910 and in July of the same year was re-opened as a lunatic's asylum. During the First World War, the asylum admitted patients from the various African troops fighting in the war who were considered insane. The inmates were mainly of Africans descent with though there were a few Indians and Europeans. The Europeans were admitted while waiting to be repatriated to their countries for further care. In 1924, the asylum was renamed Mathari Mental Hospital and retained the name until 1964 when it was changed to Mathari Hospital. In the early years, the environment was prison-like; restrictive and isolated with more emphasis on 'safe custody' of the inmates. The hospital wards had thick walls with a high ceiling, and small, high placed windows with thick metal bars to prevent escape by the patients. Treatment was also custodial. This gave the hospital and the wards a gloomy, dark and often-damp atmosphere. Later attempts to renovate and modernize the wards and the custodial impression have not been as successful.

With time, the demand for psychiatric services in Kenya grew, and more wards come up. However, there was no clear attention to clinical care and, with a lack of long-term development plans, the hospital developed in a hazard manner. Essential services like catering, sewage and drainage, water supply and laundry services, alongside staff housing and other essential facilities, did not receive much attention. Until 1962, Mathari Hospital was the only institution providing psychiatric service in the whole country. Consequently, the hospital could not cope with the increased patient and staff population. The decentralisation of psychiatric services started in 1960 with the completion of several psychiatric units attached to the general hospital in other towns. Similarly, outpatient's psychiatric clinics are now to be found in most district hospitals all over the country.

Mathari is also a training hospital and has, for many years, offered a clinical experience for trainees from various health disciplines in the country. Unfortunately, it has not managed to shed the '*Jela Ya Wazimu'* (prison of the insane) tag. But the mentally ill are not prisoners much as mental hospitals are not prisons; they are not confined as a danger to society. They should be discharged from hospital just like any other patient, but when mentally ill patients leave a hospital without authority, they are said to have escaped (run away hence fugitives). In medical settings, when patients leave the hospital before being officially discharged, they are said to have absconded. This negative connotation has contributed to the social stigmatization attached to patients visiting or admitted to Mathari Hospital.

At present, several hospitals offer psychological counselling services and have been gazetted as mental institutions with some facilities for the admission and discharge of people with a mental health condition. In 1989, the Mental Health Act repealed the Mental Treatment Act. This was revolutionary, in that it markedly simplified the admission procedures for patients.

Essential developments in mental health care in Kenya and at the Mathari Mental Hospital include:
- Establishment of community psychiatric services.
- Use of long-acting injectable tranquillizers.
- Better follow up services (out-patient clinics).

- Shorter hospitalization period for in-patients.

Plans in psychological counselling services include the involvement and participation of the community, with emphasis on preventive and effective care. This involves the integration of counselling and therapeutic services in various hospitals, alongside intensified community-based psychiatric services all over the country. However, counselling psychological services will require to be incorporated as part of the National Health Service (NHS). Mathari Hospital, for instance, has already started on integration, opening a dental unit, a general outpatient casualty and a maternity unit.

3.2. *Problems in Access to Mental Health Care*

Many individuals with mental distress, especially in the rural areas and among underprivileged populations, are disadvantaged because of poor access and effectiveness of treatment (Kovandžic et al., 2010; Meltzer et al., 2000). In the first instance, there is the stigmatization of mental health leading to outright discrimination (Henderson et al., 2014; Mascayano, Armijo, & Yang, 2015; Semrau et al., 2015). Indeed, mental illness is among the leading causes of disability and social exclusion in the World (Ebuenyi et al., 2019; Steel, 2016). Secondly, care is not readily available due to the lack of hospitals, and even sometimes, the lack of professionals in several health centres. Thirdly, the interaction with professional care-givers is difficult for family members who in many instances expect immediate results that are healing. Fourthly, mental illness in the more traditional societies is perceived to be an act of the gods, a curse from the ancestors as a result of evil or wrongdoing. This tends to deter or divert help-seeking either because family members are convinced that they already understand the reasons for the sickness, and/or because help is sought elsewhere such as from traditional healers and religious leaders (besides or in addition to medical help).

The provision of adequate mental health must comprehensively seek to understand the circumstances of the more contemporary traditional societies, especially in the modern context (Wango, 2013; 2017a). This is because these societies have their context and content. That way, it will be possible to suggest ways of accessing medical health as well as improving the quality

of care linked to other interventions (Gask et al., 2012; Gierisch et al., 2014; World Health Organization, 2018a; 2018b). Both access and effectiveness of medical care are paramount.

3.3.   *Definition of Treatment and Challenges in Treatment in Kenya*

A significant challenge of mental disorders is in treatment (Bandura, 1997; Moore, 2017; National Institute for Health and Clinical Excellence. 2008; Stein et al., 2015). Proper intervention includes therapy as well as the medical treatment, and at times a combination of the two in terms of psychopharmacological approaches. In my view, Kenya must look beyond what it has achieved and learn from others, especially those who have taken a multi-faceted approach to mental health care and treatment (Bhui, Shanahan, & Harding, 2006; Cheraghi-Sohi et al., 2006; Kernaghan, 2009; Lamb, Rogers, Bower, Dowrick, & Gask, 2012; Moller, Ryans, Rollings, & Barkham, 2019; World Health Organization, 2013; 2018a; 2018b). Here below, I have outlined several challenges with reference to the Kenyan scenario.

Firstly, a significant challenge with treatment is that clients, and sometimes client-cum-patients, rarely seek treatment and even when they do, hardly follow it through to completion. In the more traditional-cum-contemporary societies, this is as the result of the stigma and discrimination associated with mental illnesses. Understandably, health care professionals use specific labels to assist in diagnosis and treatment, which is also the case for psychological services (American Psychiatric Association, 2013; Wango, 2012). Despite apparent benefits, the labelling, unfortunately, activates stigmatization and stereotyping (Ebuenyi et al., 2019; Mascayano, Armijo, & Yang, 2015; Semrau et al., 2015). Additionally, the stigma could lead to discrimination with a significant and negative impact on interpersonal relationships, care and treatment. In the more traditional communities, the impact also extends to the family caregivers of persons diagnosed with mental illness. Religion and spiritualism also play a part as most families tend to isolate, or worse lock up the patients, rendering them helpless victims of a condition no one comprehends. In that case, referrals are rare.

Secondly, both clients and patients often do not complete treatment. This is predominantly because they fail to attend subsequent appointments, or receive attention only during the initial treatment. This is a sad state of affairs given that follow up is necessary and essential for acute

cases of depression, suicidal thoughts and other psychiatric disorders. This, in turn, raises issues relating to the effectiveness of treatment (including therapies, a broad comparison is given that may not effectively assess the recovery rate or evaluate the sessions). Additionally, data on treatment, choices and satisfaction may not be favourable. Essentially, the data on treatment has low return rates making it invalid in terms of the effectiveness of treatment.

Thirdly, another significant policy concern that should be addressed by the Task Force is the provision of pharmacological and non-pharmacological treatments such as psychological therapy. This includes mental health educational programmes. Although such treatments are generally more immediately available and somehow more appealing and acceptable to clients than medication, they may not be as controlled by the government. There is, therefore, need for strengthening of counselling and psychological associations (Weiste, Voutilainen, & Perakyla, 2015). Even then, access and effectiveness are still restricted owing to limitations in the number of adequately trained therapists.

In all these, information is lacking on outcomes of access and treatment. Yet such information is significant so that it can be collated with other social-psychological variables such as follows: age; gender; regions (rural, urban); ethnicity and culture; religion, spiritualism and faith; employment status; sexual orientation; special disability, the aged and minorities (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Wango, 2013; Wexler, & Gone, 2012). In effect, it would be difficult to focus on the interplay of factors, including a logical assessment of local economic deprivation which is an essential indicator of outcomes for a number of client and patient groups. For instance, data on students and adults, as well as employment status, would enable the government to identify the category of those on benefits payments. Overall, the data can be published alongside the annual population census.

4.0. Development of a Conceptual Model of Access and Effective Mental Health Care in Kenya

This section describes the development of a conceptual model of access and effectiveness to care for common mental health problems in Kenya. This should stem from a comprehensive policy framework with effective implementation schemes.

4.1.   Understanding the delivery of mental health care and Services in Kenya

It is notable that in Kenya, public and policy interest in matters of mental health care has largely been confined to several areas (Republic of Kenya, 2008b; 2011; 2014). Unfortunately, these areas are not as interlinked, thus missing out on the synergy. These are:

(1) *Psychiatry and Clinical Psychology*. This includes the introduction of programmes and courses on psychiatry and clinical psychology in mental health hospitals such as Mathare Mental Hospital. Scholars such as Parikh et al. (2019:1) have argued that mental health problems tend to be a leading cause of the disease burden in adolescents and this is highly significant in low- and middle- income countries (LMICs) in which adolescents constitute a high proportion of the total population. There is also a lot of stigma and discrimination (Mascayano, Armijo, & Yang, 2015; Semrau et al., 2015), including gender disparities in discernment (Ebuenyi et al., 2019).

(2) *Guidance and counselling, mentoring and coaching*. This includes assistance offered to pupils and students in schools and other educational institutions (Barkham et al., 2019; Parikh et al., 2019; Wango & Mungai, 2007), public service including HIV/AIDS programmes (Republic of Kenya, 2008a; 2008b; 2009) as well as other clients including individual, group and family counselling. Other proposed services include counselling for specific groups such as the armed forces, parents and the bereaved (Wango, Wairire, & Odiemo, 2018; Wango, & Wairire, 2018; Wango, & Gatere, 2019)

(3) *as well as pastoral counselling and chaplaincy*. There are several programmes that aim to assist individuals, groups and families using a religious or faith approach. Additionally, religion and aspects of spiritualism and faith contribute greatly to individual and community wellbeing.

(4) *Social work*. Various social workers and non-governmental organisations have devoted time and energy to enhanced mental health care. Admittedly, some of these programmes are supported by the government, including those on counselling as well as drug and substance abuse (Republic of Kenya, 2011; 2014).

In the first instance, Kenya too must take a broad approach with a focus on NCDs. Stein et al. (2019) propose a five-by-five approach that includes mental disorders as well as social and environmental contributors, as illustrated in Table 1.

Table 1:   Five-by-Five Approach to Tackling NCDs

Disease types	Risk factors
• Cardiovascular diseases	• Tobacco use
• Diabetes	• Unhealthy diet
• Cancer	• Physical inactivity
• Chronic respiratory diseases	• Harmful use of alcohol
• Mental disorders and other mental health conditions	• Environmental risk factors

It is noteworthy that risk factors such as alcohol and tobacco use, unhealthy, diet, physical inactivity, and other unfriendly environmental factors are a feature in people with mental disorders. Suicidality, too, is associated with feelings of anxiety and loneliness, hopelessness, abandonment and self-hatred. For instance, Hendin, Maltsberger, and Szanto (2007) coined the term 'suicide crisis' to describe the intense affective state that is indicative of acute risk for imminent suicide. Similarly, the term Repetitive Negative Thinking (RNT) has been used to depict levels of anxiety, worry, mood and pervasive thinking (Drost et al., 2014; Ehring & Watkins, 2008; McEvoy, Mahoney, & Moulds, 2010; McEvoy, Watson, Watkins, & Nathan, 2013; Segerstrom, Tsao, Alden, & Craske, 2000). There are many types of counselling psychological treatment or therapies applied in general practice, including in Kenya (Wango, 2015; Republic of Kenya (2014) as depicted in Figure 1.:

Figure 1:   Counselling Psychological Services

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The main types of counselling and psychological therapies widely used include Clinical Psychology; Counselling; Guidance, Mentoring and Coaching; Pastoral Counselling and Chaplaincy; Psychiatry; and Psychotherapy. The range of brand names is different as it depends largely on the help provided, and the specialist or institution. Individuals and institutions apply diverse approaches in different settings according to the designated principles (Wango, 2017b; 2017c). Besides, nursing and social work may include some therapy. The role of psychotherapy as an intervention should be highlighted.

Provision of psychological therapies varies considerably depending on the profession and the client/s. Each of the therapies can be practised with individuals on one-on-one, couples, families or groups. Subsequently, the government through the Department of Health requires to develop an influential pathway for common mental health problems in line with existing regulations, including the use of psychotherapeutic approaches (Gierisch et al., 2014; Voutilainen, & Perakyla, 2015). This includes an intervention and care model that must be followed in meeting the needs of the general population, as demonstrated below:

Figure 2:   Pathways to Mental Health Care Model
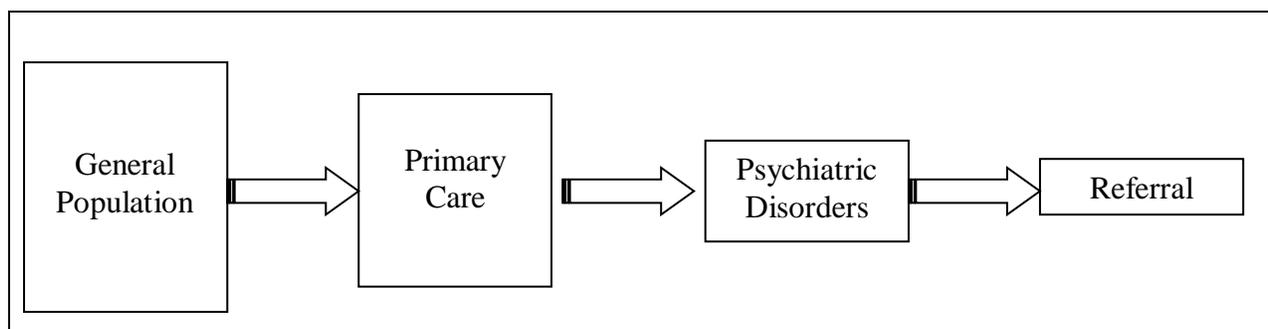
Adopted from: Gask et al. (2018).

The model identifies the relationships that exist between patients with mental health needs in the general population and different 'levels' of care. Aspects such as suicidal ideation and repetitive negative thinking, as well as anxiety and depression in the general population, must be clearly highlighted. A major highlight is the importance of recognition of mental health problems by various primary care 'gatekeepers' that include: counsellors, clinical psychologists, psychiatrists and social workers (including teachers and members of the clergy). Indeed, metapsychiatry

(spiritual teaching and form of psychotherapy based on metaphysical concepts of man and the universe) may be highly considered in the more traditional societies (Oettinger, 2020). With time, there will be expanded awareness of mental health issues, care and treatment including in the media.

This model can be demonstrated using the following table:

Table 2:   Pathways with varying Levels and Filters to Ensure Effective Mental Care

Level	Pathway	Characteristics Features	Level description
1	General population	Awareness of mental health	The general population must be made aware of the need for healthy well-being. This includes social, emotional, physical and psychological well being
		Filter > Primary CareGivers, preventing illness behaviour	
2	Primary care	Reduced stress and anxiety disorders.	Primary care should aim at dealing with challenges of living, including stress and anxiety disorders, thus preventing psychiatric disorders. Primary care professionals such as counsellors and social workers can assist in recognizing some of the symptoms and in dealing with them.
		Filter > Primary CareGivers, Dealing with illness behaviour	
3	Psychiatric morbidity and referral services	Treatment and care for psychiatric illnesses.	Mental care and treatment must aim at the general population, including social actors such as teachers, religious leaders, counsellors and social workers, in order to make life and circumstances less challenging. Aspects such as childhood adversities should be dealt with to prevent more psychiatric problems.
		Filter > Primary CareGivers, Preventing escalating morbidity	
4	Specialised care services	Professionalism and referral services	The Ministry of Health and other stakeholders must intensity training and research to ensure enhanced psychological services.

Provision of psychological therapies varies considerably depending on the profession and the client (Gask et al., 2012; Moore, 2017; Gierisch et al., 2014; Oettinger, 2020). Each of the psychological therapies, for instance, can be practised with individuals on one-on-one, couples, families or groups bases. Psychological therapies are provided by members of different professional disciplines, including clinical psychologists, psychiatrists, specially trained mental health nurses, occupational therapists, art and drama therapists, counsellors, psychologists and

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psychotherapists. Some therapists have generic roles, providing therapy as an integral part of care programmes within mental health teams. Others provide stand-alone services. For instance, while a psychiatrist or clinical psychologist can legally prescribe certain medication, a counsellor, chaplain, pastor, psychologist or social worker will adopt psychotherapeutic approaches. Psychiatrists, on their part, will deal with the more acute cases of mental disorders.

Mental care will be perceived in four dimensions, taking into consideration access and effectiveness of mental health.

Table 3:   Core Dimensions of Access and Effectiveness

Level	Pathway	Characteristics and Description
1	General population	If mental health care is promoted, many persons in the general population will, and should, take the opportunity to enhance wellness, leading to heightened physical and mental care.
2	Primary care services	Gaining access to primary care, such as ways of dealing with stress and anxiety, will enable people to cope effectively with the activities of daily living (ADL). Additionally, caregivers, including counsellors and social workers, should take the opportunity to bring awareness to the general population on the need to access health care. This includes personal organisation as well as ways of dealing with challenging issues such as work, finances and relationships.
3	Psychiatric morbidity, physical and mental health services.	Mental health services should be readily available to enable satisfactory health living. This includes aspects such as therapy (guidance and counselling, mentorship and coaching, pastoral care and chaplaincy). Effective mental health care and services can help prevent more morbid psychiatric conditions.
4	Specialised and referral services	In the case of psychiatric disturbance, aspects of treatment (medical and therapy) should be readily available and not conditional. This includes the availability of treatment and psychiatric services. In that case, the government, through the Ministry of Health, as well as stakeholders in health and mental care, should ensure the accessibility of specialised mental health care services. This includes treatment and care for marginalised groups such as the aged, children and persons with special needs.

These dimensions can be explained using the various available professional services, as outlined in *Figure* 3 below. It must be understood that mental and psychological conditions are not homogenous and cannot be discussed collectively. This is because there are different types of

mental disorders and psychological disturbances, ranging from general and mild anxiety to the more severe such as schizophrenia.

Figure 3:   Counselling Psychological Service Providers
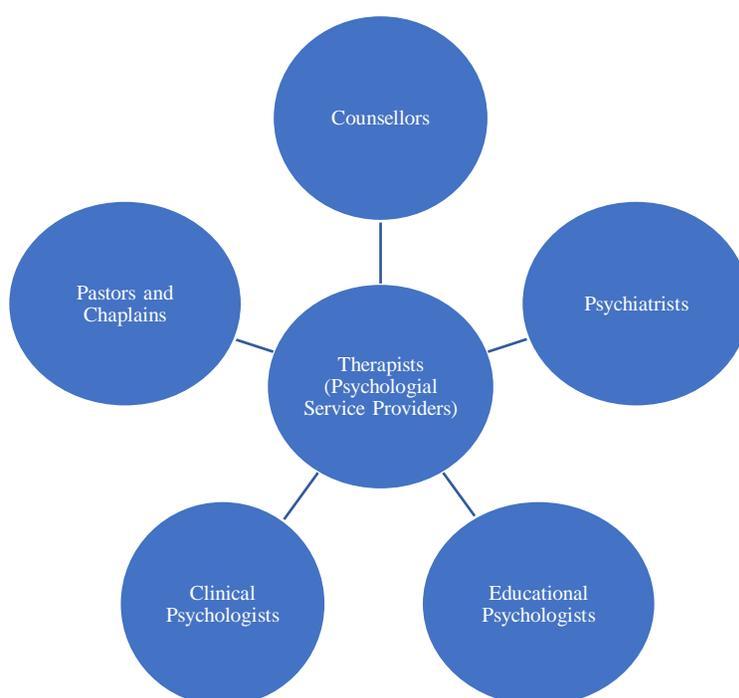
In that case, not all psychological disturbances and mental illnesses disrupt our ability to think, act and organise our everyday life. Every one of us is likely to forget an umbrella on a rainy day or miss a bus, leaving us anxious. All people encounter varying difficulties at work, home, on the road and in relationships.

4.2.   *Improved Mental Health Care in Kenya*

Access in mental health is not as explicit as in physical fitness (Patel et al., 2018; World Health Organisation, 2018a; 2018b). Instead, it is much more complex and tends to be more problematic owing to several factors such as income and social inequalities (Patel et al., 2018). This includes perceived stigma and discrimination, together with cases of suicide and depression. In the same way, the coercion associated with help-seeking for mental health problems makes both treatment

and follow up difficult, including of suicidal attempts, stigma and suicidality prevention (Lehmann, Hilimire, Yang, Link, & Devylder, 2016; Knox, Conwell, & Caine, 2004; Rimkeviciene, Hawgood, O'gorman, & De Leo, 2015).

Developing interventions aimed at improving access to mental health care, and treatment is a policy priority. In that case, it should lead to (1) policy innovations; (2) information on mental health care; and, (3) enhanced access to treatment. The first must begin with a review of all existing laws and policies on mental health, including suicide. The second must incorporate psychosocial education as well as a link with existing programmes and courses that conduct training on mental health. Part of this must include standardised screening instruments. Finally, the Ministry of Health has to come up with strategies on treatment, including payments. There is the additional training of various professionals, particularly on the application and effectiveness of DSM classifications, to enable both improve recognition and referral as well as standardization of psychological services.

4.3.   *Improving Access to Psychological Therapies*

There is a need for improved access and effectiveness of psychological therapies. I would highly recommend a programme on Improved Access to Psychological Therapies (IAPT) using the England model (Moller et al., 2020). The model incorporates the National Health Service (NHS) and is part of the primary care mental health programme in England. In the same way, Kenya should incorporate a programme using the National Hospital Insurance Fund (NHIF). This implies that it would be possible to identify cases of mental health as well as monitor and evaluate referral services. The IAPT database should collect routine session-by-session consultations, thus enabling the monitoring of data for the mental health population, including outcomes for anxiety and depression, suicide and psychiatric illnesses.

In my view, this will enable Kenya and other developing countries to set up improved care models for anxiety and depression as well as other psychological problems. This should include a range of psychological therapies, among them psychoanalysis, existentialism, cognitive behavioural therapy (CBT) and person-centred as well as experiential therapies.

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4.4. Technology in Mental Health: Applications and Practice

Technological advancement has a great part to play in delivering mental health interventions (Goss, Anthony, Stretch, & Nagel, 2017). This includes the use of social networking, video and phone, email, blogging, video-conferencing, podcasts, synchronized chats, gaming and virtual reality. There is also media, YouTube, SMS services and others that can provide emotional support for those in crisis. Admittedly, increased numbers of people of all ages are able to make use of laptops and smartphones to access health, including psychological care. Healthcare delivery has been interlinked with technology, including websites devoted to health and health care provision such as Telehealth and treatment by a tele-psychiatrist. Technologies are now available for the provision of counselling and therapy, clinical psychology and psychiatry, and general medical care. Online mental health services are now a reality in various countries, and Kenya should take a leaf and enhance technology for the achievement of the same.

Major concerns in mental care and treatment include ethical issues and professionalism in the delivery of services via technology. In that case, care-givers, including therapists, must establish which services are available, and how to deliver them safely. Aspects worth consideration include confidentiality, theoretical orientation, standards of care (face-to-face-delivery and use of chats), managing risk via technology, and boundary issues. This includes possible alternatives, such as how to set up as a provider. Again, there are potential dangers as well as legal and ethical pitfalls that must be discussed in context, such as the use of virtual environment technologies for treating clients with mental health issues. Various scholars have provided an expanded view of the use of information and technology and how it can be incorporated significantly in medical care (Goss et al., 2017). In the end, the task force could recommend a more detailed exploration of online mental health interventions as well as technological applications.

4.5. Other Approaches to Mental Care

Stein et al. (2019) propose the 4Cs model of care and treatment. The 4Cs are: collaboration, coordination, continuity, and centred on the person. This highlights the need for integration of mental healthcare into existing health care models. Additionally, it is consistent with the management of various health conditions, particularly chronic. In agreement with Stein et al. (2019) the emphasis on access and effective treatment of mental health largely depends on

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several principles that include: a comprehensive understanding of mental health (including a metapsychiatric viewpoint); excellent communication; a shared decision-making process; and proactive monitoring and evaluation. In that case, the Task Force must adopt a multidisciplinary guideline that integrates well-being with mental health.

We must explore various ways of assisting in the care and mental treatment. This includes spiritualism, as well as adopting a closer relationship with the client in therapy, for example, through the use of shared decision-making. Shared decision making (SDM) is a form of patient-clinician communication where both parties bring expertise to the process and work in partnership to make a decision, thereby facilitating improved outcomes3 and quality of health care. Ultimately, Kenya, as well as other developing countries, has to explore various approaches to mental care and health, including suicide prevention strategies (Calear, Batterham, & Christensen, 2014; Patel & Kleinman, 2003; Saraceno et al., 2007; Wexler, & Gone, 2012; World Health Organization, 2012; 2014; 2018a).

5.0. Conclusion

Improved access and effectiveness of mental health care must include legal amendments as well as the social change to deal with stigmatisation. Additionally, it is imperative to establish a national database to help in prioritizing prevention and treatment intervention strategies. Subsequently, the model for mental health care in Kenya must take into account more traditional-cum-contemporary societies. Improved access and effectiveness in mental health care must incorporate interventions at various levels that comprise: community engagement (including education and media); primary health care; and the development and sustainability of various psychosocial interventions. At the initial stages, education and training of the public will be essential in order for people to seek mental health services. At the same time strengthening community-based services, including psychosocial intervention and institutions that provide mental health care. In addition, targeted child or school-based interventions can greatly enable improved mental health and well-being (Doll, Nastasi, Cornell, & Song, 2017; Fazel, Patel, Thomas, & Tol, 2014; Rones, & Hoagwood, 2000; Skiba, 2017). Arguably, schools, in particular, have been increasingly highlighted as critical in various efforts aimed to reduce mental health disparities. This is because such programmes can target and deal with childhood

emotional and behavioural difficulties. This includes greater focus and content of school-based mental health services (SBMHS) and programmes (Parikh et al., 2019).

Despite the challenges highlighted in this paper, in various newspapers as well as in research, there is a notable increase in the amount of information in the public domain about mental health issues (Loewenthal, & Avdi, 2016; Wahlström, 2017; Weiste, Voutilainen, & Perakyla, 2015). There—is also an increase in the number of professionals including counsellors, clinical psychologists, psychiatrists and social workers though their performance may not be easy to extract and evaluate. However, this is just a starting point ~~and~~ as this Task Force and various papers have highlighted the points of concern, with suggested improvement on multiple fronts. This includes improved public knowledge, enhanced courses and programmes on mental health, more professionals and further researcher. In essence, a dataset on mental health will allow for more detailed assessment and evaluations of treatment programmes that will inform policy.

Notes

Traditional society *The term 'traditional society' implies the systems, habits, viewpoints, traditions, rituals and beliefs of society before the emergence of industrialization, modernization, scientific and technological development as opposed to the more modern, industrialized and scientific community. This does not mean that the traditions are immoral or dreadful, nor does this paper castigate them. Inevitably, all societies are in transition,—including the presumably more traditional societies. Hence, this paper adopts the phrase 'traditional' and 'contemporary, traditional society' to depict a community that is transiting from the more accustomed to modern practices.*

Traditional-cum-modern society *The World is more global, and hence all societies are in transition and will take in other customs and practices. However, human communities which are technologically unsophisticated are persuaded to allow the sacred (religious) to invade their secular and philosophical interpretations (more traditional societies). In contrast, others who adopt modernity will be inclined to take in new ideas and interpret the World using newly-found knowledge and information (traditional-cum-modern societies). A person in a traditional-cum-modern society will be transiting between the two spheres of influence.*

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Appendix 1: *Improved Access and Effectiveness of Mental Health Matrix*

	Feature	Components	Suggested intervention strategies	Time Frame
	Stress, Mood and Stress Disorders, Burnout	-Improved daily living. -Interpretation and inversions of basic meanings.	- Talks and shows on mental health. - Counselling / Mental Health Week.	
		Repetitive negative thinking.	- Treatment for anxiety and RNT.	
	Anxiety and Anxiety Disorders	Existential, philosophical and religious (spiritualism) perspectives.	Counselling for depression (CfD).	
	Depression Suicide		Critical incidence management.	
	Substance Disorder		Critical incidence management.	
	Suicide	Suicide ideation	- Perception, attitudes and reactions towards suicide. - Programmes to support suicide attempt survivors and suicide loss survivors in coping with suicide stigma and secrecy.	
		Suicide attempt survivors (stigma and discrimination).		
		Families left after suicide (suicide loss survivors).		
	Psychiatric Cases	Clinical and therapeutic treatment	Improved management and treatment	
	Research and publications		Research in counselling, psychotherapy and mental health.	
	Stigma and Discrimination	Stigmatization and stereotyping.	Improved labelling and categorization in order to enhance care and treatment.	
	Children, Pupils and Students	Children mental health and well-being	- Differentiation between issues in child growth and development, wellbeing and mental health - School-based interventions	
	Unspecified (including training and mental health programmes)	Mental health and well-being	- Meanings, functions, clinical management and priorities - Comprehensive, practical, careful and wide-ranging diagnostic assessment	

The Task Force can identify various activities/programmes and provide a time frame.