Education About Mental Health and Illness: Innovative Approach for the Kenyan Context

10

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Contents

Abstract

Over the years, there has been growing evidence on the disheartening impact of mental health in developed and developing countries. However, ongoing efforts towards improving current systems, practices, and structures towards addressing

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this impasse are not sufficient to effectively address the ever growing mental health treatment gap.

Continued lack of adequate budgetary support for mental health, instability in mental health governance, dismal interest in psychiatry as a career amongst students and emerging health workers, limited efforts in capacity building the existing mental health workforce, continuous lack of priority for mental health among development partners and anthropological dissonance about the role of informal and formal mental health systems especially in developing countries have derailed any push towards adequate delivery of universal mental health.

Recent advancement towards integration of mental health services with existing primary health care models has had significant impact in addressing the mental health treatment gap, especially in developing countries, which consequently illuminated the huge influence of informal mental health service providers and indirect users of psychiatry on mental health service delivery; actors who had carved out a niche in addressing the treatment gap prior to this integration.

Therefore, there is need to focus on enhancing mental health literacy for all stakeholders in mental health for effective service provision. This chapter delves into the importance and subsequent impact of education on mental health and illness for all actors on mental health and illness including consumers of mental health services, the family unit, and formal and informal mental health care systems.

Keywords

Mental health · Education · Consumers of mental health · Family unit · Formal systems · Informal systems · Stakeholders

List of Abbreviations

GBD	Global burden of disease
GDP	Gross domestic product
LMIC's	Low and middle income countries
MDG	Millennium development goals
MNS	Mental, neurological, and substance use disorders
MOH	Ministry of Health
NCD	Noncommunicable diseases
NGO's	Nongovernmental organizations
PTSD	Post traumatic stress disorder
WHO	World Health Organization

Introduction

According to a recent study on the global burden of disease, the leading cause of death and disability over the last two decades has changed from communicable diseases in children to noncommunicable diseases in adults (IHME Seattle 2013).

Mental health disorders such as depression, anxiety, and substance abuse are the global primary drivers of disability accounting for approximately 40 million years of disability amongst youth.

According to the World Health Organization, as at 2015, Kenya had a population of approximately 46.05 million people (WHO 2016), total health expenditure as a percentage of gross domestic product (GDP) was 5.7, and approximately 100 trained psychiatrists as at 2016. The World Health Organization estimates that non-communicable diseases will be responsible for 73% of deaths and 60% of the burden of disease globally by 2020 (WHO 2014). Furthermore, according to the Kenya National Strategy for the Prevention and Control of Non Communicable Diseases, despite the strong connection between mental health diseases and other non-communicable diseases, consumers of psychiatry do not receive the medical attention they deserve.

Global Perspective on Mental Health

Mental, neurological, and substance use disorders (MNS) account for a substantive proportion of global health problems (Murray et al. 2013) with MNS accounting for 13% of the global burden of disease (Mathers et al. 2008).

Previous studies have shown that MNS disorders have earlier ages-of-onset than most physical disorders (Kessler et al. 2007) and rarely occur in isolation (Whiteford et al. 2013) with up to 80% of deaths of people living with these disorders occuring as a result of other coexisting physical illnesses (Crump et al. 2013). In 2010, mental and substance use disorders were the leading cause of the number of years people lived with disabilities.

Despite these statistics and the pressure on global health systems to address the gaps in mental healthcare, there are a number of challenges inhibiting the effective implementation of mental health illness management systems globally. For instance, the earliest manifestations of poor mental health often occur at youth or adolescent years, though in most instances, even in high income countries, this treatment is often administered many years after the onset of the disorder (Wang et al. 2007). Furthermore, these symptoms can be attributed to other health and environmental concerns including poverty, substance abuse, and violence. (Patel et al. 2007a).

The absence of mental health in the Millennium Development Goals (MDG's) widely contributed to reduced national focus on mental health in low and middle income countries (Patel et al. 2007b) with some LMIC's recording up to 90% mental health treatment gap.

Kenyan Perspective of Mental Health and Illness

Factors such as lack of proper information on mental health across formal and informal sectors, sociocultural misconceptions towards the cause, nature and treatment of mental health have contributed significantly towards the mental health

treatment gap in rural Kenya. Trained psychiatry practitioners often turn to private practice within the nations' capital, leading to shortage of public health care workers trained in psychiatry thus makes it even harder to provide quality mental health care within the rural regions of Kenya. In addition, there are very few specialists to supervise and train those healthcare providers at the community level (Ndetei et al. 2007)

The cost of accessing treatment and management of mental health care in Kenya continues to cause a huge burden on people seeking these services. The out-of-pocket expense borne by patients and family members seeking mental health services in public hospitals in Kenya was $51 USD per admission (Kirigia and Sambo 2003). High costs of medication, frequent unavailability of subsidized medication at public hospital pharmacies and patients, especially in rural areas, having to travel long distances to access this care takes a huge toll on people living with mental illness and their families, especially in sub-Saharan countries.

Associated self and social stigma on mental health issues in Kenya further complicates the matter. There is a prevalent belief that mental health conditions can only be treated by witchdoctors, traditional healers, or faith healers and that treatment of these disorders is beyond the formal mental health care system. This misinformation coupled with the desire to hide the occurrence of mental illness from the community for fear of condemnation, decreases the possibility of an individual receiving care at the onset of the illness, and reduces any chance of early management (Ndetei et al. 2016).

This belief system provides insight as to why a large number of the rural population in Kenya seek mental health treatment and management services from informal health workers (Musyimi et al. 2016) despite their lack of professional training. These include: traditional healers, faith based healers, community health workers, expert patient (expert patients are patients who have received medical services for a long period of time and can share experiences with other patients), local self-help groups, community-based organizations, families and community opinion leaders. This creates a worrying scenario for quality mental healthcare delivery in Kenya.

Scarcity of mental health human resources is also a well-established barrier towards mental health service provision. Poor working conditions, lack of recognition of mental health care workers, insufficient and non-practical formal mental health training, and lack of public health skills amongst mental health policy makers contribute to this barrier (Saraceno et al. 2007). The study goes on to state that redefining the role of mental health specialists from clinical practice to learning and community supervision is key in addressing this gap.

Mental Health Literacy in Kenya

The Canadian Alliance on Mental Illness and Mental Health defines mental health literacy as "the knowledge, beliefs and abilities that can enable the recognition, management or prevention of mental health problems." According to Reavley et al.

(2012), mental health literacy focuses on knowledge of early detection, prevention, service providers, available treatment, self-help strategies, and basic skills to improve service delivery of mental health disorders.

Numerous studies have shown that members of the public are not able to recognize symptoms of mental health and illness, diverse information regarding causes of mental illness, and self-help strategies. This in turn impacts attitudes and beliefs towards seeking help and treatment for various mental health issues.

Education is considered an essential component in promotion of health and disease prevention globally. Formal systems have relied on education through formal school curriculums, training programs, and practical approaches. Social online campaigns and the use of information, education, and communication materials and events have also played a huge role in education through awareness creation and capacity building in rural communities (Nutbeam 2000). Although little has been done to diversify the promotion of mental health literacy, recent efforts towards the promotion of school-based mental health programs and capacity building for informal health workers (e.g., community health workers) have been documented.

Psychiatry training in Kenya is very much a reflection of the British School of Psychiatry for various reasons:

1. Kenya inherited directly the British school of psychiatry system including Mental health Acts which were lifted from British mental health acts prevailing at the time of independence and nearly all the pre-independence psychiatrists in Kenya were British
2. The post colonization Kenyan psychiatrists were all trained in UK by the British government and upon return they took both administrative and academic leadership replicating what they had learnt in UK. The approach was also adopted by those who went into private practice.

However, the current practice in Kenya is not an exact replica of the current system of training in UK. Current training has been influenced by the DSM III, IV, and V, where one of the authors of this chapter, Prof. David Ndetei, was involved in the revision of the cultural aspects of the DSM V. Other LMIC countries may adopt systems as guided by their predominant schools of thought.

Kenyan psychiatrists do realize that there are fundamental differences as far as cultural aspects are concerned. In the training of psychiatrists and medical students, it becomes necessary to expose the trainees to these differences, e.g., the presentation of depression is modified by cultural explanation of those conditions and less emphasis on psychological explanation which they may not quite understand; depression may be explained by Kenyan patients in the form of physical illness which they understand. Many people with depression may present with psychosomatic symptoms or even attribute depression to chronic malaria. The presentation of psychotic symptoms such as hallucinations may not be easily conceptualized as medical or psychological problems but attributed to external supernatural causes. How can anybody hear voices of people which other people cannot hear?

As a science, the model is very much a mix of American approach as well, because of the overwhelming influence of DSM III and V which are the handbooks for students. These are also supplemented by textbooks written and used for teaching in the USA, as well as the UK, e.g., the textbook of psychiatry published in UK. The sample questions that are used for testing students are adopted and adapted from those of the Royal College of Psychiatrists in UK and the American Board of Psychiatry and Neurology.

The Nursing Council of Kenya, in partnership with the Kenya Medical Training College introduced a diploma course in mental health nursing in 2012, and the "Kenyan Mental Health Policy 2015–2030" was recently launched. This policy is cognizant of the fact that mental health interventions are not only broad in nature but cut across different sectors, thus there is a need to utilize multidisciplinary and inter-sectoral platforms to adequately address mental health needs with an aim of attaining the highest standards of mental health in Kenya (Kenyan Mental Health Policy 2015–2030).

Despite all this, general knowledge and attitudes regarding mental disorders is very low amongst many members of the public. This knowledge includes information related to the types, risk factors, causes, psychiatric terminologies, and available interventions (both institutional and self-care based). This chapter is therefore dedicated to highlighting the need for education on mental health within the Kenyan context, in order to ensure that mental health is viewed as part and parcel of overall health, from the basic family unit to the national level.

This chapter will also focus on addressing access to mental health and institutional collaboration building on mental health literacy across the following community units: consumers of mental health services, the family unit, formal healthcare system, and informal health care systems.

Attributes of Mental Health Education in Low and Middle Income Countries

Given the diverse and mostly unmonitored number of models in mental health service delivery, there is need to educate consumers' mental health service providers and their support systems to promote overall mental health literacy in the community. In most instances, models used in LMIC settings often originate from developed countries and are adapted to suit local settings.

Various models of mental health education and literacy in various low and middle income countries have been documented and this section seeks to highlight key attributes of such models:

(a) **Affordable** – A recent study on the growth, inequality, and poverty in sub-Saharan Africa revealed that Kenya, Burundi, Madagascar have shown minimal improvement since the 1990s (Fosu 2015). Therefore, education models designed for such contexts need to be affordable to the majority of the population in order for the community to even be able to consider it. The Kenyan government has conducted several public campaigns to encourage adoption of the

national insurance fund which offers subsidized medical services at affordable monthly premiums, which can be used by patients seeking mental health services in public hospitals.

(b) **Promotion of Mental Health Services Scale-Up** – LMIC's are characterized by very low psychiatrist to population ratios. In Nigeria, for example, there are only 200 psychiatrists catering to a population of 200 Million people (Gureje et al. 2015). In order to address this huge treatment gap, the integration of mental health services in primary health care models is often the preferred system. This system has its challenges including reluctance by mental health professionals due to vested interests; however, it is one of the most widely accepted avenues for provision of mental health care for a huge population of people seeking mental health services (Group, L. G. M. H 2007).

(c) **Cultural Adaptation** – Methodologies and measures used to provide services as well as conduct research on the contribution of various models towards mental health promotion need to be contextualized and culturally adapted to suit local needs. Cultural adaptation can be achieved through several means including providing services in clients' native language and translating assessment and/or data collection tools.

(d) **Needs Driven** – Psychiatry often adopts a purely medical approach to the treatment of mental health issues and rarely takes into consideration social effects that dictate changes within the individuals' environment (Jenkins et al. 2010a). Different communities exist in different environments which influence their way of life and general perception of standards of living. It is therefore pertinent to adapt mental health education models to satisfy the needs arising from an individual's natural environment.

In 2005, the Kenya Ministry of Health (MOH) in partnership with the World Health Organization Collaborating Center, the Kenya Medical Training College, and the Kenya Psychiatric Association embarked on a project to increase the mental health literacy of mental health professionals by providing a cost-effective, five day interactive course in mental health, which adopted an intersectoral and health systems approach. As of 2010, 1673 professionals had been trained and the study showed a 35% mean score in improvement of knowledge within the first 1000 trainees. In addition, the study also showed an increase in networking with informal mental health service providers including faith-based healers, community chiefs, etc., in health facilities where trainees worked (Jenkins et al. 2010b). This education model was also adopted in Nigeria (Gureje et al. 2015), where mental health faculty were trained on various approaches towards community mental health using a similar curriculum.

Similarly, a study conducted on the role of traditional healers in the provision of mental health services in an urban, informal setting in Kenya revealed the need for increased training on the recognition and understanding of mental illness and the need for effective collaboration with formal mental health service providers. Furthermore there is a need to have the preferred treatment methods of traditional healers such as herbalists, tested by certified agencies to ensure they are fit for human consumption (Mbwayo et al. 2013).

Within the Kenyan context, there is growing interest in partnerships with government to incorporate locally generated evidence for promotion of mental health integration in primary health care and networking of formal and informal health care workers. In a recent study in Makueni County (rural Kenya), the county government supported an initiative to engage formal health care workers from 20 health facilities, community health workers, traditional and faith-based healers to build their capacity through training on screening of mental illness using the WHO's Mental Health Gap Action Programme (MhGAP) intervention guide. This was done in order to develop a sustainable referral channel between formal and informal systems for patients diagnosed with mental health symptoms. Furthermore, this training promoted increased mental health awareness, while maintaining community support and respect for each service providers' unique role.

The use of online-based platforms to promote education on mental health is also increasing in popularity. Online-based tutorials and courses have been used to provide mental health training from Western universities to local mental health care professionals. Webinars have also been used to increase supervision time between specialists and mental health care faculty and service providers across various settings.

Consumers of Mental Health Services

The Oxford Dictionary defines a consumer as "someone who purchases goods and/or services for personal use." A consumer of mental health services is an individual who seeks/pays for mental health services for their personal well-being. In Kenya, we have five main categories of mental disorders (i) common mental disorders such as depression, anxiety, etc.; (ii) severe mental disorders such as psychosis, schizophrenia, bipolar disorders, etc.; (iii) neurological disorders such as epilepsy, dementia, etc.; (iv) childhood disorders such as autism, attention deficit/hyperactivity disorder, etc.; and (v) alcohol and substance use disorders. Although age, gender, ethnicity, race, and other sociodemographic factors do not influence nature and occurrence of mental health illness in individuals, the severity of these conditions may be affected by various sociocultural factors in an individual's environment (Evans 2003).

Psychoeducation can be defined as a form of education therapy geared towards increasing knowledge on mental health illness to an individual receiving mental health care and in some instances, their family members, caregivers, or friends (Tol et al. 2011). According to research, consumers of mental health services who have received adequate psychoeducation on their nature, symptoms, treatment, and management of their illness tend to improve faster than those who are not as informed (Sörensen et al. 2006). In addition, majority of individuals who seek these services in the Kenyan system are often not aware of the condition they have the ways to effectively manage their manifestations aside from medication.

Moreover, there is little research on the quality or effectiveness of psychoeducation in Kenya. The common methods of psychoeducation for consumers of mental health services include (AIPC 2014):

(a) **Individual psychoeducation**: Focus on content and information related to an individual's specific needs. Mostly used when an individual requires/prefers confidentiality, initial interaction/exposure to formal psychiatry treatment, an individual is not comfortable sharing in the presence of many people, etc.
(b) **Group psycho-education**: Focus on educating clients on various aspects of their illness in a group format. This mostly involves only people with similar health issues and can relate with each other's experiences. This is not ideal when dealing with complex individual issues or instances requiring confidentiality.
(c) **Group psychoeducation in presence of family and/or caregivers:** This is mostly administered with only one consumer of mental health services accompanied by caregivers/family or friends. In some instances, multiple patients can be accompanied by their family/caregivers to one group session and focus on general issues.

There are several factors that influence the uptake of education on mental health issues amongst consumers; these include:

(a) Lack of individual awareness on presence of mental health issues as a general health illness: Most people living in low and middle income countries such as Kenya believe that symptoms related to mental health conditions are not a result of an actual illness but either personal lifestyle choices (e.g., substance abuse) or cultural beliefs (e.g., witchcraft) or social/communal beliefs (e.g., symptoms mostly related to a particular season) (Muga and Jenkins 2008). Therefore, elimination of these mental illness manifestations can be brought about by changes in lifestyle by the individual, removal of the ill-omen causing the symptoms through exorcism or prayer and withstanding the environmental conditions accompanying a particular season with the hope that it will get better at the onset of the next season.
(b) Lack of information regarding availability of mental health services: Given the fact that Kenya faces a huge scarcity when it comes to mental health service provision or focus on national government on mental health advocacy, a majority of Kenyans, regardless of their personal encounter with mental health illness, are not aware that mental health illnesses are indeed treatable (Eaton et al. 2011). Furthermore, most people are not aware that there are other institutions, other than the national teaching and referral hospital for psychiatric conditions, Mathari hospital, providing mental health services, have the capacity and/or personnel to adequately deal with these illnesses.
(c) Burden of mental health care workers: Due to the scarcity of trained mental health care workers throughout the country, one psychiatrist or psychiatry nurse can tend to clients coming from several counties in the country. For instance, Machakos County hospital has one psychiatrist who also serves clients from neighboring Makueni, Kajiado, Kitui, and at times Nairobi counties, i.e., approximately 3 million people. Therefore, given this huge volume of people seeking such services, it is almost impossible to give each client enough time to ensure that they not only understand their condition but gradually learn how to effectively manage it; most health workers often resolve to administer treatment and schedule follow up appointments.

As a result, effects of lack of psychoeducation among the consumers of mental health services can result to: lack of adherence to prescribed treatment methods (medication and counseling) when symptoms reduce, difficulty in identification of triggers and personal support systems thus not able to manage subsequent relapses, self-stigma arising from personal and communal ridicule and rejection, lack of trust in the available mental health care services due to the apparent failure of their treatment schedule to completely rid them of their condition, as is the case with most health-related issues, and result to seeking alternative sources of treatment.

To address this gap, various private stakeholders have joined hands with national government to introduce or complement existing platforms on pyschoeducation for consumers of mental health services. For example;

(a) Users and Survivors of Psychiatry in Kenya, an organization whose membership is comprised of people who were previously or currently receiving treatment for various mental health issues across several counties in Kenya, conduct regular group sessions among their members to promote an environment to share personal experiences and management techniques regarding mental health services and illness management.
(b) One outcome of the Community Recovery Achieved Through Entrepreneurism, a pilot project conducted in Machakos County by Western University (Canada), in partnership with Queens University and Africa Mental Health Foundation focusing on recovery of people living with serious mental illness through employment and psychoeducation, is the development of a low-cost, contextualized toolkit of psychosocial rehabilitation that focuses on educating individuals on their illness and providing them with skills towards management of their illness through various techniques such as identifying triggers, support system, workplace wellness, and dealing with social and self-stigma.
(c) In a similar initiative carried out in Kibera urban informal settlement in Nairobi County, Kenya, women diagnosed with Post Traumatic Stress Disorder (PTSD) receive regular group counseling through Group Support Psychotherapy Manual in the presence of mental health clinicians, social workers, and community health workers.

Mental Health and Illness Education Within the Family

The World Health Organization (WHO) defines health determinants as "the range of personal, social, economic and environmental factors which determine the health status of individuals or population." General health and well-being of an individual is often influenced by the stability of the surrounding social, political, and cultural environment. A family is the primary source of learning and development for an individual from birth and continues to act as a pillar of support throughout the individuals' lifetime. Therefore, a family is a critical determinant to the overall health of an individual, including mental health and wellness.

As the popular saying goes, "it takes a village to raise a child" goes to show that the responsibility to create and nurture a positive environment for growth and overall well-being of an individual belongs to the entire community/clan/village. In a traditional African set-up, the concept of an orphan is almost nonexistent owing to the fact that the family unit was not bound by blood ties only but extended to clan and community ties. This goes to show that even in adversity, an individual will always have a support system to turn to. However, the African community is highly reverent on issues touching on religion/cultural belief norms (Ngui et al. 2010). Mental health unfortunately has from time immemorial been regarded as a taboo issue, symbolic to curses or misfortunes, and as usual in such cases, communal support is replaced by communal discrimination. Most people suffering from mental health issues are often alienated from society and those with mild manifestations of the illness do their best to suppress these symptoms for fear of rejection.

Although modernity continues to erode these communal family ties especially in urban settings, the burden of mental illness on a family still remains a taboo issue and with it, a great deal of stigmatization on the patient and family members. Coupled with the cost of accessing treatment to mental health issues as well as the other numerous issues families living in low and middle income countries face, mental health is often viewed as an immense burden to the family.

Research for a long time has indicated that social support is one of the strongest drivers of mental health recovery (Ganster and Victor 1988). Family support has one of the highest impacts towards this social support. The family is often the initial indicator of how a person suffering with mental illness will manage their illness. With good family support, mentally ill patients are able to be more at ease with their condition, able to manage their symptoms, identify their triggers, and clearly identify other supports within their environment with the help of their families. In contrast, people from families who stigmatize and apprehend their illness often struggle with illness management and adherence to treatment.

From our experience, there is an increase in involvement of family in mental health–related initiatives (Topor et al. 2006). It is also quite common, given the resources, to find nurses involving family in counseling sessions or regular clinical follow up or community health workers attached to mental health services in the community conducting home visits to assess progress in individuals' management of the illness and adherence to treatment, especially from the family's perspective. In as much as family members may do little to change the course of their loved one's illness, their contribution towards improving their overall quality of life is essential.

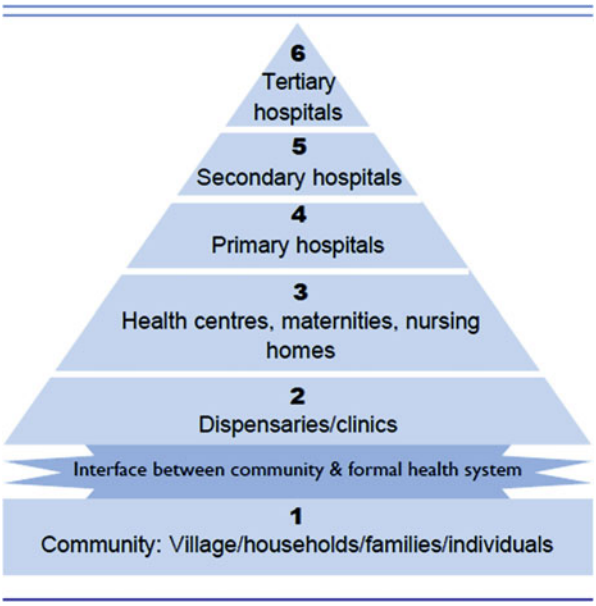
Through psychoeducation, family members are able to understand the nature and associated triggers of their loved ones' illness. In addition, it increases their capability to better communicate to their family member, improves how they cope with the financial and social burden associated with caring for and interacting with a person living with mental illness on a daily basis with the general aim to help the individual to be comfortable with the support she or he receives from the family, increases their ability to share on what they feel, and increases possibility to reduce occurrence of relapses (Ohaeri 2003).

Education on Mental Health Within Formal Health Systems

Over the past decades, there has been gradual progress in development of formal mental health services in low and middle income countries. Existing literature attributes this slow progress to various factors including resistance to decentralization of mental health services, little priority awarded to mental health in public health agendas, and scarcity of mental health human resources.

According to the Human Resources Strategy 2014–2018 of the Ministry of health In Kenya, there are 7795 health facilities in Kenya of which 3956 are government facilities, 2652 private facilities, 881 faith-based facilities, and 306 NGO run facilities (Republic of Kenya Ministry of Health 2014). The new constitution further classifies national government health system in six main levels:

1. National Referral Hospital (or Tertiary Hospitals)
2. County referral hospital (or Secondary Hospitals)
3. Sub-county hospital (or Primary Hospitals)
4. Health center
5. Dispensary
6. Community health worker (Meyer and Ndetei 2016)



Source: KHSSP 2005–2010

In Kenya, the psychiatrist to population ratio is approximately 1: 500,000. Furthermore, on average, 42% are based in a public health facility, 24% teach in learning institutions, and 34% in private practice. Furthermore, only 20% of the government facilities and 11% of the private practices with psychiatrists are based in rural areas

(Ndetei et al. 2007). It is also quite common to find majority of those based in public facilities run private practices concurrently thus further decreasing the focus and overall quality of service provided at the public institution.

As at 2010, Kenya had only 500 trained psychiatry nurses of whom less than 50% are practicing psychiatry in public health facilities while the others branched off to other disciplines or in NGO's. As a result, in the current situation, majority of the trained mental health professionals are only found at the National Referral, County Referral Hospitals, and a few Sub-County Hospitals (Jenkins et al. 2010a). Unfortunately, most often this is not the case. Majority of the mental health workers especially in the sub-county hospitals have not undergone complete training in psychiatry.

In a study targeting final year medical students across 20 countries, only 4.5% were definitely interested in pursuing psychiatry as a career (Farooq et al. 2014). There exists very limited opportunities for training and development of health workers in Kenya as a form of motivation by the government (Mathauer and Imhoff 2006), especially with regards to mental health therefore making it difficult for the service providers to remain up to date with the relevant trends and methods to effectively treat mental health–related illnesses. This therefore provides deep insight into the plight of mental health service distribution and access in Kenya, which resonates with the global disease burden and human resources gap in mental health.

In our experience, due to poverty, poor transport and communication networks, lack of adequate and timely provision of medicines by the government, and numerous sociocultural factors, mental health care workers in rural Kenya often bear the brunt of this burden as compared to their counterparts in urban areas (Brownie and Oywer 2016). This coupled with the shortage of trained staff in these rural facilities often forces clinicians from other disciplines to double up as mental health service providers thus reducing the accuracy and quality of intervention provided at these facilities. This exacerbates the gap in mental health knowledge amongst mental health providers in Kenya.

In accordance to the new constitution guideline towards devolution, health services management and operations was devolved from the national level to county level. This in turn provides opportunity for private sector stakeholders to gain direct access or audience with decision makers within the health system in a bid to promote initiatives surrounding advocacy, capacity building, and policy formation within mental health.

A similar initiative in Machakos and Makueni County provided online training for formal and informal health workers on the identification and treatment of substance use disorders (Mendenhall et al. 2016). As a result, mental health workers are in a better position to access knowledge and information geared towards an increase in quality of service provision, employee motivation, and job satisfaction generated from positive treatment outcomes.

Education on Mental Health Within Informal Mental Health System

Informal health systems in this case refer to systems where provision of healthcare or health-related services are done by people with no formal training in healthcare. These care providers significantly contribute to the overall health system, not only

mental health, in developing countries as it provides for the bulk of health services consumers, especially the poor. (Sudhinaraset et al. 2013)

There exists no concise definition relating to the nature and structure of informal health systems; they are made up of heterogeneous components guided by different frameworks relating to areas of focus, treatment methods, provision and payment of services, operational environments, etc.

Research on informal health systems in the developed countries commonly relates to family members, care givers, laypeople, and expert users of healthcare. In developing countries, this list goes on to include traditional healers, faith-based healers, herbalists, and community health workers. Traditional medicine is one of the oldest forms of health service provision in most communities.

A study that focused on uptake of informal mental health services in an informal settlement in Kenya pointed out that out of the total patients that visit traditional healers, 95% of them are often satisfied with the services (Mbwayo et al. 2013). A qualitative study conducted in South Africa found that community members choose traditional healers because they do not improve after visiting health facilities, doctors do not explicitly explain the cause of their ailments like the healers and the healers are readily available with shorter waiting lines. As a matter of fact, 70% believed that traditional healers are more holistic in their approach to health (Mathibela et al. 2015).

Informal mental health care services are often frowned upon by practitioners in the formal system because of:

(a) Unwarranted harmful treatment strategies – It is common to find that most traditional or faith-based healers attribute mental illness to witchcraft or curses thus resulting in unconventional methods to rid the individual of these "evil spirits." These exorcism rituals often cause physical and physiological harm to these individuals as the root cause of the illness is not adequately addressed. (Keikelame and Swartz 2015)
(b) Mental health care knowledge and practices – Despite the fact that informal mental health care workers have no formal training, most are capable of clearly identifying mental health–related symptoms and able to classify depression, schizophrenia, bipolar disorder, and drug addiction as mental condition. However, they usually provide alternative forms of treatments, e.g., herbs, prayers, rituals as solutions to these disorders which then lead to delayed proper treatment of these illnesses. Most of the times, people with mental health conditions in rural areas often visit the formal mental health systems when everything else has failed and/or one has lost the ability to manage his/her symptoms (Mbwayo et al. 2013).

As highlighted earlier, there exists a huge gap in treatment, availability of service and human resources. Given the preference and demand for informal mental health care service providers, especially in rural settings where there is little access to such services, there exists an opportunity to improve the mental health treatment gap in integrating both formal and informal mental health systems through training and development.

Several mental health programs and initiatives in Kenya and across Africa have made positive strides towards integration of informal and formal mental health systems through capacity building efforts aimed at increasing knowledge on mental health conditions focused on debunking associated communal myths on mental health, sensitization on mental illness as a treatable and manageable condition, encourage re-integration of people living with mental illness within the community, and general information about local health institutions offering basic mental health services.

Subsequently, these initiatives have in turn shown positive uptake from traditional healers especially in acknowledging the need for formal treatment, timely referral to hospital systems, and their unique role in positively influencing community perception and general atmosphere towards mental health (Musyimi et al. 2016; Bruni 2014).

Conclusion

Although there have been extensive studies on the mental health treatment gap in low and middle income countries and the focus on integration of mental health service provision in primary health care as a possible solution in bridging this gap, there is little evidence to show the efficacy and the various implementation strategies of this proposed model.

Traditionally, mental health education has been associated with formal systems of delivery and practice, i.e., institutions of learning or health service providers. With the recent shift to integration of mental health service provision, the role of the consumers, support systems/family, and informal health service providers cannot be ignored. Existing literature supports utilization of available human resources in the communities who have had prior exposure to addressing mental health issues as they represent a resourceful pool that would provide complementary services hence strengthening the mainstream health care system in resource-limited settings. This includes expert patients or patients who have received psychiatry services for a long period of time. They understand several issues associated with mental health treatment and have developed mechanisms to cope with the long-term management of mental health conditions. Through peer to peer interaction, people who have recently been diagnosed with mental health issues are able to relate and find comfort in the company of the expert patients with the proper education on mental health systems. These consumers could be a vital source of information to others thus contributing to creation of awareness on mental health systems.

Family members are usually the most prominent support source for people living with mental illness and more often than not, due to the stigma associated with mental health, family members are at times the only company a person living with mental health issues would want to interact with. The pressure on family members to adapt to the new situation brought about by a loved one's illness may be at times too much to bear. Family members ought to be educated on mental health issues and how best to support their loved ones in their long-term journey to recovery thus improving

overall communication and coping skills which provide an enabling support environment for the patient.

There is need for continued efforts on improving the national focus on mental health care service provision through research and critiques on existing policies. This can only be achieved by developing cost-effective, innovative measures to support the improvement of mental health service delivery. These measures will be efficiently adopted when all direct and indirect mental health stakeholders can understand the basics of mental health, access and effectively utilize the existing mental health services. Educating all stakeholders on mental health and illness is therefore one of the existing platforms to achieve this. Finally, future efforts towards research on the effectiveness and applicability of the existing mental health and illness education models would be recommended as the evidence generated will contribute towards defining innovative and cost-effective models of increasing mental health literacy and overall reduction in the mental health treatment gap.

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Kenyan Mental Health Policy 2015–2030
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