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Exploration of the State of Mental Healthcare Services for Youth in Nairobi

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Acknowledgments

Abstract

This paper is formative research concerning the state of mental health care for youth in Nairobi, Kenya. Using a mixed methods design, the objectives of this study were to identify the most prevalent mental health concerns among youth in Kenya, to explore the availability and acceptability of youth friendly mental health care services, and to explore the quality of and challenges to providing youth friendly mental health care services. Results indicate that substance abuse, conduct disorder, and family conflict may be among the most pressing mental health concerns for young people. Furthermore, while young people may be willing to seek mental health care services, they may not feel these services are available. Additional some of the major challenges to providing mental health care services are lack of governmental policy, lack of family support, and the financial burden of treatment.

Exploration of the state of mental healthcare services for youth in Nairobi

Mental illness is an issue accounting for 12% of disability adjusted life years worldwide (Disability-adjusted Life Years, 2016). Access to quality mental healthcare service is a human right, and it is important that resources are allocated to the prevention and treatment of mental illness. Often time manageable cases of mental illness can become exacerbated due to neglect. It is the case, particularly in low to middle income countries, that the mental health system is underfunded and underdeveloped. As a result, those most vulnerable members of the population are left without access to quality care. Among these vulnerable population are the youth.

Youth are defined by the United Nations (UN) as persons 15-24, however, this term is sometimes used interchangeably with the term young people which is defined by the World Health Organization (WHO) as persons 10-24 years of age (Recognizing Adolescence, 2014). Thus, the term young people encompasses adolescents which are defined as by WHO as persons in the second decade of their lives (10-19 years of age) (2014). For the purposes of the present study, the term youth may be used interchangeably with young people; furthermore, it is defined as persons between 13 and 26 years of age.

According to the World Health Organization, 10-20% of children and adolescents experience mental illness globally. Neuropsychiatric conditions are the leading cause of disability among young people in all regions (Child and adolescent, 2016). Half of those suffering from mental illness experience onsets by the age of 14, and three quarters are captured by mid-20s (Child and Adolescent, 2016). Given these statistics, it is important that young people have access to quality mental health services.

As previously stated, moderate cases of mental illness can develop into severe cases when left untreated. For example, depression is a common condition which can be treated in the

primary care setting, and untreated major depressive disorder (MDD) in adolescents has been associated with later development of anxiety disorders, bipolar and mood disorders, and substance abuse disorders (Khasakhala et. al., 2012). Adolescents suffering from mental illness often struggle in school, have negative social relations, and may be more likely to engage in risk-taking behaviors.

Research looking into the challenges youth with mental illness face is glaring scarce. Basic information such as the prevalence of mental illness among youth in Kenya is virtually non-existent and underreported at best. As the country is improving its mental health care services, it must integrate youth friendly mental healthcare services into its plan in order to have a more equitable and comprehensive system.

Background

Mental disorders are categorized as "…[having] some combination of abnormal thoughts, emotions, behaviour and relationships with others" (Mental Disorders, 2015). According to the World Health Organization (WHO), upwards of 450 million persons suffer from mental illness globally (Mental Disorders Affect, 2001). Among the most common disorders are depression and mood disorders, with the former being the leading cause of disability among adolescents (Child and Adolescent, 2016). Mental illness can take a toll on the individual, their family, and the broader society. It is projected that by 2020, the burden of mental health disorders will reach 15% which would disable more people than complications associated with AIDS, heart disease, and traffic combined (Ngui et. al., 2010). Despite these statistics, the majority of persons suffering from mental illness do not have access to quality treatment.

Low income countries, such as Kenya, struggle to provide adequate care for persons suffering from mental illness. It is estimated that 76% to 85% of people with mental illness in

low to middle income countries do not receive treatment (Mental Disorders, 2015). According to

one study, the mental health work force in Kenya has a ratio of 10.7 staff per 100,000 persons

(Marangu, Sands, Rolley, Ndetei, & Mansouri, 2014). Past research has indicated that while

there is a need for mental health care services, the current system is both under-resourced and

underdeveloped.

Policy

The main policy governing mental health care in Kenya is the Mental Health Policy

(Ministry of Medical Services, 2012). The development of this policy was led by the Ministry of

Medical Services, and was created to address the increase need for mental health care services

and recognize the need to reform the preexisting mental health policy. The document's main

focus is on health policy intervention and draws from national and global knowledge,

specifically the World Health Organization, concerning mental health service delivery.

The framework and objectives of the policy are outlined in chapter three of the document.

Strategic objectives include: promoting mental health and well-being, preventing the

development of mental illness and disorders, reducing the impact of mental illness and disorders,

and protecting the rights of mentally ill persons (2012). Youth are discussed in chapter 2. Under

Section 1.7 "Mental Health and Vulnerable Groups," children and adolescents are mentioned as

the first group. The policy reads as follows:

   a. Children and adolescents

Children are often prone to mental disorders either at birth where there was

inadequate pre-natal care or if their environment does not promote care, affection,

love, stimulation for cognitive abilities or other emotional and social support.

Adolescents face behavioral challenges and exposure or pressure to risky behavior

such as use of psychoactive substances that make them vulnerable to mental

disorders. (p. 11)

While the policy recognizes that youth are a population with specialized needs within

mental healthcare services, there are no provisions within the policy for youth specific services.

In other words, the policy does not cater for youth friendly services (YFS).

 The basic principle of youth friendly services/youth friendly health services

(YFS/YFHS) is orienting health services to better suit the needs of young people. The framework

for youth friendly service policy was first described by the World Health Organization. The

WHO provides a framework for services under six principles: that services be accessible,

acceptable, equitable, appropriate and effective (World Health Organization, 2012). The National

Guidelines for Provision of Youth Friendly Services guides the policy for youth friendly health

services in Kenya (Ministry of Health, 2005). It is important to note that youth friendly services

under these guidelines are directed towards reproductive health, although mental health is briefly

mentioned as an area of concern. This is a trend not exclusive to Kenya; YFHS have been

generally tailored towards reproductive health services and were first introduced by the WHO as

a reproductive health concern (World Health Organization, 2012).

Under the national guidelines, youth friendly services are defined as "Broad based health

and related services provided to young people to meet their individual health needs in a manner

and environment to attract interest and sustain their motivation to utilize such services"(p. 10-11,

2005). An abbreviated list of minimal conditions for YFS is provided below:

- Affordability and accessibility

- Safe and basic range of services

- Privacy and confidentiality

- Provider competence/attitude

- Quality and consistency

- Reliability and sustainability

- Inbuilt monitoring and evaluation system (p. 12)

The guidelines also provide for strategies and actions for making services youth friendly; however, as previously mentioned, the document caters to reproductive health. The present study will therefore seek to assess the extent to which youth friendly services are integrated into mental healthcare services.

Literature Review

Research regarding mental health in Kenya is limited. According to Kiima, Njenga, Okonji, and Kigamwa, most mental health research is done through dissertation work for the Department of Psychiatry at the University of Nairobi (2004). In their paper ", Kenya Mental Health Country Profile," Kiima et. al. discuss the development of mental health policy in Kenya and current barriers to the establishment of a comprehensive mental healthcare system and the future development of mental healthcare policy. Some current challenges to providing mental health care services are persistent cultural beliefs about the origins of mental health, lack of mental health care facilities and human resources, and lack of funding. The researchers recommend several steps be to improve the mental health care system including demystification of mental disorders and the mentally ill, de-stigmatization of mental disorders and the mentally

ill, de-institutionalization of the mentally ill, incorporation of mental health into primary health care activities, and rehabilitation of the mentally ill into their families and communities (2004).

Another gap in research is reliable reporting of the prevalence of mental disorders in Kenya. Ndetei et. al. conducted a study of the prevalence of mental disorders of upper primary school children grades five through seven in Kenya (2015). 2267 students participated and were able to self-report symptoms using the Youth Self-Report instrument. Results showed that the combined prevalence of mental disorders was 37.7% among students. Furthermore, factors such as male sex, not being in the grade appropriate for one's age, and living in a peri-urban area was associated with increased risk for mental disorders. Having divorced or separated parents as well as having separated parents and a mother that was employed were also associated with some disorders. The findings of this study suggest that prevalence of mental disorders among children and adolescents may be higher than previously estimated. Researchers also suggest that early identification of behavior and emotional problems are key measures in preventing the development of mental illness among young people (2015).

Recognition of mental illness is just one aspect of issues in providing youth mental health services. Youth, particularly in developing countries face many challenges in accessing health services.

In their paper ", Adolescents and youth in developing countries," Fatusi and Hindin argue that a holistic approach is needed in order to address the issues youth face, specifically in developing countries which contain comparatively higher proportions of young people in their population than developed countries, contain a disproportionately high burden of youth-related problems, and experience greater resource challenges (2010). Information presented was drawn from papers presented at the International Conference on the Health and Development of Young

people. The researchers propose that adolescents face particular challenges because of the biologic processes (puberty) as well as the social transition into adulthood as a legally and economically autonomous being. This period of a person's life can often be filled with confusion and instability.

Fatusi and Hindin identified that some of the major health issues adolescents face are sexual and reproductive health issues, accidental and intentional injuries, mental health problems, substance use and abuse, and eating behaviors (2010). These issues are exacerbated in developing countries where many youth may live in poverty and governments may have limited resources dedicated to health services. Poverty specifically relates to health trajectory in several ways including youth's likeliness to participate in risky behavior.

Conversely, family relations and school connectedness can prove protective factors for adolescent health (Fatusi & Hindin, 2010). Family, and particularly parents are often the first source of health information for adolescents; furthermore, parents are often the ones who direct youth to obtain health services. Conversely, youth may avoid seeking health services out a fear of their parents' response particularly as it relates to the youth's sexual behavior (2010).

On the other hand, school connectedness is defined as "feeling that someone in a young person's school cares about his or her well-being" and has been negatively correlated with poor school performance, school drop-out, early sexual initiation, risky sexual activity, violence and substance use (p. 504, 2010). Ultimately Fatusi and Hindin argue that it is necessary for policies to address adolescents and youth friendly services:

> Services that are designed specifically to meet their needs in an effective manner, responds to their challenges with sufficient understanding, use approaches that are appropriate and acceptable to them, and set in an environment that is respectful to

young people, ensure confidentiality, as well as be receptive and friendly to them.

(p. 501)

Having care that is youth friendly is important to treating young people. WHO has provided guiding principles with which to construct youth friendly health services; however, in regards to evaluating proposed youth friendly care, few measures have been based on youth self-report of quality, satisfaction, or experience (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013).

In their study Ambresin et. al. conducted a review of literature on young people's perspective on health care in order to create indicator for youth-friendly care (2013). The researchers defined young people as persons between the age of 10 and 24 years. After applying study criteria, the researchers included both qualitative (n=16) and qualitative (n=7) including one article with mixed methods design. After assessing the quality of the studies, researchers developed a summary of the domains and examples of relevant indicators which include accessibility of health care, staff attitude, communication, medical competency, guideline-driven care, age-appropriate environment, involvement in health care, and health outcomes. These 8 domains were then summarized under four constructs: satisfaction with care, experience of care, quality of care, and patient-centered care. Findings show that youth place an emphasis on holistic care, and indicators provide guidelines for the appropriateness of care.

Overall, the literature indicates that there are research gaps concerning mental health care in low-income countries in general. Furthermore, the gaps are more startling for research concerning the prevalence of mental illness among youth in low-income countries, youth friendly treatments available to this population, and the availability of such treatments.

Study Objectives

The broad object of this study is to understand the experiences of youth receiving mental health care services in Nairobi, Kenya. Furthermore, there are four specific objectives of this study. The first objective is to identify the most prevalent mental health concerns youth in Kenya are facing; secondly, to explore the availability and acceptability of youth friendly mental healthcare services in Nairobi form the perspective of youth; thirdly, to explore the quality of youth friendly mental healthcare services in Nairobi from the perspective of school counselors and professional healthcare providers; and lastly, to explore the challenges to providing youth friendly mental healthcare services in Nairobi from the perspective of school counselors and professional healthcare providers.

Setting

The study site for this project is in Nairobi (see map below). Nairobi is the capital city and largest city in Kenya. It has a population of approximately 3.1 million people in which approximately 32% (994,425) of people are between the ages of 10 and 24 (Kenya National Bureau of Statistics Kenya National Bureau of Statistics, 2009). Public health concerns related to urbanization such as overcrowding, waste disposal, and urban poverty are major concerns in Nairobi. There are limited resources dedicated to the mental healthcare system, although Nairobi contains the two national referral hospital, Mathari National Hospital and Kenyatta National Hospital of which the former was the first established mental healthcare hospital in Kenya.

(Traveleditor, 2014)

Methodology

Data was collected in three parts. For the first part, anonymous surveys were handed out to a purposeful sample youth between the ages of 13 and 26. When possible, youth were recruited from facilities; other youth were recruited from persons on the street. A total of 73 surveys were filled out. Of the total surveys collected 13 surveys were discarded because the participant declined to share his or her age, participant was over age, or the survey was incomplete. To conserve as many responses as possible, the age range was extended to include participants who stated they were between 12 or 27 years of age. The distribution of age is included in Table 1 in the Results section. 46.7% (N = 28) of participants reported they were currently in school. 21.7% (N = 23) completed primary school as their highest level of education while 30% completed a mid-level degree (N = 9) or a first degree (N = 9). Furthermore, 16.7% (N = 10) reported being diagnosed with a mental disorder or illness. 60% (36) of participants

reported having a counseling services at their school while 21.7% (N = 13) reported they did not have counseling services, and 18.3% (N = 11) were not sure.

The survey consists of a total of 15 questions. Surveys were filled anonymously and verbal consent was obtained by each participant. For participants under the age of 18, consent was obtained either by the participant's parent when possible, or, for youth recruited at facilities, the practitioners were able to give consent.

Information from the survey was used to address the second objective which is exploring the availability and acceptability of youth friendly mental health care services from the youth perspective. The survey consists of five major sections. The first section contained demographic information which included their age, sex, education level, and student status. The second sections assessed experiences with mental healthcare services and asked participants whether they have talked to a school staff or professional about a mental health issue and whether they had previously been diagnosed with a mental illness. The third section assessed perceived availability of mental health care services. Availability was defined as how easy or difficult it would be to obtain services, and participants were asked on a scale of 1 (very easy) to 4 (very difficult) how available services were inside and outside of school. The fourth section assessed mental health care education and asked how often (not at all to almost all the time) one has been talked to about the importance of mental health inside and outside of school. The final section assesses health seeking behavior which was used as an indirect measure of acceptability. The present researcher used the WHO definition of acceptability which is whether youth are willing to obtain the available health services (World Health Organization, 2012).

Note that the described sections were not presented to participants in the exact aforementioned order. Also note that several of the survey question pertained to being in school.

If participants reported they were not currently in school, they were asked to reflect on the last time they were in school to answer the question. A copy of the survey is included in Appendix A. Responses were used to generate frequency data using SPSS 23 software.

The second part of data collection was conducting in depth interviews with mental healthcare providers. A total of five mental health care providers were interviewed: one psychiatrist, one head nurse, one psychiatric nurse, one psychologist, and one school counselor. Four interviewees were female and one was male. Four interviewees received specialized training to work with youth; one interviewee was a doctoral degree holder, three obtained master degrees, and one obtained a bachelor's degree. Experience working professionally in the mental health field ranged from six months to 12 years. Facilities professionals were recruited from are listed in Appendix B; pseudonyms are used to maintain confidentiality.

Interviews were approximately 30 minutes long each. Interviews were semi structured, and separate interview guides were used to differentiate between school counselors and other mental health care professionals. Interviews are labeled school counselor and professional practitioner respectively; a copy of the interview guides is included in Appendix C and D.

Interview responses were used to address the second object which is to explore the quality of and challenges to providing youth friendly mental health care services from the perspective of mental healthcare professional. Quality of services was measured by asking professionals if they provided YFS, the extent of those services, and if their organization/facility had policies governing youth friendly services. Quality was further assessed by observing the area in which youth patients were served, asking the professionals how they built rapport with youth patients, and asking professionals how they receive feedback from youth patients. To assess challenges, professionals were asked about general challenges in treating youth patients as

well as systemic challenges and other challenges to incorporating YFS into the mental healthcare system. Reponses were also used to guide data collection on the first objective, which is to identify the most prevalent mental health concerns of youth in Kenya.

The last part of data collection is a review of secondary data to supplement findings of the primary data. Since it was not possible, given the duration and limited resources of this study, to collect primary data concerning the prevalence of mental illness among youth in Kenya, the current researcher relied heavily on secondary data to address the first objective. Note that data search was guided by the response from the interviewed professionals and do not represent the extent of mental illness among youth in Kenya, nor does the subsequent literature review represent the full breadth of research conducted concerning the mental health of youth in Kenya.

Results

Table 1

Distribution of Age

Age	f	rf (%)	cf (%)
12-14	2	3	3
15-17	9	15	18
18-20	18	30	48
21-23	18	30	78
24-26	11	18	96
27+	2	3	100
Total	60		

Note. f = frequency. rf = relative frequency. cf = cumulative frequency

To address the first objective, identifying the most prevalent mental health concerns of youth in Kenya, professionals were asked "what are the common condition youth come in for." A compilation of responses are provided in Table 2 below. Among the most sited conditions were school misconduct/conduct disorder, substance use and abuse, and problems at home (e.g. divorcing parents, absentee parenting, sibling bullying). These responses guided the subsequent search for literature related to the prevalence and epidemiology of mental illness among youth in Kenya. Databases searched include the University of North Carolina at Chapel Hill online library, PsychInfo, and Google Scholar. Research in regards to studies conducted in Kenya yielded the most results in regards to substance abuse among youth in Kenya while there were virtually no studies concerning the diagnosis of conduct disorder among youth or studies

concerning family conflict and mental health outcomes for youth in Kenya. Findings will be

further discussed in the discussion section.

Table 2

Responses of Common Conditions

Mental illness/disorder	Drugs	Interpersonal Conflict	Other
Bipolar disorders (2) Psychosis secondary to epilepsy	Substance use/abuse (3)	Problems at home Conflict with parents (3)*	School difficulties Truancy Homosexual behavior [+] Death in the family
Postpartum psychosis Conduct disorder(2)	Drug induced psychosis	Sibling bullying Romantic relationship conflict	Disruptive class behavior

Note. Numbers in parenthesis denote frequency of responses

* Conflict with parents include divorce, separation, absentee, and alcoholic parent

[+] Homosexual behavior reported as personally distressing or distressing to parent

The second objective of this study is to explore the availability and acceptability of youth friendly mental healthcare services in Nairobi form the perspective of youth .To address this objective, histograms of responses have been provided below for each of the question sections pertaining to perceived availability of services in school (M = 2.30, SD = .8497), perceived availability of services outside of school (M = 2.50, SD = .9465), acceptability of services in school (M = 2.48, SD = 1.081), and general acceptability of services (M = 2.95, SD = .8911) in Figures 1, 2, 3, and 4 respectively.

Figure 1

Figure 2

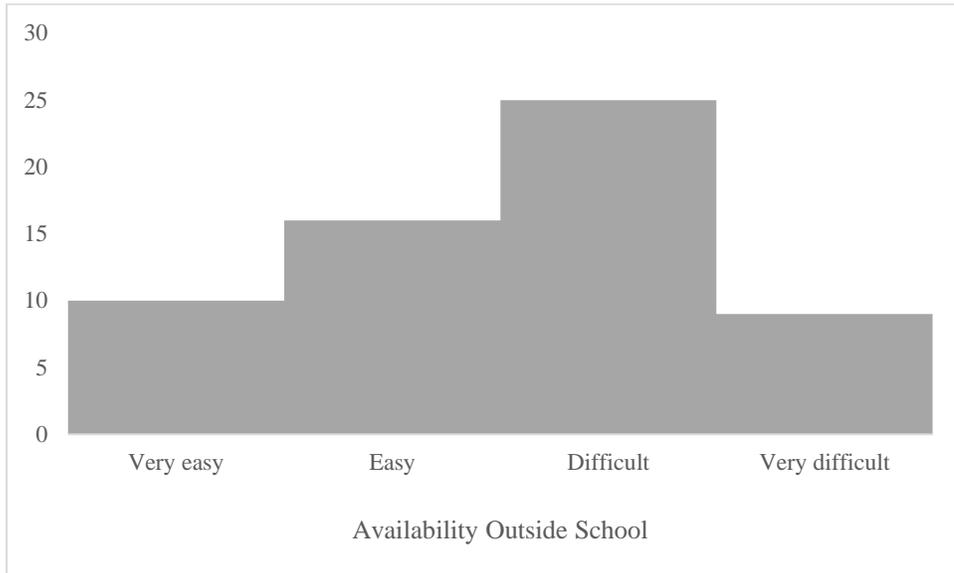Availability Outside School
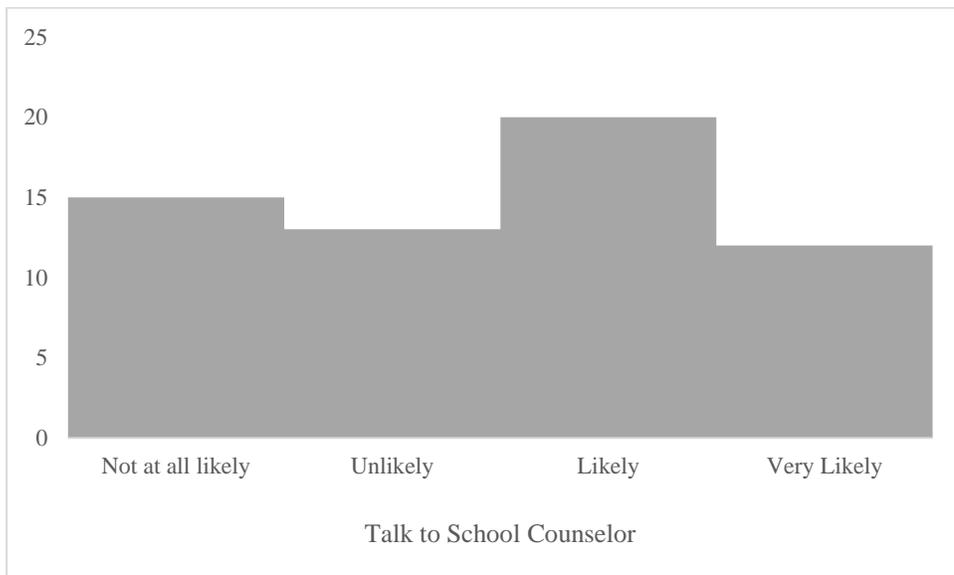
Figure 3

Talk to School Counselor

Figure 4
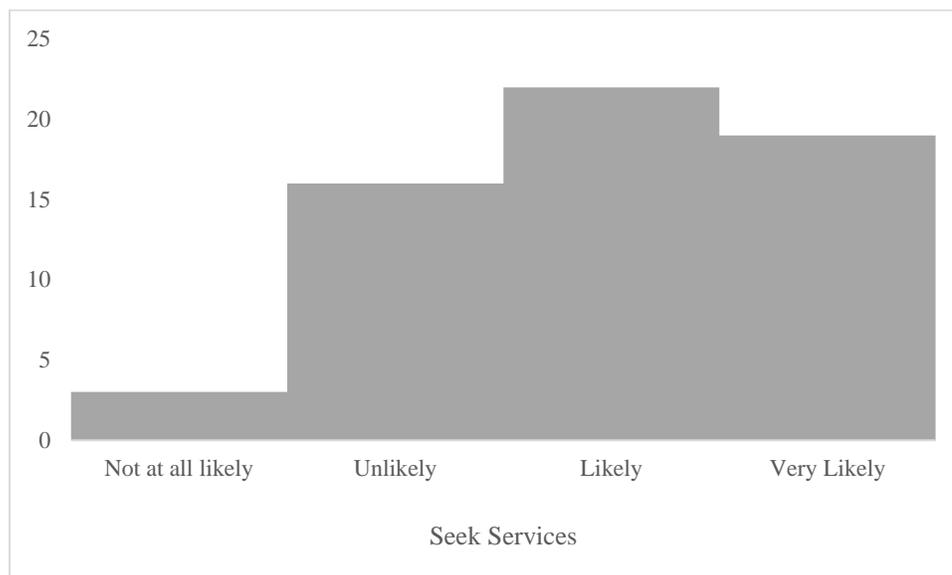
The third objective was to explore the quality of youth friendly mental healthcare services in Nairobi from the perspective of school counselors and professional healthcare providers. Providers were asked questions concerning the services they provided to youth and challenges they faced in providing those services. Out of the four providers (excluding the one school counselor), only two reported having YFS in accordance to the National Guidelines and having organizational policies dedicated to providing youth friendly treatment. Note that these two interviewees worked at the same public facility; furthermore, their facility was the only facility containing a separate area of the facility dealing only with youth patients. All professionals (excluding the school counselor) reported having a system to receiving patient feedback. In regards to building rapport with youth, common responses were treating youth with respect, being non-judgmental, building trust, having clear communication, and involving youth in the process of treatment.

Professionals were asked three questions concerning challenges in working with youth patients (refer to Appendix D questions 7, 8, and 9). A summary of response are included in Table 5.

Table 5

Challenges to Providing YFS

Individual	Family	Organizational and Governmental	Other
Miss appointments/come at different time (2)	Lack family support (3) +	Availability of services (4)!	No system for ensuring parents follow through with treatment
Fail to complete assignments	Parent unable/unwilling to provide transportation	Lack separate facility (e.g. youth center) for youth patients	Persistent existence of superstition and witchcraft
Resistance (3)*	If below 18, must gain parent consent to begin counseling	No in-patient care	Cannot provide holistic youth services (2)
May feel like parents brought them	May not like when parents come to sessions	Small facility	Medication is expensive (3)
Lack motivation	May not want certain information shared with parents	Insufficient governmental policy concerning mental health care (5)	Most insurance do not cover mental health care services (4)
		YFS have been focused on reproductive services (2)	Stigma
		.1% of government funding spent on mental health	
		Government cannot supply medication demand	

Note. Numbers in parenthesis denote frequency of responses

* Include unwillingness to open up and not adhering to treatment

+ Include lack of family recognition and acceptance of condition

! Include lacking personnel, hours of operation to accommodate youth who work or who are in school, and hours of operation on the weekend

Discussion

Discussion of Common Conditions

Of the most common conditions mentioned by the mental health care professional, research concerning substance abuse among youth in Kenya was most available. Drug abuse, particularly among persons between the ages of 16 and 30 has been an issue of global concern. Contributing factors to adolescent drug use include peer influence, decrease social control mechanisms such as traditions or taboos around drug use, decrease parental supervision, and the availability of drugs (Chesang, 2013). According to Chesang, in Nairobi alone, 50% of students have taken drugs in the past. The issue of drug abuse has been recognized as major concern by the Kenyan government since the establishment of the National Campaign against Drug Abuse (NACADA) in 2001 (2013). The goal of this organization is to coordinate the efforts of individuals and organizations to combat drug abuse. According to Chesang, combating the issue of youth drug abuse and misuse will require the participation of multiple actors including parents, school officials, non-governmental organizations, and the government.

Another study conducted in Kisumu, Ngesu, Ndiku, and Masese sought to determine the most common drugs abused by secondary school students and investigate the contributing factors of drug abuse among students (2008). The study was conducted with a stratified simple random sample of 150 students in Kisumu as well as a purposeful sample of ten heads of departments of guidance and counseling and ten heads of secondary schools. Researchers found that alcohol was the most frequently abused drug followed by miraa, kuber and bhang. Furthermore, the majority of participants stated that peer pressure led to their taking of drugs. Of students who abused drugs, they reported having experiences of memory loss, over suspicion, depression and anxiety, sudden changes of appetite, and frequent complaints of headache among other symptoms.

Given the widespread issue of drug abuse/use among youth, it is important to have services that can meet their specific needs. For example, school and community based intervention programs, having anonymous clinics, and outpatient clinical care. Another issue that was addressed in regards to providing services for addicted teens is the gendered differences in drug abuse. In an interview with Ms. Beta, a school counselor, she stated that boys were more likely to use drugs than girls, and when girls used drugs, it was often accompanied by depressive symptoms. Furthermore, that because of this gender trends drug rehabilitation centers general cater to the male population and few accept female patients. Based on these findings, it seems that furthermore policy is needed to address drug abuse and use among youth.

As previously stated, no studies could be found concerning the prevalence of conduct disorder among youth in Kenya. According to the Diagnostic and Statistical Manual Edition 5 (DSM-5), conduct disorder is defined as "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated…" (American Psychiatric Association, 2013).

Erskine et. al. conducted a research review to determine the prevalence of ADHD and CD worldwide. 2010 marked the first year that ADHD and CD were included in the Global Burden of Disease Study (GBD) (2013). Erskine et. al. conducted a systematic review of global epidemiology of ADHD and CD based on a literature search of the Medline, PsycInfo and EMBASE databases. Their research yielded 56 prevalence estimates of CD from a total of 25 studies which covered 19 countries and 10 GBD regions. Results showed among persons between the ages of 5 and 19 male prevalence of CD in 2010 was 3.6% while female prevalence was 1.5%. However, a limitation to the study is that data was sparse, and many world regions had no estimate for either of the disorders being studied, this includes the East African Region.

Further research on the prevalence of conduct disorder should be done. CD is generally diagnosed before the age of 18, although adults can be diagnosed with CD if they do not meet the symptoms for Antisocial Disorder (Erskine et. al., 2013). CD has been linked to criminal and violent behavior as well as difficulty with adjustment; furthermore, it has been predictive of mental health problems (e.g., substance abuse), legal problems (e.g., risk for arrest), educational problems (e.g., dropping out of school), social problems (e.g., poor marital adjustment), occupational problems (e.g., poor job performance), and physical health problems (e.g., poor respiratory function) (Frick & Nigg, 2012). With conduct disorder, identifying the age of onset is critical in making a proper diagnosis, determining the trajectory of the illness, and determining strategies for intervention and treatment. Thus conduct disorder is an important area for future research.

Research was also scarce in regards to the relationship between family conflict and adolescent mental health outcomes in Kenya. Particular problems mentioned by professional were interparental conflicts such as separation and divorce, absentee parents, and sibling bullying. Past research has shown that family conflict is a large contributing factor to adolescent well-being. In one study, Lucas-Thompson, Lunkenheimer, and Dumitrach, found that adolescent conflict appraisal of marital conflict had implication for adolescent mental health; youth who self-blamed for parental conflict experienced abnormal cortisol production and displayed poor adjustment. (2015). In another study, Smokowski, Bacallao, Cotter, and Evans found that parent–adolescent conflict related to higher adolescent anxiety, depression, aggression, lower self-esteem, and lower school satisfaction (2015). In addition, Tucker, Flinkelhor, Turner, and Shattuck found that children ages zero to 17 who experienced sibling aggression reported greater mental health distress (2013).

Above, several areas of concern have been briefly highlighted in regards to mental health issues among youth in Kenya. The literature review indicates that further research in the area of mental health issues concerning Kenyan youth is needed.

Quality of Current Services

In regards to availability of services, it seems that youth felt it was easier to obtain mental health care services inside of school versus outside of school. 65% reported that it was either very easy or easy to receive mental health care services inside school as appose to 43.3% who reported the same for services outside of school. This may be related to the fact that nearly half (46.7%) of participants reported that they were currently in school. These findings indicate that the youth feel mental health resource outside of school are not accessible which means that youth who are not in school may have a more difficult time of finding mental health care services.

Conversely, an unanticipated finding was that 71.1% of the youth reported never talking to a school staff or professional about a problem with their mental health. This was surprising because at least a third of participants were recruited from facilities which provide mental health care services. These results may be due to participants' misinterpretation of the question. Participants may have interpreted the question (refer to Appendix A, question 5) as talking to a counselor or professional about a diagnosis they received.

Furthermore, general mental health literacy was poor even among youth recruited from facilities in regards to terms such as mental disorder, diagnosis, and psychologist/psychiatrist. Jorm et al. define mental health literacy as "'knowledge and beliefs about mental disorders which aid their recognition, management and prevention" (as cited in Marangu et. al., 2014). It is important for medical professionals as well as patients to have mental health literacy in order to identify and define possible symptoms of mental illness. Nearly a third (29%) of participants

reported that they were never talked to about the importance of mental health in school and 26% reported they were never spoken to about the importance of mental health outside of school. Having limited information concerning mental health and mental health care service can contribute to misunderstandings concerning what are signs of mental distress and what mental health services entail. One study suggests that school-based mental health literacy programs may improve knowledge, attitudes and help-seeking behavior of youth (Wei, Hayden, Kutcher, Zygmont, & McGrath, 2013). Ms. Delta, a psychologist commented that many youth were hesitant in the initial stages of treatment because they did not know what to expect and often had preconceived notions that counseling would be a negative experience. Therefore, lack of knowledge pertaining to mental illness and mental healthcare services may deter youth from seeking services.

Despite this finding, over half (53.3%) of participants reported that they were either likely or very likely to talk to a school counselor if they were experiencing any difficulties, and over two thirds (68.4%) of participants stated they were either likely or very likely to seek out mental health care services if they felt they needed them.

These findings show that youth are willing to use mental health care services; however, accessibility as well as knowledge concerning mental illness and services may prove a barrier.

Challenges to Providing Services

One of the major challenges identified was the lack of governmental policy concerning mental health. The Kenyan government considering mental health as a priority is a recent shift in the country's policy. It was not until 1982 that Kenya began its own psychiatry-training program in the medical school at the University of Nairobi; the Division of Mental Health was created

within the Ministry of Health in 1987. Furthermore, it was not until 1991 that the first national mental health program of action was implemented (Kiima et. al., 2004).

Furthermore, policy concerning YFS has been umbrella-ed under reproductive health. Ideally, YFS would be integrated into general health care policy, however, it seems that youth could benefit if youth friendly mental health services were made a greater priority. As Dr. Alpha, a psychiatrist stated, although her facility provide reproductive services, 80% of patients required mental health services in conjunction to or separate from reproductive health issues.

Another major challenge identified was family support, particularly parents recognizing their child's mental health issue and acquiescing in their treatment. It is the case that parents may not understand their child condition and this may result in parent child conflict; or children may be left at in patient wards and abandoned by family. Conversely, a parent may choose to seek a more traditional treatment for their child rather than seeking a formal treatment. As of now, traditional healers are not recognized by the Kenyan government and little research has analyzed the safety and effectiveness of their methods.

Another issue is the financial cost of treatment. All professional interviewed mentioned that virtually no insurances cover mental health services. Although the sampled facilities generally provided either free or reduce priced services, the biggest issue was paying for medications. The cost of medication may also contribute to parents' choice to seek tradition medicines which may be more affordable. On the other hand, patients may have to settle for first generation medicines. Mr. Espilon, a psychiatric nurse, stated that first generation drugs are those medications first developed by scientist in the 1980's and they generally are less safe and have more severe side effects than second generation, contemporary medications. However,

these first generation medications may be a more affordable option to poor patients; at the same time, patients may be less likely to take their medication due to the severe side effects.

Many of the aforementioned challenges are rooted in poor governmental policy, lack of funding, and lack of knowledge concerning mental illness. In order to address the mental health care needs of young people, the participation of the government, health care providers, schools and parents are all required.

Limitations and Recommendations

This study had several limitations. One limitation was the small sample size. Only five mental health care professionals were interviewed, and 60 youth were surveyed. Furthermore, participants were conveniently sampled. Therefore, results cannot be generalized to the population.

Another limitation to the study was the language barrier. Surveys were written in English, and not all participants were English proficient. Translations relied on facility personnel, a cab driver, and other convenient personal. Because these impromptu translators were not trained in the way to translate questions and were only superficially briefed on the study goals, the meaning of questions could have been lost in translation. Furthermore, certain words, such as psychologist and diagnosis do not translate well in Swahili. Participants who spoke English well seemed to understand the term mental disorder/mental illness; however, it is not clear if this translated well for participants who could not speak English.

The environment was also a limitation. Many participants, particularly those recruited on the street, filled out surveys in open and pubic areas in the presence of other people. Given the subject matter, it is possible that participants did not feel comfortable answering questions truthfully.

Several improvements could be made for future research. First, a larger sample size would be ideal. During the data collection period, many young people were on term break which limited access to a larger sampling pool. Furthermore, many institutions require special research approval through their organization's IRB which is a process that needs to be started at least a week in advance. Future studies should take these constraints into account when planning a study.

Additionally, having in depth interviews with youth who have used mental health care service would be valuable in understanding the experiences of these youth and identifying gaps in services.

Lastly, it would benefit future research to collect information from Mathari Hospital. Due to several factors, it was not possible to interview personnel at Mathari Hospital. In addition to being the first psychiatric hospital in Kenya, Mathari Hospital is one of the few facilities that provide in-patient care for mentally ill individuals. Thus, the hospital would be a valuable source of information for mental health research.

Conclusion

The present study sought to explore the state of mental health care for youth in the Nairobi area. Results have shown that while youth may be willing to seek out mental health care services, these services may not be readily available. In addition, misconception of the causes of and role of treatment for mental illness are still an issue. In regards to youth friendly services, practitioners and youth face many challenges including lack of governmental policy, lack of family support, and high cost of treatment, specifically medications. Further findings highlight that there are many gaps in past research and more studies needs to be done in the field of psychology in Kenya. As mental health continues to be a global concern, and is gaining greater

recognition in developing countries, it is important that research be done in order to inform policies. Without information concerning the prevalence of illnesses, evaluation of intervention and treatment strategies, and other relevant research, government cannot hope to create comprehensive policies which best meet the needs of its people.

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Appendix A

My name is Rashiidah Richardson, I am an American exchange student and I am completing a term paper on mental health. This is an anonymous survey asking young people their opinions on the availability of mental health services. Anonymous means that you will **NOT** be asked to give your name, and your answers will not be linked back to you in any way. Participation in this survey is voluntary. You may choose not to participate at all or to skip any question you do not feel comfortable answering. If you have any further questions about this survey you may contact Rashiidah Richardson at **0706241775**.

Survey

1. What is your age? ____
2. What is your sex?   __Male   __Female
3. What is the highest level of education you have completed?
   __None   __Primary school   __Secondary school   __Mid-level   __First degree
4. Are you currently in school?
   __Yes __No
5. Have you ever talked to a school staff or a professional about a problem you had with your mental health? This could include stress, a problem with another student, or other issues.
   __Yes __No
6. Have you ever been diagnosed with a mental disorder or mental illness?
   __Yes __No
7. At what age were you diagnosed? **Do not answer this question if you answered *No* for question 6**
   _____ Age
   __ Check here if you rather not answer
8. What were you diagnosed with? **Do not answer this question if you answered *No* for question 6**
   _____ Diagnosis
   ___ Check here if you rather not answer
9. Does your school provide counseling services?
   __Yes __No   __I'm not sure

10. How likely are you to talk to a school counselor about any difficulties you may be facing with school work, other students, or issues at home?
    __ 1 Not at all likely   __ 2 Unlikely   __ 3 Likely   __ 4 Very likely

11. In your opinion, how available are mental health care services at your school (for example, talking to a school counsellor). Think of available as how easy or difficult it would be to get service.
    __ 1 Very easy   __ 2 Easy   __ 3 Difficult   __ 4 Very difficult

12. In your opinion, how available are mental health care services from outside of your school to people your age (for example, talking to a psychologist or psychiatrist). Think of available as how easy or difficult it would be to get service.
    __ 1 Very easy   __ 2 Easy   __ 3 Difficult   __ 4 Very difficult

13. In the last year, how often have you been talked to about the importance of mental health at school? This can be from a teacher, a counsellor, or at a school function.
    __ I have not been talked to about the importance of mental health in school
    __ Not often (less than once a month)
    __ Often (2-4 times a month)
    __ Almost all the time (more than 4 times a month)
14. In the last year, how often have you been talked to about the importance of mental health outside of school? This can be at home, at church, or by an organization/club not related to school.
    __ I have not been talked to about the importance of mental health outside of school
    __ Not often (less than once a month)
    __ Often (2-4 times a month)
    __ Almost all the time (more than 4 times a month)
15. How likely are you to seek out mental health care services for yourself if you felt you needed them?
    __ 1 Not at all likely   __ 2 Unlikely   __ 3 Likely   __ 4 Very likely

Appendix B

Professional	Facility
Dr. Alpha	Kenyatta National Hospital
Ms. Beta	Hillcrest International School
Ms. Gamma	Kenyatta National Hospital
Ms. Delta	Hidaya Timeless Solutions
Mr. Espilon	Kamili Organization

Note. Pseudonyms are used to maintain confidentiality of interviewees

Appendix C

Provider Interview (School Counselor)

1. How long have you been working as a counselor?

2. What age range of student do you usually work with?

3. Was there certain type of training you had to go through in order to work with youth?

4. What is your role as a counselor in ensuring the well-being of the students?

5. Describe the procedures involved when students come for counseling services? What general issues do students usually come to you about?

6. If you feel a student may suffer from a mental illness, how do you handle that?

7. What is the frequencies of students that have to be referred to a mental healthcare professional? Have you ever referred students to rehabilitation centers? What is the frequency for that?

8. In your experience, what interventions and mechanisms are put in place to help youth maintain mental health? In your experience, what are the biggest challenges youth are facing in maintaining their mental health?

9. Are there any challenges you face in working with students? Do they generally follow through with your instructions or referrals? If they don't what are the common reason for low adherence? Are there any challenges in building a good relationship with the students?

10. Based on experiences you've had, what are the skills necessary to working with youth?

Appendix D
Provider Interview (Professional practitioner)

1. What is your background? Do you have any specialized training in the mental health field? What services does this facility offer youth?

2. How long have you been working in the mental health field?

3. Do you have youth friendly health services? What does the youth friendly services entail? Are there any policies within your organization dedicated to youth friendly treatment?

4. What is the proportion of your work load that involves youth patients? Is there a particular training or program you have to go through to treat youth patients?

5. What are the common conditions youth come in for? What are the standard procedures in the process of treatment?

6. (Observe) Is there a separate wing or area in the facility dedicated to treating youth patients? Do you think that affects the quality of the care provided?

7. Are there any challenges in treating youth patients? Do youth generally adhere to treatment? If not, what are some of the factors that contribute to this trend?

8. Are there any systemic challenges to treating youth patients? (for example lack of organizational or government policy, lack of funding)

9. What are some challenges in general to incorporating youth friendly health services into the mental healthcare system?

10. Do you feel your training fully prepared you for working with youth? Is there anything you would've added to your training?

11. Do you think making mental health care services more youth friendly will improve youth uptake of services? Are there any current challenges to youth uptake of services?

12. Do you have a system to receive patient feedback? Do patients often give feedback? What are the common feedback comments?

13. How do you build a working relationship with youth patients so that they feel more at ease during treatment?