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Mental Health as Human Security Infrastructure in Kenya: The Case for Community Receiving Systems

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Abstract

Kenya's Mental Health Policy (2015–2030) and Action Plan (2021–2025) articulate a progressive, rights-based shift towards universal mental health coverage, yet a profound implementation gap persists. This article argues that the core problem is not policy design but an unscalable clinical model. This biomedical, clinician-centric infrastructure cannot be expanded within Kenya's fiscal and demographic constraints. With approximately one psychiatrist per 500,000 people and mental health receiving roughly 0.01% of the national health budget, clinical coverage is mathematically impossible. Using Causal Layered Analysis and the Futures Triangle, the paper situates this failure within Kenya's colonial legacies, ongoing neuro-decolonisation, and competing visions for system transformation. It argues that mental health must be repositioned as a human security asset, and that viable reform requires augmenting the clinical-dominant paradigm with distributed receiving systems built on community-initiated, task-shared, and culturally grounded care. The paper makes three contributions: it explains Kenya's mental health crisis through human security and neuro-decolonisation lenses; reframes reform as building distributed receiving systems rather than simply expanding services; and identifies the current convergence of legal reform, climate stress, and financing shifts as both a risk and an opening for paradigm change.

Keywords: *Causal layered analysis, community-initiated care, human security, mental health, neuro-decolonisation*

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Introduction

Kenya has seen a rapid, visible expansion of mental health policy. The Mental Health Policy (2015–2030), the Action Plan (2021–2025), constitutional recognition of mental health as a right, and the January 2025 High Court ruling decriminalising attempted suicide together signal a decisive normative shift away from colonial-era custodialism towards a rights-based framework. Yet despite this policy activity, the lived reality for most Kenyans remains defined by profound treatment gaps, uneven access, and continued reliance on informal or carceral responses to distress. This disjuncture raises a central question: why does Kenya's mental health crisis persist despite progressive reform? This paper argues that the core blockage is paradigmatic. Dominant efforts remain anchored in a clinician-centric biomedical model that cannot scale to Kenya's demographic, fiscal, and environmental realities, repeatedly turning policy ambition into operational impossibility. Rather than a mere capacity deficit, this reflects a structural mismatch between the prevailing model of care and the conditions under which care must be delivered.

The Methodology section outlines the multi-method qualitative design. The Theoretical Context establishes three interlocking frameworks—human security, neuro-decolonisation, and paradigm theory—as the analytical architecture and conceptual foundation. The Literature Review applies the Futures Triangle to examine the forces shaping Kenya's mental health trajectory. The Discussion and Analysis employs Causal Layered Analysis (CLA) to diagnose why the system is stuck and where leverage exists, and proposes an alternative hybrid receiving-systems architecture, defined as the distributed infrastructure required to accept, hold, and support individuals in distress who are diverted away from the criminal justice system or specialised psychiatric facilities. The Conclusions and Recommendations draw out policy implications, centred on the argument that mental health must be governed as a distributed social infrastructure rather than a scarce specialist service. This review uses the Futures Triangle (Inayatullah, 2008) to synthesise the literature shaping Kenya's mental health trajectory. The Futures Triangle maps present-day pushes, normative pulls, and historical weights to foreground not only what is known but how different configurations of forces constrain or open plausible futures.

Background

Pushes of the Present: Forcing Functions Reshaping the Ecosystem (2024–2026)

The period between 2024 and 2026 is characterised by an unusual convergence of shocks that collectively render the status quo increasingly untenable. These pushes do not merely increase demand. They fundamentally alter the system's operating assumptions, exposing the fragility of clinician-centric models. The High Court's January 2025 ruling decriminalising attempted suicide constitutes an irreversible paradigm shift, legally reframing suicidality as mental distress rather than criminal intent. It creates an immediate operational obligation. Police and courts must now refer people in crisis to care. Yet the ruling also exposes the system's weakest point—the receiving infrastructure is thin, uneven, and often absent outside major urban centres. Without parallel investment in community-based receiving structures, scholars warn that decriminalisation may lead to informal detention, non-response, or system overload (International Association for Suicide Prevention, 2025). This is not a reform option; it is a non-reversible push that forces adaptation regardless of readiness.

Climate change is also emerging as a direct mental health multiplier. A peer-reviewed study examining women in rural Kilifi links climate shocks to elevated suicidal ideation, with low rainfall associated with a 28.7% increase in risk (Mostert et al., 2025). This chronic, cumulative stress is concentrated in rural and arid counties with the weakest clinical capacity, making centralised hospital models structurally inadequate and reinforcing the case for distributed, community-embedded responses. The 2025 donor withdrawal triggered a fiscal cliff for Kenya's health sector. An estimated 41,500 donor-funded health workers face furlough or termination, with a health financing gap exceeding KES 78 billion (Physicians for Human Rights, 2025). Mental health, which had long relied on shadow capacity funded through vertical USAID/PEPFAR programmes, is particularly exposed. Simultaneously, the 2024 youth-led protests expanded public discourse on mental health—normalising therapy and trauma language—while also generating new trauma through exposure to police violence and state intimidation, driving demand from groups least served by current systems (Human Rights Watch, 2025).

The formal integration of mental health into the Social Health Insurance Fund (SHIF) benefits package in October 2025 marked a policy breakthrough, but early implementation has been marred by reimbursement failures and contested tariffs, signalling that insurance inclusion does not automatically translate into functional access (Mukonyo, 2025; Capital FM, 2025).

Pulls of the Future: Competing Visions

Four dominant visions compete for primacy in how Kenya's mental health future is framed and financed. The strongest institutional pull is Universal Health Coverage under Taifa Care, which frames progress as financial protection and formal inclusion through SHIF. Mental health becomes "real" to the system when codified into benefits and tariffs—yet UHC can expand formal access without resolving stigma, workforce shortages, or the absence of services in low-capacity counties (Mukonyo, 2025; Mumbi, 2025). A second pull is deinstitutionalisation: moving from centralised psychiatric warehousing towards decentralised, preventive, community-based care. This vision aligns with a human security lens in which population resilience depends on accessible care ecosystems rather than specialist hospitals. However, "deinstitutionalisation without infrastructure" can shift burdens onto families and leave people to fall through service gaps (Ministry of Health, 2020). A third pull is digital enablement, in which telepsychiatry and AI tools bridge workforce shortages—but risk creating enclaves of access for urban users while excluding rural and low-literacy populations. A fourth pull is integrated pluralism, in which structured collaboration between biomedical providers and traditional or faith healers increases legitimacy and earlier help-seeking, but also raises governance challenges around standards and accountability (Jama et al., 2024).

The most consequential insight is that these pulls imply different answers to a single underlying question: what counts as mental health infrastructure? If infrastructure is defined narrowly as hospitals, clinics, and specialists, the system will continue to under-serve the majority. If it is expanded to include community-based receiving nodes, culturally resonant practices, and task-shared care networks, the preferred future shifts toward models that can scale under real constraints.

Weights of the Past: Colonial Legacies and Structural Drag

Kenya's mental health system bears unusually heavy historical burdens. The 1910 Lunacy Ordinance cast mental illness as a threat to public order rather than a health condition, thereby legitimising segregation and indefinite detention. The Nairobi Lunatic Asylum—later Mathari

Hospital—cemented a centralised, custodial model that equated psychiatric care with social isolation (Paukwa, 2026). Colonial psychiatry was explicitly racialised. African patients were confined to inferior conditions and denied meaningful treatment, while psychiatry served as an instrument of political repression. These practices entrenched three enduring patterns: hyper-centralised services, a tight association of mental illness with criminality, and deep public mistrust of formal psychiatric institutions (Kamundia & Ombati, 2023). Post-independence Kenya largely preserved this architecture. For decades, policy prioritised communicable diseases while Mathari remained the sole national referral facility. The 1989 Mental Health Act nominally transferred oversight to the Ministry of Health but retained a custodial, biomedical orientation. Decentralisation remained largely on paper as funding and political attention stayed concentrated at the top. Documented human rights violations—including indefinite detention and shackling—further entrenched stigma, solidifying perceptions of mental health care as punitive (Kamundia & Ombati, 2023).

Chronic underfunding is the most constraining structural weight. Mental health has long received only 0.01–0.05% of Kenya's health budget, far below international benchmarks (Ministry of Health, 2021; Wachira, 2023). At county level, this results in "budget silence"—mental health is largely absent from operational plans. Brain drain, poor working conditions, and the urban concentration of specialists exacerbate workforce gaps. Widespread cultural interpretations that associate mental distress with witchcraft or spiritual possession add a fourth weight, shaping help-seeking patterns and delaying or bypassing formal care. These beliefs are not mere ignorance but adaptive responses to the absence of accessible, trustworthy services (Musyimi et al., 2018). Together, these weights explain why progressive post-2010 policies have not closed the treatment gap. Ambitious frameworks have accumulated atop unchanged operational and epistemic realities.

Theoretical Basis

Three bodies of scholarship frame the analysis. Together they explain not only why mental health matters at a societal level, but how particular forms of knowledge and care come to dominate and with what consequences for Kenya.

Human Security and Mental Well-being

The first framework situates mental health within a human security lens. The UNDP's foundational framing of security as "freedom from fear" and "freedom from want" shifts attention from state-centric threat models to the protection and empowerment of individuals in their everyday lives (UNDP, 1994). From this perspective, mental wellbeing is not a secondary health outcome but a foundational condition for social stability, economic participation, and political agency. Untreated psychological distress amplifies vulnerability to violence, exploitation, and social fragmentation; conversely, widespread mental wellbeing serves as upstream resilience. Kenya exemplifies how mental ill-health breaches the security threshold. The 2020 Taskforce recommendation to declare mental ill-health a National Public Health Emergency recognised that the burden of disease now threatens human capital and exceeds the capacity of clinical silos (Ministry of Health, 2021). Paris (2001) cautions that broad security definitions risk vagueness, and Tadjbakhsh (2013) warns that "securitising" social issues may inadvertently favour rapid responses over long-term development. These critiques are acknowledged. This paper uses the human security lens not to militarise mental health but to elevate it as core infrastructure, recognising that in Kenya, the convergence of climate stress,

structural poverty, and unhealed collective trauma constitutes an indivisible existential challenge that resists compartmentalised intervention.

Neurodecolonisation of the Mental Health Paradigm

The second framework asks whose knowledge and healing practices are recognised when mental health is governed as a security concern. Neurodecolonisation, drawing on Ahenakew et al. (2025), interrogates how Western, diagnosis-driven models treat WEIRD (Western, Educated, Industrialised, Rich, Democratic) subjectivities as normative while marginalising embodied, relational, and culturally grounded realities in the Global South (Henrich et al., 2010). This is not merely a theoretical critique: in Kenya, the biomedical system's epistemic hierarchy is structurally enforced through credentialing, financing, and regulatory frameworks that formally exclude traditional and faith-based healers, even though they constitute the most accessible and socially trusted points of care for the majority of the population (Musyimi et al., 2018; Ndetei & Rachel, 2008; Jama et al., 2024). In postcolonial contexts shaped by this dynamic, mental health systems become formally legitimate yet socially distant—producing avoidance, mistrust, and low uptake that undermine even well-designed service expansion efforts (Mills, 2014; Kamundia & Ombati, 2023). Yellow Bird (2013) frames this explicitly as a problem of neurodecolonisation: the logics of separability, superiority, and subjugation embedded in colonial governance have not only shaped institutions but also conditioned what communities believe counts as healing, whose suffering is legible, and whose knowledge deserves resources.

Operationally, neurodecolonisation shifts healing from individual cognitive pathology towards collective co-regulation, somatic practice, and culturally resonant narrative. In this frame, trauma is not a malfunction confined to a single brain but an embodied, relational wound shaped by historical violence, ongoing insecurity, and disrupted social ecologies—a lived response to structural conditions rather than a diagnostic category to be managed (Maté & Maté, 2022; Epstein, 2013). Neurodecolonised practice therefore prioritises somatic regulation—breath, rhythm, movement, ritual—and collective meaning-making, alongside the visual vernaculars and local metaphors that translate psychosocial concepts into culturally meaningful forms, reducing stigma and democratising access to knowledge about distress and healing (Lichty, 2022; Yellow Bird, 2013; Ahenakew et al., 2025). Evidence from community-initiated care models in Kenya shows that these approaches are not soft cultural add-ons but functional infrastructure. The Green String Network's healing circles, for example, demonstrate measurable reductions in distress and increases in social cohesion precisely because they are grounded in relational and embodied modalities that biomedical services cannot replicate at the community level (Waibochi et al., 2023; López et al., 2019; Kuwania & Yoder Maina, 2026). It is not an adjunct to clinical systems but enabling infrastructure that helps community-based models operationalise human security principles—agency, dignity, resilience—under conditions of scarcity and historical trauma (Im, 2025; Lichty, 2025).

Paradigms, Power, and Mental Health Futures

The third framework positions the biomedical paradigm as a political and epistemic system rather than merely a technical choice. Paradigms determine what counts as legitimate care, who is authorised to deliver it, and where resources flow. The dominance of the clinician-centric model in Kenya is not simply a product of evidence; it reflects inherited colonial architecture, global health financing incentives, and credentialing structures that concentrate authority in specialists and tertiary facilities, reproducing exclusion where expertise is scarce (Thornicroft

et al., 2022; Iemmi, 2022). With approximately one psychiatrist per 500,000 Kenyans and a mental health budget allocation of roughly 0.01%, the clinical model is structurally misaligned with demographic and fiscal realities, making incremental optimisation insufficient (Waibochi et al., 2023; Ministry of Health, 2021). Meaningful transformation requires a shift in the governing worldview: from centralised containment to distributed social scaffolding.

Community-based paradigms treat mental health as relational and embedded in everyday life, enabling task-sharing and scalable non-specialist support that redistributes power and aligns with embodied and collective healing logics (Patel et al., 2018; Ahenakew et al., 2025). Taken together, these three conceptual frameworks provide the article's core analytical logic. Mental health in Kenya is not merely a clinical concern, but a societal, political, and epistemic issue. These frameworks show why distress must be understood as embedded in histories, systems, and relationships, and why meaningful reform requires shifting from specialist-centred treatment toward culturally grounded, distributed receiving systems.

Methodology

This study employs an interpretive, synthesis-based qualitative methodology that integrates three complementary methods. First, a structured literature review drew on peer-reviewed scholarship, policy documents, and grey literature spanning mental health systems, human security, decolonial theory, and futures studies. Sources were selected for relevance to the Kenyan context and methodological rigour, with a focus on material published between 2015 and 2026. Second, the study incorporates reflexive insights from prior empirical research conducted as part of an MPhil in Futures Studies at Stellenbosch University, including fieldwork with practitioners, policymakers, and community actors in Kenya. This material is used interpretively rather than as a standalone dataset, grounding the analysis in lived institutional and community realities. Third, CLA, developed by Inayatullah (2008), provides the organising analytical framework. CLA structures inquiry across four layers—headline symptoms, systemic drivers, worldview/paradigms, and myth/metaphor—enabling the analysis to move from surface crisis narratives to the deeper epistemic and cultural assumptions that sustain them.

The Futures Triangle complements CLA by organising the literature review around historical weights, present-day pushes, and normative pulls that shape plausible futures. Used together, these methods provide a coherent scaffold linking diagnosis to foresight. Findings are context-specific rather than statistically generalisable across all sub-national or comparative settings. These constraints are inherent to the method and appropriate to its purpose. The study is designed to surface structural patterns, paradigmatic blockages, and leverage points for transformation, not to produce population-level estimates or causal inference.

Analysis of Findings

Insights from Causal Layered Analysis (CLA)

CLA is a futures research method developed by Sohail Inayatullah (2008) that examines issues across four interlinked layers and is used here to analyse Kenya's mental health context between 2024 and 2026 (see Figure 1). CLA moves analysis beyond surface-level problem descriptions towards the deeper structural, cultural, and epistemic layers that sustain them.

Unlike conventional policy analysis, CLA is explicitly futures-oriented. By making visible the assumptions that reproduce current trajectories, it simultaneously opens space for alternative imaginaries and more transformative options at each layer. In this study, CLA provides a coherent scaffold for linking diagnosis to foresight—clarifying not only what is happening in Kenya's mental health ecosystem and why, but also what would need to shift at each layer to enable a more equitable and resilient future.

Headline Layer

At the headline layer, observable symptoms related to Kenya's mental health crisis suggest a saturation of alarmist indicators. The burden of disease is substantial (see Table 1). Depressive disorders account for 40.5% of Disability-Adjusted Life Years from mental and substance use disorders globally, with Kenya ranking fourth in Africa for depression prevalence (Syme & Hagen, 2020). Nationally, approximately four people die by suicide each day; the suicide mortality rate is 11.0 per 100,000. Among adolescents aged 12–17, the prevalence of major depressive disorder is estimated at 17%, and 33.5% of adults with mental illness have a co-occurring substance use disorder (Ooko, 2025). These headlines frame the public face of the crisis, but they do not explain its root causes.

Table 1

Kenya's Mental Health Status

Indicator	Metric / Value	Context
Suicide Mortality Rate	11.0 per 100,000	Age-standardised, national
Daily Suicide Deaths	~4 deaths	National average, 47 counties
Adolescent Depression (12–17 yrs)	17%	Major Depressive Disorder
Adults with MI: Substance Use Disorder	33.5%	High co-morbidity
Outpatient Clinical Burden	25%	Clients seeking mental healthcare
Inpatient Clinical Burden	40%	Facility admissions
Africa Depression Ranking	4th	High regional prevalence

Source: Ooko, 2025

Systemic and Structural Layer

At this second layer, the primary failure is the structural inversion of service delivery. The WHO's optimal services pyramid (see Figure 1) dictates that the majority of care should occur at community and primary levels, with specialised services reserved for a small minority. Kenya's system is inverted: resources are concentrated in high-cost specialist institutions inaccessible to most citizens. This creates what the literature calls a "mathematical impossibility" for scaling mental health care. As Table 2 shows, even the most generously resourced professional category—psychiatric nurses—faces a shortfall of more than 7,000 practitioners. The system is not merely under-resourced within a sound paradigm; it is structurally incapable of meeting population-level need under current fiscal and governance conditions. A core argument of this study is that the lower two levels of the pyramid require significant resources (staff, funding, infrastructure, etc.) to build the necessary receiving systems to best meet Kenya's mental health needs cost-effectively and efficiently.

Table 2

Comparative Resource Ratios and Professional Shortfall

Professional Category	Current Ratio (per population)	Ideal Ratio (per population)	Estimated Shortfall
Psychiatrists	1: 1,000,000	1: 30,000	1,400+
Psychologists	1 : 4,600,000	1 : 15,000	3,000+
Psychiatric Nurses	1 : 117,000	1 : 6,000	7,000+

Source: Muhia et al., (2021); ICJ, (2022)

Systemic dysfunction is compounded by the legal treatment of mental illness as a security threat. Before the 2025 ruling, criminalisation of attempted suicide funnelled individuals in crisis into prisons and courts rather than care pathways (Kenya National Commission on Human Rights, 2025). Available specialised facilities—Mathari in particular—have documented human rights violations, including indefinite detention and degrading conditions, functioning more as warehouses for the "socially undesirable" than as sites of healing (Kenya National Commission on Human Rights, 2023; Kamundia & Ombati, 2023). A further systemic barrier is the complete disconnection between mental health and peacebuilding or security sectors. Counter-terrorism and security strategies address physical terrain but neglect the "human terrain" of trauma and psychological resilience, rendering economic and security interventions less effective (Ventevogel et al., 2015).

Worldview, Mindsets, and Paradigm Layer

At the worldview layer, the crisis is sustained by a dominant discourse that frames mental distress as individual biological malfunction—divorced from social context—and treats credentialed Western expertise as the only legitimate authority (Mills, 2014). This paradigm is not ideologically neutral. It reflects what Henrich et al. (2010) call WEIRD (Western, Educated, Industrialised, Rich, Democratic) subjectivities elevated to universal norms, producing diagnostic categories and treatment protocols designed for populations whose social and historical experiences differ substantially from those in postcolonial contexts such as Kenya. Within this worldview, trauma is pathologised as a disorder located inside a single brain—PTSD as individual cognitive malfunction—rather than recognised as a reasonable response to structural violence, displacement, or colonial rupture (Maté & Maté, 2022; Young, 1995). The psychiatrist becomes the sole legitimate arbiter of suffering, and local healing practices are systematically delegitimised as unscientific or dangerous, even where they constitute the only accessible and culturally trusted form of care (Incayawar et al., 2009; Ndetei & Rachel, 2008).

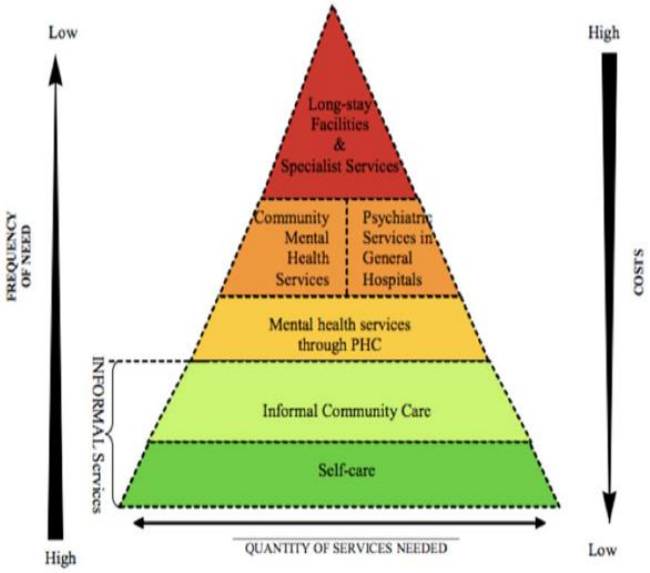

Figure 1 - World Health Organization's Mental Health Pyramid Framework (Source: WHO, 2007)

This worldview marginalises the African alternative. An understanding rooted in Ubuntu philosophy positions trauma not as individual pathology but as a rupture in the social fabric, requiring relational integration rather than clinical excision (Mbiti, 1969; Somé, 1999). Within the Ubuntu frame, personhood is irreducibly communal—a person is constituted through and within relationships—so distress is both produced and healed at the collective level rather than the individual (Epstein, 2013). Traditional and faith-based healing practices in Kenya operationalise this logic precisely. They mobilise social networks, ritual, and shared meaning-making in ways that biomedical protocols cannot replicate or adequately measure (Musyimi et al., 2018; Wollie et al., 2025; Thobakgale et al., 2024). The failure to integrate these worldviews does not merely create a gap in service provision; it produces what Ahenakew et al. (2025) describe as "attentional violence"—systems that reduce human beings to sets of symptoms, ignoring the full relational, historical, and ecological context of their distress.

For Kenyan communities navigating colonial wounds, economic precarity, and climate stress simultaneously, this truncation of the healing frame is not a minor cultural oversight but a structural barrier to care that is trusted, sought out, and sustained over time (Kagotho et al., 2025; Patel et al., 2018). Transforming this worldview layer therefore requires more than adding community programmes as a supplement to clinical services; it demands a fundamental shift in what counts as evidence, whose knowledge is treated as valid, and which healing logics are embedded in national guidelines and financing structures (Thornicroft et al., 2022; Iemmi, 2022).

Table 3 contrasts the dominant biomedical/psychosocial model with traditional/supernatural explanatory frameworks that coexist in Kenyan communities. The comparison clarifies how differing causal logics shape help-seeking, crisis interpretation, and power dynamics—revealing why culturally misaligned reforms struggle to gain legitimacy or scale.

Table 3

Divergent Causal Models of Mental Illness in Kenyan Discourse

Feature	Biomedical/Psychosocial Model	Traditional/Supernatural Model
Primary Cause	Genetics, trauma, and chemical imbalance	Witchcraft, magic, ancestral anger
Role of Community	Support network for the individual	Necessary for the restoration of spiritual harmony
Treatment Focus	Medication, therapy, de-escalation	Rituals, herbal remedies, exorcism
View of Crisis	Medical emergency needing stabilisation	Spiritual calling or moral failure
Power Dynamics	Practitioner-patient hierarchy	Healer as mediator with the divine

Sources: Wollie et al. (2025); Wasosa (2025); Thobakgale et al. (2024); Ndetei & Rachel (2008)

Myth and Metaphor Layer

At the myth and metaphor layer, two foundational narratives sustain the status quo and resist transformation even when policy and systemic conditions shift around them. The first is the "Broken Machine" metaphor of the biomedical model, which casts the human being as a biological mechanism and the psychiatrist as a technician whose role is to locate and repair the

malfunctioning component. Within this story, trauma is a disorder located in a single brain—a chemical imbalance, a misfiring circuit—requiring pharmaceutical or clinical intervention to "fix" (Maté & Maté, 2022). This metaphor carries profound structural consequences, as it naturalises the concentration of resources in high-cost, high-technology institutions, renders community-based and relational forms of care invisible as legitimate "treatment," and sustains the inverted service pyramid in which the least accessible and most expensive tier of care becomes the aspirational standard (World Health Organization, 2007). It also creates a sharp binary between the healthy and the sick, blinding the system to the reality that, in contexts of structural violence, poverty, and colonial rupture, psychological distress is not a defect but a reasonable human response to an unreasonable set of conditions (Fisher, 2021; Young, 1995).

Running alongside it is the second foundational narrative: the cultural myth of the "Madman" or the "Cursed." In many Kenyan communities, mental distress is metaphorically framed as spiritual possession, the consequence of witchcraft, or moral transgression—marking the sufferer as a vessel of danger or contamination whose condition threatens the reputation, marriageability, and social standing of the wider family (Musyimi et al., 2018; Incayawar et al., 2009). This myth drives the practical dynamics of exclusion, concealment, and shackling documented in rights assessments of Kenya's mental health system (Kamundia & Ombati, 2023; KNCHR, 2023). It frames the person experiencing distress not as a member of the community in need of support but as "the Other"—someone to be removed, contained, and managed rather than held and healed (Ndetei & Rachel, 2008). Crucially, this cultural myth and the Broken Machine metaphor are not opposites; they are reinforcing. Both position the person in distress as fundamentally dangerous and fundamentally other, and both justify responses organised around removal and containment rather than integration and care. Together, they explain why Kenya's formal and informal responses to mental illness have converged, across colonial and post-colonial eras alike, on custodial logic rather than healing logic.

Both narratives must be actively displaced—not merely critiqued—by regenerative alternatives that can mobilise collective emotional resonance and reshape what feels possible. The first alternative is the metaphor of “social scaffolding”, whereby infrastructure is understood not as buildings and specialists but as the web of relational supports, trusted community nodes, peer facilitators, and culturally grounded practices that hold people through distress and prevent crisis from escalating (Waibochi et al., 2023; López et al., 2019). The second alternative is the Ubuntu concept of the Wounded Healer, rooted in African relational philosophy, which holds that those who have survived suffering carry a form of wisdom that is essential rather than incidental to the community's capacity for healing (Somé, 1999; Hübl, 2020). Unlike the biomedical model, which separates the credentialed expert from the suffering patient, these narrative positions they lived experience of distress as a source of authority and belonging.

The trauma survivor is reframed not as a broken victim to be managed, but as a Wayfinder—someone whose passage through darkness equips them to guide others, and whose reintegration into the community is itself a form of collective healing (Fisher, 2021). Taken together, these two regenerative narratives do not reject the necessity of clinical care, but they reposition it within a broader story in which healing is communal, infrastructure is relational, and the goal is not symptom elimination but restored agency, dignity, and connection (Ahenakew et al., 2025; Patel et al., 2018).

A Convergence Moment: When Pushes Overwhelm the Weights

What distinguishes the 2024–2026 period is that current pushes are not incremental; they are system-forcing and, in several cases, irreversible. The decriminalisation of attempted suicide in Kenya creates an operational obligation that cannot be ignored, shifting responsibility from the criminal justice system to health and social support systems (Mental Health (Amendment) Act; Kenya Law Reform Commission, 2023). Therefore, referral without capacity to receive is not a system but a legal fiction.

At the same time, climate-induced stress is increasingly chronic rather than episodic, elevating baseline psychological distress in arid and semi-arid lands (ASALs), where mental health service availability is already limited (Intergovernmental Panel on Climate Change, 2022; Cunsolo & Ellis, 2018). In parallel, the contraction of donor funding for health systems in low- and middle-income countries has exposed structural fragilities that were previously masked by external support (Dieleman et al., 2016; Schäferhoff et al., 2019). Taken together, these dynamics signal that Kenya is entering a compression phase in which decisions that were previously optional—such as scaling community-based care or reforming financing models—are becoming mandatory. This aligns with broader analyses of health system transitions, in which multiple stressors converge to drive rapid institutional adaptation (Kruk et al., 2018).

The Paradigm Mismatch and the Case for Receiving Systems

The evidence points to a fundamental arithmetic and design problem. A clinician-centric model cannot meet population-level mental health needs, even with significant increases in funding, because demographic growth, urbanisation, and climate-related stressors outpace the expansion of specialist capacity (Patel et al., 2018; World Health Organisation, 2022). Kenya, like many low- and middle-income countries, faces a severe shortage of psychiatrists and psychologists, with services concentrated in urban centres, leaving large rural populations underserved (Kiima & Jenkins, 2010; WHO, 2022). Causal Layered Analysis (CLA) helps explain why this misaligned paradigm persists despite its poor empirical fit (Inayatullah, 1998). At the worldview layer, legitimacy remains tied to credentialed biomedical authority, rendering community-led and task-shared models as "informal" even when they are the only scalable option (Patel et al., 2011). At the myth and metaphor layer, narratives such as "madness as danger" sustain carceral and exclusionary responses, while the notion of "infrastructure as concrete" privileges hospitals and specialised facilities over relational and community-based systems (Summerfield, 2008; Kleinman, 1988).

This mismatch generates risks across three domains. First, a rights risk emerges as decriminalisation increases the constitutional and ethical obligation to provide care, exposing the state to accountability for system failures (KNCHR, 2023). Second, a security risk arises as untreated psychological distress undermines social cohesion, increases vulnerability to violence, and weakens community resilience—key elements of human security (United Nations Development Programme, 1994; World Bank, 2011). Third, a fiscal risk becomes evident as high-cost, specialist-driven models prove unsustainable under constrained public budgets and declining external financing (Kruk et al., 2018; Schäferhoff et al., 2019). The analytical response is to redefine mental health infrastructure as receiving systems—distributed capacities that enable individuals in distress to be met, held, stabilised, and appropriately referred. This aligns with the growing global evidence base supporting task-sharing and community-based mental health care as scalable and cost-effective approaches (Patel et al., 2018; WHO, 2021). Such systems operate through a hybrid architecture that integrates community supports, stepped clinical care, and coordinated referral pathways, guided by a

central organising principle: what must exist everywhere is not a psychiatrist, but a functioning receiving system.

Within this framework, the design of Kenya's Social Health Insurance Fund (SHIF) becomes a decisive governance question. If financing mechanisms prioritise only facility-based services, they risk reinforcing existing inequities and inefficiencies. Conversely, if SHIF supports hybrid models that include community-based and preventive care, it could catalyse a structural shift toward a more inclusive, resilient, and human security-aligned mental health system (Barasa et al., 2021; WHO, 2022).

Conclusion

This paper argues that Kenya's mental health challenge is best understood not as a deficit of services or expertise, but as a systemic misalignment between inherited paradigms and contemporary realities. The persistence of the treatment gap reflects deeper historical, epistemic, and political dynamics. Colonial legacies of containment continue to exert drag even as progressive legal frameworks articulate a rights-based vision. At the same time, present-day forcing functions—decriminalisation, climate stress, donor withdrawal, and SHIF—have compressed the time available for incremental change. The prevailing clinician-centric paradigm is not merely under-resourced; it is structurally incapable of scaling to meet population-level need under current fiscal, demographic, and environmental constraints.

Mental health must therefore be repositioned as a core element of human security infrastructure. Untreated psychological distress undermines productivity, erodes social cohesion, and increases vulnerability to violence and political manipulation; conversely, systems that support collective resilience function as stabilising assets under conditions of uncertainty and shock. The required shift is not incremental but paradigmatic—repositioning clinical care within a hybrid architecture in which community-embedded, task-shared supports serve as the first line of response, and neuro-decolonisation is treated as an operational requirement rather than a cultural supplement. Kenya's mental health future will ultimately be shaped by whether the country is willing to confront the deeper narratives governing who is considered treatable, where care is permitted, whose knowledge counts, and to align law, financing, culture, and practice accordingly.

Recommendations

The following six recommendations translate the analysis into actionable leverage points. They are mutually reinforcing and should be pursued as a coordinated package, directed primarily at the national Ministry of Health, county health departments, and the Social Health Authority, with implications also for security, justice, and climate adaptation sectors. Reframe Mental Health as Core Human Security Infrastructure. The Ministry of Health, in collaboration with the National Treasury and National Security Council, should formally adopt a human security framing for mental health, positioning psychological well-being as integral to economic productivity, social cohesion, and public safety. Mental health indicators should be integrated into national resilience, disaster risk reduction, and climate adaptation frameworks, recognising climate-related distress as a predictable risk multiplier. Mandated cross-sector coordination—spanning Health, Interior, Justice, Social Protection, and Climate—should be established for mental health planning, particularly in the post-decriminalisation context. Build Distributed Receiving Systems at the Community Level. Investment in community-based receiving nodes—supervised peer facilitators, Community Health Promoters/Volunteers, school-linked

supports, and faith community networks—should be treated as first-line mental health infrastructure, not supplementary programming. Standardised referral and escalation pathways should link community supports to Level 3–6 facilities with clear criteria for clinical handover. Geographic equity requires prioritising rural and ASAL counties, where clinical density is lowest and climate stress is highest.

Institutionalise Task-Sharing and Supervised Community Care. Task-sharing should be formally recognised within mental health policy and regulation, with defined roles, competencies, and supervision requirements for non-clinical providers. National standards for training, supervision, and safeguarding in community-initiated care should be grounded in trauma-informed and culturally aligned practices. Counties should be incentivised to adopt task-shared models through conditional grants or performance-linked financing mechanisms. Align SHIF Financing with Hybrid Models of Care. SHIF benefit packages and tariffs must explicitly cover supervised community-based mental health supports, not only facility-based services. Blended payment mechanisms combining capitation with outcome-linked add-ons should be piloted to support preventive and relational care that does not fit fee-for-service logic. Rapid feedback loops between providers, counties, and the Social Health Authority are needed to correct tariff and reimbursement distortions early.

Operationalise the Post-Decriminalisation Referral Mandate. Standard Operating Procedures for police and first responders must integrate health and community referral pathways as a matter of legal obligation. Mandatory trauma-informed training for frontline officers emphasising de-escalation, psychological first aid, and referral competence should be rolled out across all 47 counties. Local community receiving options should be mapped and accredited so that referral is operationally meaningful everywhere, not merely a legal formality. Advance neurodecolonised, culturally legitimate care. Embodied, relational, and narrative-based practices should be integrated into national mental health guidelines as legitimate first line supports, not alternative add-ons. Structured collaboration with trusted community actors—including faith and traditional leaders should be supported under clear safeguarding frameworks. Public communication should shift from pathology-focused messaging toward wellbeing, dignity, and collective resilience, reducing stigma without medicalising distress.

Taken together, these recommendations constitute a decisive shift from treating mental health as a scarce specialist service to governing it as a distributed social infrastructure. The choice facing Kenya is no longer whether to reform, but how deeply. Incremental adjustments within the existing paradigm will not keep pace with climate stress, demographic pressure, or legal obligation. A hybrid, human security-aligned system—grounded in community capacity, supervised care, and cultural legitimacy—offers a more plausible and resilient path forward.

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