

Mental Health Support for Security Personnel: Evaluating the Effectiveness of Healing-Centred Resilience Training for Police Officers in Kenya

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Abstract

Police officers in Kenya operate within a polycrisis environment of terrorism, intercommunal conflict, and violent crime that generates chronic trauma with consequences extending into families, institutions, and communities. This empirical study evaluates *Muamko Mpya: Healing the Uniform*, a co-designed, healing-centred trauma-informed programme grounded in Healing-centred Peacebuilding (HCPb) — a decolonised, peer-based framework that prioritises community ownership and cultural grounding over clinical expertise. Synthesising findings from three complementary evaluation phases (2018, 2020, 2024) conducted in partnership with Kenya's National Police Service, the study employs quasi-experimental baseline-endline designs using quantitative instruments (Kessler 10 Psychological Distress Scale) and qualitative methods, including Most Significant Change methodology, focus group discussions, and observations of peer-facilitated healing circles. Findings demonstrated statistically significant reductions in psychological distress ($p < 0.011$), with 67% of Phase 3 officers reporting four or more adverse childhood experiences before service — substantially exceeding international benchmarks and reframing officer mental health as a pre-service developmental challenge. Ninety per cent of officers sustained use of emotional regulation tools at ten to eleven months post-intervention. Phase 3 showed trauma awareness improving from 67% to 99%, with peer-trained officers independently facilitating healing circles and achieving outcomes exceeding those of expert-facilitated workshops. By synthesising all three evaluations, this paper documents the programme's development, effectiveness, and scaling potential, advancing evidence at the intersection of psychological health and national security. The study recommends integrating adverse childhood experience-informed education from recruitment, establishing a formal Training of Trainers pathway, and extending the model to Kenya's broader security sector and regionally across Africa. The findings provide evidence for decolonised, non-clinical mental health approaches within security institutions, with implications for national security strategies that position officers' psychological well-being as a foundation for institutional effectiveness and community peacebuilding.

Received: 20 October 2025
Revised: 25 January 2026
Accepted: 19 March 2026
Published: 11 May 2026

Citation: Yoder-Maina, A., & Mbugua, E. (2026). Mental health support for security personnel: Evaluating the effectiveness of healing-centred resilience training for police officers in Kenya. *National Security: A Journal of the National Defence University-Kenya*, 4(1), 131–143. <https://doi.org/10.64403/azxkvyk95>

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Keywords: *adverse childhood experiences, healing-centred peacebuilding, police officers, trauma-informed practice*

Introduction

Globally, police officers operate within environments characterised by chronic exposure to traumatic incidents, occupational stress, and complex psychological demands (Ferguson & Hay, 2024; Kruger, 2020; Queirós et al., 2020; Quin, 2025). As first responders, “police officers confront cruelties and horrors that the rest of the civilian population view from the sanitised distance of their newspapers and television screens” (Former National Police Service Inspector General Hillary Mutyambai, cited in Yoder-Maina et al., 2019). In Kenya, where officers address terrorism, intercommunal conflict, violent crime, and natural disasters (Opondo & Gioto, 2021), cumulative trauma affects emotional health, family relationships, professional judgement, and community engagement (Ndero et al., 2024a; 2024b). These pressures occur within a broader polycrisis environment – a context of simultaneous, compounding crises rooted in colonialism, authoritarian governance, regional instability, and structural poverty – that creates intergenerational trauma burdens affecting not only individuals but entire institutions. Police officers carry invisible psychological wounds (Mooren et al., 2024; Roycroft & Brine, 2021) with ripple effects extending into families (Campbell et al., 2022; Meffert et al., 2014) and the wider society (Eikenberry et al., 2024; Eliasson, 2022).

Unaddressed trauma – defined here as trauma that has not been acknowledged, processed, or supported through any formal or peer-based means – manifests through two interconnected pathways: the “victim experience” and the “aggressor cycle” (Botcharova, 1988). The victim experience encompasses inward-directed harm: depression, anxiety, isolation, substance misuse, and suicidality. The aggressor cycle encompasses outward-directed harm: anger, aggression, corruption, and the perpetuation of violence against the communities’ officers are mandated to protect (Kruger, 2020; MacNair, 2012). This dual pathway is particularly significant in the security context, where trauma symptoms such as emotional numbing and diminished critical thinking can predispose officers to reasoning that validates violence as an institutional duty (MacNair, 2012). State violence by security actors is recognised as a major driver of violent extremism among young people in Africa (Villa-Vicencio et al., 2016). However, comprehensive evidence on mental health interventions for security personnel remains limited in African contexts, where the limitations of individualistic, deficit-based clinical frameworks rooted in colonial legacies are increasingly recognised (Jacobs et al., 2015; Miller, 2017; Yoder-Maina, 2022).

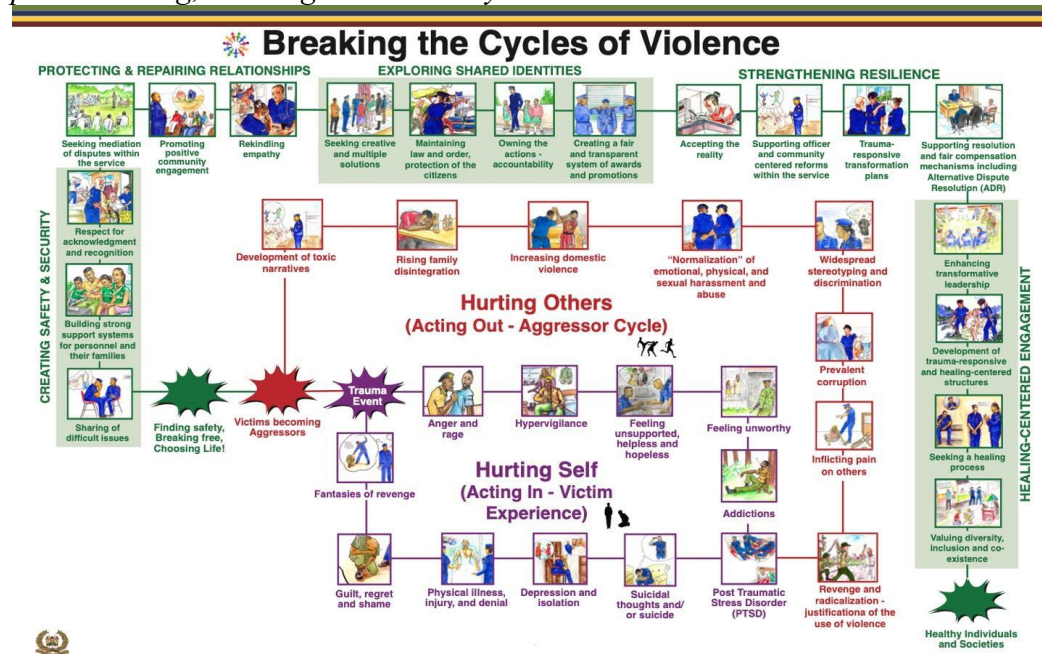
Recognising this evidence gap, Kenya's National Police Service (NPS) adopted a formal Psychological Counselling Policy in 2018. It partnered with the Green String Network (GSN) to develop a healing-centred approach to officer resilience (Yoder-Maina et al., 2019). The co-design process involved over 50 police officers, civilians, and GSN team members, resulting in *Muamko Mpya: Healing the Uniform* (*Muamko Mpya* meaning “Great Awakening” in Kiswahili) – a programme that positions officers as agents of healing within the police service, their families, and communities.

This study synthesises findings from three phases of evaluation spanning 2017–2024. A 2018 pilot (López et al., 2018) tested trauma-informed resilience training with 45 officers across four stations. A 2020 evaluation (Mbugua et al., 2020) assessed the co-designed programme with an expanded participant base, including officer spouses. A 2024 evaluation in Starehe Sub-County, Nairobi (Gache & Yoder Maina, 2024) examined whether peer-trained officers could effectively facilitate healing circles independently. By synthesising all three evaluations, this

paper documents the programme's development, effectiveness, and scaling potential, advancing evidence at the intersection of psychological health and national security.

Figure 1

The Muamko Mpya healing-centred framework for officer resilience and community peacebuilding, co-designed with Kenya's National Police Service



Source: Yoder-Maina et al., (2019)

Theoretical Basis

The programme is grounded in the Wellbeing and Resilience (WebR) framework, which operates within the broader Healing-centred Peacebuilding (HCPb) paradigm. Healing-centred peacebuilding is defined as a decolonised, peer-based approach to building psychological resilience that prioritises community ownership, cultural grounding, and the recognition of collective trauma over individual clinical diagnosis (Ayindo, 2022; Ginwright, 2018; Yoder-Maina, 2022a). The paradigm emerges from a recognition that in contexts of chronic violence and intergenerational collective trauma, Western biomedical approaches – rooted in individual pathology, clinical expertise, and formal service delivery – will never meet the scale of need nor address the systemic, relational, and institutional dimensions of trauma (Ahmed & Khider, 2025; Benjamin & Fourie, 2019). Conventional clinical models in security institutions present specific dangers: officers who seek formal help risk institutional punishment and career consequences (Ndero et al., 2024a; 2024b), face coercive treatment practices and poor-quality care (Holguín et al., 2024; Izarali et al., 2019), and often experience abandonment by systems unable to respond to their needs. These barriers are well-documented internationally: a study of 248 law enforcement officers found that public stigma and self-stigma together explained 56% of variance in attitudes toward seeking psychological help (Karaffa & Koch, 2016), while systematic reviews confirm that organisational stressors – lack of supervisory support, arbitrary management, and excessive workload – demonstrate stronger associations with officer mental health than operational trauma exposure itself (Drew & Williamson, 2025; Purba & Demou, 2019; Syed et al., 2020).

HCPb addresses these limitations through a strength-based framework that asks "What is right with you, your relationships, your colleagues, and your institution?" rather than "What is wrong with you?" – recognizing that individuals and institutions experiencing trauma possess sophisticated healing wisdom embedded in cultural practices and collective memory (Ginwright, 2018; Wessells, 2007; Yoder-Maina, 2022a). Peer-led healing sessions reduce shame and isolation by creating collective spaces where officers discover they are not alone (Drew & Martin, 2023; Ward & Belkin, 2024). Evidence from comparable contexts is instructive: Zimbabwe's Friendship Bench demonstrated that community grandmothers trained in structured problem-solving conversations achieved mental health outcomes comparable to clinician-delivered care (Chibanda, 2025), and trauma-informed training integrated from police recruitment onward is significantly more effective than reactive referral after crisis onset (Bartkowiak-Theron & Atkinson, 2024). The horizontal trust inherent in peer relationships operates precisely where clinical hierarchy cannot reach (Ward & Belkin, 2024).

Resilience in African contexts is understood not as an individual trait but as a collective phenomenon grounded in social and spiritual relationships – consistent with Ubuntu philosophy, which holds that individual wellbeing is inseparable from communal life (Atuha, 2025; Bila, 2024; Møller & Roberts, 2021). Healing-centred peacebuilding's theory of change, operationalised through a "scaling deep to go wide" approach, holds that wide and durable impact is achieved not through standardised replication by external experts but through deep community ownership that transforms relational networks from the inside (Ayindo, 2022; Boström et al., 2018; Yoder-Maina, 2022). This distinguishes the HCPb model from task-shifting – in which laypeople are trained to deliver clinical protocols as lay clinicians – by situating the source of change in relational infrastructure, shared experience, and community ownership rather than in proximity to clinical methods.

The ACE (Adverse Childhood Experiences) framework also informs the programme's design. Felitti et al.'s (1998) original study established a dose-response relationship between childhood adversity and adult health outcomes, including four- to twelve-fold increased risks for depression, substance misuse, and suicidality among those reporting four or more ACEs. Expanded frameworks add adverse community environments (Ellis & Dietz, 2017) and adverse cultural and climate experiences, including colonisation and displacement – dimensions directly relevant to Kenya's context. Multi-country data from sub-Saharan Africa confirm that 72–82% of young adults have experienced at least one ACE (Amene et al., 2024), with graded associations between ACE exposure and mental distress, substance use, and violence perpetration (Brown et al., 2024). In law enforcement, ACE scores are significantly associated with post-traumatic stress ($\beta = 1.70$, $p < 0.001$) and misconduct (Halford, 2025; Violanti et al., 2021), reframing police mental health as a pre-service developmental challenge requiring intervention from recruitment.

Methodology

This paper synthesises findings from three complementary evaluation phases conducted in partnership with Kenya's National Police Service between 2017 and 2024. Each phase employed a quasi-experimental design with pre- and post-intervention (baseline and endline) assessments incorporating both quantitative and qualitative methods, designed with sensitivity to the power dynamics and trust-building requirements of the police organisational context. Phase 1 (López et al., 2018) evaluated an adapted civilian curriculum – Kumekucha: It is a New Dawn – with 45 police officers across four stations (Nairobi, Mombasa, Malindi, Kwale) between December 2017 and January 2018. Endline data were collected from 31 officers (69%

retention rate) ten to eleven months post-intervention. The sample was 84% male, with a mean age above 35 years, and 74% married or cohabiting. The Kessler 10 (K10) Psychological Distress Scale (Kessler et al., 2002) served as the primary quantitative instrument and was validated for Kenyan populations (Ongeri et al., 2022). Additional measures assessed resilience indicators, including support systems, spiritual practice, and community engagement. Phase 2 (Mbugua et al., 2020) evaluated the co-designed Muamko Mpya programme among officers and spouses at two sites (Nairobi and Kiganjo). The same K10 instrument enabled baseline-endline comparison, supplemented by the Most Significant Change (MSC) methodology (Davies & Dart, 2005), focus group discussions, and key informant interviews with station commanders. Phase 3 (Gache & Yoder Maina, 2024) examined the scaling question: whether officers trained through Muamko Mpya could independently facilitate peer-led healing circles for colleagues. Conducted in Starehe Sub-County, Nairobi, in 2024, the evaluation used a quantitative assessment of trauma awareness and tool use, alongside qualitative data from surveys, focus group discussions, and direct observations of peer-facilitated circles under weekly GSN supervision.

Quantitative data across all three phases were analysed using descriptive statistics and paired comparisons, with statistical significance set at $p < 0.05$. Qualitative data were analysed thematically (Patton, 2011), with MSC methodology in Phase 2 enabling identification of unanticipated outcomes. Ethical considerations were addressed consistently across phases, proportionate to each evaluation's nature. Phase 1 received formal Institutional Review Board (IRB) approval, with written informed consent obtained from all participants before data collection. Phases 2 and 3 were conducted as programme evaluations – a designation common in practitioner-led development contexts where evaluation is understood as embedded programme accountability rather than independent research (Patton, 2011) – and therefore did not require separate IRB oversight. Participation was voluntary across all phases; data were treated confidentially and not shared with institutional supervisors or used in performance assessments, a protection explicitly communicated to participants given the power dynamics of a uniformed service. Facilitators were trained to work within the programme's emotional regulation framework rather than as clinical interviewers, and participants were not required to disclose specific traumatic events. Referral pathways to the Chaplaincy and Counselling Directorate at NPS were available throughout.

Analysis of Findings

Findings are presented thematically, beginning with quantitative outcomes before turning to qualitative evidence and analytical interpretation. All three phases delivered Green String Network's Wellbeing and Resilience (WebR) curriculum through two formats: a five-day intensive WebR Encounter workshop (Phases 1 and 2) and a twelve-week peer-facilitated Healing Circle (Phase 3). Both formats equip participants with practical emotional regulation tools – including meditation, controlled breathing, cognitive restructuring, and relational problem-sharing – alongside education on trauma, adverse childhood experiences, and their consequences for identity, behaviour, and relationships.

Psychological Distress and Wellbeing Outcomes

Phase 1 baseline data revealed clinically significant distress: 53% of officers ($n=24/45$) scored outside the “likely to be well” range on the K10 scale – exceeding the approximately 2% rate of high distress in general Kenyan adult populations (Ongeri et al., 2022) and the approximately 13% rate found in U.S. population surveys (Kessler et al., 2002). This elevation is consistent with a global meta-analysis finding pooled prevalence rates of 14.6% for depression and 14.2%

for post-traumatic stress among police personnel across 24 countries (Syed et al., 2020), confirming that elevated distress in this population is not an artefact of the Kenyan context but a structural feature of frontline policing. At endline (n=31, 10–11 months post-intervention), 71% (n=22) scored in the “likely to be well” range ($p < 0.011$), with statistically significant improvements in hopelessness ($p < 0.041$), restlessness ($p < 0.0001$), depression ($p < 0.030$), and worthlessness ($p < 0.027$) (López et al., 2018). Stress management capacity improved from 48% (n=22/45) to 84% (n=26/31) ($p < 0.002$). Table 1 presents quantitative outcomes for Phases 1 and 2.

Table 1

Psychological Distress and Support Outcomes, Phases 1 and 2

Measure	Phase 1 Baseline	Phase 1 Endline	Phase 2 Baseline	Phase 2 Endline	Sig.
K10 “Likely well”	47% (n=21/45)	71% (n=22/31)	—	—	p<0.011
Stress management “well/very well”	48% (n=22/45)	84% (n=26/31)	—	—	p<0.002
Depressed “none of the time”	—	—	61%	84%	—
Overall support “very good”	—	—	54%	73%	—
Tool use sustained (10–11 months)	—	—	—	90%	—

Sources: Authors (2026)

Phase 2 extended the evaluation to include officer spouses. The proportion of officers reporting depression “none of the time” increased from 61% to 84%. Overall support ratings of “very good” improved from 54% to 73%, and workplace support from 53% to 65%. Ninety percent of officers sustained tool use at the ten-to-eleven-month follow-up, indicating durable behavioural change well beyond the intervention period (Mbugua et al., 2020). These results are consistent with international evidence: Drew and Martin (2023) find that peer support creates conditions for sustained behavioural change by reducing stigma and building horizontal trust, while Ward and Belkin (2024) identify shared lived experience as the mechanism that makes peer-facilitated models effective precisely where clinical models face the greatest barriers.

Adverse Childhood Experiences and the Pre-Service Burden

Phase 3 baseline data revealed the scale of adversity officers carry into the institution before any occupational exposure occurs. Sixty-seven percent of officers (n=40/60) reported four or more ACEs prior to entering service – compared to 12.5% in the original ACE study's general adult population (Felitti et al., 1998) and approximately 25% reporting three or more in U.S. law enforcement research (Merrick et al., 2018; Violanti et al., 2021). Multi-country Violence Against Children and Youth Survey data from five sub-Saharan African countries, including Kenya, found 72–82% of young adults had experienced at least one ACE (Amene et al., 2024), consistent with Brown et al.’s (2024) findings of graded associations between ACE exposure and mental distress, substance use, and violence perpetration across the region. In law

enforcement, ACE scores are significantly associated with post-traumatic stress ($\beta = 1.70$, $p < 0.001$) and depressive symptoms ($\beta = 1.29$, $p < 0.001$) (Halford, 2025; Violanti et al., 2021). The Phase 2 qualitative data made the behavioural consequences visible: young officers described as resorting to “negative coping mechanisms with self-harming behaviours such as alcohol abuse from feeling unworthy,” driven into “self-isolation, with some of them even ganging up to socialise their guilt through negative groupthink” (Mbugua et al., 2020). These patterns correspond precisely to what ACE research predicts for individuals with high pre-service adversity encountering institutional stressors without adequate support, confirming that effective intervention must begin before occupational exposure accumulates.

Trauma Awareness, Tool Use, and Peer-Facilitated Scaling

Trauma awareness improved substantially across all three phases: Phase 1 from 62% ($n \leq 28/45$) to 97% ($n \leq 30/31$); Phase 2 from 81% to 99%; Phase 3 from 67% ($n \leq 40/60$) to 99% ($n \leq 60/60$) – with Phase 3's gains achieved entirely through peer-facilitated circles rather than expert instruction. Emotional regulation tool use was high and deepened in successive cycles. In Phase 1, 90% of officers ($n = 28/31$) reported sustained tool use at endline across all four tools: problem-sharing, meditation, breathing exercises, and cognitive restructuring. Officers described the change: “I have learnt healthy coping strategies, rather than drinking alcohol when I was stressed”; “I share my problems with family and friends now as a support system” (Phase 1, López et al., 2018). Phase 2 sustained 90% tool use at ten to eleven months. Phase 3 showed marked intensification: 42% weekly ($n \approx 25$) and 40% several times per week ($n \approx 24$), with only 19% ($n \approx 11$) occasional use – compared to Phase 1's 46% occasional use ($n \approx 14/31$). Table 2 presents Phase 3 outcomes in comparative perspective.

Table 2

Phase 3 outcomes compared to Phase 2 (percentage-point change)

Measure	Ph. 3 Baseline	Ph. 3 Endline	Change (pp)	vs. Ph.2 Δ
Trauma awareness	67% ($n \approx 40$)	99% ($n \approx 60$)	+32pp	+18pp
Stress management “well/very well”	36% ($n \approx 22$)	91% ($n \approx 55$)	+55pp	+19pp
Overall support “very good”	36% ($n \approx 22$)	89% ($n \approx 54$)	+53pp	+34pp
Workplace support is “very good”	42% ($n \approx 25$)	92% ($n \approx 55$)	+50pp	+38pp
Tool use: weekly or more	$\sim 10\%$ ($n \approx 6$)	82% ($n \approx 49$)	+72pp	+29pp
ACE score ≥ 4 (pre-service)	67% ($n \approx 40$)	—	—	—

Sources: Authors (2026)

Phase 3's central finding was that peer-trained officers successfully facilitated independent healing circles, achieving outcomes that met and exceeded those of expert-facilitated workshops. This directly challenges the assumption that high-adversity populations require professionalised clinical intervention to recover (Fuhr et al., 2014; Ginwright, 2018; Wessells, 2007) and the task-shifting model by demonstrating that results stem from the quality of relational infrastructure, shared experience, and community ownership rather than proximity to clinical methods. Organic replication was evident in every phase: Phase 1 officers spontaneously initiated WhatsApp support groups without any institutional mandate; Phase 2 spouses independently organised Muamko Mpya activities through women's savings circles (chamaas), adapting the journey-of-life exercise for their families; Phase 3 formalised these patterns into institutionally owned infrastructure. This spontaneous dissemination is the theory

of change made visible: healing spreads through the same relational networks that carried the original harm.

Relational, Organisational, and Family-Level Impacts

Phase 1 data showed all 31 endline respondents reporting improved community interactions, with a shift from transactional enforcement toward trauma-informed engagement: “I used to jump into conclusions, but now I take my time to understand a situation” (López et al., 2018). Phase 2 documented an emerging leadership transformation: officers who had completed the programme began recognising distress in colleagues and creating space for peer conflict resolution through active listening, demonstrating that individual healing generates changed institutional behaviour without formal instruction (Mbugua et al., 2020). Phase 2's inclusion of officer spouses brought family dynamics into direct view. One spouse described the transformation: “I was full of aggression at my husband as well as displaced aggression at my kids, whom I would beat immediately after quarrelling with my husband to a point where they would at times run away from home. This is no more. Muamko Mpya ilinisaidia sana [Muamko Mpya helped me so much]” (Mbugua et al., 2020). One spouse independently adapted the journey-of-life exercise with her adolescent children; through this process, the children came to understand their parents' burdens, thereby strengthening family bonds and reducing resentment. These family-level outcomes carry preventive significance: the programme generated the conditions that Bethell et al. (2019) identify as Positive Childhood Experiences – documented protective factors that buffer against the long-term consequences of accumulated adversity.

Organisational Barriers

Phase 2 identified significant institutional barriers to integration. Toxic leadership was documented as endemic, with junior officers reporting: “I cannot share much with my boss ... They do not know how to deal with personal issues, they are poor listeners” (Mbugua et al., 2020). Arbitrary transfers emerged as a major source of institutional trauma: “You are transferred at the wrong time – November when kids are about to do KCPE and given no time for the kids to clear their exams” (Mbugua et al., 2020). This aligns with research showing that organisational stressors are more strongly associated with officer mental health outcomes than operational trauma exposure itself (Drew & Williamson, 2025; Purba & Demou, 2019). Phase 3's dramatically low baseline support scores (36%, $n \approx 22/60$) directly reflect this institutional neglect. Peer-led circles achieved a 50-percentage-point gain in workplace support within the same environment – demonstrating the resilience of community-owned approaches while also making plain their structural limit: peer support creates an alternative care structure within a hostile institution but cannot substitute for the institutional transformation the evidence consistently demands.

Limitations and Contrasting Perspectives

Several limitations warrant acknowledgement. All three evaluations used pre-post designs without randomised control groups, so observed improvements cannot be attributed solely to the intervention without a counterfactual comparison. Retention between baseline and endline varied across phases, and some indicators rely on self-report measures that are susceptible to social desirability effects in a uniform service context. The Phase 3 approximate n-figures reflect proportional estimates from the source evaluation report rather than precisely disaggregated counts. Furthermore, the evidence base for healing-centred, peer-led models in

African security contexts remains nascent; while the findings are consistent with international peer support literature (Drew & Williamson, 2025; Ward & Belkin, 2024), independent replication studies in comparable settings have yet to be conducted. Some researchers caution that peer-led models risk overburdening facilitators and that, without robust supervision and institutional support structures, outcomes may not be sustainable (Fallon et al., 2023; Klingemann et al., 2025).

The present study addresses this partially through the weekly supervision structure in Phase 3, but longer-term follow-up data are needed. Taken together, these limitations point to the need for longitudinal evaluation with comparison groups and independent implementation studies before the model can be described as definitively established. Notably, the broader field is moving in the direction these findings point toward: relational and network-based approaches such as Open Dialogue – which centres social networks, shared decision-making, and continuity of care over clinical hierarchy – are currently under large-scale RCT evaluation in the UK (Pilling et al., 2022), suggesting that the evidence base for non-clinical, relationally grounded models of care is an active and expanding area of inquiry rather than a fringe proposition.

Implications for Security Policy and Decolonised Practice

Taken together, the three phases produce a coherent argument for a paradigm shift in how security institutions approach officer wellbeing. Officers carrying four or more ACEs, operating within an institution documented to cause additional psychological harm, achieved outcomes through community-owned peer-led approaches that meet and exceed those of expert-facilitated clinical models – positioning healing-centred peacebuilding as a viable alternative framework for security sector mental health that is culturally grounded, institution-owned, and scalable without dependence on external expertise.

Conclusion

The three phases of Muamko Mpya evaluation, spanning nearly a decade, yield five evidence-based conclusions with implications extending beyond the Kenya National Police Service. First, officers enter service carrying substantial pre-existing adversity. With 67% (n≤40) of Phase 3 officers reporting four or more ACEs before entering service – a threshold associated with a four- to twelve-fold increased risk for depression, substance abuse, and suicide attempt (Felitti et al., 1998) – the institutional challenge is not occupational health alone. It is comprehensive human development, beginning before the uniform is put on.

Second, peer-led, culturally grounded approaches achieve outcomes that meet and exceed expert-facilitated interventions, particularly among the most isolated and adversity-burdened cohorts. Phase 3 station-level officers achieved the most dramatic improvements of any cohort: support systems from 36% (n≈22) to 89% (n≈54), stress management from 36% (n≈22) to 91% (n≈55), and trauma awareness from 67% (n≈40) to 99% (n≈60) – through circles facilitated by fellow officers. Third, healing-centred approaches generate change at multiple levels simultaneously. Individual symptom improvement, family system transformation, and peer-driven institutional replication are emergent properties of a single coherent approach operating through existing relational networks. Family-inclusive intervention represents active prevention of the next generation's accumulation of adversity.

Fourth, organisational barriers remain the primary structural constraint. Toxic leadership and cultures that punish vulnerability were documented as active sources of trauma. Peer-led approaches achieve significant outcomes despite this, but the evidence consistently points to the need for senior leadership engagement with trauma-informed principles and institutional protections that make vulnerability safe.

Fifth, the findings extend across Kenya's security sector and the African continent. The conditions documented – high pre-service adversity, institutional cultures suppressing vulnerability, and the absence of culturally grounded support – are not specific to the NPS. Green String Network's implementation across Kenya, Somalia, Ethiopia, and South Sudan provides preliminary evidence of cross-contextual adaptability (López et al., 2017; López et al., 2019a; López et al., 2019b; Waibochi et al., 2025; Yoder-Maina & Gache, 2023). As one officer stated: “Without self-awareness in police work, one can go from stress to trauma to death” (Mbugua et al., 2020). Healing-centred peacebuilding – peer-led, culturally grounded, institutionally owned – offers an evidence-supported pathway to breaking that trajectory.

Recommendations

Integrate ACE-informed education and peer mentorship from recruitment. Given that 67% (n≈40) of Phase 3 officers entered service with four or more ACEs, recruitment and basic training curricula should incorporate ACE-informed education designed for officer self-awareness and empowerment. ACE frameworks must function as a resource, never as a gatekeeping or screening instrument. Establish a formal Training of Trainers programme to institutionalise the Circle Keeper model. The NPS should create a structured Training of Trainers pathway equipping officers and spouses who have completed Muamko Mpya to become certified Circle Keepers, with ongoing supervision through the NPS Counselling and Psychosocial Support Directorate. Sustainability requires institutional ownership, not external programme dependency.

Formalise officer spouse and family inclusion as a standard programme component. Phase 2 demonstrated that family inclusion is integral to officer wellbeing and generates Positive Childhood Experiences for the next generation of police families, interrupting the intergenerational transmission of unaddressed adversity. Engage senior leadership with trauma-informed organisational practice. The barriers documented in Phase 2 require targeted leadership development that contextualises trauma-informed principles for rank and command responsibilities. Explicit institutional protections against career consequences for officers who seek psychological support are a necessary complement. Extend the model to Kenya's broader security sector and share learning regionally. The Kenya Defence Forces and Kenya Prisons Service face structurally similar conditions. Kenya's National Police Service – with a decade of documented healing-centred practice – is positioned to become a regional reference point for peer-led security sector wellbeing across Africa.

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