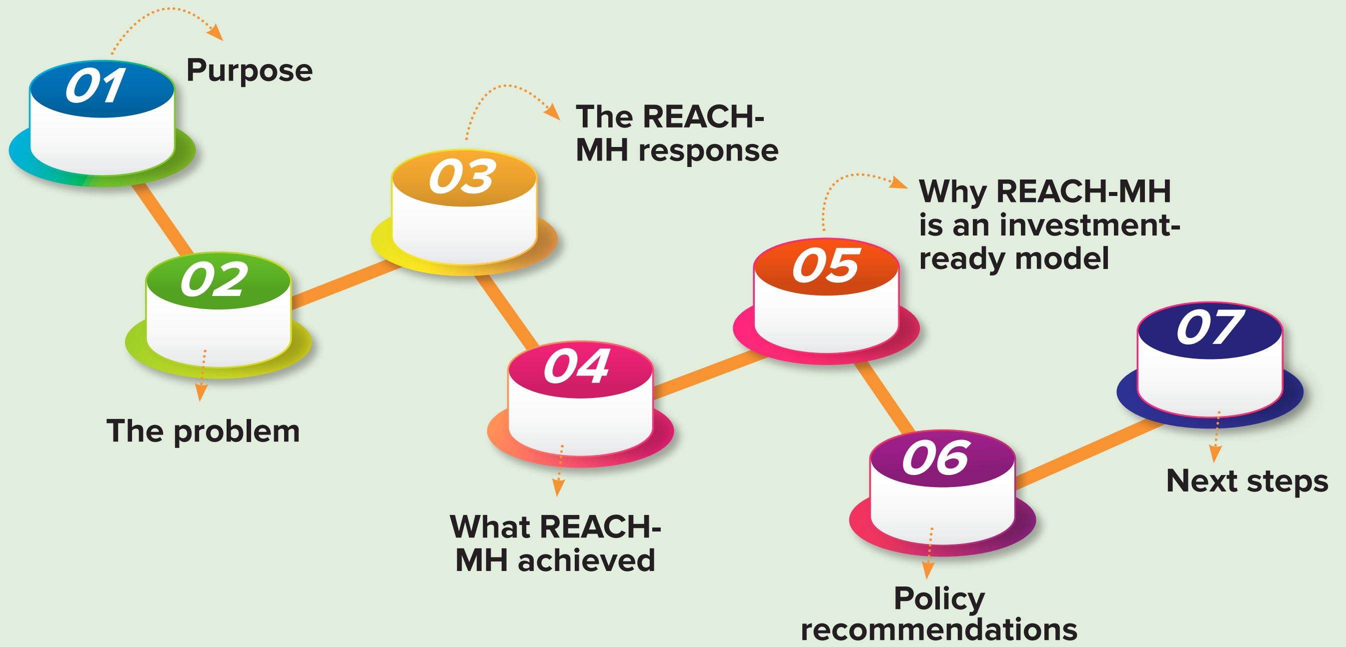
POLICY BRIEF

REACH - MH

REACHING AND ENGAGING ADOLESCENTS AND YOUNG ADULTS FOR CARE CONTINUUM IN MENTAL HEALTH

PI: Peter Memiah, Dr, PH	Co-PI: Fernando Wagner, DSc	Co-PI: Lillian Otiso, MD, MBA
UMB	UMB	LVCT HEALTH

From Evidence to Action:
Lessons from the REACH-MH; Addressing Adolescent Mental Health through Youth-Led Digital Innovation in Kenya



1

Purpose

This brief summarizes key evidence and policy implications from the REACH Mental Health (REACH-MH) initiative, a youth-led, digitally enabled platform implemented in Nairobi, Mombasa, and Kisumu counties between 2021 and 2025. It is intended to inform county and national decision-makers, development partners, and funders seeking scalable, system-embedded approaches to adolescent and youth mental health in Kenya.

2

The problem

Adolescent and young adult mental health is a critical but underprioritized public health issue. Globally, around 1 in 7 adolescents live with a mental disorder, and suicide is among the leading causes of death in young people. In Kenya, available evidence suggests that nearly 30% of adolescents and young adults report symptoms of depression or anxiety and about 10% meet criteria for a current mental disorder. An estimated four people die by suicide daily, with many of these deaths occurring among young people.

Despite this burden, adolescent mental health in Kenya suffers from fragmented, facility-based data, limited youth engagement in evidence generation, and significant gaps between policy commitments and implementation. Service capacity is constrained by workforce shortages, limited integration of mental health into primary care and community platforms, and persistent stigma, especially in urban informal settlements.

There is a pressing need for locally generated, youth-centered evidence that can guide county-level planning, resource allocation, and practical service models aligned with Kenya's devolved health system and national mental health policies.

3

The REACH-MH response

REACH-MH (Reaching and Engaging Adolescents and Young Adults for the Mental Health Care Continuum) was designed as an integrated evidence-to-implementation platform rather than a single research study. REACH-MH explicitly applied an implementation science lens, using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to guide how evidence was generated, interpreted, and translated into action across counties.

Core features

Digital mental health assessment platform: A youth-friendly, offline-capable app with 13 modular domains covering mental health symptoms and key psychosocial, economic, relational, and structural determinants of wellbeing.

Youth-led evidence generation: Youth Advisory Champions for Health (YACH) were trained as co-researchers, mobilizers, and peer facilitators, supporting ethical, trusted engagement around topics such as distress, self-harm, violence, and substance use.

Embedded referral pathways: The app was integrated with LVCT Health's established hotlines and counseling services, ensuring that risk indicators triggered immediate referral and support, not just data collection.

System-anchored partnerships: Implementation was led by LVCT Health in partnership with county governments, the Ministry of Health's Division of Mental Health, and the University of Maryland, Baltimore, aligning evidence generation with policy and service delivery systems.

What REACH-MH achieved

Scale and feasibility

During implementation across Nairobi, Mombasa, and Kisumu, REACH-MH demonstrated strong feasibility and acceptability among adolescents and young adults. The platform recorded over 3,000 app downloads and approximately 1,800 completed surveys uploaded to a central server. Twelve youth-led focus group discussions provided in-depth qualitative insight into lived experiences and service preferences.

Youth-reported mental health needs

Across the three counties, adolescents and young people reported widespread emotional distress:

- Around 30–40% reported frequent symptoms of stress, anxiety, or low mood.
- More than half described recurring sleep disturbance, fatigue, poor concentration, or feelings of hopelessness.
- Economic pressure, family and social expectations, relationship stress, violence and safety concerns, and uncertainty about the future were consistently identified as key drivers, with notable variation by gender, age, and county context.
- Risk behaviors and coping reflected this distress. Between 20–25% reported experiences or thoughts related to self-harm, and many described withdrawal, substance use, or risky behaviors during periods of heightened stress.
- Non-disclosure emerged as a critical signal: 20–30% of youth were unwilling or uncomfortable disclosing experiences related to violence, sexual health, or self-harm, suggesting that observed prevalence likely underestimates actual need. Youth emphasized confidentiality, trust, and accessibility, with strong demand for youth-friendly digital and hotline-based options.

Systems and capacity gains

REACH-MH delivered a set of system-relevant outcomes, including:

- County-specific mixed-methods datasets on adolescent and youth mental health, suitable for planning and policy dialogue.
- A trained cadre of Youth Advisory Champions who can support ongoing data collection, community engagement, and co-design of interventions.
- Strengthened research-to-practice linkages between digital platforms, community services, county health management teams, and national stakeholders.
- A multi-institution learning network linking LVCT Health, county governments, the Ministry of Health, and academic partners.

5

Why REACH-MH is an investment-ready model

Evidence from REACH-MH demonstrates that youth-led, digitally enabled, community-embedded approaches can generate implementation-ready mental health evidence at scale in urban Kenyan settings. The model directly addresses key challenges highlighted in recent analyses of adolescent mental health policy in Kenya, including limited data, weak youth participation, and gaps between policy and implementation. REACH-MH shows not only *what* problems exist, but also *how* to move from exploration of needs to preparation, implementation, and sustainment of youth-centered

Key comparative advantages for policy and investment include:

- **Alignment with Kenyan policy frameworks:**
  REACH-MH supports implementation of the Kenya Mental Health Policy (2015–2030), the Mental Health Action Plan, and adolescent health policies by generating locally owned evidence and linking youth to care.

- **Systems integration:**
  The platform is anchored in existing service ecosystems (LVCT Health hotlines, county health services, and national structures), reducing fragmentation and duplication.

- **Youth workforce and governance:**
  YACH champions embed youth voice into evidence generation and service design, directly countering the exclusion of adolescents from decision-making highlighted in recent political economy analyses.

- **De-risked scale:**
  The model has been tested in three diverse urban counties, creating a proven foundation for expansion to additional counties and settings.

6 Policy recommendations

For the Ministry of Health (national level)

1. **Recognize and adopt REACH-MH as a scalable model for adolescent mental health data and service linkage.**
   - Integrate REACH-MH indicators and tools into national adolescent mental health surveillance and monitoring frameworks.
2. **Formalize youth participation in adolescent mental health policy and program design.**
   - Use YACH and similar structures as formal advisory and co-design bodies at national and county levels.
3. **Invest in digital mental health infrastructure and standards.**
   - Develop national guidance on youth-friendly digital mental health tools, including data protection, referral protocols, and linkages to national hotlines.

For county governments

4. **Use REACH-MH data to inform county planning and budgeting.**
   - Incorporate REACH-MH findings into County Integrated Development Plans, Annual Workplans, and adolescent/youth health strategies, with explicit budget lines for mental health.
5. **Scale youth-led digital screening and referral in priority sub-counties.**
   - Expand REACH-MH or similar platforms in informal settlements, schools, TVET institutions, and community hubs, with clear referral pathways to county and partner services.
6. **Strengthen multisectoral collaborations.**
   - Engage education, labor, social protection, and community-based organizations to address structural drivers of distress, including unemployment, violence, and poverty.

For development partners and funders

7. **Support county and national scale-up of REACH-MH.**
   - Fund expansion to additional counties, adaptation for rural and humanitarian settings, and integration with broader youth health and social protection initiatives.
8. **Invest in youth research and implementation capacity.**
   - Provide multi-year support for YACH and similar youth leadership models as core system assets, not time-limited project roles.
9. **Back innovation within a tested platform.**
   - Use REACH-MH as a foundation for piloting enhanced content (e.g., trauma-informed modules, gender-based violence, substance use), AI-supported triage, and inclusive design for marginalized groups.

Next steps

With a functioning digital platform, trained youth workforce, and established partnerships across three counties, REACH-MH is ready to transition from a successful implementation initiative to a sustained national asset. Strategic investments in scale-up, systems integration, and continuous learning can help Kenya move from fragmented, under-resourced responses toward an equitable adolescent mental health system grounded in youth voice, ethical practice, and local ownership.