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ANGLICAN CHURCH OF KENYA'S ROLE IN HANDLING THE MENTAL HEALTH CRISIS: TOWARDS A WHOLESOME MINISTRY

(The Anglican Church of Kenya's 50th Anniversary Celebrations)

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Abstract: **In its 1948 constitution, the World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being. Currently, there is inadequate research information on the prevalence of mental health, neurological, and substance use in Kenya. However, the Kenya National Commission on Human Rights (KNCHR) estimates that up to 25% of outpatients and up to 40% of in-patients in health facilities suffer from mental conditions. The 2010 Kenyan Constitution, in article 43 (1a), provides that every person has the right to the highest attainable standard of health, which includes the right to healthcare services. This includes mental health. The Kenya Mental Health Policy 2015-2030 advocates for comprehensive policy measures and strategies for achieving the aforesaid goal. The 2014-2030 Kenya Health Policy gives directions to ensure a significant reduction in the overall ill-health in Kenya in line with the country's Vision 2030 and the 2010 Kenyan Constitution. But, Kenya's health ministry estimates that 75% of people in need of medical services for mental health challenges cannot get them. The Church exists to evangelize; holistic evangelization is her defining identity. Because Christ came to give humanity an abundant life, the Church should embrace the full Gospel, which focuses on an abundant (holistic) life. So, the Church should be concerned with people's medical well-being. Accordingly, the research question is, what is the Anglican Church of Kenya's role in handling the mental health crisis? This article sets out to establish the Anglican Church of Kenya's role in handling the mental health crisis towards a wholesome ministry. It will rely on the review of the relevant literature and historical archives to collect the relevant data and use the prescriptive analysis technique to analyse the said data towards answering the research question and solving the research problem.**

Keywords: **Mental Health Crisis, Suicide, Anglican Church of Kenya, Griffin, Mental Disorders.**

1. INTRODUCTION

A 2014 report by the World Health Organization estimates that the suicide rate for males in Kenya is 24.4 males for every 100,000 males, whilst the rate for females is 8.4 males for every 100,000 females. Worse still, the Kenya National Police Service's annual crime report recorded 320 cases of suicide in 2015. In his official 1st June 2019 Madaraka Day speech, His Excellency President Uhuru Kenyatta admitted that Kenya has been facing a mental health crisis. In his response, the President ordered the Ministry of Health and other well-wishers to address the problem.

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According to the WHO, "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948)." In practice, thus, mental health is an important ingredient of human health. Poor mental health negatively affects the socio-economic development of individuals, households, families, communities, nations, and the world at large. According to the Ministry of Health of Kenya, comprehensive mental health services should be universally accessible. Indeed, all general hospitals are gazetted to treat and admit people suffering from mental disorders according to section 9 of sub-section 2 of the Mental Health Act 1989; Cap. 248 of the Laws of Kenya. But, truth be told, the government alone cannot successfully manage the mental health crisis in Kenya without multidisciplinary and inter-sectoral collaboration.

Armed with that understanding, the Kenya Mental Health Policy 2015-2030 observes that mental health promotion should be offered to individuals, families, and communities at large. The same policy puts it that the aforesaid mental health promotion should be spearheaded by the primary health care team at each county level together with other government sectors, Non-Governmental Organizations, Community Based Organizations, Faith-Based Organizations, and the private sector (Bukusi, 2015). In this context, as a major stakeholder in the Kenyan realm of human health, the Anglican Church of Kenya has a role to play in the management of the mental health crisis in Kenya. Hence, this article sets out to establish the Anglican Church of Kenya's role in handling the said mental health crisis towards a wholesome ministry.

A. Understanding a Mental Health Crisis

The Church of England and the Roman Catholic Church were heavily criticized after a priest took his own life because of a mishandled inquiry into false child abuse allegations and other related fallacious accusations. Fr Alan Griffin was a rector of St. James Garlickhythe in the City of London and chaplain to the Lord Mayor of London before converting to Catholicism in 2012. The unjust investigation into the aforesaid child abuse claims started in October 2019 after an official in the Anglican Diocese of London retired and undertook a "brain dump" to his archdeacon, including gossip acquired over two decades. The aforesaid investigation into allegations of child abuse was started by the Anglican Diocese of London in 2019, and the baseless claims were passed to Roman Catholic safeguarding authorities (BBC News, 2020).

Fr Alan Griffin, 76 years old, died by suicide[1] at his home in East London. Fr Griffin hanged himself at home on Sunday, 8th November 2020, having spent a year under investigation without ever having the allegations explained to him; he was denied knowledge of the nature and source of his accusers and accusations. Strictly, he was given no information about the groundless allegations that led to his death by suicide. Accordingly, before his above-mentioned death, Fr Griffin endured a year of mental pressure and torment (BBC News, 2020).

After Fr Griffin's death, the Coroner Mary Hassell took a detailed investigation into his tragic death. After her investigation, Hassell reported the matter to the Church of England[2] and the Catholic Church.[3] Thereafter, the Diocese of London and Lambeth Palace (London home of the Archbishop of Canterbury) thanked the Coroner for unmasking the tragic death of Fr Griffin to the Archbishop of Canterbury. In reality, The Coroner's report revealed that Fr Griffin did not abuse children, have sex with young people under the age of 18, visit prostitutes, and endanger the lives of others by having sex with people whilst an HIV risk. The Coroner observed that there was no evidence that Fr Griffin did any of the above-mentioned things (BBC News, 2020).

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[1] These days, mental health advocates employ the term "died by suicide," as it removes culpability from the person who has lost life and allows a discussion about the disease or disorder from which the said person was suffering.

[2] Ultimately, the Church of England admitted that it made mistakes in its handling of the unsubstantiated allegations of child abuse against Fr Griffin. It also accepted that further steps should have been taken to verify the information regarding Fr Griffin's conduct before sharing it with Roman Catholic authorities. Besides, the Church of England observed that it will ensure concrete actions are taken to prevent future deaths by suicide among the clergy.

[3] After the inquest into Fr Griffin's death, Coroner Mary Hassell wrote a damning report that exonerated Fr Griffin and heavily criticised the Church. On the one hand, the Coroner blamed the Church of England for falsely accusing Fr Griffin. On the other hand, she accused the Roman Catholic Church (Catholic Diocese of Westminster) of failing to carry out professional scrutiny of the allegations that came to them from the Church of England and refusing to offer Fr Griffin extra pastoral care while he was under investigation.

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Worse still, the Coroner ruled that Fr Griffin committed suicide[4] because he could not mentally cope with an investigation into undisclosed allegations against him that were supported by no complainant, no witness, and no accuser. The Bishop of London, the Rt. Rev. and Rt. Hon. Dame Sarah Mullally, said that Fr Griffin's death by suicide was a regrettable tragedy, whilst the Lambeth Palace confirmed that the Archbishop of Canterbury received a copy of the Coroner's report and promised that the matter will be taken seriously. Precisely, in their remorseful response to this ecclesiastical injustice, the Roman Catholic Diocese of London and Lambeth Palace expressed their deep regret and sorrow at the death of Fr Alan Griffin. They also acknowledged that there were either poor processes (or systems) or mistakes, which led to unreasonable mental pressures on Fr Griffin and his consequential death. Furthermore, without criminalising Fr Griffin for killing himself, they took responsibility for what went wrong, including putting him into a mental health crisis, which led to his stress-related death by suicide. In the end, adhering to the Covid-19 rules, the Roman Catholic Church gave Fr Griffin a full funeral Mass that was celebrated by Mgr Newton at Warwick Street on 4th December 2020 (BBC News, 2020).

As evidenced in the above sad story of Fr Griffin, suicide is one of the consequences of a mental health crisis, but not a crime or unforgivable sin. The context of Fr Griffin's death by suicide evidences that suicide is caused by a mental health problem; specifically, one of the most important causes of suicide is mental illness. To further elucidate this reality, let us turn to the following seven suicides in the Bible and their respective contexts:

1. Abimelech

King Abimelech of Israel was ruthless. His evil knew no limits, and after killing many people, and even taking the lives of 69 of his 70 half-brothers, God allowed one woman to stop him. After she dropped a millstone on his head, he was so injured that his pride led him to take his own life. So that no one could "say a woman killed him" (Judges 9:50-55). Indeed, in Judges 9:54, it is said that King Abimelech hurriedly called to his armour-bearer and in a patriarchal spirit said, "Draw your sword and kill me, so that they cannot say, 'A woman killed him.'" To that end, his servant ran him through, and he died by suicide.

2. Samson

Sometimes, revenge can be a symptom of a mental health crisis. Samson wanted to take revenge on his enemies because they had subjected him to a situation of physical and mental anguish. To that end, under the influence of his psychosocial experiences, Samson was willing to die when he killed the Philistines in the crowded temple. Braced between two pillars, Samson used his final strength to push them down, and take his own life along with his enemies (Judges 16:25-30). According to Judges 16:30, Samson said, "Let me die with the Philistines..."

3. King Saul

Because of defeat by the enemy and great fear after being wounded, Saul chose to end his life, rather than face abuse by his captors. Saul wanted to avoid the abuse and shame that he would have endured if he was captured. When his armour-bearer refused to kill him at his request, he took his own life by falling on his sword (1 Samuel 31:3-5). King Saul died by suicide.

4. Armour-bearer to Saul

King Saul's death by suicide put his armour-bearer in a situation that can be described as a mental health crisis. Because he did not want to admit his failure to protect his king, the armour bearer killed himself. Out of hopelessness and terror after seeing that King Saul was dead, the assistant to the king (armour-bearer) impulsively took his life as well. Like his boss, he died by suicide (1 Samuel 31:5).

5. Ahithophel

As a one-time close companion of David, and grandfather of Bathsheba, Ahithophel eventually took up the cause of Absalom's rise against him. But, when he noticed that his advice had not been taken to lead to final defeat over David's army, out of possible fear, rejection, or complete hopelessness, he chose to go home, "put his house in order, and then

[4] Strictly, the term "committed suicide" puts some responsibility on the victim and suggests an almost criminal intent. But, in this article, this term is employed loosely without an intention of blaming the victim.

hanged himself" (2 Samuel 17:23). All in all, Ahithophel's death by suicide was prompted by a mental health crisis. Ahithophel was a bitter, angry, and defeated man whose counsel had been rejected, and he was now doomed to be executed anyway for treason against King David.

6. Zimri

Zimri was an evil king of Israel who encountered an intense mental health crisis. Zimri did not enjoy his rule long. When news of the death of Elah reached the army that was engaged in a siege around the city of Gibbethon, the men at once proclaimed their famous and much-loved captain Omri, King of Israel. Abandoning the siege, the army proceeded to Tirzah that was eventually captured. Seeing that the capital had fallen to Omri's army and that there was no chance of escape, Zimri set his royal palace on fire and died in the flames. His reign only lasted seven days. Zimri's mental health crisis was characterized by, among other things, a total defeat that faced him as well as his impending capture, torture, and loss of power. In this context, Zimri lacked a way out, except to take his own life. All in all, Zimri was a wicked, murderous man who tried to take over the kingdom of Israel, reigned for seven days, and died by suicide (1 Kings 16:15-20).

7. Judas Iscariot

Judas Iscariot was one of the Twelve Apostles of Jesus Christ. Judas betrayed Christ by disclosing His whereabouts for 30 pieces of silver. Judas brought men to arrest Jesus and identified him with a kiss of betrayal. Then, Jesus was arrested, ruthlessly tortured, tried, and executed. In great despair and guilt after betraying his master, Jesus Christ, the mental burden that Judas carried led him to choose death by suicide. His story is probably the most well-known account in the Bible on the tragedy of suicide (Matthew 27:3-4). Matthew 27:5 says, "So, Judas threw the money into the temple and left. Then, he went away and hanged himself."

B. Causes of a Mental Health Crisis

The mentioned earlier Fr. Griffin's suicidal death and the above seven suicides in the Bible, happened in depressing psycho-social settings that are tantamount to a mental health crisis. As elucidated by all the above-mentioned cases of suicide, a mental health crisis is any situation in which people's behaviour put them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community. Many things can lead to a mental health crisis. The following are examples of situations that can lead or contribute to a mental health crisis:

I. Home or environmental stressors such as:

❖ Changes in relationship with others, for example, a boyfriend, girlfriend, partner, or spouse

❖ Losses of any kind because of death, estrangement, or relocation

❖ Conflicts or arguments with loved ones, relatives, or friends

❖ Trauma or exposure to violence, for example, domestic violence

II. School or work stressors such as:

❖ Worrying about upcoming projects or tasks

❖ Feeling singled out by co-workers or peers that leads to loneliness

❖ Lack of understanding from peers, co-workers, teachers, or supervisors

❖ Real or perceived discrimination

❖ Poor academic grades

❖ Losing a job

III. Other stressors such as:

❖ Being in crowds or large groups of people

❖ Experiencing community violence, trauma, natural disasters, or terrorism

❖ Pending court dates

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- ❖ Using or abusing drugs or alcohol
- ❖ Starting new medication or new dosage of current medication
- ❖ When treatment fails to work
- ❖ Stopping medication or missing doses

C. Warning Signs of a Mental Health Crisis

Note that warning signs are not always present when a mental health crisis is developing. Common actions that may be an indication that someone is undergoing a mental health crisis are as follows:

- ❖ One's inability to perform daily tasks, such as bathing, brushing teeth, or changing clothes
- ❖ One's rapid mood swings, increased energy level, and inability to stay still
- ❖ One's increased verbal threats, violence, out-of-control behaviour, and destruction of property
- ❖ One's increased alcohol and drug abuse
- ❖ One's miserable words such as "nothing matters anymore or life is not worth living"
- ❖ One's withdrawal from friends, family members, and normal activities
- ❖ One's sense of total hopelessness and helplessness
- ❖ One's history of suicide attempts or other self-harming behaviours
- ❖ One's abusive behaviour to self and others, including substance use or self-harm (cutting)
- ❖ One's isolation from school, work, family, friends
- ❖ One's loss of touch with reality (psychosis); this may involve an inability to recognize family members or friends, confusion, having strange ideas, thinking that they are someone they are not, inability to understand what people are saying, hearing strange voices, and seeing things that do not exist
- ❖ One's struggle with paranoia, that is, a mental condition that is characterized by delusions of persecution, unwarranted jealousy, or exaggerated self-importance

D. When the Mental Health Crisis Involves the Risk of Suicide

The risk of suicide is a major concern for people living with mental health conditions and those who love them. Encouraging people who are living with mental health conditions to get religio-medical help is the first step towards saving their lives. As shown hereinbefore, people who attempt suicide typically feel overwhelming emotional pain, frustration, loneliness, hopelessness, powerlessness, worthlessness, shame, guilt, anger, and self-hatred. The religio-social isolation so common in the lives of those living with mental illness can reinforce the belief that no one cares if they live or die. When such people talk about suicide, they should be taken seriously. Suicidal behaviours are a psychiatric emergency. In practice, many people who attempt suicide start by giving some verbal and non-verbal warning. Also, if somebody had attempted suicide before, there is a great risk of attempting it again. Some common warning signs of suicide are as follows:

- ❖ Giving away personal possessions
- ❖ Talking as if a person is saying goodbye or going away forever
- ❖ Taking steps to tie up loose ends, like organizing personal papers or paying off debts
- ❖ Making or changing a will
- ❖ Stockpiling medicines or obtaining a weapon
- ❖ Preoccupation with death
- ❖ Sudden cheerfulness or calm after a period of despondency

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E. Mental Health Services: Integration into Ministerial Services

Mental health and physical health are fundamentally related. On the one side, a person living with a serious mental illness is at higher risk of experiencing a wide range of chronic physical health conditions, such as asthma, epilepsy, heart disease, cancer, and diabetes. On the other side, a person living with chronic physical health conditions may experience depression and anxiety at twice the rate of the general population.

Besides, co-existing mental and physical health conditions can diminish one's quality of life and lead to longer illness duration and worse health outcomes. This situation also generates economic costs to society because of lost work productivity and increased health service use. The Church exists to evangelize and holistic evangelization is her greatest defining identity. Just like His multifaceted growth (Luke 2:52), Jesus Christ came to give humanity an abundant life (John 10:10). Luke 2:52 says, "And Jesus grew in wisdom and stature, and in favour with God and man." Hence, the Church should embrace the full Gospel that focuses on an abundant (holistic) life. The Church should be concerned with the mental, physical, spiritual, and social growth of humanity.

Specifically, the Church should be concerned with people's medical well-being, namely, their physical and mental well-being. In that vein, both the Ministry of Health of Kenya and the Anglican Church of Kenya should integrate mental health services into healthcare services and Christian ministerial services respectively. To that end, the following is an attempt to unearth the Anglican Church of Kenya's role in handling the mental health crisis.

F. Anglican Church of Kenya's Role in Handling the Mental Health Crisis

Mental health is a fundamental determinant of the overall health and socio-economic development of a particular person and the involved community (WHO, 2009). Mental disorders lead to a negative impact on particular individuals, families, communities, and nations (WHO, 2003). In the year 2012, the Sixty-fifth World Health Assembly adopted Resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive coordinated response from the health and social sectors at country level (WHO, 2012). Afterwards, in the year 2013, the Sixty-sixth World Health Assembly adopted Resolution WHA66.8; this resolution requested member states to develop comprehensive mental health action plans in line with the Global Comprehensive Mental Health Action Plan 2013-2020 (WHO, 2013).

In Kenya, the implementation of the Global Comprehensive Mental Health Action Plan 2013-2020 is still ongoing (Bukusi, 2015). The Kenya Mental Health Policy 2015-2030 advocates for comprehensive policy measures and strategies for achieving optimal health status and capacity of each individual. The goal of this policy is the achievement of the highest standard of mental health. This policy recognizes that it is the responsibility of all stakeholders in the public and private sectors to ensure that this goal is attained. Primarily, the implementation of this policy calls for an employment of a multi-disciplinary and inter-sectoral approach (Bukusi, 2015). In that vein, the Church's role in handling the mental health crisis should be considered as an essential aspect of the required comprehensive response to the mental health crisis in Kenya. In this context, this article seeks to establish the Anglican Church of Kenya's role in handling the mental health crisis towards a wholesome ministry. It is to this intricate task that we now turn.

a) Rehabilitation of People Living with Mental Disorders

Apart from the services within the Kenyan health system, the population-level and community-based interventions[5] are also important for the comprehensive management of the mental health crisis in Kenya. The aforesaid management may involve the treatment, care, and rehabilitation of people living with Mental, Neurological, and Substance use (MNS)

[5] Put simply, population-level health interventions are policies or programs that shift the distribution of health risk by addressing the underlying social, economic, and environmental conditions. Some examples of population-level interventions are smoking bans in public places to reduce population levels of smoking, water fluoridation to reduce population levels of caries, and mandatory folate fortification policies to reduce population prevalence of neural tube defects. Community-based interventions target larger portions of the population to address a recurring problem among these groups, who are categorized into the same demographic (and share the same problems) by regional trends, age, parental status, education level, socioeconomic status, or other factors. Examples of community-level interventions include parental education programs, public health programs, and educational programs. Another example of the same interventions is preventive programs that may involve drug and gun amnesty days, adolescent pregnancy prevention, anti-gang initiatives, anti-drug initiatives, and suicide prevention programs.

disorders. Comprehensive mental health services should embrace the promotion of good mental health, prevention of MNS disorders, treatment, and rehabilitation of people living with MNS disorders.

Does the Anglican Church of Kenya have any role in the above-mentioned comprehensive mental health services? The Anglican Church of Kenya can initiate rehabilitation centres for the rehabilitation of people living with MNS disorders. In practice, the leadership of the said Church can promote the initiation of at least one rehabilitation centre in each of its dioceses.

b) Full Church Funerals for the People who Die by Suicide

In African culture and religion suicide is said to fall into the large category of murder. In this case, murder is seen as the unjustified killing of a fellow human being. Indeed, murder is considered as an act that is often totally condemned. Nevertheless, in African society, killing is permitted in war situations and for self-defence. But, for other circumstances, it is seen as a crime, which is punishable by both the Supreme Being and divinities (Aderibigbe, 2002). In this case, the common forms of killings that have common moral implications in African culture and religion are human sacrifice, infanticide, and suicide. Suicide is not tolerated in most parts of Africa. For example, among the Yoruba of South-West Nigeria, suicide is seen as a "bad death." So, the people who die by suicide are not given full burial rites; such people are buried in the "bad bush" outside the village (Aderibigbe, 2002). The same position is maintained by the Ibos (Igbos). In most of the Ibo clans, the people who die by suicide are denied burial rites as their deaths are seen as a grave offence against "Ala," the earth goddess (Aderibigbe, 2002; Onwubiko, 1991; Awolalu, 1976).

Generally, society has historically viewed suicide with fear, hostility, and condemnation. This regrettable attitude has come under increasing scrutiny in recent years as society's attitudes towards suicide have become more tolerant (Wright, 2017). For example, Judaism considers suicide as one of the most serious sins. In most cases, suicide is forbidden by Jewish laws (New World Encyclopedia, 2013; Exodus 20:13). But, generally speaking, the condemnatory traditional Jewish attitude towards suicide is being abandoned. The New World Encyclopedia (2013) puts it that although in the past the bodies of Jewish people who "committed suicide" were buried in the outskirts of Jewish cemetery, this traditional repercussion has been abandoned. To take another example, the traditional Christian teaching views suicide as a grave crime and sin (McDonald, 2013). Generally, in its attitude towards suicide, Christianity relies on the sixth commandment, namely, "...You shall not murder..." (Exodus 20:13; Phipps, 2013). In this context, up until the 19th century, the Anglican Church refused to offer Christian funerals for people who had "committed suicide" with a "sound mind." However, this position was updated in the 1880s to permit priests to bury those who had taken their own life but without the standard service set out in the Anglican Book of Common Prayer.

Every suicide is a tragedy (Wright, 2017). One Anglican interviewee whose request for anonymity is honoured observed that she does not attend church services because she was refused a church service for her husband who died by suicide. Another Anglican interviewee revealed that he hates black colour because his wife who died by suicide was cruelly buried like an animal by a priest who wore a glittering black cassock. This interviewee said, "my priest looked like an Angel separating the sheep from the goats, whilst his black cassock and judgemental sermon evidenced the condemnation of my wife's soul to hell; I wept much, because I felt mentally wounded, alone, and unloved...I hate black colour because it triggers my painful memories."

Is suicide a criminal offence or a consequence of a mental health issue?[6] Maybe, no one should be blamed for "committing suicide." Perhaps, we should say that a person died by suicide, but not of suicide. On the one hand, the former term, namely, *by suicide*, suggests that the person who "committed suicide" did it because of a certain mental health problem. In this case, the act of suicide is not considered as a sin or crime, but it is a regrettable act that should be discouraged and prevented. On the other hand, the latter term, namely, *of suicide*, blames the person who "committed suicide." Herein, almost always, suicide is considered as a sin or crime (Phipps, 2013).

Mental health problem is a global phenomenon (WCC, 2016). The Ministry of Health of Kenya holds that people with mental disorders are often subjected to stigmatization and discrimination. Sometimes, persons with mental disorders are

[6] A mental health issue interferes with a person's cognitive, emotional, or social abilities. There are diverse kinds of mental health issues and each of these can occur with a varying degree of severity. Examples of the said health issues include depression, anxiety, bipolar disorder, schizophrenia, personality disorders, eating disorders, and psychosis.

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denied economic, social, and cultural rights. For example, in most cases, such people are not permitted to work, go to school, and participate in cultural events. Worse still, they are denied their reproductive rights and the right to the highest attainable standard of health. Unfortunately, in some cases, they are subjected to unhygienic and inhumane living conditions, physical and emotional torture, sexual abuse, neglect, as well as harmful and humiliating treatment practices in health facilities (Bukusi, 2015). Unfortunately, the 2010 Kenyan Constitution still criminalizes suicide.[7] Section 226 of the Kenyan Penal Code defines attempted suicide as a misdemeanour. Categorized under the section offences connected with murder and suicide, a misdemeanour is punishable by a jail term of up to two years, or a fine, or both, as stated by section 36 of the Penal Code of Kenya.

Worse still, people with mental disorders are often denied civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and wholly in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society. Also, in some cases, mental disorders lead individuals and families into poverty, homelessness, and inhuman confinement (Bukusi, 2015). Perhaps, what is even more humiliating is the degrading burial ceremonies that the people who "commit suicide" because of mental disorders are subjected to.

As demonstrated in the mentioned earlier Fr Griffin's death by suicide and seven suicides in the Bible, there is a link between suicidal deaths and mental disorders, such as mood disorders (for example, depression and bipolar disorder), post-traumatic stress disorder, psychotic disorders, and alcohol use disorders. Besides, the aforesaid Fr Griffin's death by suicide and seven suicides in the Bible evidence that many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, defeat, shame, joblessness, powerlessness, relationship break-up, chronic pain and illness, and so on. Moreover, experiencing violence, poverty, conflict, disaster, abuse, loss, and an intense sense of isolation are associated with suicidal behaviour. Furthermore, suicide cases are high amongst vulnerable groups who experience discrimination, such as refugees and migrants; indigenous peoples; homosexuals, bisexual people, transgender people, intersex people; and prisoners. But, the strongest risk factor for suicide is a previous suicide attempt.

According to the WHO, more than 700,000 people die because of suicide every year. The WHO also holds that suicide is the fourth leading cause of death in 15-19-year-olds. For example, the WHO observes that suicide was the fourth leading cause of death among 15-29 year-olds globally in 2019. Regrettably, every suicide is a tragedy that harms the involved families, communities, and countries. Usually, the aforesaid tragedy causes long-lasting effects on the people left behind. But, generally speaking, disgraceful burial ceremonies for the people who "commit suicide" worsen an already worse situation of the aforesaid families and communities.

Is it possible that in the Anglican Church of Kenya, the people who "commit suicide" are buried inhumanly, whilst, in some situations, their relatives are verbally ill-treated during the burial ceremonies? In a suicide, the victim is the perpetrator. Maybe, the aforesaid inhuman burial and ill-treatment happen because the victims (perpetrators) are considered as sinners and criminals who committed unforgivable sin or a punishable crime, namely, suicide (Dignitas, 2013; Phipps, 2013). Is suicide a sin or an effect of a mental health issue? Is it a sin and an effect of a mental health issue? If it is a sin, is it unforgivable sin? If animals run away from life-threatening situations, how can mentally healthy persons desire to die and take their lives? As said by the WHO, suicide is a serious public health problem in the world.

Perhaps, suicide should be considered as a mental health problem, but not unforgivable sin or crime (Phipps, 2013). In support of that reality, the 2019 report of the Taskforce on Mental Health in Kenya recommended that the Kenyan parliament should move fast to decriminalise suicide attempts in order to reduce stigma and discrimination and encourage people who feel suicidal to seek counselling services.

In the Anglican Church of Kenya's Book of Common Prayer (2018), we have two burial liturgies, namely, the burial liturgy for Christians and the burial liturgy for those who *die by suicide*. In the former burial liturgy, it is obligatory for priests to put on their priestly vestments (liturgical garments) when they are burying Christians. But, in the latter burial liturgy, the introductory rubric says, "it is not obligatory for priests to put on their priestly vestments." Put simply, in

[7] The law (Section 226 of the Kenyan Penal Code) should be either changed or repealed towards the decriminalisation of suicide.

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Kiswahili, the aforesaid rubric says, "*Si lasima makasisi kuvaa majoho*," whilst in Kikuyu the same rubric says, "*To nginya atungatĩri mehumbe nguo cia magongona*" (Anglican Church of Kenya's Book of Common Prayer, 2018:408; Anglican Church of Kenya's Book of Common Prayer, 2016:207). Is that ecclesiastical instruction condemnatory and discriminative? Relying on the above rubric, some priests use black cassocks, whilst some of them chose to wear no vestment in the burial ceremonies of the people who die by suicide. Does the above reproving burial ceremonies show that suicide victims "go" to hell? Does the same burial ceremonies discourage suicide survivors from committing suicide or inflict further mental pain on them?

Is having the aforesaid two kinds of liturgy stigmatizing, condemnatory, judgemental, and discriminatory? Does having the two diverse liturgies separate Christians who pass away because of other things from Christians (perpetrators) who die by suicide? Between the two liturgies, which liturgy is suitable for a Christian who was shot dead as he attempted to rob a bank? Does having the two kinds of liturgy imply that Christians who die by other ways "go" to heaven, whilst Christians who die by suicide "go" to hell? Does having the two kinds of liturgy show that the two groups of Christians do not "go" to the same heaven? Are the people who die by suicide othered by the Anglican Church of Kenya (Matthew 25:31-46)?

The question is, which liturgy is suitable for Christians who die by suicide? By its very nature, the mentioned earlier rubric, which gives rise to the two kinds of liturgy, implies that unlike Christians who pass away because of other things, Christians who die by suicide should not be given full church (Christian) funerals because they are *the others*. Perhaps, the Anglican Church of Kenya can consider having one kind of a burial liturgy for all Christians regardless of one's nature or cause of death. This move can be a significant turnabout for the people who die by suicide and suicide survivors. The aforesaid move can involve giving full church (Christian) funerals for those who die by suicide. In addition, the Anglican Church of Kenya should offer counselling services to suicide attempt survivors and suicide survivors.[8]

c) Preventive Pastoral Care and Counselling Services

Globally, MNS disorders affect more than 25% of all people at some point during their lifetime (WHO, 2001). In addition, the WHO observes that it is estimated that about 10% of the adult and child populations at any given time suffer from at least one mental disorder, as defined in the International Statistical Classification of Diseases and Related Health Problems. Moreover, at least 20% of all patients seen by primary health care professionals have one or more mental disorders. It was projected that by 2020, the burden of MNS disorders would be 15% of the total Disability-Adjusted Life Years (DALYs), a rise from 12% in 2000 (WHO, 2001). The WHO estimates that 60% of people attending primary care clinics have a diagnosable mental disorder (WHO, 2008). Mental disorders are important risk factors for other diseases, as well as unintentional and intentional injury. By their very aetiology, mental disorders increase the risk of getting ill from other diseases such as HIV, cardiovascular disease, diabetes, and vice-versa.

Stigma and discrimination against patients and families prevent people from seeking mental health care. Human rights violations of people with mental and psychosocial disabilities are routinely reported in most countries; however, the reported cases may be far below the actual numbers. The Anglican Church of Kenya can stand in that gap and, therein, attempt to give preventive pastoral care and counselling services to the general public, especially suicide survivors and suicide attempt survivors. To that end, it can also defend the human rights of people with mental and psychosocial disabilities because the violations of their said rights can lead to suicide.

Globally, there is huge inequity in the distribution of skilled human resources for mental health. Shortages of psychiatrists, psychiatric nurses, psychologists, and social workers are among the main barriers to providing treatment and care in low- and middle-income countries. Low-income countries have 0.05 psychiatrists and 0.42 nurses per 100,000 people. The rate of psychiatrists in high-income countries is 170 times greater and for nurses is 70 times greater. Even in the low-income countries, there are internal inequities in the distribution of these already low numbers of mental health workers, whereby the available professionals are concentrated in cities and teaching hospitals (which are often in the capital cities), while rural areas are left with far fewer professionals (O'Broin-Molloy, 2016).

[8] Maybe, the Anglican Church of Kenya should discourage subjecting suicide survivors to further emotional and mental punishment by having a separate burial liturgy and carrying out a substandard burial ceremony for the Christians who die by suicide. Regrettably, in most cases, a suicide's death punishes the living (Omomia, 2017).

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Accordingly, it is estimated that four out of five people with serious mental disorders living in low and middle-income countries do not receive the mental health services that they need. Also, Neuropsychiatric disorders are estimated to contribute to 13% of the global burden of disease (WHO, The Global Burden of Disease – 2004). It is against that backdrop that the Church is called upon to make an intervention in the mental health crisis by offering pastoral care and counselling services to the people living with mental disorders, their families, and the involved communities. In the same sphere of pastoral care and counselling services, the Church can also offer a prophetic voice for the poor masses towards minimizing the cases of mental health disorders. In that vein, the following is a discussion of the way the Anglican Church of Kenya can offer preventive pastoral care and counselling services as well as the related prophetic voice for the poor masses.

i) Pastoral Care and Counselling Services

Presently, there is scanty data on the prevalence of MNS in Kenya. However, it is estimated that up to 25% of outpatients and up to 40% of in-patients in health facilities struggle with mental conditions (KNCHR, 2011). In the global war against mental health crisis, participation should be encouraged in the design and delivery of interventions towards maximizing the contributions of different actors. To that end, the Kenyan war against the mental health crisis should entail the employment of a multi-disciplinary and inter-sectoral paradigm. In this sphere, the Anglican Church of Kenya should consider offering organized pastoral care and counselling services to the people living with mental disorders, their families, and the involved communities. Those services should be provided equally to all persons in a community irrespective of their state of mental health, religion, gender, age, culture, and socio-economic class. Therefore, the said services should be characterized by inclusiveness and non-discrimination. Offering the above-mentioned services can be termed as making particular visitations of the homes and communities of the people living with mental disorders. In this case, all the Anglican dioceses in Kenya can ensure that their respective parishes make the aforesaid particular visitations to offer pastoral care and counselling services to the people living with mental disorders, their relatives, and their communities at large.

ii) Prophetic Voice for the Poor Masses

Kenya should be a country where mental health is valued and promoted, mental disorders are prevented, and persons affected by mental disorders are treated without stigmatization and discrimination. But, in the realm of the mental health crisis in Kenya, the poor masses who have been crying for the bread of psychosocial support (preventive and curative) receive an underdose of the said support, negligence, or an empty promise of waiting till later, which almost always means never. For instance, there are so many communities in Kenya that are begging their political leaderships to obliterate the sale of illegal drugs to young people. But, in most cases, these cries fall on deaf ears. This reality begs the questions, who are the main drug peddlers in Kenya? Are there some politicians who endeavour to enrich themselves by peddling drugs in Kenya? Is fighting against drug peddling and abuse an aspect of the Church’s missionary mandate? What is the role of the Anglican Church of Kenya in the fight against drug peddling and abuse? Finally, is it possible for the Anglican Church of Kenya to offer a constant prophetic voice against drug peddling in Kenya towards the prevention of mental illnesses, especially among youths?

Offering a prophetic voice can play a pivotal role in the ecclesiastical fight against socio-economic and political ills in a particular community. Normally, a prophetic voice becomes the voice of the voiceless poor masses, which offers a spiritual and moral compass that makes a particular community focused on God’s plan. In this context, the Anglican Church of Kenya can offer a perpetual prophetic voice against drug peddlers in Kenya who seek to enrich themselves at the expense of the mental health of the voiceless poor masses. In the same vein, the said church should always offer its prophetic voice against the worsening corruption in Kenya, which escalates the importation and distribution of illegal drugs that have turned some youths into “zombies.”

iii) Resurrecting the Community Health Workers

Because mental health problems are caused by multiple factors, their interventions should be made via a multidisciplinary and inter-sectoral collaboration. So, it is necessary to train workers in other sectors in mental health. In almost all the dioceses of the Anglican Church of Kenya, there are trained community health workers who maybe inactive today. In their fight against the mental health crisis in Kenya, the said dioceses can resurrect their community health workers. To that end, the dioceses of the Anglican Church of Kenya can retrain and recruit the aforesaid community health workers

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and, therein, make some of them community mental health workers. Furthermore, the Anglican Church of Kenya can establish community health financing programmes to support its mental health services. All in all, community mental health workers can, among other things, promote the primary prevention of MNS disorders as well as the identification and case detection of the said MNS disorders. Also, the above-mentioned health workers can lead campaigns against stigma and discrimination to provide psychosocial help to suicide attempt survivors and suicide survivors. The same health workers can also fight against drug and substance abuse in their localities, offer mental health education, parenting skills education, and life skills education towards the management of the mental health crisis in Kenya.

iv) Mental Health Departments

Many Anglican dioceses in Kenya possess several departments for various groups of people, such as youths, women, choirs, men, children, Sunday school, and so forth. Mostly, the aforesaid departments are used as vehicles through which diverse groups of people receive pastoral care and counselling services. In its fight against the mental health crisis in Kenya, the Anglican Church of Kenya can encourage each of the above-mentioned dioceses to consider establishing a diocesan department of mental health for preventive interventions and other related services. To that end, the Anglican Church of Kenya can break the ice by establishing its department of mental health as an example to all its dioceses.

v) Mental Health Literacy

Mental health literacy can be used to prevent mental health disorders in Kenya. In this case, the Anglican Church of Kenya can advocate the incorporation of mental health literacy in curricula at all levels of education, especially in its sponsored primary schools, high schools, colleges, and universities. The 2019 report of the Taskforce on Mental Health in Kenya says that apart from incorporating mental health literacy in curricula at all levels of education, the government should promote mental health and wellness in families and communities through *community health* and *wellbeing programmes*. In this context, the Anglican Church of Kenya can also initiate medical health literacy programmes in the local communities of the Anglican dioceses. The aforesaid programmes can be propelled by the mentioned earlier diocesan community health workers and diocesan health departments.

2. CONCLUSION AND RECOMMENDATIONS

The WHO's Mental Health Action Plan 2013-2020, which was endorsed by the World Health Assembly in 2013, recognizes the vital role of mental health in achieving health for all people. One of the objectives of the aforesaid plan is the provision of comprehensive and integrated mental health and social care services in community-based settings. The 2010 Kenyan Constitution, observes that every person has the right to the highest achievable standard of health; the said health includes mental health. Against that backdrop, a successful fight against the existing mental health crisis in Kenya calls for employment of a multi-disciplinary and inter-sectoral approach.

It is worth reiterating that the research question of this work is, what is the Anglican Church of Kenya's role in handling the mental health crisis? In response to this question, this work has established that the Anglican Church of Kenya can, *inter alia*, seek to initiate rehabilitation centres for the rehabilitation of the people living with MNS disorders, consider having one kind of a burial liturgy for all Christians irrespective of one's nature or cause of death, offer preventive pastoral care and counselling services as well as the associated prophetic voice for the poor masses, encourage each of its dioceses to consider establishing a diocesan department of the mental health for preventive interventions and other related services, and advocate the incorporation of mental health literacy in curricula at all levels of education; it can also promote the initiation of medical health literacy programmes in the local communities of each of its dioceses.

In its response to the mental health crisis in Kenya, the Anglican Church of Kenya may consider the following recommendations. To begin with, the Anglican Church of Kenya should declare the mental health crisis a national public health emergency because the involved high burden of mental illness is a threat to its growth and national development at large. Better still, the Anglican Church of Kenya may request all its dioceses to officially adopt the observance of the World Mental Health Day, which is celebrated annually on 10th October.[9] During that day (Diocesan Mental Health Day), the aforesaid dioceses can raise awareness of mental health issues and raise funds for their respective mental health departments and rehabilitation centres.

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[9] The World Mental Health Day is celebrated annually on 10th October to raise awareness of mental health issues around the world and mobilize efforts in support of mental health.

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