**Highlighting key aspects of legal reform based on the CRPD**

My name is Elizabeth Kamundia, and it is an honour and a privilege to address the Human Rights Council consultation on mental health and human rights. I work as the focal point on disability at Kenya’s National Human Rights Institution, the Kenya National Commission on Human Rights. The Commission is the designated monitoring agency under the CRPD. My presentation today will highlight key aspects of legal reform on mental health in Kenya, based on the CRPD.

Kenya’s Mental Health Act dates back to 1989. There have been various attempts to amend this law, including the current Mental Health (Amendment) Bill 2020 which has this November been committed to the National Assembly Departmental Committee on Health for consideration, having undergone the first reading.

The Kenya National Commission on Human Rights convenes a network of persons with disabilities and their representative organisations. Jointly, we have made submissions to Parliament on the Mental Health Amendment Bill. Proposals made include:

* incorporate right to legal capacity (including recognising advance directives and supported decision-making agreements)
* repeal provisions on involuntary and emergency admission and treatment
* abolish use of seclusion and restraints.
* Include persons with psychosocial disabilities in the various decision-making organs set up in the Bill including the Mental Health Board and various committees proposed to be established at county level.

I will begin with some of the positive features. In line with our recommendations, the bill provides that a person with mental health condition has the right to legal capacity. The Bill also recognises the role of supporters in decision-making as required in General Comment No. 1 of the CRPD Committee on equal recognition before the law. The Bill has expansive provisions on the right to access mental health services within the community.

On the other hand, the bill maintains that a representative can still be appointed against the will of the person with a mental health condition. Additionally, the Bill maintains the use of seclusion and restraints, even though we had strongly advised against this in line with the Committee on the Rights of Persons with Disabilities[[1]](#footnote-1) as well as the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment[[2]](#footnote-2) who have called for an end to all coercive and non-consensual psychiatric interventions.

In our submissions, we had proposed that the Bill should include, in its appendix, a template to guide what a supported decision-making agreement should look like. The reason for submitting this template was to guard against misinterpretations of what supported decision making actually is and ensure that it does not get co-opted to become a form of guardianship. Unfortunately, this proposal was rejected.

**Challenges faced**

In terms of challenges faced in the law reform process, a key challenge has been how ingrained the biomedical model of disability is in the mental health sphere. When we made our submissions orally before the Departmental Committee, we faced push-back from the members; and at the core of that pushback was the idea that surely, surely, persons with mental health conditions are not capable of making treatment decisions at all. Essentially then – our participation, to some extent seems tokenistic (certainly from where we sit) – we haven’t been able to get some of the proposals accepted that we feel very strongly about – such as protection against involuntary admissions, and use of seclusion and restraints.

**Opportunities**

Thankfully, we have some experience about what is needed to overcome these challenges. To start with, the Bill has a strong focus on provision of community-based services, and we believe we can use these provisions towards greater rights enjoyment.

Another opportunity relates to supporting and scaling up user led initiatives. One example of this is the Nairobi Mind Empowerment Peer Support Group, Users and Survivors of Psychiatry – Kenya, which was featured in the ‘WHO good practice guidance on community based mental health services promoting human rights and recovery’. Peer support presents a non-coercive environment for decision-making, which reinforces individual autonomy. Our hope is that evidence-based initiatives of this nature speak for themselves – and can be highly persuasive for policy makers – who need to see how alternatives to the medical model of mental health work in practice.

The WHO good practice guide that I mentioned is part of WHO’s QualityRights initiative which aims to improve the quality of care and promote the human rights of people with psychosocial, intellectual and cognitive disabilities. Kenya is the second country in Africa, after Ghana, to take up this initiative. The Ministry of Health, Directorate of mental health has brought together a multi-stakeholders committee comprising government Ministries, Departments and Agencies and non-governmental actors to implement this initiative in Kenya. Being able refer to guidance from the WHO on a human rights-based approach to mental health is persuasive; and we have witnessed this during oral engagements with the Parliamentary committees when making submissions before them.

The Government of Kenya, in 2019, set up a mental health taskforce to look into the mental health situation of Kenyans. This taskforce recommended the reform of the Mental Health Act – and is therefore a powerful advocacy tool for the reform of this law. The taskforce also recommended enhanced budgetary allocations to mental health, which is needed in tandem with law reform.

Another opportunity is leveraging on ongoing law reform processes relating to laws that impact on those with mental health conditions. These include, for example, laws that criminalise suicide, or that criminalise behaviour that is associated with mental health crises.

I must say that reflecting on this now, what would have really helped Kenya in its efforts to develop rights based mental health law, would have been to have specific technical guidance available to help formulate the law so that it is compliant with the CRPD.

Finally, I need to emphasize, once again, that the Commission works closely with organisations of persons with psychosocial disabilities, in the spirit of article 4(3) of the CRPD the need to ensure their active participation and effective engagement in all decision-making processes, including law reform on mental health.

1. Office of the High Commissioner for Human Rights ‘Report on Mental Health and Human Rights (31st January 2017) [↑](#footnote-ref-1)
2. Report of the special rapporteur on torture and other cruel, inhuman or degrading treatment or punishment submitted during the 22nd session of the Human Rights Council (11th February 2013) [↑](#footnote-ref-2)