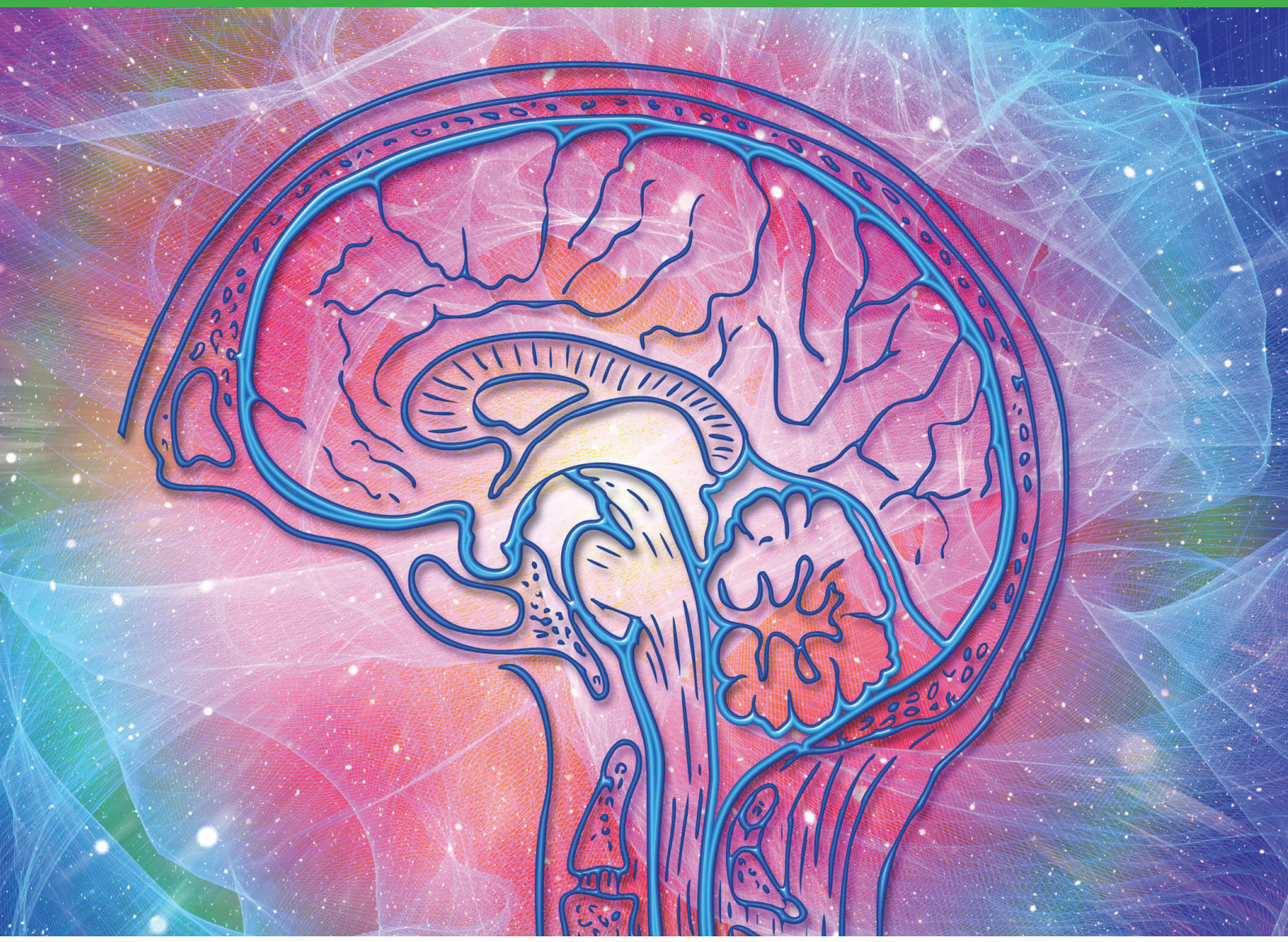
HERAF
Health Rights Advocacy Forum

MENTAL HEALTH POLICY

An Analysis of the Global, Regional and National Policy Commitments to Mental Health in Kenya.



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Finally, we appreciate the legal expertise of Lynette Etemesi from HERAF who researched, analysed and compiled the report.

LIST OF ABBREVIATIONS

CIDP	County Integrated Development Plans
COVID- 19	Coronavirus Disease 2019
CRC	Convention on the Rights of a Child
CRPD	Convention on Rights of Persons with Disabilities
FGM	Female Genital Mutilation
HERAF	Health Rights Advocacy Forum
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IRA	Insurance Regulatory Authority
KNCHR	Kenya National Commission on Human Rights
MHPSS	Mental Health and Psychosocial Support
MP	Member of Parliament
MTRH	Mathari Teaching and Referral Hospital
NHIF	National Hospital Insurance Fund
OAU	Organization of African Unity
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage

1.0 BACKGROUND

Since attaining independence from Britain in 1963, Kenya has engaged in several health reforms to strengthen health services, eradicate communicable diseases, and improve health access for the whole population. Whilst there have been improvements concerning child and maternal mortality and a reduction in morbidity and mortality rates related to communicable diseases, access to healthcare is still hampered by poverty, political instability, corruption and rapid population increase. Mental healthcare has received little attention in Kenyan health reform, and it remains a low policy and budget priority.

Stigma and discrimination against people with mental illness (and the healthcare staff who work in mental health settings) are significant challenges for Kenya's capacity-building efforts. This may explain why only a few health professionals choose to work in mental health services. Efforts to improve mental health services in Kenya must commence by, firstly, addressing the endemic issues of stigma and lack of mental health literacy among the health workforce and, secondly, addressing the society on a broader scale through advocacy and creating awareness around mental health. Mental Health Legislation and policies are integral to setting the agenda for planning and delivering mental health services. Kenya lacks proper legislation on mental health and has not implemented its international and regional commitments, limiting the mental health reform agenda. Health workers, civil society groups and other stakeholders need to play a role in influencing politicians to take a more active role in advocating for mental healthcare, including ensuring that there is the integration of mental healthcare into the national and county health sector strategic plans (national, county and community levels) These plans are likely to lead to better, more sustainable changes and positive health outcomes.

This report aims to review Global, Regional and National Commitments and the strides taken to ensure that these commitments in conventions, policies, and legislative frameworks are implemented in Kenya.

2.0 POLICY ANALYSIS ON KENYA'S MENTAL HEALTH SYSTEM

Article 2(6) of the 2010 Constitution of Kenya states that any treaty or convention ratified by Kenya shall form part of the law in Kenya[1]. To breathe life into this provision, Kenya, through the National Assembly, enacted the Treaty Making and Ratification Act (No. 45 of 2012). This act also outlines the procedure of ratification of treaties. The fact that Kenya has signed and ratified the treaties shows its intention to be bound by them.

Some of the Global treaties Kenya has ratified concerning human rights that contain aspects of Mental Health include:

2.1 Rights of the Child

a) CRC 1990: Convention on the Rights of the Child

Article 23 states that ratifying states should recognise that a mentally or physically disabled child should enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate the child's active participation in the community.[2] The government has developed schools for persons with special needs, including those who are mentally disabled, to learn at their own pace, avoid discrimination, and achieve the right to education. However, schools need to integrate mental health responses, such as having mental health professionals such as counsellors in schools rather than having teachers double up as counsellors. Yet, they have no professional experience to handle mental health conditions.

Additionally, the Ministry of Health should create access to mental health facilities and services for children at the primary facilities. This includes creating a conducive and child-friendly environment. They are not exempt from special packages. Like adults, insurance policies and National Hospital Insurance Fund (NHIF) packages do not cater to children in need of mental health services, making it a costly affair to access mental health services. There is a need to prioritise this as children are under vulnerable groups, and there is an urgent need for intervention in this space.

Article 24 states that the ratifying state should recognise the child's right to the enjoyment of the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health. [3]States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. Kenya has provided for Article 43 to ensure the highest attainable level of Health care, including mental health. Children are listed under vulnerable groups in the Mental Health Policymaking them qualify for targeted mental health institutions as they are prone to mental disorders in instances where there might have been inadequate prenatal care or if their environment does not promote care, affection, love, and simulation for cognitive abilities. Additionally, adolescents face behavioural challenges and exposure to some behaviours such as psychoactive substances: making them vulnerable to mental disorders.

1. Article 2(6) of the 2010 Constitution of Kenya http://kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=Const2010
2. Convention on the Rights of the Child 1990: Article 23 https://www.ohchr.org/en/professionalinterest/pages/crc.
3. Convention on the Rights of the Child 1990: Article 24https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

3.0 GLOBAL CONVENTIONS ON HUMAN RIGHTS

i) International Convention on Civil and Political Rights

The United Nations International Covenant on Civil and Political Rights (ICCPR) attempts to protect civil and political rights. The United Nations General Assembly adopted it on 19th December 1966, and it came into force on 23rd March 1976. The International Covenant on Economic Social and Cultural Rights, the Universal Declaration of Human Rights, and the ICCPR and its two Optional Protocols are collectively known as the International Bill of Rights.

The ICCPR recognises each individual's inherent dignity and undertakes to promote states' conditions to enjoy civil and political rights. Countries that have ratified the Covenant are obligated "to protect and preserve basic human rights… [and] "compelled to take administrative, judicial, and legislative measures to protect the rights enshrined in the treaty and to provide an effective remedy." There are currently 74 signatories and 168 parties to the ICCPR. Collectively, the convention has 53 Articles.[4]

ii) International Covenant on Social Economic and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is a multilateral treaty adopted by the United Nations General Assembly on 16th December 1966 through GA. Resolution 2200A (XXI) and came into force on 3rd January 1976. It commits its parties to work toward granting economic, social, and cultural rights (ESCR) to the Non-Self-Governing and Trust Territories and individuals, including labour rights and the right to health, the right to education, and the right to an adequate standard of living. As of July 2020, the Covenant has 171 parties. A further four countries, including the United States, have signed but not ratified the Covenant.

The ICESCR (and its Optional Protocol) is part of the International Bill of Human Rights, along with the Universal Declaration of Human Rights (UDHR) and the International Covenant on Civil and Political Rights (ICCPR), including the latter's first and second Optional Protocols. The Covenant is monitored by the UN Committee on Economic, Social and Cultural Rights.[5]

3.1 Kenya's Commitment towards this convention

The domestication of these rights into the constitution, such as the right to the highest attainable standard of healthcare, including mental health breaks the barriers to access to mental health care services.

Assent of the constitutional regulations that provide procedural ways of dealing with Human Rights Violations. These regulations are available to remedy human rights violations, and those with psychosocial, cognitive and intellectual disabilities can use this to seek redress.

4. International Convention on Civil and Political Rights https://ccla.org/summary-international-covenant-on-civil-and-political-rights-iccpr/#:~:text=The%20United%20Nations%20International%20Covenant,force%20on%20March%2023%2C%201976.
5. International Covenant on Social Economic and Cultural Rights https://en.wikipedia.org/wiki/International_Covenant_on_Economic,_Social_and_Cultural_Rights.

3.1.1 Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities[6] was ratified in Kenya on 19th May 2008. The convention is meant to state in detail or elaborate on the rights of persons with disabilities and provide a code for implementation. A code of implementation is where a country develops a way to incorporate the convention and domesticate the law within their jurisdiction. Under Article 2(5) and (6), the 2010 Kenyan Constitution[7]recognises that general rules of international law and any treaty or convention ratified in Kenya forms part of the law. Therefore, in this case, the convention on the Rights of Persons with Disabilities is provided with the law's status as per the constitution; hence, it should be adopted in full.

Article 4 states that countries that join in the convention should develop and carry out policies, laws, and administrative measures to secure the rights recognised in the Convention and abolish laws. Therefore, there should be regulations, customs and practices that curb discrimination around mental health. As a result of this, Kenya has developed the Mental Health Policy 2015 - 2030 to provide guidelines towards a legal framework around mental health.

Article 9 of the Convention requires countries to identify and eliminate obstacles and barriers and ensure that persons with disabilities can access their environment, transportation, public facilities and services, and information and communications technologies. Kenya has committed to it. However, it should be noted that those with psychosocial, intellectual and cognitive problems face challenges on access to mental health services. Often, they encounter inadequate medication and access to mental health specialists as there are very few in public health facilities. This gap was identified in the Kenya Mental Health Policy 2015 – 2030, but this has not been addressed due to failure in implementing the policy. In 2020 the President of Kenya issued an executive order that uplifted the Mathari National Teaching and Referral Hospital's status to a fully-fledged national referral hospital with its board of management. This directive should enable the facility to develop its plans and budget and get funds directly from the exchequer instead of depending on the Ministry of Health. There are also plans to establish regional mental health facilities across the country to ensure specialised mental health services are devolved. Though this strategy is welcome, it negates the principle of community-driven mental health services. Many states are moving away from institutionalisation deemed the bio-medical model to the social model where the community-based model is in place at the epicentre.

Article 12: It reads, 'State Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law. Therefore, it guarantees the right to legal capacity. According to article 12 of the CRPD, the right to legal capacity can never be taken away from a person. Everybody has the right to legal capacity irrespective of their decision-making skills. A psychosocial, intellectual or cognitive disability can never justify denying someone the right to legal capacity. Legal capacity is an inherent and inalienable right. It includes two dimensions:

- the right to hold rights; this the capability and power under the law of a person to occupy a particular status or relationship with another to engage in a specific undertaking or transaction; and
- The right to exercise these rights. This denotes the ability to perform civil acts as defined by law, such as the capacity to devise, to bequeath, to grant or convey lands, to enter into contractual agreements

6. Convention on the Rights of Persons with Disabilities https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html.
7. Article 2(5) and (6), the 2010 Kenyan Constitution https://www.klrc.go.ke/index.php/constitution-of-kenya/106-chapter-one-sovereignty-of-the-people-and-supremacy-of-this-constitution/167-article-2-supremacy-of-this-constitution

The right to legal capacity is necessary for the enjoyment of all other rights. However, in Kenya, there are some instances where legal capacity is denied, and this includes:

1. Political Participation

In this case, Kenyan law does not allow people with psychosocial, cognitive, and intellectual disabilities to bind political decisions on an equal basis legally. The constitution also provides that a voter must be someone who is "not declared to be of unsound mind. This also applies to the Elections Act 2011.[8]Additionally, political candidates should be declared of unsound mind. Therefore, there is a need for a threshold to determine those of unsound mind.

2. Mental Health Services

Involuntary admission and treatment deny people the right to exercise free and informed consent to health care. The Mental Health Act, 1989 allows the director of a psychiatric hospital to restrict a person's legal capacity by detaining them in the psychiatric hospital.[9]

Legal capacity is also denied to people who are not involuntarily admitted and treated because, even in these cases, staff assume that a person cannot make decisions. The simple threat of involuntary admission and treatment may result in accepting unwanted practices by some people.

3. Law of Succession

The Law of Succession Act 1981 adopts the position that people of "unsound mind" lack the capacity to make wills. A person making a will is of "sound mind" unless he or she is in a state of mind arising from mental or physical illness, drunkenness, or any other cause that makes the person unaware of what they are doing.[10]

4. Access to Justice

The Civil Procedure Act is the law that prescribes in detail the rules of civil litigation. It treats people considered to be of "unsound mind" as if they were children. No guidance is given as to how a court is to establish this. If the court declares that someone in a proceeding is of "unsound mind", it will appoint a "next friend" when the person is issuing and a "guardian ad litem" when the person is being sued.

The Mental Health Act, 1989 does not guide how courts are to judge someone's decision-making capacity. Notwithstanding the rarity of the cases coming before the courts, those that judges decide seem to be about restricting decision-making rights instead of putting in place access to a range of supports that preserve legal capacity.

There is the risk that several human rights are violated in such proceedings, including:

- they have neither the right nor the opportunity to present their evidence (including witnesses) nor the chance to challenge opposing evidence.
- Very little evidence is required to deprive someone of their legal capacity.
- appeal routes are closed for the individual concerned, who loses their legal personality as a result of the proceedings

8. Elections Act 2011. http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ElectionsAct_No24of_2011_New.pdf
9. Mental Health Act _Cap. 248 - No. 10 of 1989http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/MentalHealthAct_Cap248.pdf
10. Law of Succession Act 1981http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/LawofSuccessionAct_Cap160.pdf

This system does not comply with Article 12 of the CRPD, which requires States to ensure that systems provide support for people with disabilities to exercise their legal capacity – in this case, to sue and be sued.

The law needs to change so that the question is not "can the person participate alone without any help in court proceedings?" but "What supports need to be put in place for the person to participate in court proceedings

5. Ownership of Data

The Data Protection Act 2019 denies persons of unsound mind to hold their data against Article 12 of the CRPD.[11]

6. Land Ownership

Article 12(5) provides for the right of people with disabilities to own and inherit property, including land. The Land Registration Act 2012 did not make substantial changes. A person "of unsound mind" is treated as a child. Both are prohibited from dealing with or having an interest inland. Guardians can act on behalf of a person deprived of their legal capacity

Article 12(3) of CRPD requires States to ensure that law provides access to support to people with disabilities who may need it to exercise their legal capacity. States should also create regulatory frameworks to address situations where, after all, efforts are made, an individual's wills or preferences cannot be ascertained. In these rare cases of last resort, there should be an option to facilitate decision-making (appointing an outside decision-maker) when support has been exhausted. Kenya being a signatory of the convention should follow suit in supported decision-making; a support person never makes decisions for, on behalf of, or instead of the person with a psychosocial, intellectual or cognitive disability. All forms of support, including the most intensive, must be based on the person's will and preferences.

The person's will and preferences are different from what others perceive as being in their "best interest". In Kenya, the standard for deciding for a person is their best interest. This needs to change. When the person is unable to communicate their wishes and preferences directly, decisions must be made based on the best interpretation of the will and preferences of the person by, for example:

- referring to what is already known about the person;
- referring to planning documents containing the person's will and preferences;
- when nothing is known about the person/person unable to communicate wishes, staff must do their best to try to understand will and preferences

There is an urgent need to repeal and amend laws that tend to take away or limit the legal capacity of persons with psychosocial, cognitive and intellectual disabilities. The right to legal capacity seeks to address the historical lack of legal recognition provided to many people with disabilities, mainly including people with intellectual disabilities and people with psychosocial (mental health) disabilities.

It requires Kenya to take the lead in moving away from restriction and denial of the decision-making rights of people with disabilities ('substituted decision-making') towards ensuring their autonomy in all areas of life and the right to access support in exercising this.

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11. Data Protection Act No24of2019 http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/2019/TheDataProtectionAct__No24of2019.pdf

Article 25 states that persons should attain the highest standard of health and not be discriminated against through insurance provision. The Constitution advocates for this under Article 27 and 43 states that persons should; however it should be noted that many insurance companies do not cater for mental health services, and the Insurance Regulatory Authority (IRA) needs to include mental health services and make them mandatory on the health policies issued by the various insurance companies. In addition to this, the National Hospital Insurance Fund (NHIF) should include mental health services in their packages, and failure to incorporate this echoes discrimination. Kenya committed to this and therefore should work towards ensuring insurance companies provide mental health service.

The convention also provides persons with mental health disabilities to be termed as persons with psychosocial, intellectual and cognitive disabilities. However, legislations still contain disparaging language that violates the right of persons with disabilities to be treated with dignity and respect. Persons with mental health conditions face most of these derogatory terminologies, including but not limited to lunacy, insanity, unsoundness of mind, mentally retarded, mental incapacity, amongst others. The resulting consequences of these insulting terminologies include continued stigmatisation, discrimination and, as a whole, violation of the rights of persons with psychosocial disabilities. Some of the laws laden with derogatory terms are listed in the table below:

NO.	LAW	DEROGATORY SECTIONS AND TERMINOLOGIES
	Children's Act 2001	Part 1(2) "disabled child" means a child suffering from a physical or ***mental handicap*** which necessitates special care for the child. Section 55 (c) to have the child provided with appropriate medical treatment or professional counselling if the child's conduct is attributable to drug abuse or if the child is of ***unsound mind*** or is suffering from a mental illness. Section 95 (b) has left the jurisdiction of the court for an indefinite period, or is dead, or is incapacitated or has become of ***unsound mind***, or has been imprisoned or has been declared bankrupt.
	Constitution of Kenya, 2010	Article 83(1)(6)- (b) one is disqualified from registration as a voter if he/she is not declared to be of ***unsound mind***. Article 99(2) (e) one is disqualified as an MP candidate if he/she is of ***unsound mind***. Article 193(2)(d) one is disqualified from election as a member of a county assembly if he/she is of ***unsound mind.***
	County Governments Act No. 17 of 2012	Section 40(1) (e) removal of a member of the executive committee based on the physical or ***mental incapacity*** rendering the executive committee member incapable of performing the duties of that office.
	Criminal Procedure Code Revised Edition 2012(2010)	Section 162: Inquiry by the court as to the ***soundness of mind*** of accused. Section 163: Procedure where a person of ***unsound mind*** subsequently found capable of making defence. Section 166: Defence of ***lunacy*** adduced at trial.

	Elections Act No. 24 of 2011	Section 9: Where a person has been adjudged or declared to be of ***unsound mind***.
	Evidence Act (Cap 80) Revised Edition2014 (1989)	Section 125(2) A ***mentally disordered person or a lunatic*** is not incompetent to testify unless he is prevented by his condition from understanding the questions put to him and giving rational answers to them. Section 126*:* ***Dumb*** witnesses[1]
	Local Government Act Revised Edition 2010(1998)	Section 53C Any rules made by the Electoral Commission under sections 53, 53A, or 53B may, in order to permit any person who has been adjudged or declared to be of ***unsound mind***
	Marriage Act No. 14 of 2014	Section 12 (a) (ii) a marriage is voidable if either party was and had ever since remained subject to recurrent attacks of ***insanity***.
	Mental Health Act, No. 10 of 1989	Section 1(2) "person suffering from a mental disorder" means a person who has been found to be so suffering under this act and includes a person diagnosed as a ***Psychopathic*** person with mental illness and person suffering from mental impairment due to alcohol or substance abuse.
	National Land Commission Act No. 5 of 2012	Section 21: (a) Removal of the Commission Secretary owing to the inability to perform the functions of the office of the secretary arising out of physical or ***mental incapacity***;
	Penal Code Cap 63 (2012)	Section 12. ***Insanity:*** A person is not criminally responsible for an act or omission if, at the time of doing the act of making the omission, he is through any disease affecting his ***mind incapable*** of understanding. Section 255. Definition of kidnapping from the lawful guardianship-Any person who takes or entices any minor under fourteen years of age if a male, or under sixteen years of age if a female, or any person of ***unsound mind.*** Section 146: Any person who, knowing a person to be an ***idiot or imbecile***, has or attempts to have an unlawful carnal connection with him or her under the circumstances not amounting to rape, but which prove that the offender knew at the time of the commission of the offence that the person was an ***idiot or imbecile***, is guilty of a felony and is liable to imprisonment with hard labour for fourteen years.
	Persons with Disabilities Act 2003	Section 18(3) Special schools and institutions, especially for the deaf, the blind and the ***mentally retarded***
	Prisons Act 2009	Section 38. removal of prisoners of ***unsound mind***.

Therefore, there is a need to revise these terms and align them with the convention on the Rights of Persons with Disabilities.

4.0 KENYA'S REGIONAL HUMAN RIGHTS COMMITMENTS

Kenya has been a member of the African Union (AU) and its predecessor, the Organization of African Unity (OAU), since its independence in 1963. At the regional level, Kenya has ratified the following critical human rights Instruments.

4.1 The African Charter on Human and Peoples" Rights (African Charter)

The Charter was adopted in 1981 and came into force in 1986. This Charter expresses that all persons are equal and should not be subject to any form of discrimination and a shield against human rights violations. The Charter through a protocol under Article 34(6) provides for the establishment of an African Court where individuals and non-state Actors will seek remedies for human rights in the event domestic remedies are exhausted, an African Court of Justice similar to the International Court of Justice. Incorporation of some articles of the African Charter of Human and People's rights into the constitution, such as Article 49 and 50 on the right to arrest and a fair hearing additionally the provision for rights and freedom from torture and degrading treatment of a person. 12

In terms of promoting mental health, there are Constitutional rules on Human Rights violations that provide for the procedural ways of seeking redress from human rights violations, including when the right to health. It is not limited to persons with mental health illnesses as they can seek redress when their human rights have been violated.

4.2 The African Charter on the Rights and Welfare of the Child

Provides that every child should be allowed to enjoy the rights and freedoms in this Charter, regardless of race, ethnic group, colour, sex, language, religion, political or other opinions, national and social origin, fortune, birth or another status.

It also provides that every child who is mentally or physically disabled has the right to special protection to ensure his or her dignity, promote his self-reliance and active participation in the community. Kenya is committed to this and created the Children's Act 2001 as a point of reference that incorporates special giving treatment to children faced with mental illnesses and protecting them from any harm and any form of abuse. This is provided for under Section 119 of the Children's Act, and upon contravention, one is subject to imprisonment. Additionally, adding children into the vulnerable group's category in the Mental Health policy requires targeted mental health interventions.

Despite these provisions that advocate for the best interest of the child who has been diagnosed with mental health conditions, there is still rampant violations of the rights of children with mental disabilities or conditions. A recent case in point was Petition No. 23 of 2018; Rose Ajwang and (Kenya National Commission of Human Rights Commission (KNCHR) vs Holy Ghost Coptic Africa and seven others: [13]In this particular case, the Petitioners (Rose Ajwang and KNCHR) filed a petition against the Holy Ghost Coptic Church as the Petitioner. Rose's son was taken to church to be prayed for to cast out the demon that, in a real sense, is mental illness. However, during his stay in the church, he was flogged endlessly as a way of exorcism, denied food, and subjected to deplorable conditions. The court held that his rights had been violated as he had been removed from school. Therefore, his right to education had been violated. Additionally, it was also held that the child was subjected to physical, psychological and mental torture, which also falls under the ambit of human rights violation among children.

13. African Charter https://www.achpr.org/legalinstruments/detail?id=49

Therefore, to ensure that children with mental health conditions are accorded special protection, there is a need for civil society groups, Non-Governmental Organisations to create advocacy around mental health to reduce mental health stigma. Additionally, the National Council of Child Services that fall under the Ministry of Labor and Social Protection should ensure the Children Protection Officers are trained to protect children with mental health conditions and develop a system of accountability or place to avoid these rampant human rights violations.

4.3 The Protocol to the African Charter on the Rights of Women in Africa

States that the parties should ensure there is no discrimination against women and no degrading treatment towards them. Elimination of harmful cultural practices that interfere with their dignity; this is because women's vulnerability exposes them to a high prevalence of the mental disorder. Kenya has committed to this and through the Mental Health Policy 2015 – 2030. Women are included in the category of vulnerable groups for targeted mental health interventions. Additionally, Kenya has committed to this by outlawing cultural practices that are deterrent to mental wellbeing, such as Female Genital Mutilation (FGM), through the Prohibition of the Female Genital Mutilation Act 2011 [14]makes Female Genital Mutilation an illegal and retrogressive practice.[15]

5.0 NATIONAL COMMITMENTS ON HUMAN RIGHTS

5.1 The Constitution

Under Article 2(5), the constitution recognises the international law's general rules as part of Kenya Law and any treaty or convention ratified by Kenya as part of Kenya. Therefore, any treaty or convention ratified by Kenya is considered law in Kenya. One of the key instruments that safeguard the right to mental health in the United States convention on the Rights of Persons with Disabilities (CRPD). It seeks to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by people with disabilities, including persons with mental health conditions. Kenya has ratified the convention. Therefore, the government must meet all the convention's obligations on the Rights of Persons with Disabilities, including cost mental health plans and resource allocation, including human, financial, and technical and infrastructure for mental health services. Additionally, in 2015, Kenya joined the global community in endorsing the 2030 Sustainable Development Goals (SDGs). The goals obligate the states to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing[16]

Furthermore, the constitution recognises the right to health as a fundamental economic, social and cultural right, and this has been stipulated under Article 43 of the Constitution. Article 43 of the Constitution states that 'Every person has the right to the highest attainable standard of health, including the right to health care services, including reproductive health care. Mental Health is not an option concerning this provision. The highest attainable standard implies that certain key elements must be in place.

Under General Comment No.14 on the interpretation of the right to health means that the services should be Available: there should be functioning public health care facilities, goods, services and programs, accessible, the facilities, services and programs must be accessible physically, economically and information must be available to all without discrimination, Acceptable; the facilities, goods and services must be respectful of medical ethics, culturally appropriate and sensitive to Gender. Despite adopting and domesticating these provisions in our constitution, Kenya still lags behind inadequate investment and policy framework despite its high commitment level.

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14. Genital Mutilation Act 2011 http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProhibitionofFemaleGenitalMutilationAct_No32of2011.pdf
15. Protocol to the African Charter on the Rights of Women in Africa https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf
16. Constitution of Kenya, 2010 http://kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=Const2010

5.2 The Mental Health Policy 2015 – 2030

Through the Ministry of Health, the National Government came up with Mental Health Policy 2015-2030 [17]as a basis for the legal framework. The Policy Document addresses Human Resource Development, Financial Resources, creation of a Mental Health Information System, Infrastructure, and Advocacy and Partnership matters. The document itself is a gold mine, but there has been little or lack of implementation, therefore maintaining the country's mental health sector's status quo.

The Mental Health Policy's rationale is to ensure that organisation of mental health services will be as per the constitution where the National Government shall be responsible for health policies, capacity building and offer technical assistance to the counties; the counties will be responsible for county mental health facilities and ensure an effective mental health referral system.

The policy further states that the ministry is tasked with establishing a Mental Health Directorate and Substance Abuse to provide overall leadership and coordination around mental health matters. However, this particular policy point is yet to be implemented at the National Level. We currently have the Division of Health, which still falls as a Department under the Ministry of Health. Implementing this policy point is critical. It will elevate mental health status from being a mere department within the Ministry of Health to being an independent institution, viable for adequate budgetary allocation. Additionally, the policy points out other important aspects, such as integrating mental health response to national disasters and disease outbreaks, which are incredibly relevant and timely due to the emergence and spread of the COVID-19 pandemic.

In March 2020, when COVID-19 was declared a global pandemic and brought the country to a standstill. The National Disaster Response Plan, the Kenyan government's blueprint for disaster management, has operationalised objectives relating to mental health. However, some objectives are not specific to the COVID-19 context (for example, the plan emphasises the need to ensure access to social activities such as religious activities and schooling), limiting its applicability during the current pandemic. Therefore, through its Division of Mental Health, the Ministry of Health has embarked on efforts to deliver mental health care during the pandemic, which is also a policy point under the Mental Health Policy. This was achieved by creating COVID-19 rules and guidelines to create a mental health response during the pandemic. Some of them include:

- Psychological First Aid (Psychological First Aid) guide for COVID-19 response in Kenya, the guide states that PFA can be offered wherever it is safe. This is often in; Community settings, places where distressed people need assistance, such as hospitals or quarantine areas. The guideline also states how persons of all age groups, persons with mental health conditions can manage stress and anxiety during the COVID-19 pandemic

- A comprehensive guide on Mental Health and Psychosocial Support during the COVID-19 pandemic.

This guideline was developed to ensure effective management of mental health during this COVID-19 pandemic. It came into effect on 1st April 2020. It was a comprehensive guide on Mental Health and Psychosocial Support during the COVID19 pandemic, covering the needs of the population, people on treatment for COVID -19, those in quarantine and isolation, people with mental health conditions requiring continuing care in these settings, and health workers.

17. Mental Health Policy 2015 – 2030 https://publications.universalhealth2030.org/uploads/Kenya-Mental-Health-Policy.pdf

It aimed to acknowledge that feeling stressed was a typical response in this abnormal situation, educate on what the signs of stress are, educate on how to cope with the stress of COVID-19. Additionally, it covered the general population, those in quarantine/isolation centres and persons with mental health conditions.

i) Standard Operating procedures for psychological counsellors and psychologists providing MHPSS for the COVID-19 response in Kenya, 2020.

The purpose of having these Standard Operating Procedures is to ensure that all the counsellors and psychologists involved in mental health response resulting from COVID-19 were for applying uniform processes and procedures while delivering services. The Standard Operation Procedures were divided into sections addressing various aspects of the intervention, namely:

1. COVID-19 information on-boarding
2. Reporting/linking with the site official in charge, reporting structure
3. Relevant safety procedures, use of technology in the MHPSS
4. Documentation requirements
5. Ethical considerations
6. Identifying and contacting clients, delivering intervention protocol
7. Referral network
8. Clinical supervision
9. Self-care

ii) Public Mental Health Education during COVID-19 pandemic 2020

This was a document /guideline developed by the Ministry of Health to educate persons on various aspects of mental health during the pandemic, such as:

1. Ways in which COVID-19 affects mental health
2. Ways to identify one's mental health is being affected as a result of the pandemic.
3. Ways in which one can stay mentally healthy during the pandemic.
4. How to reduce stigma against persons who have or are suffering from COVID-19 and their care-givers.
5. How children, adults, bereaved persons and persons with mental health conditions can cope during this time.

iii) Interim guidance on continuity of Mental Health Services

The guidance addresses the following areas:

1. Continued management of stable patients on follow-up as outpatients
2. Continued surveillance of patients already admitted in the psychiatric wards
3. Admission of patients with existing mental disorders who have relapsed
4. Admission of patients with newly diagnosed mental disorders
5. Management of patients who test positive for COVID-19 with mild to moderate
6. Psychological distress but not meeting criteria for a significant mental disorder
7. Diagnosis.
8. Provision of a clear path to care and/or referral for patients with co-morbid mental disorders and COVID-19.
9. Guidance on telepsychiatry; maximising on use of digital and online channels
10. This guidance also guides healthcare managers through the COVID-19 pandemic to ensure that they can
11. Support healthcare facilities to maintain essential services during the COVID-19 outbreak

12. Give practical solutions to challenges facing the provision of healthcare services during the COVID-19 outbreak
13. Monitor essential health service provision throughout the COVID outbreak
14. Communicate appropriately to health care workers and the public regarding access to standard health services.
15. These are the guidelines created by the Ministry of Health. However, there is a need to ensure there is the maximum implementation of these policies and also to ensure that they are integrated with the COVID-19 response as mental health has been a looming crisis during this COVID-19 period

Other recommendations include: Establishment and integration of mental health into the disaster management teams, protection of vulnerable groups against the impacts of a disaster or emergency, and the vulnerable groups stipulated in the policy include children and adolescents, women, older persons and prisoners. The counties were accorded responsibilities that were deemed as priority areas. These included ensuring mental health inclusion in the County Integrated Development Plans (CIDP), Strategic Plans and Annual Implementation Plans, Resource mobilisation, monitoring and evaluation and capacity building, and technical assistance for implementing the policy.

The Mental Health policy 2015 – 2030 is indeed an informed guideline on Mental Health and can make radical changes within the mental health sector. However, the Ministry of Health admitted that the policy document had not been fully implemented. The ministry, however, resolved to look into the implementation. In this case, civil society should act as a watchdog and hold the National Government accountable if this resolution is side-lined. This can be done through rigorous lobbying by Civil Society organisations and other stakeholders to ensure that Mental Health Policy 2015 – 2030 was fully implemented.

5.3 The Mental Health Act, 1989

The Mental Health Act No. 10 of 1989 repealed the British's English Mental health Act 1959 during the colonial era. The Mental Act No.10 of 1989 is the main piece of legislation that handles matters of mental health

The Current Mental Health Act No 10. Of 1989, it has never been fully implemented due to its lack of political will and poor budgetary allocation. The act introduces the medical model of mental health. It heavily focuses on institutionalisation as the main course of treatment when one is perceived to have a mental disorder or condition. The act also brings out some aspects that qualify as human rights violations, such as involuntary confinement, where one is hospitalised against their will. This goes against the convention on the Rights of Persons with Disabilities. Therefore there has been a rallying call to repeal the law in its entirety as a piece of legislation. This is because the Mental Health Act mirrors the English Mental Health Act of 1959, retrogressive and does not the human rights-based approach. As provided by the Quality Rights Initiative.

Additionally, the act is not in tandem with the new constitution. An example is that the show provides for establishing district mental health councils, and the constitution introduced county and national governments. Another example is that in recent years, the CRPD and various human right conventions have been ratified and require to be adopted and be streamlined in our laws; therefore, making peace meal amendments on this particular piece of legislation will not be viable.

The Mental Health Act, 1989 should be relevant. It should incorporate a human rights-based approach and be in line and promote the constitution's national values and principles under Article 10, including human dignity, inclusiveness, equality, human rights, and non-discrimination and protection of the marginalised.

5.4 The Health Act 2017

The Health Act assented on 22nd June 2017. The Health Act's purpose was to establish a unified health system, coordinate the interrelationship between the national government and the county government systems, and provide for the regulation of health care service and health care service providers, health products, and health technologies for connected purposes.

The Health Act 2017 recognises the need to develop separate mental health legislation, which the Division of Mental Health endorsed the development of all-encompassing mental health law.[18]

5.5 The Mental Health Amendment Bill 2018

The 'Mental Health Amendment Bill, a Private Members Bill, 'was introduced to the Senate to repeal the current Mental Health Act of 1989. [19]The Amendment Bill was a breath of fresh air compared to the current Mental Health Act of 1989. The Bill deviates from the aspect of institutionalisation that is heavily objectified in the Mental Health Act 1989. The Current Amendment Bill seeks to introduce a human rights-based approach as stipulated by the CPRD, and The United Nations Resolution 32/18 recognises the need for States to take active steps to fully integrate a human rights perspective into mental health and community services with a view of eliminating all forms of violence and discrimination within and to promote the right to everyone to full inclusion Some of the rights of persons of mental health conditions stipulated in the Bill include participation in treatment planning, suitable to supported decision making among others. It also establishes County Mental Health Councils to look into mental health matters and establish a Mental Health Board at the National Level. It prioritises other services, i.e., community health, outpatient and primary mental health care against institutionalisation drafting of this Bill and its memoranda involved various stakeholders such as Civil Society Organisations, which ensured it followed the human rights-based approach. The Bill has made tremendous progress as it has already been passed at the Senate and gone through Public Participation on the National Assembly.

The Bill was converted to a money Bill (A Money Bill is a Bill that contains provisions dealing with taxes; the imposition of charges on a public fund or the variation or repeal of any of those charges; the appropriation, receipt, custody, investment or issue of public money; the raising or guaranteeing of any loan or its repayment. A Money Bill can only be introduced in the National Assembly). To rid this mentality, Civil Society Organizations should engage the National Government through the Ministry of Health to have further deliberations around the mental health's social determinants to develop an integrated model, not to dwell on the bio-medical model. The Current Bill in Parliament, The Mental Health Amendment Bill 2018, maybe a good start. However, it is a Money Bill it may take a bit longer to be enacted and assented to unless there is a change in attitude by the political class. Therefore, civil societies need to speak in a unitary voice and develop a bill that will be watertight and incorporate all the determinants of mental health

5.6 The Mental Health Task Force Report

The President gave a directive resulting from the BBI (Building Bridges Initiative) in November 2019 for a task force to look into mental health policies and laws. On 11th December 2019, a task force was formed by the Cabinet Secretary of Health.

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18. The Health Act 2017: http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf
19. The Mental Health Amendment Bill 2018 https://ilakenya.org/the-mental-health-amendment-bill-2018/#:~:text=The%20purpose%20of%20this%20Act,the%20incidences%20of%20mental%20illnesses

The task force conducted public hearings from 13th January – 27th January 2020, both at the National and County Levels. The Taskforce, in the conduct of its duties, reviewed existing literature on mental health in Kenya and the global context, and also received memoranda and met Kenyans across the country to listen to what they thought were the priority mental health problems in the country and provide ideas on the potential solutions. As a result, the Mental Health Taskforce Report[20] was launched on 7th July 2020. Some of the significant recommendations in the Task Force Report included:

1. Mental Health Literacy is incorporated in curricula at all levels of education from schools, colleges and universities, and similar programs designed and implemented in the community
2. Promote mental health and wellness in families and communities through community health and wellbeing programs.

In August 2020, Civil Society Organizations wrote an advisory on the Taskforce Report, and there were positive and negative findings. The positive findings included:

1. Legislative reform to among other things, decriminalises suicide, amend and align the Mental Health Act, 1989 with the convention on the Rights of Persons with Disabilities, and the Committee on the Rights of Persons with Disabilities' Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities, the Right to Liberty and Security of Persons with Disabilities
2. Removal of derogatory language used about persons with mental illness or persons with psychosocial or intellectual disabilities.
3. Establishment of programs to address mental health needs of children, youth, refugees, women, prisoners, disciplined forces, sexual and gender minorities and survivors of sexual and gender-based violence. We especially welcome recommendation tasking the national and county government health ministries and departments to integrate mental health services with prenatal and ante-natal care.
4. Mental health financing calling for an increase in public funding for mental health to reduce out of pocket expenditure, provision of mental health services under the universal health coverage benefits package and provision of social security and
5. Protection for persons with psychosocial, intellectual or cognitive disabilities. Decentralising and integration of mental health services in general health facilities. Which are people-centred, recovery-oriented with a human rights-based approach.
6. Awareness creation on mental health, especially recommendations on the inclusion of mental health curriculum in school learning Programme and establishing community preventive programs to train community health workers, community and peer groups.

20. Mental Health Taskforce Report https://mental.health.go.ke/download/mental-health-and-wellbeing-towards-happiness-national-prosperity-a-report-by-the-taskforce-on-mental-health-in-kenya/

Recommendations were addressing the social and cultural determinants of mental health. Some findings five issues were included in the findings that required further actions, these were:

1. The deprivation of liberty of persons with mental illness or persons with psychosocial or intellectual disabilities;

2. The establishment of Special Courts to screen and link to care special needs offender with mental health conditions; further aggravates the element of negative discrimination. Inclusion for persons with mental health conditions or persons with psychosocial or intellectual disabilities means providing services within the society's existing frameworks. The spirit of the convention on the Rights of Persons with Disabilities builds a solid and resilient community by respecting human beings' diversity. Therefore, creating mental health courts goes against this spirit, and it is an expression of segregation and exclusion from mainstream society.

3. The establishment of the National Mental Health and Happiness Commission; which requires a constitutional amendment. There are ongoing efforts to amend the Mental Health Act with a proposal to entrench the role of County Governments in the provision of mental health services and the establishment of a Mental Health Board with a mandate to, among other things, advise the government on the state of mental health and mental health service delivery in Kenya. It is noteworthy that the commission's proposed functions and that of the current Mental Health Board are overlapping to provide advice and regulation in the sector. The Mental Health Board has critical statutory functions essential in ensuring a rights-based approach to Mental Health.

4. The involvement of persons with lived experiences, persons with disabilities, cares givers and their representative organisations as they tend to be segregated.

5. These groups' participation and involvement are essential to ensuring a people-centred, recovery-oriented and human rights-based approach to the realisation of mental health care. The consultation and participation should be done through a meaningful framework that deliberately identifies and addresses barriers that prevent persons with lived experiences, persons with disabilities and their representative organisations from meaningfully participating in all structures set up to implement the report's findings.

The representation here is that Kenya lacks a comprehensive legal framework that addresses strictly mental health and intersects mental health issues and the law. Primarily excluding marginal mentions of mental health and mental wellbeing in pieces of legislation. The following form the concrete statute books that address to a reasonable extent mental health and wellbeing:

1. Mental Health Act No. 10 of1989,

2. Penal Code 2012, and

3. Criminal Procedure Code.

This can be attributed to the side lining of mental health and lack of consideration of government policy's mental health issues, lack of comprehensive and periodic legislation review. An example would be the Penal Code that criminalises suicide attempts is an urgent need to repeal the provision. There is also a failure in the governance system and governance structures resulting in a lack of data and information on mental health and wellbeing in the country

Therefore, instead of having legislation that intersects and cuts across mental health issues, such as the Persons with Disabilities act, there is a need to create mental health legislation that solely addresses mental health and the institutions established around it to develop autonomy and structure for proper budgetary allocation.

6.0 CONCLUSION

The Global, Regional and National Commitments towards Kenya's Mental Health are fundamental in ensuring that Mental Health Rights are achieved to avoid harmful discrimination of persons with psychosocial, cognitive and intellectual disabilities. In essence, these commitments are meant to remedy the ills and human rights violations perpetrated on persons with psychosocial, intellectual and mental disabilities to reclaim their dignity and enable them to be integrated with society and participate in all aspects of life.

It is not enough to incorporate the various commitments in Kenya's policies and legislative framework. There is a need to ensure that they are fully implemented and their outcomes assessed. This will provide accountability and transparency to ensure what is drafted on paper is brought to life as Kenya is good at developing a myriad of legislations and policies but very poor in their implementation. For example, the Mental Health Policy 2015-2030, despite its completion in 2015 it was not until 2019 when it was officially launched in the country. The policy is progressive and incorporates all the side-lined aspects of mental health that require prioritisation, such as an increase in human resource for mental health, the need for mental health financing as the sector is underfunded, the incorporation of alternative mental health practitioners. Yet, this policy is to be implemented. There is a need to call to action implementation of this policy to drastically revive the mental health sector and make it more functional.

There is also a need to enact comprehensive legislation around mental health. Legislation precedes investment or funding. Lack of legislation on mental health undermines investment. Therefore, there is a need to ensure that the Mental Health Amendment Bill 2020 that was recently re-introduced to the Senate gets enacted by Parliament. This calls for immense lobbying by the Mental Health Stakeholders to ensure Parliament passes the Bill. Also, the public should be mobilised to provide their views during the public participation forums organised by the Assembly.

There is a need for equity when it comes to access to mental health services. An example is the inclusion of mental health in insurance packages by the NHIF and the UHC Packages to curb discrimination which is a contravention to the Constitution and Articles within the Convention on Rights of Persons with Disabilities (CRPD). To achieve mental health financing under UHC, a defined set of mental health conditions and interventions should be explicitly recognised and included in the essential list or package of health benefits offered to all citizens by the county and national government. With regard to NHIF, following the draft budget policy statement 2021/2022, there was an increase in the amount allocated towards households to Ksh 6,000 per household on mental health. This is commendable. However, the National Hospital Insurance Fund requires taking an additional step to list further the mental health care services catered for by the NHIF.

Additionally, the President's Executive Order on 12th November 2020 upgraded Mathari Teaching and Referral Hospital to a semi-autonomous institution transformed into a state-of-the-art facility. Further, there will be regional facilities in sync with Mathari Teaching and Referral Hospital that will curb the barrier of limited access to mental health care services within the counties and the country. Furthermore, Mathari Hospital's status as a semi-autonomous institution will enable it to have funds channelled directly, avoiding the bureaucracy of having to go through the Ministry of Health; this will tremendously improve the standards and quality of mental health care services.

Finally, there is also the need for periodic reviews of these international, regional and national commitments to prevent other forms of human rights violations in terms of mental health and devise new ways around mental health policy advocacy, revision, amendment and development of mental health policies, legislation and Standards & guidelines that uphold human rights in the delivery Mental health services.

7.0 RECOMMENDATIONS

Kenya is deemed to be excellent with regard to the drafting of legislation. However, implementation is where the challenge is considered to be. However, some of the recommendations that suffice include:

1) Aligning Kenya's policy and legal framework to the Convention on Rights of Persons with Disabilities and all the other conventions that have been ratified and formed part of Kenya Law concerning mental health will go a long way in ensuring progressiveness in terms of mental health.

2) Lobby around the passing of the Mental Health Amendment Bill 2018 that has been re-introduced to the Senate.

3) Implementation of the Mental Health Policy 2015-2030, the Community Health Strategy 2020 and the COVID-19 policies that emphasise mental health have neither been initiated nor operationalise.

4) There should be advocacy by civil society groups and other mental health stakeholders on the commitments, policies and legislation around mental health.

5) Health is slowly becoming a devolved function. Therefore, there is a need for the national & county Governments to establish mental health facilities in every county to remedy the barrier to access to mental health services. Mental health Advocacy should take a multi-sectoral approach to ensure that every sector develops policies to curb the stigma associated with mental health. Lobby for setting a funding quota for mental health within the existing health Budget at the national and county level.

6) Urge the Inclusion of Expanded Mental health Services in the basic package of NHIF cover and, where possible, a waiver for all extreme cases of mental health cases that seek care in Government health facilities.

(Footnotes)
1. Evidence Act (Cap 80) Revised Edition2014 (1989) http://research.tukenya.ac.ke/images/downloads/Evidence_Act_Cap_80_of_1963.pdf

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