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Mental Health in Kenya: Tensions Between Human Rights Approaches and Colonial Care

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ABSTRACT *The mental health situation in Kenya has been termed a silent epidemic threatening the mental wellbeing of the population. Deeply entrenched stigma and discrimination is systematic and directly influences access to mental health care, human rights violations, and social exclusion. Despite commitments to improve mental health care infrastructure, the ongoing impact of colonization perpetuates biomedical responses to mental health. Kenya ratified the* UN Convention on the Rights of Persons with Disabilities (CRPD) *in 2008 though mental health, criminal, and civil laws continue to be in violation of the Convention. We take a human rights and equity lens to critically analyze the biomedical dominance in mental health policy and practice. We employ an intersectional analytic framework to contextualize experiences of mental health injustices and apply aspects of an Intersectionality Based Policy Analysis Framework to the Ministry of Health's* Kenya Mental Health Policy 2015-2030 *(2015) and the Ministry of East African Community (EAC) Labour and Social Protection's* National Plan of Action on Implementation of Recommendations made by the Committee on the Rights of Persons with Disabilities *(2016) to explore how policy discourses influence understandings of mental health and responses. We analyze a*

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disjuncture between human rights and social determinants framings of mental health in policy, and how a default to western biomedical solutions for addressing mental distress dominate institutionally and in practice. We urge the Kenyan government to abolish coercive mental health practices, remove systemic barriers that hinder participation, and establish supports to empower people with psychosocial disabilities and their organizational representatives (USP-Kenya) to ensure mental health responses are consistent with international human rights treaties.

Introduction

Deeply entrenched stigma and discrimination portray persons with psychosocial disabilities as burdens and curses to Kenyan society (KNCHR, 2016).[1] This influences access to mental health supports and care, and fosters an environment that encourages human rights violations and social exclusion. The Ministry of Health (2020a) has called the mental health concerns of the Kenyan population a "silent epidemic" resulting from years of neglect of mental health services, which threatens national development and requires "new, innovative, and appropriate approaches" to speak to the "magnitude of the problem" (p. 2). Neglect of resource provision for mental health care is evident in mental health financing where only 0.01% of the Kenyan Government's health budget goes to mental health (Ministry of Health, 2020a; Ministry of Health, 2021b). The funds that go to mental health care go almost exclusively to inpatient hospital care, which is itself inadequate with most care provided in one specialized hospital (Mathari National Teaching and Referral Hospital) and in general hospitals in big cities (Ministry of Health, 2021a). Kenya has no comprehensive government funded community based mental health care and within the public health sector only one percent of government owned health facilities provide mental health care (Ministry of Health, 2021a). Systemic discrimination through the exclusion of mental health care from medical insurance schemes has meant that persons with psychosocial disabilities must pay out-of-pocket for treatment; consequently 75% of Kenyans are unable to access mental health care (Ministry of Health, 2020a). The result is that support for people with psychosocial disabilities is primarily left to family members in the community.

The history of colonization in Kenya endures in mental health legislation and governance, including adherence to western biomedical framings of mental distress over traditional African knowledges and Indigenous practices. In an attempt to improve the problematic state of mental health care, President Uhuru Kenyatta issued an Executive Order in 2020 to elevate Mathari National

[1] In this paper we have chosen to primarily use the term "psychosocial disability" in line with the language used in the UNCRPD and because it is favoured by disability and mental health advocates in Kenya. However, we recognize that people with lived experience of mental distress identify themselves in a variety of ways (e.g., as psychiatric survivors, mental health consumers, service users).

Teaching and Referral Hospital to a semi-autonomous national mental health hospital named the East Africa Premier Mental Health Facility (Kenyatta, 2020). Very few people access Mathari hospital due to the centralization of public mental health services in Nairobi which limits accessibility for many people living outside the capital (KNCHR, 2011). The President's choice to only bolster medical-based responses to mental ill health, improving bed capacity and hospital infrastructure, ignores the overlapping and intersecting social determinants of mental health that if not addressed by social policy create specific disadvantages for populations who experience inequities such as poverty, gender discrimination, and violence (KNCHR, 2011; Ministry of Health, 2020a).

The *Convention on the Rights of Persons with Disabilities* (CRPD), ratified by Kenya in 2008, aligns with Kenya's constitution by reframing mental health needs in the context of human rights, addressing "issues of discrimination, torture, social and economic justice, access to health, and education for the largest minority in the world: the disabled community" (Ibrahim, 2017, p. 130). Kenya, however, did not ratify the Optional Protocol to the Convention,[2] which means that there are no formal mechanisms through which to monitor progress related to the Convention, although monitoring can be taken up voluntarily (KNCHR, 2016). Through its *Mental Health Act*, Kenya still allows for the use of involuntary detainment and treatment, and other forms of coercive practice that are clearly in violation of the Convention (Ibrahim, 2017). Grassroots organizations, like Users and Survivors of Psychiatry Kenya (USP-Kenya),[3] have thus been pivotal in actively resisting violent and coercive practice in mental health and advancing the rights of persons with psychosocial disabilities (USP-Kenya, 2020a).

This paper is situated in broader discussions of human rights and equity in mental health care that aim to expose and challenge biomedical dominance in mental health policy and practice, which has traditionally excluded people with lived experience in the planning of their care and has overlooked the use of violence in the formal mental health system. We argue that holding policies accountable to obligations within international human rights conventions, bolstering the involvement of people with lived experience in policy development, and improving collaboration between western and African derived forms of service delivery can reduce care gaps and advance equity. We use intersectionality, which understands experiences of mental health as embedded in broader social and political contexts (Halinka-Malcoe & Morrow, 2017; Josewski, 2017), as our analytic framework. Intersectional frameworks

[2] The Optional Protocol was proposed as a means in which the Committee on the Rights of Persons with Disabilities could oversee alleged violations of the Convention by a State party (KNCHR, 2016). Canada and 99 other states parties have signed on to the Optional Protocol (Library of Parliament, Canada, 2021).

[3] USP-Kenya is affiliated with the World Network of Users and Survivors of Psychiatry and its African affiliate the Pan-African Network for People with Psychosocial Disabilities (formerly PAN-USP).

understand oppressions and privileges based on social locations such as race, gender, class, and ability as overlapping and intersecting:

> When it comes to social inequality, people's lives and the organization of power in a given society are better understood as shaped by not a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. (Hill Collins & Bilge, 2016, p. 2)

Intersectional methodology can therefore provide more attuned ways of contextualizing experiences of mental health injustices (Josewski, 2017). We apply aspects of an Intersectionality Based Policy Analysis Framework (IBPA) (Hankivsky, 2012) to the Ministry of Health's *Kenya Mental Health Policy 2015-2030* (2015) and the Ministry of East African Community (EAC) Labour and Social Protection's *National Plan of Action on Implementation of Recommendations made by the Committee on the Rights of Persons with Disabilities* (2016), to explore how policy discourses influence understandings of mental health and engender particular responses. Key principles of IBPA include attention to diverse knowledges, social justice, equity, intersecting social categories, resistance and resilience (Hunting et al., 2015). IBPA applies a set of flexible descriptive and transformative questions grounded in the key principles of intersectionality to better understand how social problems are framed and the implication of this framing – for example, what is the policy "problem" under consideration? How have representations of the problem come about? and how are groups differentially affected by this representation of the problem? (Hankvisky, 2012). Using these questions as analytic entry points, in our analysis we expose a disjuncture between human rights and social determinants framings of mental health in policy, and the reality for Kenyans in their communities, and illustrate how a default to western biomedical solutions for addressing mental distress continue to dominate institutionally and in practice. We conclude with a discussion of how intersectional and human rights frameworks and the support of organizations that are led by people with lived experience can enhance equity and social justice.

Colonial Histories: The Shaping of Mental Health Legislation, Policy, and Practice

Colonialism and its Social Legacy

We begin with a brief history of colonialism in Kenya and its impact on current laws and policies as colonialism is a key factor in intersectional approaches and in the perpetuation of biomedical dominance. In many countries in Africa, laws pertaining to mental health and discourses around psychosocial disability have been inherited from colonial governments that sought to control African populations as a means to protect white settler rule (Ibrahim, 2017, p. 113). Indeed, psychiatry and western medicine have played an active role in the

colonial project through the oppression and racialization of Africans (Ibrahim, 2017, p. 115). This is evident through the Kenyan legislative framework spanning from the *Lunacy Act* of 1910 to the *Treatment Act* of 1949, later repealed by the *Mental Health Act* of 1989 (Ministry of Health, 2020a). In 1895, Kenya became a British colony and up until the mid-1960s adhered to British colonial medical practice (Njenga, 2002). Through false scientific grounds Africans were pathologized to be "less intelligent and mature than their white counterparts" and as such were rationalized to be inferior to them "as colonial subjects, servants, labourers, and slaves" (Ibrahim, 2017, p. 116). Likewise, legislation such as the *Witchcraft Suppression Act*, restricted and punished those practicing and using African healing systems (Luongo, 2011) and even "lethally suppressed" "freedom fighters" as a means of "colonizing and depriving Africans" of their own "cultural healing and educational systems" (Ibrahim, 2017, p. 119; Luongo, 2011). Mathari, the only national psychiatric hospital, stands as a stark reminder of this colonial history. Initially built in 1910 as a smallpox isolation centre and later used to serve colonial armed soldiers during the First and Second World Wars who had become "mad," it was eventually converted into the "Nairobi Lunatic Asylum," where pathologized "natives," who formed more than 95% of the inmates, lived in grossly overcrowded bomas (or livestock stockades) while slightly better conditions were reserved for Indian patients, and the best for the European population (KNCHR, 2011; Ministry of Health, 2020a; Njenga, 2002).

Discrimination has also been codified in laws that use derogatory language in reference to psychosocial disabilities; these include, the *Penal Code* (2009), in which section 226 criminalizes attempted suicide; the *Marriage Act* (2014) that excludes people suffering from psychosocial, intellectual, and cognitive disabilities from marriage; and the *Persons with Disabilities Act* (2003) (Ministry of Health, 2020a, p. 46; Ibrahim & Morrow, 2015). While the *Mental Health Act* of 1989 made attempts to de-stigmatize psychosocial disability by making care "less centralized" and "protecting the rights of people to request treatment," many provisions of the Act were not enforced (KNCHR, 2011, p. 19; Ministry of Health, 2020a). Furthermore, the 1989 Act focused primarily on in-patient treatment without stipulating procedural safeguards for such treatment (KNCHR, 2011). Neither the 1991 amendment to the Act nor the most recent amendment, Bill 2018, which is currently in the National Assembly (Ministry of Health, 2020a), take into consideration the perspectives of people with lived experiences of psychosocial disability, nor incorporate language to align the Act with national and international law, specifically the constitution and the UN CRPD. The implication is that the *Mental Health Act* still allows for forced treatment, the deprivation of liberty, and denies legal capacity for decision making for people with psychosocial disabilities. For example, sections 26 and 107 (the latter pertaining to children) of the Act allow for "guardianship" and "appointment of a manager to manage property on behalf of a person with disabilities" (USP-Kenya, 2018, p. 12). Although many people with psychosocial disabilities are not under formal guardianship, "the

substitute decision-making model that is prevalent is informal" (USP-Kenya, 2018, p. 12), such that family members and third parties can make decisions on behalf of the person with disabilities as if they were under formal guardianship. A consequence of substituted decision-making has been forced treatment, where often family members, ill-equipped to support their loved-ones, rely on consent from their relatives for treatment that is "acquired through duress, manipulation, coercion and/or domination" (USP-Kenya, 2018, p. 44).

While colonialism has definitively shaped the understanding and responses to mental health in Kenyan society, the Ministry of Health (2020a) found that "religious bias" and "deep rooted traditional and cultural beliefs" (p. 87) have also influenced experiences of social stigma. Examples include beliefs that people with psychosocial disabilities are "being punished, are bewitched, cursed, mad, dangerous and lack capacity to make decisions" (Ministry of Health, 2020a, p. 87). These beliefs can lead to the alienation of people suffering from mental distress and their exclusion from socio-cultural, economic and political decision-making opportunities, and in some instances can result in inhumane practices such as "ritual beatings" performed to "rid evil" (Ministry of Health, 2020a, p. 87).

Through an intersectional lens, psychosocial disability and framings of it are intertwined with colonialism and other experiences of marginalization. That is, the impact of psychosocial disabilities has been exacerbated by colonial legacies and is more keenly felt by people living in poverty, children and youth, women, refugees, prisoners, members of the armed forces, sexual minorities, people living with chronic physical illnesses, persons with disabilities, and survivors of gender-based violence (Ministry of Health, 2020a). Additionally, post-election violence, conflict between communities, loss of homes due to natural disasters like floods and mudslides, as well as the resettlement process of refugees or displaced persons, can cause further trauma and anxiety among those affected (Ministry of Health, 2020a).

In the Kenyan context, ethnicity and tribalism are also key factors that shape people's experiences of mental well-being and access to resources (Nyambura, 2017). In precolonial times, tribal belonging was not used in systematically oppressive ways. Tribalism in Kenya dates to the British colonial era (1920-1963) (Nyambura, 2017) when communities were played against each other, and thus tribal affiliation began to take on new meanings. Currently, majority ethnic groups have influenced who is elected, owing to their numerical advantage and this has led to other ethnic groups being marginalized when it comes to economic development, public service employment and access to natural resources (Nyambura, 2017).

Politics of African Knowledge

Alternative forms of care provided by traditional healing practitioners (THPs) have been found to reduce barriers to mental health care (Musyimi et al., 2016;

Musyimi et al., 2017). Indeed, 80% of people in South Africa report seeking traditional healers for their psychosocial health needs (Boum et al., 2021). The role of traditional health practitioners in low-resource settings increases accessibility and affordability of care and is seen as particularly effective in countering the untreated mental health effects associated with poverty as well as physical comorbidities in disadvantaged populations (Musyimi et al., 2017). However, the dichotomy of "modern" western versus "primitive" African knowledge (Ibrahim, 2017), introduced by colonialism, has produced stigma in which African education and cultural healing systems continue to be attributed to witchcraft or stereotyped as "dirty" by formal practitioners (Musyimi et al., 2016). Consequently, a mistrust exists between "formal" and "informal" practitioners who have historically operated in silos (Musyimi et al., 2016). For example, traditional health practitioners often refer patients to clinicians, but this is not reciprocated on the part of biomedical practitioners (Musyimi, et al., 2017) illustrating a serious rupture in care that could be ameliorated by building respectful collaborations and allowing Kenyans to make choices about the types of supports they access. While new services and supports are undoubtably needed, herein lies an opportunity to align existing services and develop new supports using intersectional and human rights informed frameworks.

Mental Health Resources

Reports over the last decade auditing the state of the country's mental health system have called on the government to fulfill the right to health through documentation of "infrastructure disrepair, inadequate human resources, and a lack of community integration" (Ministry of Health, 2020b, p. 29). Documentation of mental health resource deficits has engendered solutions that have primarily focused on building up medicalized services (hospital infrastructure and bed capacity) in lieu of community-based social supports. Much has been said and documented relating to hospital infrastructure. For example, Mathari, the largest psychiatric hospital in Kenya,[4] has been decried "as [a] century old monument of national shame" (Ministry of Health, 2020a, p. 2) for its inhumane and unsanitary conditions, which have changed little since 1910 (KNCHR, 2011). Mathari has been described to have poor quality of services, a lack of food, a lack of security, and limited availability of psychotropic medications (KNCHR, 2011; Ministry of Health, 2020a). Another example of crumbling mental health infrastructure can be found in Kisumu County Referral Hospital. Kisumu was assessed for compliance with the CRPD (using the World Health Organization's (2012) QualityRights

[4] Kenya has only one hospital dedicated to inpatient psychiatry (Mathari) but there are other smaller hospitals with psychiatric beds, for example, Port Rietz Hospital in Mombasa with about 80 beds.

toolkit) and the facility was found to be insufficiently meeting the requirements of the CRPD with standards of living reported as being "grossly inadequate" and rights of service users' to legal capacity, social inclusion, and health being violated (Ministry of Health, 2020b, p. 2). The assessment mirrors the previous audits of an under-resourced mental health system in serious violation of the human rights of Kenyans and international treaty obligations.

New investments to renovate Mathari hospital were announced in November 2020 and will help to resolve some of the concerns raised about hospital infrastructure. However, the current plan is to build a new hospital in a wealthy district which will further entrench biomedical approaches to mental health and ensure the inaccessibility of medical care to those who are marginalized through poverty and other social determinants of health. Indeed, the concentration of mental health resources in one hospital has produced inequities in mental health service provision, and attention needs to be turned towards providing supports at the community level that can address the social and structural determinants of mental health and allow people choices in the types of care and support they receive.

Policy Discourses and Their Effects

Introducing the Policies

Over the last decade, the Ministry of Health's *Kenya Mental Health Policy 2015-2030* (2015) along with the Ministry of EAC Labour and Social Protection's *National Plan of Action on Implementation of Recommendations made by the Committee on the Rights of Persons with Disabilities* (2016) have been developed in response to calls to reform mental health systems and service delivery in Kenya. The *Kenya Mental Health Policy 2015-2030* was developed in consultation with stakeholders and calls for a multi-disciplinary and inter-sectoral approach to its implementation (Ministry of Health, 2015). The Ministry proposes the establishment of a Directorate of Mental Health and Substance Use to provide institutional leadership and coordinated implementation of mental health policies (Ministry of Health, 2015). The roles and responsibilities of county governments is also clearly stated wherein county governments are responsible for including mental health in their strategic and implementation plans (Ministry of Health, 2015; Ministry of Health, 2020a). The Ministry was critiqued for lacking a mental health action plan (Ministry of Health, 2020a), so in June 2021, six years after its release, they put forth a five-year *Mental Health Action Plan 2021-2025* operationalizing the Policy's objectives for improving mental health in Kenya (Ministry of Health, 2021b).

A key related document which holds Kenya to its commitments under the *Convention on the Rights of People with Disabilities* and to addressing psychosocial disabilities is the *National Plan of Action on Implementation of*

Recommendations made by the Committee on the Rights of Persons with Disabilities (Ministry of EAC Labour & Social Protection, 2016). The National Plan addresses the recommendations made by the Committee on the Rights of Persons with Disabilities in relation to Kenya's initial report submitted to the Convention in April of 2012. The Plan establishes objectives, activities, indicators, and outputs informed by the Committee's recommendations and identifies the roles of State and non-State actors for implementation (Ministry of EAC Labour & Social Protection, 2016).

Soon after we began our analysis of these documents, the Ministry released the Taskforce's report on mental health in Kenya in 2020 and, as mentioned, the *Mental Health Action Plan 2021-2025* in 2021. The Taskforce was formed through a Cabinet directive in 2019 with a mandate to study the "increasing burden due to [mental ill health]" (Ministry of Health, 2020a, p. 2). The Taskforce provided evidence on mental health financing, discrimination and stigma, governance, policy, and legislation. The Taskforce's report along with the *Mental Health Action Plan* have been used to support our analysis of the latest mental health policies and plans in Kenya. While each document reflects a new reiteration of the problem, we challenge the gaps that remain in their respective representations.

In our examination of these key Kenyan policy documents – hereafter referred to respectively as the *Policy*, *CRPD National Plan of Action*, *Taskforce/ Taskforce's report*, and *Action Plan* – two key policy framings are evident. The first is that while mental wellbeing is understood in the documents to be influenced by a combination of social, political, economic, and biological factors, counter-discourse emerges in each of the documents that returns mental health to an individualized biomedical problem needing prevention, management, and control. As such, the solutions suggested focus on the use of western psychiatric practices and colonial-inflected laws like the *Mental Health Act*. The second is that although the problem of mental health is articulated as one of human rights there is a disjuncture between the framing and what is sanctioned through law and practice on the ground, revealing a misalignment with international and national human rights commitments. Particularly relevant is the lack of commitment to ensuring the leadership and involvement of people with lived experience in policy and program development and evaluation.

Colonial Remnants

Kenya's colonial history plays a role in how the problem of mental health is understood and the responses offered. It is clear in the policy documents that we examined that western psychiatric understandings of mental health are favoured over local Indigenous African knowledge systems. Faith-based care and traditional healing get very little airing in the *Policy*, forming only a very small section at the end of the document, where "enhancing positive

sociocultural practices" (Ministry of Health, 2015, p. 20) are discussed. And yet at present these forms of healing inform the bulk of grassroots support for people experiencing mental distress. The failure to more fully engage with these traditional supports misses a key opportunity to resist colonizing practices and embrace collaborative models of care that better integrate western understandings of mental distress with those rooted in diverse African experiences. The *Action Plan* recommends the "training of traditional practitioners, religious and community leaders on mental health promotion, prevention & advocacy" (Ministry of Health, 2021b, p. 58) with the aim of "integration of traditional practitioners, religious & community leaders into the mental health care and support system" (Ministry of Heath, 2021a, p. 58) as one of its "strategic actions towards promotive and preventive mental health" (Ministry of Health, 2021b, p. 3). However, it fails to provide indicators of how this activity and output will be monitored or measured; in fact, it is the only strategic action without indicators in the report. Meanwhile, the focus on training non-medical providers rather than encouraging the sharing of knowledge between care providers suggests a bias against the value that traditional practitioners, religious, and community leaders can offer. Colonialism is even more evident in the recommendations about where resources should be directed, that is, towards bolstering medical infrastructure, based on western psychiatry while ignoring the need for community-based resources to support traditional healing practices and to address the underlying systemic and structural causes of psychosocial disabilities. Implicit in the *Policy* is that Kenyans will unquestioningly accept western psychiatric models of care. Calls for decentralizing care are made in the *Policy*, which would provide much needed resources at the county level, and yet the mechanisms required to decentralize care and the funding needed to accomplish this are lacking. Indeed, resources continue to be targeted at existing hospital infrastructure, rather than at the community level, where transformative system change is more likely to occur.

Understanding Mental Health: Tensions Between the Social and the Biomedical

In examining how the policy problem of mental health is represented and discussed in the policy documents what emerges is that, while mental health is clearly positioned as an equity and human rights issue, this is juxtaposed with a default understanding of mental health as primarily a biological and clinical problem requiring rehabilitation. That is, while the social determinants of mental health are acknowledged, they are never fully integrated into an understanding of mental health that demonstrates its complex embeddedness in social arrangements of privilege and power, based on things like gender, age, sexual orientation, disability, ethnic affiliation and social status. This is evident within the *Policy*, which shifts between a broader understanding of the

impact of social and political events, such as "accidents and disasters as well as violence and conflicts," on cases of "suicide, homicides, and violence" (Ministry of Health, 2015, p. 9), and an understanding that reinforces a narrow biomedical framework based on the "burden" of "mental disorders" (p. 3).

The *CRPD National Plan* confirms the importance of social determinants of mental health through its recommendations in line with the CRPD, especially Article 9 on "accessibility" in which it makes reference to the role of "physical environments" in shaping access to care (Ministry of EAC Labour & Social Protection, 2016, p. 15) and Article 11 on "situations of risk and humanitarian emergencies" in which the protection of persons with disabilities in situations of risk is to be ensured (p. 17). The aim to have the CRPD fully implemented by 2022 required all governments to commit to a human rights and social model of mental health. However, as indicated in the *Policy* the tendency to individualize mental health is evident in the solutions and recommendations proffered for improving mental well-being. The strategies discussed reflect a biomedical understanding of mental illness that can be "solved" by bolstering hospital infrastructure and further investments in health, particularly "health products and technologies" which include access to drugs, better health information systems, and access to medical technologies (Ministry of Health, 2015, p. 16). To be sure, these recommendations hint at the need for broader system change, as do calls for resources, mental health promotion, education and intersectoral collaboration, and policy reform (Ministry of Health, 2015, pp. 13-19). What is absent however, is a fulsome accounting of how to address the diverse social determinants of mental health, and little is said about the structural factors that underpin the vulnerability of populations singled out in the documents (e.g., women, children and adolescents, older persons, prisoners and those surviving conflict and natural disasters) (Ministry of Health, 2015, pp. 19-20). Additionally, in the *Policy*, equity is often construed as synonymous with access to services: "the principle of equity is meant to ensure universal health coverage for all" (Ministry of Health, 2015, p. 6). In the *Policy*, services are envisioned as being "provided equally to all individuals in a community irrespective of their gender, age, caste, color, geographical location, culture, and social class. Focus should be on inclusiveness, non-discrimination, social accountability, and gender equality" (Ministry of Health, 2015, p. 6). While this is a laudable goal, the *Policy* does not adequately explore the root causes of inequities in mental health and mental health care and does not widen the definition of services to include those beyond hospital-based clinical care. This perpetuates reductive and stigmatizing ideas of mental distress as a problem of particular populations rather than the environments in which they live.

The more recent report from the *Taskforce* on Mental Health in Kenya (Ministry of Health, 2020a) does a better job in identifying populations that are disenfranchised because of their social locations, and illustrates the need for systemic change. Specifically, the *Taskforce* discusses the role of gender, age,

sexuality, migration status, and disability as key factors impacting mental health.

Mental Health as Human Rights: The Misalignment of Policy with Practice

There is a serious misalignment between the *Policy* and what is sanctioned in law and practice. In the *Policy* there is recognition that "persons with mental disorders often have their human rights violated, as a result of stigma and discrimination" (Ministry of Health, 2015, p. 2). The *Policy* describes how "persons with mental disorders" can be subjected to "unhygienic and inhumane living conditions, physical and sexual abuse, neglect, as well as harmful and degrading treatment practices in health facilities" (p. 2). Stigma and discrimination are linked to "prevent[ing] people from seeking mental health care" (p. 4). However, the *Policy* is said to be "managed in accordance with the overall *Health Sector Management and Coordination Framework*, *Mental Health Act* and other related Laws of the Republic of Kenya" (p. 2). This challenges the Policy's acknowledgement of violations of "civil and political" rights (p. 2), including the rights to marry and vote. These violations are entrenched in Kenyans laws that restrict rights to "personal liberty" and "legal capacity" (p. 2). As such, the current legislative frameworks in Kenya undermine the *Policy's* call to uphold human rights and puts Kenya in contravention of the CRPD. So, while the *Policy* frames mental health in human rights terms by embracing holistic and recovery-oriented practices that promote community inclusion, many of Kenya's laws are not in alignment with the Kenyan Constitution, including the *Mental Health Act* which allows for coercive practices (USP-Kenya, 2020b).

The *CRPD National Plan of Action* is designed explicitly to ensure compliance with the CRPD and therefore puts forth a framework consisting of recommendations in line with human rights (Ministry of EAC Labour Social Protection, 2016, p. 5). Despite these commitments, neither supported decision-making nor legal reforms in fulfilling human rights and fundamental freedoms of persons with disabilities have been realized (Ministry of Health, 2020a; USP-Kenya, 2020b). However, in establishing "national implementation and monitoring" of the CRPD (under article 33(1)), the *CRPD National Plan of Action* recommends the appointment of a "governmental body to be the focal point for the implementation of the Convention" along with "a national mechanism to monitor [its implementation] with the participation of the Kenya National Commission on Human Rights … [and] ensur[ing] the full participation of persons with disabilities and their representative organizations in the monitoring process, including by providing the necessary funding" (p. 31). If this recommendation was undertaken, it could support more transformative change and might therefore be embraced by "all stakeholders to take the disability sector in Kenya to the next level" (Ministry of East African Community [EAC] Labour and Social Protection, 2016, p. 6).

The contradictory policy positions in the Kenyan documents we reviewed reveal tensions related to the role of mental health systems in providing "social care" versus functioning as mechanisms of "social control." In turn this reflects a tension with respect to understanding psychosocial disability through a social versus biomedical lens, rather than an understanding that allows for the social and biological to co-exist and fundamentally interact. In the documents mental health care often becomes synonymous with hospital and clinical care, with little attention given to community-based supports and mechanisms to support persons with psychosocial disabilities to exercise choice in accessing care and support.

Involvement of People with Lived Experience

The *Policy* encourages "a people-centred approach" to mental health interventions in which "community involvement and participation" is key (Ministry of Health, 2015, p. 6). While the approach to implementing the *Policy* is identified as being participatory and people-centred, the *Policy* is elusive in how it plans to support the community, particularly people with lived experiences of mental distress and their caregivers, in sharing in the design, delivery and evaluation of mental health interventions (Ministry of Health, 2015, pp. 6, 14-15). The *Policy* appears to give a key role to people with lived experience by indicating that they should participate in "structures of governance and policy implementation" (Ministry of Health, 2015, p. 18). However, this appears to be over-ridden by also giving responsibility to the establishment of a Kenya Board of Mental Health to "provide critical oversight" in implementing the *Policy* (Ministry of Health, 2015, p. 21), and the Board does not include a designated position for a "user, consumer, or caregiver" (National Commission of Law Reporting, 2012, p. 6), effectively undercutting the role of people with lived experience.

Although people with lived experiences are discussed in the *Policy* as key participants in policy and governance structure (Ministry of Health, 2015, p. 18) they are also simultaneously linked to carers and family associations, which has the impact of muting their autonomous voices and knowledge bases. Thus, policy declarations in Kenya support the idea of the involvement of people with lived experience, however, the mechanisms to ensure their leadership in all aspects of mental health policy and practice development, including evaluation are lacking. This standard is one that is recommended by the World Health Organization (World Health Organization, 2022) and is arguably the only way to systematically address power imbalances within the mental health care system.

Discussion

Central to the IBPA framework is attention to power dynamics within policy discourses that shape lived experiences (Hankivsky et al., 2014). Evident in our examination of Kenyan mental health policy are the vestiges of colonialism manifest in the continued domination of biomedical approaches in the mental health and the failure to fully address oppression, human rights violations, and the restriction of personal liberties of people with psychosocial disabilities in Kenya. While the social determinants of health are found to contribute to the "adverse mental health status in the country" (Ministry of Health, 2020a, p. 74), investments in medical infrastructure and institutional care are prioritized over community-based services and traditional African healing practices. The discrimination and deprivation of liberty and legal capacity of persons with psychosocial disabilities enforced by mental health legislation furthers situations of dependency, where often the majority of persons with psychosocial disabilities live with their families (USP-Kenya, 2018) or are segregated in poorly run mental health care institutions.

Notwithstanding the current amendment at the National Assembly (which has not yet been gazetted), the existing *Mental Health Act* (1991) is not aligned with international human rights standards (CRPD) (Ministry of Health, 2020a). Lack of national, county, and sub-county mental health leadership and governance, as structures within the Act including the Kenya Board of Mental Health and District Mental Health Council were never operationalized, has "left mental health unattended as a priority public health and socioeconomic agenda" (Ministry of Health, 2020a, p. 78). The history of poor governance and the dominance of biomedical responses fail to take into account the context in which mental distress occurs in Kenya and the structural causes. For example, Kenya's report to the Committee on the Rights of Persons with Disabilities (2012) acknowledged "the majority of persons with disabilities live in extreme poverty" (United Nations Human Rights Office of the High Commissioner for Human Rights, 2012, p. 43) and yet poverty as a social condition underlying psychosocial disabilities is virtually ignored in the mental health policies reviewed (USP-Kenya, 2018).

Transformative Systems Change

Disability advocacy groups in Kenya, such as USP-Kenya (see footnote 3), have proved key in drawing attention to human rights abuses, and specifically to laws and practices that challenge the ability of persons with psychosocial disabilities to exercise their legal capacity (USP-Kenya, 2018). They have also worked to make visible the ways in which mental health policies ignore key practices that impact the lives of people with psychosocial disabilities; for example, raising awareness about substitute decision making and its implications for forced treatment (USP-Kenya, 2018). USP-Kenya's advocacy

resulted in this fact being recognized by the CRPD Committee in its concluding observations on the initial report of Kenya where it urged the country to eliminate and replace substituted decision-making with a system of supported decision-making (USP-Kenya, 2018, p. 13).

Advocacy organizations have also bolstered the role of peer support and explored the links between peer support and exercise of legal capacity by persons with psychosocial disabilities in Kenya (USP-Kenya, 2018). In their 2016 study on peer support and legal capacity, USP-Kenya (2018) found that there is both a direct link between peer support and the making of decisions that have legal consequences, and an indirect link in which peer support boosts agency and autonomy and in turn the exercise of legal capacity.

As watchdogs of government policy, both USP-Kenya (2020b) and the Civil Society Stakeholders Forum on Mental Health (2020) produced memoranda on reinforcing and strengthening recommendations put forth by the *Taskforce* (Ministry of Health, 2020a). These memoranda call upon the Government to implement measures connected to law reform, access to justice, participation and consultation, and service delivery and financing in line with the Constitution of Kenya and the CRPD. In supporting the *Taskforce's* recommendation for Parliament to amend and repeal discriminatory and derogatory laws (that hail from the colonial era) and ensure all laws affecting mental health conform with human rights standards, USP-Kenya (2020b) recommends legislation on a general law on legal capacity that is in "compliance with Article 12 and the General Comment No. 1 which reinforces people's rights to make their own decisions and to have those decisions respected by others" (p. 3). We agree with USP-Kenya that the Kenyan government must work towards the abolition of laws and policies that enable coercive and damaging practices like shackling, seclusion, and other restraints. In securing active and full participation of persons with psychosocial disabilities in matters affecting their lives, USP-Kenya also urges the Government to develop concrete and sustainable mechanisms to remove systemic barriers that hinder participation and establish supports to empower people with psychosocial disabilities and their organizational representatives to ensure representation in all levels of the implementation of recommendations arising from the *Taskforce* (USP-Kenya, 2020b, p. 8). In doing so, USP-Kenya (2020b) draws attention to the work of the Human Rights Council Resolution on Mental Health that calls on the Government to redirect mental health investments "to rights-based supports; non-coercive alternatives that address the psychosocial determinants of health; and the development of practices that are non-violent, trauma-informed, community-led, healing and culturally sensitive" (p. 4). Implementing this recommendation requires "increasing financial support to sustainable, cross-cutting programmes that reduce poverty, inequalities, discrimination on all grounds and violence in all settings," and that "support the development of a new, holistic list of essential psychosocial and population-based interventions … supported and developed by participatory, rights-based principles" (USP-Kenya, 2020b, p. 4).

Sustained efforts in decentralizing care must also be focused on reducing discrimination and improving collaboration between western biomedical and traditional African healers. Providing alternative, non-biomedical forms of care that are located primarily in the community can enable people with lived experiences of psychosocial disability to exercise their autonomy and choice in accessing care.

Conclusion

The application of key IBPA questions to Kenyan mental health policy documents reveals tensions between representations of mental health as intricately intertwined with people's social realities and living conditions and the tendency to see mental distress as biological in its origins. The implication of this tension is that a biomedical framing allows space for mental health laws that limit the freedoms and rights of people with psychosocial disabilities and prevent a more complex understanding of how social and structural factors give rise to mental distress. The result is that government priorities continue to be focused on hospital beds and clinical care, rather than community focused resources and supports. The ongoing impact of colonization with respect to laws that govern everything from substitute decision making, involuntary detainment and treatment, and basic rights of citizenship like marriage, limit the ability of domestic policy statements and commitments to make truly transformative change that would involve the leadership of people with psychosocial disabilities and the full protection of their human rights.

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