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## **POSITION PAPER ON THE MENTAL HEALTH CARE BILL 2013**

A mental health law by essence departs from the general health laws regulating the health system. It introduces an exception to the principle of informed consent and creates a separate and lower standard that allow for forced admission and treatment only for persons with psychosocial disabilities. Particularly after the adoption of the Convention on Rights for Persons with Disabilities (CRPD) that is a problematic position that should be scrutinized with care. It raises the question whether a “*mental health*” law can at all upholds rights. Are there parts which are better be lifted out and included in general laws, in order to align between the standards applying to the general population and to people with disabilities? Does determination of general capacity belong in this law? Can the establishment of medical services be incorporated into a law applying to the general health system? Would not respecting rights and preventing discrimination belong better in the general equality law applying to persons with disabilities?

What is the bare minimum that needs to remain?

These probing questions must be asked to ensure that stakeholders are aware of and attentive to the changes mandated by the CRPD and are making every attempt to approach the issue from the perspective of the CRPD’s core principles. The discussion should also be preceded by an overview of other laws regulating the health system, in order to gain an understanding of whether options exist for folding parts of the mental health laws into other laws.

### **Overview of gaps in the draft bill**

The Current draft of the Mental Health Care Bill 2013 is a version of draft template laws introduced by the World Health Organization at the start of the century, before the CRPD was adopted. Such templates are improved versions of archaic laws often dating back to the turn of the 20<sup>th</sup> Century. They do not however embody the paradigm shift required by the CRPD<sup>1</sup>.

As a result:

1. Concepts appearing in the current draft such as rights, rehabilitation, integration, preserving one’s dignity, improving quality of life, and improving the mental health status of the population, are negated by the provisions governing legal capacity, which easily curtail legal capacity according to pre-CRPD tests such as “best interests” and “unable to manage one’s own affairs.” These tests have resulted the world over in the mass denial and curtailing of legal

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<sup>1</sup> WHO has since adopted a higher standard for rights protection in mental health care, such as a seclusion and restraint-free approach, and a prohibition on the use of force, as reflected in “WHO Quality Rights Toolkit – Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities.” 2012. [http://www.who.int/mental\\_health/publications/QualityRights\\_toolkit/en/index.html](http://www.who.int/mental_health/publications/QualityRights_toolkit/en/index.html)

- capacity and a host of human rights violations, and do not reflect the principles of supported decision making, and apply over-broadly to mental health decisions and beyond.
2. Consequently, other concepts in the Bill that rest on how legal capacity is addressed are flawed. These include consent to treatment (very problematically qualified and used interchangeably with consent by un-appointed “others” – family member, guardian, friend), confidentiality (disregarded on the basis of “best interests”), participation in treatment planning (limited), and involuntary and emergency admission and treatment (extremely wide margins). In addition, rights of families/carers are conflated with the rights of the individuals themselves, in a way which undermines the foundation of legal capacity and choice for the individuals, and perpetuates one of the major gaps through which rights violations occur for persons with psychosocial disabilities (mental health conditions)
  3. Administering seclusion and restraints continues. Practice around the world demonstrates that qualifying seclusion and restraints where “it is the only means available to prevent immediate and imminent harm to the person....” Clause 37(2) is the loophole through which seclusion and restraint continue. Moreover, the bill perceives seclusion and restraint as a form of treatment (Clause 38): “Restraint and seclusion shall be implemented alongside other forms of treatment only as a last resort and when other forms of treatment fail”
  4. Electro-Convulsive Therapy (ECT), psychosurgery and other invasive treatments remain largely unregulated (apart from the limit on administering them as part of “emergency treatment”).
  5. Provisions around prisoners with psychosocial disabilities (Clause 36: “a prisoner or remandee ....of unsound mind”) that authorize forced psychiatric confinement and treatment, as well as a separate placement within the prison, should be revisited in light of Article 14 and the principles that the existence of a disability shall in no case justify a deprivation of liberty through any process, they shall be treated on an equal basis with others including by provision of reasonable accommodation.”
  6. The emphasis on the bill on developing “community mental health” is a good one; it is however, undermined by the provision in Clause 6(2) that the priority granted to “community health and primary mental health care and treatment as opposed to institutionalization” is conditional on the “mental health condition of the person with mental illness” and subject to the “economic and social status of the community”: it is not clear what is the remaining significance of the stated “priority” of community services.

The detailing of types of services that need to be developed is helpful. The obligations on the system, however need to be made concrete and monitor-able in order to give more clout to this section. For example, an obligation can be placed on the Minister to develop within a certain time frame a plan for a transition to a community-based system, in consultation, among others, with organizations of persons with psychosocial disabilities; the essential components of such a plan should be enumerated already in the bill.

### **Lack of a legal capacity framework undermines rights in the mental health care bill**

Since legal capacity and protecting people’s rights in the area of mental health are intertwined, it is worthwhile to explain in more detail the connection between the two areas and understand the implications for the Mental Health Care Bill

A condition for arriving at a mental health law that is compliant with the CRPD is that a legal capacity framework which draws from the principles of the CRPD is developed. A legal capacity framework would provide the building blocks for decision-making, consent, intervention or non-intervention in one’s decisions, which can then be used and adapted for the area of mental health. There is no way to reach a CRPD-compliant mental health law without first revision the perception of “capacity” and “incapacity”, and introducing and incorporating supported decision-making into the equation – in short, drawing a framework for legal capacity.

We are not aware that such a process has taken place in the process around the mental health bill. This is reflected in the current bill, which resorts to a paradigm of incapacitation, intervention in one’s decision and forcing confinement and treatment.

The aim of Article 12 of the CRPD (Legal Capacity) is to ensure that persons with disabilities are “subjects of the law capable of determining their own destinies and deserving of equal respect and not ‘objects of the law to be managed and cared for by others.’” They should not be patronized, paternalized or treated like children.

Four examples are brought below:

1. **Continued use of the “best interest” test:** The first example is the positing of the “best interests” test as an overarching one in decisions “concerning the care and treatment of a person with mental illness (including a decision to make an admission order.....)” (see clause 27). The “best interests” test is the classical test at the heart of a pre-CRPD substituted decision-making approach, justifying intervention by others in an individual’s own decision making, in the name of the “best interest” of the individual as perceived by others. The CRPD drastically changes this notion. From now on the basis is the individual’s will and preferences. Everything else – treatment, confinement, disclosure of information etc must derive from a reworked framework of reaching to and validating a person’s will and preferences. If there are any exceptions, they must be defined in as narrow way as possible and kick in only after a real process of engaging with the individual as a subject, providing her/him with choices and respect his/her choice, has taken place.
2. **Misunderstanding of representation:** The second example has to do with “representation”. In clauses 26, 28, 29, 31 there seems to be a conflation of key concepts. “Representation” should

mean that a person chooses someone to represent him/her in communicating his/her choices and having these choices respected – the implication being that someone who was not duly appointed by the individuals cannot step in. This is a fundamental block in legal capacity.

This notion is undermined by the definition in clause 3 of “representative” as “spouse, next of kin, partner, parent or guardian of the person with mental illness - the very opposite of what representation means, which is the individual’s choice of whom should represent him/herself. Aside from the circular decision, this clause defines a list of people who are considered representing a person with mental illness by virtue of the fact that they are family, next of kin or guardian. In other words, one’s right to confidentiality, having one’s choices respected and informed consent be a condition for treatment retreat before any family member. A family member’s “consent” to confinement and treatment is seen as the individual’s own consent.

Guidance on what constitutes representation is exactly what should be developed in a framework of legal capacity, which to our best of understanding has not happened in the current mental health bill amendment process.

3. **Conflating rights of families/carers with rights of the users/individuals themselves:** This runs throughout the bill. One example has been noted above around representation. Another example appears in clause 26 which stipulates that families and carers “*have the right to access information regarding the medical status and treatment plans of a person with mental illness...[and] be involved in...decision making, reviews and appeals relating to a person with mental illness.*” Family members’ choices and consent are viewed as the individuals’ choice and consent by virtue of their relation to the individual, not by the choice of the individual him/herself – effectively negating an individual’s right to confidentiality, decision-making and informed consent.

A strange provision appears in clause 9(2) according to which families should be accorded support to “*reduce their exposure to mental illnesses caused by catastrophic incidences and emergencies and interaction with the person with mental illness.*” That is certainly not the perspective through which support to families is to be viewed!

4. **Continued use of archaic rights-violating guardianship model.** The fourth example refers to section IX of the bill on “*Care and administration of property of persons with mental illness.*” A section that addresses legal capacity beyond the area of mental health is misplaced in a law that deals with mental health. As to its content, it is almost entirely a replication of the parallel section in the outdated 1991 law: an individual is divested from control of his/her financial matters, ownership of property, management of assets etc.. on the grounds of being a person with mental illness, based on the application of a “parent, spouse...friend, relative or any interested person under whose care or charge the person with mental illness is.” The court may

make an order for the administration and management of the person’s estate and appoint a manager with power to manage the estate as the court considers necessary.”

This stands in contrast to CRPD Article 12, which reaffirms the right to legal capacity and its exercise, and the state’s obligation to provide access to support that may be needed in exercising legal capacity. Article 12 of the CRPD also obligates states to *“take effective measures to ensure the equal right of persons with disabilities to...control their own financial affairs....and shall ensure that persons with disabilities are not arbitrarily deprived of their property.”*

Article 12(4) of the CRPD refers to measures that relate to the exercise of legal capacity with the provision from the State (Kenya a signatory to the treaty) to prevent abuse using procedural guarantees or safeguards:

1. Respect the rights, will and preferences of the person
2. Be free of conflict of interest and undue influence
3. Be proportional and tailored to the person’s circumstances
4. Apply for the shortest time possible
5. Subject to regular review by a competent, independent and impartial authority or judicial body

The safeguards above have to be proportional to the degree to which such measures affect the person’s rights and interests

### **Mental Health Care Board**

Two roles assigned to the Mental Health Care Board seems to be conflated – sitting as an appellate tribunal for *“any matter referred to it by a person with mental illness or relative or any representative of a person with mental illness or relative or any representative of a person with mental illness concerning the treatment of the person with the mental illness at a mental facility,”* and at the same time advising the government *“on the state of mental health”* and *“coordinating the mental health care activities in Kenya.”* It is questionable whether two such broad and distinct roles should reside within one body. Additionally, the matter of appeals – crucial to providing a check on denial of people’s liberty through forced hospitalization and treatment remains unregulated.

In addition, no mention is made of shifting the weight towards a community-based system and the Board’s potential role in advising towards that objective.

Finally some would question the appropriateness of representation of caregivers on the Board Clause 52(1)(d), given the potential and often real complexity in the relationship of the caregivers and individuals (users) themselves which at times leads to rights violations in the hands of the caregivers. What is clear, however, is that the final member, cited in clause 52(1)(e) cannot be anyone with *“sufficient levels of experience in advocating for the rights of*

*mentally ill persons”* (currently the only criterion) but must at the same time also represent an organization of people with psychosocial disabilities (mental health conditions)

