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A CRITIQUE OF THE RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA

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11TH November 2016

DECLARATIONS

I declare that this thesis is my original work and has not been presented before for a degree in this or any other university.

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This thesis has been submitted for examination with my approval as university supervisor.

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DEDICATION

This thesis is dedicated to Winnie Achieng' for the support and encouragement you offered me, especially in times when I contemplated giving up. You remained my inspiration and thank you for your contribution in helping me build a future that is promising.

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A CRITIQUE OF THE RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA.

1.0 INTRODUCTION

1.1 Background of the study

From history some people in society are considered to lack legal capacity, for instance women, children and people with disability. In this case Legal capacity was a preserve of only men. For instance in most countries women could not enter into contracts to transfer or hold property in their own names and people with disabilities were considered unable to make any decision. Legal capacity means that a person has sufficient knowledge and understanding to reach the threshold of capacity necessary to commit to a legal contract or take legal action on his or her own behalf.[1] It may also be used to refer to rights that an individual has and not necessarily his or her cognitive competence.[2] It is one's capacity to be a holder of rights and to have the ability to exercise those rights.[3] The right to hold and exercise human rights is integral to the concept of legal capacity because they establish the rights and responsibilities of persons with disabilities to make their own decisions.[4] To be a holder of rights includes the right to be a subject before the law; for instance, to

[1] Barbara Carter and others, Supported Decision Making. Background and Discussion Paper.doc - zotero://attachment/107/' <zotero://attachment/107/> accessed 9 November 2014.
[2] Ibid.
[3] Ibid note 1.
[4] Gerard Quinn, 'Personhood & Legal Capacity Perspectives on the Paradigm Shift of Article 12 CRPD.' (HPOD Conference, Harvard Law School, 20 February 2010) http://www.nuigalway.ie/cdlp/documents/publications/Harvard%20Legal%20Capacity%20gq%20draft%202.doc accessed 19 November 2014.

be somebody who can own property, have a job or start a family.[5] While the ability to exercise rights goes further and includes the power to dispose of one's property and claim one's rights before a court. The importance of the right to legal capacity therefore lies in its facilitative nature. As such, the right to legal capacity places the acts of an individual within the framework of the law and makes him a subject of law. In Kenya for instance legal capacity is normally pegged on whether an individual has attained the age of 18 which is the age of adulthood though this is not the position adopted for people with mental disabilities who are treated as 'objects' of pity who requires help and sympathy from the society as opposed to rights holders with interests, preferences and desires.[6] It is assumed that persons with disability that they automatically lack capacity to be right holders and subject of the law. In this study I will adopt the definition of legal capacity to be rights that an individual possess together with capacity to exercise those rights and completely delink it from mental capacity and its cognitive competence.

Unfortunately for many years the right to legal capacity was simply based on cognitive abilities of an individual as a result this led to segregation, discrimination and marginalization of various people in society. Society developed various stereotypes which they used to label these groups like women are a weaker sex, people with mental disability are sick and ill and therefore have no rights of their own. Several movements arose with an aim of fighting this marginalization and injustices and though change is eminent in areas touching on the right of women and children much is yet to be achieved for the rights of People with Disability (PWD) and especially those with mental, intellectual and psychosocial disability. They still face a lot of discrimination based on their ability

[5] Ibid
[6] The Kenya National Commission on Human Rights and The Open Society Initiative for Eastern Africa, 'Briefing Paper on Legal Capacity-Disability Rights.pdf' http://www.knchr.org/Portals/0/GroupRightsReports/Briefing%20Paper%20on%20Legal%20Capacity-Disability%20Rights.pdf accessed 20 November 2014.

to exercise their legal capacity. The society treats them as sick, unwell and incapable of understanding the consequences of their decisions and choices. Some are locked up and completely forgotten in medical facilities away from their families and against their own wishes.[7] The decision to place them in medical facilities is normally based on sole assessment of their status by a doctor and without their input. The consequence of this is that the right of persons with mental disabilities (PMDs) to live independently and have access to other services is violated. Some remain locked by their parents for fear that they will either harm others or themselves and also based on the ridicule the parents face from society. As a result their rights continue to be substituted. The assistance given to them disguises itself as support but in reality the person with disability has to live with choices and decisions made by the assistant who is deemed to know what is good for the PMDs.

It is unfortunate to note that the situation in Kenya is not different and many people with mental disability continue to suffer the consequences of non-recognition of the right to legal capacity. During the 2013 election in Kenya, I had an opportunity to interact with persons with mental disability during the Kenya Integrated Civic Education (KNICE) program.[8] Through observation, I noted that PMDs faced a lot of discrimination and stigma from the public. This motivated me to work on their case which was filed at Milimani court challenging the policies on mental disability that stigmatize and marginalize PMDs.[9] Unfortunately, this case was dismissed by Majanja J. who stated that "I think the petitioners have brought this case to address the whole spectrum of issues

[7] David McKenzie, 'World's Untold Stories: Locked up and Forgotten' http://www.cnnasiapacific.com/edm/mkt_edm/PR/110216_wus_lockedupandforgotten/lockedupandforgotten_110216.html accessed 30 September 2014

[8] The Kenya Integrated Civic Education (KNICE) is a Programme pioneered by the Government of Kenya in partnership with non-state actors to provide civic education to the electorate.

[9] 'Petition 155A of 2011 - Kenya Law' <http://kenyalaw.org/caselaw/cases/view/86061> accessed 30 September 2014.

concerning persons with disabilities. In their submissions, the petitioners have dealt with the right to education, the right to health, the right to employment, access to justice, the right to justice and political rights. In a nutshell, what the petitioner requires is for the Court to direct the State to take steps to adopt its proposals for reform and promotion of persons with disabilities. The Court's purpose is not to prescribe certain policies but to ensure that policies followed by the State meet constitutional standards and that the State meets its responsibilities to take measures to observe, respect, promote, protect and fulfill fundamental rights and freedoms and a party who comes before the Court."[10]

My experience in the field exposed me to the dehumanizing conditions that people with mental disabilities live in. It was during this period that the World Health Organization had released a report[11] indicating that more than 10 percent of the world populations are people with mental, intellectual and psychosocial disability. According to the Kenya National Population Census, 2009, the overall disability rate in Kenya is 3.5% which translates to 1.330,312 million persons with Disabilities. Of this population 44.8% are people with mental disability.[12]

In 1993 the Kenyan government set up a task force to review and to come up with laws relating to persons with disabilities. Following the task force report the government enacted the *Persons with Disabilities Act* of 2003 which became operational on January 9th 2004. The Act is deficient in some aspects and concentrates on people with physical disability. Philip Armstrong argues that the

[10] Ibid
[11] WHO | The World Health Report 2001 - Mental Health: New Understanding, New Hope' (WHO) http://www.who.int/whr/2001/en/ accessed 10 October 2014.
[12] Kenya National Commission on Human Rights, 'Kenya's Initial Report Submitted under Article 35(1) of the United Nations Convention on the Rights of Persons with Disabilities' http://disabilitycouncilinternational.org/documents/CRPD_C_KEN_1_6970_E.doc accessed 9 October 2014.

Act is in need for review for it does not represent the findings of the Task Force.[13] The person with disabilities Act and other existing laws in Kenya cluster people with disabilities together arbitrarily without regard to their specific individualized interventions that each group requires. The Mental Health Act[14] and the Children Act[15] provides for a guardianship system that allows guardians, trustees and estate managers to be appointed when a PMD is incapable of taking care of himself and his life affairs. [16] It is trite to note that the procedures for determining a person's legal capacity, both judicial, administrative and medical in Kenya do not respect the choices, will or preferences of the PMDs and instead assesses what is in their best interest.[17]

Kenya became a party member to the United Nation Convention on the Rights of Persons with Disability (UNCRPD) in 2008 and by dint of Article 2 (6) of the Constitution of Kenya 2010 became part of its laws.[18] The Convention establishes legal capacity as a key principle and component of a person's autonomy. It states that state Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.[19] The convention for the first time acknowledges that PWDs are persons before the law and that they are to exercise legal capacity on an equal basis with others.[20] Article 12 of the UNCRPD further imposes a duty on the States to put in place a system of support to ensure that the existing barriers which hinder the exercise of legal capacity are removed and that PWDs fully enjoy and exercise

[13] Philip Armstrong and others, 'Disability in Kenya: The Nairobi Workshop Introduction' (2009) 29 Disability Studies Quarterly.
[14]Ibid, Section 14.
[15] Ibid, Section 103.
[16]'MDAC_Kenya,Legal_capacity_2apr2014.pdf'http://mdac.info/sites/mdac.info/files/mdac_kenya_legal_capacity_2apr2014.pdf> accessed 3 October 2014.
[17] Ibid.
[18] Ibid.
[19] Convention on the Rights of Persons with Disability, Article 12(2).
[20] Ibid, Article 12 UNCRPD.

capacity.[21] This will require a complete paradigm shift from a system that looked at PWDs as sick and ill and therefore in need of sympathy and help, to a system where PWDs are seen as right holders with ability to exercise their rights on an equal basis with others.[22] This shift will involves a move away from the traditional system of substituted decision-making to a system of supported decision-making which embodies the legal aspects of living independently, exercising autonomy and having the freedom to make one's own choices.[23]

Although Kenya ratified and adopted the Convention, the area of legal capacity still remains a difficult area of rights to implement. For instance, policy makers and those involved in implementation of the policies are yet to understand the implications of Article 12 of the Convention. For instance, the proposed bill on mental disability does not meet the requirements under the Article.[24]

This study therefore will interrogate the question of the exercise of legal capacity by people with mental disabilities in Kenya, and challenges faced in its implementation. The study will examine further to what extent the existing and proposed legislations fail to address the question of legal capacity as set out in Article 12 of the CRPD. It will further examine whether the system of committing individuals to medical detention without necessarily considering their choices, will and preference is a violation of their right to legal capacity.

[21] Convention on the Rights of Persons with Disability, Article 12(4).
[22] Ibid.
[23] Marianne Schulze, Understanding The UN Convention on The Rights of Persons with Disabilities: A Handbook on the Human Rights of Persons with Disabilities September 2009, Handicap international, 3rd edition, 2010
[24] Section 17 of the mental health bill still provides for guardianship on the basis of incapacity. It provides that 'Where a person is, by reason of his or her mental illness, deemed by law not to have legal capacity, such person shall be entitled to the appointment of a personal representative to manage or conduct his or her affairs'.

1.2 Statement of the Problem

People with Mental Disabilities are prone to discrimination and other forms of injustices compared to other people with other disabilities. They are viewed as instruments of pity worthy of mercy and sympathy.[25] They are marginalized by the legal, administrative and judicial systems in Kenya which are uninformed of their needs. The legal system in Kenya for instance presumes that PMD lack legal capacity to make important decisions about themselves such as to enter into contracts, marry and even dispose of their property.[26] The implementation of Article 12 of the CRPD still faces several challenges and is yet to be fully made applicable in Kenya to ensure that PMD live in dignity and independently in society. This paper will find out whether the legal regime existing in Kenya meant to implement the UNCRPD gives full effect to the right to legal capacity on an equal basis and without discrimination.

1.3 Theoretical Framework

There are different theories of disabilities which include the medical theory, the social theory and the human rights theory of disability. This dissertation is based on the human rights theory. Other theories of disability will be discussed to demonstrate why the human rights theory is the right theory for contextualizing the right to legal capacity for persons with mental disability.

[25] Supra note 5.
[26] Section 14 of the Mental Health Act Kenya, see also Section 107 of the Children Act, Kenya.

1.3.1 **Human Rights Theory of Disability**

This paper adopts the theory advanced by the human rights theory of viewing and contextualizing disability. The human rights theory is currently the cornerstone of disability work around the world and the basis of the UNCRPD. The human rights theory is underpinned in the natural law theory. The natural law theory emphasizes law to be grounded in justice and the common good.[37] The defining characteristics of natural law theory derive from the nature of humanity and postulate that true law must not only reflect the nature of humanity and answer to a higher law‘ (the divine law), but it must also derive from and respect absolute fundamental rights inherent in humanity.[38]

The chief proponent of the natural rights theory was John Locke, who developed his philosophy within the framework of seventeenth century.[39] John Locke in his *Second Treatise of Government* claimed that everyone had natural rights to life, liberty and property and that government was a trust established to protect these rights through the rule of law.[40] John Locke envisaged the existence of human beings in a state of nature with freedoms, ability to determine their actions and in a state of equality where no one was subjected to the will or authority of another.[41]

The human rights theory therefore views people with disability as right holders. It moves away from the predominant positions of the traditional theories that view PWDs as instruments of pity and charity. According to this theory, all human beings have rights inherent within them and are to enjoy them on an equal basis and without discrimination. By emphasizing that the disabled persons are equally entitled to rights as others, this theory builds upon the spirit of the Universal

[37] Handicap International, Inclusion Guidelines on Disability and Mainstreaming for Development Programs in Kenya, September, 2010.
[38] Ibid.
[39] Jerome J Shestack, ‘The Philosophical Foundations of Human Rights’ in Janusz Symonides (ed), *Human Rights: Concept and Standards* (Dartmouth Publishing Company Limited 2000).
[40] Smith and Anker (2005).
[41] Ibid.

Declaration of Human Rights, 1948.[42] It therefore views PWDs as subjects of rights who should enjoy full access to the benefits of basic freedoms and doing so in a way that is respectful and accommodating of their differences and preferences. It calls upon governments to abolish policies that perceive people with disabilities as sick, unwell and a problem and instead viewing them as right holders.[43]

The pillars of this theory are dignity, autonomy, equality and solidarity, which are important if the person with disability is to live independently in society.[44] Article 28 of the Constitution of Kenya spells out the right of every citizen to human dignity. Quinn and Degener[45] argues that people are to be valued not just because they are economically or otherwise useful but because of their inherent self-worth; and that recognition of the value of human dignity serves as a powerful reminder that people with disabilities have a stake in and a claim on society that must be honored quite apart from any considerations of social or economic utility. They are ends in themselves and not means to the ends of others.[46]

This theory of disability therefore militates strongly against the societal norms and practices that tend to rank people in terms of how useful they are to the society and to screen out those with

[42] Universal Declaration of Human Rights, Article 1 provides that "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." *Available at* http://www.un.org/en/documents/udhr/ *last accessed on 2/2/15.*

[43] Gerard Quinn, Theresia Degener and Anna Bruce, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability (United Nations Publications 2002). https://books.google.com/books?hl=en&lr=&id=c3RQURYh1bMC&oi=fnd&pg=PR7&dq=%22Treatment+or%22+%22Degener+is+a+German+lawyer+and+Law+Professor+specializing+in%22+%22(Council+of+Europe).+He+is+a+Professor+of+Law+at+the+National+University%22+&ots=NLho3O3_vD&sig=V7fVvC6inNLAvyaAePlvftPwsP4 accessed 2 February 2015.

[44] Ibid.

[45] Ibid.

[46] www.gripvzw.be .

significant differences. It provides a cure to the mindset of societies that view disability as a burden and a shame and provides solutions to atrocities of the magnitude of the holocaust.

The human rights theory is different from both the medical theory and the social theory of disability. The human rights theory comes into play to rewrite the injustices created by the medical theory of disability. The medical theory of disability postulated that disability is one rooted on clinical diagnosis[47] and focused on persons' medical traits such as their specific impairments.[48] The problem that this theory posed was that it located disability within the person.[49] This means that once an individual is diagnosed with a specific mental disability he / she automatically lost his right to legal capacity and other right. It reinforces the established view that disabled people are 'passive' and non-disabled people 'active'. The medical theory looks at the person with disability and gives him a label of 'disabled' even without assessing other factor. Once the doctor makes an assessment on the status for instance, of the PMDs, his decision becomes the basis upon which consecutive treatment is based. The consequence of adopting the medical theory is that PMDs is treated as instruments that need care and treatment and sometimes detained in health facilities on the basis that they are dangerous to themselves and to others. This is in direct violation of their rights to liberty and to live a dignified life. This theory assumes that people with disability are 'lesser person' in society and have no capacity to make any right decision affecting them and as consequence their decisions becomes subject of substitution. The difference between this theory of disability and the human rights theory is that the latter focuses on the inherent dignity of the human being and subsequently places the individual person at the center stage in all decisions affecting

[47] Simon Brisenden, 'Independent Living and the Medical Model of Disability' (1986) 1 Disability, Handicap & Society.
[48] Ibid at 174.
[49] Ibid (175 – 178).

him/her. This dissertation therefore advocates for a complete departure from the medical theory and a transition to the human rights theory of disability.

On the other hand the social theory of disability is based on the Sociological theory which emerged as a theory of juristic thinking in the 19th century. Several jurists are credited with this school including Auguste Comte, (1798 -1857), R. Von Jhering (1818 – 1892), Max Weber (1864 -1920) Emile Durkheim (1858 – 1917), Eugene Ehrlich (1862 – 1922), and Roscoe Pound (1870 – 1964). Comte[50] believed that society developed according to certain principles, the pattern and essence of which would be discovered. Durkheim drew on Comte's work but argued that sociology must study social facts for instance aspects of social life that shapes our actions as individuals. Durkheim was preoccupied with the changes transforming society in his own lifetime. Durkheim's thesis was that law was the measuring rod of any society.[51] According to Jhering, the function of the law is to serve the needs of society and to secure the conditions of social life. He discussed the inevitable conflict between social interests and individual's self-interests. That to reconcile this conflict the state employs both the method of reward by enabling economic wants to be satisfied and the method of coercion.[52] To Jhering, the origin and ultimate purpose of the law is social control and therefore law is an instrument of serving society.[53] The basis of Pound's[54] theory lay in the search of the solutions to the problems of the American society at the time. His studies believed in using the knowledge of the social sciences as an instrument of bringing about social change.[55] A solution could best be attained by the application of the developing social sciences. To

[50] M.D.A Freeman, Lloyd's Introduction to Jurisprudence (7th edn, Sweet & Maxwell) 2001.
[51] Ibid.
[52] Ibid 48.
[53] Ibid.
[54] McManaman, Linus J, *Social Engineering: The Legal Philosophy of Roscoe Pound* (2013).
[55] Ibid.

him law was an instrument of social control to be employed in enabling just claims and desires to be satisfied.[56] His view was that law must serve a particular function in society and the ultimate purpose of the law is social control.[57] He propounded that law must be developed in relation to existing social needs and should engineer society to law and order at the same time provide a balance of interests both individual interests, public and social.[58]

Social theory of disability therefore borrows a lot from the works of the sociological theorist and argues that, disability rights are part of building a collective working class consciousness. It believes that disability is as a result of barriers that incapacitate PWDs and these barriers are placed by society and for people with disability to live independently such barriers should be removed. Law therefore acting as a tool of social engineering should move society towards elimination of those barriers that marginalize and disable some members of the society. The social theory therefore presents disability as a consequence of oppression, prejudice and discrimination by the society against disabled people. It is the society that raises barriers that prevent people with impairments from enjoying benefits of social life.[59] These barriers are both social and economic in nature. Therefore for PWDs to participate on an equal basis with others in society and to build a unity in practice, aid and adaptations in society for instance in schools, universities and workplaces should be provided. The basis of this school of thought is not to eliminate impairments but to provide a foundation for individual appreciation and celebration of diversity and therefore promote mutual interdependence. Social model of disability departs from the medical model that expounds disability from a personal and individualistic medical condition. It instead it views disability as a

[56] Ibid.
[57] Ibid
[58] James A Gardner, 'Sociological Jurisprudence of Roscoe Pound (Part I), (1962) 7 Vill. L. Rev. at 1.
[59] Ibid

form of oppression that could be fought against and overcome. This paper acknowledges that the human rights theory borrows a lot from the sociological model. Thus addressing the human rights issues will automatically remove the barriers placed by society that disables people with disabilities.

1.4 Literature Review

There is a lot of literature internationally on the right to legal capacity for persons with disability. Many scholars who have addressed the issue have adopted differing positions on what constitutes legal capacity and how it should apply to persons with disability especially those with mental and intellectual disability. However very little literature exist on violations of the right to legal capacity in Kenya with emphasis to involuntary institutionalization and forced treatment of persons with mental disability to legal capacity. This research intends to breach that gap. In addition several issues have arisen with the application of Article 12. Central to this research is the proper conceptualization of the right to legal capacity and whether or not competency and rationality are a determinant for exercising legal capacity for persons with mental disability. Lastly, is whether limitations placed on the exercise of the right to legal capacity in Kenya are in themselves a violation of Article 12 of the CRPD?

1.4.1 How is the Right to legal Capacity conceived? Is rationality a determinant?

There are two dimensions to the right to legal capacity which are the elements of *legal personality* and *capacity to act.*[60] According to John Chipman Gray, "the technical legal meaning of a 'person' is a subject of rights and duties."[62]

Tina Minkowitz[63]argues that legal capacity is very important element to the exercise of the right to free and informed consent by PWDs. The absence of equal legal capacity to a person with disability will hamper this right and therefore offer very little protection against violations and especially against forced psychiatric interventions. She argues that the convention replaces the dualistic model of capacity vis a vis incapacity with an equality model which complements full legal rights to individual autonomy and self-determination with entitlement to supports when needed, and to ensure substantial equality to opportunities to exercise those rights. She argues that legal capacity encompasses both passive rights such as ownership or inheritance of property and active rights such as the rights to conclude contracts, administer property, appear in court as a party or witness, or give or refuse consent to medical procedures.[64] This therefore implies that every person should be accorded both "capacity for rights" and "capacity to act," irrespective of how rational his decisions and choices are. He concludes by noting that the interpretation of legal capacity without the capacity to act will mean that an individual possesses rights and

[60] Gerard Quinn, 'Personhood & Legal Capacity Perspectives on the Paradigm Shift of Article 12 CRPD.' (HPOD Conference, Harvard Law School, 20 February 2010) http://www.nuigalway.ie/cdlp/documents/publications/Harvard%20Legal%20Capacity%20gq%20draft%202.doc accessed 19 November 2014.
[62] John Chipman Gray, The Nature and Sources of the Law (New York, The Columbia university press 1909) http://archive.org/details/natureandsource04graygoog accessed 23 November 2014.
[63] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34 Syracuse Journal of International Law and Commerce.
[64] Ibid.

responsibilities in name only, and decision-making authority can be transferred to another person or institution.[65]

Bach, Michael[66] agrees with Tina's arguments and insists that legal capacity implies that an individual possess personal authority to exercise rights and responsibilities. Bach, Michael observes that capacity to act presupposes the capacity to have rights. I agree with this proposition but state that both capacity for rights and capacity to act should be treated with same magnitude as the two cannot survive on their own. For a person with disability to exercise his legal capacity he must first understand that he is a right holder. These will then empower him / her to act to fulfill these rights. It appears that Article 12(1) of the CRPD recognizes basic civil rights of people with disabilities. For instance the right of every person with disabilities to be registered at birth, to be free from exercise of arbitrary power by the State, from being sold into slavery, to have fundamental freedoms like freedom of association protected. This is an important recognition and protection of the rights to legal personality or personhood. However, on its own, it falls short of protecting the right to one's agency, to act in the world by entering legal relations with others and to being a person who is recognized as one who can take on legal obligations of a contractual or tortuous nature.[67]

Bernadette and Kay[68] argue that the purpose of legal capacity is to accord people with disability especially those with mental disability autonomy. They appear to suggest that the drafters of the Convention intended to balance rights. They state that society was prepared to give individuals

[65] Ibid
[66] Bach n.54
[67] Ibid.
[68] McSherry, Bernadette and Wilson, Kay, 'Detention and Treatment Down Under: Human Rights and Mental Health Laws in Australia and New Zealand' (2011) 19 at 548.

with mental illnesses autonomy at the expense of 'some kind of humane existence.[69] Article 2[70] and Article 3[71] has been interpreted to signal a move away from substituted decision-making schemes to that of 'supported' decision-making.[72] Thus, if an individual with mental illness needs assistance with making a treatment decision, Article 12 implies that he or she needs to be given support to make a decision rather than immediately having a substitute decision-maker exercise that decision in his or her place.

Gerard Quinn[73] on the other hand sees legal capacity and rationality as a legal shell through which to advance personhood and it opens up zones of personal freedom. He argues that individual's rationality is shaped by his/her preferences. Therefore for an individual to be considered a person, he/she must possess the capacity to rationally process information, to rationally choose among several options, to rationally apprehend the consequences of choices and to weigh them up so as to arrive at a rational outcome, and it assumes a capacity to express our choices in the shape of informed decisions. Quinn also viewed legal capacity as a shield that helps persons fend off decision made against them or otherwise 'for' them by third parties. The underlying argument in Quinn's writing is the liberating potential of Article 12 that lies in its promise to open up zones of affirmative choice for persons with disabilities.

[69] Ibid.
[70] Paragraph 2 of Article 12 of the UNCRPD requires States Parties to 'recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
[71] Paragraph 3 then imposes a duty to 'take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'.
[72] A Lawson, *The United Nations Convention on the Rights of Persons with Disabilities,* (2007) 34 SJILC at 563 and 597.
[73] Supra note 43.

He looks into various approaches to the question of legal capacity which include status approach[74] and the outcomes approach[75]. He notes that there is nothing wrong with substituted decision making as long as the person with disability is allowed to pick the substitute and the substitute simply mimics his/her will and preferences. Quinn's contribution to this research is based on the various approaches that exist in determining how rational an individual's decision should be for him to be considered to possess the required legal capacity.

1.4.2 Involuntary Institutionalization and Forced Treatment as a Violation of the Rights of Persons with Mental Disability to Legal Capacity in Kenya

"On almost every account people with mental health problems are among the most excluded groups in society and they consistently identify stigmatization, discrimination and exclusion as major barriers to health, welfare and quality of life."[76]

The mentally disabled persons in Kenya have for a long times been considered objects of pity, compassion, or abuse by their caretakers and society at large. They are rarely seen as subjects, as citizens, as persons with equal entitlement to fulfillment. The notion and conception that human

[74] Concerns itself with the medical model of disability that looks at the PWDs from the perspective of his cognitive abilities.
[75] Under the outcome approach one is deemed to lose capacity simply by making inference from bad decisions, pattern of bad decisions or a flawed process of decision-making. The problem with this approach is its inability to appreciate that, just because someone is assumed to have full capacity doesn't mean that we use this capacity to rationally sift information and make cold analytic choices.
[76] European Commission, 'The European Platform against Poverty and Social Exclusion: A European Framework for Social and Territorial Cohesion.'(2010) http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0758:FIN:EN:PDF *accessed 10 September 2015.*

beings are independent, rational, and capable of self-sufficiency is one that society at large continuous to deny people with mental disability.[77]

Amid this broader reassessment of the rights of persons with mental disability to legal capacity are two issues of concern that includes the processes of involuntary placement and involuntary treatment.[78] It is trite to note that there is hardly no literature on this issues in Kenyan context specifically. These issues are linked to two central fundamental rights: the right of the PWDs to make independent decisions with supports on one hand and the right to dignity, equality and non-discrimination. The Preamble of the Charter of the United Nations states that human dignity is a value that the members of the United Nations strive to achieve.[79] The principle of dignity is also captured in several other international instruments including the Universal Declaration of Human Rights,[80] the International Covenant on Civil and Political Rights,[81] the International Covenant on Economic, Social and Cultural Rights.[82]

[77] Eva Feder Kittay, 'When Caring Is Just and Justice Is Caring: Justice and Mental Retardation' 13(3) at 557.
[78] There is no internationally accepted definition of involuntary placement or involuntary treatment. This paper adopts the standards set out in the Council of Europe's Recommendation Rec (2004) at 109. Article 16 characterizes involuntary placement and involuntary treatment as those "measures that are against the current will of the person concerned.
[79] The words are part of the second paragraph of the Preamble, which reads in full as follows:" to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small."
[80] The preamble to the Universal Declaration proposes that human rights and dignity are self-evident, the "highest aspiration of the common people," and "the foundation of freedom, justice and peace." "Social progress and better standards of life in larger freedom," including the prevention of "barbarous acts which have outraged the conscience of mankind," and, broadly speaking, individual and collective well-being, are considered to depend upon the "promotion of universal respect for and observance of human rights.
[81] Article 10 provides that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
[82] Article1 (3) states that "education shall be directed to the full development of the human personality and the sense of its dignity.

Oscar Schachter[83] Argues that human dignity demands that all human beings should be treated as an end and not as a means. Respect for the intrinsic worth of every person should mean that individuals are not to be perceived or treated merely as instruments or objects of the will of others. He outlines a number of violations which amounts to threat of human dignity.[84] These violations includes: Statements that demean and humiliate individuals or groups because of their origins, status or beliefs, denial of the capacity of a person to assert claims to basic rights, and punishment of detained persons by psychological or physical means that are meant to humiliate or ridicule their beliefs, origins or way of life. He postulates that psychiatric treatment that involves coercive means to change beliefs or choices that are lawful; and medical treatment or hospital care that is insensitive to individual choice or the requirements of human personality are in themselves a violation to the right to dignity. I agree with Oscar's assertion and assert that people are to be respected and their dignity upheld irrespective of their status. Every human being has inherent rights within him and therefore any medical processes that are conducted on him/her should only be done once he consents to them.

Mann, Gostin and others[85] adds to the literature by arguing that the state's failure to recognize or acknowledge health problems that preferentially affect a marginalized group violate the right to non-discrimination by leading to neglect of necessary services, and in so doing, adversely affect the realization of other rights.[86] It's worth noting that the impact of health problems are obvious in

[83] Oscar Schachter, 'Human Dignity as a Normative Concept' (1983) 77 The American Journal of International Law at 848.
[84] Ibid 582.
[85] Jonathan M Mann and others, 'Health and Human Rights' (1994) 1 Health and Human Rights at 6.
[86] Including the right to "security in the event of...sickness (or) disability..." (UDHR, Article 25), or to the "special care and assistance" to which mothers and children are entitled (UDHR, Article 25).

understanding certain severe human rights violations, such as torture, imprisonment under inhumane conditions, summary execution, and disappearances.

Majority of persons with mental disability are involuntarily locked up because they are either deemed dangerous to themselves or to other persons.[87] The CRPD does not refer explicitly to involuntary placement but reiterates the formulation of the right to liberty and security of the person and that the deprivation of liberty based on disability would be discriminatory.[88] In the concluding observations on Spain, the CRPD Committee criticized legal regime allowing the institutionalization of persons with disabilities especially those with mental disability; the committee also expressed its concern on trends where urgent measures of institutionalization are resorted to without considering the wishes of the affected individuals.[89]

In support of the committees observation Tina Minkowitz[90] is concerned that forced psychiatric interventions does not only violate the right to dignity of persons with disability but that it disregards the universal prohibition of torture and that it should be criminalized and reparation provided to survivors. CRPD lays the basis for this argument to be developed in a series of steps, starting from the recognition of equal legal capacity, free and informed consent of persons with disabilities, and the right to respect for physical and mental integrity. These obligations are contained in Articles 12, 25, 17, and 15 of the Convention and requires for immediate cessation of forced psychiatric interventions against persons with disability.

[87] Supra note 1.
[88] CRPD Article 14 (1).
[89] Ibid.
[90] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34 Syracuse Journal of International Law and Commerce.

Robert perske[91] on other hand argues against institutionalization of persons with mental disability. He views institutionalization as violation of a person's dignity. He is categorical that some activities meant to ensure that persons with disability leave comfortable lives are in themselves unlawful. For instance overprotection and voidance of risks through limiting the behavior and interaction, as methods, though well intended by caregivers and guardians but in the long run constitutes a violation to the right of an individual to human dignity.

The right to be free from nonconsensual medical treatment has been recognized by the Committee on Economic, Social and Cultural Rights (CESCR) as one of the freedoms incorporated in the right to the highest attainable standard of health.[92]Thus, the right to free and informed consent is not merely a function of domestic laws, but is one of the human rights and fundamental freedoms that is guaranteed to all persons, and that must be applied without discrimination based on disability. Any limitation of the right to free and informed consent that applies only to persons with disabilities, or disproportionately affects persons with disabilities, would constitute discrimination.

People with mental disabilities are the major victims of institutionalization either in institutions or homes and are thus denied an opportunity to live independently. Shantha[93], agrees with this and states that 70% of persons with mental and intellectual disability live in institutions without their consent. She argues that these people have no means to challenge their institutionalization. I agree with Shantha and reiterate that their inability to challenge decisions to place them under institutions stems from the dominant believe that they are incompetent and therefore lacks capacity

[91] Robert Perske, *'The Dignity of Risk and the Mentally Retarded'* (1972) 10 http://cje.net/sites/default/files/documents/PerskeThe_Dignity_of_Risk1972.doc accessed 10 September 2015.
[92] Ibid.
[93] Shantha Rau Barriga, 'World Report 2012: Events of 2011', From Paternalism to dignity: Respecting the Rights of Persons with Disabilities (Seven Stories Press 2012).

to know what is good for them. This observation as Shantha puts it is basis upon which discrimination occurs. For instance they are stripped off their right to participate in the political life of their states. She draws an example of Peru where more than 23000 persons with intellectual disability were excluded from the voter registry thus disenfranchising them.[94] The question that remains then is whether the assumption that people with mental disability cannot make independent decision is justifiable in law?

Shantha identifies three most areas of violations that affect human dignity of people with mental disability. [95]They include the right to health, the right to political participation, and right to access justice and freedom from arbitrary detention. In addition their right to liberty is non-existence due to placement and confinements in detention centers. These confinements are normally done with the sole opinion, either of a guardian or the medical officer. The danger of this is that the decision makers tend to assume what is the best interest of the person with mental disability without consulting them. There is no system in most jurisdictions of checking how decisions were arrived at and whether due process was followed.[96] On the right to health she argues that it cannot be enjoyed effectively without an individual being accorded right to free and informed consent. Violations occur for instance where a person with mental disability is forced to undergo sterilization, some have been infantilized and some given forced injections. All this are made on the assumption that it is in their best interest.

1.4.3 Are restrictions placed on the ability of persons with disabilities in Kenya to make their own choices justifiable within the provisions of Article 12 of CRPD?

[94] Ibid.
[95] Ibid.
[96] Ibid.

On this issue Bonthuys[97] argues that legal recognition of status and assignment of legal capacity are political acts which enhance and protect certain interests at the expense of others. In this regard therefore the limits placed upon legal capacity are generally justified on the basis that they are designed to protect the vulnerable, as is evident in the case of wives, people with mental illness and children. He however, notes that sometimes the limits could likewise be detrimental to those who lack decision-making capacity and advantageous to those who have the capacity to decide on their behalf. For instance the ability of parents to decide, whom their children may associate with, could protect children against the consequences of their own unwise choices, but it also allows adults to make decisions which suit their own convenience, prejudices and views. This view of legal capacity is detrimental in such a way as it promotes substituted decision making and it assumes that some members of society lack capacity. It therefore empowers certain individuals to make decisions for them. This replaces the vulnerable person from the center of decision making. In most cases the person appointed to act of his behalf is required to act in his (person with disability for instance) interest. Most of the time, this model of legal capacity does not consider the will, preference and choice of the person with disability.

Another issue that is key to this study is the concept of disability. Article 260 of the constitution of Kenya 2010, defines disability to include mental and psychosocial disabilities.[98] Social model of disability is a critique of the medical model and presents disability as a departure from species of

[97] Elsje Bonthuys, 'Legal Capacity and Family Status in Child-Headed Households: Challenges to Legal Paradigms and Concepts' (2010) 6 International Journal of Law in Context at 45 http://journals.cambridge.org/article_S1744552309990292 accessed 9 January 2015.

[98] "Disability" includes any physical, sensory, mental, and psychological or other impairment, condition or illness that has, or is perceived by significant sectors of the community to have, a substantial or long- term effect on an individual's ability to carry out ordinary day-to-day activities."

typical functioning or as a harmed condition. Simona[99] argues that people are disabled by their environment and social conditions which fail to acknowledge different abilities, uniqueness and richness in variety of individuals. She argues that it is this failure that hinders the PWDs from participating in society fully. She disagrees with the notion that its individual limitations that cause the problem for the PWDs. To her it is societal constraints and failure to provide appropriate, specific supports and interventions to PWDs that curtail his/her ability to live independently. It can then be argued if the society puts in place mechanisms for early and timely intervention then the PWD will not feel marginalized and as a result he will easily integrate in the society. Genevra [100] discusses the medical modal of disability and explains that the person offering assistance must always ask himself what is the best interest of the PWD. This system therefore completely eliminates the PWD from decision making because it begins by looking at him as a sick person. One of the criticisms she outlines with this view is that it often times causes injustices and more suffering to persons with mental disability.[101]

On the question of how Article 12 should be interpreted there is little literature on it but Bach and Kerzner[102] proposes a three tiered model of interpreting which I propose to adopt but with adequate safeguard which are clearly set for in law. This model involves: first legally independent status where no support is required, secondly, supported decision making status where support is required and finally facilitated decision making status where a form of substituted decision making would be employed in cases of severe mental cases.

[99] Simona Giordano, 'A heaven without giants or dwarfs' (2014) 1 Cambridge Quarterly of Healthcare Ethics 23.
[100] Ibid.
[101] In re F (Mental Patient: Sterilization (1989) 4 (HL), the HL held that treatment and care which would otherwise amount to an assault was lawful under common law principle of necessity in case of an adult who lacked capacity to consent provided that it was in that persons best interest.
[102] Ibid

1.5 Objective of the study

i. The study will seek to examine and establish what gaps exist in the conception of the question of legal capacity in Kenya that allows for violation of the rights of people with mental disability.

ii. The study also seeks to examine whether Kenyan law and policies on involuntary institutionalization and treatment of persons with mental disability comply with Article 12 of the CRPD.

1.6 Justification of the Study

Mental disability is the most stigmatized disability in Kenya. Unlike other types of disabilities; mental disability is associated with strong social, religious and cultural stigma. As a result such persons live under cover-up and their rights to choice and to make independent decisions is diminished. Their rights are substituted by parents and caregivers. They are normally considered to be dangerous to themselves and others and as a result they remain excluded from mainstream society and denied the right to live independently like other people. They are normally considered helpless individuals who required care and protection. Most of them end up locked up in institutions where they are arbitrarily detained against their wishes and will.[103] In these institutions they are mishandled, sometimes tortured, face physical, sexual, psychological and verbal abuse.[104] This study is therefore important to policy makers as it help them appreciate the importance of the right to legal capacity to PMDs and that with supports PMDs are capable of making independent choices about their lives and thus live independently as other people. This study will also highlight

[103] Kenya National Commission on Human Rights, 'OBJECTS OF PITY OR SUBJECTS WITH RIGHTS: - Objects of Pity OR Individuals with Rights - Final April 2007.pdf' (2007)http://www.knchr.org/Portals/0/OccasionalReports/Objects%20of%20Pity%20OR%20Individuals%20with%20Rights%20-%20Final%20April%202007.pdf accessed 27 April 2016.
[104] Ibid.

various violations that people with mental disability face especially in institutions where they are held. The purpose of this is to help in closing up gap in legislation and thus provide laws that comply with the provisions of Article 12 of the CRPD. The study will also be important in helping the administration and judiciary develop policies that respect the autonomy and independence of persons with mental disability and shift the attention from the medical model of disability which has for year's marginalized PWDs to a human rights perspective that respect people with disability as right holders.

1.7 Research questions

The study will seek to answer the following question:

i. Whether the Kenyan law and policies on involuntary institutionalization and forced treatment of persons with mental and intellectual disability violate the right to legal capacity?

ii. Will the ultimate recognition of the right to legal capacity change societal, institutional and legal perception on stigmatization, involuntary incarceration and involuntary treatment of persons with mental disability?

1.8 Hypothesis

The study is based on the following hypothesis that the existing legislation and policies on legal capacity in Kenya discriminate on the persons with mental, intellectual and psychosocial disability and thus deny them a right to live independently in society like other people. That even though

Kenya has ratified the CRPD and by dint of article 2(6) of the constitution of Kenya is part of its laws a little has been done in incorporating its principles in the existing policies to make them compliant with international standards. For instance the laws on mental health and government policy on mental disability still advocates for guardianship and institutionalization of persons with mental disability. The result of these laws and policies is that they have led to marginalization of persons with mental, intellectual and psychosocial disability.

1.9 **Scope of the study**

The study will be limited to the examination of how legal capacity is viewed in Kenya and only on persons with mental disability. The study will also be limited to examining the impact of the CRPD to the existing legal regime. In addition the study will concentrate on the application of Article 12 in committing a person with mental disability to institutions especially in the medical practice.

1.10 Research methodology

The methodology of this study is based on both primary and secondary sources of data. Primary data was collected through interviews which will encompass both face to face interviews and the use of questionnaires; and observation methods[105]. These modes of data collection were considered appropriate to this research because the research aimed at eliciting information from the stakeholders in the disability sector on the key challenges faced in interpreting and implementing the right to legal capacity for people with mental, psychosocial and intellectual disability. To arrive at a reliable conclusion I interviewed specific groups which will include parents of people with

[105] The introductory letter and questionnaire are attached as appendices to this thesis.

mental disability, carers, psychiatrics, psychologists, lawyers practicing in the disability area, judge, the national council for persons with disability and the non-governmental organizations representing persons with disability.

The research was limited to Kenya since all the categories of the interviewees are within its proximity. For observation purposes Mathare hospital was be purposively selected since the location is accessible to me.

A sample size of 20 interviewees was selected for the interviews using a stratified random sampling technique. The population was divided into four distinct groups out of which individual participants were selected at random to be part of the sample. The groups were categorized as people with disabilities, their parents and carers as one group; the second group will include medical practitioners specifically the psychiatrics and psychologists; the third group included the judicial officers including judges and lawyers and the last group included the national council for persons with disabilities and the NGOs representing people with disability. These groups were chosen as respondents because they are directly involved in either interpreting and or implementing Article 12 of the CRPD in Kenya.

The research instruments used to collect data included the interview schedules, questionnaires and observation. Questionnaires were used especially in situations where it was difficult to schedule an interview with the respondent. Most of the respondents especially PWDs and care givers are illiterate and therefore the use of questionnaires will not apply to them. A structured interview was used with six key questions. The rationale of using a structured interview was to increase the reliability of information gathered because every interviewee was subjected to similar questions with the others. The purpose of primary sources was that the data collected will be used as a basis

of analysis into the situation under study and applied to come out with the appropriate position in international law with regard to the right to legal capacity.

The secondary data collection technique entailed going through secondary materials including books, articles, journals, conference papers and information from the Internet on the subject of the right to legal capacity for persons with mental, psychosocial and intellectual disability as a pillar for the implementation of the CRPD and ensuring autonomy for PMDs. Secondary data also included reports made by official bodies established by the constitution of Kenya to inquire into the situation under study, for instance the Kenya National Human Rights commission, as well as any other data with a government department, agency or other credible organizations that have conducted inquiry into the situation. The information from these sources was applied in the analysis of the information from the primary sources.

1.11 Chapter Breakdown

This study will be broken down into four chapters. The first chapter is the introduction of the study. It discussed inter alia the background of the study, the statement of the problem, the research question, the hypothesis and the literature review.

The second chapter will address the right to legal capacity by persons with mental disability. In particular this chapter will address the concept and ingredient of the exercise of the right to legal capacity for persons with disability in international human rights law. It will analyze the concept of legal capacity from the human rights based approach and juxtapose the obligations of state towards realizing the right to legal capacity for persons with mental disability. Finally, this chapter will address the normative content of the right to legal capacity as provided for in the CRPD.

Chapter three will address whether the laws in Kenya comply with the international legal capacity standard. In responding to this, a case study of Kenya on involuntary institutionalization and forced treatment and whether they violate the rights of expression and informed consent of persons with mental disability is undertaken. The chapter further examines the violations of the right to legal capacity in Kenya and the limitations placed on the exercise of legal capacity for persons with mental disability and whether they violates their rights to non-discrimination. It also examines the legal framework upon which the question of legal capacity is addressed in Kenya and later the effect of denial of legal capacity to PWDs.

Chapter four will provide recommendations on how to realize the right to legal capacity for persons with mental disability in Kenya. It will also give concluding remarks on the importance of addressing the right to legal capacity for persons with disability especially those with mental disability.

CHAPTER TWO

2.0 CONCEPTUALIZATION OFTHE RIGHT TO LEGAL CAPACITY:

IS RATIONALITY A DETERMINANT?

2.1.0 INTRODUCTION

The right to legal capacity is a right recognized in International law.[106] It grants an individual rights and obligations to make decisions and have his choices respected. Legal capacity is what defines an individual as a person before the law and thus making him or her subject of the law.[107] The importance of legal capacity is its facilitative nature. In this case legal capacity is an enabler right that enables an individual to make choices on his life for example on what job to take up, whom to marry and be married to, who to contract with and the inheritance of property among other issues.

[106] Flynn, Eilionoir, and Anna Arstein-Kerslake. "Legislating personhood: realising the right to support in exercising legal capacity", International Journal of Law in Context, 2014.
[107] Anna Nilsson and others, 'Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities' http://works.bepress.com/anna_nilsson/1/ accessed 10 June 2015.

This chapter will explore therefore the historical foundations of the right to legal capacity for persons with disability in international human rights law. It will analyze the concept of legal capacity from the human rights based approach; and whether rationality in decision making is the right measure of legal capacity. The analysis is based on human rights theory in discussing the obligations of state towards realizing the right to legal capacity for persons with mental disability. Finally, this chapter will address the normative content of the right to legal capacity as provided for in the CRPD.

2.2.0 Historical Foundation of the Right to Legal Capacity for Persons with Mental Disability

World Health Organization (WHO), [109]estimates show that there are more that 450 million people around the world who suffer from mental, psychosocial or intellectual disability. Unfortunately, majority of the world States have no mental disability laws and policies in place and those countries with policies have allocated very few resources to address mental disability.[110]The advocacy for the recognition of the rights of persons with disability arose immediately after World War II and the events therein. It is alleged that between the periods of 1939-41 more than 250,000 people with intellectual, mental and physical disability were systematically murdered by the Nazi regime through the Aktion T4 racial hygiene program.[111] As a precursor to this, 1933-39 saw the German authorities forcibly sterilize 360,000 disabled Germans.[112] At inception and during its

[109] World Health Organization (WHO), The World Health Report 2001: Mental Health: New Understanding, New Hope, 1 (2001) [hereinafter World Health Report 2001].
[110] Ibid.
[111]Disabled people's history - Disability Equality North West, https://www.google.com/webhp?ie=utf-8&oe=utf-8#q=un+law+on+disability+history, Jarlath Clifford, 'The UN Disability Convention and Its Impact on European Equality Law' (2011) 6 The Equal Rights Review at 11 http://www.corteidh.or.cr/tablas/r27132.pdf accessed 10 September 2015.
[112]Ibid.

early years of operations, the UN focused on promoting the rights of persons with disabilities but with a focus on physical disabilities through a range of social welfare approaches.

The UN adopted the International Covenant on Civil and Political Rights (ICCPR)[113] and the International Covenant on Economic, Social and Cultural Rights (ICESCR)[114] which re-evaluated the rights of all individuals with disabilities including those with mental, intellectual and psychosocial disability. The ICESCR provided that every individual had a right to the enjoyment of the highest attainable standard of physical and mental health and obligated member states to ensure that this is implemented.[115] Though these instruments were important in creating awareness on equality of all human beings they did not specifically address mental disability as such. The UN bowing to pressure and international concern of the rights of person with disabilities proceeded to adopt various instruments and declarations with a view of addressing the problem and filling in the gap. This concerns were addressed in a number of disability-specific non-binding international instruments which included the Declaration of the Rights of Mentally-Retarded Persons,[116]the Declaration on the Rights of Disabled Persons,[117]and by proclaiming 1981 as the International Year for Disabled Persons.

Later on the UN through the General Assembly adopted World Programme of Action concerning Disabled Persons,[118] at its thirty-seventh session in 1982. This programme adopted the

[113]Adopted by General Assembly resolution 2200 A (XXI) of 16 December 1966.Entered into force on 23 March 1976 in accordance with Article 49.
[114]Adopted by General Assembly resolution 2200 A (XXI) of 16 December 1966. Entered into force on 3 January 1976 in accordance with Article 27.
[115] Collard, International and Regional Instruments, Standards, Guidelines and Declarations, Mental illness Discrimination and the Law Fighting for Social Justice, 2012.
[116] Adopted by General Assembly resolution 2856 (XXVI) of 20 December 1971.
[117] Adopted by General Assembly resolution 3447 (XXX) of 9 December 1975.
[118]Adopted by General Assembly Resolution 37/52 of 3 December 1982, accessed at www.miusa.org.

equalization of opportunities strategy principle to advocate for inclusion and full participation of PWDs in all areas of life and development and on an equal basis.[119] The programme's main achievement lied in its ability to transform the disability issue from one of "social welfare" to that of 'human rights' thereby integrating all persons with disabilities in development processes.[120] Other important instruments adopted include: the Tallinn Guidelines for Action on Human Resources Development in the Field of Disability,[121] Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,[122]Standard Rules on the Equalization of Opportunities for Persons with Disabilities,[123]ILO Recommendation concerning Vocational Rehabilitation of the Disabled,[124] and Sundberg Declaration on Actions and Strategies for Education, Prevention and Integration.[125] The UN later in 1983 adopted the standard rules on the equalization of opportunities for PWDs which provided for a human rights perspective for disability-sensitive policy design and evaluation as well as for technical and economic cooperation.[126]

[119] www.un.org.
[120] Ibid.
[121]Ibid 105, Adopted by General Assembly Resolution 44/70 of 8 December 1989.
[122]These principles lay down provisions to promote the rights of mentally disabled persons in health care. There are specific provisions on informed consent, confidentiality, standard of care and treatment and the rights available to inmates of mental disability institutions. Principle 1(4) prohibits discrimination on the ground of mental disability. It was adopted by General Assembly resolution 46/119 of 17 December 1991. At www.doras.dcu.ie .
[123]Adopted by General Assembly resolution 48/96 of 20 December 1993.
[124]Convention No. 159 and Recommendation No. 168, Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159).
[125]Adopted by the UNESCO World Conference on Actions and Strategies for Education, Prevention and Integration, Malaga (Spain) adopted in November 1981.
[126] A/RES/48/96, United Nations Resolution adopted by the General Assembly at its 48th session on 20 December 1993.

The UNCRPD became the first human rights instrument to specifically and comprehensively deal with the rights of PWDs. It is a product of *Ad Hoc* Committee,[127] established by the UN General Assembly to consider proposals for a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities, based on the holistic approach in the work done in the fields of social development, human rights and non-discrimination.[128] The Convention, and its Optional Protocol, was adopted in 2006, [129]and entered into force on 3rd May 2008, after receiving its twentieth instrument of ratification in accordance with its articles.[130]

By adopting the UNCRPD, State Parties undertook to ensure that all PWDs realize all human rights and fundamental freedoms without discrimination of any kind on the basis of disability. It is important to note that all previous efforts on the rights of PWDs did not address the question of legal capacity. The UNCRPD for the first time in the history of disability comprehensively recognized that PWDs are persons before the law and that they have legal capacity to make their own choices.[131]

2.3.0 Concept of Legal Capacity from the Human Rights Approach.

The Universal Declaration of Human Rights sets a universal and common standard of achievement for all peoples of all nations.[132] The human rights theory is embedded in the fact that rights belong

[127]General Assembly Resolution 56/168 of 19 December 2001.
[128] www.handicap-international.fr.
[129] General Assembly resolution 61/106 of 13 December 2006.
[130]CRPD Article 45(1).
[131] CRPD Article 12.
[132] UDHR preamble states that, "…as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance,

to individuals; they inhere to individuals because they are human and they apply to all people around the world. Human rights theory place human beings at the center of decision making and focus its attention on the inherent dignity and worth of every human being.[133] All actions by different actors therefore are to be geared towards ensuring that this dignity is not only upheld but also respected. This theory principally involves the relationship between the state and the individual persons. The primary responsibility and obligation of the state in this relationship is to guarantee, protect and promote rights of all persons. Tony argues that even though it's the role of the state to protect and promote human rights of individuals within their jurisdictions, the value of these rights have over time diminished due to globalization and the emerging global order.[134]He posits that the emerging world order may be a cause of many human rights violations. Even with emerging markets and globalization the state still remains in a better position to guarantee the protection of the rights of its citizens than any other body or organization.

Human rights perspective emphasizes that the needs of people with mental disability and their satisfaction should be seen as a matter of right and not as an act of charity.[135] In this respect therefore, the law, norms, programs and institutions should not only recognize these needs but also make them effective. Those institutions that deny an individual of his rights are therefore to be reviewed to guarantee that everyone enjoys his rights without discrimination. As regard persons with mental disability, Jonathan M. and others argue that health policies, norms and practices have

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both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction."

[133] Omar Grech, Organisation and Mediterranean Academy of Diplomatic Studies, A Human Rights Perspective on Development (Educating and Acting for a Better World and the Mediterranean Academy of Diplomatic Studies 2005) 19.

[134] Evans Tony, The Politics of Human Rights: A Global Perspective (Pluto Press 2001).

[135] Ibid.

an impact on human rights, whether positive or negative.[136] They further state that human rights violations impact on the health of individuals. For instance human rights violations that are severe in nature and which take place for prolonged periods like continuous institutionalization have a consequence of making the health condition of a person with mental disabilities worse. It is vital to note that serious human rights violations are usually designed, not to inflict so much physical pain, but disguised as a medical procedure that is intended in keeping the person with mental disability on check.[137] Lastly, they also argue that promotion and protection of human rights and safeguarding both the physical and mental health of individuals in a particular state are fundamentally connected.[138] In this case failure to fulfill one will have a dire effect on the other.

Gostin states that under the human rights theory persons with mental disabilities seek four interrelated human rights: liberty, dignity, equality, and entitlement.[139] He argues that correlative to these rights are four themes which involve involuntary detention, the conditions of confinement, civil rights, and access to mental health services. Human rights approach therefore demands that any civil commitment of persons with mental disability must follow a "procedure prescribed by law" and should not be arbitrary. Apart from the person recognizing mental illness and requiring that an individual be confined for the purposes of treatment, the victims consent must be sought first. Though this ought to be the position, most jurisdictions have capacity limiting legislation which tends to empower either judicial officers or medical officers to make decisions without the victims consent. This in return is a violation which does not respect the autonomy and personhood of person with disability.

[136] Jonathan M Mann and others, 'Health and Human Rights' (1994) 1 Health and Human Rights at 6.
[137] Ibid.
[138] Ibid.
[139] Lawrence O Gostin, 'At Law: International Human Rights Law and Mental Disability' (2004) 34 The Hastings Center Report at 11.

In conclusion approaching the question of legal capacity from a human rights perspective for persons with mental disability requires a paradigm shift away from a public health approach in its conventional sense. [140] The CRPD provides an explicit social development dimension which encompasses human rights approaches to disability. It marks a "paradigm shift" in attitudes and approaches from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing them as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. Thus, the Convention constitutes a significant global commitment to a human rights framework in which issues of achieving substantive equality and the full and unfettered rights of persons with disabilities are placed at center-stage.

In light of the CRPD, public health approach is considered inadequate, as it serves to reinforce paternalism and charity in identifying mental disability as a medical issue necessitating a medical solution. In contrast, rights-based approaches to mental disability means acknowledging the social, economic, and political forces that result in the disability experienced by people with impairments.

2.4.0 Normative Content of the Right to Legal Capacity

2.4.1 Legal Personality

Article 12, paragraph 2 of the UNCRPD, recognizes that persons with disabilities enjoy legal capacity on an equal basis with others in all areas of life. This Article in general address identity requirements of legal capacity and recognizes the personhood of a person with disability. Quinn notes that Article 12 is emblematic of the paradigm shift described by the deceptively simple

[140] Jonathan Kenneth Burns, 'Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability' (2009) 11 Health and Human Rights at 19 http://www.jstor.org/stable/pdf/25653100.pdf accessed 17 July 2015.

proposition that persons with disabilities are 'subjects' and not ''objects' of the law, meaning that they are human beings like all others deserving equal respect and equal enjoyment of their rights.[154] He explains that the primary role of legal capacity is to provide the legal shell through which to advance personhood in the life world. It enables persons to sculpt their own legal universe which is a web of mutual rights and obligations voluntarily entered into with others. So it allows for an expression of the will in the life world.[155]

The right to be recognized as a person before the law forms a foundational basis to the exercise of legal capacity by an individual. It's therefore important that the right to personhood is guaranteed as its denial will mean that an individual cannot be a subject/ holder of rights and cannot therefore exercise those rights on an equal basis with others, and he/she is likely to face civil death. Therefore to intentionally remove an individual from the protection of the law may constitute a refusal to recognize that person before the law. It then follows that such an individual will be deprived of his or her capacity to exercise their rights as recognized under various legal instruments. In addition the individual who is deprived recognition will find it difficult to access the possible legal remedies available for any violations he/she faces.

Before the adoption of the CRPD most persons with mental disability were considered merely as objects of pity by many societies.[156] In Kenya, the Mental Health Act presumes that a person suffering from mental disability and is incapable of expressing himself or unwilling to receive treatment should be subjected to involuntary treatment.[157] Questions arise therefore on what

[154] Gerard Quinn, 'Personhood & Legal Capacity Perspectives on the Paradigm Shift of Article 12 CRPD.' (HPOD Conference, Harvard Law School, 20 February 2010) http://www.nuigalway.ie/cdlp/documents/publications/Harvard%20Legal%20Capacity%20gq%20draft%202.doc accessed 9 September 2015.
[155] Ibid.
[156] Ibid
[157] Section 14

mechanisms are adopted by the medical practice to ascertain what amounts to refusal to consent. Can mere silence from the person with mental disability amount to unwillingness and if so does one possess the capacity to refuse treatment even though beneficial to him? This question shall be discussed further in chapter 3. The adoption of the CRPD therefore was meant to bring about a paradigm shift in the way persons with disability are addressed. Prior to CRPD many states did not recognize them as persons on an equal basis with others who didn't have a disability but as instruments of pity therefore the state took the responsibility of providing a guardianship system to ensure that certain individuals are chosen to take care and act on behalf of the PMDs.[158] The operating principle behind the actions of the assistant was to act in the best interest of the person with disability irrespective of their wishes, will and preferences.

The right to recognition before the law was first recognized in the Universal Declaration of Human Rights[159] and later in the Convention on Civil and Political Rights.[160] Article 2 of the declaration provides that these rights apply to all persons without distinction. Even though the declaration does not state specifically disability as a ground upon which distinction should be based, it can be argued that the term 'other status' is sufficient enough to include disability.

The right to be recognized as a person is central to the conception of human rights.[161] As a legal person, an individual enjoys, and is subject to, rights and duties at law. It recognizes the existence of the individual as a human being with distinct needs, interests, and opinions and is a necessary

[158] Kenya National Commission on Human Rights, 'OBJECTS OF PITY OR SUBJECTS WITH RIGHTS: Objects of Pity OR Individuals with Rights, 2007.
[159] UDHR, Article 6.
[160] Ibid, Article 16.
[161] Working group on enforced/ involuntary disappearance, General Comment on the Right to Recognition as a Person before the Law in the Context of Enforced Disappearance.

prerequisite to all other rights of the individual.[162] Legal capacity and capacity to act are treated as synonyms, meaning the ability of an individual to carry out legally significant acts. By including both recognition as a person before the law and legal capacity, Article 12 restates the connection between the two. It has been hailed as one of the most significant provisions of the CRPD because it creates a presumption of legal capacity for all persons with disabilities.[163]

The centrality of the right to legal capacity therefore is based on the fact that it expresses the right of every human being not only to be a holder of rights but also bestows on individual and other actors an obligation to act in a given way under the law. This right incorporates many components and important rights, freedoms and duties. These includes: the right to be recognized by the legal system of a certain country regardless of a person legal and other status; the right to be equally protected everywhere in law and practice; the right to be subjected to the protection of human rights and freedoms define at both national and international level; and the right to have access and fair process of justice.[164]

Legal capacity should be distinguished therefore from mental capacity for persons with mental disability to be able to live independently in society. Legal capacity as earlier discussed implies the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency). It is the key to accessing meaningful participation in society. While on the other hand mental capacity refers to the decision-making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including

[162] Margaret Edith Brett, 'The Right to Recognition as a Person before the Law and the Capacity to Act under International Human Rights Law' (2012) 9 http://www.chiark.greenend.org.uk/~chrisj/Right_to_Recognition.pdf accessed 10 July 2015.
[163] Gerard Quinn and Martin SCHEININ, 'Disability and Human Rights: A New Field in the United Nations', International Protection of Human Rights: A Textbook (Åbo Akademi University Institute for Human Rights 2009) at 262 http://cadmus.eui.eu/handle/1814/12357 accessed 10 July 2015.
[164] An analysis on the right to recognition as a person before the law, Dec 2006, http://www.legalguide.com last accessed 22/07/2015.

environmental and social factors.[165] Under Article 12 of the Convention, perceived or actual deficits in mental capacity are not to be used as justification thereof for denying legal capacity to persons with mental disability.

In conclusion, PMDs have the right to develop a full human life and such development cannot happen without the opportunity to exercise capacity. To deny this opportunity to any group of persons is to perpetuate exclusion and to legitimize discrimination; and as a consequence acts as a legal reinforcement of social prejudice. It is therefore paramount that Article 12 be read in a manner that is consistent with the general principles and purpose of the CRPD. Article 1 of the CRPD describes the purpose as: "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all PMDs, and to promote respect for their inherent dignity". The general principles on the other hand include "Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons" and "Full and effective participation and inclusion in society".

2.4.2 Is Competency and Rationality in decision making a determinant in assessing legal capacity?

The standards relevant to the assessment of decision-making capacity can vary from jurisdiction to jurisdiction. Majority of the jurisdictions have adopted a common standard which includes the ability of a PMD to evidence a choice, ability to understand Information, ability to appreciate a situation and likely consequences, and ability to manipulate information rationally.[166] It is notably

[165]The general comment on Article 12 on equal recognition before the law was prepared pursuant to Rule 47, paragraphs 1 and 2 of the Committee's Rules of Procedure (CRPD/C/4/2) and paragraph 54 of the Committee's Working Methods (CRPD/C/5/4).
[166] Raphael J services London, *Mental Capacity* http://www.dls.org.uk/Pages/Advice/Factsheet/community_care/mental_capacity/Mental_Capacity.pdf.

important that this criteria is used by doctors and medical practitioners in advising judges or when making a decision on whether one possess legal capacity to make independent decisions. It is the position of this paper that this standard is erroneous and cannot be adopted in determining legal capacity. Rationality and competency test are based on mental capacity of an individual. Genevra Richardson[167] argues that mental capacity is a prerequisite component for the exercise of capacity by an individual. He defines mental capacity as an essential ingredient of individual's autonomy and uses it to draw a line between what decision is legally effective and legally ineffective.[168] It follows therefore that a person who is considered to have mental capacity will qualify as having legal capacity to act and their decisions will be upheld as being sound, rational and therefore respected. Such a person will therefore be considered competent. On the other hand those persons who are presumed to lack mental capacity will end up considered as lacking in legal capacity and incompetent therefore their decisions will become a subject of substituted decision making.[169] On establishing whether an individual has mental capacity, Dr. Ludwig F. Lowenstein states that a number of factors should be taken into consideration which includes healthcare policies, human rights principles, demographic and social attitudes which indicate that the law must protect the interests and rights of people who may or may not have capacity.[170] It is therefore the position of this dissertation that the legal capacity is a human rights issue that must be looked at from a human rights perspective and that the determination of legal capacity only based on a person's mental status and how rational their decisions are is erroneous.

Accessed 9 October 2014Leo, 'Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians' (1999) 1 Primary Care Companion to The Journal of Clinical.

[167] Genevra Richardson, 'Mental Capacity in the Shadow of Suicide: What Can the Law Do?' (2013) 9 at 87.

[168] Ibid.

[169] Ibid.

[170] Ludwig F. Lowenstein, 'Mental Capacity – Recent Research | CL&J' (2013).

2.4.3 Supported Decision Making.

The overriding theme in the Mental Health Act of Kenya is acting in the best interest of the PMDs. It's upon this premise that guardianship and management orders are provided for under section 26 of the Act. Where these orders are granted by the court a guardian or a manager/ trustee steps into the shoe of the PMD and makes decisions for him/her. This system of decision making is referred to as substituted decision making. Substituted decision making is based on the fact that instead of the substitute mimicking the will and preferences of the person with disability, there was almost a conscious disregard of the will and preferences - even where it was clearly detectable.[171] The CRPD provides a departure from this system under Article 12, paragraph 3, which recognizes the right of persons with disabilities to support in the exercise of their legal capacity. States must refrain from denying persons with disabilities their legal capacity, and instead must provide PMDs access to the support that may be necessary to enable them to make decisions that have legal effect. Support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making.[172]

The United Nations Handbook[173] on the Convention defines support as a framework within which a person with a disability can be assisted to make valid decisions. Barbara outline empowerment, choice and control as the essentials of support which should ensure that one has the right to make their own decisions and to receive whatever support they require to do so.[174] Supported decision-making may take many forms ranging from support persons communicating an individual's intentions to others or help him understand the choices at hand. They may also help others to

[171] Ibid.
[172] Ibid.
[173] http://www.un.org/disabilities/default.asp?id=242
[174] Ibid.

realize that a person with significant disabilities is also a person with a history, interests and aims in life, and is someone capable of exercising his/her legal capacity.

Supports are necessary to enable individuals with mental disability to exercise legal capacity. They encompasses both informal and formal support arrangements, of varying types and intensity; and may include persons with disabilities choosing one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy, or assistance with communication.[175] Nina A, Jeremy A. & Amy T argue that supported decision making provides an alternative to guardianship and if properly implemented it can act to remedy the problems posed by surrogate decision-making processes.[176]

The basis of supports is the belief that as human beings we exhibit a mix of characteristics sometimes stable and on other occasions unstable, while sometimes our decisions are rational and on occasions irrational. Because of these, human beings find themselves in a web of supports that augment their personhood.[177] These supports give individuals confidence to begin shaping their autonomy.

Even though article 12 of the CRPD begins with a presumption that people with disabilities have a right to legal capacity on an equal basis with others, it however proceeds to acknowledge the

[175] Piers Gooding, 'Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law' (2013) 20 Psychiatry, Psychology and Law at 431 http://www.tandfonline.com/doi/abs/10.1080/13218719.2012.711683 accessed 10 September 2015.
[176] Nina A Kohn, Jeremy A Blumenthal and Amy T Campbell, 'Supported Decision-Making: A Viable Alternative to Guardianship?' (Social Science Research Network 2013) SSRN Scholarly Paper ID 2161115 http://papers.ssrn.com/abstract=2161115 accessed 10 September 2015.
[177] Ibid.

importance of supports in exercising it. The concept of supported decision making recognizes a number of issues. These issues include:[178]

a) That the persons autonomy is a fundamental legal principle and therefore there should be no transfer of this right to other individual;
b) That individuals should be empowered to take risk in their lives, provided those risks are balanced by the proper provision of information and advice; and
c) That all human beings are subject to the influence of and are to some extent dependent on others.

One major challenge with the system of supports is in its model. Unfortunately majority of the models proposed tend to borrow a lot from substituted decision making model. Tina observes that innovative measures should be adopted to develop a support system but fails to outline what should constitute a viable support system that doesn't substitute the decisions of the PMDs.[179] Bach[180] proposes a model of support which includes decision-making assistance for demonstrating and exercising one's full personhood including one's legal capacity to act.[181] Assistance in this case refers to provision of any type of assistance to an individual in making a decision, expressing

[178]Ibid.
[179] Supra note 52.
[180] Michael Bach, 'The Right to Legal Capacity under the Convention on the Rights of Persons with Disabilities (Institute for Research and Development on Inclusion and Society (IRIS) Kinsmen Building, York University 2009) https://irisinstitute.files.wordpress.com/2012/01/the-right-to-legal-capacity-under-the-un-convention_cr.pdf accessed December 2014.
[181] Decision-making assistance would include: Informal assistance of family and friends in making daily decisions and carrying out activities of daily life; Individualized plain language assistance, assisted/adaptive communication, visual aids, etc; Supported decision-making representatives/ networks (which includes assistance in developing and maintaining supported decision-making representatives/networks, registration systems so that individuals can designate those who are to represent and assist them in decision making, conflict mediation, monitoring) ; Support to other parties engaging in relations with an individual with a disability – to help those parties understand how a person communicates, and to meet their duty to provide reasonable accommodation ; and protections from liability for support decision-making representatives/ networks and other parties in assisting a person in making decisions, and for entering agreements with an individual via supported decision making. **General comment on Article 12 of CRPD.**

their will, or having others help communicate their personal identity to potential parties to a legal arrangement. Assistance provided on an informal basis would be recognized and would include aids, interpreters as well as supported decision-making networks or representatives. These are people designated by an individual on the basis of trust and commitment to assist a person in making decisions and to help represent them in exercising legal capacity but without being substitute decision makers.[182] Safeguards should therefore be put in place to help guard against individuals who have been appointed by the PMDs from substituting their rights and decisions. It would also include assistance to other parties to understand a fuller conception of personhood, alternative means of communication, and their duty to accommodate others' unique expressions of intention and personal identity. The model of support will also encompass information and awareness campaigns about human rights, legal capacity, decision-making assistance, including supported decision-making networks[183] and lastly advocacy support to individuals to exercise and protect their right to legal capacity.

It's important to note that the need for support is to retrieve the will and preference of a person no matter how hidden and to create conditions of social embedness that will eventually spark the will. To achieve this, safeguards are relevant to supported decision-making especially to those rare instances where decision will have to be made 'for' some persons regardless. To ensure that this goal is achieved Article 5 empowers the state parties to carry out affirmative action measures aimed at ensuring that PMDs live independently and their wishes and preferences are respected.[184]

[182] Ibid
[183] Ibid.
[184] CRPD Article 5, provides that specific measures (sometimes called 'positive' measures) which are necessary to accelerate or achieve de-facto equality of persons with disability do not constitute discrimination. It is important to appreciate that differential treatment related to the provision of adjustments and modifications necessary for persons with disability to enjoy or exercise fundamental rights

Pathare & Shields[185]argues that there is no single best practice for supporting PMDs to reach decisions, as systemic factors impact the provisions of these accommodations as well as individual factors. They however suggest that, certain components from successful models that embody the support paradigm be extracted and utilized in systems and settings wishing to shift away from a guardianship model.

The concept of supported decision making is a new one and should be approached cautiously. It must be noted that though the system presents an alternative to guardianship it should be given serious consideration as to how it might be incorporated into public policy as no current empirical evidence exists to show the extent to which it can remedy the problems posed by surrogate decision-making processes. Supported decision-making may take two forms, as either purely informal where something is done without legal sanction; or it can be formalized through a private but legally enforceable agreement between the PMD and a trusted third party.[186]

This model of decision making will thus require the abolishment of any system of substituted decision making which for a long has characterized mental health laws. Substituted decision making removes a PMD from the center of decision making process and replaces him or her with an assistant who acts in his/her best interest. In most instances the assistant always make decisions which do not reflect the will, preference and wishes of the person especially where disability is severe and long term. A good example of the manifestation of the system of substituted decision

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and freedoms, or as a result of a positive measure aimed at achieving de facto equality for persons with disability do not constitute discrimination, and by extension are not 'arbitrary.' In fact, they are positively required by the CRPD. This applies to measures designed to assist persons with disability exercise legal capacity.

[185] Soumitra Pathare and Laura Shields, 'Supported Decision-Making for Persons with Mental Illness: A Review' (2012) 34 Public Health Reviews http://www.publichealthreviews.eu/upload/pdf_files/12/00_Pathare.pdf accessed 10 March 2015.

[186] Nina A Kohn, Jeremy A Blumenthal and Amy T Campbell, 'Supported Decision-Making: A Viable Alternative to Guardianship' (2012) 117 Penn St. L. Rev. at 1111.

making can be witnessed in majority of legislations that require a PMD to undergo involuntary treatment.[187]

Bernadette[188] argues that supports for involuntary treatment criteria should be based on decision making capacity rather than the notion of dangerousness. In this case it should respect the rights, wills, wishes and preferences of the person with mental disability. Supported decision making is closely linked to non-discrimination and particularly to the idea of reasonable accommodation safeguards provided for in Article 12(4) which states that, "*States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.*" The principle of safeguards is therefore important when supports are actualize since individuals giving support must be checked to ensure that they do not substitute the rights, will and preferences of PMDs and they are also important in enabling him/ her to function or exercise their rights on the same basis as others. It is an essential part of prohibiting discrimination against PMDs since the discrimination faced usually arises from general features of society rather than directly discriminatory conduct.

[187] Section 14, Mental Health Act.
[188] Bernadette M McSherry, 'Legal Capacity Under the Convention on the Rights of Persons with Disabilities' (Social Science Research Network 2012) SSRN Scholarly Paper ID 2490972 http://papers.ssrn.com/abstract=2490972 accessed 10 September 2015.

2.4.4 The Principle of Autonomy in Decision making.

As discussed above, majority of persons with mental disability require supports in exercising their right to legal capacity. The main challenge in law is on how to protect autonomy of persons with mental disability who are in need of supports to make independent life decision, and especially where the supports are granted in a way that may restrict his or her autonomy. For instance, the state in carrying out its positive obligation of providing care and support may advance various services and funds to PMDs but in return the recipient of this services loses his/her right to say 'no' or to choose an alternative method of supports and treatment[189] The challenge this arrangement raises therefore is on how the state's obligations can be shaped in a manner that respects the wishes of the PMDs, meets their needs and at the same time ensure that people are supported and enabled to exercise and enjoy their autonomy and legal capacity.

Autonomy connotes that an individual who conforms to the dominant notions of independence and self-sufficiency is both freed from the prospect of regulatory government action and freed through governmental structures from interference by other private actors.[190] This freedom is the noninterventions of governments stated in positive terms that people have 'the right to be let alone' which is also the guarantee of the right to privacy.[191] To guarantee and ensure this the state grants them autonomy.

[189] Supra note*
[190] Michael Bach and Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity' <http://repositoriocdpd.net:8080/handle/123456789/449> accessed 26 February 2016.
[191] Nandini Devi, 'Supported Decision- Making and Personal Autonomy for Persons with Intellectual *Dis abilities:* Article 12 of the UN Convention on the Rights of Persons with Disabilities.' (2013) 41 J.L. Med. & Ethics 792.

There are two approaches to autonomy of an individual. First autonomy implies a situation where the state does not intervene to determine what life paths are best for individuals to pursue.[192] In this case the state will not define what will constitute the 'good life' for individuals rather, it protects their rights to define and pursue this for themselves. The role of the state in this view is to set the broad constraints for individual choice and decision making through criminal, contract, corporate, civil, and health law.[193]

The second approach in protecting autonomy arises where a state defines who cannot exercise autonomy.[194] In this approach a boundary is drawn between the competent and the incompetent. This approach which is in operation in most jurisdictions and which was the operative approach to autonomy for persons with mental disability before the enactment of the CRPD, guarantees freedom from restraint and the right to privacy and autonomy for only those who can meet the standards of competence to exercise autonomy. This boundary draws a zone that limits state intervention in order to protect the exercise of autonomy. The state defines a minimum threshold in order to protect the integrity of the various transactions, contracts and agreements individuals make with others, thus protecting the autonomy of all the parties.[195] The hallmark of this approach is based on the medical model where an individual must demonstrate independent capacities to understand information and appreciate the consequences of one's actions and decisions. Those unable to do so are defined as mentally 'incompetent' or incapable of exercising autonomy. Removing from persons their legal capacity to transact with others and therefore justified not only in the name of protecting the integrity of the transaction, but also of protecting the person. With the ratification of the CRPD and the constitution this position must be reviewed. An interpretation that

[192] Ibid.
[193] Ibid.
[194] Ibid.
[195] Supra note 1.

allows a person to channel and define what will constitute good life must be encouraged. Therefore any limitation should only remain within the constitutional means and only where anecdotal evidence exist to justify such limitation and on an equal basis with others. Blanket condemnation should be discouraged and proper guidelines adopted before these limitations are applied.

2.4.5 The Principle of voluntary and Informed Consent.

Art 25(d) of the CRPD is fundamental in informing the health policies and practices that affects persons with mental disability. This article requires that health care to be provided to PMDs on the basis of free and informed consent and on an equal basis with others.[196] The right to free and informed consent is recognized as one of the international standards for the right to health.[197] Informed Consent principle implies that before an individual is accorded treatment or any medical test and examinations carried out on him, his permission must be sought. [198] This requires a medical practitioner to explain to the PMD the nature of treatment or examination required, its benefits, impacts and side effects. For consent to be valid therefore, it must be voluntary and informed.[199] Voluntariness implies that the decision to consent or not to consent to treatment must be made by the person out of his own will and must not be influenced unduly or obtained through coercion or trickery.[200] Informed decision on the other end denotes that all information is given to the PMD to help him make his decision. This information may include the type of treatment, its benefits and risks and whether reasonable alternative treatments exist and the consequences to the

[196] www.hrlrc.org.au.
[197] Office of the United Nations High Commissioner for Human Rights and the World Health Organization, 'The Right to Health.' Fact sheet No. 31.
[198] N. H. S., 'Consent to Treatment' www.hshackletonnevillstreet.co.uk accessed 13 June 2016.
[199] Ibid.
[200] Supra note 42.

PMD of withholding such consent.[201] Based on this premise therefore, it must be noted that an adult who voluntarily and acting on information given to him by the medical practitioners refuses to consent to a particular treatment, or rejects being institutionalized, their decision must be respected.

2.4.5.1 Is Consent an Absolute Requirement?

There are several situations where the law allows treatment without the person's consent. For instance: where one requires emergency treatment to save their life, but they are completely incapacitated and their consent cannot be procured;[202]or where a person immediately requires an additional emergency procedure during an operation and those with a severe mental health condition. This position is erroneous in terms of article 12 of CRPD. The CRPD contemplates the existence of support system which will allow a PMD to make his choices known to a support person in advance. Support person is specific to an individual and can retrieve what his client PMD needs and this position should only be reverted to as a last resort.

James F, notes that a patient's decision must be informed and free, and he/she must be competent either to consent to or to refuse treatment.[203] Unfortunately opinions differ on what scale should be used to determine an individual's competence to consent. Rather than have a blanket condemnation, a presumption of existence of legal capacity to all persons should first be affirmed. The issue of whether or not one is competent therefore should be individualistic and evaluated

[201] Ibid.
[202] Incapacitated in this case implies that an individual is totally unable to give his consent. This may be due to injury that has rendered him unable to. For instance where one is in a coma and his consent cannot be procured on time.
[203] James F Drane, 'Competency to give an informed Consent. A Model for making Clinical Assessments.' The Journal of the American Association.

based on facts before hand. Juma suggests in determining the standard to be adopted, a scale should be adopted that requires high and more stringent standard where the risks involved with the consequences of the patient's decision is high.[204] This means that the standard of competency to consent to or refuse treatment should depend on how dangerous the treatment decision is.[205] However, with various abnormalities accompanying mental disabilities, a model with proper guidelines should be provided to aid the physician responsible in making a determination of competency to consent. This paper adopts this position only to individuals with severe mental disability who are in a state where their consent cannot be procured and no support persons had been identified prior to hospitalization.

2.5.0 Obligation of the State

The state parties have three main obligations under international law. This includes an obligation to respect, protect and fulfill the right of PMDs.

2.5.1 Obligation to Respect

Obligation to respect is defined as the obligation not to interfere with the enjoyment of the rights of PMDs.[206] For instance the state must respect the right of PMDs to health by not carrying out medical experiments on them without their informed consent and against their free will. In ensuring the respect of the right to legal capacity the state should refrain from actions that deprive PMDs of the right to equal recognition before the law and should take action to prevent non-State

[204] Interview with **Juma** in Nairobi, Kenya (10th July 2016).
[205] Ibid note 213.
[206] House of Lords and House of Commons, Joint Committee on Human Rights, *Implementation of the Right of Disabled People to Independent Living*, 23rd Report of 2010-2012 pp.15 Para 25.

actors and private persons from interfering in the ability of PMDs to realize and enjoy their human rights, including the right to legal capacity.[207]

2.5.2 Obligation to Protect

Obligation to protect means that, the state must take positive steps to protect the rights of disabled people against violations by third parties, including private individuals and organizations.[208] This will include the state ensuring that people with mental disability for instance are not subjected to inhuman and degrading treatment. The state in this regard is to abolish any systems that empower other actors to exercise various authorities to deny legal capacity. This is because systems that deny legal capacity based on status violate article 12 because they are prima facie discriminatory, as they permit the imposition of substitute decision-making solely on the basis of the person having a particular diagnosis.[209]

2.5.3 Obligation to Fulfill

Obligation to fulfill on the other hand refers to the appropriate actions taken towards the full realization of the right to legal capacity by the state which include executive, legislative, administrative, budgetary and judicial actions.[210]States in this connection should therefore review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences.[211]

[207] General comment on Article 12 of CRPD page 5 paragraph 20.
[208] Ibid paragraph 26.
[209]General comment on Article 12 of the CRPD page 5 paragraph 21.
[210]Ibid paragraph 27.
[211]General comment on Article 12 of CRPD page 5 paragraph 22.

2.6.0 Conclusion.

This chapter has taken the position that the proper construction of legal capacity can only be found in progressively applying article 12 of the CRPD to give it full effect and not limiting its application. Several challenges still manifest which include: the overreliance on medical evidence as the only factor in determining legal capacity questions, PMDs are not involved in decisions that affect them and the unavailability of a support system whether formal or informal to help PMDs make their own independent decisions; or where support persons make the decisions on behalf, that decision respects the will, wishes and preferences of the person.

This chapter has therefore demonstrated how people with mental disabilities are never placed at the center of decision making process in matters affecting them and that even though Kenya has ratified the CRPD with no reservations, a lot is yet to be achieved in the construction of legal capacity.

CHAPTER THREE

VIOLATION OF THE RIGHT TO LEGAL CAPACITY FOR PERSON WITH MENTAL DISABILITY IN KENYA.

"Persons with mental disorder and emotional crises e.g. schizophrenia and Down syndrome are normally seen to be mentally ill and disabled. Unfortunately, such persons have no place in most societies as they are viewed as insane or mad. Others are viewed as possessed by evil spirits, bewitched or suffering from a bad omen. They themselves have been made to believe that they are sick and in need of sympathy and help. The result of this perception is that people with mental disability are feared and viewed as dangerous not only to the society but also to themselves. They are therefore kept away from mainstream society and deemed incapable of living normal and independent lives."[212]

3.0 Introduction.

There is continued recognition of the duty of states to protect, respect and fulfill the rights of PWDs as discussed in chapter two, in international law; despite this, the duty to protect violations against the right to legal capacity has continued to pose a great challenge. One of the greatest challenge that PMDs face is in the area of decision making. The assumption that people with mental disability lack in capacity has resulted in various violations of the rights of persons with mental disability. These violations will be analyzed and they include involuntary institutionalization and forced treatment of persons with mental disability. There is a common belief among different societies that there will always be people in society for whom legal

[212] Interview with **Valery** in Nairobi, Kenya (15th May 2016).

capacity cannot be realized.[213] This chapter therefore interrogates the legal system in Kenya and how it protects the right to legal capacity in Kenya. This chapter will also discuss other human rights violations that occur as a result of the denial of the right to legal capacity. The question is how this violations affects a person's ability to be at liberty and have his dignity upheld..[214] This chapter will also look at judicial determination of legal capacity in Kenya and how this practice continue to rob people with mental disability of the right to mental disability. Another theme that shall form the basis of this chapter is whether PMDs have a right to refuse or reject treatment; the place of informed and voluntary consent to treatment and whether their consent is required before being placed in medical institutions. This chapter also seeks to answer whether involuntary placement of persons with mental disability violates their rights legal capacity, liberty and inherent dignity?

3.1 legal protection of the right to legal capacity in Kenya.

Kenya is one of the countries that have ratified the UNCRPD and therefore recognizing the rights of PMDs to legal capacity.[215] The constitution of Kenya 2010 recognizes any treaty instrument or convention ratified in Kenya as part of the laws in Kenya.[216] It is by this article that the UNCRPD is read as part of the law in Kenya and addresses issues affecting PMDs. For a long period PMDs in Kenya have suffered stigma, discrimination and all forms of violations because of the existing perceptions in the society that they lack the prerequisite capacity to live an independent lives. As a result, the constitution of Kenya provided under article 54 specifically for the rights of PWDs. This article provides that a person with any disability shall be entitled to be treated with dignity and

[213] Ibid.
[214] Article 28 and 29 of the constitution of Kenya 2010.
[215] Kenya ratified the UNCRPD on the 19th day of May 2008.
[216] Ibid, Article 2(6).

respect and to be addressed and referred to in a manner that is not demeaning.[217] Article 54 was meant to deal with prevailing stereotypes and labeling of the persons with disability. The constitution of Kenya provides an expansive bill of rights that dictates that all persons shall be treated in a manner that respects their inherent dignity.[218] This right is to be enjoyed equally by all people and without any form of discrimination.[219]

The Constitution in its preamble recognizes the aspirations of all Kenyans for a government that is based on essential values of human rights, equality, freedom, democracy, social justice and the rule of law. The PMDs are therefore supposed to enjoy all rights and freedoms in equal measure with other people. For the first time the constitution defined disability to include any physical, sensory, mental, psychological or other impairment, condition or illness that has or is perceived by significant sector of the community to have, a substantial or long term effect on an individual's ability to carry out ordinary day-to-day activities.[220] This definition for the first time included persons with mental disability as subject of human rights and with right to exercise them on an equal basis with others.

The right to legal capacity is an enabler right that is provided for in various international instruments which Kenya has ratified.[221] By virtue of this ratifications it forms therefore one of the important rights for PMDs.

With the promulgation of the constitution of Kenya and the ratification of the UNCRPD, laws and policies on mental disabilities and especially on area of legal capacity were to be reviewed. The Mental Health Act provided for a presumption of lack of legal capacity for persons with mental

[217] Ibid, Article 54(1)(a).
[218] Ibid, Article 28.
[219] Ibid, Article 27.
[220] Ibid article 260.
[221] Article 1 of the international Covenant on Civil and Political Rights.

disability. This law created a situation where people with mental disability were seen as sick and in need of medication and not as a subject and holder of rights. Both the constitution and the UNCRPD empowers the state to abolish all those laws that discriminate on persons with disability and hamper them from achieving full exercise of legal capacity.[222] For instance the constitution provides that any law that is inconsistent with the Constitution is void to the extent of the inconsistency, and that any act or omission in contravention of this Constitution is invalid.[223] On this basis the Mental Health Act is in itself unconstitutional based on the fact that it provides for a presumption of lack of legal capacity on the PMD and therefore requires review.

Kenya initiated effort to review this Act by introducing the Mental Disability Bill to parliament. Unfortunately since 2007 to date the bill is yet to be tabled for the second reading. It is important also to note that even though the bill recognizes the right to legal capacity it still falls below the requirement of legal capacity under the UNCRPD and international standard.

3.2 Determination of Legal Capacity in Kenya: A case of Rationality in Decision Making.

In Kenya the procedure and requirements considered by judicial officers before adjudging one incapable of taking care himself and making decision is purely based on medical evidence. This practice and policy is in violation of article 12 of the CRPD and of rights of person with mental disability. Article 12 is set out to ensure that states ensure that PMDs have legal capacity on an equal basis with others. The law in Kenya has adopted a presumption of legal capacity for all persons considered adults. [224] Unfortunately, this law allows for full and partial deprivation of this

[222] Ibid, article 12 of the UNCRPD.
[223] Ibid, article 2(4) of the constitution.
[224] Age of Majority Act, 1974 CAP 33.

capacity in cases where one suffers from mental illness or disability.[225] The Children Act allows guardianship of a child to extend beyond a child who has attained the age of majority in exceptional circumstances which includes where a child has mental or physical disability or an illness that renders him/her incapable of maintaining themselves or managing his or her property and affairs without the assistance of a guardian.[226] A person's relative "or any other suitable person" may send a petition to the High Court, which can appoint a guardian for anyone suffering from a "mental disorder" the court may appoint a relative or the Public Trustee as estate manager and guardian.[227] Where the court views that the person concerned is able to manage most areas of their lives but is incapable of managing their estate, they may decide to place these matters under the responsibility of an estate manager, leaving other areas of legal capacity intact. The order may include provision for maintenance of the person and their dependents but need not include custody or guardianship of the person.

Two reported Nairobi High Court cases illustrate the process which courts take in legal capacity proceedings: Waiganjo v. Waiganjo[228] and Re Francis Mwaura Kamau[229].

In Waiganjo v. Waiganjo, William Waiganjo applied to the court to put his older sister Leah Waiganjo under his guardianship. He said that Leah suffered from a "mental disorder" that rendered her incapable of managing her affairs and that her two landed properties were in danger of alienation following another court's judgment against her (in proceedings she was not involved in). William wanted to save the estate and wanted legal power to challenge the judgment by

[225] Ibid.
[226] Section 107(1) (2).
[227] Children Act, Section 107(3).
[228] Leah Wachu Waiganjo v. William Kibera Waiganjo, High Court of Kenya at Nairobi, Misc. 330 of 2012.
[229] High Court of Kenya at Nairobi, Re Francis Mwaura Kamau, Misc. Civil Application no 81 2003.

becoming a guardian ad litem. The High Court relied on what he said and two medical reports from 1997 and 2012. There is no evidence on record of the judge calling the doctors to give evidence. There is also no evidence of the judge ensuring legal representation for Leah or allowing her or a representative appointed by her to cross examine the doctors or present alternative expert evidence to challenge the doctors' testimony. In June 2012, the judge met Leah in court and described her as a middle-aged lady who appeared well-nourished and well-groomed, able to state correctly her home address and the names of her father and other relatives. The judge noted that she responded with hesitation and probing, and therefore found her incapable of making sound decisions, and not capable of taking care of her own affairs and estate. The judge appointed William as Leah's guardian ad litem thereby taking away Leah's ability and rights to decide anything about her life and assets.

It's important to note that evidence of medical report signed by Dr. Kanyuira reads that the subject "...suffers from Temporal Lobe Epilepsy and periodic depressions. She has had three episodes of acute psychosis necessitating her admission to hospital for in-patient management. She is regular on medication since 1980 and it's necessary that she continues on the treatment. Any attempt to reduce or stop medication she is on makes her get into confusion states of mind, loss of memory and acute psychosis of fits."[230]

In Re Francis Mwaura Kamau, Wangari Kamau applied to be the guardian of Francis Mwaura Kamau, her husband, as he had a "mental disorder". The court relied on three medical reports that the husband was suffering from dementia, as well as testimony of the wife and their two children. The court found Francis Kamau to be suffering from a mental disorder within the meaning of the

[230] See also the Second medical report which was signed by Dr. Mutinda which states that "The above is a patient on follow up in our facility for a Bipolar Mood Disorder complicated by Temporal Lobe Epilepsy. She is currently on medication but has not yet stabilized. She is unable to make sound judgment."

Mental Health Act and that his "affairs and estate required immediate care and preservation". It appointed Cecilia Kamau as Francis Kamau's guardian and requested her to submit medical reports, an inventory of the properties and debts every six months. There is no evidence in the court file that Francis Kamau knew anything about these proceedings that happened without his involvement. He was given no opportunity to participate, and no lawyer was appointed to represent him.

These two cases illustrate the faults in procedures used by courts to make a determination on a person's legal capacity. They fall short of the requirements of Article 12 of the CRPD, which requires States to shift away from restricting legal capacity under substituted decision-making arrangements and move towards providing supports for people to exercise their legal capacity. For instance, in the first case, the judge could have spoken to Leah about what she needs to be able to manage her estate as she wishes. The judge could have put in place a structure to preserve her legal capacity while making sure that her brother does not unduly influence her in investment decisions. In the second case the judge could have at the very least spoken to Francis Kamau, and asked him about his opinion, then put in place some supports which would have ensured that his finances and daily care needs were taken care of.

It is important to note that till today court procedures lack the meaningful participation of the PMD whose legal capacity is in question. The process pays no respect to the will and preferences of the person concerned. Mere hesitation and probing in answering questions by the victim is sufficient enough evidence for the judge to declare an individual to lack capacity. This procedures therefore violate the requirement under Article 12 of the CRPD. This Article requires that efforts be made to ascertain the types of supports an individual suffering from mental disability may need to live and

exercise her rights. The Mental Health Act provides no guidance as to how courts are to judge someone's decision-making capacity. Unfortunately , cases that have been decided upon touching on legal capacity seem to have been decided in a manner that restrict decision-making rights instead of advancing decision making capacity by putting in place access to a range of supports which preserve legal capacity.

Article 12 of the UNCRPD requires all decision makers to have a presumption of the existence of legal capacity for all persons with disability on an equal basis with others.[231] Where one faces challenges in exercising his right to make his choices and decisions, services of support person shall be used to help ascertain his wish, will, intention and preferences. Majanja J, pointed out the correct position in the case of Wilson Morara vs. R[232] where he stated that "the approach taken by the prosecution and the learned magistrate that the complainant is an object of social protection rather than a subject capable of having rights including the right to make decisions such as whether to have sexual intercourse or not, was inconsistent with Art 12 of the CRPD."[233] He acknowledged that a blanket view of legal capacity is improper and inconsistent with the convention and an affront to the right of dignity of person protected under Article 28 of the constitution, to label any person as mentally retarded and thus proceed on the basis that the person is incapable of making a free choices.

3.3.0 Violations of the Right to Legal Capacity in Kenya: A case for Involuntary Institutionalization and Forced Treatment.

[231] Gerard Quinn*, 'The United Nations Convention on the Rights of Persons with Disabilities: Toward a New International Politics of Disability' [2009] Jacobus tenBroek Disability Law Symposium <https://www.youtube.com/watch?v=lWRd6Z8pWVY&list=PLCAA7BAA778E3DE6F> accessed 1 July 2016.
[232] Criminal appeal no. 17 of 2014, high court at Migori, formerly Kisii HCCRA NO.61 of 2013.
[233] Ibid.

Most persons with mental disability suffer from stigma and as a result they remain ostracized from their communities.[234] Their ability to live as independent individuals, earn an income, lift themselves out of poverty and gain access to treatment and support to integrate into their community and recover from their illness is tremendously affected.[235] Most persons with mental disability are denied the right to make their own decisions and choices especially those that involve their treatment. As a result their right to exercise legal capacity on an equal basis with others is hampered. In Kenya for instance, when a determination of incompetence is made a substitute will be appointed to take care of all your affairs including making decisions on where you will stay and the type of treatment one gets. The result of this is that many persons with mental disability have been forced into institutions against their will. In these institutions PMDs have to cope up with deplorable conditions and poor or no medical facilities. Unfortunately, the situation is not different to those who cannot access this facilities and remain locked up in their homes.[236]Conditions are equally same at homes because most of these families are very poor.[237]

The right against involuntary confinement is founded in the right of every individual to self-determination.[238] It encompasses the right to exercise control over one's body by exercising legal capacity to make important life decisions affecting them, for example, the right to accept or refuse medical treatment. Before the CRPD came into force, the position as regard one's ability to refuse

[234] United Nations Educational, Scientific, and Cultural Organization (UNESCO), EDUCATION FOR ALL GLOBAL MONITORING REPORT 179 (2006), http://www.unesco.org/education/GMR2006/full/chapt7-eng.pdf.
[235] Natalie Drew & others, 'Human Rights Violations of People with Mental and Psychosocial Disabilities: An Unresolved Global Crisis' (2011) 378 The Lancet at 1664.
[236] Observation at Mathare hospital on 20th August, 2016.
[237] The United Nations estimates that twenty percent of the poorest people in the world have disabilities. Persons with disabilities have been described by the United Nations as the world's "largest minority. The causes of disability vary, but they include social and economic deprivation, malnutrition, violence, and warfare.
[238] Psychiatry 131 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC181079/> accessed 19 April 2016.

medical treatment was completely paged on the rationality test. This means that only persons considered competent could give consent to treatment or reject it and is, therefore, accountable for the choices made.[239] Based on this premise, once an individual is deemed incompetent, measures are taken to 'protect the incompetent patient from the consequences of imprudent decision making.' Such a person is considered to have no legal capacity and therefore can no longer be able to exercise the right to accept or refuse treatment thus condemning them to decisions and choices made by other people.[240]

It is therefore important to note that, it is upon the premise of incompetency and lack of legal capacity that involuntary institutionalization and forced treatment is borne. Often, medical professionals feel that a patient who refuses a recommended treatment is incompetent until proven otherwise.[244] Such a stance is inaccurate by legal standards and is paternalistic by nature and a violation to the right to legal capacity by persons with mental disability.[245] Hundred percent (3 out of 3) of the physicians and medical practitioners interviewed, would refuse to withhold treatment from a patient where the patient withholds consent on the basis that, if anything happens to the patient then they are likely to face criminal charges. They are of the opinion that if the physician does not take reasonable steps to obtain some other legally valid authorization for treatment, then they may stand charges for being negligent. Dr. Oluhano[246] in her assessment argues that, if a patient objects / refuses treatment with a highly favorable outcome and low risk or assents to an intervention with unfavorable outcomes and high risk, then questions regarding his legal capacity

[239] Ibid.
[240] After determining that the de jure incompetent cannot make prudent decisions in his or her own best interest, the court assigns a guardian to make decisions on the person's behalf. This system of decision making is predominant in the mental health Act. Note that prudent decision making has not been defined and so it's left to the discretion of medical professionals to determine.
[244] Interview with **Jacky** in Vihiga, Kenya (14th February 2016).
[245] Interview with **Vanesa** in Nairobi, Kenya (4th March 2016).
[246] Interview with **Oluhano** in Mbale, Kenya (14th February 2016).

to make such a decision are likely to be raised. She notes the procedure in such situations concerns about the reasoning capacity of the patient that will warrant formal assessment of capacity. On the other hand, when the patient consents to a treatment intervention with a likely favorable outcome and low risk, or elects to forgo a treatment which incurs great risks or has questionable or unfavorable outcomes, concerns about decision-making capacity are less apt to be raised.[247] In such cases, a low standard for determining legal capacity is undertaken. It is important to state at this point that this position which is shared with other physicians and medical practitioners is erroneous in the light of the Articles of the CRPD. Unfortunately majority of individuals in the medical practice are unaware of these provisions.[248]

Mental health policies and programs on involuntary institutionalization and forced treatment in Kenya affect and violate the rights to legal capacity of PMDs in various ways.[249] Majority of people interviewed noted that, although institutionalization and treatment can be seen as a voluntary exercise that involves non coercion, they often involve the exercise of government's coercive power.[250] This power includes that to restrain, to treat and other rights. It is this power that the state uses in order to institutionalize people they deem 'mentally sick' and so in need of help. The exercise of this power is normally justified by the government on the basis of protecting either the victim from himself or the protection of the public in general. The nature of government's authority affects a variety of personal interests such as autonomy, bodily integrity,

[247] Ibid.
[248] Of the three medical practitioners interviewed only one has heard of the CRPD and had no knowledge of its contents. To them the law protecting mental disability is the mental health Act and that their decisions are based on the Act.
[249] See Kenya Mental Health Policy 2015–2030; see also the Kenya cash transfer program for persons with disabilities which is a social program that gives out cash stipend to persons with disabilities to enable them live a comfortable life. Unfortunately, majority of the beneficiaries are people with physical disabilities as noted by Jacky, a disability expert.
[250] 90% of the interviewees (18 out of 20).

privacy, property and liberty; which give rise to human rights claims when mental health powers are exercised arbitrarily in a discriminatory manner and in the absence of fair process.[251]

Once individuals with mental disability are institutionalized they are exposed to prolonged mental disability or lifelong suffering in institutions where they are held. Apart from formal institutions, several persons are locked up by their caregivers in their homes.[252] Winnie notes that majority of parents and caregivers are overwhelmed with the burden of mental disability and where no help is forthcoming, they would rather surrender him/her to institutionalization or do it themselves in their houses.[253]

Whereas opinion is divided on functional abilities of PMDs with a majority of eighty percent of people interviewed (18 out of 20) holding that, people with mental disability are completely unable to rationally make independent decisions in health matters and matters that affect themselves and the community. For instance, Grace believes that the rights to participate in political life of a state, or make decisions on the sanctity of contracts and medical decisions are only limited to persons who can properly rationalize information.[254] It is upon this premise that majority of persons with mental disability are denied a right to legal capacity thus their decision making ability is blurred.

3.4 Does involuntary institutionalization amount to deprivation of liberty?

Deprivation of liberty may be defined as any form of detention, imprisonment, institutionalization, or custody of a person in public or private institutions which that person is not permitted to leave at

[251] Lawrence O Gostin, 'At Law: International Human Rights Law and Mental Disability' (2004) 34 The Hastings Center Report 11.
[252] Supra note 17.
[253] Interview with **Winnie** in Nairobi, Kenya (14th January 2016).
[254] Interview with **Grace** in Nairobi, Kenya (15th October 2015).

will, for reason of humanitarian assistance, treatment, guardianship or for protection.[255] The right to liberty extends beyond the constitutional bounds to include the rights of an individual to choose and refuse; the right to be alone and one to plan own life as you deem fit; freedom from bodily restraint and compulsion.[256]

Freedom and choice is a core element to the exercise of the right to liberty and plays an important role in an individual's successful functioning. Ojuok[257] argues that not only do people strive for freedom but also enjoy making simple choices. Unfortunately, people with mental disabilities are in most spheres of life considered incompetent and therefore lack capacity to participate and enjoy such freedoms. It is this thinking that then informs either selections of a substitute inform of a guardian to act in the place of the PMDs and make important decisions on his behalf; or his institutionalization. Forty percent of persons interviewed (8 out of 20) thought that people with mental disability are capable of making their own choices though with support. Unfortunately only ten percent of those who agree believe that these decisions are rational enough to be acted upon. Those who disagree cited different factors that hinder a PWD from making such decisions. These factors include; demonic spirits, family genetic problems, social and religious beliefs and the fact that such persons lack capacity to do so. This group still favors the central role of substitutes in making the decisions for PMDs. Unfortunately ninety percent of all those interviewed agree that the substitutes decisions in most cases do not always mimic the will, wishes and preferences of persons they represent.

[255] DJ Bannerman and others, 'Balancing the Right to Habilitation with the Right to Personal Liberties: The Rights of People with Developmental Disabilities to Eat Too Many Doughnuts and Take a Nap.' (1990) 23 Journal of Applied Behavior Analysis 79.
[256] Ibid.
[257] Interview with **Ojuok** in Kisumu, Kenya (2nd May 2016).

A challenge that arises therefore is how to strike a balance a balance between absolute exercise of freedom on one end and the exercise of service provider's functions in meeting the standards for habilitation on the other end. The interplay between this two manifests in situations where, for instance, the carers interprets refusal by a person with mental disability as merely resistance instead of an expression of preference. [258]

Majority of people who are against the right to liberty, freedom of choice and granting a legal capacity status to persons with mental disability base their arguments and reasoning on the fact that people with mental disability may make bad decisions.[259] Unfortunately, this argument is untenable since even rational people make bad decisions in their lifetime and therefore this cannot solely be used as a reason to deny one the full realization of his right to choice. Others argue that giving PMDs the right to choose may hinder their acquisition of critical independent living skills.[260] For instance, choosing a hobby instead of vocational task which may hinder him from getting opportunities for employment.

On the other side those who argue for absolute right to freedom of choice and the abrogation of the legal incapacity status note that they are a legislative guarantees to be enjoyed on an equal basis with other people and a denial will amount to discrimination under article 27 of the constitution.[261] In addition, the exercise of choice prepares an individual to live in community where individuals are expected to make decisions and choices. They believe that inclusion and integration of persons

[258] Supra note 31.
[259] Frédéric Mégret, 'The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?' (2008) 30 Human Rights Quarterly 494, see also Nandini Devi, 'Supported Decision- Making and Personal Autonomy for Persons with Intellectual *Dis abilities:* Article 12 of the UN Convention on the Rights of Persons with Disabilities.' (2013) 41 J.L. Med. & Ethics 792.
[260] Nandini Devi, 'Supported Decision- Making and Personal Autonomy for Persons with Intellectual *Dis abilities:* Article 12 of the UN Convention on the Rights of Persons with Disabilities.' (2013) 41 J.L. Med. & Ethics 792.
[261] Supra note 1.

with mental disability into main stream society can only be achieved when an individual's choices, wishes and preferences are respected.[262]

On the question of whether or not a PMD has capacity to make medical decisions, informed and voluntary consent as discussed in chapter must be procured otherwise the decision of the medical practitioner to forcibly treat him/her amounts to a violation of right to legal capacity. Majority of the Respondents (10 out of 12) believe that there exists a dilemma in providing a balance between respecting and protecting the rights of an individual with mental disability to make his independent medical decisions on one hand and that of protecting him /her from harm that maybe caused due to refusal to consent to treatment. Dr. Oluhano gives a case where a lady exercised her right to reject/ refuse an operation to be contacted on her. Her son gave his consent and the doctors proceeded with the operation which turned up to be successful. In this case a decision to withhold consent by the victim would have resulted in permanent disability and even death. [273]

Even though a person has a right to consent or refuse to consent to medical treatment and procedures, there is no provision in law that can empower such a person to ask for a specific treatment. Unfortunately the decision on which treatment a person with mental disability will receive is left in the sole hands of the physician. Valery [274] notes that 'the medical practitioners have no time for persons with mental disabilities opinion and often times they will construe refusal as resistance to medication. In addition most of the medications given to this people are very strong which often times make the situation worse.' All the interviewees (3 interviewees) with

[262] Interview with **Otwoma** in Nairobi, Kenya (25th July 2016).
[273] Hayden A Snow and Bill R Fleming, 'Consent, Capacity and the Right to Say No' (2014) 201 Medical Journal of Australia <https://www.mja.com.au/journal/2014/201/8/consent-capacity-and-right-say-no> accessed 19 April 2016.
[274] Supra note 1.

mental disability complained of the physicians not listening to their complaints and opinions. In his own view Maina[275] explained that '*We are seen and treated differently because of the perception that we are sick and not as people first. Majority of us would wish to stay at home with our parents and be integrated in our families but we are viewed as a burden and a danger to ourselves and to the community. People believe that we have no right to say what we want and that's why all the decisions affecting us are made by other people without our input.'*

In the case of Re Burke v General Medical Council and Disability Rights Commission,[276] the court in UK was of the view that even though patients have a right to refuse treatment they, however, do not have a right to demand certain treatment.[277] In this case Burke, who was suffering from a chronic and progressing neurological illness, wished to receive artificial nutrition and hydration (ANH) when he lost his ability to swallow and he did not want doctors to make decisions on his behalf.[278] He argued that the relevant general medical council guidelines infringed on his human rights. Initially the High Court ruled in his favor stating that the Human Rights Act (1998) entitles a person to demand life-prolonging treatments such as ANH. However this decision was overturned by the Court of Appeal which acknowledged the right-based analysis of the High Court's decision but went ahead to state that 'an advance directive to withdraw treatment in a case of persistent vegetative state must be respected, but it does not automatically lead to a reverse decision in opposite cases; and that an advanced directive demanding life-prolonging treatment would not be in consistence with the law which requires the doctor to take the incompetent

[275] Interview with **Maina** in Kiambu, Kenya (15th July 2016).
[276] (2004) EWHC 1879.
[277] SelingeR and Christian P, 'The Right to Consent: Is it Absolute?' British Journal of Medical Practitioners.
[278] Ibid.

patient's best interest into consideration.[279] The court concluded that demanding certain treatments leads to injustice.

The impact of this decision is that where a person is of the opinion that certain medication is not the best for him due to its effects on him/her, such an opinion cannot be respected. The result is that one is condemned to continue with treatment even if it does not work for him/her.

3.5.0 Consequences of limiting legal capacity/ legal incapacity order.

An order declaring a person with mental disability to lack legal capacity has dire and harsh consequences on him/her. The right to legal capacity is an enabler right that facilitates the enjoyment of other rights. This means that its denial will affect the enjoyment of other rights and may lead to unending suffering by the PWMDs.

Numerous reports have documented a wide range of abuses against patients and individuals under medical supervision and in institutions where they are held.[287] Health providers allegedly withhold care or perform treatments that intentionally or negligently inflict severe pain or suffering for no legitimate medical purpose and without the victims consent.[288]Medical care that causes severe suffering for no justifiable reason can be considered cruel, inhuman or degrading treatment or

[279] Ibid note 220.
[287] See for example, Juan E Méndez, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' <http://109.74.198.40:8087/jspui/handle/123456789/294> accessed 26 April 2016.
[288] Ibid note 1.

punishment, and sometimes may be considered to be torture where state power is involved and with specific intent.[289]

Persons with mental disabilities experience a range of human rights abuses both at home, community and in institutions where they are held. Majority of those who are held up in mental health institutions are ostensibly sent there by their family members, police, or their communities for help and without their consent.[290] They are subjected to multiple and aggravated forms of human rights violation, including the neglect of their most basic survival related needs. It is possible for PMDs to die of starvation, to have life-sustaining medical treatments denied or withdrawn in health services, to be raped and assaulted without any reasonable prospect of these crimes being detected, investigated or prosecuted by the legal system and to have their children removed by child protection authorities on the prejudiced assumption that disability simply equates with incompetent parenting.[291] The following are some of the rights that may not be achieved by people with mental disability whose legal capacity have been restricted:

3.5.1 The Right to Human Dignity.

Persons with mental disabilities seek four interrelated human rights: liberty, dignity, equality, and entitlement.[292] A denial of the right to legal capacity means that a right to these interrelated rights is lost. In most cases PMDs who are declared to lack legal capacity are subjects of

[289] Tina Minkowitz, 'The United Nations Convention on the Rights of Persons with Disabilities and the Right to Be Free from Nonconsensual Psychiatric Interventions' (2007) 34 Syracuse Journal of International Law and Commerce.
[290] Human Rights Watch, 'Once You Enter, You Never Leave: Deinstitutionalization of Persons with Intellectual or Mental Disabilities in Croatia'.
[291] Ibid.
[292] Lawrence O Gostin and Lance Gable, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (2004) 63 Maryland Law Review 8.

institutionalization and substitution. Unfortunately, most of them are held up in institution with deplorable conditions that infringe on their right to human dignity.

The theme of dignity bears on the living conditions in institutions for persons with mental disabilities. Seventy percent (14 out of 20) of those interviewed agree that the institutions where the PMD are held are in deplorable conditions. Jacky[295] noted that PMD are subjected to long periods of isolation in filthy, closed spaces with lack of adequate care and medical treatment; and severe maltreatment, such as being beaten, tied-up, and denied basic nutrition and clothing. This is evident in most medical facilities and homes where PMDs are held.[296]

Seventy percent of the respondents (14 out of 20) noted that the living conditions in mental facilities are inhuman and degrading because of problems such as overcrowding, outbreaks of preventable diseases caused by unsanitary conditions and poor physical infrastructures. Deficiencies in the built environment of mental health facilities can impede effective treatment and recovery, which can result in worsened mental and physical health of service users.[297] Valery, noted that her institutionalization was one night mare which was characterized by unhygienic living conditions, physical abuse, nakedness, and lack of enough food.[298] That the experience, she narrates, " taught me that mental hospitals are more of a torture chamber causing more mental anguish and torment than ameliorating the mental situation of patients…It led to feelings of worthlessness, helplessness and hopelessness".[299]

[295] Interview with **Jacky** in Vihiga on 14th February, 2016.
[296] Observation at Mathare mental hospital and many homes visited shows that most physical facilities are in a sorry state that require reconstruction and decongestion.
[297] Ibid.
[298] Supra note 1.
[299] Ibid.

Patrick cited overcrowding as a serious problem in public mental facilities and hospitals.[300] He noted that sometimes the facilities stank of urine and feces, and there is inadequate water for drinking or bathing.[301] Overcrowding together with significant staff shortages has created terrible living conditions for PMDs.[302]

The medical personnel and caregivers cite lack of appropriate facilities for persons with mental disabilities as the main challenge in ensuring that those who have been committed to detention live in dignity.[303] The government on the other side believes that its resources have been overstretched. [304] Apart from the conditions in medical facilities it is important to also note that proscription of inhuman and degrading treatment also include actions that are designed to humiliate PMDs.[305] Such actions include use of abusive language and terms, sexual harassment, denial of treatment and confinement in poorly lit rooms. In some instances PMDs were either locked in chains inside fully built and semi-permanent structures, or chained to a tree or concrete floor.[306] Movement was impossible beyond the length of the constraint. Praxides, who has a boy with mental disability in chains believes that if his son is left free the society will harm him since people view him as a dangerous person.[307] In addition she indicated that his son has once been raped and to avoid that they keep him in chains. Even though she uses chains to restrain his son's movement, she believes

[300] Interview with **Patrick** in Nairobi, Kenya (5th July 2016)
[301] Ibid.
[302] The human rights watch report in Ghana noted that in two psychiatric hospitals they visited, urine, flies, and cockroaches competed for space in the toilets, and nurses, lacking cleaning equipment, instructed patients to clean the wards and toilets, including removing other patients' feces, without gloves.
[303] Supra note 19.
[304] Ibid note 71.
[305] Ibid.
[306] Supra note 85.
[307] Interview with **Praxides** in Rongai, Kenya (20th March 2016)

that his son would be happy to be let free. Her only fear is that he will be endangered by other people who have no disabilities.

The right to human dignity is embedded in the principles of equality. It is one of the core principles of the CRPD.[308] The convention intends to promote a life of dignity, equality and inclusion for persons with mental disability and all other disabilities.[309] Involuntary detention is a violation to the right to legal capacity and inherent dignity of the person with mental disability. It is vital to note that, simply because a person has a mental disability, or is subject to confinement, does not mean that he or she is incapable of exercising his rights. Unfortunately, fifty percent of the respondents (10 out of 20) believe that involuntary institutionalization is justifiable on the basis that people with mental disability cannot arrive at rational decisions. Richard, argues that it is a violation of the right to dignity and fair administrative processes where persons with mental disability are denied the right to property, to parental rights, and to be a hearing in the determination of competency or placement into institutions of care.[310]

3.5.2 Involuntary treatment and inaccessible mental health services.

Persons living in psychiatric hospitals are subjected to involuntary treatment through the use of force, coercion, and sedation. Respondents said they were forced to take treatment against their will, even when medicine failed to work or led to serious side effects or complications.[311] "I don't

[308] The preamble of the convention recognizes that the comprehensive and integral function of the CRPD is to promote and protect the rights and dignity of persons with disabilities with an aim that it will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries. Article 3 of the CRPD states that, "The principles of the present Convention shall be: a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons…."

[309] Article 3 of the CRPD.

[310] Interview with **Leonard** in Vihiga on 9th June, 2016.

[311] Clarence J Sundram, 'A Discussion on Legal Capacity in the Draft Convention on Disability'. (2006) Dublin National Disability Authority.

like the medicine I receive….The drugs cause my legs to swell, eye pains, and insomnia."[312] Some patients reported being beaten if they refused to take medication, and staff at psychiatric hospital admitted using physical coercion, and in extreme cases, and involuntary sedation via injection.[313]

The result of arbitrary detention is that people often times are locked in hospitals for years without their legal or medical status being assessed, and subjected to psychiatric interventions without informed consent. Seclusion, isolation, and restraint are the main feature of many institutions.[314] The special rapporteur on torture regards as torture, any prolonged isolation of an inmate from others for at least 22 hours a day.[315] People are isolated for up to three days, sometimes for refusing to take medicine. Patients complained that isolation rooms lacked proper sanitation and lighting facilities.

Interviewees with mental disabilities revealed their desire to leave the hospital and institutions where they are held but they would not be allowed by the administrators because family members did not either come to pick them up or doctors were too busy to approve their discharge. Some remained even after discharge because their families had abandoned them, and they could not return to their home communities. It is important to note that no persons with mental disabilities who is a subject to prolonged detention has been before a judge to review or challenge their detention since no mechanism exist to enable them institute this review.

[312] Interview with **Susan** in Nairobi on 15th July 2016.
[313] The effect of this strong sedatives can easily be seen as most patients under such medication could not move around. They remained a sleep for long hours. An example is a patient who I found sleeping on the floor and after three hours I still found him where I left him. Valary, explains that the medical practitioners use these sedatives to silence an individual they claim to be too aggressive.
[314] Ibid.
[315] Ibid.

Access to basic mental health care is another area that poses a great challenge to persons with mental disability.[316] Most of these services are unaffordable. In some medical facilities this services are completely non-existence.[317] Dr. Oluhano noted that the number of mental health professionals is not sufficient compared to the large number of persons with mental disability in need for service.[318] Valery agrees that because of the unavailability of these professionals, people with mental disability are never attended to.[319] Narrating her own experience she said It took her several days just to get to be diagnosed; and that even after receiving it she didn't receive medication because the doctor was not available.[320] A further problem is the use of harmful practices often described as mental health treatments.

3.5.3 Discrimination and Stigma.

A declaration of legal incapacity means that one is condemned to a civil death. This means that he is neither a holder of rights nor can he/she exercise rights for the betterment of his/her life (Discussed in chapter Two). Such a person is left at the mercy of the society and as a result he /she will have to endure stigma and discrimination in the health sector, at home, and in the community. Some of the interviewees' argued that persons with mental disabilities are deemed incapable, hostile, demonic, evil, controlled by spirits, useless, and anti-social. Such perceptions result into stigma which in turn may cause family members to abandon persons with mental disabilities in psychiatric hospitals without visiting them nor picking them up after discharge. Some give a false address so they cannot be traced. Stigma also deters persons with mental disabilities from seeking

[316] Article 43 of the constitution 2010.
[317] Observation at Mbale hospital in Vihiga on 15th April 2016.
[318] Interview with **Oluhano** in Mbale, Kenya (14th February 2016).
[319] Supra note 1.
[320] Ibid.

professional services in psychiatric hospitals.[321] The consequence of stigma is not only felt by the victim but also by family members who have to bear the shame and ridicule of the society.[322]

The denial of the right to work because of discrimination and mental disability perceptions is a frequent rights violation with far reaching consequences. Lenah reported that people with mental disability face discrimination at all stages of the employment process.[323] She stated that 'difficulties begin at the stage of finding work, even though I'm trained social worker, I find it difficult to get jobs because I'm deemed to be 'insane' and not in the right frame of mind to do any meaningful work'.[324] To buttress this, Jacky notes that even when a person has a job, the discrimination continues where people with mental disability are underpaid and overworked.[325] Mental disability has adversely affected several person's ability to live a gainful life and as a result majority of persons affected live in abject poverty. 18 respondents (90%) believe that disability contributed directly to poverty.

Most PMDs cannot get employment opportunities because of discriminatory policies in most organizations. Where they are employed restrictions have been placed which makes it difficult for them to work and eventually they are dismissed from employment. For instance where an organizations policy is to the effect that staff are only allowed a total of three toilet breaks a day and applies to all staff. This policy will be discriminatory especially to a person who suffers from anxiety and irritable bowel syndrome. Such an organization should be allowed to put in place reasonable accommodations to enable the PMD to work.

[321] Observation at Mathare mental hospital.
[322] Supra note 259.
[323] Interview with **Lenah** in Nairobi, Kenya (5th July 2016).
[324] Ibid.
[325] Supra note 71.

3.5.4 Freedom of Expression and Opinion and Access to Information.

Many PMDs are deemed to have no legal capacity in all areas of life. For instance their decisions are considered inferior, they cannot contract and they cannot challenge decisions that are made by their guardians even when those decisions are an outright infringement of their rights. To compound this they lack awareness and knowledge of their rights or where to go in the event of a violation. Most PMDs have no access to quality education and therefore remain ignorant of their rights. Other barriers to information and the right to exercise freedom of expression include:[335]limited or no accessible information is available to them in formats that are accessible to them; non-development and recognition of alternative and augmentative communication systems used by people with mental disabilities to communicate with others; and limited access to independent advocacy services and supports.

The right to information is fundamental to persons with mental disability especially where they are called upon to make important legal capacity decisions. For instance before they give consent all relevant information must be made available to them. In medical treatment a denial of the right to information in relevant formats may lead to a situation where the individual may withhold his/her consent thereby causing him continuous suffering.

[335] See Jonathan Kenneth Burns, 'Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability' [2009] health and human rights 19. See also, Lawrence O Gostin and Lance Gable, 'The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health' (2004) 63 Maryland Law Review 8.

3.5.5 Equal Recognition before the Law and Access to Justice.

Kenyan law and subsequent institutional mechanisms for dealing with complaints do not sufficiently protect or promote the human rights of PMDs:[336] Jacky notes that Complaint handling agencies are often inaccessible for people with mental disabilities.[337]

3.5.6 Freedom from exploitation, violence and abuse.

PMDs are victims of all forms of abuse and neglect. Abuse relates to both physical, sexual, psychological, financial, legal/civil and systemic abuse as well as constraints and restrictive practices.[338] As for neglect, it can be physical, emotional, passive or wilful. Due to increased vulnerability, people with mental disability are even more exposed to abuse and neglect than other groups of people with disability.[339]

Women with disability forms one of the most vulnerable groups that experience restrictions in realizing their rights to full legal capacity in several areas including reproductive freedom which include the right to sex education, to informed consent regarding birth control, to terminate a pregnancy, to choose to be a parent and to access reproductive information, resources, medical care, services and support. They are at greater risk of physical, sexual, and emotional or psychological abuse as well as to other forms of violence, such as institutional violence, chemical

[336] The Mental Health Act is still operational even though most of its provisions are unconstitutional. An attempt by parliament to enact the mental health Act has stalled since after the first reading, the bill has never been brought back to parliament for debate. Also note that even though Article 27 of the constitution on non-discrimination, people with mental disability still face discrimination from society.
[337] Supra note 71.
[338] pwd.org.au.
[339] Ibid.

restraint, and drug use, control of reproduction, medical exploitation, isolation, humiliation and harassment.[340]

3.5.7 Restrictions faced by women.

Examples of such violations include abusive treatment and humiliation in institutional settings; involuntary sterilization; forced abortions and; violations of medical secrecy and confidentiality in healthcare settings, such as denunciations of women by medical personnel; and the practice of attempting to obtain confessions as a condition of potentially lifesaving medical treatment.[341]

There is substantial anecdotal evidence that shows that unlawful sterilization of children and young people with mental disability, mostly girls continues to occur in the absence of medical needs such as diseases of the reproductive tract.[342] Women from marginalized communities and women with disabilities are normally forced to undergo involuntary sterilization because of discriminatory notions that they are "unfit" to bear children. Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.[343] Zedekiah notes that once a young girl shows symptoms of mental illness in some communities, she will immediately be sterilized.[344] The reason behind the

[340] www.pwd.org.au.
[341] Ibid.
[342] See WHO's *Mental Health and Development* report, children and adolescents with mental and psychosocial disabilities face disproportionate barriers in accessing their right to inclusive education.1 Poverty-related constraints mean they are usually the first to be deprived of the possibility of going to school. In many low-income and middle-income countries, children and adolescents with mental or psychosocial disabilities are institutionalized in facilities that do not offer any kind of education.9, 10 If they are able to go to school, children in many countries are sent to segregated or so-called special schools that offer low-quality education, rather than being included in mainstream education with tailored support.
[343] Ibid.
[344] Interview with Zedekiah in Kiambu on 15th July, 2016.

practice is that such girls are likely to pass the disability to their children. To some it is because of the perception that mental disability is a curse.[345]

Severe abuses, such as neglect, mental and physical abuse and sexual violence, continue to be committed against people with mental disabilities in healthcare settings. The Special Rapporteur on Torture reaffirmed that the Convention on the Rights of Persons with Disabilities offers the most comprehensive set of standards on the rights of persons with disabilities, inter alia, in the context of healthcare, where choices by people with disabilities are often overridden based on their supposed "best interests", and where serious violations and discrimination against persons with disabilities may be masked as "good intentions" of health professionals [346] In 2008 the UN mandate on PWDs made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill treatment.[347]

3.6 CONCLUSION.

This Chapter traced the constitutional protection of the right to legal capacity in Kenya and how legal capacity is rationalized in Kenya. In contextualizing legal capacity in action, it looked at case study of involuntary institutionalization and forced treatment and looked into various violations that people with mental disability face as a result of the restrictions placed on the exercise of legal capacity.

[345] Ibid.
[346] wwda.org.au.
[347] The Convention on the Rights of Persons with Disabilities also provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of disability, superseding earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991 Principles).

This chapter has therefore demonstrated that a denial of the right to legal capacity has adverse consequences on the PMDs. This effects not only do they affect the person with mental disabilities but also their immediate families.

CHAPTER FOUR

HOW TO REALISE THE RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA

4.0 INTRODUCTION.

Recognition of the right to legal capacity for persons with mental disability in Kenya is inevitable. For decades people with mental disabilities have continuously suffered injustices due to denial of the right to make own independent choices. A denial of the right to legal capacity has led to discrimination, stigmatization and marginalization of people with mental disability. It is these issues that necessitated the negotiations and the enactment of the CRPD.

The passage of the Kenya constitution 2010 and the ratification of the CRPD by Kenya in 2008 provided a paradigm shift in the way legal capacity is to be conceptualized. By dint of article 2 of the constitution, the CRPD is read as part of our laws. Kenya drafted the mental health bill and unfortunately it is yet to be taken back to parliament for second reading. Even though the bill has reinforced the rights of persons with mental disability it still has failed to address the question of legal capacity. The bill still advocates for a presumption of incapacity on persons with mental disability. The result then will be those important decisions affecting people with mental disability such as where to live whether at home or in institutions; whether to refuse treatment; contracting and even the right to own property remains with substitute. This paper sought to answer two questions. First, whether the Kenyan law and policies on involuntary institutionalization and treatment of persons with mental and intellectual disability comply with the provisions of Article 12 of the CRPD? And secondly, whether the ultimate recognition of the right to legal capacity will change societal, institutional and legal perception on stigmatization, involuntary incarceration and

involuntary treatment of persons with mental disability? The recommendations for this research are as follows.

4.1 RECOMMENDATIONS.

The state should recognize that people with mental disability have equal rights to legal capacity like any other persons. In this case the state should strive to remove all equations of disability with legal incapacity. A presumption of legal capacity must be upheld in all cases involving persons with mental disability and blanket condemnation of people with mental disability as lacking in capacity criminalized. Recognition of the right to legal capacity has the effect of changing societal perception towards respecting the inherent dignity of persons with mental disability. As a consequence, it lays the foundation of eradicating stigma, discrimination and marginalization of persons with mental disability.

The state should promote deinstitutionalization and integration of people with mental disability into the community. Article 12 as observed in chapter two is the foundation upon which the convention was enacted. In order for integration and deinstitutionalization to be successful, the state must raise awareness especially on the right of the people with mental disability to live as independent persons and with all other entitlements like other people.[348]It is critical to work with persons with disabilities, their families, community leaders, other opinion shapers and ultimately communities to drive forward the inclusion and participation agenda. Community based rehabilitation services should be reconfigured to include all persons with mental disabilities and shaped within the human and social model of disability.

[348] Article 8 of the CRPD

Most of the people with mental disability face marginalization because of the societal perceptions on mental disability. For instance 80% of the people interviewed believe that dealing with mental disability perceptions will at large contribute to removing obstacles at achieving and exercising capacity by people with mental disability. Human rights awareness should also be raised among people with mental disabilities, their relatives and carers, and the general community about their human rights and specifically the right to legal capacity. These actions should include making use of different media options, radio, television, newspapers and should target all levels of the education system.[349]

In addition, it is critical that the government should provide training for policy-makers and relevant stakeholders (including PMDs themselves, as well as governmental officials, health care personnel, and the business community, who come into contact with people with disabilities) on the meaning of legal capacity and especially the area of supported decision-making through training that is concrete and practical as well as grounded in a solid philosophical and legal framework of autonomy, equality and non-discrimination.[350]

Raising awareness should include the provision of information and education on how to avoid, record and report instances of abuse to all the stake holders. It's important that the medical practitioners are aware of the requirements under Article 12 and that measures be developed to

[349] Eyong Mbuen, Reima Maglajlic and Oliver Lewis, 'The Right to Legal Capacity in Kenya' <http://sro.sussex.ac.uk/48143/> accessed 1 July 2016.
[350] Robert D Dinerstein, 'Implementing Legal Capacity under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making' (2011) 19 Hum. Rts. Brief 8.

help them respect the will, choices and preferences of people with mental disability in respect to forced treatment.[351]

Supports are a very important component of the exercise of legal capacity. The government should therefore develop a support system that respects the wills and wishes of persons with disability. In this case the government should first abandon guardianship and embrace a system which respects the "inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons". Development of support system means that the existing guardianship system under the Mental Health Act should be abolished. The UN Committee on the Rights of Persons with Disabilities (CRPD Committee) in its concluding observation has noted that the government must take action to develop laws and policies to replace regimes of substitute decision-making with supported decision-making;[352] and provide all relevant public officials, civil servants, judges, social workers and other stakeholders with training in consultation and cooperation with PMDs and their representative organizations, at the national, regional and local levels. This should be on a human rights model of disability and recognition of the legal capacity of PMDs and on mechanisms of supported decision-making.[353]

[351] Article 16(2) of the CRPD

[352] UN Office of the High Commissioner of Human Rights, Thematic Study on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities, U.N. Doc. A/HRC/10/48 at 45 (Jan. 26, 2009).

[353] In 2009, the Office of the United Nations High Commissioner for Human Rights wrote: In the area of civil law, interdiction and guardianship laws should represent a priority area for legislative review and reform. Legislation currently in force in numerous countries allow the interdiction or declaration of incapacity of persons on the basis of their mental, intellectual or sensory impairment and the attribution to a guardian of the legal capacity to act on their behalf. Whether the existence of a disability is a direct or indirect ground for a declaration of legal incapacity, legislation of this kind conflicts with the recognition of legal capacity of persons with disabilities enshrined in Article 12, paragraph 2.2.

In order to ensure effective implementation of Article 12 the state should come up with a pilot supported decision making system. This system should be molded on following principles.[354] The system must first recognize the right of everyone to legal capacity and right to exercise it. Recognizing legal capacity as a universal right will help deal with stigma and discrimination that has marginalized PMDs. Accommodations (adjustments) and access to support should then be made available where necessary to exercise legal capacity. The accommodations should be individualized and in accordance with a specific person's needs. Regulations should then be developed that ensures that support given respects the person's will and preferences; including the establishment of feedback mechanisms to ensure that support is meeting the person's needs.

This means that governments should develop legislation that recognizes the right to legal capacity of everyone with disabilities. The new structures must:[355] recognize that supported decision-making is built on relationships of trust; assign clear roles to supporters to provide information to help PMDs to make choices, and to assist them to communicate their choices to third parties (such as banks, doctors, employers); and prevent and remedy exploitation, violence and abuse, as detailed in Article 16 of the CRPD.

Therefore a good supported decision-making system is one that guarantee that a person's legal capacity remains intact. This would mean that supports provided will give primacy to a persons will and preference instead of depriving him/her of her legal capacity and placing her under the guardianship of someone. This would also mean that the person instead of spending his whole life

[354] Kristin Booth Glen, 'Changing Paradigms: Mental Capacity, Legal Capacity Guardianship, and Beyond' (2012) 44 Colum. Hum Rts. L. Rev. 93.

[355] The High Commissioner's report continued, with emphasis as well on the affirmative steps necessary for compliance with Article 12: Besides abolishing norms that violate the duty of States to represent the human right to legal capacity of persons with disabilities, it is equally important that measures that protect and fulfill this right are also adopted, in accordance with Article 12, paragraph 3, 4 and 5.

locked somewhere in an institution, he/she could live in the community by deciding to use community-based support services instead of her guardian deciding to place her in an such institutions. Apart from this it also will mean that with the help of supports, a person with mental disability can make important decisions involving his life like medical decisions and general social life decisions. The fact that people with mental disability have been disenfranchised, a good support system will mean that one would be able vote for the candidate of her choice, using the assistance of a person of her choice instead of being excluded from political life.

For this system to work properly Article 12 contemplates the existence of safeguards to help prevent and remedy exploitation, violence and abuse;[356] and to ensure that they do not over-regulate the lives of the individuals utilizing them and become invasive and burdensome; and that third parties give legal recognition to the role of support people and to decisions made with support.[357]

The right to equal recognition before the law is a civil and political right and therefore requires immediate realization, rather than an economic, social or cultural right subject to progressive realization. There are several laws in force in Kenya which appear to discriminate against people with mental disabilities.[358] The Mental Health Act permits forced medical admission, treatment and confinement at medical facilities.[359] Under the Matrimonial Causes Act, a petition for divorce may be submitted on the ground that the respondent is incurably of unsound mind.[360] In addition,

[356] Article 16 of the CRPD
[357] Thomas Hammarberg, 'Legal Capacity in Europe' <http://mdac.org/sites/mdac.info/files/legal_capacity_in_europe.doc> accessed 8 August 2016.
[358] Elizabeth Kamundia, 'Independent-Living-for-People-with-Disabilities-in-Kenya.doc' <http://www.nuigalway.ie/media/housinglawrightsandpolicy/Kamundia,-E---Independent-living-for-people-with-disabilities-in-Kenya.doc> accessed 8 August 2016.
[359] Mental Health Act, 1991, s16.
[360] Matrimonial Causes Act 1941, section 8(1) (d). The respondent must also have been continuously under care and treatment for a period of at least five years immediately preceding the presentation of the petition.

persons who have been found to be of 'unsound mind' are denied legal capacity in some important areas, including voting in elections and are disqualified from standing for election to Parliament or a County Assembly.[361]

Legislative measures should therefore be taken by the state in order to abolish medical practices that marginalize people with mental disability and stigmatize their families. The mental health Act should be reviewed and amended to comply with the requirement on legal capacity under Article 12. It is important for the state to note that disability stereotypes contributes immensely at marginalizing people with mental disability and that they reinforce negative attitudes in society which result in discrimination. Therefore legislation should not only be aimed at abolishing laws but also stereotypes that exists especially in medical practice that has for decades contributed to disabling an individual.

The state should legislate to provide mechanisms for removing any laws that provide for full or partial incapacitation and plenary guardianship and the assumption of legal capacity not only extended to PMDs but completely affirmed. Having mental disability should not be a reason for not benefitting from the presumption of capacity. In addition to abolishing laws that incapacitate persons with mental disability the state should also review and reform discriminatory legislation depriving persons with mental disabilities of other human rights such as their rights to vote and to property for reasons linked to disability or impairment. This laws are not in contravention of the constitution of Kenya[362] but also of the international obligation that the state has under international law.

[361] Lawrence Mute, "Shattering the Glass Ceiling: Ensuring the Right to Vote for Persons with Intellectual Disabilities In Kenya", *Thought and Practice: A Journal of the Philosophical Association of Kenya (PAK),* New Series, Vol. 2, No. 2, December 2010, p. 6.
[362] Article 27 of the constitution of Kenya 2010.

The state should identify and remove barriers to health services access encountered by persons with mental disabilities as discussed in Chapter Three. One of the predominant challenge to access to consensual treatment by the people with mental disability is the financial costs involved. The state should therefore come up with equalization laws that will help remove financial barriers to accessing services for those with mental disabilities. Access to healthcare being key to recovery of the person with mental disability, the state should ensure that adequate personnel is available and that proper training on human rights is provided to them. As indicated that majority of the people who do not respect the right of individuals with disabilities to make independent decisions are medical practitioners the state should not only provide training but also investigate and prosecute any violations and abuses of the rights of persons with mental disability.

The state should also improve the physical conditions of medical facilities that cater for persons with mental disability.

The state should promote a proper judicial and administrative mechanism that is accessible to persons with mental disability to enable them review any decision affecting them especially those related to the exercise of legal capacity and decisions on placement and involuntary treatment. In this respect an independent body can be established with the responsibility to investigate allegations of serious violations of the rights of individuals who are in a supported or where there are reasonable grounds to indicate that a person is unable to act legally independently.[363] This investigations should be documented and presented for action to be taken. In addition, the state should establish an administrative tribunal with exclusive jurisdiction to deal with recommendations arising from these investigations. The tribunal should be empowered to make determinations about an individual's decision-making status and authorize accommodations and

[363] Michael Bach and Lana Kerzner, 'A New Paradigm for Protecting Autonomy and the Right to Legal Capacity' <http://repositoriocdpd.net:8080/handle/123456789/449> accessed 26 February 2016.

state provision of needed supports. Legal counsel and independent advocates would be made available to those whose cases are subject to investigations to guarantee autonomy.

The government should also consider provision of 'reasonable accommodations' in provision of decision-making assistance and proper safeguard to ensure that decisions are not substituted. Examples of accommodations for instance include a situation where employees with mental disabilities is given Flexible Workplace such as telecommuting and/or working from home to more effectively perform their jobs. Other possible accommodations for such a person may include: Part-time work hours, job sharing, and adjustments in the start or end of work hours, compensation time and/or "make up" of missed time.

The government, courts, health care and other service providers have to make their services more accessible to persons with mental disabilities. The convention acknowledges that suitable accommodations are a fundamental right and domestic policies, planning, and legal reform need to be informed by an acknowledgement of this right.[364] Reasonable accommodation to persons with disabilities trying to access their services is the minimum. This includes the provision of information in plain language and the acceptance of a support person communicating the will of the individual concerned.[365] For instance if a person communicates his/her intention, accommodations may be needed to manage this particular decision/act or enter this legal

[364] Ibid, Article 12(4) of the CRPD.
[365] Anna Nilsson and others, 'Who Gets to Decide? Right to Legal Capacity for Persons with Intellectual and Psychosocial Disabilities' <http://works.bepress.com/anna_nilsson/1/> accessed 10 March 2016.

arrangement; such accommodations maybe be inform of an interpreter, translator, augmentative communication device and communication assistance to other parties.[366]

4.3 CONCLUSIONS.

People with mental disability form one of the most marginalized group in Kenya today. Article 12 of the UNCRPD on the right to legal capacity was meant to draw a paradigm shift on how this group is viewed and looked at in society. Most of the violations people with mental disability face on a day to day basis are based on the exercise of one's capacity to live an independent life. The denial of legal capacity leads to civil death for the individual who is the victim of such determination. Therefore, being a first generation right, the right to legal capacity should be immediately realized to allow people with mental disability to live independently and in societies where they feel appreciated.

This research was based on the hypothesis that the existing legislation and policies on legal capacity in Kenya discriminate on the persons with mental, intellectual and psychosocial disability and thus deny them a right to live independently in society like other people. The denial of the right to legal capacity merely on the basis of disability has contributed immensely to the suffering and violations suffered by people with mental disability. Such violations discussed in chapter three have in return marginalized people with mental disability further to an extent that their right to live independently in society cannot be achieved.

This paper concludes that Human Rights approach should be adopted in all areas of legal capacity affecting people with mental disability. It's the position of this paper that a presumption of the

[366] Michael Bach, '*The Right to Legal Capacity under the UN Convention on the Rights of Persons with Disabilities Key Concepts and Directions from Law Reform.'* (Institute for Research on Inclusion and Society 2000) <http://public.eblib.com/choice/publicfullrecord.aspx?p=3287460> accessed 12 July 2016.

existence of legal capacity should be the guiding principle in all matters affecting people with mental disability. A paradigm shift is required to move the focus away mental disability issues from a purely medical issue to a human rights issue. The state should therefore put in place measures both legislative and administrative to ensure its immediate realization. This measures will include abolishing laws and policies that limit capacity for persons with mental disability and setting up support systems that will ensure that people with mental disability are empowered to communicate their preferences.

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APPENDIX 1: SCHEDULE OF INTERVIEWS

PARTICIPANT NO.	PSEUDONYM	SEX	PLACE OF INTERVIEW	OCCUPATION OF THE PARTICIPANT	DATE OF THE INTERVIEW
1.	Mary	Female	Nairobi	Social worker	2nd June 2016
2.	Praxides	Female	Rongai	Carer /parent to PWDs	20th March 2016
3.	Zedekiah	Male	Kiambu	Social worker/ nurse	15th July 2016
4.	Leonard	Male	Nairobi	Advocate	9th June 2016
5.	Maina	Male	Kiambu	PWD	15th July 2016
6.	Vanesa	Female	Nairobi	Psychologist / tutor	4th March 2016
7.	Jacky	Female	Vihiga	Disability expert	14th February 2016
8.	Valery	Female	Nairobi	Disability expert	15th July 2016
9.	Otwoma	Male	Nairobi	Lawyer / lecturer	25th July 2016
10.	Oluhano	Female	Mbale	Doctor	14th February 2016
11.	Susan	Female	Nairobi	PWD	15th July 2016
12.	Grace	Female	Nairobi	Advocate	15th October 2015
13.	Winnie	Female	Nairobi	Student	14th January 2016
14.	Patrick	Male	Nairobi	Psychiatrists	5th July 2016
15.	Sam	Male	Rongai	Peasant / parent to PWD	20th March 2016
16.	Racy	Female	Nairobi	Peasant / Parent to PWD	15th July 2016
17.	Reuben	Male	Gilgil	Self employed	22nd December 2015
18.	Lenah	Female	Nairobi	PWD	5th July 2016
19.	Ojuok	Male	Kisumu	County administrator	2nd May 2016
20	Juma	Male	Nairobi	Lawyer	10th July 2016

APPENDIX 2: QUESTIONNAIRE BACKGROUND

Study Title: **A CRITIQUE OF RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA.**

Researcher: Zadock Amboko, LL.M Candidate, University of Nairobi.

Supervisor: Ms. Asaala Evelyne.

Introduction

Dear Sir/Madam,

Thank you for accepting to participate in this interview. I am currently pursuing my Master Degree of Laws at the University of Nairobi. As part of the course complement, I am required to write and present a Project Paper in an area of interest. As indicated above, my topic of study is "A CRITIQUE OF THE RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA."

This questionnaire is administered as part of a study on violations of the legal capacity for persons with mental disability and whether different practices such as institutionalization and forced treatment are justifiable in law. The study is intended to assess the problems affecting the realization and exercise of legal capacity by people with mental disability in Kenya and in light with the Article 12 of the Convention on the Rights of Persons with Disability.

As a participant in this interview, please note the following:

- Your participation is entirely voluntary. You may at any time withdraw from the interview;
- The interview is intended to take approximately 30 minutes;
- In the event that any question administered during the interview is not clear, feel free to ask for clarification;
- Your responses will be recorded on the questionnaire; and

- Your identity as a participant in this interview will be protected by an identifying number known only to the researcher. You will not be named in any study reports, presentations or publications.
- Do you agree to participate in this study?

Yes: _____No: _____

Please sign below confirming your decision:

Signature: _____

(Accept/Decline)

APPENDIX 3: QUESTIONNAIRE

SECTION 1: BACKGROUND INFORMATION

Name _____

(Name to remain confidential if provided)

Age: _____ Sex: (Male/Female) Occupation _____

Date of interview: _____

Time of interview: Start _____ End _____

Language of interview, if not English _____

SECTION 2: GENERAL QUESTIONS

1. What in your view is mental disability?

2. What in your view is the cause of mental disability?

SECTION 3: PERCEPTIONS ON MENTAL DISABILITY AND LEGAL CAPACITY

1. Before the promulgation of the Constitution of Kenya 2010 and the ratification of the CRPD?

a. Do you think people with mental disability are competent to make independent decisions and choices that affect themselves?

b. Do you think that people with mental disability are denied a chance to make independent decisions and choices about their lives? Why?

2. Since the passage of the Constitution of Kenya 2010 and coming into operation of the CRPD;

a. Do you think the perception on mental disability has changed? Why?

b. Do you think that people with mental disability have the right to do the following?

- Own property?
- Make medical choices/ refuse or accept treatment?
- Have a bank account?
- Have insurance?
- Consent to institutionalization?

3. What challenges in your view face the people with mental disability in exercising legal capacity today?

4. What proposals would you make towards addressing these challenges?

SECTION 4: TOWARDS ATTAINING LEGAL CAPACITY STANDARD FOR PERSONS WITH MENTAL DISABILITY.

1. Are you aware of Article 12 of the CRPD?

2. Do you think that people with mental disability are persons before the law and with equal legal capacity to other people? Why?

3. Should legal capacity be limited for people with mental disability?

4. What do you think should be considered before involuntary institutionalization is used against person with mental disability?

5. Do you think informed consent of the person with mental disability is required before important decisions about him are made?

6. What is the role of supports and support person in decision making for person with mental disability?

7. Is there anything else you wish to add?

That concludes our interview. I wish to thank you very much sparing your time to participate in this interview. Good day/evening.

APPENDIX 4: INTRODUCTION LETTER

[Name, address of interviewee]

Dear Sir/Madam,

My name is Zadock Amboko. I am currently pursuing my Master Degree in Laws at the University of Nairobi. As part of the course complement, I am required to write and present a Project Paper in an area of interest. My topic of study is ***"A CRITIQUE OF THE RIGHT TO LEGAL CAPACITY FOR PERSONS WITH MENTAL DISABILITY IN KENYA.***"

As part of this research, I would like to interview legal practitioners and other members of the public who are involved in the disability right sector. The interview will be study the importance of the right to legal capacity in promoting independence of persons with mental disability. The study is intended to look at the challenges affecting PWDs who are denied the right to legal capacity and propose solutions to deal with these challenges. If you would be willing to be interviewed as part of this research project, it would be much appreciated.

Interviews should take no more than one hour, and can be conducted at a location and time that is convenient for you. Interviewees WILL NOT be asked to divulge any information that they regard sensitive.

If you would be willing to take part in this research project, or require any additional information about the interviews, please contact me on 0729609778 or zadambo@gmail.com.

Yours

Amboko Zadock.