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RESEARCH ARTICLE

Decolonizing African Mental Health Laws: A Case for Kenya

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Abstract

The aim of this article is to use a decolonial approach to interrogate Kenya's laws and policies that compel the admission and treatment of persons with psychosocial disabilities. Against the backdrop of the colonization of Africa, the article appraises the historical development of Kenyan mental health laws. It critically analyses domestic policies, legislation, court decisions and the Constitution as they apply to admission to healthcare facilities of persons with psychosocial disabilities and to the freedom to decide about treatment, in order to reveal the persistence of coloniality. It highlights gaps in the protection of equality, dignity and liberty. It also draws on pertinent provisions of the Convention on the Rights of Persons with Disabilities as a juridical method for translating a decolonial agenda into a normative framework. Ultimately, the article proposes a framework for decolonizing Kenya's mental health laws and policies.

Keywords: Mental health laws; persons with psychosocial disabilities; colonialism; coloniality; decolonial turn; Kenya

Introduction

Existing mental health laws in Kenya violate the fundamental rights of persons with psychosocial disabilities. The laws construct persons with these disabilities as objects that should be detained and subjected involuntarily to treatment in mental health asylums and prisons. The oppressive and coercive orientation of the laws has its genesis in the colonization of Africa: colonial regimes introduced laws, policies and practices that regulated the management of psychosocial disability through the drastic curtailment of the liberty and dignity of affected persons in ways analogous to arbitrary incarceration. At independence, Kenya steadfastly retained the laws, thus perpetuating a harmful legacy on the pretext of administering treatment.

This article seeks to use a decolonial approach to interrogate colonial mental health institutions, laws and policies that compel the admission and treatment of persons with psychosocial disabilities. It focuses on laws and policies relating to admission to healthcare facilities and to the freedom to decide about treatment for these persons in Kenya, against an African background. At the same time as appraising domestic jurisprudence, it also considers the implications of international and regional instruments, especially the Convention on the Rights of Persons with Disabilities (CRPD) and its regional counterpart, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa (African Disability Rights Protocol), for domestic

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legal reform.[1] We argue that an African-centred decolonial approach that is accompanied by a human rights framework offers a remedial and transformative way forward for Kenya.

The article has four parts. The first part is the introduction, while the next examines the history of mental health laws in Kenya against the background of the colonization of the African continent. We then advance a decolonial and human rights law agenda for mental health systems, laws and policies that compel the admission and treatment of persons with psychosocial disabilities in Kenya, before giving our conclusion.

Management of psychosocial disability: The genesis in coloniality

Psychosocial disability is a social construct. It refers to the interaction between psychological and social or cultural components of disability.[2] In this article, we use the term "person with a psychosocial disability" as a person-centred description of people previously described as "lunatics", "mentally ill", "insane", "mad" or "crazy".[3] We subscribe to a human rights-based approach; our goal is to embrace a shift from a discourse that has historically sought to stigmatize psychosocial disability, seeing it as an intrinsic limitation arising from a mental health deficit, to one that sees it as a limitation arising out of the interaction between the mental health condition of an individual and their environment. The human rights approach that is inscribed in the CRPD complements our decolonial objective. It is a normative tool for facilitating the transformation of a decolonial agenda into a juridical framework for respecting, protecting, promoting and fulfilling the rights to equality and human dignity of Africans with psychosocial disabilities on an equal basis with others. We recognize persons with disabilities as persons with legal capacity, as is enjoined by the CRPD.[4]

Under the CRPD, legal capacity is linked to human dignity. By ensuring the full and equal enjoyment of all human rights and fundamental freedoms by persons with psychosocial disabilities, article 12 of the CRPD promotes respect for their inherent dignity.[5] Accordingly, any deprivation of liberty on the basis of actual or perceived impairment or health conditions in prisons or mental asylums which deprives persons with psychosocial disabilities of their rights amounts to a violation of both their dignity and their legal capacity under the CRPD.[6] As will be discussed later, the right to legally act on an equal basis with others implies the end of forced institutionalization and treatment under the law, as was decided by the African Commission on Human and Peoples' Rights in *Purohit and Moore v the Gambia* (*Purohit*).[7]

The development of systems for managing psychosocial disability across Africa can be divided into three stages: the precolonial, colonial and postcolonial periods. A good place to begin a review of the management of mental health legislation in Africa is by defining the features of precolonial and colonial mental health regimes and the conditions they sought to address.

Precolonial management of psychosocial disability

Contrary to the essentializing colonial imaginary, Africa is not one culturally homogenous country but a continent with diverse cultures.[8] However, notwithstanding any differences among Africans,

1 Convention on the Rights of Persons with Disabilities (CRPD), UN doc A/61/611 (adopted 13 December 2006, entered into force 3 May 2008); Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa (adopted 29 January 2018, not yet in force).

2 World Network of Users and Survivors of Psychiatry "Implementation manual for the UN Convention on the Rights of Persons with Disabilities" (February 2008) at 9, available at: <http://psychrights.org/Countries/UN/0802CRPDManual.pdf> (last accessed 26 November 2021).

3 F Mahomed "Stigma on the basis of psychosocial disability: A structural human rights violation" (2016) 32 *South African Journal on Human Rights* 490 at 491.

4 CRPD, art 12.

5 Guidelines on the right to liberty and security of persons with disabilities, UN doc (adopted September 2015), para 4.

6 Id, para 10.

7 *Purohit and Moore v the Gambia* [2003] AHRLR 96 (ACHPR 2003).

8 C Ngwena *What Is Africanness? Contesting Nativism in Race, Culture and Sexualities* (2018, Pretoria University Law Press), chap 3.

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broad generalizations can be made. Precolonial Africa is marked by the absence of allopathic medicine. Worry and more particularly moral retributive magic were understood to be the main causes of psychosocial disabilities, and common forms of treatment included suggestion, confession, faith, medication and group support.[9] In some instances, especially where the psychosocial disability was not caused by worry, no medical treatment was required. Instead, the patient was simply advised to confess, apologize or make compensation. Religion or spirituality was a cardinal component of curative approaches.

In North Africa, psychosocial disabilities were treated by healers using traditional medicine.[10] Such disabilities were sometimes perceived as a family curse, affecting children because their parents had transgressed divine law.[11] Therapeutic strategies for milder psychosocial disabilities involved religious forms of healing.[12] North Africans believed that milder psychosocial disabilities occurred when someone was possessed by *j'nun*, or invading spirits. Spiritual healers, or *marabouts*, meaning "men connected to God", who practised exorcisms were sought out in order to reconcile the possessed person with the invading spirit and to offer protection against future possession. For persons with severe psychosocial disabilities, treatment was in the form of confinement in the home or in *maristans*, where they were treated by physicians according to Islamic medical theories.[13]

Other parts of Africa, including Central, East and West Africa, had thriving indigenous medical traditions before the arrival of colonialists. In East Africa, people depended on traditional healers for treatment of all types of illnesses, including those related to mental health.[14] Faith in the healer was one of the methods used to treat psychosocial disabilities.[15] Group support was considered key; for example, the Ndembu of Zambia used kinsmen to join with persons with psychosocial disabilities in what amounted to group therapy, complete with confessions and social reintegration as a form of treatment.[16] Suggestion involved the use of a healer's personality to treat people without the use of any direct or indirect communication.[17] This could be done through rituals or religious and magical representations.[18]

The arrival of colonialists was the beginning of the marginalization of traditional and spiritual healers across Africa, as most of their healthcare practices were dismissively lumped into superstition, witch-doctoring, fetishes and idolatry.[19] Writing about mental health in colonial Lesotho, Thabane describes the attitude of colonialists as follows: "In typical colonial thinking and colonial ways of doing things, the new regime excluded not only indigenous knowledge and how mental illnesses were diagnosed and treated before colonial rule, but also questioned skills, knowledge and authority of even those Basotho who had received medical training at British universities."[20] Legislation banning and criminalizing witchcraft, magic and other African traditional healing practices was quickly put in place by the colonial administrators. Anyone found practising traditional

9 RB Edgerton "A traditional African psychiatrist" (1971) 27 *Southwestern Journal of Anthropology* 259 at 269.
10 MG Wilkinson "Malawi's mental health service" (1992) 8 *Malawi Medical Journal* 1 at 10.
11 G Brégain "Colonialism and disability: The situation of blind people in colonised Algeria" (2016) 10 *ALTER: European Journal of Disability Research* 148 at 151.
12 RC Keller "Pinel in the Maghreb: Liberation, confinement, and psychiatric reform in French North Africa" (2005) 79 *Bulletin of the History of Medicine* 459 at 471.
13 Id at 472.
14 DM Ndetei "Traditional healers in East Africa" (2007) 4 *International Psychiatry* 85 at 85.
15 Edgerton "A traditional African psychiatrist", above at note 9 at 269.
16 Id at 270.
17 Id at 271.
18 T Alanamu "Indigenous medical practices and the advent of CMS medical evangelism in nineteenth-century Yorubaland" (2013) 93 *Church History and Religious Culture* 5 at 26.
19 S Au and A Cornet "Medicine and colonialism" in J Vandendriessche and B Majerus (eds) *Medical Histories of Belgium* (2021, Manchester University Press) 99 at 102.
20 M Thabane "Public mental health care in colonial Lesotho: Themes emerging from archival material, 1918–35" (2021) 32/2 *History of Psychiatry* 146 at 151.

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medicine could be convicted of witchcraft and sent to prison. In practice, African traditional healers were only prosecuted if they worked at the level of the larger community, as opposed to on an individual basis.[21]

Colonial mental health management of psychosocial disability

The advent of colonial mental health regimes cannot be understood without first appreciating the colonization of Africa following the Berlin Conference of 1884–85, which marked a new type of colonialism.[22] It subjected the continent to a status-subordinating system that gave validity only to the western world. The system continues today in metamorphosing and pervasive forms. Colonialism ushered in what Césaire, a leading decolonial theorist, describes as a "disruptive, 'decivilizing', dehumanizing, exploitative, racist, violent, brutal, covetous and 'thingifying' system".[23] Politically and economically, Africa was perceived as a territory that existed primarily to serve the interests of the colonizing country.[24] Colonization came with a full complement of authoritarian rule, arbitrary governance and a desire to conquer the psyche of the colonized.[25] The roots of colonization in colonial Africa were in the form of knowledge claims, power relations and in a set of hegemonic cultural discourses. By 1878, European powers controlled a quarter of Africa, and by 1930 colonization of almost the entire continent was complete.[26]

The history of mental health facilities in Africa is interwoven with histories of struggles – struggles to impose a colonial social order, struggles to resist and do away with that social order, and struggles to forge new nations. Colonial psychiatry is inextricably tied to racism and oppression.[27] Africans' cognitive abilities were equated with lobotomized Europeans. The colonialists characterized Africans as childish, impulsive, hypersexual and biologically incapable of suffering more "refined" forms of psychosocial disabilities, such as melancholia.[28]

Colonialists viewed disability from the perspective of a medical model, leading to a distinction between "normal" and "abnormal". Normal people were considered to have both normal bodies and normal behaviours, while abnormal people had abnormal bodies and exhibited deviant behaviours.[29] One of the objectives of health activities in colonial territories was to treat abnormal bodies.[30] Such treatment used psychotherapy, electroshock therapy, work therapy, tentative social re-adaptation, water treatment and sedation as panaceas for a range of psychosocial disabilities.[31] To a point, colonial psychiatrists endeavoured to treat and care for persons with these disabilities as a way of ameliorating their living conditions. The colonial medical model also sought to "civilize" and develop occupied territories.[32] To the extent that colonial psychiatry purported to introduce

21 S Feierman "Healing as social criticism in the time of colonial conquest" (1995) 54 *African Studies* 73 at 87.

22 M Craven "Between law and history: The Berlin Conference of 1884–1885 and the logic of free trade" (2015) 3 *London Review of International Law* 31 at 31.

23 A Césaire *Discourse on Colonialism* (trans J Pinkham, 2000, Monthly Review Press) at 32.

24 Brégain "Colonialism and disability", above at note 11 at 150.

25 T Modie-Moroka "A historical evolution of mental health services in Botswana: Past and present" (January 2016) at 2, available at: <https://www.researchgate.net/publication/318837827_A_historical_evolution_of_mental_health_services_in_Botswana_Past_and_present> (last accessed 23 November 2021).

26 Id at 4. Ethiopia is Africa's oldest independent country; apart from a five-year occupation by Italy, it has never been colonized.

27 S Swartz "Madness and method: Approaches to the history of mental illness" (2009) 37 *Psychology in Society* 70 at 71.

28 S Swartz "Colonial lunatic asylum archives: Challenges to historiography" (2008) 34 *Kronos* 285 at 287.

29 P Businge "Disability and armed conflict: A quest for Africanising disability in Uganda" (2016) 3 *Disability and the Global South* 816 at 817.

30 A Binagwaho and R Freeman "Decolonization of the legal code: The end of colonial laws in Rwanda and a model for other post-colonial societies" (2021) 62 *Harvard International Law Journal Online* 95 at 105.

31 Keller "Pinel in the Maghreb", above at note 12 at 470.

32 PD Coene "Therapeutic trajectories in 1950s Usumbura, Ruanda-Urundi: A historical research into colonial psychiatry and its limits" (Masters dissertation, Ghent University, 2020) at 12.

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colonial mental health-service structures that were based on allopathic practices which discouraged reliance on superstition and beliefs in moral retribution, they can be said to have ushered in a liberating discourse which was juxtaposed with oppression.

Colonial doctors focused more on the differences between African and European mentalities. Colonialists used mental institutions to colonize the consciousness of the indigenous people into accepting a Eurocentric hierarchization of power. Indigenous Africans were portrayed as liminal subjects. For example, in *Curing Their Ills*, Megan Vaughan affirms that Africans with psychosocial disabilities emerged "in the colonial historical record not as standing for the 'Other' but more often as being insufficiently 'Other'".[33] She continues to state that the "madness" of colonial subjects was feared because it was "indicative of 'deculturation' and the breaking of barriers of difference and silence".[34] The objectification of indigenous Africans by colonial psychiatry was an attempt to produce the "coloniality of being" among mental health patients so as to construct radical ontological differences between the colonized and the colonialists, based on a series of fundamental existential characteristics and symbolic realities. Apart from treating Africans with psychosocial disabilities as biologically different from Europeans with such disabilities, colonialists also discriminated against them in terms of treatment. According to Kang'ethe, race played a key role in determining the quality of care that was offered to Africans with psychosocial disabilities.[35] Europeans with psychosocial disabilities were accorded better treatment and accommodation, compared to Africans in colonial asylums.[36]

Colonial mental health regimes as instruments of control

Colonial institutions for the care and management of persons with psychosocial disabilities replicated mental asylums in Europe. They were also mediated by the colonial project of effecting state repression to suppress political insurrection.[37] JED Esquirol, a French psychiatrist tasked with formulating state policy on the "insane", played a key role in designing French laws establishing asylum psychiatry as the sole legal model for the care of the "mentally ill". He believed that isolation directly affects the brain, resulting in "repressing the liveliness and mutability of impressions" and "moderating the exaltation of ideas and affectations" in asylum patients.[38] Reports of the British colonial psychologist John Carothers, in his books *The African Mind in Health and Disease* and *The Psychology of Mau Mau* that propagated theories of psychological differences between African and European cognitive abilities, were used by the British colonialists to crack down on political rebellion in Kenya.[39] Indigenes who posed a threat to the rule of the Europeans had to be incarcerated. Robert Edgar and Hilary Sapire write about the incarceration of indigenous South Africans in mental asylums, stating that colonial authorities

> "invariably only confined deranged Africans in asylums when they disrupted the regimes and disciplines of work on white farms, in the kitchens, and mines or when they threatened social peace more generally, whether in the street or 'native reserves'. The primary concern in confining mad Africans thus was less with 'curing' or alleviating their mental pain than with removing them as a source of disturbance to society as a whole."[40]

33 M Vaughan *Curing Their Ills: Colonial Power and African Illness* (1991, Boston University African Studies Center) at 118.
34 Ibid.
35 MW Kang'ethe "The insanity of Kenya's 'guilty but insane' verdict" (2021) 6 *Strathmore Law Review* 13 at 21.
36 Swartz "Madness and method", above at note 27 at 71.
37 Ibid.
38 Ibid.
39 JC Carothers *The African Mind in Health and Disease: A Study in Ethnopsychiatry* (1953, World Health Organization); JC Carothers *The Psychology of Mau Mau* (1954, Government Printer, Nairobi); see Coene "Therapeutic trajectories", above at note 32 at 17.
40 R Edgar and H Sapire *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (2000, Ohio University Press) at 34.

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This argument is echoed by Lynette Jackson in her study of the Ingutsheni Asylum in colonial Zimbabwe. She states that "the most common reason for admitting African women to the colonial mental hospital was 'strayness', meaning that African female admissions were generally those who, for one reason or another, were thought to be in the wrong place".[41] Therefore, in order to maintain docile communities, individuals who the colonialists considered disruptive were labelled insane and jailed or committed in mental asylums. For example, the prophet Nontetha Nkwenkwe was confined in a South African asylum because of his popularity, which the colonialists considered to be a threat to their rule.[42] "Appropriate" social niches were very important to the colonialists, and anybody who went against them was "mad" and had to be confined.[43]

Colonial mental health regimes and the construction of the criminally insane and the unfit

Another common factor that led to the establishment and development of asylums in African colonies was the need to separate the "criminally insane" from other prisoners.[44] Many of the colonial mental health laws primarily focus on involuntary admission and treatment, restraints and seclusion, thus limiting rather than promoting the autonomy and liberty of persons with psychosocial disabilities who were declared criminally insane. Colonial laws empowered the government to admit and treat such people against their will in cabins or cells of the civil and military hospitals or in other colonial hospitals.[45]

The "criminally insane" were declared so by colonial courts.[46] However, the concept of "insanity" was influenced by other factors which went beyond the law, to include social, cultural, medical and political factors. These factors led to difficulties in defining the phrase "criminally insane". Once somebody was socially labelled "insane", the role of experts was only to ratify them as such.[47] Persons with psychosocial disabilities were considered a danger to themselves and to the public and had to be removed from the society. For example, the British mental systems were administered as prison annexes, and were used to house Africans who were considered dangerous.[48] However, this was not the case for all the colonial powers: the French asylums focused more on cultural assimilation, which had the effect of tempering, though not eradicating, a racist system.

Colonial mental health laws were also meant to govern "lunatics", "idiots" and any other "persons of unsound mind" who were declared unfit.[49] The procedures for admitting persons with psychosocial disabilities into colonial asylums, and for discharging them, were established. The laws provided for their involuntary detention until they were fit to return to the community.[50] The

41 L Jackson *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe, 1908–1968* (2005, Cornell University Press) at 127.

42 Swartz "Madness and method", above at note 27 at 71.

43 Other vagrancy-related offences were found in the laws of other British-controlled territories, such as Botswana (in secs 179 and 182 of its Penal Code 1964), Malawi (in secs 180 and 184 of the Penal Code 1930), Mauritius (secs 26 and 28 of the Criminal Code 1870), the Seychelles (secs 173 and 174 of the Penal Code 1952), Tanzania (secs 176 and 177 of the Penal Code 1930) and Zambia (secs 178 and 181 of the Penal Code 1930).

44 M Vaughan "Idioms of madness: Zomba lunatic asylum, Nyasaland, in the colonial period" (1983) 9 *Journal of Southern African Studies* 218 at 220.

45 Ibid.

46 P Bermingham "Criminal lunacy and colonial discourse in Ireland, 1833–1916" (PhD thesis, Nottingham Trent University, 2021) at 77.

47 H Deacon "Insanity, institutions and society: The case of the Robben Island Lunatic Asylum, 1846–1910" (August 2003) at 5, available at: <https://www.researchgate.net/publication/290948067_Insanity_institutions_and_society_The_case_of_the_Robben_Island_Lunatic_Asylum_1846-1910/citations> (last accessed 26 November 2021).

48 R Keller "Madness and colonization: Psychiatry in the British and French empires, 1800–1962" (2001) 35 *Journal of Social History* 295 at 307; Thabane "Public mental health care", above at note 20 at 154.

49 AH Westbrook "Mental health legislation and involuntary commitment in Nigeria: A call for reform" (2011) 10 *Washington University Global Studies Law Review* 397 at 404.

50 Ibid.

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procedural requirements for commitment provided for by the colonial mental health laws involved the use of both a medical practitioner and a judicial officer.[51] The laws ensured the control of persons with psychosocial disabilities by the colonial government through the police and other public administrators.

Structures in colonial mental health facilities

Most colonial mental asylums had several different units. For example, in Belgian territories, colonial asylums were divided into a communal unit, which housed "normal" mental health patients, and isolation units, which were reserved for the most difficult and most agitated patients.[52] These were people accused of offences such as murder, arson and assault. There was also a racial policy for segregating black and white patients, without any considerations for patients with both black and white ancestry.[53] The health system in Portuguese colonial territories also had a racist structure, and the asylums were concentrated in the cities and towns where the majority of the colonialists lived.[54] Since the majority of the locals lived in rural areas, they relied on traditional medicine as a way of securing their health.

Poor conditions in colonial mental health facilities

Colonial mental asylums were extremely basic, with no specialist facilities and little or no capacity for treating persons with psychosocial disabilities. For example, European settlers housed in British colonial asylums were mainly people with alcohol-use disorders who could not be cared for in conventional hospitals. Africans were mainly employees who were experiencing challenges transitioning from a rural agricultural tradition to urban wage labour.[55] These asylums resembled penitentiaries rather than medical facilities; colonialists viewed Africans as people who were irremediably primitive and criminal by nature.[56] Public-order confinements rapidly increased the population of people in asylums, which housed an amalgamation of patients, people with no settled residence and criminals. For example, in Zimbabwe the British Lunacy Ordinance empowered magistrates or constables to apprehend, convey to prison or hospital and present for legal proceedings any person who was found wandering at large, as that was a sign that the person was "mentally ill".[57]

As a result of overcrowding, conditions in mental facilities became deplorable, with substandard hygiene. Conditions in the asylums have been described as atrocious.[58] For example, in the Sadiki asylum in North Africa, persons with psychosocial disabilities lived in tiny cells resembling dark dungeons, furnished with only straw mats and blankets. Residents living around the asylum continuously complained of hearing screams from the cells. The Tekia women's facility resembled cages, with chains hanging from the walls. Three or four patients shared cells designed for one,

51 SA Ndiaye-Ndongo et al "The history of mental health in Senegal: Healthcare and educational infrastructures" (2020) 41 *Revista de Historia de la Psicología* 45 at 46. Some of these laws include the French law of 1838 on Assistance to the Insane, Rwanda's Ordonnance du 22 août 1888, relating to infectious and epizootic diseases, and the French ordinance of 7 September 1840.

52 Coene "Therapeutic trajectories", above at note 32 at 30.

53 Id at 43.

54 PI Garrido "Health, development, and institutional factors: The Mozambique case" (WIDER working paper 2020/131) at 2.

55 Keller "Madness and colonization", above at note 48 at 309.

56 F Fanon *The Wretched of the Earth* (1963, Grove Weidenfeld) at 296–304.

57 Lunacy Ordinance of 1908 (Laws of Southern Rhodesia); L Jackson "Gendered disorder in colonial Zimbabwe: Case analyses of African female inmates at the Ingutsheni Mental Hospital, 1932 to 1957" (2012) at 74, available at: <https://sas-space.sas.ac.uk/4234/1/Lynette_Jackson_-_Gendered_disorder_in_colonial_Zimbabwe,_Cape_alalyses_of_African_female_inmates_at_the_Ingutsheni_Mental_hospital.pdf> (last accessed 27 November 2021).

58 Keller "Pinel in the Maghreb", above at note 12 at 494.

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and many died from exposure to infectious diseases and overcrowding.[59] The facilities were loosely guarded, thus leading to frequent escapes. However, Europeans were housed under better conditions.

Colonial mental institutions were also characterized by other factors, such as the removal of persons from their relatives, not allowing the family access to the patient during their recovery period, barring any contact between the patient and the community, and encouraging the patient's dependence on the institution instead of their independence.[60] These factors led to overcrowding in mental asylums, stigma, reinforcement of "mental illness" and inadequate care.[61] However, persons with psychosocial disabilities were not separated from their families in all cases; the Dutch colonial empire made allowance for them to be looked after by their families.

Development of mental health laws in Kenya

This section will focus on the persistence of coloniality in Kenya's mental health laws and will discuss a decolonial agenda for ensuring the liberty and dignity of persons with psychosocial disabilities. Kenya's mental health laws developed from British colonial laws, which the country inherited after independence. British colonial mental health laws treated many people with psychosocial disabilities as "things", and the coloniality of objectification subsists in post-independence Kenya. Involuntary detention and treatments, which were employed to control persons with psychosocial disabilities, are still used to manage mental health in Kenya.

The persistence of coloniality in Kenya's mental health laws

Kenya became a British colony in 1895 and has since adhered to British colonial medical practice. Its mental health system has improved little since the country gained independence, as coloniality subsists.[62] Kenyan mental health laws are still largely a reproduction of colonialism; the experiences, imaginations and knowledge of Kenyans count for less, or simply do not count at all.

The concept of coloniality exists as embedded logic.[63] It is epistemological, continues to enforce domination and exploitation, and is always portrayed as being good for everyone. Coloniality is hidden in institutions and laws that govern psychosocial disability in Kenya's mental health system. Nelson Maldonado-Torres states:

> "Coloniality is different from colonialism. Colonialism denotes a political and economic relation in which the sovereignty of a nation or a people rests on the power of another nation, which makes such a nation an empire. Coloniality, instead, refers to long-standing patterns of power that emerged as a result of colonialism, but that define culture, labour, intersubjectivity relations, and knowledge production well beyond the strict limits of colonial administrations. Thus, coloniality survives colonialism. It is maintained alive in books, in the criteria for academic performance, in cultural patterns, in common sense, in the self-image of peoples, in aspirations of self, and so many other aspects of our modern experience. In a way, as modern subjects we breathe coloniality all the time and every day."[64]

59 M Mathai and DM Ndetai "Overcrowded prisons and low psychiatric provision: The situation of mentally ill prisoners in Kenya" in N Konrad, B Völlm and D Weisstub (eds) *Ethical Issues in Prison Psychiatry* (2013, International Library of Ethics, Law, and the New Medicine) 249 at 250–53.

60 Wilkinson "Malawi's mental health service", above at note 10 at 11.

61 Id at 12.

62 F Njenga "Focus on psychiatry in East Africa" (2002) 181 *British Journal of Psychiatry* 354 at 354.

63 J Seroto "Dynamics of decoloniality in South Africa: A critique of the history of Swiss mission education for indigenous people" (2018) 44 *Studia Historiae Ecclesiasticae* 1 at 3.

64 N Maldonado-Torres "On coloniality of being: Contributions to the development of a concept" (2007) 21 *Cultural Studies* 240 at 243.

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Coloniality is still operative in Kenya's mental health system; persons with psychosocial disabilities are the *damnés de la terre*, "the wretched of the earth".[65] According to Frantz Fanon, they belong to the "zone of non-being".[66] Ghassan Hage classifies them as people living on the wrong side of the "global apartheid", and Arundhati Roy identifies them as the "surplus people".[67] Kenya's mental health system objectifies persons with psychosocial disabilities and considers them "disposable".[68] Decoloniality, which is against all vestiges of colonialism and realities of coloniality, champions the "delinking" of Africa's mental health systems from the colonial regimes in order to allow African epistemic formations to be acknowledged, reckoned with and considered as alternatives to colonialism.[69]

Kenya gained independence in 1963 but adopted some of the previous common law legal system and its sources of law.[70] The Judicature Act provides that Kenya's sources of law include

> "(b) subject thereto, all other written laws, including the Acts of Parliament of the United Kingdom cited in Part I of the Schedule to this Act, modified in accordance with Part II of that Schedule; (c) subject thereto and so far as those written laws do not extend or apply, the substance of the common law, the doctrines of equity and the statutes of general application in force in England on the 12th August, 1897, and the procedure and practice observed in courts of justice in England at that date."[71]

The published text of many of these laws is nowhere to be found in Kenya. Most people do not know which pre-independence mental health laws are in force in the first place. Despite this, these lesser-known colonial laws remain presumptively valid until they are either repealed by Parliament or struck down by the judiciary. The image of colonialism is reflected in Kenya's postcolonial mental health laws, which are still informed by involuntary institutionalization and treatment.

The main mental health institution in Kenya is the Mathari Mental Hospital.[72] It was established by British colonialists to act as an isolation centre for patients suffering from chickenpox in the late 19th century; it later changed to the Nairobi Lunatic Asylum in 1910. As a mental asylum, the Mathari hospital provided care and treatment to persons with psychosocial disabilities. Although it is more than a century old, it represents the state of Kenya's mental health care from both a historical and a contemporary perspective. It still bears the legal and practical hallmarks of colonialism, and patients still suffer from marginalization, neglect, lack of accommodation and overcrowding.[73]

Presently, it is divided into two units: the civil unit and the maximum security unit. The civil unit houses ordinary patients, while the maximum security unit is for offenders with mental disabilities who have committed capital offences or those who have been referred for mental assessment and treatment within the criminal justice system. Criticisms have been levelled against the conditions in the Mathari hospital: it is inadequately resourced, and staff lack the necessary skills required to care for patients.[74] Mental health is among the lowest priorities in Kenya; the national mental

65 Fanon *The Wretched of the Earth*, above at note 56 at 249–50.

66 F Fanon *Black Skin, White Masks* (trans CL Markmann, 1967, Grove) at 2.

67 G Hage *Is Racism an Environmental Threat?* (2017, Polity Press) at 38–39; A Roy *The Ministry of Utmost Happiness* (2017, Hamish Hamilton) at 95.

68 C Gallien "A decolonial turn in the humanities" (2020) 40 *Journal of Comparative Poetics* 28 at 30.

69 W Mignolo "Delinking: The rhetoric of modernity, the logic of coloniality and the grammar of de-coloniality" (2007) 21 *Cultural Studies* 449 at 449.

70 DM Ndetei, J Muthike and ES Nandoya "Kenya's mental health law" (2017) 14 *British Journal of Psychiatry International* 96 at 96.

71 Judicature Act 14 of 1977 (Laws of Kenya), sec 3.

72 M Ibrahim "Mental health in Kenya: Not yet uhuru" (2014) 1 *Disability and the Global South* 387 at 393.

73 Ibid.

74 London School of Economics "Hospital escapees highlight need for community mental health in Kenya" (5 February 2017), available at: <https://blogs.lse.ac.uk/africaatlse/2013/05/20/hospital-escapees-highlight-need-for-community-mental-health-in-kenya/> (last accessed 27 November 2021).

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health budget amounts to less than 1 per cent of the total public health budget. It has also been reported that conditions in the Mathari hospital are appalling and that persons with psychosocial disabilities live under the constant threat of exploitation, violence, neglect and abuse.[75]

Kenyan legislation dealing with psychosocial disabilities positions the state as *parens patriae*, assuming guardianship over persons with such disabilities. The right of the state to intervene in the lives of these people is determined on the basis of two categorizations, guardianship and dangerousness. With regard to the former, the state in its paternalistic and protective role considers itself to have a moral obligation and responsibility to uphold the rights of persons with psychosocial disabilities to receive treatment and safe custody and to be returned to society as a healthy person. In line with ideas of diminished responsibility associated with mental illness, guardianship in this context implies that these interventions are undertaken for the good of the suffering individual, who is incapable of making informed decisions about his or her own welfare or affairs.

Kenya's mental health legislation is also informed by the colonial medical and charity model of disability, which views disability as a disease that needs to be cured and the disabled person as a problem that needs to be removed to mental institutions.[76] The CRPD abhors the medical model of disability and instead calls for the adoption of the human rights model, which focuses on mainstreaming disability and removing "attitudinal and environmental barriers" which cause the marginalization and stigmatization of persons with psychosocial disabilities.[77]

The first mental health legislation was introduced in Kenya in 1933 by the British government and was known as the Indian Mental Health Act. In 1949, the colonial Parliament in Kenya enacted the Mental Treatment Act, which was based on a prototype from Britain and which determined how patients were treated. In 1959, the Mental Treatment Act was replaced with the English Mental Health Act; most of its provisions were borrowed from Britain.[78] On psychosocial disabilities, the Mental Health Act provided for the medical treatment of "mental illness" and for community mental health services.[79] Although at the time this Act was touted as progressive, it was replaced in 1989 by the current Mental Health Act (1989).[80] Among the aims of the 1989 Act are the provision of care for persons who are suffering from "mental disorder" or "mental subnormality with mental disorder", custody of their persons and the management of their estates, and the management and control of mental hospitals.[81]

The second focus of concern in relation to the notion of guardianship and the *parens patriae* of the state is the issue of persons with psychosocial disabilities who are violent and dangerous and pose a threat to the public. Public-order charges brought against persons with such disabilities on the pretext of social security and defence are another driving force behind involuntary commitment in Kenya. These public-order offences include loitering, being a disturbance, indecent exposure, causing public nuisance, urinating or defecating in public, and being drunk and disorderly.[82] Section 16 of the 1989 Mental Health Act also gives significant discretionary power to the police with regard to the involuntary admission of persons with psychosocial disabilities into institutions. Police officers are empowered to take a person into custody where they believe that the person is

75 E Kamundia "Choice, support and inclusion: Implementing article 19 of the CRPD in Kenya" (2013) 1 *Africa Disability Rights Yearbook* 49 at 55.

76 P Juma "Right to self-representation for people with mental disabilities in Kenya's courts" (2019) 7 *African Disability Rights Yearbook* 81 at 86.

77 CRPD Committee cases: *X v United Republic of Tanzania* (Communication 22/2014 (31 August 2017), UN Doc CRPD/C/18/D/22/2014), para 7.6.

78 English Mental Health Act 1959 (Laws of Kenya).

79 Njenga "Focus on psychiatry", above at note 62 at 355.

80 Mental Health Act of 1989 (Laws of Kenya).

81 Id at long title.

82 Article 48 Initiative (A48), Arthur's Dream Autism Trust (ADAT) and Southern Africa Litigation Centre "An exploratory study of the interaction between the criminal justice system and persons with intellectual and psychosocial disabilities in Nairobi, Kenya" (September 2021) at 6.

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suffering from a mental disorder, where the person is dangerous to him/herself or to others, or when the person is not under proper care and control.

Colonial laws on compulsory civil commitment and the category of "dangerousness" with regard to persons with psychosocial disabilities have impacted on mental health policies and practices in Kenya's criminal justice system. Sections 162, 166 and 167 of the Criminal Procedure Code are the main provisions that deal with the issue of detention of persons with such disabilities in Kenya's criminal justice system.[83] Sections 162 and 167 empower the court to involuntarily detain and treat an accused person who is found unfit to plead or to proceed with the trial. Section 166 empowers the court to make a special finding of guilt against an accused with a psychosocial disability by holding that they were "insane" at the time of the offence.[84] This allows the court to make a report to the president and in the meantime detain the accused in manner that it deems proper.[85] After receiving the report, the president may make an order for the person to be detained in a mental hospital, prison or other suitable place of safe custody.[86] Detention is involuntary and was declared unconstitutional in *Kimaru and 17 Others v Attorney General* (*Kimaru*).[87] This case involved the detention of persons with psychosocial disabilities in various prisons in Kenya at the president's pleasure under the Criminal Procedure Code. The High Court declared sections 162(4) and (5), 166(2)–(7), 167(1)(a) and (b), and 167(2)–(4) of the Code, which allow for the detention of persons with psychosocial disabilities at the pleasure of the president, to be unconstitutional. According to the court, the provisions infringed on the rights of these persons to equality, human dignity, freedom and security of the person, fair hearing and the rights of persons detained, held in custody or imprisoned, as enshrined in the Constitution of Kenya 2010 (the Constitution).

Further reform proposals were raised by the Court of Appeal of Kenya in the case of *Wakesho v Republic* (*Wakesho*). Firstly, the court held that the phrase "guilty but insane" under the Criminal Procedure Code should be replaced with "guilty by reason of insanity". The latter, according to the court, is more appropriate where an accused person is "suffering from a defect of reason caused by a disease of the mind at the time of the commission of an offence".[88] Secondly, the court proposed that judges should be granted discretion to impose appropriate measures to suit the circumstances of each case, upon a finding of not guilty by reason of insanity. In *Wakesho*, the appellant had been convicted of the offence of murder despite indications that he was suffering from a disease which affected his mind and made him incapable of understanding what he was doing or knowing that what he was doing was wrong at the time of the commission of the offence. The court substituted the conviction with a special finding that the appellant did the act charged but was insane at the time.

Despite the decisions in *Kimaru* and *Wakesho*, the dominant medical attitude of the state towards persons with psychosocial disabilities is still reflected in Kenya's court system. In the case of *Republic v CMW*, the High Court, after finding the accused "guilty but insane", recommended that the country should build "a mental asylum where persons with psychosocial disabilities facing trial for various offences may be held, and properly medically treated".[89] Similar reasoning is also found in *Republic v SOM*, where the court, after finding the accused "guilty but insane", recommended that he be committed to a mental institution for a term of 15 years, subject to periodic reviews by the court in accordance with section 166 of the Criminal Procedure Code and in any case before the expiry of every two years.[90]

83 Criminal Procedure Code of 1930 (Laws of Kenya), cap 75.
84 Id, sec 166(1).
85 Id, sec 166(2).
86 Id, sec 166(3).
87 *Kimaru and 17 Others v Attorney General and Others* [2022] KEHC 114 KLR.
88 *Wakesho v Republic* [2021] KECA 223 KLR, para 57.
89 *Republic v CMW* [2018] eKLR, para 48.
90 *Republic v SOM* [2018] eKLR, para 19(c).

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Article 54 of the Constitution provides explicit protection for disabled persons and affirms their rights, including the right to be treated with dignity and respect. Kenya ratified the CRPD on 19 May 2008 and the African Disability Rights Protocol on 15 November 2021; article 2(5) of the Constitution provides that the "general rules of international law shall form part of the law of Kenya". The CRPD encompasses international standards regulating the deprivation of liberty for persons with psychosocial disabilities. Article 14 states:

> "States Parties shall ensure that persons with disabilities, on an equal basis with others: (a) Enjoy the right to liberty and security of person; (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty. (2) States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation."

The right to liberty and security of persons is reaffirmed in article 9 of the African Disability Rights Protocol. Liberty denotes "freedom from confinement of the body", while security of the person concerns "freedom from injury to the body and the mind".[91] The landmark policy initiated by the government on the liberty of persons with psychosocial disabilities is the Persons with Disabilities Act, which provides for the rights and rehabilitation of disabled persons.[92] However, it does not expressly make provisions against involuntary admissions and the treatment of persons with psychosocial disabilities.

Although article 14 of the CRPD forms part of Kenya's legal framework, it has not resulted in any amendment of laws that allow for the involuntary admission and treatment of persons with psychosocial disabilities. Instead, the state has enacted the Person Deprived of Liberty Act, which together with the 1989 Mental Health Act sets out the criteria for the involuntary admission and treatment of persons with psychosocial disabilities.[93] Kenya reformed its mental health laws through the Mental Health Amendment Act.[94] However, section 22 of this Act contains provisions on involuntary admissions of persons with psychosocial disabilities. This is a Eurocentric way of reforming laws. Kenyan mental health laws and institutions are vestiges of colonial norms and asylums, rooted in what the British colonial masters conceived as normal, ideal or rational. In *Purohit*, the African Commission validated the connection between mental health and human rights, providing regional fora for recognizing and enforcing the human rights of persons with psychosocial disabilities.[95] In that case, the complainants were mental health advocates who submitted the communication on behalf of patients detained at a psychiatric unit in the Gambia, under the Lunatics Detention Act (LDA).[96] They alleged that there were no review or appeal procedures against a determination or certification of one's mental state for both involuntary and voluntary mental patients under the LDA and no remedy for wrong certification or diagnosis. The African Commission found that the LDA did not comply with articles 2 and 3 of the African Charter on Human and Peoples' Rights (African Charter) on equal protection of the law and non-discrimination, which Kenya ratified on 23 January 1992.[97]

91 CD Aguilar "Ending the deprivation of liberty on the basis of disability" (A/HRC/40/54) at 9.
92 Persons with Disabilities Act 2003 (Laws of Kenya), at long title.
93 Person Deprived of Liberty Act 23 of 2014 (Laws of Kenya).
94 Mental Health Amendment Act of 2022 (Laws of Kenya).
95 *Purohit*, above at note 7, para 1.
96 Lunatics Detention Act of 1942 (Laws of Gambia).
97 African Charter on Human and People's Rights (adopted 1 June 1981, entered into force 21 October 1986).

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The *Purohit* decision is a milestone in the promotion and protection of the rights of persons with psychosocial disabilities in Africa. It analysed disability from a human rights perspective. This rights-based approach affirms that persons with psychosocial disabilities have a right to equal protection of the law and non-discrimination. Abbay has argued that the *Purohit* communication is important because it clearly articulates the rights of persons with disabilities, which were not adequately addressed under the African Charter.[98] The case offered the opportunity to test the extent to which disability rights are protected under the African system. The African Commission expounded the understanding of disability rights by relying on regional human rights instruments, such as the African Charter, thus paving the way for future challenges to violations of disability rights in the region. In the absence of other jurisprudence dealing with disability rights on the continent, the decision in *Purohit* remains a beacon of hope for persons with psychosocial disabilities and may encourage similar communications in the future. However, the fact that the Commission has only ever received one communication relating to disability rights may be interpreted as a sign that persons with disabilities in Africa are still perceived as objects, as opposed to subjects of rights.

The East African Community (EAC), which Kenya is party to, has also taken initiatives to protect the rights of persons with psychosocial disabilities by adopting the EAC Policy on Persons with Disabilities (EAC Policy).[99] The EAC Policy stipulates that state parties shall through this policy promote the development or establishment of disability user-friendly facilities and infrastructure, including in health and the judiciary. Kenya must embrace the ideals espoused in the CRPD, the EAC Policy and the *Purohit* decision and take the necessary practical measures to articulate and ensure the rights of persons with psychosocial disabilities.

A decolonial agenda for Kenya

Colonial laws ignored and continue to ignore the unique characteristics of African society. The British imported the common law from England which now governs Kenya's civil and criminal mental health laws. The decolonial agenda for Kenya should involve four intersecting dimensions: structural, relational, epistemic and personal.

Structural decolonization denotes the reopening of mental health institutions in ways that do not echo and reproduce colonial relations.[100] Community living is part of structural decolonization and one of the ways of empowering persons with psychosocial disabilities in order to enable them to live independently.[101] In Kenya, care services for persons with these disabilities have traditionally been provided in segregated mental institutions, a practice based on the colonial medical model of disability. In contrast, community living has been defined as providing support for community participation. Persons with psychosocial disabilities in Africa have been reported as preferring support from the community, as opposed to being institutionalized.[102]

Relational decolonization announces the human agency and interdependence of persons with psychosocial disabilities.[103] It calls for equity, mutuality and reciprocity, as opposed to paternalism and power over such persons. Relational decolonization can be called upon to remediate all forms of domination against persons with psychosocial disabilities in Kenya's mental health system. According to the medical model of disability – a form of relational coloniality upon which most of Kenya's laws are based – psychosocial disabilities are illnesses that needs to be treated. Instead

98 F Abbay "An evaluation of disability human rights under the African regional human rights system" (2015) 23 *African Journal of International and Comparative Law* 476 at 502.

99 East African Community Policy on Persons with Disabilities, African Commission [2012].

100 S Kessi, Z Marks and E Ramugondo "Decolonizing African studies" (2020) 12 *Critical African Studies* 271 at 273.

101 M Runo "Independent living for persons with disabilities" (2012) 46 *The East African Review* 1 at 11.

102 M Amuyunzu-Nyamongo "The social and cultural aspects of mental health in African societies" (2013) 1 *Commonwealth Health Partnerships* 59 at 62.

103 Ibid.

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of focusing on the involuntary admission and treatment of persons with these disabilities, the law should focus on support and empowerment. Article 19 of the CRPD and article 14 of the African Disability Rights Protocol provide for the right of persons with psychosocial disabilities to live independently and to be included in the community. The term "community" denotes belonging; it presupposes commonality, consensus and interdependence, as opposed to individuality, personal will and self-dependence.[104] Persons with psychosocial disabilities, and their families, who are adequately supported and empowered are capable of living independently or semi-independently.

Epistemic decolonization avoids reproducing Eurocentric assumptions about legitimate ways of caring for and treating persons with psychosocial disabilities in Africa. Colonial laws present serious epistemic barriers to the health, human rights and development of persons with these disabilities. The provisions of involuntary admission and treatment are in conflict with both the CRPD and the Constitution of Kenya, which require the dignity and liberty of persons with psychosocial disabilities to be respected, promoted, protected and fulfilled.[105] One of the main barriers presented by colonial laws is epistemic in nature. Judicial involuntary admission and treatment in hospitals or prisons are themselves deterrents to ensuring the mental health of persons with psychosocial disabilities.[106] This article makes a case for the repeal of all colonial mental health laws in Kenya, which were crafted to perpetuate health inequalities between Europeans and Africans. In modern Africa, the effect of these discriminatory colonial laws and policies continues to be felt in practice by persons with psychosocial disabilities, who are separated from their community, without access to the options and choices that are available to non-disabled people.

Epistemic coloniality is also found in Kenya's criminal justice system, the state public-order laws of which should be repealed. These laws were meant to promote mental hygiene and were intended to target the poor and marginalized groups, including persons with psychosocial disabilities.[107] Such laws undermine the rights of these people to an adequate standard of physical and mental health, perpetuate social exclusion and economic hardship, and lead to involuntary detention and treatment.[108] Judicial involuntary admissions and treatment should also be applied sparingly. Instead, the judiciary should adopt other, non-incarceration measures, such as the use of traditional dispute resolution mechanisms, alternative dispute resolution mechanisms and the diversion of cases away from the court system.

The other example of epistemic coloniality in Kenya's mental health systems can be found in the use of diagnostic criteria of psychosocial disorders, as exemplified in the World Health Organization's International Classification of Diseases and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which are pegged on the power of modern Eurocentric psychiatry and international health organizations. The essence of decolonialism is to offer alternative diagnostic epistemologies to persons with psychosocial disabilities. Decoloniality calls for the de-normalization of Kenya's mental health laws; it destabilizes colonial mental health structures that continue to oppress persons with psychosocial disabilities under the regime of modern coloniality.[109] It also problematizes default positions, such as the institutionalization of persons with psychosocial disabilities and, particularly, psychiatric hospitalization.

104 Kamundia "Choice, support and inclusion", above at note 75 at 54.

105 United Nations "Chapter Two: The Convention in detail – Obligations of States parties under the Convention", available at: <https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-two-the-convention-in-detail-4.html> (last accessed 28 November 2021).

106 SK Goldsmith et al (eds) *Reducing Suicide: A National Imperative* (2002, The National Academies Press) at 357.

107 Southern Africa Litigation Centre "The persistence of colonial vagrancy laws in Southern Africa" at 27, available at: <https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/05_SALC-NoJustice-Report_The-Persistence-of-Colonial-Vagrancy-Laws-in-Southern-Africa.pdf> (last accessed 28 November 2021).

108 Ibid.

109 Gallien "A decolonial turn", above at note 68 at 28.

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Personal decolonization is both an individual and a collective awareness of the dynamics of hegemony and a commitment to disrupting dominant colonial mental health practices through everyday occupational consciousness.[110] Religion and spirituality have a crucial role in combating personal coloniality through the coping strategies of the parents and caregivers of disabled persons.[111] It is estimated that traditional and spiritual healers manage at least 80 per cent of the healthcare needs of rural inhabitants of East Africa.[112] The Constitution and the Persons with Disabilities Act allow persons with psychosocial disabilities the right to participate fully in cultural activities.[113] Like other disabled people, persons with psychosocial disabilities also have religious and spiritual affiliations, which provide meaning and purpose to their lives and assist them in coping with stressful life events such as loss and illness, among other things. The role of spiritual healers may provide an important source of support both to the families of persons with psychosocial disabilities and to those people themselves. Other community-based practices that may be used to alleviate the conditions of persons with such disabilities without infringing on their rights include the use of community health workers and peer-based support.

Conclusion

The extended domination of colonial laws over Africa is a form of coloniality. A "decolonial turn" in Kenya's mental health epistemicides can productively enhance the rights of persons with psychosocial disabilities. Kenya's society has its own traditional methods of empowering and accommodating these people. Colonial mental health systems have power and a purpose which have come with a very restricted view, denigrating other African conceptions and ways of coping. However, it is colonial mental health laws that have become a part of Africa's responses to dealing with psychosocial disabilities. Postcolonial African laws still view persons with such disabilities as objects of charity, medical treatment and social protection. They are based on colonial laws, which also objectified such persons. The decolonial turn in Africa requires a shift from all forms of objectification towards viewing these people 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 of being active members of society.

Colonial medical traditions of involuntary treatment and admission have proved unsuccessful in articulating the experiences of Africans. Radical revision is needed of Kenya's mental health laws and policies. Laws and policies that promote the right of persons with psychosocial disabilities to live independently and in the community are important. Policy-makers should recognize the need for a cross-cultural approach when dealing with psychosocial disabilities in Africa, entailing the use of both local practices and local languages when providing mental health services. These policies must also be accompanied by adequate resource allocation in order to combat Africa's most prevalent mental health challenges. Non-Eurocentric training of mental health providers on supportive counselling and facilitating the creation of community self-help groups and peer-support services is also important.

Parliament has the power to legislate in Kenya. The country also has a strong Law Reform Commission and a competent independent judiciary which is in charge of interpreting laws. The long-term mechanism for fundamental reforms and their subsequent maintenance is therefore in place. Colonial laws do not reflect modern, postcolonial states' values and appreciation for the principles of international human rights norms. By identifying and discussing the origins of such laws, governments are better able to determine their continued utility or the lack thereof. These efforts

110 Kessi, Marks and Ramugondo "Decolonizing African studies", above at note 100 at 275.

111 S Mkabile and L Swartz "Spiritual healers' explanatory models of intellectual disability in Cape Town, South Africa" (2022) 26/1 *Journal of Disability & Religion* 1 at 3.

112 Ndetei "Traditional healers", above at note 14 at 96.

113 Constitution of Kenya, art 54; Persons with Disabilities Act, sec 26(1)(e).

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must be supported. What remains is the process of reviewing and invalidating obsolete colonial mental health laws and replacing them with African-centred human rights model laws which focus on mainstreaming disability and removing "attitudinal and environmental barriers" that cause the marginalization and stigmatization of persons with psychosocial disabilities.[114] Ridding itself of colonial mental health laws will enable Kenya to not only restore its full sovereignty and bring legal clarity, but will also ensure the full realization of the rights of these persons.

The burden of mental health coloniality has removed the liberty of persons with psychosocial disabilities in Kenya, who still live under the domination of oppressive colonial laws. Decolonial thinking emphasizes the re-experiencing, re-imagining and re-thinking of Kenya's mental health system, based on different epistemic mental health foundations and ontologies.[115] Decoloniality theorists advocate for a broad "decolonial turn" that involves the "task of the very decolonization of Kenya's mental health systems".[116]

Competing interests. None

114 *X v United Republic*, above at note 77, para 7.6.

115 Gallien "A decolonial turn", above at note 68 at 33.

116 Maldonado-Torres "On coloniality of being", above at note 64 at 243.

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