

# Understanding the Mental Health Indication for Legal Abortion

*[S]ome countries have interpreted “mental health” to include psychological distress caused by, for example, rape or incest, or by diagnosis of fetal impairment. In other circumstances, countries have also included in the interpretation of a threat to women’s mental health, distress caused by detrimental socioeconomic circumstances.<sup>1</sup>*

*The scope of mental health includes psychological distress or mental suffering caused by, for example, coerced or forced sexual acts and diagnosis of severe fetal impairment. A woman’s social circumstances are also taken into account to assess health risk.<sup>2</sup> - World Health Organization*

## THE MENTAL HEALTH INDICATION FOR ABORTION IN KENYA

### THE NEW KENYAN CONSTITUTION PERMITS ABORTION ON MENTAL HEALTH GROUNDS.

- **The 2010 Constitution explicitly permits abortion when “in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.”<sup>3</sup>**
- The World Health Organization (WHO) defines health as **“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>4</sup>**
- The WHO has further made clear that:  
*In many countries, the law does not specify the aspects of health that are concerned but merely states that abortion is permitted to avert risk of injury to the pregnant woman’s health. **Since all countries that are members of WHO accept its constitutional description of health as “a state of complete physical mental and social well-being and not merely the absence of disease or infirmity”, this description of complete health is implied in the interpretation of laws that allow abortion to protect women’s health.**<sup>5</sup>*
- The African Charter on Human and Peoples’ Rights,<sup>6</sup> the International Covenant on Economic, Social and Cultural Rights,<sup>7</sup> the Kenyan Ministry of Health,<sup>8</sup> and the Kenyan Medical Practitioners and Dentists Board<sup>9</sup> also define health to include both mental and physical health.
- As such, **under the new Kenyan Constitution, women have the right to access safe and legal abortion where the pregnancy presents a danger to their mental and physical well-being.**

### DANGER TO THE PREGNANT WOMAN’S “LIFE OR HEALTH” IS DETERMINED BY THE TRAINED HEALTH PROFESSIONAL IN CONSULTATION WITH THE PATIENT.

- The Constitution permits a trained health professional to make this decision alone—**without having to consult with other health care providers.**
- A “trained health professional” should be interpreted to include doctors, clinical officers, and nurses and midwives who have the appropriate training. This was the clear intention of the Committee of Experts that drafted this Constitutional provision.<sup>10</sup>
  - The trained health professional does not need to have a specialty in psychiatry to determine whether a woman meets the mental health indications for abortion.<sup>11</sup>

## MAKING A DETERMINATION

**DETERMINING WHETHER A PREGNANT WOMAN MEETS THE MENTAL HEALTH INDICATION FOR A LAWFUL ABORTION IS A MULTI-STEP PROCESS THAT REQUIRES CAREFUL CONSIDERATION OF THE INDIVIDUAL WOMAN'S CIRCUMSTANCES.\***

There are currently no comprehensive government guidelines on how to determine whether a pregnancy may be terminated on mental health grounds. However, the Ministry of Public Health and Sanitation's 2009 National Guidelines on Management of Sexual Violence in Kenya outline one clear ground for a mental health indication for abortion: women who have experienced sexual violence. **These guidelines state that a woman who becomes pregnant as the result of sexual violence should be informed that termination of pregnancy is an option in Kenya.**<sup>12</sup>

Studies and practices in other countries can also help inform this decision-making process. The following guidance is derived from the scholarship of leading legal and mental health experts.

1. First, any decision to terminate a pregnancy must be made in **good faith**. The trained health professional must objectively and professionally determine that the pregnant woman meets the criteria for termination to preserve her mental health.<sup>13</sup> Evidence that a health professional has acted in good faith includes the following:
  - › Avoiding arbitrary and subjective decisions based on personal opinion, self-interest, or personal objection to abortion.
  - › Reaching an informed opinion through professional standards of assessment, including inquiry into a patient's family and personal mental history, as well as circumstantial factors about the patient's life (e.g., current social circumstances [see below for key indicators and factors to evaluate]).
  - › NOTE: If a trained health professional declines to perform an abortion on mental health grounds, another trained health professional can still decide that the situation does meet the mental health grounds criteria. As long as a decision is made in good faith, it does not have to be in agreement with the opinion of other trained health professionals. In other words, an opinion from one trained health professional does not preclude a woman from seeking or obtaining the opinion of additional trained health professionals who may, in good faith, reach a different conclusion.
2. Second, the trained health professional must evaluate whether the patient meets the criteria for termination on mental health grounds. **Mental health should be understood broadly, according to the WHO's definition: "Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."**<sup>14</sup>

**To help guide an evaluation, experts have identified at least three key indicators that could be considered. These indicators are simply an effort to guide decision making; only one needs to be met for a patient to meet the mental health indication for abortion.**<sup>15</sup>

- › INDICATOR ONE: **Risk of future negative mental health outcomes.** To determine this, the trained health professional can ask two questions:
  - a. **Is there reason to believe that continuation of the pregnancy would endanger the pregnant woman's future mental health?** In answering this question, the following factors may be evaluated:
    - i. *Vulnerability*
      1. Genetic inheritance, indicated by the patient's personal and family psychiatric and medical history

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\* This section is drawn extensively from Rebecca Cook et al., *Legal Abortion for Mental Health Indications*, 95 INT'L J. GYNECOLOGY & OBSTETRICS 185, 188–89 (2006).

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2. Early childhood experiences that may affect the emergence of a mental disorder, such as
  - a. Neglect and abuse
  - b. Multiple shifting of school or home
  - c. Education
  - d. Personality characteristics, such as impulsiveness
- ii. *Precipitating factors*. Typically, these are events that have occurred recently and that could potentially lead to mental disorder. Here it is important to assess how well the patient deals with, and has dealt with, stress. Examples of precipitating events include
  1. Bereavement (a recent death)
  2. Termination of a significant intimate relationship
  3. Loss of employment
- iii. *Maintaining factors* or chronic difficulties that reinforce or perpetuate a mental health problem, such as
  1. Poverty
  2. Marginalized social status
  3. Lack of social support
  4. Frustration in obtaining appropriate services<sup>16</sup>

**OR**

**b. *Are there pregnancy-related factors or adverse social circumstances that appear so distressing as to be likely to cause depression or another psychiatric illness?***

- i. Specific risk indications include
  1. *Pregnancy resulting from rape or incest*. As mentioned above, in Kenya, access to safe abortion in cases of pregnancy resulting from sexual violence has long been understood as central to preserving women's life and health.<sup>17</sup>
  2. *Diagnosis of harmful fetal conditions*.<sup>18</sup> The Human Rights Committee, which oversees compliance with one of the key human rights treaties, the International Covenant on Civil and Political Rights, stated in *K.L. v. Peru* that "[t]he omission on the part of the State in not enabling [K.L.] to benefit from a therapeutic abortion [after a diagnosis of severe fetal impairment, such as anencephaly] was, in the Committee's view, the cause of the suffering she experienced. The Committee has pointed out . . . that the right [to freedom from cruel, inhuman, and degrading treatment] relates not only to physical pain but also to mental suffering."<sup>19</sup>
  3. *Adolescent pregnancy*. Adolescents who become pregnant may experience stigma or familial or community ostracism, as well as the end of educational opportunities.
  4. *Pregnancy outside of marriage*. As legal scholar Rebecca Cook has noted, a pregnancy outside of marriage may cause "fear of familial and/or social ostracism, and significantly reduces prospects of marriage and of [a woman's] own future family life. It may also create fear of subjection to physical violence, and even of death."<sup>20</sup>

➤ **INDICATOR TWO: *Acute risk of suicide***

- a. Does the patient have an immediate intent to harm herself?
- b. Does she have a specific suicide plan in mind?

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c. If the answer is yes to both these questions, she meets the criteria for the mental health indication for abortion.

### ➤ INDICATOR THREE: **Current serious and/or chronic mental illness**

a. Does the patient have a mental illness (e.g., depression, schizophrenia, or bipolar disorder)?<sup>21</sup>

b. If yes, does the patient feel she is able to parent a child?

i. If the answer is no, then a termination of pregnancy on mental health grounds is permitted.

c. However, before performing the termination, the trained health professional must ask the following: Does the patient have the ability to understand her condition and the options available?

i. If not, every effort should be made to stabilize the patient so that she may give her informed consent to the procedure before a pregnancy is terminated.

3. Third, once the trained health professional, in consultation with the pregnant woman, has determined whether she meets the mental health indication for abortion, the trained health professional should obtain her informed consent in writing.

4. Finally, both prior to and following the procedure, the trained health professional should offer *non-mandatory and non-biased counseling* to the patient, as well as information on available family planning options.

### **ABORTION AND WOMEN'S MENTAL HEALTH**

#### **TERMINATING AN UNWANTED PREGNANCY DOES NOT INCREASE THE RISK OF MENTAL HEALTH PROBLEMS.**

**. . . for women with an unwanted pregnancy, abortion does not appear to harm their mental health.<sup>22</sup>**

— *NCCMH Report, UK Royal, College of Psychiatrists (2011)*

The belief that terminating an unwanted pregnancy can harm a woman's mental health has been widely debunked by experts. Instead, mental health experts have found that, in many ways, it is the stigma surrounding abortion that harms women most.<sup>23</sup>

In 2011, with funding from the UK Department of Health, the National Collaborating Centre for Mental Health (NCCMH) undertook a scientific review of the relationship between mental health and abortion. The NCCMH was established in 2001 at the Royal College of Psychiatrists, in partnership with the British Psychological Society. Its primary role is to develop evidence-based mental health reviews and clinical guidelines. After a comprehensive assessment, the NCCMH determined that:

- *The rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth.*
- *An unwanted pregnancy was associated with an increased risk of mental health problems.*
- *The most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion.<sup>24</sup>*

More specifically, the NCCMH's review found that:

- *[T]he risk of mental health problems following an abortion was comparable to the risk of mental health problems following a delivery.<sup>25</sup>*
- *The association between abortion and mental health outcomes are unlikely to be meaningful. . . . When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has an abortion or goes on to give birth.<sup>26</sup>*

In 2008, the American Psychological Association (APA) Task Force on Mental Health and Abortion also found that:

*Based on our comprehensive review and evaluation of the empirical literature published in peer-reviewed journals since 1989, this Task Force on Mental Health and Abortion concludes that the most methodologically sound research indicates that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy for nontherapeutic reasons, **the relative risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.** This conclusion is generally consistent with that reached by the first APA task force (Adler et al., 1990).<sup>27</sup>*

In addition, the report stated that “[a]cross studies, prior mental health emerged as the strongest predictor of postabortion mental health (Major et al., 2000).”<sup>28</sup>

## ENDNOTES

- 1 WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 86 (2003) [hereinafter WHO, SAFE ABORTION (2003)].
- 2 WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 92 (2012) [hereinafter WHO, SAFE ABORTION (2012)].
- 3 CONSTITUTION, art. 26(4) (2010).
- 4 WHO, Constitution of the World Health Organization, signed July 22, 1946, pmbl. (entered into force Apr. 7, 1948).
- 5 WHO, SAFE ABORTION (2012), *supra* note 2, at 92. The WHO has also stated clearly that a “restrictive interpretation of legal grounds,” such as the health ground, can create barriers to the provision of safe, legal services and can contribute to unsafe abortion. *Id.* at 94.
- 6 African Charter on Human and Peoples’ Rights, adopted June 27, 1981, art. 16, O.A.U. Doc. CAB/LEG/67/3, rev.5, 21 I.L.M. 58 (1982) (entered into force Oct. 21, 1986).
- 7 International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, art. 12, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976).
- 8 See, for example, the Ministry of Health’s *National Guidelines on Management of Sexual Violence in Kenya*, which permit access to safe abortion services in cases of sexual violence as part of the mental health exception to the law criminalizing abortion in Kenya. MINISTRY OF PUBLIC HEALTH AND SANITATION & MINISTRY OF MEDICAL SERVICES, NATIONAL GUIDELINES ON MANAGEMENT OF SEXUAL VIOLENCE IN KENYA 13 (2d ed. 2009), available at <http://www.svri.org/nationalguidelines.pdf> [hereinafter NATIONAL GUIDELINES].
- 9 See CENTER FOR REPRODUCTIVE RIGHTS, IN HARM’S WAY: THE IMPACT OF KENYA’S RESTRICTIVE ABORTION LAW 35 (2010) (documenting interviews with both the chairman and the chief executive officer of the Kenyan Medical Practitioners and Dentists Board, in which each states clearly that the definition of health encompasses both physical and mental health).
- 10 The Committee of Experts explained its rationale when drafting this language, stating that “[t]he requirement that abortion could be performed by medical practitioners alone . . . raised concerns. It would mean that women in poor rural communities without such services would be unable procure abortions with potentially serious or fatal repercussions for some poor women.” COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW, FINAL REPORT OF THE COMMITTEE OF EXPERTS ON CONSTITUTIONAL REVIEW 111 (October 11, 2010), available at [http://www.ldphs.org.za/resources/local-government-database/by-country/kenya/commission-reports/CoE\\_final\\_report.pdf](http://www.ldphs.org.za/resources/local-government-database/by-country/kenya/commission-reports/CoE_final_report.pdf).
- 11 Rebecca Cook et al., *Legal Abortion for Mental Health Indications*, 95 INT’L J. GYNECOLOGY & OBSTETRICS 185, 188 (2006).
- 12 NATIONAL GUIDELINES, *supra* note 8, at 13.
- 13 Cook et al., *supra* note 11, at 188–89.
- 14 WHO, What is Mental Health? (Sept. 3, 2007), <http://www.who.int/features/qa/62/en/index.html>.
- 15 The three indicators outlined in the following section were developed by American psychiatrist George Engel and are described in Cook et al., *supra* note 11, at 188–89.
- 16 The WHO has also recognized that “countries have . . . included in the interpretation of a threat to women’s mental health, distress caused by detrimental socioeconomic circumstances.” WHO, SAFE ABORTION (2003), *supra* note 1, at 86.
- 17 See *Rex v. Bourne*, [1939] 1 K.B. 687; Mehar Singh Bansel v. R, [1959] E. Afr. L. Rep. 813 (affirming *Rex v. Bourne* in the East African Court of Appeal); NATIONAL GUIDELINES, *supra* note 8, at 13 (“If [survivors of sexual violence] present with a pregnancy, which they feel is as a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006). If the woman decides to opt for termination, she should be treated with compassion, and referred appropriately.”). See also WHO, SAFE ABORTION (2003), *supra* note 1, at 86 (“[S]ome countries have interpreted ‘mental health’ to include psychological distress caused by, for example, rape or incest.”).
- 18 See WHO, SAFE ABORTION (2003), *supra* note 1, at 86 (“[S]ome countries have interpreted ‘mental health’ to include psychological distress caused by, for example, . . . diagnosis of fetal impairment.”).
- 19 K.L. v. Peru, Human Rights Committee, Communication No. 1153/2003, para. 6.3, U.N. Doc. C/PR/C/85/D/1153/2003 (2005). The Kenyan government has ratified the International Covenant on Civil and Political Rights.
- 20 *Id.*
- 21 AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV-TR (4th ed. text revision, 2000).
- 22 NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH (NCCMH), INDUCED ABORTION AND MENTAL HEALTH: A SYSTEMATIC REVIEW OF THE MENTAL HEALTH OUTCOMES OF INDUCED ABORTION, INCLUDING THEIR PREVALENCE AND ASSOCIATED FACTORS 126 (2011) [hereinafter NCCMH, INDUCED ABORTION AND MENTAL HEALTH].
- 23 *Id.* at 15, 122; see also AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) TASK FORCE ON MENTAL HEALTH AND ABORTION, REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 4, 12

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(2008) [hereinafter APA, MENTAL HEALTH AND ABORTION].

<sup>24</sup> NCCMH, INDUCED ABORTION AND MENTAL HEALTH, *supra* note 22, at 8. Other key findings included the following: “The factors associated with increased rates of mental health problems for women in the general population following birth and following abortion were similar. There were some additional factors associated with an increased risk of mental health problems specifically related to abortion, such as pressure from a partner to have an abortion and negative attitudes towards abortions in general and towards a woman’s personal experience of the abortion.” *Id.*

<sup>25</sup> *Id.* at 124.

<sup>26</sup> *Id.* at 125.

<sup>27</sup> APA, MENTAL HEALTH AND ABORTION, *supra* note 23, at 92 (emphasis added). It is worth noting that the 50 studies reviewed for this report were conducted primarily in the United States; however, studies from Finland, New Zealand, Norway, the United Kingdom, Brazil, Israel, and Canada, among other countries, were also examined.

<sup>28</sup> *Id.*