

STIGMA IN MENTAL DISORDERS: WHAT IS PSYCHIATRY ABLE TO DO?

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SUMMARY

The problem of stigma in mental health is connected to the problem of human rights. Mental health professionals, psychiatrists included, display stigmatization of people with mental disorders mostly through social distance, even though they have “politically correct” opinions about their patients. Negative beliefs and attitudes in psychiatric profession should be opposed because of their important influence on public opinion, opinion of patients’ themselves and of their family members. The “disabling environment” formed through discriminative practices in all society levels can be improved through mental health policy documents and plans that involve clear human rights protection premises, resource allocation and development priorities in line with international standards. Slovenia invests at least 80% of mental health budget in psychiatric hospitals and social care institutions, which employ 90% of psychiatrists. Redirection of these resources to local level, together with reallocation of human resources, should improve attitudes of mental health workers towards people with mental problems, because of timely, effective and needs-led approach that enables recovery.

Key words: stigma - mental disorders - human rights

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Over the previous few decades, many studies have confirmed that people with mental disorders feel discriminated in various areas of their lives. Stigma was already seen as one of the most important obstacles to improving mental health care decades ago. Consequently, human rights protection of people with mental health vulnerability was incorporated into EU Mental Health Action Plan in Objective 2, i.e. “Services must be provided and activities undertaken that empower individuals as well as communities to realize their potential, while protecting and promoting their human rights”.

RESEARCH ON DISCRIMINATION

Two of the most prominent pieces of stigma research were INDIGO (Thornicroft et al. 2009) and ASPEN (Lasalvia et al. 2012), both proving that discrimination does not vary much among countries and that positive discrimination is rare, as well as that people use different strategies to cope with stigma, relying most of all on personal networks. Important and frequent discriminative practices are present in the psychiatric profession itself, as proved by Schulze’s review in 2007. The review showed that stigma related to mental health care accounted for nearly one quarter of all stigma experiences reported.

Discrimination was demonstrated through predictions about negative prognoses, through the social distance between staff and patients, through the limiting of information about the treatment and the follow up in the community that patients receive. Patients expressed a general feeling that there is only one standard psychiatric treatment for everyone and criticized that a psychiatric diagnosis is often given with a negative prognosis. These statements were perceived as disheartening and as reducing patients to their illness-related deficits. In

addition, family members noted that during in-patient treatment, patients did not get the personal attention they needed, ‘craving for personal contacts with someone other than their fellow patients’, while doctors and nurses were ‘sticking to work to rule’. Patients claimed that adequate psychiatric treatment should involve users in all relevant decisions and that a comprehensive treatment plan should be developed individually. Other studies also showed pessimistic and stigmatising views of mental health professionals (Magliano et al. 2004, Lauber et al. 2004, Lauber et al. 2006, Loch et al. 2013).

PRESENTATION OF MENTAL DISABILITY

The problem of discriminative attitudes of professionals is further complicated and extended with abundance of reductionist presentations in psychiatric meetings all over the world, for example about ventricular enlargement in schizophrenia as a proof of progressive degenerative brain disease in line with the Kraepelin’s diagnosis Dementia praecox, for example (DeLisi et al. 2006). This stand is opposed by a few research works, for example of Zipursky et al. in 2013 showing that cognitive decline and brain atrophy might be the consequence of many factors, among them a lack of cognitive stimulation because of stigma, poverty and scarce opportunities of this discriminated group, as well as the consequence of common comorbid addiction diagnosis and antipsychotic medication. The loss of function in schizophrenia is different than in other neurodegenerative diseases. Lysaker & Buck (2008) claimed that using increasingly complex models of recovery with clearly defined operationalized criteria, numerous longitudinal studies have provided data pointing out that progressive deterioration is more of an exception than a rule for people with this condition.

SELF STIGMA OF PROFESSIONALS

The discrimination in health profession might also be attributed to self-stigma. The recent publication of Szmukler (2017) calls for attention about the “coercive shadow” that looms over mental health care regarding involuntary treatment. Patients as well as psychiatrists know about fear, distress, humiliation, and stigma of compulsory orders in the community and in hospitals. Psychiatrists are allowed to use preventive detention for people with mental disorders solely on the basis of risk to others, which is not possible with any other population group. Common practice of risk assessment and risk management in psychiatric practice is performed in spite of the fact that mental health variables contribute little to the prediction of violence (Mullen 1999, Large et al. 2011). The moral costs of risk performance, changes in professional behaviours and discrimination against people with mental disorders are enormous (Szmukler & Rose 2013), and they move us away from attempts to understand the person as an individual, narrow the range of interventions and set public interest over the patients.

EXISTING REGULATION

The UN Convention of the Rights of the people with disabilities (UN-CRPD) signed by many countries, including Slovenia, states that “respect for the inherent dignity, individual autonomy, freedom to make one’s own choices, full and effective participation and inclusion in society, respect for difference and acceptance of persons with disabilities as part of human diversity and humanity and equality for opportunity”, are rights of all people with disabilities. Substitute decision-making must be replaced by supported decision-making. Persons with disabilities are involved in monitoring of UN-CRPD. According to WHO and EU Mental Health Action Plans (2013) mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the UN-CRPD and other international and regional human rights instruments. Besides taking responsibility for humans’ rights protection, countries should strengthen effective leadership and governance for mental health; provide comprehensive, integrated and responsive mental health and social care services in community-based settings; implement strategies for promotion and prevention in mental health.

NATIONAL MENTAL HEALTH PLAN SLOVENIA

In this paper we are looking at the impact of above mentioned knowledge and recommendations to the Resolution of the National Mental Health Plan (RNMHP) in Slovenia, accepted by the Slovenian parliament in March 2018.

RNMHP took more than 10 years to be passed, in addition to the time it took to process the Mental Health

Law in Slovenia before that. Obstacles to RNMPH documents are not listed here, although they were all a consequence of a lack of political will to change, which might be at least partly attributable to highly institutionalized mental healthcare in Slovenia as reported by international agencies (ECC 2010, Mental Health Europe 2010). In 2017 finally, alerted by NGOs, the Health Ministerial Secretary took notice of WHO Matt Muijen Mental Health Mission Report in Slovenia, which detected low access to services, overinvestment in institutional care, lack of services for children and many other problems in organization, as well as strengths of existing providers. This report was the cornerstone of development of the RNMPH, which was in few months intensively discussed with all stakeholders and remade by recognising numerous remarks. This document is actually a compromise among professions, NGOs, political parties and users’ groups (RNMPH 2018).

With the RNMHP, Slovenia is planning to improve access to prevention, promotion, treatment and care at the primary level in health, social work and NGO centres to provide comprehensive and needs-led services. Human resources in mental health at this level are to be improved and financed, systematically closing the human resource gap through the establishment of 25 regional mental health centres for adults and children/adolescents. Besides community organization of services, special attention is focused on prevention of suicide and high alcohol consumption.

Human rights are to be better protected with a series of professional educational courses including direct contact with service users. Public anti-stigma campaigns are to be implemented in every region, every year, led by people with experience of mental disorders to improve public attitudes. Users and their carers are involved in every governing body planned to implement the reform as counsellors and decision makers with professionals and policy makers. Decisions about implementation are to be made at the regional, local and government level with their participation and control.

CONCLUSION

It is important to say that this document was written because of the commitment of an influential politician, professionals that work at the primary level of care (in health, social and NGO sector), public health professionals, and autonomous organizations representing service users and representatives of their families. Psychiatrists had their role as well. In the working group preparing the document, three individuals with backgrounds in ambulatory care, community psychiatry and the field of mental health promotion and prevention for children and their families were the most influential. These three lines of thinking and practice made communication with policy makers, users and NGOs possible and fruitful, albeit with full concern and understanding that people with mental disorders are actually leading the way.

Acknowledgements: None.

Conflict of interest: None to declare.

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