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TRAINING MENTAL HEALTH PROFESSIONALS: TOWARDS RIGHTS-BASED CARE

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Abstract

Currently in mental health and in a generalized way we work using nosologies created within the biomedical model, focused on generating diagnoses that allow the administration of treatments aimed at reducing psychopathological symptoms. Despite the search for objectivity, the exercise of diagnosing in mental health is not a neutral process, but a biased one. This process is influenced by personal values and ideologies, both from professionals who generate them and from users who receive them. Another factor involved in this process is the stigma and prejudices that surround mental health problems, especially the prejudice of irrecoverability. All this distance professionals from the needs and reality that users experience. The recovery movement came to revolutionize this point of view, downplaying the symptomatology and highlighting the importance of the recovery of a life project in an idiosyncratic way during the recovery process. Beyond this recovery approach, we consider the final objective of any mental health treatment to necessarily be the recovery of the full citizenship of the users, so that they can exercise their rights like any other member of society. However, rights recognized in the Convention on the Rights of Persons with Disabilities of the United Nations are still being violated through practices such as involuntary admission, forced treatment, or mechanical restraints. As an alternative to these practices, professionals have different tools such as, among others, informed consent, the document of anticipated wills and peer support among people who have experienced a mental health problem. The objective of this chapter is to justify and briefly develop the main foundations of a course developed through a participatory process that has included affected people, family members, and mental health professionals.

Keywords

Stigma, recovery, rights, citizenship, peer support.

Introduction

The process of deinstitutionalization carried out in Spain during the 80s and 90s (Vázquez-Barquero & García, 1999), in which mental health institutions gradually went from asylum confinement to community care, meant a significant reduction in stigmatizing and paternalistic behaviours, increased attention to rights, among which the reduction of the use of coercive measures stands out, and the shift from a vision focused on symptom reduction to psychosocial rehabilitation and more recently, to Recovery (Rosillo Herrero, Hernández Monsalve, & Smith, 2013).

Despite the improvement of the situation, today we are still far from optimal care conditions for the group of people with mental health problems. Therefore, there are still numerous complaints regarding the treatment received in the care field since the perception of stigmatizing and paternalistic practices carried out by mental health professionals continues to be worrying (Corker et al., 2013; Harris, Leskela, & Hoffman-Konn, 2016; Henderson et al., 2014).

As a result of this feeling among users of mental health care services, there is a need to implement training for professionals in the field of mental health in which topics that bring attention closer to the preferences of users are addressed. After a participatory process carried out through focus groups and interviews with key actors, alternatives to current nosologies, the formulation and establishment of objectives based on Recovery values, the tools available in order to respect the rights of users visiting mental health services and the practice of mutual support have been chosen. Similar trainings are already taking place in other countries and can serve as precedents and examples. (Gaebel et al., 2017; Mabe, Rollock, y Duncan, 2016; Singh et al., 2016). The objective of this text is to justify and briefly develop the main bases of this course.

Criticism of nosologies, stigma and alternatives

Over centuries and until today, mental health care has been structured around psychiatric diagnoses and that is why a great effort has been devoted to the development of nosologies such as the different versions of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. Despite the search for the maximum possible objectivity, several studies have shown that the exercise of diagnosing is not a neutral process in which only the manifest symptomatology influences, but that there are other interfering variables. Among these variables we find

political and religious ideologies (e.j. Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990), culture and ethnicity (e.j. Bhui & Bhugra, 2002; Delphin-Rittmon et al., 2015), or gender differences (e.j. Mora-Ríos & Bautista, 2014). On the other hand, the low reliability of certain disorders recognized in the most used diagnostic manuals (Regier et al., 2013; Rosenhan, 1973) have aroused criticism of current nosological systems.

Some of the criticisms are structured around the prevailing biomedical conception in psychiatry. In this sense, Wilhelm Reich (1942) Pioneer in mentioning the social transmission of psychological distress, rejecting biological factors and considering socioeconomic factors as fundamental in the genesis of psychic suffering. Foucault also opposed the application of the biomedical model in psychology because it involves establishing an arbitrary boundary between normality and psychological pathology, which implies qualifying as pathological what is out of the ordinary. (Foucault, 1954).

In turn, the antipsychiatry movement, origin of both the critical aspects of the practice of clinical psychology and psychiatry and survivors movement of users (Rissmiller & Rissmiller, 2006), gathered a wide range of opinions and criticisms regarding conventional psychiatric practice. Some of these criticisms are the political use of psychiatry and its use as an instrument of social control, the medicalization of social problems, stigmatization because of diagnoses, the links of psychiatry with the pharmaceutical industry and involuntary treatment.

All these criticisms and many others culminate in the opposition by a sector of psychology professionals to the most used nosological systems today (Beutler & Malik, 2002) especially to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders due to the poor diagnostic reliability shown in various mental disorders (Regier et al., 2013; Rosenhan, 1973).

It is important to highlight the impact on the lives of users to receive a mental health diagnosis because this fact has been corroborated as a predisposing factor to suffer stigma from both the social environment of the person. (Schomerus et al., 2012), and by mental health professionals and by mental health professionals (Hansson, Jormfeldt, Svedberg, y Svensson, 2011).

According to Corrigan (2006), Stigma is composed of three components: cognitive, represented by stereotypes, emotional, represented by prejudice and behavioral, represented by discrimination. Among all the prejudices attributed to people with mental health problems, some of the most frequent are irrecoverability, dangerousness, unpredictability and infantilization (Angermeyer y Dietrich, 2006;

Obertament, 2016; Rüsç, Angermeyer, y Corrigan, 2005). This results in the fear and exclusion of these people from micro and macrosocial circles. (Corrigan, Edwards, Green, Diwan, y Penn, 2001), influencing your interpersonal relationships, job opportunities (Stuart, 2006), access to housing, etc.

Sometimes, due to the influence of the social environment, the stigmatized person himself accepts and reproduces these prejudices and discrimination towards himself and his collective, which has been called self-stigma (Corrigan y Watson, 2002). El autoestigma puede tener como consecuencia una baja autoestima y autoeficacia (Corrigan, Watson, y Barr, 2006), fear of stigma for asking for help in mental health devices (Rüsç et al., 2005; Thornicroft, Rose, Kassam, y Kassman, 2007), reduced adherence to empirically validated treatments (Sirey et al., 2001), difficulties in recovery-oriented achievements and lower quality of life (Rüsç, Corrigan, Todd, y Bodenhausen, 2010), etc.

Due to the great repercussions that can have adjudicating a diagnosis mental disorder and the poor reliability of current nosological systems, it is necessary to take into account existing alternatives such as working with personal narratives. Working from this perspective saves resources and facilitates interpersonal communication, especially at the evaluation stage. Listening to personal narratives can be helpful in finding elements of resilience that help users overcome their suffering. In this line Cromby, Harper and Reavey (2013) have created a nosology based on personal experiences and personal narratives, as opposed to nosologies created from the reading of medical histories.

Formulation and objectives based on Recovery values

As a result of the synergies created between the claims of people with mental health problems, their families, and professionals in the field of psychosocial rehabilitation, at the end of the 80s a new movement was born that defends recovery in mental health as a personal and idiosyncratic process that is driven by the person himself, through their empowerment, and which can be given through various channels (Substance Abuse and Mental Health Services Administration, 2012). This movement is today known as "Recovery" (Davidson, 2016) and has promoted a total reform of the mental health system with greater role for users and their families in making decisions about treatment.

The main characteristic that distinguishes the Recovery movement from psychosocial or community rehabilitation orientations is that the first affects all areas of

mental health, including hospitals, since the recovery process should begin from the first moment of contact with the care network (Singh, Barber, and Sant, 2016).

Some of the strategies to be used by mental health professionals when working from the Recovery model are the separation of the person from the diagnosis, the exploration of the person's needs, the exploration and attention to their style of autonomy, the negotiation of personalized recovery plans, the exploration of the power dynamics that occur between professional and user, the reduction of coercion and teamwork in the most horizontal way possible (Davidson et al., 2016).

Citizenship and mental health rights

The Recovery model approach is an important step in the process of improving care for users of mental health services. However, it is vitally important to go one step beyond recovery and work on the restoration of full citizenship of users of mental health services, understanding this as the recovery of a role of full citizen.

For this, it is necessary to move from the conception of mental health care from the perspective of the biomedical model, which conceives the user as an object of care and care policy, to the perspective of the social model, which conceives the person as a subject of rights.

The Convention on the Rights of Persons with Disabilities includes persons diagnosed with mental disorders and recognizes this group rights such as equal and non-discriminatory treatment, receiving understandable information, expressing themselves freely, deciding on lives and treatment, maintaining confidentiality and privacy, receiving protection from torture and other cruel treatment, living independently, being included in the community and working (Pérez-Pérez & Eiroa-Orosa, 2017).

Despite the improvements that have occurred since the beginning of the deinstitutionalization process, currently in Spain and in many other countries practices considered torture and/or degrading treatment by the United Nations in the field of mental health care continue to be carried out (Gaebel, Rössler, and Sartorius, 2017).

Examples of this human rights violation include involuntary admission, forced medication, overmedication, invasion of privacy, coerced electroconvulsive therapy, mechanical restraint, confinement and solitary confinement, and total and arbitrary incapacitation.

Among the tools available to mental health professionals as alternatives to practices that violate users' fundamental rights are informed consent, advance directive

and advance decision planning, as well as mutual support between people who have experienced a mental health problem.

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