

Editorial

Towards a mental health democracy

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Introduction

Despite advances in research and medical technology, between 76% and 85% of people with serious mental disorders had received no treatment in the previous year according to the world mental-health survey conducted by the WHO in 2011 (1). Still, nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice (2,3,4). Although WHO has stressed the importance of social determinants in health and mental health, public policies continue to neglect how poverty affects mental health, creates violence, social exclusion and breakdown of communities.

As the Special Rapporteur to the UN on the right of everyone to enjoy the highest attainable standard of physical and mental health points out precisely “the crisis in mental health should be managed not as a crisis of individual conditions, but as a crisis of social obstacles, which hinders individual rights. Mental health policies should address the “power imbalance” rather than “chemical imbalance” (3:19). These obstacles are:

- Dominance of the biomedical model
- Power asymmetries
- Biased use of evidence in mental health

Situation in Greece

In Greece, those obstacles are evident at every level. The doctor – patient relationship remains central; still there are two trends in the way this relationship is manifested. On the one hand, as a consensual and complementary relationship; here, the doctor ideally straggles to restore patient’s health and protect him. According to existing social norms, patients have to want to recover and the doctors are the ones to help. On the other hand, as one of conflict. The perception here is that the patient-doctor relationship, generally and particularly in the area of mental health, appears to be one of conflict and full of challenges. The underlying assumption of both the consensual and conflicting approach is that the doctor-patient relationship is asymmetrical, with health care professionals drawing their power from their established authority. This, in turn, permits them to operate as mediators in social control (3:190-191). However, the extent to which a doctor must exercise such an authority remains particularly questionable. Patients have to face a double bond. On the one hand, they encounter more and more declarations calling them to claim their rights in information and decision-making, to seek information from multiple sources and to have a say in the quality of services provided, and on the other hand, they are required to submit to the doctor’s judgement and expertise. Development of psychiatry, closely following relevant social developments, is constantly transforming clinical-theoretical models, means of organising services and a relationship with users and their families. Decision-making power in mental health is concentrated in the hands of biomedical gatekeepers, in particular biological psychiatry backed by the pharmaceutical industry. At the clinical level, power imbalances reinforce paternalism and

even patriarchal approaches, which dominate the relationship between psychiatric professionals and users of mental health services. Organised professional associations such as those of psychiatrists and trade unions exacerbate this imbalance by resisting reform of service provision and working models.

The asymmetry of the medical therapeutic relationship is organised around the scientific knowledge and technical know-how, around the ignorance of the individual's needs and their wishes. Thus, opinion is legalised socially and supplies the stereotype dominating relationships between the psychiatric team and patients-users, even if this is conducted in a theoretically "open" community framework and not within a total psychiatric institution (5, 6). In this asymmetrical game, however, where one "loses" and the other "wins", each one is aware of both roles, the one stigmatising and the other being stigmatised. User participation grants to those specified roles a mental, social and institutional opening, strengthening, as F. Basaglia stated, the negotiating position of the weak.

The basis of common action and transformation of traditional psychiatric culture towards a collective democracy of health can be established from such a beginning. In a statement regarding ethics, P. Ricoeur (7) describes the doctor-patient relationship as an agreement of trust, a kind of forged alliance between two people against a common enemy, the disorder. However, before an agreement of trust can be established, there must be a stage of suspicion, embarrassment and reluctance. The patient expresses a request for treatment, suspicious against the one who is in theory the expert, and the doctor who tries to cater to patient requests, may, in turn, become suspicious of non-compliance to the treatment prescribed by him.

In order for the agreement to be established, Ricoeur stressed that both involved parties must recognise the uniqueness of this relationship, the "non- interchangeable character of one with the other". Therefore, the only possibility for this agreement to work is to consider the contracting parties as authentic partners rather than a "democratic alibi" used as argument of legacy by mental health professionals which requires the active involvement of the patient in the management and development of his treatment and care.

We can, however, observe three paradoxes in this agreement. The first paradox is that the subject is not an object, but the body is a part of the physical reality observed and is "objectified" by ethics, the approach and the technical arsenal of biological medicine-psychiatry. Psychiatry is often on a slippery slope, following the disconnection of body and soul in a simplistic biological reductionism, obscuring a big part of understanding and consequently the holistic care of the ailing subject.

The second paradox has to do with the fact that the individual is not a commodity, nor should medicine be subject to the laws of the market; however, in fact, medicine has a price and a high social cost for public health and private healthcare. The last paradox overlaps the previous ones: suffering is private, but health is public. If all these contradictions generate conflict and if misguided psychiatrisation and the penalisation of social problems create enormous contrasts, the only possible framework where a possible solution may emerge is the consensual/conflicting process of the involved parties (8).

We would add to the obstacles the democratic function level, what we would call "democracy deficit". Open access of European citizens to quality healthcare, social welfare and education services, as well as the declared aim of reducing social inequalities and social exclusion formed part of the European identity. The principles of social protection came close to such an axiological, ethical, legal and institutional level that Western Europe was characterised a "secure" society, in the sense that it was capable of providing security and protection to its members. The need for bold reforms in Greece was already clear since the birth of the Greek state in the face of the "ineffective, irrational and/or morally unacceptable mode of operation of its institutions" (9). The lack of resources driven by the biomedical model that obscures social factors leads, especially during the economical, political and social crisis in our country, to shifting the burden of care to society rather than building and reinforcing a protection system.

Suggestions

On the basis of a “joint morale”, we are required to discuss collectively and democratically the relations between disease and health and what we call personalised care, treatment and life plan to showcase a “third way” where the involved parties, namely, the social groups receiving services, the people involved in general health and mental health and local communities with their representatives, will empower their participative movement and will become involved in openly processing and evaluating a health system, where all coexist (10, 11, 12). The “open dialogue” approach may represent a promising tool promoting a radical change of traditional psychiatric culture and practice.

User involvement should become national policy with a specific framework that will be structured gradually on the basis of good examples. In cases where users offer services (care, consultancy, participation in research and training), the relationship with the service or with the action in general must be remunerated, so that obligations are met on both sides and there are no phenomena of patronising. Training programmes must be established, structured by users for users and professionals.

At European level, very few users’ and relatives’ movements are independent and powerful in terms of funding, while most are supported by a specific few number of people and are vulnerable to crises (13). In order for user participation to work properly, there should be allocation of authority and recognition of user and family associations as institutional interlocutors with validity and arguments (14) and users must be considered active citizens with rights and obligations and not faceless collateral losses of a dysfunctional system. Provided we continue to recognise the right of individuals to self-determination, besides any social dictates describing fear of the unfamiliar and the unwillingness to take on responsibility and to delete whatever is different, we can continue talking about the non-negotiable dignity inherent in any individual, irrespective and beyond social, political, financial and cultural crises or “trends”. Concerted efforts – from policymakers, epidemiologists, health economists, clinicians, patients and their families – for ameliorating the mental health impact of the recession in

Greece are urgently needed, in order to militate against exacerbation of psychiatric morbidity in the foreseeable future and to avoid a potential outbreak of suicides (15).

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