Mentalworld

The 4S anathema on Mental Health:

Self / Social / Structural Stigma

ABSTRACT

The stigma on Mental Health (MH) refers exclusively in the context of social conditions and policies for the field while it is not associated with Mental Disorders (MDs) *per se*. Stigmatization has a specific historical course and types that follow respectively the evolution of the wider range perceptions about the nature and causes of MDs as well as the mainstream policies on MH.

Stigmatization is used in many ways as a mechanism
- for the control of sufferers
- maintaining the causes of MDs and their deterioration trend
- obscuring the inadequacy of mental health policies
- to exploit the MDs for the reproduction of the dominant ideology regarding diversity and the eventual maintenance of the ruling social, economic and political order.

The current approach to stigma consists in recognizing it as a human rights issue with a focus on the principles of tolerance and equity. With this perception it is indirectly introduced and becomes in principle an acceptable framework for distinguishing between mentally "sick" and "healthy" while there is not yet an objective and commonly accepted scientific definition of mental illness beyond the empirical clinical descriptions of each MD. Intense scientific dichotomies are characteristic even at the elementary level of the classification of MDs.

Despite this strong dimension related to Human Rights, stigma is a **major Public health issue** that results in the overall functioning of the political / economic system: if something hinders the integrated provision of health services then elements of the core of the state, as it is described and legitimized in modern perceptions of its acceptance and operation, are affected, violated, or ignored.

The effective fight against and elimination of stigma can consist of the revision of the perceptions about MDs, the relevant rehabilitation practices, and the formulation of an updated strategic approach to the field of Mental Health. This is not a single entity work. A list of 10 axes for action concludes this statement.

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I . THE GENERAL FRAMEWORK

A. DEFINITIONS

« The investigation of the meaning of words is the beginning of education» (Antisthenes, 444- 365 BC)

1. The definition of the concept of 'Mental Health' has proved to be a very difficult task. According to WHO «Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. (…) Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.
https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

A similar effort by the American Psychiatric Association (APA) has resulted in the following::
Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities.
Mental Health involves effective functioning in daily activities resulting in

- Productive activities (work, school, caregiving)
- Healthy relationships
- Ability to adapt to change and cope with adversity

Mental Illness refers collectively to all diagnosable mental disorders — health conditions involving
Significant changes in thinking, emotion and/or behavior
Distress and/or problems functioning in social, work or family activities
https://www.psychiatry.org/patients-families/what-is-mental-illness
(the emphasis is ours)

2. As we try to define the concepts of MH, MDs and then stigma not in terms of their philosophical, epistemological or historical dimensions the focus is on their clinical dimension and characteristics. In this we will be helped by a comparison to the definition of cancer: "A term for diseases in which abnormal cells divide without control and can invade nearby tissues."

https://www.cancer.gov/publications/dictionaries/cancer-terms/def/cancer

By selecting from the definitions their qualitative data, we can examine them in terms of their scientific accuracy and integrity applying two criteria, 1st the clinically proven harmfulness and 2nd the experimentally proven measurability of the data:

MENTAL DISORDERS	Harmfulness	Measurability	**CANCER**	Harmfulness	Measurability
Significant changes in thinking, emotion and/or behavior	NO	NO	abnormal cells divide	YES	YES
Distress and/or problems	NO	NO	without control	YES	YES
functioning in social, work or family activities	NO	NO	normal control	NO	YES
			can invade nearby tissues	YES	YES

But beyond the above comparative examination, all factors/terms/characteristics even binders that are necessarily used to articulate the definitions of both Mental Health and Mental Illness/Disorder are completely subjective and relevant. Let us explore options:

- **Significant changes in thinking, emotion and/or behavior:** Choosing monastic life or divorce?
- **successfully:** listed in the annual Forbs list of billionaires or a funeral from natural death without pain in his/her sleep at the age of 95 where 14 grandchildren and the whole village are attending?
- **normal stresses of life**: securing water in a prolonged drought in sub-Saharan Africa or complying with the dictates of fashion?
- **work productively:** according to the company's productivity norms or according to the response to a consumer standard that the individual chooses?
- **make a contribution to his or her community:** activating an explosive device as a member of the IRA or contributing to the Red Cross fundraiser?
- **effective functioning in daily activities:** as a leading figure of legitimate hooligans clubs or by voting every four years?
- **Healthy relations**: tacit acceptance of domestic violence/incest rape incidences or raisinf children through example;
- **Adaptability:** limiting the standard of living to the levels of unemployment allowance or by underusing colleagues in the working environment?
- **can cope with the normal stresses of life:** legally regulated assisted suicide or suicide to stop torture?
- **or/and:** divisive or necessarily cumulative?

Top of course remains the supplementary wording: «Health is …… and not merely the absence of disease or infirmity**».** If according to a first reading it seems to lead to a "holistic" definition of Health, the literal intake of the wording allows the conclusion that **even if there is no problem or disorder, a person does not necessarily qualify as healthy unless he/she meets the abovementioned conditions**.

The above simple comparative approach makes clear that the official efforts of the definitions of MH and MDs

- suffer from intense subjectivity as the characteristics used have little to do with scientific documentation
- are vulnerable to prejudice or bias.
- are decisively based and reproduce more established ideas despite the fact of the given variability of ideas according to historical context or updated scientific observation.

Regarding the last point, we must be lenient in the process of development of scientific research and the stability of theoretical hypotheses. It is enough to remember that the overthrow of the existence or rather the necessity of the concept of "ether" for the interpretation of a series of natural phenomena and the validity of the natural laws formulated until then is only a hundred years away. The overthrow, or the other reading, however, was enough and probably necessary, for the development of the Special Theory of Relativity that paved the way for the Third Industrial Revolution. In this light**, scientific research is responsible for the impossibility of an accurate and effective definition in a much smaller percentage than the first two of the three factors.**

Notes:

(a) The selection of the above two definitions was made on the sole criterion of their prominent official character on the basis of the entities which have processed and developed them. But others milder, such as the following, suffer from the exact same defects but also additional as of tautology:

- Mental illness is a pattern of thought or behavior, or an abnormality that causes pain or even impotence, and which is not developmental or socially defined.
- Mental illness is a concept that typically indicates the existence of an emotional or thought disorder or personality disorder, which negatively affects a person's mental well-being, health and safety.

b) The analysis of the mainstream definitions was carried out to demonstrate that by approaching Mental Health we come into contact with particularly extensive business, professional, legal or educational fields which are developed in a highly controversial scientific context. This is demonstrated by the intense controversy within the MH experts over the description and classification of MDs, which is absolutely necessary for

- the development of general models of interpretation and intervention;
- the development of therapeutic protocols,
- the production of medicinal products,
- the elaboration of state policies and
- shaping of the general public behaviour.

B. CLASSIFICATION OF MENTAL DISORDERS

It does not belong to the objectives of this statement to engage in the substance of scientific disagreements on the question of classification. References to them will be used to raise arguments and

final proof of the above claim of an unclear and conflicting scientific framework that, starting from the impossibility of definitions, reveals the still incomplete scientific documentation of mental processes and results in a empirical, and as such completely subjective approach.
For many years, beginning in 1952, the **Diagnostic and Statistical Manual *of* Mental Disorders** (DSM) of the American Psychiatric Society (APA) was the bible of the global scientific community. This continuous review process has not been able to lead to its full and uninterrupted acceptance:

"In 2011, psychologist Brent Robbins co-authored a national letter for the Society for Humanistic Psychology that brought thousands into the public debate about the DSM. Approximately 13,000 individuals and mental health professionals signed a petition in support of the letter. Thirteen other American Psychological Association divisions endorsed the petition.[55] In a November 2011 article about the debate in the San Francisco Chronicle, Robbins notes that under the new guidelines, certain responses to grief could be labeled as pathological disorders, instead of being recognized as being normal human experiences.[56] In 2012, a footnote was added to the draft text which explains the distinction between grief and depression.[57]

The DSM-5 has been criticized for purportedly saying nothing about the biological underpinnings of mental disorders.[58] A book-long appraisal of the DSM-5, with contributions from philosophers, historians and anthropologists, was published in 2015.[59]

The financial association of DSM-5 panel members with industry continues to be a concern for financial conflict of interest.[60] Of the DSM-5 task force members, 69% report having ties to the pharmaceutical industry, an increase from the 57% of DSM-IV task force members.[60]

A 2015 essay from an Australian university criticized the DSM-5 for having poor cultural diversity, stating that recent work done in cognitive sciences and cognitive anthropology is still only accepting western psychology as the norm.[61]"

(Source: https://en.wikipedia.org/wiki/DSM-5 based on and refers to a detailed presentation of the reactions: https://web.archive.org/web/20131013231434/http://dsm5-reform.com/.)

The DSM-5 is not the only classification method as the World Health Organization's "**International Classification of Diseases**" (ICD) system provides corresponding guidelines / recommendations on classification. But the focus DSM system on seems exclicable as "although the ICD is the official US system, health professionals do not realize it because of the dominance of the DSM" despite the fact that criticism is catalytic.
https://en.wikipedia.org/wiki/International_Classification_of_Diseases#cite_note-39.

The mechanism for the consolidation of this reported dominance is described in the study "Interactions between physicians and the pharmaceutical industry generally and sales representatives specifically and their association with physicians' attitudes (!) and prescribing habits(!): a systematic review" https://bmjopen.bmj.com/content/bmjopen/7/9/e016408.full.pdf as part of the documentation of the Report **"Shedding light on transparent cooperation in healthcare: The way forward for sunshine and transparency laws across Europe"** of Mental Health Europe **network** https://www.mhe-sme.org/shedding-light/. The emphasis on physicians, attitudes and habits is due to

the fact that unfortunately, as we will see below, we are not necessarily talking about protocols or even prescribing exclusively by MH professionals(!).

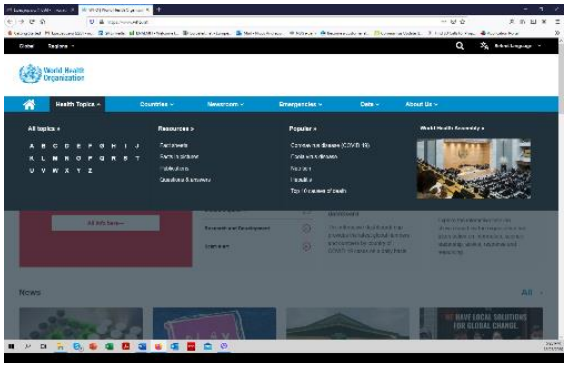
This remark is particularly useful as the US influence in the wider field is decisive for many reasons as we will see below. But especially for the DSM-5 definition of Mental Disorder, we draw from Bruce Thyler's 2015 publication in Springer **«The DSM-5 Definition of Mental Disorder: Critique and Alternatives»** with 62 references to related studies and research:

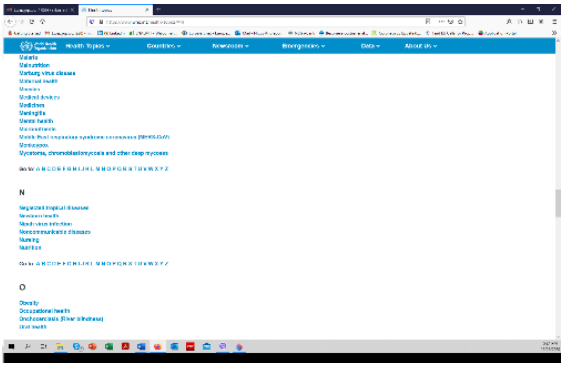
"The chapter begins by dissecting the definition of mental disorder offered in the latest edition of the diagnostic manual, incisively pointing out its flaws and shortcomings. These flaws are of two kinds. First, there is the DSM's overreach in what it "counts" as a mental disorder—e.g., enduring conditions with a clear biological etiology such as Down's syndrome; temporary states caused by events such as alcohol intoxication, dehydration, or fever-induced delirium; and reactions to adverse environmental stressors. For a condition to be categorized as a mental disorder, its etiology ought to be mentally related, not simply represent a condition that adversely effects mental functioning; indeed, distress and dysfunction can be caused by a wide range of factors, not all of which constitute "mental disorders." Second, there are fundamental errors in logical reasoning found throughout the manual—e.g., the assumption that diagnoses represent natural and coherent syndromes, as well as the pervasive reification and tautological reasoning in how mental disorder is "explained" by the very elements that comprise its definition. Alternatives to the DSM are explored including various forms of "denialism," symptomatic treatment, and functional behavioral assessment. The chapter concludes with a reflection on the consequences for clinical assessment and treatment of the DSM's vision of mental disorder and a call for social workers to critically examine its tenets and decide for themselves the model(s) they wish to use."
https://link.springer.com/chapter/10.1007/978-3-319-17774-8_3

C. MENTAL HEALTH, MENTAL DISORDERS OR WHAT?

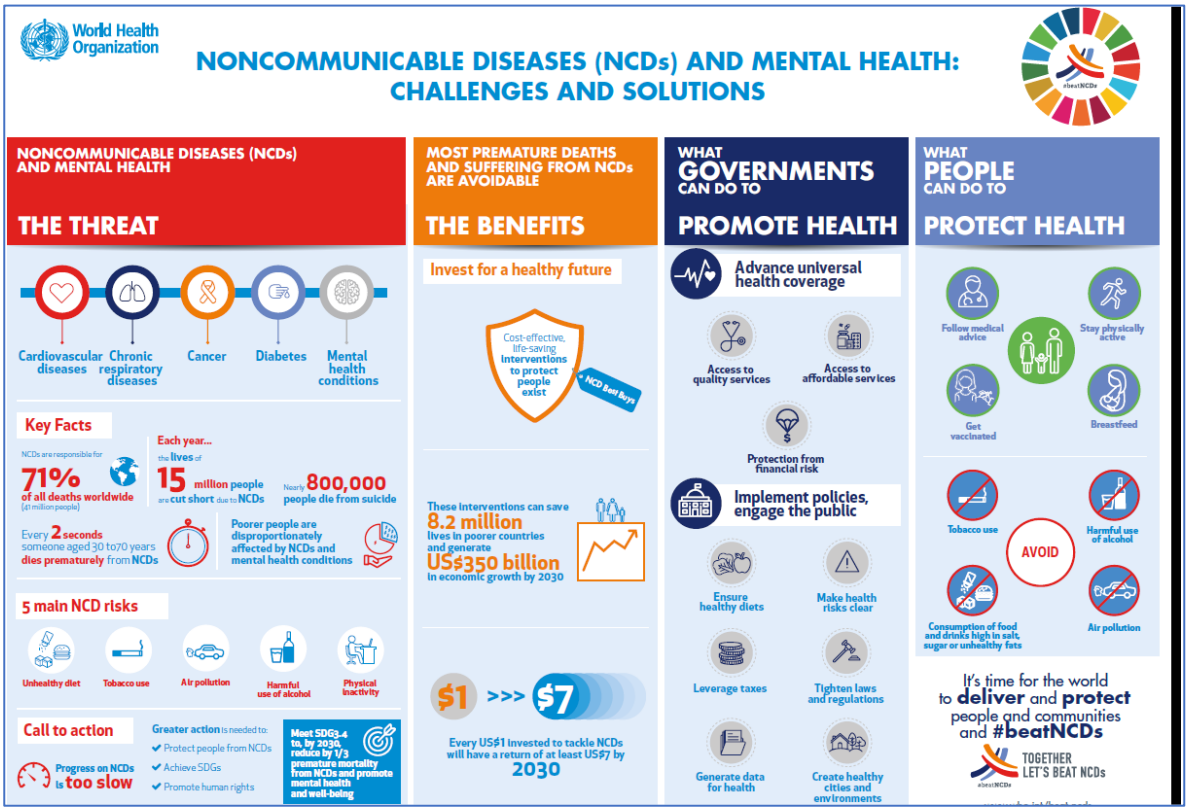
It is therefore no wonder about the scientific imperfections and functional ambiguity of the dominant definitions for Mental Health and Mental Disorders. But if we insist on referring to both of these terms at the same time, it is because this not so innocent confusion is caused by their indiscriminate and often overlapping use. This confusion contributes to the dark background of stigma according to the related analytical reference found in the epilogue of the presentation of MENTAWORLD: https://mentalworld.site/epilogue/

"Regarding terminology, the term "Mental Health" is used in a foggy way and certainly not in contrast or equivalent to the term "Physical Health". Typical examples we draw from the most authoritative / largest health organization WHO: following the main menu of the WEB Site https://www.who.int/, in the drop-down menu of "Health topics" a "Mental health" option appears while nowhere will we find an entry "Physical Health".





For a “strange” reason mental disorders are often considered in association with “non-communicable diseases” while a precise and official list of the above diseases is missing. The confusion turns out to be much greater when these two terms are listed at the same time:



“NONCOMUNICABLE DISEASES AND MENTAL HEALTH” is the title of the WHO Infographic where if the descriptive adjectives “noncommunicable” and “mental” are removed, the essential “diseases” and “health” remain connected and equated semantically!https://www.who.int/nmh/publications/ncd-infographic-2014.pdf?ua=1

The above scientific failures and the methodological confusion caused by these arbitrary -anti-systemic connections are not accidental. However, it seems to provide the ability to obscure the image and inadequate processing of real data.

Indeed, it is difficult to understand what "solutions" requires "mental health" as long as it is by definition a positive state / concept or why the new completely neutral term "mental health conditions" is introduced? (Could we use such terms referred to cancer or cardiovascular disease?). There is no source that has suggested anything like this, possibly for the sake of eliminating the stigma, on the contrary, the proposed terms are 'mental health problem' or “mental ill health” and always when it comes to mass communication and not for scientific purposes where the terms 'disorder' or 'illness' are undeniably used. In addition to the possibility of an internal fear or a 'politically correct charity', does this intend to expand the market for psychopharmaceuticals since this allows practically prescription by non MH professionals even to people who are not diagnosed, as we have previously pointed out and it is officially denounced:

"One of the main factors leading to an increase in antidepressant prescribing is the increasing number of primary care providers and **others outside the field of psychiatry** prescribing for **patients who do not have a clinical psychiatric diagnosis"** according to a study published in the Health Affairs Journal in August 2011."

"Our research showed that between 1996 and 2007 the proportion of visits prescribed to non-psychiatrically diagnosed people increased from 59.5 % to 72.7%," says researchers Ramin Mojtabai, Johns Hopkins Bloomberg School of Public Health, and Mark Olfson, of the College of Physicians and Surgeons of Columbia University in New York, and a research physicians at The New York State Medical Institute.

https://www.healthaffairs.org/do/10.1377/hblog20110808.012879/full/

This approach is not limited to the dimensions of research results. It has now taken the form of a global movement for a comprehensive review of perceptions and practices about MH. Here it follows the introductory excerpt of the presentation of the initiative for a "Declaration of Human Rights for Mental Health":

“All human rights organizations set forth codes by which they align their purposes and activities. The Mental Health Declaration of Human Rights articulates the guiding principles and goals of Citizens Commission on Human Rights (CCHR).

In 2017, Dr. Dainius Pūras, the United Nations Special Rapporteur on the right to health, called for a revolution in mental health care around the world to “end decades of neglect, abuse and violence,” and stating “ There is now unequivocal evidence of the failures of a system that relies too heavily on the biomedical model of mental health services, including the front-line and excessive use of psychotropic medicines, and yet these models persist.”

Human rights include the right to one’s own mind, and to protect oneself and one’s loved ones against any abusive or harmful “treatments” given under the guise of mental health. Every man, woman and child is entitled to the fundamental human rights set forth in this Mental Health Declaration of Human Rights, regardless of race, political ideology, religious, cultural or social beliefs. Given the fact that

virtually no human or civil rights to protect citizens from mental health abuses, it is vital that the following rights be recognized and that all countries adopt this Declaration.

A. The right to full informed consent, including:

1. The scientific/medical test confirming any alleged diagnoses of psychiatric disorder and the right to refute any psychiatric diagnoses of mental "illness" that cannot be medically confirmed.

2. ……»

https://www.cchrint.org/about-us/declaration-of-human-rights/

It is now obvious that the ambiguity of definitions and diagnostic procedures/frameworks alone are not innocent. And if field experts, researchers/professionals/administrators, along with those who shape the terms of official policies are not able to provide a unified and coherent view on Mental Health and Mental Disorders, then how can we demand this from citizens? And as long as there isn't such a solid point of view, why do each of us

not to be afraid of the worst of a mentally ill?

not to accept any arbitrary image of the disorder;

and not to stigmatize on the basis of this image one or all sufferers collectively;

These questions lead us to try to understand the stigma that is the real purpose of this text.

II . THE STIGMA

A. INTRODUCTION

As an introduction we borrow a general description of the stigma from the relevant text of the psychiatrist-psychotherapist K. Stavrianakos:
*"The phenomenon of stigma was recorded theoretically and empirically for the first time in 1963 by the sociologist Erving Goffman,*who defined the stigma as an "undesirable and defamatory property attributed to the individual and deprives him of full social acceptance, while forcing him to conceal the cause of this negative *treatment". Three years later (1966)* the sociologist *Thomas Scheff* formulated the *"labeling theory"* according to which social attitudes towards people who exhibit some kind of specificity do not depend so much on their behaviour, as much as the *"label"* attributed to them by their social environment, based on the stereotypes of the time.
Today the stigma is considered to be governed by three interrelated components, stereotypes, prejudices and discrimination. Stereotypes are negative beliefs, usually oversimplified, distorted and misleading, that are collectively accepted and lead to uncritical generalizations about individuals and groups. Cognitive and emotional reactions that follow the acceptance of stereotypes are characterized as biases, while behavioural reactions resulting from prejudices constitute discrimination. Stigma is perhaps the sharpest "stack" in the effort to prevent, diagnose and treat psychiatric disorders. ***It is estimated that about half of patients suffering from major psychiatric disorder do not receive treatment; 85%*** **of them avoid psychiatric follow-up due to factors related to the stigma of mental illness."**
https://bit.ly/3t3bDrx

The above describes stigmatization as a process of personal prejudice that results in individual behavior. But what are the characteristics of the process as social practice, that is collective behaviour? Because we have to admit that

- we don't all stigmatize
- we don't stigmatize the same in every historical phase
- not everyone is stigmatized equally and in the same way
- not everyone is affected the same by the stigma

In addition, however, looking at stigmatization in the context of official MH policies and specific actions to address it, we must admit that there is no commonly accepted and applied

- comprehensive research documentation on its content
- scientific quantitative assessment of the phenomenon and its evolution.

In the context of this effort, It is not possible to answer with scientific competence all the above questions that could, and should normally already, have been main research questions and have yielded the necessary results. In this light, we could be accused of possibly dealing with a small size matter, of low priority or negligible ultimately effect on the conditions for the development and treatment of mental disorders and the overall care of good mental health of the population.
Convinced of the repeated official declarations on this, we believe that this is not the case. So, we will form a framework for working cases so that we can move forward.

Regarding this context, we can be inspired by the World Health Organization's description of the situation according to which the stigma:

- is a major factor in discrimination and exclusion
- adversely affects self-esteem, family relationships, socialisation and meeting housing and work needs
- prevents the prevention of MDs and the promotion of good MH
- prevents the provision of effective treatment as many sufferers avoid receiving MH services due to the stigma

  while
- the efforts of the MH services' users and their caregivers to address it receive low support and advocacy which prevents the design of policies that are effective and consistent with their needs and desires;
- negative experiences of treatment and care contribute to the failure to commit reforms that are needed to increase the confidence and effectiveness of the care provided
- the MH policies should combine structural reforms of services in conjunction with a focus on quality ensuring the provision of safe, effective and acceptable treatments by competent professionals.

This time it is not a methodological confusion: WHO links, as directly as it is allowed by its nature as a global institutional organisation, the stigmatization with the quality of the services provided, the competence of service providers and the real dynamics of official policies to address the stigma. Confirming in this way that we have listed for the criticality of vague definitions, classification/diagnosis systems and their findings in treatment. According to WHO, **structural changes in the construction of MH are one of the conditions for dealing with stigma.**
https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination

B. TYPES OF STIGMATIZATION

The preference for the use of the dynamic term 'stigmatization' in relation to the static 'stigma' may already be perceived, as the first also includes the element of the procedure, while the latter is limited to the result or the situation. Unlike the examination of a natural phenomenon, where the link to root causes offers knowledge but is often not necessary for its immediate response (snow – climate crisis), the case of stigmatization cannot be considered productively if it is disconnected from the personal, social, political and economic processes that are created and evolving within them.

On the basis of the relevant literature, three types of stigma are distinguished:

Self-stigmatization: it is the personal process in which the mentally ill develops negative feelings and thoughts, incorporates dominant stereotypes, experiences discrimination and is socially alienated as a result of personal processing of internal and external stimuli.
More at https://nami.org/Blogs/NAMI-Blog/February-2021/The-Many-Impacts-of-Self-Stigma

Social/public stigma: refers to community attitudes towards people in a particular social group. The perceived public stigma refers to discrimination and devaluation by others.
More at https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201200561
Structural stigmatization: refers to the rules, policies and practices of social institutions that arbitrarily restrict rights and opportunities for people with mental illnesses. In this form of stigma, the dominant cultural ideology is integrated into institutional systems, so that differences of power are legitimized and social disadvantages are justified.
More at
https://www.mentalhealthcommission.ca/sites/default/files/MHCC_OpeningMinds_MentalIllness-RelatedSructuralStigmaReport_ENG_0_0.pdf

Notes:

- The interconnection of the three sides of the phenomenon is a given. However, each one has its own special significance for the parties closest to it. For example, while self-stigmatization is a crucial factor in the healing process itself, social stigma is often the result of structural. It is reasonable to focus here on these two aspects (structural and social) with emphasis on structural as our goal is not therapeutic.
- Social and structural stigmatization are expressed equally either by active – overt practices (violation of rights, exclusions) or by the absence of actions normally expected or even institutionally imposed with potential legal effects (negligence, infidelity, damage, etc.) on the administration.

C. DEVELOPMENT THROUGH HISTORY

The stigmatization of the mentally ill seems to follow the evolution of scientific perceptions about MH but is not only influenced by them. We probably do not have sufficient information on the possible existence, extent and expressions of the phenomenon in the earlier times from antiquity to the Middle Ages. The picture becomes more evident in modern times when purely psychiatric institutions appear, but this trend is in line with the process of urbanization, the dramatic change of production processes/relationships within the first industrial revolution, the rearrangement of ideological control mechanisms by reducing the role of the church (Enlightenment), the formulation of new fundamental philosophical concepts (the separation of body and mind of Descartes), the development of new historical narratives (national states, central administration) and the concentration of such a population of sufferers that acts as a critical mass for the implementation of new practices, but without being able to accurately identify the contribution of these processes to the evolution of perceptions for MH and stigma.

It is only in the 20th century and more in its second half when stigma is included in scientific interests and research processes are developed. This will also help the ever-increasing understanding of the usefulness of data, the development of their collection and processing (statistics, information technology) and, above all, the understanding of their importance for the mechanisms for the exercise of political power / state authority.

At this point, it can only be particularly pointed out that it is at this very historical stage where the mechanisms for creating and projecting lifestyle standards (cinema) and mass communication (television) are also become giants .

Η αναφορά στην ιστορική εξέλιξη δεν θα μας απασχολήσει πολύ γιατί γίνεται και μόνο για να δειχθεί ότι:

- οι αντιλήψεις του πληθυσμού για τις ΨΔ αλλά και οι όροι για το στίγμα δεν είναι στατικές αλλά μεταβαλλόμενες
- δεν συνδέονται κατ' ανάγκη με το δοσμένο επίπεδο και περιεχόμενο της επιστημονικής γνώσης για τις ψυχικές διαταραχές σε μια χρονική περίοδο και
- εν τέλει διαμορφώνονται από ισχυρούς εξωγενείς του πεδίου της ΨΥ παράγοντες.

The reference to historical development will not take much because it is done just to show that:

- people's perceptions on MH and the conditions for stigma are not static but changing
- they are not necessarily linked to the given level and content of scientific knowledge on MDs over a period of time;
- they are ultimately formed by strong exogenous factors in the field of MH.

A good presentation of this view is provided by the educational material of the State University of New York / Monroe Community College (2021) **"**Stigma of Mental Illness" https://courses.lumenlearning.com/diseaseprevention/chapter/stigma-of-mental-illness/ with a number of references to research documentation. As this is an extensive text but a critical source of documentation it could be included **as Annex 1** to this statement. While drawing its conclusions mainly from the period 1950 to 1990, particularly important because of the temporal proximity but also the MH contents of the period, it also includes key illuminating references of a more general nature: *'(...)*Explanations for stigma stem, in part, from the misguided split between **mind and body first proposed by Descartes.** Another source of stigma lies in the 19th-century separation of the mental health treatment system in the United States from the mainstream of health. These historical influences exert an often immediate influence on perceptions and behaviors in the modern world."

Although we must study this material in detail, let us settle here for the sedation of some of its data:

..... Public attitudes about mental illness: from 1950 to 1990

In the 1950s, the public viewed mental illness as a stigmatized condition and displayed an unscientific understanding of mental illness. Survey respondents typically were not able to identify individuals as"mentally ill" when presented with vignettes of individuals who would have been said to be mentally ill according to the professional standards of the day. The public was not particularly skilled at distinguishing mental illness from ordinary unhappiness and worry and tended to see only extreme forms of behavior—namely psychosis—as mental illness. Mental illness carried great social stigma, especially linked with fear of unpredictable and violent behavior (Star, 1952, 1955; Gurin et al., 1960; Veroff et al., 1981).

By 1996, a modern survey revealed that Americans had achieved greater scientific understanding of mental illness. But the increases in knowledge did not defuse social stigma (Phelan et al., 1997) …. The public attributed mental illness to a mix of biological abnormalities and vulnerabilities to social and psychological stress (Link et al., in press). Yet, in comparison with the 1950s, the public's perception of mental illness more frequently incorporated violent behavior (Phelan et al., 1997). This was primarily true among those who defined mental illness to include psychosis (a view held by about one-third of the entire sample). Thirty-one percent of this group mentioned violence in its descriptions of mental illness, in comparison with 13 percent in the 1950s. In other words, the perception of people with psychosis as being dangerous is stronger today than in the past (Phelan et al., 1997). …. Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past (Phelan et al., 1997)…... This finding begs yet another question: Are people with mental disorders truly more violent? Research supports some public concerns, but the overall likelihood of violence is low. … Yet the risk of violence is much less for a stranger than for a family member or person who is known to the person with mental illness (Eronen et al., 1998). In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder. Because the average person is ill-equipped to judge whether someone who is behaving erratically has any of these disorders, alone or in combination, the natural tendency is to be wary. Yet, to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small (Swanson, 1994).

Because most people should have little reason to fear violence from those with mental illness, even in its most severe forms, why is fear of violence so entrenched? Most speculations focus on media coverage and deinstitutionalization (Phelan et al., 1997; Heginbotham, 1998). One series of surveys found that selective media reporting reinforced the public's stereotypes linking violence and mental illness and encouraged people to distance themselves from those with mental disorders (Angermeyer & Matschinger, 1996). And yet, deinstitutionalization made this distancing impossible over the 40 years as the population of state and county mental hospitals was reduced from a high of about 560,000 in 1955 to well below 100,000 by the 1990s (Bachrach, 1996). Some advocates of deinstitutionalization expected stigma to be reduced with community care and commonplace exposure. Stigma might have been greater today had not public education resulted in a more scientific understanding of mental illness.

In the past it was families, religious institutions, schools, and respected members of the community who instilled cultural attitudes. "Today, this is done by the mass media," says George Gerbner, founder of the Cultural Environment Movement, and a researcher whose career includes 30 years of monitoring the cultural impact of television on society. Television is, in Gerbner's words, "the wholesale distributor of the stigma of mental illness." His research has shown that characters portrayed on television as having mental illnesses have four times the violence rate and six times the victimization rate of other characters. Gerbner notes that "Violence and retribution are shown as inherent in the illness itself and thus inescapable. No other group in the dramatic world of television suffers and is shown to deserve such a dire fate."

The portrayal of mental illness in the movies is similarly distorted. In the late 1980s, Steven E. Hyler of Columbia University and his colleagues identified six categories of psychiatric characters in films:

homicidal maniac, narcissistic parasite, seductress, enlightened member of society, rebellious free spirit, and zoo specimen. Hyler concluded concluded that these predominantly negative stereotypes had a damaging effect on the viewing public and on the patients themselves, their family members, and policy makers.2 More recently, Otto F. Wahl of George Mason University, an authority on public images of mental illness, found that in the decade from 1985 to 1995, Hollywood released more than 150 films with characters who have mental illnesses, the majority of them killers and villains.3 There can be no doubt that Hollywood stereotypes are a large part of what people know, or think they know, about people with psychiatric vulnerabilities. Newspaper reports about mental illness are often more accurate than the characters one sees in TV entertainment and movies. Still, people with psychiatric histories generally are reported negatively. In 1991, researchers Russell E. Shain and Julie Phillips, using the United Press International database from 1983, found that 86 percent of all print stories dealing with former mental patients focused on violent crime.4 A 1997 British study found similarly skewed stories, and a 1999 German study concludes that selective reporting about mental illness causes audiences to distort their view of the "real world."

(…) Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved.

(…) Ironically, these examples also illustrate a more unsettling consequence: that the mental health field was adversely affected when causes and treatments were identified. As advances were achieved, each condition was transferred from the mental health field to another medical specialty (Grob, 1991). For instance, dominion over syphilis was moved to dermatology, internal medicine, and neurology upon advances in etiology and treatment. Dominion over hormone-related mental disorders was moved to endocrinology under similar circumstances. The consequence of this transformation, according to historian Gerald Grob, is that the mental health field became over the years the repository for mental disorders whose etiology was unknown. This left the mental health field "vulnerable to accusations by their medical brethren that psychiatry was not part of medicine, and that psychiatric practice rested on superstition and myth" (Grob, 1991).
These historical examples signify that stigma dissipates for individual disorders once advances render them less disabling, infectious, or disfiguring. Yet the stigma surrounding other mental disorders not only persists but may be inadvertently reinforced by leaving to mental health care only those behavioral conditions without known causes or cures. To point this out is not intended to imply that advances in mental health should be halted; rather, advances should be nurtured and heralded. The purpose here is to explain some of the historical origins of the chasm between the health and mental health fields.

Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited will power but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate. Still, fresh approaches to disseminate research information and, thus, to counter stigma need to be developed and evaluated. Social science research has much to contribute to the development and evaluation of anti-stigma programs (Corrigan & Penn, 1999). As stigma abates, a transformation in public attitudes should occur. People should become eager to seek care. They should become more willing to absorb its cost. And, most

importantly, they should become far more receptive to the messages that are the subtext of this report: mental health and mental illness are part of the mainstream of health, and they are a concern for all people.

(…) Violence and Mental Illness: The Facts

The discrimination and stigma associated with mental illnesses largely stem from the link between mental illness and violence in the minds of the general public, according to the U.S. Surgeon General (DHHS, 1999). The belief that persons with mental illness are dangerous is a significant factor in the development of stigma and discrimination (Corrigan, et al., 2002). The effects of stigma and discrimination are profound. The President's New Freedom Commission on Mental Health found that, "Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders—especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment (New Freedom Commission, 2003)."

This link is often promoted by the entertainment and news media. For example, Mental Health America, (formerly the National Mental Health Association) reported that, according to a survey for the Screen Actors' Guild, characters in prime time television portrayed as having a mental illness are depicted as the most dangerous of all demographic groups: 60 percent were shown to be involved in crime or violence. Also most news accounts portray people with mental illness as dangerous (Mental Health America, 1999). The vast majority of news stories on mental illness either focus on other negative characteristics related to people with the disorder (e.g., unpredictability and unsociability) or on medical treatments. Notably absent are positive stories that highlight recovery of many persons with even the most serious of mental illnesses (Wahl, et al., 2002). Inaccurate and stereotypical representations of mental illness also exist in other mass media, such as films, music, novels and cartoons (Wahl, 1995).

Most citizens believe persons with mental illnesses are dangerous. A longitudinal study of Americans' attitudes on mental health between 1950 and 1996 found, "the proportion of Americans who describe mental illness in terms consistent with violent or dangerous behavior nearly doubled." Also, the vast majority of Americans believe that persons with mental illnesses pose a threat for violence towards others and themselves (Pescosolido, et al., 1996, Pescosolido et al., 1999).

As a result, Americans are hesitant to interact with people who have mental illnesses. Thirty-eight percent are unwilling to be friends with someone having mental health difficulties; sixty-four percent do not want someone who has schizophrenia as a close co-worker, and more than sixty-eight percent are unwilling to have someone with depression marry into their family (Pescosolido, et al., 1996).

But, in truth, people have little reason for such fears. In reviewing the research on violence and mental illness, the Institute of Medicine concluded, "Although studies suggest a link between mental illnesses and violence, the contribution of people with mental illnesses to overall rates of violence is small," and

further, "the magnitude of the relationship is greatly exaggerated in the minds of the general population" (Institute of Medicine, 2006). For people with mental illnesses, violent behavior appears to be more common when there's also the presence of other risk factors. These include substance abuse or dependence; a history of violence, juvenile detention, or physical abuse; and recent stressors such as being a crime victim, getting divorced, or losing a job (Elbogen and Johnson, 2009).

In addition:

"Research has shown that the vast majority of people who are violent do not suffer from mental illnesses (American Psychiatric Association, 1994)."

". . . [T]he absolute risk of violence among the mentally ill as a group is still very small and . . . only a small proportion of the violence in our society can be attributed to persons who are mentally ill (Mulvey, 1994)."

In a 1998 study that compared people discharged from acute psychiatric inpatient facilities and others in the same neighborhoods, researchers found that "there was no significant difference between the prevalence of violence by patients without symptoms of substance abuse and the prevalence of violence by others living in the same neighborhoods who were also without symptoms of substance abuse (Steadman, Mulvey, Monahan, Robbins, Applebaum, Grisso, Roth, and Silver, 1998)."

People with psychiatric disabilities are far more likely to be victims than perpetrators of violent crime (Appleby, et al., 2001). Researchers at North Carolina State University and Duke University found that people with severe mental illnesses—schizophrenia, bipolar disorder or psychosis—are 2 ½ times more likely to be attacked, raped or mugged than the general population (Hiday, et al., 1999)."

D. WHICH TYPE OF STIGMA SHOULD INTEREST US AND WHY?

As long as we now know the types and contents of the stigma and have closely followed the historical development, we can answer briefly the question of the title of the paragraph:

- Stigma in principle has been documented as an eminent obstacle to the search for treatment by the sufferer. Therefore, if we are really interested in treatment, this barrier must be eliminated. Non-intensive effort towards this goal leads to the perpetuation of PSD.
- Stigmatization leads to the marginalization of sufferers, so it directly threatens social cohesion.
- The perpetuation, preservation and prevalence of PSOs adversely affect growth, productivity, public finances and a number of other factors, essential components of social/economic prosperity.

Therefore, whether and how stigmatization is combated is **the litmus test**

- To understand the true dynamics of therapeutic approaches
- To confirm the reliability of the declarations and policies implemented
- To disclose the actual objectives if reliability is not confirmed

Thus, in order not to allow our logical edifice to stand with head down and feet up, we must accept that

- self-stigmatization is only the personal integration of a stigma that exists in the external environment

- social stigma does not automatically spring up but is shaped by detectable processes and
- the structural stigma is what coordinates and directs the formation of perceptions at the social level, in the so-called "fish stinks from the head".

For the valid approach of official policies, it is necessary to speak in the same words of the competent authorities. At this point we will be assisted by the official report of the MENTAL HEALTH COMMISSION of the Federal Government of Canada entitled "Mental Illness-Related Structural Stigma: The Downward Spiral of Systemic Exclusion Final Report" of James D. Livingston, PhD Assistant Professor, Department of Sociology and Criminology, Saint Mary's University, Halifax, Nova Scotia, October 31, 2013 (206 scientific references)
https://www.mentalhealthcommission.ca/sites/default/files/MHCC_OpeningMinds_MentalIllness-RelatedSructuralStigmaReport_ENG_0_0.pdf

Copying from Summary: *"Increasingly, governments, non-governmental organizations, and private corporations in Canada and around the world are mobilizing resources towards preventing and addressing mental illness-related stigma. The Mental Health Strategy for Canada [1] highlights the need to "fight stigma by including opportunities in promotion, prevention and early intervention initiatives to meet and talk with people living with mental health problems and illnesses" (p. 23) and to "review and, where necessary, update legislation and revise policies across jurisdiction and sectors to achieve alignment with the UN Convention on the Rights of Persons with Disabilities" (p. 45). In addition, the Mental Health Commission of Canada initiated Opening Minds in 2009, which is a systematic effort to reduce stigma related to mental illnesses, with a specific emphasis on healthcare providers, youth, media, and the workforce. At the same time, many Canadian provinces and territories have released long-term mental health plans that identify stigma-reduction as a priority for action [e.g., 2,3,4]. Across multiple life domains, people with mental illnesses must contend with arbitrary restrictions on their rights and opportunities—even in countries with advanced legislative protections against discrimination, such as Canada. Stigma cannot be eradicated without attending to structural stigma; that is, the inequities and injustices that are woven into the policies and practices of our institutional systems. Despite the dearth of empirical evidence about how to address mental illness-related structural stigma effectively, there is a robust body of knowledge offering brilliant ideas about the most promising methods for beginning to break down the structural barriers facing people with mental illnesses. This report summarizes what is known about mental illness-related structural stigma. It begins with an overview of the concepts of stigma and structural stigma, including how they are understood by contemporary scholars. The report then outlines the different ways in which structural stigma manifests in modern institutional systems and social contexts, including: healthcare; employment and income; housing; education; criminal justice; privacy; public participation; travel and immigration; media; and reproduction and parenting. It is apparent there are few areas of social policy affecting people with mental illnesses that remain untainted by stigma. The final sections of the report synthesize the existing knowledge pertaining to addressing structural stigma. The most promising methods involve a combination of legal and policy action, advocacy, inclusive efforts, healthcare reform, education, and research."*

The mere existence of the report is, in principle, a full recognition of the problem. However, its content is revealing not only in terms of full documentation that is provided, but above all in terms of the concepts which the Commission accepts and uses for interpreting of the phenomenon:

"... Structural stigma may be intentional or unintentional
... Practices designed for intentional stigmatization.
... the dominant ideology in society
... people with resources and power have an increased likelihood of influencing social policy;
... institutional practices, usually guided by unwritten customs or procedures
... Structural stigma is difficult to detect and study because it is "buried under layers of rules and regulations"
... Mental illness has been systematically downgraded in the allocation of health care funding
… cheaper drugs may be available to people with mental illnesses, rather than comparatively newer, more expensive and more effective drugs that have fewer side effects
... people with mental illnesses may have access to pharmacological interventions, but not to other forms of care that are equally or more effective, such as psychological treatments
... inadequate coverage for mental health care compared to that provided for physical illnesses
... preventing their recovery and putting them at risk for a number of negative effects
*... the absence of an effective mental health care system is a **'lack of freedom'***
... prevent people with mental illnesses from achieving other forms of freedom, such as full participation in social and political life.
... underestimation of mental illness by society;
... people with mental illnesses are far over-represented in the criminal justice system
... as soon as people with mental illnesses enter the criminal justice system, they consolidate the structural stigma
... people with mental illness are systematically disadvantaged in the criminal justice system."

The above formulations have been selected only from the chapters referring to **Health/Care** and **Criminal Justice** as in them the state has a direct executive role and authority. The other areas approached are equally critical and the figures equally revealing for Employment/Income, Housing, Education, Privacy, Public Participation, Mobility/Immigration, Media, and Reproduction/Parenthood but there the role of the state is more regulatory.

The value and contribution of this Report is such that it must also be seen as an integral part of our approach as **Annex 2**.

The combined reading of our two main references / annexes (State University of New York and Mental Health Commission of Canada) allows us to introduce for consideration the assumption that we are dealing with **a hybrid of structural and social stigma** with the former loudly or implicitly organizing the institutional and functional background and thus inspiring, maintaining and finally legitimizing the latter as a necessary framework for political support for the former. This hybrid, although the concept of stigmatization is directly related to Mental Disorders, develops and operates in the overall field of Mental Health not limited to sufferers. If this hypothesis is correct, then **the stigma is secondarily only a question of Human Rights and the main issue is a matter of public health which results in the overall**

functioning of the political/economic system: if something prevents the integrated provision of health services then elements of the core of the state as described and legitimized in modern perceptions of its acceptance and functioning are proposed.

If such a factor is identified and recognized as a problem in Canada, we can easily see its extent and intensity on the outskirts of the Western world and better not look for it outside these limits at all. (Or if we insist on doing it, it takes another preparation that is not available to us now.) Let us therefore settle for the above by assisting the research of the European Commission's Directorate-General for Employment, Social Affairs and Equal Opportunities" published in 2007 "Measuring the stigmatization and discrimination of people with mental health problems in Europe" which fully confirms, the positions of the Canadian report.
https://ec.europa.eu/health/ph_determinants/life_style/mental/docs/stigma_paper_en.pdf

E. THE STIGMA TODAY

After the path we have followed so far by studying definitions, classification systems, types' categorization, historical evolution and descriptions of the stigma, we are now equipped enough to try to "change the world and not just interpret it".
This is the point in our analysis where we are called upon to demonstrate the view expressed in the introduction, namely that **stigmatization is a *mechanism:***

- ***to control the sufferers***
- ***for the conservation of the causes of MDs and their obfuscation of the inadequacy of mental health policies***
- ***for the use of MDs to reproduce the dominant ideology on diversity and ultimately to maintain the prevailing social, economic and political order.***

In order to prove whether the point of view is valid, we must describe the frame of reference in which we will test its truth. This framework shall be composed of the following principles:

1. Physical and Mental Health are integral terms of the general concept of Health.
2. The field of Mental Health includes equally the pursuit of the mental well-being of the population (prevention) and the effective care, protection and rehabilitation of sufferers of mental disorders (treatment).
3. Securing these two parameters is seen as a fundamental function of the State.
4. Citizens have the right to equal access to health services as a fundamental universal function.
5. MDs are mainly due to environmental causes with their characteristics and in particular the ways in which they are treated to be very closely linked to the conditions of individual development and social life organization.
6. Stigma is an accompanying phenomenon independent of the nature of MDs and caused by exogenous factors.

Note 1 : It is clear that the above reference framework is based on certain assumptions of principle and creates a field of dialogue which is presumably limited to those who accept them.

Examples: Proponents of market dominance do not agree with the perception of health as a fundamental obligation of the state. - Proponents of the biomedical model do not agree with the biopsychosocial approach.

Note 2: Practical agreement with the principles of the framework should not be taken for granted even when declared or institutionally guaranteed.
Examples: The proportion of EU Member States' health expenditure directed at prevention is only 3% (for the field of MH only 1%) without the adequacy, justification and effectiveness of this allocation being substantiated by any given. Citizens do not have equal access to health services or have access under conditions (insurance systems).

i) Health of the Population

Mental Health statistics are getting dramatically worse. The Annual Reports of the World Health Organization are particularly revealing. As the analysis is addressed to already informed experts, very few indicative data will be provided.

- Depression affects 264 million people in the world, one of the leading causes of disability.
- As many as 450 million people suffer from a mental or behavioural disorder.
- Nearly 1 million people commit suicide every year. Around half of all mental health conditions start by age 14, and suicide is the second leading cause of death in young people aged 15-29.
- Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).
- One in four families has at least one member with a mental disorder. Family members are often the primary caregivers of people with mental disorders.
- In low- and middle- income countries between 76% and 85% of people with mental health conditions receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context.
- People with mental disorders die 20 years younger than the general population.
- The estimated prevalence of mental disorders in the WHO European Region in 2015 was 110 million, equivalent to 12% of the entire population at any one time. Inclusion of substance use disorders increases that number by 27 million (to 15%), while inclusion of neurological disorders such as dementia, epilepsy and headache disorders increases the total by more than 300 million, to 50%.
- Suicide deaths are strongly related to mental illness, with approximately 90% attributed to mental illness in high-income countries. In the WHO European Region, the suicide rate is unacceptably high. In 2015, the age-standardized suicide rate was 14.1 per 100 000 population for both sexes combined, above the global average of 13.6. Moreover, 11 of the top 20.
- The median value of the MH workforce hides wide variation among countries. For instance, the number of psychiatrists per 100 000 population ranges from 48 per 100 000 in Norway and 24 in Poland to 7 in Bulgaria.

Although the above elements do not reflect timeless trends, the constant burden of the image is a common belief.

https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response
https://www.who.int/news-room/fact-sheets/detail/mental-disorders

https://www.who.int/mental_health/media/investing_mnh.pdf
https://reliefweb.int/report/world/policy-brief-covid-19-and-need-action-mental-health-13-%09may-2020
https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/fact-sheet-mental-health-2019
https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/fact-sheet-on-the-sdgs-mental-health-2018

Conclusion: the policies in the field of MH have disappointing results and do not correspond to the principle of ensuring Health as a fundamental state function. Reasonable questions arise about the causes of failure: incompetence or lack of political will?

ii) Economics of Mental Health

Current situation

- Depression and anxiety have a significant economic impact. The estimated cost to the global economy is **US$1 trillion per year in lost productivity**.
- Cost-benefit research is available for strategies to address mental health issues towards net benefits. For example, a recent WHO-led study estimates that for every US$1 in a tiered treatment for common mental disorders, there is a US$4 return on improved health and productivity.
- Dramatically disproportionate funding: WHO countries spend on MH an average only 2% of their health budgets (....) Despite the huge global financial burden on mental health conditions, spending amounts to only 1% of total health spending by governments in the WHO European region. Of these costs, 69% were devoted to state mental hospitals.

https://www.who.int/teams/mental-health-and-substance-use/mental-health-in-the-workplace

The following three reports help us approach the situation in absolute numbers and reveal the real trends and intentions:

Scaling-up treatment of depression and anxiety: a global return on investment analysis
Chisholm et al - Lancet, April 12, 2016 https://bit.ly/3a6ba1b

The net present value of investment needed over the period 2016–30 to substantially scale up effective treatment coverage for depression and anxiety disorders is estimated to be US$147 billion. The expected returns to this investment are also substantial. In terms of health impact, scaled-up treatment leads to 43 million extra years of healthy life over the scale-up period. Placing an economic value on these healthy life-years produces a net present value of $310 billion. As well as these intrinsic benefits associated with improved health, scaled-up treatment of common mental disorders also leads to large economic productivity gains (a net present value of $230 billion for scaled-up depression treatment and $169 billion for anxiety disorders).

Let us do the simple calculation described above: Investments totaling 147billion would yield total benefits (310 + 230 + 169 =) 709 billion. **Thus, there would be a net final benefit (709 – 147=) of 562 billion.**

Investing in global mental health: the time for action is now
Paul Summergrad, Lancet, April 2016 https://bit.ly/3g9fAs1

The conclusions of Chisholm et al are validated and augmented by P. Summergrad who examining the reasons for the shortfall in the necessary funding states:
"(…..) **Furthermore, mental illnesses are highly stigmatised**. Sitting at the boundary of behaviour, neurobiology, and culture, they remain—irrespective of cause—the most intimate and personal of medical disorders, and challenge expectations for self-control and more traditional views of human nature. Irrespective of these challenges, through persistent advocacy, mental health has for the first time been formally incorporated in the United Nations Sustainable Development Goals for 2016–30.4 However, concerns about the effectiveness or feasibility of investment in mental health disorders might be continuing to impede needed wide scale interventions. **Mental disorders receive a very small proportion of national health expenditures or external development support**."

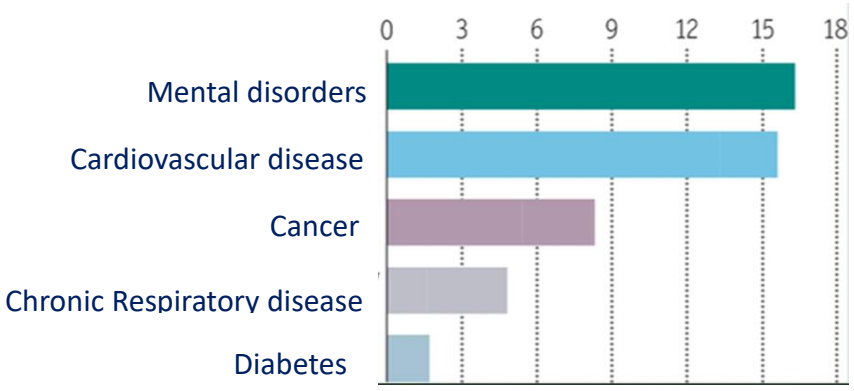
Sustainable development and global mental health—a *Lancet* Commission
Patel et al, 2016 https://doi.org/10.1016/S0140-6736(16)00208-7

*"(…) Despite this evidence, in not a single country is the investment in mental health programmes proportionate to the burden of these disorders, and most low-income countries invest less than 1% of their health budgets in mental health services. Development assistance for health from the world's richest countries fares no better, with less than 1% being devoted to mental health since 2007. The systematic discrimination against people with mental health problems—from communities to front-line health-care delivery to national and global policy making—makes mental health the most neglected of all human health conditions. Not surprisingly, this neglect has been referred to as a "**failure of humanity**".*

Addressing the burden of mental, neurological, and substance use disorders: key messages from *Disease Control Priorities*, 3rd edition
Patel, Chisholm et all, 2015 https://doi.org/10.1016/S0140-6736(15)00390-6

"The burden of mental, neurological, and substance use (MNS) disorders increased by 41% between 1990 and 2010 and now accounts for one in every 10 lost years of health globally. This sobering statistic does not take into account the substantial excess mortality associated with these disorders or the social and economic consequences of MNS disorders on affected persons, their caregivers, and society."

Trends in the finances of the MH - forecasts for 2030
Lancet Commission on Global Health and Sustainable Development
Forecasts of economic losses due to non-communicable diseases put mental illness in first place for the period 2011 – 2030 exceeding **$16 trillion** (https://doi.org/10.1016/S0140-6736(18)31612-X.)



World Economic Forum - Table **13:** Mental illness costs expected to more than double by the annual cost of mental illness is expected to more than double by **2030 -** from an estimate of **US$2.5** trillion in **2010** rising to **US$6.0** trillion in **2030.**
(Costs shown in billions of 2010 US$)

	Low- and Middle-Income Countries			High-Income Countries			World		
	Direct Costs	Indirect costs	Total cost	Direct Costs	Indirect costs	Total cost	Direct Costs	Indirect costs	Total cost
2010	287	583	870	536	1088	1624	823	1671	2493
2030	697	1416	2113	1298	2635	3933	1955	4051	6046

http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf

Conclusion: Mental Health policies are dramatically underfunded and the obvious economic benefit of dealing with mental disorders is systematically ignored, while stigma is listed as a contributing factor to decision-making.
There are reasonable questions about the causes of the choices: is there a clear political will to preserve the MDs or instead, to insure other financial interests?

iii) Prevention

- **The proportion of health expenditure in the EU Member States directed at prevention is only 3% (for the field of MH only 1%)**

- In the **Table 17: "Best Buy" interventions for NCDs prevention and control** of the World Economic Forum report does not include any prevention action related to Mental Health unlike other major categories of non-communicable diseases

- **The economic case for better mental health**
  Martin Knapp, Valentina lemmi. Publication LSE 2014, https://bit.ly/3tCkl0R

The study is supported by an extensive number of references to relevant research so that no additional sources need to be listed here.

«Key statistics

In 2000, the service costs associated with childhood psychiatric disorders were 12 times greater for frontline education services than for specialist mental health services.

Over 25 years, the total return from parenting programmes for children with conduct disorder is between 2.8 and 6.1 times the intervention cost, much of this through reduced crime.

Early intervention services that provide intensive support for young people experiencing a first psychotic episode can help avoid substantial health and social care costs: over 10 years perhaps £15 in costs can be avoided for every £1 invested.

£1 in every £8 spent in England on long-term conditions is linked to poor mental health.

More than 11% of the NHS budget is spent on treating mental illness – but the indirect costs from unemployment, absenteeism and presenteeism can be higher. These indirect costs totalled £30.3 billion in England in 2009/10 across all mental illnesses, compared with direct health and social care costs of £21.3 billion.

The economic cost of a completed suicide for someone of working age in the UK exceeds £1.6 million.

Conclusions

Efforts are needed to improve the translation and implementation of knowledge, ***to counter some deep-seated stigmatising attitudes towards mental illness*** *and the people who experience it, and to address shortages of suitably trained professionals (such as psychologists). Efforts are also needed to engage actors across many sectors – not just health, but social care, housing, education, employment, criminal justice, welfare and so on – given the complex aetiology and wide-ranging impacts of many mental health problems. Spending on evidence-based mental health services is an investment that will pay quality of life and economic dividends across much of society, over many years.*

Policy suggestions

The potential lifelong disadvantages associated with mental health problems require long-term strategic action.

Better ***integration of physical and mental health care,*** *encouraged by redesigned payment mechanisms, would further improve healthcare quality and productivity.*

National and local efforts are needed to ***address persistent negative attitudes towards mental illness,*** *particularly towards schizophrenia and other psychoses.*

Access to treatments (and hence to their therapeutic benefits) may be ***inequitably distributed*** *by ethnicity, gender, age, language, religion, income or place of residence*.»

However, the dimension of prevention is not limited to information and counselling but must also include the suppression of practices which presumably lead to the problematic situation of the field and the stigmatization of sufferers (perhaps non-sufferers also!).

- **Use of illegal addictive substances.**
  Users of officially illegal substances are variously stigmatized for their use and the situation in which they are involved despite being victims of an illegal activity. Clearly no return of intent is needed, a mandatory annual ceremony of the co-competent Ministries to present

the statistics of the period by those responsible by object (even if they were the 'cog in the wheel') would make a decisive contribution to prevention.

- **Illegal marketing practices**
  The prescription of psychopharmaceuticals by non-PSY professionals in undiagnosed patients has already been noted. For the aspect of unethical behaviour, let their professional associations deal with the competent disciplinary boards or the competent criminal and civil courts for investigating and criminally convicting cases of medical negligence or attribution of civil liability in the event of a medical error. At the same time, however, at the political level, the incentive for these anti-ethical behaviours should be sought in the illegal marketing practices for which pharmaceutical companies are regularly condemned. One of the results of these practices is to provide strong incentives for **over-prescribing or prescribing to people who do not need this treatment, regardless of the undeniable negative effects on the takers.**
  Unfortunately, however, cases of unfair marketing practices are dealt with within the framework of commercial law and are almost always settled by administrative – financial arrangements from which, moreover, the directly harmed do not benefit in the slightest. The following cases are typical:
  "AstraZeneca recently agreed to pay $520 million to settle federal investigations into its marketing practices for Seroquel-which last year alone earned the company $4.9 billion in sales. Secretary of Health and Human Services, Kathleen Sebelius noted that the company gave "kickbacks to doctors as part of an illegal scheme to market drugs for unapproved uses." (…) AstraZeneca is the fourth pharmaceutical company in the past 3 years to pay to settle federal investigations into illegal marketing of its drugs. According to the Times, Pfizer paid $2.3 billion for off-label promotion of Bextra (a painkiller) and Geodon in 2009. That same year, Eli Lilly paid $1.4 billion to setting investigations into illegal marketing of Zyprexa. In 2007, Bristol-Myers-Squibb paid $515 million to settle investigations into its marketing of Abilify. (Abilify, aripiprazole – Bipolar disorder, Depression, Schizophrenia)"
  The above examples are indicative and do not exhaust the picture, the well-known Novartis scandal has not yet been closed in a number of states.
  Πηγές: https://www.psychiatrictimes.com/view/top-25-psychiatric-medications-big-businessand-price-pay
  https://mhe-sme.org/wp-content/uploads/2019/01/MHE-SHEDDING-LIGHT-REPORT-Final-1.pdf

Taking into consideration the final results of the above cases and the constant occurrence of similar cases, we find that the treatment followed may affect (possibly) profitability at a certain period but in no way substantially threaten the viability of the companies in order to take such a risk seriously. In this sense, the existing approach at international level has no deterrent effect, and therefore no preventive effect that would, for example, have a ban on the marketing of a medicinal product burdened with illegal promotional practices.
In practice, trends in this area are a much bleaker future as even regulators are under strong pressure from the justice system to limit their jurisdiction and power. The orientation of the US legal system at the highest level towards defending the right of pharmaceutical companies to illegal commercial practices is one of the most characteristic cases of the de-establishment of the concept of democracy

since it is enlisted to guarantee **freedom of speech** for this despicable purpose and makes the debate on stigma and rights an issue for naïve:

> *«The FDA takes the position that a drug manufacturer may not promote its drug for an unapproved use, and that any such promotion is false and misleading simply because it is not FDA-approved. However, many off-label uses are in fact effective and safe, as is evidenced by subsequent FDA approval of such uses for numerous drug products. The Supreme Court has in recent years begun to address the boundaries between government regulation of pharmaceuticals and the First Amendment free speech guarantee. Some legal observers have suggested that the trend in the Court's decisions may ultimately reduce the ability of FDA to prevent broader dissemination of off-label information about approved drug products.[7]*
> *A three-judge panel of the United States Court of Appeals for the Second Circuit in Manhattan ruled on December 5, 2012 that a drug sales representative who was criminally prosecuted for making off-label promotional statements about Xyrem had suffered a violation of his First Amendment right to freedom of speech.[8]»*
>
> Source: Wikipedia https://en.wikipedia.org/wiki/Marketing_of_off-label_use

Conclusion: The dimension of prevention in Mental Health policies is completely degraded despite the obvious operational and economic advantages of its possible adoption and strengthening it. Stigma appears to be a particularly active factor in repelling prevention policies.
There are reasonable questions about the basis of the mainstream approach: are other political and economic advantages preferred that passive attitudes towards MDs ensures?

F. LET US TRY FOR ANSWERS

We have so far described stigma as a serious exogenous factor in shaping mental health policies while the ineffectiveness of these dominant policies for the prevention and treatment of Mental Disorders and stigmatization in itself has been demonstrated.
The evidence does not in itself lead to actions. They help us make assumptions about the causes in order to address them. Whereas a system that has defined the world for over 200 years and ensures its preservation probably has the necessary capacity to achieve its objectives. So, it seems reasonable to rule out the possibility of incompetence as an interpretation of the tragic situation in the field of MH. Then, of course, only the case remains for the deliberate and effective implementation of policies which quite simply have other objectives than to address the problems of Mental Health.

«Follow the money».

It has been shown that, despite official declarations, the obvious and most significant costs for states and supranational entities resulting from such a burdened situation in the field of MH are underfunded and/or maintain injurious policies. Having ruled out the possibility of political incompetence, the only logical interpretation is that profits from other sectors outweigh the damage caused. We can look for such gains in plain light but behind the curtains also:

- First, in the pharmaceutical industry. Without this being limited to the production of psychiatric preparations and their distribution as the association of MDs with a number of other physical diseases and the prescription of drugs by non-professional PSOs is documented.
- In the field of medical research in genetics, geriatrics and disability.
- In the field of the provision of MH services and not limited to the MH structures and professionals as it is documented the prescription by general doctors.
- In the field of addictions (production, promotion and use of legal and illegal addictive substances)
- In the field of gambling / betting (as addictions).

It would be interesting to have an organized projection to assess the value of the above economic activities and an attempt to describe the landscape for the global economy in the event of a 10% or 20% reduction in MH problems in five years. Without them, however, it is a given that the economic figures are unimaginably high and far exceed 1 trillion, the largest of the statistics we have mentioned, if we take into account that whole states' economies are linked to the production of addictive substances. Thus, we reasonably assume that, from an economic point of view, not addressing the problems of the MH ensures that multiple profits are retained from the other sectors and keeping thinks as they are is therefore a sound business and efficient management decision. And as such it can be the economic incentive for the dominant policy strategies and practices developed and implemented at institutional/government level. The big picture often helps to hide personal status. Perhaps here is the proof of the wording of Patel et al: "Systematic discrimination against **people with mental health problems** ... ***makes mental health the most neglected of all human health conditions. It is no surprise that this neglect has been referred to as 'failure of humanity'.***

«It is power, stupid».

This strictly economic explanation leads to an image of the political apparatus as a mere sub-operator, or second-class partner, of both legitimate and illegal economic interests.
However, the concept of profit is not limited to that of a positive cash result for a given period of time. (It happens, moreover, that the value of the corporate brand alone sometimes exceeds the valuation of the company's total assets). The conditions for profit-taking are as important as the profits themselves, even if they are intangible and not subject to economic valuation. And these terms, in a word, are nothing but the power that political complexes need to enforce it in order to be able to meet its destination. Political complexes draw power from the electorate which, by convention, represent and which entrusts it with governance in its own name. The control of these electorates is achieved by convincing in principle a part of it that it is the authentic expression of the interests of the specific section of the society, a parameter out of our concern in this analysis.
However, as this section does not usually constitute a social/electoral majority, it is necessary to

- to methodize either the recruitment of a supplementary section (which feels related) and/or
- control, marginalize and inactivate other, underprivileged and presumably opposing social categories/ groups.

This last procedure may complement the metaphor of the crime investigation we used. After the body and the motive, above identified, we are close to discovering the missing weapon.

Stigma is the weapon.

We find it thrown away after the murder in prisons, in schools and youth hangouts, in rows of unemployed in front of unemployment benefit services, in the drug markets, in minority neighbourhoods, in the mass media control rooms, in the cultivated false fear of violence about the MDs, on the electoral rolls.

In our research on the weapon will help us the recent data (March 2021) provided in the https://www.nami.org/mhstats national alliance on mental health, the largest U.S. base organization for MH:

Mental disorders prevalence – overall picture

- 18.4% of U.S. adults with mental illness also experienced a substance use disorder in 2019 (9.5 million individuals)
- Suicide is the 2nd leading cause of death among people aged 10-34 in the U.S.
- Suicide is the 10th leading cause of death in the U.S.
- The overall suicide rate in the U.S. has increased by 35% since 1999.
- 46% of people who die by suicide had a diagnosed mental health condition.
- 90% of people who die by suicide had shown symptoms of a mental health condition.
- Lesbian, gay and bisexual youth are 4x more likely to attempt suicide than straight youth.
- Transgender adults are nearly 12x more likely to attempt suicide than the general population.

Children and Youth

- 50% of all lifetime mental illness begins by age 14, and 75% by age 24
- 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year
- 50% of all lifetime mental illness begins by age 14, and 75% by age 24
- Suicide is the 2nd leading cause of death among people aged 10-34
- 50.6% of U.S. youth aged 6-17 with a mental health disorder received treatment in 2016
- 70.4% of youth in the juvenile justice system have a diagnosed mental illness

Demographic groups

Demographic group	Annual prevalence of MDs among adults (%)	% of the total population	Annual adult treatment rates (%)
Non-Hispanic Asian:	14.4	5.8	23.3
Non-Hispanic white:	22.2	59.7	50.3
Non-Hispanic black or African-American:	17.3	12.5	32.9
Non-Hispanic American Indian or Alaska Native:	18.7	0.9	43.0

Non-Hispanic mixed/multiracial:	31.7	2.3	
Non-Hispanic Native Hawaiian or Other Pacific Islander:	16.6	0.2	
Hispanic or Latino:	18.0	18.7	33.9
Lesbian, Gay or Bisexual:	44.1		

Health services

- The average delay between onset of mental illness symptoms and treatment is 11 years
- 55% of U.S. counties do not have a single practicing psychiatrist

MH services' users and rule of law / penal system

- About 2 million times each year, people with serious mental illness are booked into jails.
- About 2 in 5 people who are incarcerated have a history of mental illness
- 66% of women in prison reported having a history of mental illness, almost twice the percentage of men in prison.
- Nearly one in four people shot and killed by police officers between 2015 and 2020 had a mental health condition.
- Suicide is the leading cause of death for people held in local jails.
- An estimated 4,000 people with serious mental illness are held in solitary confinement inside U.S. prisons.
- 70% of youth in the juvenile justice system have a diagnosable mental health condition.
- Youth in detention are 10 times more likely to suffer from psychosis than youth in the community.
- About 50,000 veterans are held in local jails — 55% report experiencing a mental illness.
- Among incarcerated people with a mental health condition, non-white individuals are more likely to go to solitary confinement, be injured, and stay longer in jail.
- About 3 in 5 people (63%) with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons.
- Less than half of people (45%) with a history of mental illness receive mental health treatment while held in local jails.
- People who have healthcare coverage upon release from incarceration are more likely to engage in services that reduce recidivism.

In short, non-friendly social groups and categories are weakened and marginalized while remaining vulnerable to MDs (stigmatization prevents the search for treatment and excludes them from social opportunities) resulting in manipulation, cancellation of potentially radical discourse or even exclusion from political processes.

The weapon of stigma is also evident in the horizontal stereotypes of the "silent majority" promoted and perpetuated by their creating mechanisms (e.g. the strong connection of violence with MDs despite

scientific documentation to the contrary). We also find it hidden in charitable-type calls for the implementation of human rights while:

- A significant part of the clergy with the dogmatic cover of the church applies the official doctrine of suicide as a sin and persons committed suicide are stigmatized even "after death". This extreme attitude is not even a remnant of the past as the witnesses of faith voluntarily went up to the cross, the pyre or offered themselves as the prey of the wild animals. It is simply the ideological management of the extreme declaration of freedom marked by the act of suicide which, by the way, also provides full proof of the free will that without it there is no concept of sin. As a result of the social stigma of suicide, the number of non-officially classified suicides exceeds, according to some reports, up to 25 times that of officially declared.
- Users of officially illegal substances are variously stigmatized for their use and the situation they contain because of it, while those incompetent state officials responsible for the ineffective implementation of the prohibition legislation remain undisturbed as mentioned above.
- Self-help communities (physical or online) are little involved in the mainstream mental health policies.

And when the stigma is not sufficient to exhaust a citizen (member of an ethnic minority, imprisoned, young, LGBT, without social insurance, unemployed, addicted etc.) then the big guns are recruited: the abolition of civil rights or especially the involuntary hospitalization.
For the latter we will refer to the case of Greece, a country that claims the sad primacy in a way that brings us back to the core of the issue we are dealing with.
The title of the study by Professor of Social Psychiatry St. Stylianides and the Special Scientific Associate of the Ombudsman A. Panagos is revealing : **"Involuntary hospitalizations in Greece: from the need for treatment to the death of rights",2018.** https://bit.ly/3v4cdqq. Here are just two characteristic excerpts:
«(...) In any case, however, involuntary hospitalization constitutes a double crack in human rights: deprivation of liberty and submission to medical acts without consent and without prior commission of a delinquent act or conduct (Vidalis, 1995; Chrysogonos, 2006; Phytrakis, 2007; Giannoulis, 2018). However, the deprivation of liberty of a person is a brutal infringement of a human right and is imposed only for the commission of a crime, even after a conviction has been handed down. For this reason, involuntary hospitalization within the Council of Europe is mainly treated as a form of deprivation of liberty, such as imprisonment *(Murdoch, 2006).'*
«(...) Is it possible to talk about the protection of rights, at a time when in Greece involuntary confinement moves between 50-60% of referrals?

The previously existing regime is further exacerbated by a relatively recent Ministerial Decision (2020) which has been harshly condemned by a large part of the scientific community. We copy from the intervention of lawyer Giannis Alexakis, member of the State Special Committee for the Protection of the Rights of Persons with Mental Disorders:

"The institutional diversion created in the field of mental health is obvious, as the terms and conditions "that private psychiatric clinics must meet in order to accept patients with mental disorders for involuntary hospitalization" are not defined in this Ministerial Decision in a clear and defined manner.

Nor is the way of "interconnection of private clinics with the Special Committee for the Protection of the Rights of Persons with Mental Disorders" clearly defined, while at the same time bypassing and not mentioning anything about "the conditions and the way in which patients are monitored by the Sectoral Mental Health Committees", etc., as required by the provisions of Article 16, Law 2716/1999[2] and Article 101(2). 2 N. 2071/1992[3].12
It should be noted that the Special Committee for the Control of the Protection of the Rights of Persons with Mental Disorders has accepted and confirmed complaints of long-term involuntary hospitalizations of mentally ill patients in private psychiatric *clinics* ,as well as other irregularities».
"ΤΟ ΚΟΥΤΙ ΤΗΣ ΠΑΝΔΩΡΑΣ",30-10-2020.

In order to avoid the risk of a unilateral, Greek-centric approach, we will also refer to the enlightening report "Access to Justice for Persons with Psychosocial Disabilities& Mental Health Problems: Reflection Paper and Promising Practices", Mental Health Europe, March 2021)

EPILOGUE

What to do ?

This essay could also be read backwards, from the end to the beginning.
To start, that is, by quoting the basic claim that stigma is used multiply as a mechanism

- for the control of sufferers
- maintaining the causes of MDs and their deterioration trend
- obscuring the inadequacy of mental health policies
- to exploit the MDs for the reproduction of the dominant ideology regarding diversity and the eventual maintenance of the ruling social, economic and political order.

To continue by highlighting the economic and political interest in maintaining the tragic and ever-worsening state of Mental Health worldwide.
To describe the nature and content and methods of stigmatization and come up with its true background which are the dominant perceptions of the causes and nature of mental disorders (definition of Mental Health). And with this reverse path we would conclude that:

- **Stigma is mainly a Public Health issue(*)**
- S**tructural changes in the construction of MH are one of the conditions for dealing with the stigma.**

This view does not in any way degrade the dimension of stigma as a violation of human rights. On the contrary, it strengthens advocacy arguments, aggregates stakeholders/supporters in this direction and prevents the spread of responsibility.

What do we need for these?

An order of forces corresponding to the types of stigma (self, social, structural) and actions according to the following axes:

1. **Strengthening the autonomous organisation, interaction, and public expression of the MH services users** – encouraging the creation of formal and informal structures and supporting them
2. **Strong institutional recognition of the role of organisations of MH service users –** Strong consultation and evaluation/accountability processes
3. **Clear definition of public and private sector's roles and boundaries**
4. **Protection of policymaking and services' provision processes by external actors –** Data management - Self-commitment and control procedures
5. **Embedding the perception of stigma as a public health issue for professionals and actors in the field –** Developing protocols to address stigma, integrating it into educational curricula
6. **Coordination in action of networks and organisations in the fields of Mental Health and Human Rights** – we maintain stigma by building microcosms.
7. **Extensive and customized information to the general population on the situation in the field and actual prevention –** Mental Health is everyone's business as a future sufferer as long as the situation is perpetuated.
8. **Intensification of scientific research** - root causes, types and characteristics of Mental Disorders, dialogue and rehabilitation.
9. **Quantitative and qualitative upgrading of Mental Health policies** in supranational and national contexts.
10. **Open doors -** the key factor for the success of each of the above directives.

Moral

As will have already been understood, not a single new idea has been presented on these more than 30 pages, nor has a new research result been mentioned. This indicates that the necessary knowledge is not lacking. At the same time, the numerus and diverse sources underline the enormous value of cooperation as a prerequisite to interpret, for instance, the substantial absence of Mental Health from EU4HEALTH and HORIZON, the core EU programmes on Health and Research for the period 2021 to 2027 or the characteristic disregard of the integration of Physical Activity into Mental Health concept despite its beyond doubt scientific documentation.

(*) «Addressing Stigma. Towards a More Inclusive Health System»
Chapter 2 – Stigma is a Public health Issue.
The Chief Public Officer's Report on the State of Public Health in Canada 2019
https://bit.ly/3gCszCL