THE STIGMA AGAINST MENTAL ILLNESS
Public myths and policy failures as barriers to the protection of persons with mental disabilities.

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Abstract

Stigma is a universal phenomenon. In all cultures of the world mental illness is surrounded by unfounded myths, stereotypes and prejudice. Myths and misconceptions surrounding mental illness are the underlying causes of the so-called stigma, which effects deeply harm those who suffer from a mental illness. The media and the psychiatric labeling are considered the main vehicles for the perpetuation of this phenomenon. Mental illness stigma leads to social exclusion and discrimination, resulting in the violation of a wide range of civil, political, economic, social and cultural rights. The fear of stigmatization prevents the mentally ill people from seeking proper treatment, which is currently seen by psychiatry as one of the main barriers for mental illness recovery and the mentally ill integration in society. The distinction between the public (general society prejudice and discrimination against people with mental illness), self (when stigma is internalized and accepted by the ill person) and structural (specific private and public policies, statutes and legal remedies meant to suppress discrimination) types of stigma is key to the understanding of this process. However, research shows that negative and stigmatizing stereotypes about the mentally ill can be changed and the public understanding and acceptance of mental illness improved by the promotion of anti-stigma programs and trough the adoption of different strategies such as contact (interaction between the public and the people with mental illness), education (more information about mental illness) and protest (social activism against mental illness stigma and discrimination).
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<td>Committee on Economic, Social and Cultural Rights</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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Introduction

The aim of the thesis is to analyse the reasons why mental illness is still neglected by state policies and legal and social systems and why it is still a taboo in nowadays societies. In all the parts of the world, mental illness is mystified, misunderstood and the mentally ill stereotyped and stigmatized. The thesis will show how myths and misconceptions associated with mental disability, the so-called stigma, severely impact the lives of these people, acting as a barrier to the enjoyment of a wide range of economic, social, cultural and political rights and also as a barrier to mental illness treatment itself. Stigma is universal and can affect anyone. Being an unquestionable reality, stigma represents a challenging issue for psychiatry and also for human rights because it is often seen, by psychiatrists, as one of the main challenges of mental illness treatment and/or recovery and the mentally ill rehabilitation and integration in society. Disability, including mental disability, represents one of the main sources of stigmatization. The stigmatized are victims of several forms of social exclusion and discrimination, whether on their private and familiar lives or on their workplaces, which, in turn, seriously compromises the full enjoyment of their human rights.

In order to understand this phenomenon, it is essential to address and frame mental illness and understand how its social perceptions changed throughout history as well as defining some key concepts, which are: wellbeing, mental health and mental illness. Therefore, in the first chapter of the thesis, I will briefly describe the social approach of madness throughout history, followed by the contemporary definition of mental illness and serious mental illness. Following this, I will address the three types of stigma against mental illness, which are public stigma, self-stigma or internalized stigma and structural stigma. Myths and stereotyped views about the mentally ill are in the genesis of this phenomenon. Frequently, people believe that the mentally ill are aggressive and dangerous and blame them for the commitment of the majority of the crimes, when in fact they represent a major risk for themselves rather than for other people. In addition, it is wrongly believe that mental illness is chronic and not treatable and for that reason the patients cannot recover in time or have control of their disease. The outcome of such a myth is the
perpetuation of the stigma by society, which still keeps its distance from the mentally ill sufferers, leaving them with the responsibility for their disease. The media and the psychiatrists are pointed out as the main vehicles of the negative endorsement of these stereotyped visions of the mentally ill, through the psychiatric diagnostic and consequent labeling of the patients. The media often link mental disease with violence or portray mentally ill persons as a risk to society, connoting them as violent, dangerous, criminal and unable to live normal lives. While reporting some tragic news or showing dramatic programs, the media automatically stresses the histories of mental illness behind those news, reinforcing the stereotype around the mentally ill as aggressive and dangerous, which helped to perpetuate the fear among the public. However, in the same way that the media can act as a vehicle for the reinforcement of stereotypes and stigma, they can as also play a proactive and positive role in the promotion of a wider and educational perspective about mental illness. Research findings have shown that negative and stigmatizing stereotypes about the mentally ill can be changed and the public understanding and acceptance of mental illness improved. In the following section I will address the impact of mental illness stigma as a barrier to mental illness treatment and/or recovery as well as a barrier to the enjoyment of a wide range of economic, social, cultural and political rights. Once diagnosed as mentally ill, people are automatically exposed or more vulnerable to discriminatory practices in all dimensions of their lives, for instance, they face more obstacles to find a job, to rent a house or even to have the last decision over their treatment. In contexts of deep economic crisis, such as those experienced in countries such as Portugal or Italy, mental illness and disorders cases have increased quite significantly. It is of general knowledge the harmful effects of this crisis on people’s health and, in particular, on mental health. High rates of unemployment, precarious labour conditions, strong social cleavages and housing instability are one of the main risk factors, leading to high rates of depression, anxiety disorders and suicides. However, it is also in times like these, when people with mental illness requite more protection, that it really lacks the most. Mental health is not taken as seriously as it should despite of the number of people suffering from corresponding diseases. As such, this contradiction needs to be analyzed in order to focus on these persons and their rights.
In the second chapter, I will focus on international human rights law which provides an essential framework for the promotion of mental health. The focus will be put on key United Nations conventions and regional human rights treaties which also recognize, promote and protect the right to mental health, with particular emphasis on the UN Convention on the rights of persons with disabilities (CRPD), considered as a big step towards the promotion and protection of the rights of disabled people in general, including people with mental disabilities. Thus, the right to health is recognized as a basic human right by the International Humans Rights discourse. This right comprehends physical and mental Health and was firstly mentioned in the Constitution of the World Health Organization (WHO) in 1946. Two years later, it is recognized by the Universal Declaration of Human Rights adopted in 1948 and by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR), both adopted in 1966, which together represent the so called, International Bill of Rights. In this context, I will highlight the important role of the World Health Organization (WHO) in the international promotion and protection of mental health, its policies and action plans. According to the World Health Organization (WHO) data, governments budget for mental health promotion and protection are extremely and alarmingly low, with percentages varying from less than 1% of the total budget in developing countries to 5% in well-developed countries. In the last part of this chapter I will describe briefly the main global goals of the WHO’s Mental Health Action Plan for 2013 – 2020, which establishes and provides the foundations for measurable collective action by Member States, such as strengthening leadership for mental health, providing integrated and effective mental health and social services in community–based contexts as well as implementing strategies for promotion and prevention in mental health.

Finally, in the last chapter of the thesis I will also address how Mental Illness Stigma can be challenged by the States and how should they promote the changing of attitudes by preventing stigma and ensuring mentally ill rights. Social Psychology research has dedicated many years to the creation of strategies which could challenge and erase public stigma and discrimination and promoting social inclusion of the mentally ill. Three main strategies will be presented in this chapter: contact, trough the regular interaction between the public and the people with mental illness, contact which is proved to reduce the stigmatization process; education, based on the idea that when society is more informed
about mental illness, its members are less likely to support the myths and discriminate and exclude the mentally ill and, finally, protest, trough the social activism that takes action to stop the discriminatory actions and practices toward these people. The concept of Social Marketing and some examples of Anti-Stigma Programs, campaigns and strategies will be given, as well as the positive role that the Media can play in this context. Finally, I will address the deinstitutionalization process, described as the process by which mental patients are reintegrated in community. In the beginning, deinstitutionalization was seen as a remarkable advance by those who actively defended treatment and care services in community/based settings. If in the past, on the one hand, these patients were often put in cages like animals, chained to walls, suffering several harmful practices, including being beaten, giving them sudden freedom without any backup support had also a very high price for the patients, leading them to the streets, without homes or jobs. Mentally ill persons, if given the adequate treatment and support, can recover fully enough to live fulfilled and productive lives. However, if asked, those who have received treatment for their mental illness will answer that their most their biggest challenge is after treatment, when trying to reintegrate or include themselves in community life. According to several scientific studies, often, even former patients, who had fully recovered from their disease, suffer the effects of stigma until the end of their lives, becoming theirs biggest handicap.
Chapter I – Conceptual Framework

Before starting the analysis of the stigma against mental illness it is important to understand how “madness”, “mental illness” or “mental disorder” were perceived by society and how its understanding changed throughout different periods of history. In this chapter, I will make a brief description of the social and historical approach of madness from Ancient Greece to track its comprehension from the beginning to reach the modern definition of mental illness and serious mental illness. Following this I will point out the most common myths about mental illness and the mentally ill as well as the three types of stigma against mental illness, which are the public stigma, the self-stigma or internalized stigma and the structural stigma. After this, I will address the role of the media and the psychiatric diagnostic/labeling, considered the main responsible for the stereotyped visions of the mentally ill. In the following and last section I will address the impact of mental illness stigma as a barrier to mental illness treatment and/or recovery as well as a barrier to the enjoyment of a wide range of rights.

1. Social-historical analysis of Madness

1.1. Madness in Ancient Greece

In Ancient Greece, Madness was considered a privilege for few and it is origin was regarded as divine. Philosophers such as Socrates and Plato stressed the existence of such a divine madness and used madness (manikê) to designate both the "divinatory" and the "delirious". The privileged had access to divine truths through delirious or hallucinations (Silveira, Lia C. e Braga, Violante A. 2005). Ancient Greeks believed in sacred insanity madness such as “prophetic, ritual, poetic or erotic”, each one inspired by the gods Apollo, Dionysus and the different muses and Aphrodite respectively. However, they
were able to make a distinction between madness of divine cause and madness caused by illness. The victims often believed that they were in touch with a superior being. Menecrates, a physician from the IVth century AD believed that he was Zeus. Quite probably, he suffered from epilepsy, such as many others. Epilepsy was considered sacred because people believed that those who suffered from this disease were possessed. For instance, the double personality also led people to believe that the person was in fact possessed. Epilepsy, paranoia and other mental disorders were believed to be caused also by the demon (Dodds, E. R., 2004).

1.2. Madness in Classical Greece
In classical Greece, the common belief was that mental illness represented the discontentment of the gods. Angry and powerful divinities were represented in dramas and comedies of the time cursing humans with psychotic symptoms, depression or bipolar disease. As a result, people with such symptoms were unable to live a normal life, in accordance with their age and position in life. The devil’s origins of mental diseases were quite expressive in works such as “The Odissey”, frequently referred in Homaro’s age (Dodds, E. R., 2004).

However, in the Classic Age, the authors start to distinguish divine madness from other types of insanity. In the one hand, the “Madmen” enjoyed a particular and quite ambiguous status in society: people in general were afraid and avoided them, but at the same time, due to the belief that they were directly in touch with higher forces or supernatural powers, they were simultaneously respected. On the other hand, Classical Greece not only viewed mental illness a curse or a punishment of the gods, but also as a disease. Contemporaries authors of Plato and Aristotle created and developed sophisticated models of psychiatric illness explained in terms of “physiological or anatomic aberrations”. Hippocrates described “psychiatric behaviours as an imbalance in the humours”, while the second century anatomist, Galen, argued that “relative temperatures of the brain accounted for mental illnesses” (Dodds, E. R., 2004).
1.3. Madness in the Middle Ages
The Middle Ages were deeply marked by the stigma of leprosy, which was widely and quickly spread in space and time. People believed that the lepers were the incarnation of the devil and that leprosy represented the punishment of God. Fear was spread among society and the lepers started to be severely stigmatized and excluded by society. However, when the Crusades ended, the foci of the infection disappeared and, consequently, the stigma associated to it (Silveira, Lia C. e Braga, Violante A., 2005). Some centuries afterwards, the madman replaced the lepers, becoming the new object of stigma and social exclusion (Silveira, Lia C. e Braga, Violante A. 2005). People with mental illness were seen as the personification of the devil or the product of the devil’s intervention. Mental illness was seen as a menace to society, which had to be eliminated before the devil’s would take more victims. This strong belief was particularly visible/expressive in the widespread practices of exorcism, in which the priests believed that they were expelling the demons inside the person trough “an emotional and spiritual war”. Quite common was also the horrific, barbaric practices of burning the person with mental disorders or killing them under the belief that the wickedness of mental illness was being erased (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Some mechanisms were established to simply withdraw the mentally ill from society, because they were not able to adapt to it (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). It was only in the 18th century that the apprehension of the madness phenomenon was transformed, becoming the “object of medical knowledge, characterizing it as a mental illness and therefore capable of cure” (Silveira, Lia C. e Braga, Violante A., 2005).

1.4. Madness in the 18th Century
It is in the “Century of Lights” that madness becomes an object of medical knowledge. The “reason” is considered the only way through which “a man can conquer freedom and happiness” and the scientific thinking occupies and prominent place. It is in this historical context that the hospital appears as a therapeutic and healing space. However, this medicalization of the hospital was not aimed at "positive action on the patient or illness, but simply an annulment of the negative effects of the hospital" (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The hospital space becomes “a world apart,
increasingly alienating the individual from his external relations” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The forced institutionalization of the mentally ill patients parts and is reinforced by the idea that the mentally ill were dangerous and were not able to adapt and live according to society norms. Here the ill person does not have any knowledge about himself or about his disease, the power is totally given to the doctor (Silveira, Lia C. e Braga, Violante A., 2005). In the 19th century asylums looked like real prisons. Considered dangerous, the mentally ill were kept away and locked in small cells or put in chains into the walls. Basic, human, needs, such as food and clothing were not taken into consideration. Sadly, many of these asylums were touristic attractions, where the patients were seen for entertainment like animals in the zoo (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). For example, historians say that Bethlehem hospital in England have received approximately 19,000 visitors in only one year. Despite the attempts to reduce the patients pain, the treatments were far from being effective and, by the contrary, it was a period of barbaric, inhuman practices, such as “bloodletting, opening a vein so that bad “humors” were ejected and replaced by sane fluids” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Other known practice was the “twirling people in a chair, tying them down for excruciatingly long periods, and dunking them in tanks filled with water” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). “Seizure-based treatments” also appeared under the belief that “the extreme chaos of seizures “resets” the brain, yielding normal brain processes”. (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). “Insulin shock and electroconvulsive strategies were prominent examples” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Instead of stemming mental illness suffering, the treatments and the hospitals/asylums where those practices took place remained terrifying during a too long period of time (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

1.5. Madness in the Post-Second World War
It is only after the end of the II World War that psychiatric movements started to call for reforms in the sector of mental health. In many countries, the hospital-centered model started to be put in question as well as the psychiatric medical model itself and its institutions. One example is the Franco Basaglia's experience in the Italian cities of
Gorizia and Trieste, which defended the deinstitutionalization (Silveira, Lia C. e Braga, Violante A., 2005).

"Men are so necessarily mad, that not to be mad would amount to another form of madness."

PASCAL

Before starting the analysis of mental illness stigma and its effects, we need to ask some crucial, basic questions, what is mental health? What is mental illness? How is it defined by modern Psychiatry? Which are the boundaries between Wellbeing and mental illness or mental disorders?

2. Wellbeing
Wellbeing is defined by the World Health Organisation’s (WHO) Constitution as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (World Health Organization, 1946). Quoting the WHO, “Mental health is also seen as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 1946). So, we can say that health implies/entails wellbeing, “There is no health without mental health” (World Health Organization, 2005). According to the WHO Director/General, Dr. Margaret Chan, “many unfortunate trends must be reversed-neglect of mental health services and care, and abuses of human rights and discrimination against people with mental disorders and psychosocial disabilities” (World Health Organization, 2013).
3. Mental illness

Mental illness cannot be defined as a homogeneous figure as frequently/generally happens. It can present different manifestations, characteristics and diverse degrees of severity from one person to the other. In the one hand, some specific symptoms and problems may affect some persons, but do not affect others or are not shared by others. These symptoms may even affect differently personal or social functioning, in a greater or lesser degree. On the other hand, mental illness can manifest and be experienced in a more serious and severe way, with high degrees of incapacity, leading the patient to long periods of hospitalization and more demanding care and treatment. However, mental illness care and treatment has suffered significant improvements by the enormous development and improvement of psychoactive drugs, such as antipsychotics, antidepressants, anxiolytics and other therapies, which led to the improvement of the quality of life and well-being as these patients (National Institute of Mental Health, 1986). Modern research has played a major role in demystifying the causes of mental diseases showing that mental illness, as in the case of many physical diseases, can be caused by biochemical imbalances. “The mentally ill should not be blamed for their condition any more than diabetics should be blamed for having diabetes” (National Institute of Mental Health, 1986). The discovery of this biochemical imbalances has led to the creation and development of treatments which compensate the lack of chemical balances. Using the example of the diabetic, “as long as a diabetic person takes the proper dosage of insulin, that person can live a normal life. It is much the same with mental illness. As long as the victim follows prescribed treatments, that person, too, can lead as normal a life as possible” (National Institute of Mental Health, 1986).

3.1. Defining Serious Mental Illness

According to the American Psychiatric Association (Diagnostic and Statistical Manual of Mental Disorders 2013, fifth edition), serious mental illnesses comprehends the “syndromes in the schizophrenia spectrum, anxiety and effective disorders, eating and personality disorders”. In the one hand, research findings show that serious mental illnesses are caused by “biological processes, Genetics (Pillai, Kalmbach and Ciesla, 2011; Shi, Gershon, and Liu, 2008) or nongenetic risk factors, including in utero insult
(such as illness or substance use and abuse during key developmental periods of pregnancy) or obstetrics complications” (Matheson, Shepherd, Laurens, and Carr, 2011). These causes are defined as “vulnerability indicators”, which, combined with “environmental factors” (Uher, 2013), such as stress and trauma (Rudnick and Lundberg, 2012), creates the illness itself (National Institute of Mental Health, 1986). In the other hand, clinical research defends that the severity and outcome of the mental illness is not only reinforced by its symptoms itself, but also by the “distress, dysfunctions, and disabilities engendered by the disorder” (Anthony and Liberman, 1992; Sanderson and Andrews, 2002; Sartorius, 2009). The authors give the example of those who appear to have less social anxiety disorders, but, in fact, may suffer a worse outcome than those with the so called serious mental illness, like schizophrenia. For example, the intense fear and nervousness which defines their anxiety, blocks them from searching even less demanding jobs, making them unable to live independent lives. However, people who suffer from schizophrenia, can live normal, independent lives, without frequent hallucinations, without suffering, being able to have a career and enjoy a normal family life (Ralph & Corrigan, 2005).

4. Stigma against Mental Illness

According to Corrigan, there are three types of stigma associated with mental illness: public-stigma, which are the society’s stigmatizing attitudes and beliefs about people with mental disorders; self-stigma, meant by the stigma internalized by the stigmatized himself, through the acceptance of the ideas and stereotypes about themselves and structural stigma or institutional stigma, which are the public policies and public and private institutional policies and cultural norms that constrains the mentally ill lives and opportunities (Corrigan, 2005a; Corrigan et al, 2009).

In this chapter these three types of stigma will be described, as well as the myths, misconceptions and negative stereotypes in which this phenomenon is rooted, reinforced and perpetuated by, as well as their impact and harmful effects in the mental health sufferer’s lives, acting as a barrier to mental illness treatment and as a barrier to the enjoyment of a wide range of economic, social, cultural and political rights.
4.1 Types of Stigma

4.1.1. Public Stigma
Merriam-Webster dictionary defines stigma as “a set of negative and often unfair beliefs that a society or group of people have about something” (Merriam-Webster). According to this definition stigma is surrounded by negative and wrong attitudes, towards a specific group. In the context of mental health stigma is defined by Corrigan as “the complex attitude underpinned by negative perceptions about people with mental illness” (Corrigan, 2000). Stigma can also be described as a “mark of shame” or, according to Goffman, an “attribute that is deeply discrediting within a particular social interaction (Goffman, 1967). The World Health Organization defines stigma as “a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society.” (World Health Organization, 2001). Among others, such as race, gender or the socio-economic status, disability represents one of the main the sources of stigmatization (Valdiserri, 2002). According to Witter, “Stigma tops the list” (Witter 2006) in terms of barriers to mental health care. According to this author, the low and inequal importance given to mental health care, in comparison to the general medical care, is another factor that perpetuates the stigma itself (Witter 2006).

4.1.1.2. Myths about Mental illness
Myths and misconceptions are in the roots of this phenomenon. Mental illness is surrounded by different myths deeply rooted in people’s minds, which not only perpetuates the stigma, but also keeps society away from the mentally ill sufferers, leaving them with the responsibility for their disease. In this section I will point out some of the most common ones, dispelled through some evidence-based arguments.
A very common myth is that Mental health issues do not affect children or youth, their problems are usually seen as normal in the growing up process. However, the reality shows that “one in five children and youth struggle with their mental health. 70% of adult mental illness begins during childhood or adolescence, including: depression, eating disorders, obsessive compulsive disorder and anxiety disorders”. “However, 79% of
youth who receive help improve significantly with treatment, which lasts less than 12 sessions for 66% of them” (Canadian Living and Pathstone Mental Health, 2017). Another common myth is that the parents are responsible for the children’s mental disorder. The truth is that “Mental health disorders in children are caused by biology, environment, or a combination of both. They can be caused by genetics or biological factors such as a chemical imbalance or prenatal exposure to alcohol or drugs. They can also be the result of abusive or neglectful treatment or stressful events” (Canadian Living and Pathstone Mental Health, 2017).

People also commonly believe that people with a mental illness are ‘psycho’ and dangerous and should be kept away from society and should be hospitalized. In reality, “most people who have a mental illness struggle with depression and anxiety. They have normal lives, but their feelings and behaviors negatively affect their day-to-day activities. Conduct disorders or acting out behaviors are consistently the primary reason for referral to a children’s mental health agency” (Canadian Living and Pathstone Mental Health, 2017).

Another common myth and deeply rooted in people’s minds is that the people who suffer from Schizophrenia are violent. However, once again, findings indicate that “very little violence in society is caused by people who are mentally ill”. “Unfortunately, Hollywood often portrays mentally ill people as dangerous. People with a major mental illness are more likely to be victims of violence than perpetrators” (Canadian Living and Pathstone Mental Health, 2017).

Another myth is the belief that Depression is merely a sign of a character flaw, laziness or weakness, and so people should easily get rid of it. Research shows that depression is the result from chemical imbalances in the brain or in brain function. The adequate medication or therapy be effective in people’s recovery (Canadian Living and Pathstone Mental Health, 2017). Addictions, which are also mental disorders, are seen by many people as a lifestyle, a choice and a lack of will to change. In fact, findings indicate that addictions can be the result of complex factors “including genetics, the environment, and sometimes other underlying psychiatric conditions such as depression”. People who previously have these underlying vulnerabilities and become addicted, have much more difficulty to overcome the addiction (Canadian Living and Pathstone Mental Health, 2017). Electroconvulsive therapy (ECT), known as shock therapy, is often seen as a
painful and barbaric practice. However, the shock therapy is one of the most effective treatments for those who suffer from depression in such a high degree that the antidepressives simply do not have any effect (Canadian Living and Pathstone Mental Health, 2017). People with a mental illness are also often seen as someone with lack of intelligence. In fact, intelligence cannot be related with mental illnesses or mental disorders. Many people with mental disorders are brilliant and creative people. History has many examples of many famous artists, writers or painters who have suffered from mental diseases. It is a fact, however, that some mentally ill people are not that brilliant or creative, but that happens because disease itself may constraint people’s memory, making it difficult remember specific facts or get involved or socialize with other people, which gives the impression that mentally ill people are cognitively limited. In general, the patterns of intelligence among people with mental illness are very alike or similar to the considered healthy population (Canadian Living and Pathstone Mental Health, 2017).

Many people think that people with a mental illness shouldn’t work because they will affect or impact negatively the rest of the colleagues. However, people with mental illness can and do perform their work as well as the others. It is not expectable that a person with a mental illness will automatically miss more days at work than the others with physical and chronic diseases. “Facts indicate that occupational therapy and work in general support recovery and strengthen the sense of self-esteem by fostering social relationships and economic independence” (Coman, Alina and SAS, 2016). The biggest problem here is the prejudice that these people face to be employed. Many employers simply do not hire a people with mental illness, leading them to a situation of isolation and exclusion that brings them more stress, making it more difficult to recover (Canadian Living and Pathstone Mental Health, 2017). There is a tendency, a trend to generalize mental illness as a “single, rare disorder”. However, mental illness comprehends “anxiety disorders, mood disorders, personality disorders, addiction disorders and impulse control disorders” which belong to many different categories of several mental illnesses, all of them with its own characteristics and causes. “Each mental illness is a variation on the theme of brain chemistry gone awry, affecting things like mood and perception and each has its own specific causes, features and approaches to treatment” (Canadian Living and Pathstone Mental Health, 2017). A very strong myth among is the belief that people with a mental illness never recover. The reality is that medical treatment works. There are more and
more sophisticated and effective treatments and medical research keeps discovering more new treatments. Thanks to these amazing improvements, many people can and almost fully recover from mental illness (Canadian Living and Pathstone Mental Health, 2017).

4.1.2. Self-Stigma

If, in the one hand, the “Public Stigma” have a negative and deep impact in the mentally ill lives, it is also true that the stigmatized themselves react and turn those negative attitudes towards themselves. This process is denominated “internalized” stigma or the so-called “self-stigma”. It can be defined as the actions and reactions of the stigmatized who often accept and relate to the negative stereotypes associated to them (Corrigan, 2005a; Corrigan et al, 2009). During this process, the person tends to lose his sense of self, his identity, which is replaced by the “illness identity” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Lally (1989) first described the process of internalized stigma as “role engulfment” and as the “acceptance of the “patient role” as the primary definition of self” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). This type of feeling is often followed by guilt. People start to search in their life history the reasons why they are in this situation. With the lack of self-esteem and self-confidence, they start to lose hope in their future, losing their motivation to achieve goals and succeed.

The self-stigma has, then, a tremendous and painful impact in this people’s lives, resulting in low self-esteem, lack of self-confidence and loss of motivation to achieve goals and search for help. The person usually perceives herself as a non-worthy person, weird, a bad or dangerous person, not able to care for herself or handle any responsibility. They believe that they are not worthy of help, respect or recognition, leading them to a vicious cycle process of isolation, unemployment and decreasing self-esteem (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). It is important, however, to make it clear that “self-stigma is not a person’s fault; nor is it a part of the person’s illness! If the public did not hold negative and stigmatizing attitudes in the first place, these would never have become internalized, causing people the painful and disabling experience of self-stigma. Thus, while self-stigma manifests itself as a personal subjective experience, it is the consequence of social forces. Eventually stigmatizing attitudes towards people with
mental illness vanish and self-stigma with it” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

4.1.3. Structural Stigma

The effects of stigma, discrimination and social injustice are, then, not only visible in the pain felt by the mentally ill suffers in their daily lives but are also addressed and materialized by Law and have been object of specific laws and legal remedies. “Structural stigmas are the social forces that emerge after many years of public stigma” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). However, the creation of laws which aims the promotion and protection of the rights of persons with disabilities have only occurred in the last decade and its implementation have been too slow. Specific laws about people mental disabilities are even more recent and have been implemented only in the last couple of years (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The way in which these laws are implemented, depend and reflect the States priorities as well as local or lower level perspectives. For instance, the *UK’s Disability Discrimination Act* (DDA), published in 1995 and the *Americans with Disabilities Act* published in 1990, are considered good examples/references of Laws that have established useful guidelines and sets of statutes to address the social injustice resulting from stigma, forbidding, specifically, employment discrimination based on disability.

However, the are other recent examples of these disability protections around the world, including the 2006 UN Convention on the Rights of Persons with Disabilities (CRPD) and its World Programme of Action Concerning Disabled Persons (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). According to these laws, for example, during an application process, the employers cannot make questions about eventual mental diseases of the candidates (nor even physical disabilities) or if they had received psychiatric treatment for that disorder. In the same line, the interviewers are not allowed to make any question about eventual past treatments, neither submitting the applicants to specific tests or other instruments to screen out people with mental illness (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). For the same reason, the employers cannot penalise or exclude a person for a job if, by chance, the person mentions that has
been hospitalized or had receives specific psychiatric treatment. In addition, if a employer finds out, through a third person (for example a co-worker) the previous psychiatric history of the person, once again, he cannot exclude use this information to exclude this person (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). After the admission process, the employers are allowed to ask the applicants to make medical examinations. However, this exam must focus on the functions which are essential for the job, which means that the tests must focus only on the issues that are relevant for the job in question. Once again, however, the employers cannot use the results of this tests to, subsequently, reject a job offer (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). To summarize, we can say that excluding a person for its mental disability constitutes discrimination and a serious violation of the persons rights.

5. Negative endorsement of Mental illness stigma

5.1. The role of the media

It is believed that the media are into a great extent one of the main responsible for mental illness stigma. Television news, programs and newspapers often emphasize the history of mental illness that is (eventually) behind the acts of violence they report. Violent crimes committed by mental patients feed the sensationalist media, which are and more appealing to the public in general and easier to sell. Many television dramas and horror movies also portray mentally ill sufferers as violent or victims of violence themselves, creating stereotypes, which are used by the television producers to induce fear and excitement in the audience. One of the main critics pointed out on televisions is portraying mental illness with danger, without supporting this information in accurate facts and data. However, it is used to strength the myth. Recognizing the power of the media to influence public opinion, they should be responsible to provide a wider and fair approach of mental illness and mentally ill sufferers. According to the National Institute of Mental Health, scientific investigations show that it is unequivocal the mass media influence on society’s behavior towards those who have received mental medical treatment or hospitalization
In fact, “the media usually reflect the beliefs of the public” (National Institute of Mental Health, 1986). Depictions of people with mental illness are still frequent and often represents them as dangerous or inept. On the radio, for example, the host repeatedly mention the words “crazies,” “daft,” “wacko,” or “nutters.” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). In the words of Corrigan et al, “The stigma of mental illness is in the forefront and hurtful” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). There are many other examples of events where the stigma of danger and mental illness is exploited, such as the Halloween or organized tours to psychiatric hospitals. Corrigan et al. mention a sad example that took place in 2007, when the Weston Hospital in Weston, West Virginia, was bought by business man and renamed as trans-Allegheny Lunatic Asylum. Ghost tours were provided and “The Asylum has had apparition sightings, unexplainable voices and sounds, and other paranormal activity reported in the past by guests and staff. Step back in time and see how the mentally insane lived, and lived, within these walls” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Another example given by Corrigan, took place in 2004, when an Insane Asylum Haunted House was advertised for the Halloween, featuring Universal Orlando Theme Parks as the most terrifying event ever and which media kits marketing of included “committal forms and straitjackets for journalists reporting the program” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

5.2. The role of the psychiatry professionals - labeling

Psychiatry is the science responsible for the treatment of “mental, emotional or behavioural disorders”, based on specific diagnoses. Therefore, Psychiatry Labeling can be defined as the practice of screening and diagnose a patient with a specific mental illness (Psychiatry Merriam-Webster). The label is usually one word, such as “conduct disorder” or “ADHD”, which does not correspondent to the symptoms of the disease itself. This practice aims to provide the patients a better understanding of their disease and give them a clear way of how to cope with it and treat it (Timimi, 2014). Another idea behind labeling it is that the patient can more easily identify himself with other patients who suffer from the same disease and find support groups to share their experience. However, if in the one hand, these are both valid arguments, there is little evidence about the positive
consequences that come from such a practice (Timimi, 2014). By thy contrary, stigma is visibly the strongest outcome, which effects I will describe in the following section.

6. The impact of Mental illness stigma

6.1. Stigma as a barrier to mental illness treatment / recovery

Despite the several efforts that have been taken to erase mental stigma at a global level, this phenomenon still severely impacts the daily lives of the mentally ill sufferers, acting as a barrier to the enjoyment of a wide range of economic, social, cultural and political rights and also as a barrier to mental illness treatment itself. A sad reality is that “While individuals can be immunized against specific diseases, they cannot be immunized against stigma” (Petit, Michele L, 2008). Once diagnosed as mentally ill, people are automatically exposed or more vulnerable to discriminatory practices in all dimensions of their lives. The negative outcomes of the psychiatric labeling and the fear of being discriminated and rejected by society often prevents mentally ill sufferers to seek proper treatment and fully recover (Hayward and Bright, 1997). According to Corrigan et al “The threat of stigma, and the effort to avoid the label, are so powerful that more than half of the people with mental illness who would probably benefit from psychiatric services never obtain even an initial interview with a professional. Stigma hurts and it is personal” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). By “labeling” or reducing the mentally ill to the dimension of his disease, the society discriminates and excludes these people, deepening their suffering with its hostile attitudes (Coman, Alina and SAS, 2016). People who suffer with mental illness are not only affected by the burden of their disease, its symptoms and disabilities in social functioning, but are also heavily affected by the double burden of social stigma, and above all – discrimination. For this reason, Stigma is often called “the second illness” (Petit, Michele L, 2008).
6.2. Stigma as a barrier to the enjoyment of rights

At the core of the main problems that people with mental illness have to face, is the public reaction to their disabilities, for example, quite often many landlords refuse to rent a house to a person that suffers from a mental disease or employers reject their applications for a job because of the illness, which denies them opportunities to work, live an independent life and pursue other life goals (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). In 1999, in the USA, Wahl realized a national survey, interviewing more than 1300 people with mental illness and their personal experiences. Wahl found out that discrimination and social exclusion were commonly experienced by these people. The respondents reported that after being diagnosed with a psychiatric disorder or after receiving mental treatment, their friends stopped calling them and neighbors started to keep distance from them, experiencing an increasing sense of isolation and alienation from their community (Chrostek, Anna et al., 2015). Another known nationwide study was conducted by Thornicroft et al., in 2009, over 27 countries and, once again, the respondents pointed out that “making and keeping friends, discrimination by relatives, keeping or finding a job and intimate or sexual relationships” were the main areas where they felt discrimination due to their disease (Chrostek, Anna et al., 2015). Due to the social stigma, persons suffering from a mental illness often experience rejection by their own families and friends, neighbors and employers, leaving them in a complete state of abandonment, loneliness and depression. The denial of a normal and equal participation in family community lives has serious effects in the recovery process itself, not only worsening the symptoms of the disease, but also because professional help is often avoided because of this fear. The social exclusion of people with mental illness also impacts the lives dynamics of the and caretakers, leading them to isolation and a sense of humiliation (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). In the words of Michel L. Petit (2008) “stigma represents a powerful and dehumanizing phenomenon”. (Michele L. Petit, 2008). In addition, these people also see often denied their civil and political rights, such as the right to marriage and to have children, citizenship rights and the right to vote and to participate in the conduct of public life. People who suffer from
mental illness are also particularly vulnerable to human rights violations. According to the World Health Organization, violations can often occur inside psychiatric institutions and services, where the patients are subjected to degrading and harmful care, inhuman treatment practices, poor and unhygienic living conditions and physical and sexual abuse.

According to Corrigan et al “Stigma is not some kind of heady abstraction experienced by an overly sensitive few. It is a social injustice that discredits many people with serious mental illness, terribly harming them in the process” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). In Corrigan’s opinion, the stigma of mental illness is, without any doubt, an issue of social injustice and must be analysed in the same line of other forms of discrimination. “Framing mental illness stigma as absence of social justice reminds us that persons with mental illness are just that: people. As people, they are entitled to the same human rights enjoyed universally in their community and culture” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

7. Recapitulation

Madness was not always considered something negative or even a disease. It evolved from being seen as a privilege, with divine origins, in which the “Madman” had access to divine truths through delirium, to being seen as the result of devil’s intervention or incarnation, or the punishments of the Gods. If in the beginning the “Madman” was respected because of the belief that he was in touch with the “superior forces”, afterwards he was seen as a threat to society, that had to be eliminated, giving origin to practices such as exorcism or the horrific burning and killing of those who suffered from mental illness. Nowadays, despite the development of medical science, mental illness is still surrounded by unfounded myths, stereotypes and prejudice that deeply harm those who suffer from it, the so-called stigma, leading to social exclusion, discrimination and the violations of the most basic Human Rights. The sensationalist news and negative images given by the media about the mentally ill and the psychiatric diagnostic or labeling are considered the main endorsers of such phenomenon.
Chapter II – Mental Health in the International Human Rights Framework

The right to Health is recognized as a basic human right by the International Human Rights discourse. It comprehends physical and mental Health and was firstly recognized in the Constitution of the World Health Organization in 1946, which stated that “The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being” (World Health Organization, 1946). Some years later, in 1966, the International Covenant on Economic, Social and Cultural Rights also recognizes this right in its Article 12, “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (United Nations General Assembly, 1966), imposing the first legally binding obligations upon the States to respect, protect and fulfil those rights.

Some people and groups are particularly vulnerable to Human Rights Violations. Discrimination and social exclusion leads often to mental health issues, acting as well as barriers for the access to medical care services and proper treatment. Mental Health and Human Rights are intrinsically linked. The Human Rights violations that occur in a certain country are proved to have a major impact on the populations mental health. So, we can say that peoples’ s mental health depends on the effective enjoyment of a set of other human rights (Gostin, 2001). In this chapter I will describe the most relevant UN and regional human rights treaties which promote and protect people with mental disabilities rights, with special focus on the Convention on the Rights of Persons with Disabilities (CRPD) and finally the World Health Organization (WHO) – policies and action plans.

1. Key UN and regional human rights treaties

The UN system provides key mechanisms and instruments to the protection of Human Rights. However, it is important to highlight that there are other regional mechanisms and instruments protecting human rights, such as the European Convention for the protection of Human Rights and fundamental freedoms (ECHR), published in 1950, the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or
Punishment, and the African Charter of Human Rights (1982), the American Convention on Human Rights (1978), the Additional protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, the Inter-American Convention on all Forms of Discrimination Against Persons with Disabilities and the Inter-American Convention to Prevent and Punish Torture. The International Human Rights framework is considered a remarkable tool to identify and analyze the structural factors of Health. Under the fundamental premise that all Human Rights are interrelated, indivisible and interdependent (Vienna Declaration and Programme of Action, 1993), the realization of the Right to Health also relies on the realization of many others basic Human Rights, as provided by the Article 25, number 1 of the Universal Declaration of Human Rights (UDHR). Although Human Rights are promoted as universal rights, protecting all society groups, there is a widespread and ongoing discourse around the human rights needs of the specific group of people with psychiatric diseases. The United Nations continuously report gross violations of human rights experienced by this group in all cultures of the world, with varying levels of intensity and severity whether in low or high-income countries. Some specific population groups, such as women, children and refugees, are considered particularly vulnerable to suffer from mental health problems and more likely to see their human rights violated as a consequence of discrimination and marginalization from society, requiring particular attention and even special measures to overcome inequalities and ensure their rights. According to the World Health Organization (WHO), the unequal gender power relationship and its intrinsic inequalities expose women to discrimination in the fields of employment and education and other civil rights and freedoms, exposing them to poverty, domestic and sexual violence and other human rights violations. The combination of such factors is reflected in a higher rate of mental disorders, such as depression and anxiety, among this group. According to the WHO 2001 World Health Report “the traditional role of women in societies exposes them to greater stresses, as well as making them less able to change their stressful environment” (World Health Organization, 2001). Recognizing this fact, the Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, focuses specifically on women’s the right to health. In the case of children and refugees, beyond the International
Bill of Rights, the UN human rights mechanism has the Convention on the Rights of the Child (CRC) and the Convention relating to the Status of Refugees (CRS) as specific legally binding instruments to protects these particular groups rights.

1.1. Universal Declaration of Human Rights (UDHR)
The Universal Declaration of Human Rights (UDHR), published in 1948, by the United Nations, aimed the promotion of international cooperation to respond to economic, social and cultural humanitarian issues, as well as establishing human rights and fundamental freedoms, without any discrimination. In the light of Article 25, number 1 of the Universal Declaration of Human Rights (UDHR), “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.

Despite its non-binding nature, the Universal Declaration of Human Rights (UDHR) is still recognized and accepted has a consensual set of basic human rights that must be protected, and which provisions represent international customary law.

1.2. International Covenant on Economic, Social and Cultural Rights (ICESCR)
The International Covenant on Economic, Social and Cultural Rights (ICESCR) was adopted by the United Nations in 1966, in accordance with the principles enunciated in the Charter of the United Nations which proclaimed that the “inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” and in accordance with the Universal Declaration of Human Rights, the Covenant sets that the ideal of “free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights”, imposing legally binding obligations upon Member States to respect, protect and fulfill these rights. The Committee on Economic, Social and Cultural Rights,
responsible for the monitoring the International Covenant on Economic, Social and Cultural Rights (ICESCR), stresses the need for the Member States to take into consideration the structural factors of health and to adopt the necessary measures to promote the civil, political, economic, social and cultural rights provided in the International Bill of Rights (understood as the combination of the Universal Declaration of Human Rights with the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights) such as the “right to life, food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, non-discrimination, equality, prohibition against torture, privacy, access to information, and freedom of association, assembly and movement”.

1.2.1. General Comment 14
The right to physical and mental health, as previously stated, is recognized as a fundamental human right to be enjoyed by everyone. In the year of 2000, the Committee on Economic, Social and Cultural Rights (CESCR) adopted a General Comment on the right to health, General Comment 14, providing key guidance on the aim and implementation of this rights by the Member States. The Committee states that “Health care services require adequate funding to ensure that health facilities, services and programs, as well as Health care professional and essential medication are available in sufficient quantity” (World Health Organization, 2005). The Committee also highlights the “importance of making Health care services (facilities, goods, services and information) accessible, not only physical but economically accessible to everyone, everyone without discrimination” (World Health Organization, 2005).

These guiding principles are even more relevant when mental health is at the stake. As stated previously, people who suffer from a mental disease are victims of Stigma and discrimination, facing several barriers to the mental health care. The fear of stigmatization leads people to fail in seeking the proper treatment. Therefore, these principles play an essential role in the promotion of mental health.
1.3. International Covenant on Civil and Political Rights (ICCPR)

The International Covenant on Civil and Political Rights (ICCPR) was adopted by the United Nations in 1966. The protection of the rights of people with mental illness is not specifically addressed, but can be subsumed from its Article 2, which forbids discriminatory practices based on the race, color of skin or other states.

It is important to note that, “by virtue of their humanity, people with mental disorders are entitled to all the same basic rights and protections found within the articles of the ICESCR and ICCPR as people without mental disorders” (World Health Organization, 2005).

1.4. Convention on the Rights of Persons with Disabilities (CRPD)

Despite the several human rights conventions to promote and protect the rights of persons with disabilities including, for instance, the UN Global Programme on Disability (which derives from the World Programme of Action Concerning Disabled Persons, adopted in 1982, and the Standard Rules on Equalization of Opportunities for Persons with Disabilities, adopted in 1993), the UN adopted in 1991 the so-called UN principles for the protection of Persons with Mental Illness and for the improvement of Mental Health Care, which already represented the UN growing concern in relation to the people with mental disorders. This growing concern, reinforced by the continuous and worldwide denial of the persons with disabilities human rights, culminated in the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol (A/RES/61/106), on the 13th December 2006, entering into force on the 3rd May 2008. The Convention is, therefore, the result of many years of work by the UN to challenge the attitudes towards people with disabilities, changing the paradigm of seeing disabled people as “objects of charity, medical treatment and social protection” towards seeing these people “as subjects with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society” (United Nations, 2006). The Convention does not comprise a new set of human rights, but reinforces very clearly the States obligations to promote, protect and ensure the rights of persons with disabilities. It not only stresses that the States should
not discriminate against these people but provides numerous steps that States must take to ensure their (equal) rights in society.

The United Nations human rights framework does not contain a specific legally binding international instrument addressing the rights of the people with mental disabilities. However, these people are commonly “considered as part of the larger group of people who are disabled for any reason including physical, intellectual, sensory and psychiatric disability” (World Health Organization, 2011).

In which mental health is concerned, the Convention on the Rights of Persons with Disabilities (CRPD) in its Article 19 - Living independently and being included in the community promotes the full inclusion and participation of people with mental disabilities in community life, including the access to good health care services in a community-based context. This new approach is particularly relevant for the deinstitutionalization process and the development of mental health and social services close to the community. In its Article 12 - Equal recognition before the law, the Convention promotes “the right to own property, to enter into contracts, to manage one's own financial affairs, to marry, work, and retain custody of one's children”, key rights that are often denied to people with mental disabilities, under the assumption that they are not able to take responsibility and make independent decisions about their lives. In the same Article, the Convention states that the “States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life” and, as such, “shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”. Trough the promotion of the rights to participation in public and political life, equal access to education and health and care services, as well as equal work opportunities, among many others, the Convention sets a very important legal framework to erase the discrimination of people with mental disabilities day-to-day lives. According to the World Health Organization, the Convention “represents a major step forward in improving the lives of people with mental disabilities” (Geneva, World Health Organization, 2007). The Convention is internationally monitored by the Committee on the Rights of Persons with Disabilities, composed by independent experts, serving in their personal capacity. These experts are responsible for the reviewing of periodic reports sent
by the States in which they describe the steps they have taken to implement the Convention.

2. World Health Organization (WHO) – policies and action plans

The World Health Organization is the directing and coordinating authority on international health within the United Nations system. Its Constitution was adopted on the 22 July by the International Health Conference and entered into force on the 7 April 1948. The “attainment by all peoples of the highest possible level of health” is set as the World Health Organization’s main objective (Article 1). The right to Health was firstly recognized by the World Health Organization’s Constitution in 1946 (two years before the adoption of the UDHR), defining Health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. According to the World Health Organization “the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (World Health Organization, 1946).

2.1. The WHO Mental Health Action Plan 2013 - 2020

One important comprehensive Action Plan being implemented by the World Health Organization is the Mental Health Action Plan 2013-2020. This plan sets a wide range of actions related to the mental health field that must be taken by Member States, the Secretariat and regional and national level partners, as well as key indicators and objectives to be used to evaluate and assess its levels of implementation and effectiveness. This plan promotes a comprehensive and multisectoral approach, through the coordination of health and social services, with special focus on the "promotion, prevention, treatment, rehabilitation, care and recovery" (World Health Organization, 2013). The plan is drawn under the universally accepted premise that there is "no health without mental health". The action plan follows the work of the World Health Organization mental health gap action programme (mhGAP), which aimed the expansion of services and mental health in "low resource settings". The aim of this global action plan is to provide guidance for the national plans, addressing the response, promotion and prevention strategies to be
taken by social and other key sectors, independently of the resource context. The action plan adopts the term "mental disorders" to refer to "a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems, Tenth revision (ICD-10)", which include serious disorders as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders, including autism. In the cases of dementia and substance use disorders, the World Health Organization sets additional prevention strategies, as those described, for instance, in the 2012 dementia report and in the global strategy to reduce the harmful use of alcohol. In addition to this, the plan includes actions to address suicide prevention and others to address epilepsy condition. The action plan includes a mental health approach, which is defined as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". As described by the Constitution of the World Health Organization, mental health is an integral part of health and well-being, defining health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". According to the World Health Organization, socioeconomic factors are underlying factors of mental health (and health in general), that must be taken into account through the adoption of comprehensive measures and strategies to promote, prevent and treat mental health by the governments. According to the World Health Organization, Health systems in general are not responding to the worldwide mental health crisis, which is reflected in the enormous gap between treatment needs and its provision. The World Health Organization reports show that in low-income and middle-income countries "between 76% and 85% of people with severe mental disorders receive no treatment for their disorder." (World Health Organization, 2013). In the case of high-income countries, this gap is between 35% and 50%, which is also considerably high. Another alarming problem is the lack of quality care for those whose who are being treated. In the Mental Health Atlas 2011, the World Health Organization gives data about the low or lack of resources that countries in general hold to respond to mental health needs, highlighting as well the unequal distribution and inefficient implementation of those resources. "Globally, for instance, annual spending
on mental health is less than US$ 2 per person and less than US$ 0.25 per person in low-income countries, with 67% of these financial resources allocated to stand-alone mental hospitals, despite their association with poor health outcomes and human rights violations" (World Health Organization, 2013); According to the World Health Organization, not only resources and investment are low, but there is also a clear insufficient number of mental health specialists in both low-income and high-income countries. "Almost half the world's population lives in countries where, "on average, there is one psychiatrist to serve 200 000 or more people; other mental health care providers who are trained in the use of psychosocial interventions are even scarcer" (World Health Organization, 2013). However, this gap is even more visible when comparing high-income and low-income countries rates of policies, plans and legislation about mental health, for example, "only 36% of people living in low income countries are covered by mental health legislation compared with 92% in high-income countries" (World Health Organization, 2013).

Taking all these problems and gaps in consideration, the WHO Mental Health Action Plan 2013 – 2020 vision is "a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination" (World Health Organization, 2013). Its global objective is to promote is "to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders" (World Health Organization, 2013).

To summarize, the Mental Health Action Plan 2013 - 2020 main objectives are the strengthening of effective leadership and governance towards mental health; the provision of a comprehensive and integrated response to mental health and social care services in community-based contexts, the implementation of strategies to promote and prevent mental health and, finally, reinforcing information systems, evidence and research in the mental health field (World Health Organization, 2013). The action plan is based on six main principles and approaches, according to which, Health coverage must be Universal,
based on the non-discrimination principle and Mental health strategies, actions and interventions for treatment, prevention and promotion must comply with the *Convention on the Rights of Persons with Disabilities* (CRPD) and other international and regional human rights instruments. The Plan promotes a comprehensive and coordinated response for mental health, which requires a multi-sector partnership between sectors such as "health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation" (World Health Organization, 2013). Finally, the Plan promotes the "empowerment of persons with mental disorders and psychosocial disabilities", that should be "involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation" (World Health Organization, 2013). However, taking in consideration the regional specific situations, the different responses to mental health needs and existing resources between high-income and low-income countries, the Plan needs to be adapted by Member States, in accordance with their own national priorities and specific national contexts. "There is no blueprint action plan that fits all countries, as countries are at different stages in developing and implementing a comprehensive response in the area of mental health" (World Health Organization, 2013).

3. Recapitulation

The right to Health is recognized as a basic human right by the International Human Rights discourse, comprehending physical and mental health. Despite the universal nature of Human Rights, there is a widespread and ongoing discourse around the Human Rights needs of the specific group of people with psychiatric diseases. The International Human Rights system provides then an essential framework for the promotion and protection of the mentally ill rights, providing key guidance on its implementation by the Member States, in which the Convention on the Rights of Persons with Disabilities (CRPD) most stands out. Being considered by the UN as a major achievement for the promotion of
people with mental disabilities rights, the Convention promotes the full inclusion and participation of people with mental disabilities in community life, including the access to good health care services in a community-based context. The World Health Organization plays a key role in the promotion of mental health through their policies and actions plans, that must be implemented by Member States, thanks to which Governments over the world and health professionals from all fields are now more aware of the importance of mental health for the well-being of the population.

In the next chapter I will address the three main strategies and anti-stigma programs developed by research to influence the public understanding and acceptance of mental illness and change its behavior towards people with mental disorders.
Chapter III – Challenging the Public Stigma of Mental Illness

Stigma has harmful effects on people with mental illness lives. In the past 50 years, advocates from all parts of the world have been fighting to end up with public stigma (Corrigan, 2012). Stigma and discrimination are not exclusive problems of the people with mental illness and their families, it implies all society and its rooted beliefs and stereotypes. It’s everyone’s responsibility to reflect on their own beliefs and harmful actions towards these people (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011)). However, research shows that prejudice and negative and stigmatizing stereotypes about the mentally ill can be changed as well as the public understanding and acceptance of mental illness. According to Corrigan et al. there are three main strategies to combat public stigma: contact (the regular interaction between the general public and the people suffering from a mental disease – reducing the former tendency to stigmatize; education (when the general public is more informed about mental illness, are also less likely to believe and support the myths about it); and protest or social activism (when important groups of society takes collective action against discriminatory behaviours) (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). “Although eliminating prejudice attitudes is important, most advocates desire behavior change - quashing discrimination or, viewed more affirmatively, promoting social inclusion” (Corrigan, 2011). Protest strategies or social activism focus on the injustice behind the different types of stigma and punishes the offenders for their stereotypes and discriminatory attitudes, appealing for a moral change in their thinking, “stop thinking that way” (Corrigan, River et al., 2001; Macrae, Bondenhausen, Milne&Jetten,1994; Penn&Corrigan, 2002). However, reality shows that such strategies have little impact in public changing attitudes or can even produce a “rebound effect”, in a way that prejudice does not change or even becomes worse (Brehm & Jones, 1970), such as the simple explanation of psychological reaction “Don’t tell me what to think!” . Education promotes change trough dispatching the myths with facts or evidence about mental illness. In past experiences, such strategies have included “public service announcements, books, flyers, videos, and other audio-visual aids to dispel myths about mental illness” (Pate, 1988). However, if, in the one hand, people who are more informed about mental illness are less
likely to support stigma and discrimination (Brockington, Hall, Levings & Murphy, 1993; Link & Cullen, 1986; Link, Cullen, Frank & Wozniak, 1987). In the other hand, evidence show that these educational programs have short-term impact in the public attitudes improvement (Corrigan, River et al., 2001; Corrigan, Rowan et al., 2002; Holmes, Corrigan, Williams, Canar & Kubiak, 1999; Penn, Kommana, Mansfield & Link, 1999). In its turn, Contact between the stigmatized and the stigmatized groups is considered the most effective strategy to overcome prejudice and mental illness stigma. However, it has more limitations to be applied in a large scale than education. The combination of both education and contact methods is seen as the ideal approach to fight stigma (Rüschi, Angermeyer & Corrigan, 2005). According to a systematic literature review about healthcare, which included 72 studies representing 38,364 researchers from 14 different countries has concluded that both strategies are effective in reducing the public stigma of mental illness. However, “contact has been found to be better than education at reducing stigma for adults, whereas for adolescents, the opposite pattern has been found” (Corrigan et al., 2012).

1. Strategies to overcome public stigma

1.1. Strategy I - contact

Research considers contact as one of the most effective methods to change people’s thinking about mental illness and respective attitudes. The lack of interaction between the public and those who suffer from a mental illness or those who have recovered from their psychiatric disability, promotes and perpetuates ignorance. When the general public interacts with people with mental disabilities who are integrated and actively contributes for the community, stigmatizing attitudes can be challenged (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). One example described by Corrigan are the advocacy groups from the United Kingdom and the rest of the West who have “speakers bureaus within local affiliates”. These “speakers bureaus can hook up with local churches, school groups, civic organizations, and others to share their poignant experiences” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Telling a story is considered more effective when the purpose of the meeting is clear. In a typical presentation of this kind,
the storyteller might be given an hour’s time. “Thirty minutes could be used to present the story followed by 30 minutes for questions and answers, as well as general discussion from the audience” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). According to Corrigan, “rather than focusing on the population as a whole, contact is more effective when it targets key groups, typically people in positions of power, such as employers, landlords, and health care providers” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Other significant Strategic Stigma Change (SSC) target groups are the religious institutions, community leaders, counsellors and the media. Targeting specific groups is very useful because it identifies the “who” of strategic contact and “what” must be changed (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Each objective implies a specific behavior changing, for example, “more employers hires, landlords leases and high/quality health services for people with mental illness (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

1.2. Strategy II - education

Educational approaches identify the myths associated to mental illness, challenging stereotypes trough the presentation of factual information about serious mental illness. Stigma can fall with evidence-based facts (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The family member of people with mental illness can play a fundamental role in the conduction of this type of educational programs. These programs can consist, for example, in “telling one’s story” or, for example, the advocate may use public lectures to provide information about mental illness (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). This kind of program would obviously imply a good knowledge of key features about mental illness, which would add more credibility to the advocate towards the audience. However, the main goal of these education programs is not to provide an extensive literature on mental illness but providing simples facts which dispel the different myths (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Research suggests that deconstructing the myths through education has positive effects on the public’s beliefs and attitudes. When the public is properly informed about the unfounded myths about mental illness, it becomes more open to change its attitudes.
towards people who suffer from it. According to many studies, explaining the causes of mental disorders, such as the chemical imbalances of the brain, in which process the person has little or no control at all, can have significant impact in the improvement of people’s attitudes and reactions towards people with mental disorders. According to Corrigan “One way to do this is to compare mental illness to better-known diseases like diabetes or cancer” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). “You don’t blame someone for taking insulin because they are diabetic!” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). In the United States, the National Alliance on Mental Illness (NAMI), promoted a campaign entitled “Open Your Mind: Mental Illness is a Brain Disorder”. Making use of letter head, pamphlets and bumper stickers, this slogan aims to reach the big public, educating about mental illness. The main idea that these campaigns aim to spread is the fact that mental illness is not a choice. It is not the person fault or responsibility to suffer from it. “It is the unfortunate result of heredity; the person is no more to blame than the individual plagued with cancer!” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). These types of campaigns are very useful for the creation and implementation of anti-stigma programs. They not only highlight the positive outcomes of such campaigns, but also alert for eventual negative responses. In fact, according to some research studies, slogans like “Mental Illness is a Brain Disorder” may have a rebound effect. If, in the one hand, this type of slogan is very effective and may lead people to believe that, for example, a person with schizophrenia is not responsible for her or his disorder, it may also lead to negative prognostications: “people with serious mental illness do not get better because it is hard-wired” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

1.3. Strategy III - protest

Protest or social activism strategies focus on the social injustice behind the different types of stigma and punishes the offenders for their stereotypes and discriminatory attitudes (Chrostek, et al., 2015). Quite often, education fails or does not produce strong or fast effects on stigma changing. Despite all the efforts to change the public’s way of thinking, a significant part of it remains ignorant about mental illness and the mentally ill
dangerousness. Sometimes, opinion leaders and the media continue to portray mental illness in a disrespectful and negative way. For example, quite often, local elected representatives endorse community fears by attributing neighborhoods problems to “those mentally ill homeless” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Other times, films about psycho killers also contribute to endorse and spread stigma about mental illness. Other times, there are some improvements in people’s attitudes, but not in their behavior. For example, people might consider themselves as well informed and open-minded about mental illness, but still discriminates someone with psychiatric disabilities when he or she applies for a job or needs to rent an apartment (Corrigan et al., 2012). Protest actions are especially useful in these cases. Protest targets are significantly different from education and contact in many aspects. While education and contact programs target mainly private attitudes, people’s ideas and perceptions about mental illness, the target of protest is public. For example, protest can be used to punish the advertisement companies that use disrespectful images of mental illness or makes jokes about it to sell their products or when radio hosts are making jokes mental illness as well (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). By its public nature, the protest targets have a wider and more harmful impact, “persons with mental illness are insulted by talk show hosts, children learn disrespectful messages from greeting cards, and people continue to believe myths because of advertising” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The movie industry is an important endorser of public stigma, portraying the mentally ill as dangerous and violent, easily killing someone. Therefore, these and other groups of people who disrespect those who suffer from a mental illness, should be targeted of protest. A very common practice is the use of words like “wacko” and “crazy” by advertisers to sell their products. Television programs and movies often makes use of the “silly” and “crazy guy” figure to make people laugh. Also, some politicians address mental illness in their personal agendas “We need to have gun control because too many psychos are packing pistols”. (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). A big part of employers refuses to hire persons with mental illness and landlords often reject renting a house to persons with psychiatric disorder. Despite being two frequent targets of protests, there are laws which forbids this type of discrimination and that should be also taken into consideration
In conclusion, it can be said that protest has two main components, a “moral message that stigma and discrimination are wrong”, that is usually direct and clear, such as “Your advertisement showing psychosis is wrong. Mental illness is not funny” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011) and a negative consequence or a reaction to stigma and discrimination which discourages similar practices in the future. Often, protest aims to punish those who disrespect mental illness or, discriminates against people who suffer from it, through the “threat” of financial consequences. For example, protest actions aim to discourage the public to buy a specific item sold by a company who use stigmatizing, offensive advertisements (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). This is proved to be an effective strategy since the public is very likely to react very quickly to this type of campaigns. Fearing such economic repercussions, the stigmatizing companies stop their discriminatory actions. However, Corrigan points out that “protest is indicated for stopping discrimination, not for changing attitudes” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). If the goal is to promote people with mental illness employment by changing the company’s ideas about mental illness, protest will not be effective and can even cause the opposite reaction. If the purpose is to stop the use of stigmatizing advertisements or offensive “jingles”, by the threat of decreasing the company’s profit, protest can be more effective (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Protest strategies can assume different forms, depending on the impact that wants to be achieved and different ways can be used to express their dissatisfaction. The activist groups can use private communications with the stigmatizing group or public manifestations of disapproval for the company’s actions, but sometimes this process demands special attention in order to an overreaction. Sometimes, a protest campaign may be very effective through the writing of letters expressing their discontent and the targeted companies can be very responsive to this kind of approaches” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).
2. Anti-Stigma Programs

2.1. Social Marketing concept

Social marketing is a strategy based on commercial marketing theories and technologies and is used by health professionals to spread health messages and promote voluntary behavior change. Social marketing targets specific audiences in order to address social justice and overcome inequities. For example, social marketing has been used to address mental illness stigma and to promote psychiatric care and mental health. The Public Service Campaigns represent the general social marketing plan.

2.2. Public Service Announcements (PSAs) are famous anti-stigma campaigns. In the past, these campaigns consisted in approximately 60-seconds announcements on the radio or on television meant to reach a specific targeted group. Nowadays, these campaigns work through social media, using platforms like Facebook. This kind of effort is key for those strategies which aims to reach the general population, rather than specific groups (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Often, Public Education Campaigns include educational materials based on previous Public Service Announcements, which alerted for the importance of a certain topic and which can be accessed on the internet. For example, Educational materials may include information about mental illness and corresponding treatments. Other times, these materials may include personal stories about someone who suffer from a mental illness and his or her experience with the disease and social stigma (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). Many public services campaigns use websites to redirect the viewers to education campaigns or to redirect them to mental health and advocacy services. Many western countries such as the United Kingdom, Canada and have been developing anti-stigma campaigns of great impact. A very interesting example was the Public Service Announcements (PSAs) and respective materials coordinated by the famous cinema actress Glen Close in 2009. Glen Close was the face of the campaign against mental illness stigma, entitled “Change a Mind About Mental Illness” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The campaign took place in a train station where the actors were wearing “yellow t-shirts, half of them labeled with a mental illness, half
by a related loved one. One man’s yield shirt says “schizophrenia,” next to him in a similar shirt is “mom”. Another reads “posttraumatic stress disorder” partnered with a person whose shirt says “battle buddy.” “Bipolar” with “better half.” Glenn Close has a yellow shirt “sister” standing next to her real-life sister Jessie with “bipolar” on her shirt”. This video can still be accessed in Youtube. The impact of these type of these Public Service Announcements (PSAs), where famous personalities give their face to the cause are huge. The message of Glen Close, “Change a Mind”, was widely spread to the television stations, internet, radio programs, and all types of online and paper news, reaching millions of American citizens (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).

3. Overcoming self-stigma through disclosure and empowerment

Because of the Social Stigma, many times mental illness is hidden by the mentally ill sufferers, contributing for the existing mental illness taboo. Quite often, a person can be fighting against her psychiatric disorder, such as depression, immerse in a deep suffering, without anyone knowing what is happening with her. According to the authors Cass and Cross, in order to overcome self-stigma, these people have to be able to recognize mental illness and admit that they suffer from such a disorder. This process can occur in both private and public levels. Admitting their mental disorder in public may bring several benefits according to the same authors (Cass, 1979; Cross, 1971). First of all, these people experience a sense of relief, not having to hide or be ashamed of who they are. Admitting their mental illness, also facilitates the contact with other people who have the same problems and with whom they can share their personal experiences with the disease itself and stigma. “The more people come out, the more public stigma is challenged” (Cass, 1979; Cross, 1971). In fact, society will understand that mental illness affects a higher number of people than what is expected. People who internalize the stigma or self-stigma, often lost their self-esteem and self-efficacy. Those who believe that can have the control of their treatment, are less likely to internalize stigma (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). According to Clay, among other options, group identification can influence personal empowerment. The affiliation with specific advocacy groups and
its public recognition, not only empowers people, but makes them less vulnerable to stigma and more in control of their lives. The promotion of group identity can be made through “Consumer-operated services”, “including mutual help programs, advocacy training, and drop-in centers” or “programs developed by people with serious mental illness, for people with serious mental illness” (Clay, 2005). Consumer services goals include “personal empowerment and accountability, choice and self-determination, recovery orientation, and spirituality focus” (Clay, 2005).

4. Overcoming the social injustices of structural stigma

As previously stated, “Structural stigmas are the social forces that emerge after many years of public stigma” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The effects of stigma, discrimination and social injustice are addressed by Law and have been object of specific laws, statutes and administrative directives to promote and protect the rights of persons with mental disabilities. The United Kingdom’s Disability Discrimination Act (DDA, published in 1995) and the Americans with Disabilities Act (ADA, published in 1990) provide useful frameworks for addressing the social injustice of stigma. However, this legislation does not force employers to hire people with disabilities, neither establish specific quotas for these people during the application process. Instead, it establishes the premise that “individuals who can complete the essential functions of the job, with or without reasonable accommodation, are qualified for the job” (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011). The United Kingdom’s Disability Discrimination Act (DDA) and the Americans with Disabilities Act (ADA), demands the employers to “accommodate” or “otherwise change a job so that persons with disabilities can complete all essential functions”. The main goal of this legislation is not to give a special advantage to people with disabilities, but to remove eventual barriers that would prevent them from work because of their condition (Corrigan, Patrick W., Roe, David, Tsang, Hector W. H., 2011).
5. Deinstitutionalization

The Deinstitutionalization process is defined as the “release of institutionalized individuals from institutional care (as in a psychiatric hospital) to care in the community” (Merriam-Webster). In the decade of 1960, anti-psychiatry movements around the world radically emerged against the incarceration of the mentally ill patients as a mechanism of social control in society (Rothman 1971). This movements investigated the harmful effects of institutionalization on the individuals personality (Goffman, 1961) and put in question the psychiatric diagnostic assessment itself (Boyd, 2018).

Mental institutions or the so-called “insane asylums” were created to provide treatment, observe and control those who suffered from severe mental illness, confining them to a place where they would be kept away from society. During many centuries, these institutions were the main form of treatment of mental illness. However, they became very known for the inhuman living conditions, barbaric practices and outrageous abuses that occurred within (Boyd, 2018). In the 18th century there were some reforms which tried to improve these conditions and creating safer places, but in the end of the next century the situation of such asylums was indescribably bad (Boyd, 2018). Despite this reality, these institutions were still seen as the ideal places for the mentally ill, under the belief that they could not live and function in society and these were the only places where they could fulfill their needs and receive treatment (Boyd, 2018). In 1955, the introduction of Thorazine in the market, the first effective antipsychotic medication, it became possible to medicate people with severe mental illnesses, such as schizophrenia. This fact had a major impact in the way mental illness was seen by some specific groups of society, culminating in a major social movement called deinstitutionalization, in which a significant number of institutionalized patients were released from the mental hospitals to live within the general population (Boyd, 2018).

However, if in the beginning, deinstitutionalization was seen as a remarkable advance by those who actively defended treatment and care services in “community-based facilities, community mental health centers, halfway houses, psychosocial rehabilitation programs, among others, such change of paradigm had also a very high price for the patients. (National Institute of Mental Health, 1986). If it is true that in the past these patients were
often put in cages like animals, chained into walls, suffering several physical abuses from the members staff, including painful and harmful treatment practices, while living in very unhygienic conditions, giving them sudden freedom without any backup support led them also to vulnerable situations of abandonment in the streets, without any jobs or homes (National Institute of Mental Health, 1986). “Deinstitutionalization, while providing freedom to the mentally ill, can also present them with an unsympathetic, unfair, and hostile society” (National Institute of Mental Health, 1986). In a certain way, “historical physical abuse or neglect has been replaced by a less visible but no less damaging psychic cruelty” (National Institute of Mental Health, 1986). Despite the more humanistic approach to mental illness patients, who are no longer forced to live far away from society, inside the mental institutions walls, nowadays society does not remove them from community, but continues to stigmatize and to exclude them (National Institute of Mental Health, 1986). This new form of social exclusion is seen as a “much more artful though equally debilitating form of ostracism” (National Institute of Mental Health, 1986). In a time of increasing medical sophistication and humanization, stigma and discrimination against mental illness becomes a great paradox. Even former patients, who had received hospitalized treatment and recovered from a mental illness, continue to be discriminated and stigmatized. Sadly, the label of mentally ill never leaves them. If in the one had society in general had improved the way it responds to mental illness, there is still a long way to go (Boyd, 2018). For example, in the case of the United States of America, research studies concluded that for the most part of the population “the two worst things that can happen to a person are leprosy and insanity” (National Institute of Mental Health, 1986). In this country, former prisoners are better accepted by society than former mental patients, seen as much more offensive and dangerous. Apparently, stigmatizing public attitudes towards people with mental illness have changed in the past decades, but they are still very harmful. “People continue to discriminate against the mentally ill, although it may be less socially acceptable to admit it openly” (National Institute of Mental Health, 1986). Discrimination exists in all social levels, among all ages, socioeconomic levels or education levels. Society in general, looks at the mentally ill patients as "fundamentally tainted and degraded" (National Institute of Mental Health, 1986). Even more shocking are the negative attitudes and rejection of the mental
patients by the health professionals, who are trained and paid to treat them. In the 1980 forum on stigma, it was concluded that many "health-care professionals harbor unconscious, unstated negative feelings about their mental patients" (National Institute of Mental Health, 1986). Other surveys from the same period concluded that some psychiatric nurses expressed prejudice against their patients and that the physically abuse of psychiatric patents, by member of the staff, was a very common practice (National Institute of Mental Health, 1986).

This situation makes us think about mental illness stigma and reflect about the main reasons behind it. Some research suggests that the term "stigma is itself the problem. Too strong a word to be useful in describing the full range of reactions toward the mentally ill, discouraging objective thinking about the problem" (National Institute of Mental Health, 1986). Other researchers suggest that "behavior, not a label, is what evokes negative response". They believe that, the more well-adjusted and well-educated a person is, even if he or she had developed a psychiatric disease, but have recovered, the less likely are to be stigmatized (National Institute of Mental Health, 1986). In this researcher opinion, "it is the more or less permanently disabled persons who tend to be the objects of fear and avoidance” (National Institute of Mental Health, 1986).

To conclude, the deinstitutionalization process that was supposed to be a very positive and humanizing approach of mental illness and a very powerful and hopeful way to overcome ostracization and to promote the full inclusion of mental patients in society failed and mental illness Stigma is the reason behind. Without a strong support system within psychiatric circles and family care as an alternative to institutional treatment, it is very difficult to ensure social inclusion and protect the persons with mental disabilities rights.
6. Recapitulation

Stigma against mental illness is deeply rooted in people’s minds. In order to challenge stigma, researchers developed three main strategies and anti-stigma programs to influence the public understanding and acceptance of mental illness and change its behavior towards people with mental disorders. The three main strategies presented are contact, meant by the promotion of regular interaction between the general public and the people suffering from a mental disease; education, through the presentation of factual information about serious mental illness, under the premise that when the general public is more informed about mental illness, are also less likely to believe and support the myths about it and protest or social activism, through the collective action against discriminatory behaviors, punishing the offenders for their stereotypes and discriminatory attitudes. In addition to this strategies, Social marketing and Public Service Announcements (PSAs) are presented as widespread targeted campaigns with recognized results on the public's behaviour change. Finally, deinstitutionalization is described as a powerful way to overcome stigma and to promote the integration of mental patients in society but proved to be inefficient without a strong support system.
Conclusion

Mental illness is not taken as seriously as health in general

Mental health is an important component of a person’s well-being and should be valued and promoted as much as health in general. One of the main conclusions of my research is that mental illness is not taken as seriously as it should and is often underestimated not only by society, but also by those who have the legal obligation to promote the well-being of the whole of the population, the governments. Consequently, I would conclude that one of the biggest problems concerning mental health is not only the impact of stigma but the lack of mental health policies and legislation and the lack of investment in mental health by governments in general. Attesting to this are the findings of the World Health Organization, according to which, approximately 40% of countries have no mental health policies and 64% of countries do not have any mental health legislation or have a very recent one. Whether we talk about a low, medium or high-income country, the government health budget consigned to mental health is disturbingly insignificant, from 1% to 5%, respectively. In my opinion, the low and inequal importance given to mental health care, in comparison to the general medical care, is an important factor that not only worsens public mental health but contributes to the perpetuation of mental illness stigma. The gap between the percentage of people who suffer from a mental disorder and the percentage of people who effectively receive the needed treatment is huge and alarming. This is even more poignant if it is bear in mind that the number of people with mental disorders worldwide is increasing exponentially and, of these mental disorders with a staggering growth, depression is leading the list. The existence of more than 300 million living with depression is a sad and disturbing reality that urgently needs to be analyzed by health stakeholders. The world is facing a mental health crisis and health systems in general are not responding in accordance. Another major problem is the lack of access to good quality mental health services experienced by people with mental disabilities in every part of the world, and when these services and facilities do exist, they are often provided through the confinement of these people into psychiatric institutions, often associated to inhuman treatment practices and
degrading and poor living conditions. In my opinion, mental health treatments and programs must take place in a community-based context that fosters the proximity of those suffering and communities. The process of deinstitutionalization must be encouraged. Non-segregation is the only way to achieve full inclusion and integration of people with mental disabilities in society. However, taking people outside the psychiatric institutions, without the right backup support, can lead them to even worse life situations, such as homelessness, marginalization and poverty. Because of the existing stigma, society must be prepared and specific conditions have to be ensured by the states to facilitate the inclusion of these people in society. Mental health policies and laws must promote the autonomy and liberty of people with mental disorders, preventing human rights violations and discrimination. The States must adopt appropriate mental health policies, laws and services that protect these targeted and vulnerable people most fundamental rights, but also that empower them to make choices about their own lives, ensuring their full inclusion and participation in the community life.

**Mental illness stigma is a product of society**

Mental illness stigma is a product of society, not the result of disease or disability, neither a flaw of character of people with mental illness. Treating the symptoms of the disease is in the hands of the patients and their specialists, but overcoming stigma is in the hands of policymakers and society as a whole. It is everyone’s responsibility to rethink their own beliefs and harmful actions towards people with mental illness. Society cannot shut its eyes to such a problem that affects a significant part of the population, even if is not as visible as it should be. We cannot underestimate the power of stigma. People must realize that mental illness can affect anyone, at any time of their lives. No human being is immune to such problems. Combating stigma and discrimination is dependent of a government’s strategy and action but it cannot be placed under its sole responsibility. In order to achieve successful outcomes, a multi-sectoral approach must be followed, involving other sectors, namely, education, employment, welfare and justice. Only through the combined efforts of professionals who work across these diverse areas will it be possible to introduce change in society. Health professionals, non-governmental
organizations, schools and universities, professional organizations, advocate groups and families should get involved and take collective action towards the promotion of mental health and changing public attitudes towards mental illness, fighting for the rights of people with mental disabilities.

**Stigma can be challenged**

The combat against mental illness stigma is not an easy or a short-term process. Despite all the efforts made by the international human rights mechanisms and institutions, such as the World Health Organization, there is still a long path to follow. Mental illness needs to be demystified and in order to reach this endeavor successfully, raising awareness and proper educative campaigns have to be put in place. As I mentioned in the third chapter of this thesis, according to recent studies, prejudice and negative and stigmatizing stereotypes about the mentally ill can be changed as well as the public understanding and acceptance of mental illness. Different strategies can be implemented to combat stigma against mental illness, such as contact, education and protest. However, these strategies have different targets and different levels of impact. One strategy, by itself, is not effective enough and may even generate rebound effects on the public reactions, but the combination of contact and education would be the most effective way to challenge and overcome stigma. Mental illness needs to be discussed in a clear, transparent way. Keeping the taboo will keep the stigma, as it happens with many other types of discrimination.

**A human rights-based approach must be followed to combat stigma against mental illness**

Mental illness stigma and discrimination are unquestionable human rights issues. The human rights framework, addressed in the second chapter of this thesis, represents a very useful tool for identifying and analyzing the structural factors of mental health. The United Nations human rights mechanisms and specific instruments representing a set of values and principles, universally accepted, are not only important guidelines for the creation, implementation and evaluation of mental health policies and laws by the States,
but also a useful tool for its assessment and promotion. Human rights empower people and their communities, granting or fighting for these rights and imposing legal obligations to the governments. They not only aim to ensure an equal distribution and balance of power, but also help to mitigate the lack of power of the most vulnerable groups. Equality and freedom from discrimination are vital principles of the international human rights framework, which calls special attention to the rights of specific vulnerable groups, such as those who suffer from mental illness. However, I consider that human rights’ activists must take a more proactive action to combat stigma. Human rights can use education and protest strategies as a powerful tool to raise awareness and educate people about mental illness and stop stigma. By combating stigma, we aim at retrieving, or, at least, alleviate, the barrier that stands between persons with mental illness and the full enjoyment of their human rights. This is one approach to be followed to address the consequences of negative attitudes towards these people, but the problem can also be targeted from a different standpoint, that of its root causes. There is a broad consensus about the deleterious consequences of economic crises on mental health, particularly on psychological well-being, depression, anxiety disorders, insomnia, alcohol abuse, and suicidal behaviour. In times of economic crisis, the emergence or increasing rates of unemployment, indebtedness, precarious working conditions, inequalities, lack of social connectedness, and housing instability are a constant. These risk factors then emerge as the main triggers to mental disorders and, hence, addressing the main causes of the situation people with mental illness find themselves into plays a tremendous role in the protection of their rights.
Bibliography

Books and Articles


Reports and Documents


Legal Documents
United Kingdom Equality Act of 08 April 2010 adopted by United Kingdom Parliament


World Health Organization, Constitution of 22 July 1946 adopted by the International Health Conference

Websites

Mental Health Foundation https://www.mentalhealth.org.uk/

Pathstone Mental Health https://www.pathstonementalhealth.ca/

World Health Organization: http://www.who.int/
The stigma against mental illness: public myths and policy failures as barriers to the protection of persons with mental disabilities

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