Psychiatria Danubina, 2014; Vol. 26, Suppl. 1, pp 195–205 *Conference paper*

STRATEGIES FOR THE PREVENTION OF STIGMA IN PSYCHIATRY: PERSPECTIVES ON LOCAL PSYCHIATRIC REHABILITATION

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SUMMARY

The author, along the many years of her experience about psychiatric clinical cases on the community work, has acquired expertise in the field 'psychiatric rehabilitation and prevention of psychological discomfort or psychiatric disorder. Particular attention she and har team have always put the issue ok killing of the stigma and prejudice about mental illness, also through an invilment of the general populazion, school and etc. Her Experiences has shown that all of the strategies, as well as drug therapies and psycoterapies, improve recovery.

Key words: *stigma – prevention - rehabilitation in mental illness - recovery*

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INTRODUCTION

Psychiatric care in the local community (community care) is synonymous with growth and respect of rights (empowerment) of people who suffer from psychiatric disorders (Amorosi 1995, Amorosi 1994, Amorosi 2002, Amorosi 2005); it results in the gradual development of an extensive network of services in the individual geographic areas (Amorosi 1995, Amorosi 1996, Amorosi 1996)

As a comprehensive strategy, mental health care in the local community translates into:

- services closer to home, including wards in general hospitals for acute episodes and including long-stay residential facilities;
- interventions designed to reduce the disability and not just the symptoms (Amorosi 1994, Amorosi 1996, Amorosi 2004);
- treatment and care in relation to the specific diagnosis and needs of the individual (Amorosi 1996, Amorosi 1988, Amorosi 1994, Amorosi 2003);
- a wide range of services to meet the different needs of people with mental disorders;
- services based on the ability of coordination between mental health professionals and other health and social agencies in the local community;
- mobile, not static, services: i.e. able to provide care at home;
- collaboration and cooperation (partnership) with family members (carers), keeping in mind their needs;
- government directives to support these strategies.

This form of assistance is not a simple organizational solution, but an overall strategy, which is based on some basic principles:

- the ability to formulate an accurate diagnosis and provide early intervention (to prevent the development of less reversible forms of disability);
- continuity of care (with the full involvement of family members, users, operators of general medical services);
- the provision of a wide and diverse range of services;
- a relationship of collaboration and partnership with patients and their families;
- the ability and active involvement of the local community;
- integration with primary health care.

To avoid the stigma and promote normality (Amorosi 1994, Amorosi 1997, Amorosi 2004, Amorosi 2008, Amorosi 2008, Amorosi 2007, Amorosi 2006, Amorosi 2006, Amorosi 2005, Amorosi 2006):

- A good community psychiatric service is virtually invisible.
- The residences for patients who are in need of accommodation are protected deliberately and are indistinguishable from the neighboring houses.
- The mental health centers shall be located in buildings in the area of competence without anything that may enable them to be identified from the outside.
- Psychiatric professionals do not wear uniforms.
- Recently, many campaigns have been organised to combat the stigma and prejudice about mental illness. This objective has also been a priority on the agenda of the Ministry of Health and the Regions.
- So far, however, none of these campaigns attempted to explain to people and the media, that it is about community care.
- We, who have sponsored and organized community care, have a duty to facilitate social integration and employment of our patients and raise the profile of our services.

- Therefore it is necessary to organise a serious campaign of communication and information, so that patients, their families and ourselves are able to cope with a more restrictive psychiatric legislation perhaps induced by the need to deal with an ill-informed public.
- The Ministry of Health has decided to implement in the field of mental health, one of the general objectives of the NDP 2003-05, the first communication campaign for the fight against exclusion of people with mental disorders.
- For this campaign, the Ministry has implemented the communication strategy followed previously for other themes, which provides a synergistic relationship between associations and institutions. Associations of volunteers and patients representatives have been called to participate actively in nationally in this campaign.

Objectives (Anthony 1990, Amorosi 1987, Amorosi 1994, Amorosi 1994, Amorosi 1997, Amorosi 2008):

- inform the public about the possibilities of care and access to services;
- make more effective and homogeneous local initiatives;
- combat the social stigma of mental illness, exclusion, prejudice and discrimination against the mentally ill;
- the meeting in Strasbourg suggests to assign priority to the assistance of vulnerable groups such as persons with serious mental illness, the chronically or terminally ill, the disabled, prisoners, ethnic minorities, the homeless, migrants, temporary workers and the unemployed;
- MEPs want the employers to introduce mental health policies in the workplace, and that any future strategy gives priority to the struggle to overcome stigma;
- for example by organizing annual campaigns to combat ignorance and injustice that lead to social exclusion of patients;
- to improve their conditions, in conclusion, Parliament must ensure that the sick have basic social and civil rights: the right to housing, economic assistance to those who can not work, marriage and the management of their assets.
- the challenges for the next five to ten years to come, will consist in developing, implementing and monitoring policies and laws that will result in actions so as to improve the welfare of the population, to avoid the problems of mental health and encourage integration and develop opportunities for people suffering from such problems.

The priorities for the next decade were, therefore, summarized as follows (Amorosi 2006, Amorosi 2005):

1) have a better understanding of the importance of mental well-being;
2) fight together against stigma, discrimination and inequality; involving and supporting those who are afflicted with mental health problems and their families, so that they can actively participate in this process;
3) plan and implement comprehensive mental health systems,which are integrated and efficient, which include the promotion, prevention, treatment and rehabilitation, treatment and social reintegration;
4) give an answer to the need for competent and effective interventions in all these areas;
5) recognize the experience and expertise of patients and their carers (family member, friend or any other person acting in a personal and private capacity), drawing ample food to plan and develop services.

Fighting against the stigma and discrimination means (Amorosi 2008, Amorosi 2005):

- Promoting community interventions articulated on different levels (awareness campaigns aimed at the public mobilization of personnel involved in primary care and local level participation of trainers and facilitators such as teachers, priests, representatives of the media, etc.).
- The development and implementation of policies on mental health should not be penalized by prejudice against mental health problems, which are very common and tends to become true discrimination.
- Very often, such discrimination is at the root of the disparity of opportunity suffered by people with mental illness.
- In that respect human rights and the respect of those who presented this type of problem are the values that should be protected.
- Empowerment is a crucial step towards the realization of these goals, to the extent that it allows a better integration and a more successful social integration.
- Failure to assign responsibility to the structures that represent patients and their entourage, as well as insufficient awareness, constitutes an obstacle to the development and implementation of policies and actions aimed at the needs and aspirations of these people.
- The exclusion of which users of mental health services are victims, whether in judicial psychiatric hospitals or in non-hospital environment, has to be fought in different ways.

It is therefore necessary to (Amorosi 2006, Amoosi 2008):

1) Encourage efforts to fight stigma and discrimination, focusing on the wide dissemination of mental health problems, that their outcome is generally favorable, the existence of processing and the fact that these problems rarely are accompanied by the violence.

2) Adopt legislation on the rights of persons with disabilities, or revise the existing one, so that even mental health is listed in a fair and equitable manner.
3) Develop and implement, at national and sectoral level and within enterprises, policies aimed at putting an end to stigma and discrimination present in today's norms and behaviors regarding their use.
4) Encourage the participation of residents in local mental health programs by supporting the initiatives of non-governmental organizations.
5) Develop a coherent program of policy and legislation aimed at combating stigma and discrimination, by including the international and regional standards in the field of human rights.
6) Establish a constructive dialogue with the media, keeping them informed.
7) Setting the standards for the presence of patients, family members and non-professional care-givers ("carers") on committees and groups responsible for planning, implementation, evaluation and monitoring of actions in the field of mental health.
8) Encourage the creation and development at the local and national level of non-governmental organizations run by patients, who represent the patients, their carers and the communities in which these people with mental suffering live.
9) Encourage the integration of children and adolescents who experience disability caused by mental health problems, into the normal school system and the teaching profession.
10) Give vocational training to those who have mental health problems and adapt workplaces and professional activities to their needs, with the aim of ensuring their regular input into the labour market.

Figure 1. Nobody helps me after so many years in a mental hospital, the municipality and the USL I was refused the aid, disabled 100 \100 (Amorosi 2009)

Figure 2. Released from the asylum, abandoned, without subsidy, no care, no one helps me, am invalid 100 % Help Me; thanks (Amorosi 2009)

Stigma is a challenge for the psychiatric professional, not only due to injury to the patient, but also due to injury to the psychiatrist.

Shrink, acchiappamatti are just a few epithets, and among the less strong, referring to the 'crazy doctor'. (Amorosi 2005, Amorosi 2006, Amorosi 2009)

With the change of culture many prejudices have fallen and mental barriers are soft, but the weight of ancestral taboos still falls on all those involved in the field of mental health both on patients and families.

The constraint of the injury is wrapped in a spiral around the participants in the relationship, sometimes with features of wraparound slings which are so narrow as to become nooses. Here are Demonstrated some underlying dynamics and are suggested strategies and models for attempting to overcome them.

Only 10% of people who have psychiatric disorders in a year are treated in psychiatric services. This is significant, especially when you consider that 20-25% of the population aged over 18 years in the course of a year suffers from at least one clinically significant mental disorder. Is psychiatric care considered effective? Not really. The answer is the stigma, which is the brand, the scar that characterizes the mentally ill and is projected on to the social group to which they belong. Stigma becomes one of the main obstacles to programs of treatment and care of psychiatric patients, who continue to remain ghettoized and discriminated against because of insanity of which we are ashamed.

The problem of stigma and stigmatization derives from the social and relational aspects of psychiatry.

It happens that psychiatry, as well as other medical disciplines based on truth, is influenced by prejudices old and new.

These prejudices obscure and demean not only the people who suffer, but also the GP, the therapeutic objects, even the healing modalities, with possible cascading effects (Amorosi).

The rest is not imaginable without psychiatric social references and cross-references.

Indeed psychiatry is probably the area of medical science in which it is particularly clear that environmental factors play an important role, often not inferior to that of biological factors in explaining the genesis, course, outcomes and results of treatment of various forms of psychological distress.

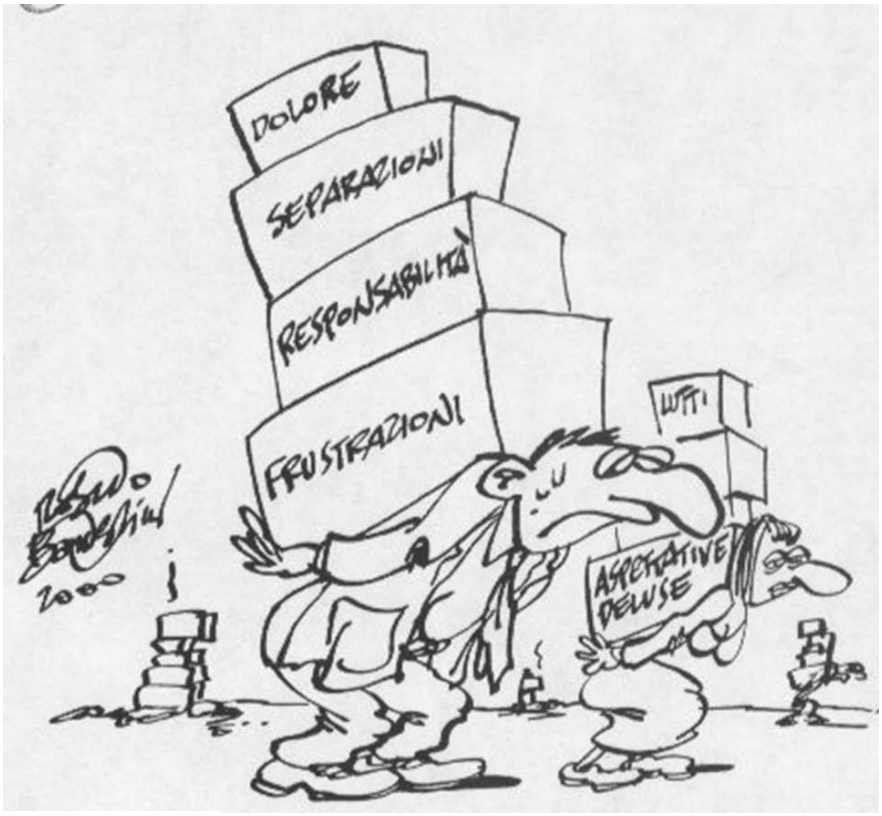

Figure 3. The Burden of Mental Illness

Figure 4. Incurability

Figure 5. Organicity

Figure 6. Dangerousness and incomprehensability

Figure 7. Campaigning against stigma

Strategies to combat stigma

During my service as director we have firmly believed that:

1. To combat the stigma: we need a strong team;
2. Campaign Against stigma: the injury and mental illness (Amorosi 2003, Amorosi 1994, Amorosi 1996, Amorosi 2005, Amorosi 2006, Amorosi 2009).

Since 2001, when I was entrusted with the direction of a Unit Complex ofl DSM Pescara,we have begun a project which went forward step by step, of removing the stigma against mental illness, and the injury which even in those years weighed on the people with mental illness. This heavy bias, which is the socio-cultural heritage of the old custodian culture, still accompanied the people with mental illness who, because of shame and fear, were somehow hidden and could not find space for the free expression of the person.

Closed, inhibited, blocked, these people lived in the shadows and on the margins of their families and society, convinced of not having any other law than that to survive (Amorosi:2006).

The introduction of new ways of thinking about mental illness, shared up in groups, the use of new drugs, which are less robotizing and also with fewer side effects on cognition, the initiation of participatory methods for interacting with the users, their families, the extension of the right information to the entire population, including the student population through activities involving the population, were the first steps that the NEW service has taken in the declared direction of reduction of mental social barriers .

The staging of a play including users, included in the bill of the summer evenings in the city, for the whole city in the first year of the new service provoked an overwhelming positive response.

This was followed by more and more activities involving other groups:

- kitchen tasks with well-known chefs in the area;
- music activities with the formation of singing groups of mixed composition including operators-users-citizens (Amorosi 2004, Amorosi 2006, Amorosi 2005);
- activities of chess with the chess team who are European champions (Amorosi 1997, Amorosi 2004, Amorosi 2007, Amorosi 2006);
- soccer Activities (Amorosi: 2003, Amorosi 2006, Amorosi 2005);
- motor activity, dance with qualified instructors and together with young persons (Amorosi);
- sharing activities in schools (Amorosi);
- educational travel trips with more and more challenging destinations (Amorosi 2003);
- job placements (Amorosi 2006, Glenn 2004, Davidson 2009).

Once he has re-appropriated his identity as a Person, a mental health patient is indistinguishable from any other person.

After only briefly mentioned the change wrought in the services, a speech requires a more in-depth look its ways of working.

Psychiatric rehabilitation is based on the assumption that the patient, despite the fact of the psychological distress and disability caused by the disease, can develop and \ or regain lost capacity to enable him/her to integrate into community life and retrieve roles most suitable to the individual being inserted within his/her family and social relationships and networks.

The rehabilitative includes (Amorosi 2005, Amorosi 2006, French et al. 2009, Amorosi 2012):

- Identification and development of internal resources and skills that each individual has despite his/her disability, starting from the identification of their needs (via the PRITT introduced in 20121\12 in Pescara DSM), in order to promote growth, recovery or the achievement of security and self-esteem.
- Reduction, through the identification of specific media, of the impact that disability has on everyday life.
- Development of environmental resources (external resources) in ways that amplify and reinforce the intervention carried out on the individual.

A key aspect in the recovery and social insertion of people with mental distress is the possibility of a work placement and defining a social role.

However, the chances of finding any kind of work for people who in their lives have suffered from mental illness are rather scarce and in some cases non-existent.

This happens for both internal factors (insecurity about their overall deficit disorder and their self esteem resulting from their experience, often repeated, of bankruptcy and social withdrawal) and external factors (stigma, research productivity in the labor market, lack of attention to the work of the disadvantaged, despite the legislative incentives).

In theoretical terms, the importance of work integration for persons with psychiatric disabilities is supported by leading experts in the field of Psychiatric Rehabilitation (J. Fallon, M. Spivak and others).

Psychiatric rehabilitation aims to increase the articulation of individuals through social learning and the use of those skills (intrapersonal, interpersonal, and instrumental) that enable the individual to respond in an appropriate and adequate way to their demands and their own needs and those with whom he lives.

Therefore, Psychiatric Rehabilitation is intended as a re-acquisition of social roles available in the contexts of life outside of psychiatry, so that people meet their career aspirations, housing, achieve other objectives, such as the positive experience of the self in interpersonal relationships, and the killing of mental barriers and prejudice against them.

Work experience is also not only gratifying in the economic aspect, but because it promotes the development of coping skills in relation to symptoms, increases personal effectiveness, redesigns lifetimes normalizing lives by inclusion in the community.

In DSM of Pescara, for years, in the use of resources made available by the Abruzzo region with the law 94\00 "establishment of labor exchanges in favor of psychiatric users" we have successfully organised work experience for 61 users who were referred to local services by the dsm which provides their treatment.

In addition, 45 scholarships have been set up to provide other work (activities "former harmony" law n.662/1996 article 1 paragraphs 34 and 34) for a total of 106 users for the ASL Pescara.

The number of scholarships for clients working until 2011 in our DSM, was however, limited to the point that the turn over that could allow others to take advantage of this experience was not possible, nor is the simple solution for users to need to understand that, having benefited from the work available successfully and with considerable improvement of the clinical picture and the quality of their life, the aim of this placement was to move on and make room for others.

The users, who are themselves participants, consider such work essential to their well-being, being a source of productivity, social relations, giving structure and meaning to their day and enhancing their autonomy.

Ultimately the job, as for everyone else, can only be a project for life.

In addition, one should not underestimate the medico-legal implications of having to discharge persons from an effective therapeutic-rehabilitative placement to achieve a turn over at all costs.

Starting from these premises, in the role of director in the years indicated dsm with effect from 2011, I have worked to try to offer a solution to this problem.

One solution has been to share these problems with the partners of DSM

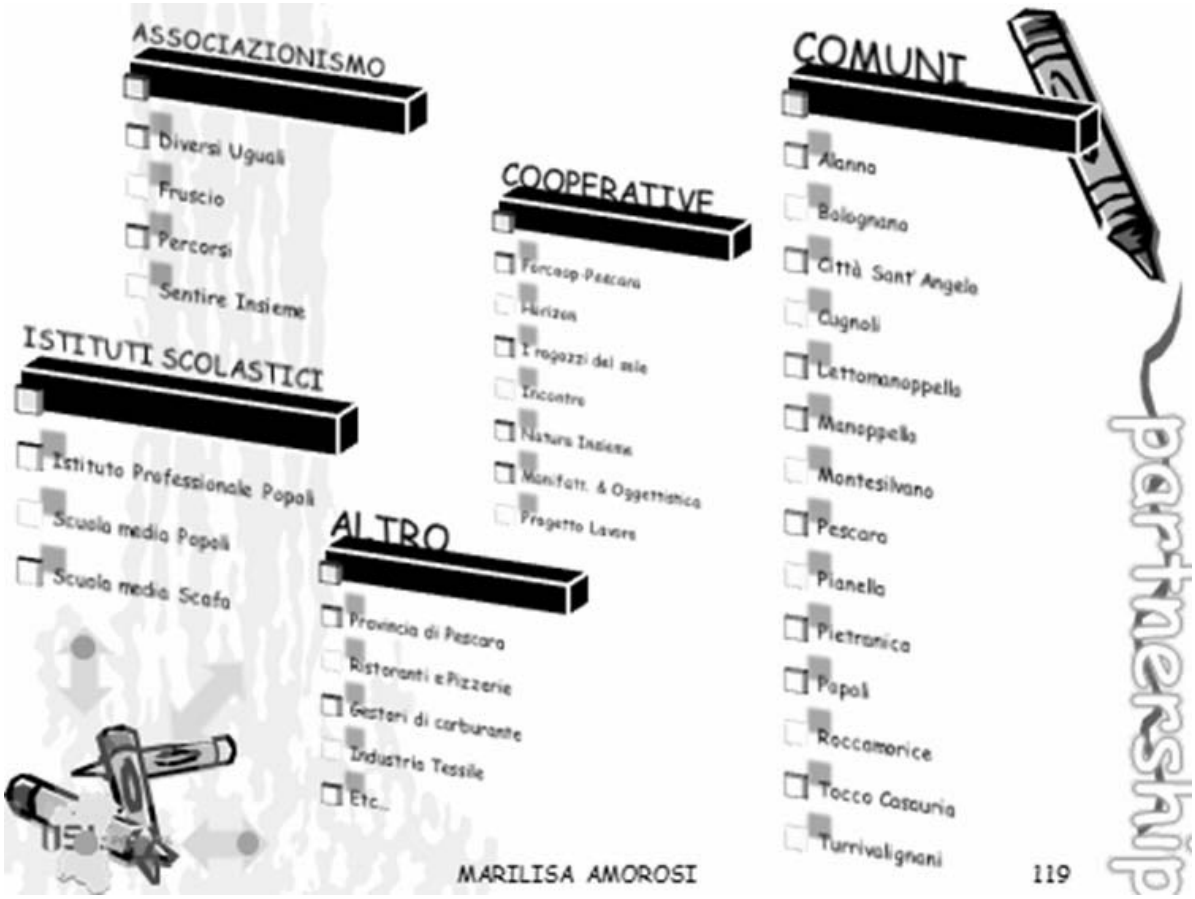

Figure 8. Inter-Agency Collaboration

With their valuable support and agreement it has been possible to enter another 17 users into work at no extra charge except that which is given to the users.

A second approach involved the proposed activation and support to cooperatives of type b.

I considered, in fact, that according to the law, the only job opportunities and work experience so far disbursed and protected by the institution of the dsm could only be those created by the activation of social cooperatives, namely cooperative societies, regulated by law 08\11\1991, no. 381.

This law provides that cooperatives are defined as enterprises that are born with the aim to "pursue the general interest of the community to promote human and social integration of citizens." This goal is pursued through the management of health services and education and conducting various activities-agricultural, industrial, commercial or service-aimed at providing employment for disadvantaged people.

We consider social cooperatives:

1 - type: those who manage health and social services, education and training, which are governed by the regulations, regional plans and programs in the field of social and health services and educational welfare (a) of paragraph 1 of Article. 1 of Law 381 \ 91)

2 - type B: those which carry out activities aimed at providing employment for people disadvantaged in accordance with subparagraph b) of paragraph 1 of Article. 1 of Law 381\91)

Thus were launched so the rehabilitation project of the DSM Pescara called:

"Activation-job training type social cooperatives b", which aims to promote activities aimed at providing employment for 40 patients who are followed up by the DSM (10 for each CSM) so the activation of social cooperatives of type b ffectively covers them in order to provide continuity of work and release automatically placed in BL.

This project, shared and appreciated in the institutional tables, has been entrusted to the associations that collaborated for years with the DSM, under the supervision of the same dsm.

For association has been entrusted with 10 users within the CSM catchment area.

In this way, today 176 users of the DSM benefit from sustained work, as you can see in the figure 9.

The project of birth and support in this activity, in the context of mental health, although already widely tested in other regions, is totally new for our region: the distinguishing feature is that users are members of cooperatives, making them directly involved in a project to life.

The health benefits are well documented and the experience of the three cooperatives prove it!

Now a year has passed and the co-SM1-SM2 SM3 are fully functional.

Figure 9. Use of Collaboratives within the Pescara Region

Now we need to support them!

We can not accept the fact that these activities, consider entrepreneurial, can record a favorable balance after only a few months after birth.

And in fact, the project provided a phase of support that has not yet been activated.

For this reason, I consider it necessary on this occasion to urge the bodies and institutions not to deny the support to these cooperatives

In this way we can expand further the number of psychiatric patients who benefit and achieve real social inclusion.

In addition to the support for this initiative work wenote the criticism that, recently (July 2013), the European Court of Justice has levelled against Italy for failing to put in place all the necessary tools to ensure access to employment and professional development of people with disabilities!

The court, in fact, pointed out that Italy was the European country with the lowest percentage of disabled people admitted to the working world (16% of all disabled persons against 49.9% in the rest of Europe).

Ultimately, in my opinion, is time to take a further step forward in the total abolition of the stigma, through the provision of innovative and more advanced services.

PLEASE, take a step forward!

Acknowledgements: None.

Conflict of interest: None to declare.

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