Are psychiatric patients victims of discrimination with regard health and social rights?

An exploratory study: the views of key informants in 17 countries

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Abstract

Objectives

To identify the perception of health professionals (HPs) about the practice which undermine the rights of people suffering from mental illnesses (PSMIs) throughout the world.

Methods

A self-administered questionnaire was submitted to health professionals through public health training networks. The respondents (n=76) are from 17 countries and 4 continents. Sixty percent are male. Nineteen and a half percent are non-psychiatric doctors and 13,5% are psychiatrists.

Results

In the area of healthcare, 72% of the respondents on average consider that PSMIs are victims of practices like being locked up, physical violence, rationing of care, seclusion within care facilities - either regularly or systematically - against 42 % regarding other patients ($p<0.001$).

Outside of care facilities, 60% of the respondents note that PSMIs are subject to serious attacks on their rights as compared to the general population.

For 80% of the respondents, the emergence and re-emergence of these practices are attributable to: the economic, social and political contexts of the countries; a lack of clear policies in the area of the mental health, the role of traditions and culture, as well as the lack of protective legislation on the rights of PSMIs. For nearly 50% of the respondents, the underprivileged social status and lower economic level of people suffering from mental illnesses encourages the violation of their rights.

Conclusion

The study shows that HPs are aware of the discrimination and stigmatization that PSMIs are more often victims of within as well as outside of care facilities. The recognition of the existence of these practices by HPs, the identification of the causes and risk factors can contribute to the elaboration of policies and action plans aimed at the protection and promotion of human rights in the area of mental health.

Key words: Mental health, human rights, violations of rights.

Background

People suffering from mental illnesses (PSMIs) are among the most stigmatized, discriminated against, marginalized and vulnerable in society [1-3]. Health professionals (HPs) are all too often not aware enough about this. Views of health professionals about the infringement of rights of PSMIs are subject to controversy and denial [4].

Literature on the rights of PSMIs covers various areas of interest such as:

• the knowledge of the texts of laws and their effects on medical practice [5-7],

• the adequacy of these texts with regards to the needs for the protection of PSMIs' rights and the application of these in psychiatry [8,9],

• the situation of human rights in psychiatry and in specific contexts [10-13],

• the various forms of violations of the rights of PSMIs and the effects on health [14-16].

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This article provides an account of the results of a study based on an opportunistic sample among health professionals of 17 countries in 4 continents, with the aim finding out what their views are with regard to the social, economic and political practices that undermine the rights of PSMIs in comparison to the general population and patients suffering from somatic diseases. The acknowledgement of the existence of such practices within and outside of healthcare systems can contribute to the development and the implementation of programmes for the prevention and promotion of PSMIs' rights in the context of mental health.

Methods

A questionnaire (a self-administered questionnaire with closed questions sent by regular mail) developed on the basis of Pettifor's model [17] was submitted to health professionals who are active in the area of psychiatry and/or mental health. They had been identified as key informants due to their knowledge of the milieux of psychiatry and mental health through a network of public health professionals, patients' organizations and human rights associations worldwide. The study took place between March and September 2004. A total of 76 replies were sent in from the following countries: South Africa, Belgium, Belize, Bolivia, Bulgaria, Cameroon, Chile, France, India, Italy, Kenya, Mali, Morocco, Nepal, Switzerland, Uzbekistan and Zambia.

The questionnaire included four parts.

The first was related to the existence and the level of the seriousness of social, economic, political and cultural practices that attack PSMI's rights in the context of psychiatric and somatic care. Ten practices were thus listed (locking patients up, no clinical diagnosis, contention, seclusion, invasion of privacy, inhuman treatment, rationing/refusal of care, abandonment, physical violence and blows, electric shocks). An evaluation scale in 4 points "never, seldom, regularly, systematically" was added to each kind of practice and enabled the respondent to evaluate the seriousness of the identified practice.

The second part was related to the various practices PSMIs are victims of in comparison to the general population in the areas of civil freedoms, and economic, social and cultural rights such as forced prostitution, attacks on freedom of religion, no access to bank credit, attacks on freedom of association or demonstration.

The third and fourth parts of the questionnaire concerned the causes and risk factors supporting such practices in countries.

The data was analysed with EpiInfo 6 software and chi2 statistical analyses were carried out.

Results

The social and demographic characteristics of the respondents are as follow:

- The group is composed of men at 59,2% and women at 40.8%; age varying from 22-59 years with an average age of 40.
- On the professional level 9% are students in medicine and health sciences, 19.5% are non-psychiatric doctors, 13,5% are psychiatrists, 10.5% are welfare workers and 22,5 % are nurses, 4% healthcare teachers and 21 % various health professionals.
- Fifty one percent of them work in psychiatric clinics, psychiatric and/or general hospitals; 49% occupy functions in public health or social work at various levels (ministries, associations, nongovernmental organizations).

Tables I and II present the main results of the study.

As a whole, health professionals consider that more PSMIs are victims of violations of fundamental human rights than normal patients and or the general population within the specific contexts of their country.

PSMIs versus other patients:

In *the area of care*, 72% of the respondents recognize that the PSMIs are victims of practices such as being locked up, physical violence, care rationing

and seclusion within care facilities regularly or systematically. In comparison, 42% consider that it is the case for patients with somatic disease ($p < 0.001$).

Three main categories of practices transpire:

- More than 80% of the respondents consider that coercive measures (seclusion, locking up and contention) are used more often against PSMIs than other patients.
- Approximately 66% of the respondents consider that practices like abandonment of patients, violence and blows wielded against them or invasion of privacy are more frequent among PSMIs.
- Acts such as inhuman and or degrading treatment and electric shock therapy (EST) are statistically more frequently used for PSMIs than other patients.

PSMIs versus general population:

In the area of social, economic, political and cultural rights, violations are generally more regular and systematic against PSMIs than in the population.

Approximately 80% of the respondents consider that impediments to marriage and family life, the lack of access to education and work, are regular or systematic with regard to PSMIs (versus approximately 55% with regard to the general population).

Two thirds of the respondents consider that obstacles to the enjoyment of political, economic and social rights such as no access to bank accounts and credit, attacks on freedom of expression and opinion, association and demonstration are more frequent against PSMIs than within the general population.

For 60% of the respondents, restrictions to access certain training channels and attacks on freedom of religion are more frequent against PSMIs than the general population.

Another category of practices relates to the violations of rights to property, slave systems and expropriations that do not seem to depend on people's mental state and in an indistinct way would concern PSMIs as well as society as a whole.

Conversely, certain practices of attacks on human rights would be more frequent within the general population and would not affect PSMIs much. Respondents consider that it is marriages and forced prostitution that concern the general population more than PSMIs specifically.

Causes and risk factors supporting such practices in countries:

For 80% of the respondents, they are to be linked to the PSMIs' and their close relations' unawareness of their rights and for 70% to health professionals' lack of training in human rights. However, 50 to 60% of the respondents consider that the durability of these practices must also be linked to the economic, social and political contexts of their countries as well as the lack of clear policies in the area of mental health, to the role of traditions and cultures and the lack of protective legislation of PSMIs' rights. Ten percent also consider that one of the explanatory factors of the recurring character of the violations of rights is the impunity of the persons who carry out these practices.

Lastly, for approximately 50% of the respondents, the people suffering from mental illnesses who are likely to experience the most serious attacks on their rights are those who have an underprivileged social status and a lower

economic level. Gender and age would only be risk factors for a fifth of the members of this panel.

Discussion

The results of this study as a whole connect with the concerns of governments, government or inter-governmental agencies and groups and associations for the defence of the rights of patients who recognize the existence of practices infringing the rights of PSMIs within various social, economic and political structures [1, 18-20].

The use of coercion and contention remains widespread in care facilities. In Finland, a study on 1543 admissions shows that coercion and restrictions were applied to 32% of the patients, recourse to mechanical means to 10% and forced administration of medicine to 8% [21]. Not far from that, two out of three patients hospitalized by force in psychiatric care units in Sweden admitted having been subject to coercive measures in 1995 [22].

In France, an investigation carried out with patients hospitalized in psychiatry indicates that 24% of them did not have the right to go outside of the institutions they were at [23].

Closer to us, a study reports the recording of coercive procedures in the admission rooms and wards of German-speaking Switzerland and finds that 84% of these structures record involuntary injections, 83% note seclusions and 78% mechanical constraints. A minority of wards record measures of forced administration of medicine forced feeding and threats in the event of patients not taking their medicine [24].

The reasons for such measures are perceived in different ways by patients and professionals as a study undertaken in an Israeli hospital shows which

concludes that contrary to the professionals, patients found that involuntary hospitalization, the use of force or physical restrictions and the non-observance of confidentiality were hardly warranted [16].

The other kinds of attacks on PSMIs' rights include ill treatment and abandonment in care services. It is in particular the humiliation and deprivation of patients, financial abuse and the lack of hygienic care. On this subject, a report of the British Medical Association notes: "*In some of the examples brought to our attention, the level of care and the conditions within the [psychiatric] hospitals appeared to be a form of unacceptable ill-treatment…In some countries mental health provision is said to be so bad that mentally ill prisoners are better off remaining in prison than being transferred to a mental institution.*"[25]. For hospitalized children and teenagers who have handicaps and mental disorders, an American study situates the proportion of the children who have been victims of a severe kind of ill treatment on behalf of caregivers at 61% [26].

In the area of care, the recourse to electroconvulsive therapy (ECT) is viewed as a practice attacking the rights of PSMIs by only 40% of respondents. This brings to light the existence of a strong controversy among professionals as to the conditions, effects and benefits this therapy offers within the framework of care of PSMIs. At the legal level, let us bring to mind that the use of this therapy is prohibited in Austria, is authorized under certain conditions in Ireland, Portugal and the United Kingdom and is explicitly authorized in Denmark [27].

A recent study reports that ECT was used at a rate of 142 treatments out of 100 000 especially for people suffering from depression in Scotland [28]. Regarding the numbers of patients treated, a study undertaken in Thailand [29] situates this rate at 11.15 patients out of 100 000 which shows a low level

of use and a variation according to contexts of medical organizations; let us point out that the rate varies from 0,5 to 120 patients per annum in university and national hospitals in Japan [30]. Although the general situation in Africa is little known, it is suitable to bring to mind that half of the Nigerian psychiatrists in response to a questionnaire on their attitudes with regard to ECT accept the use of this technique for children aged less than 16 and generally have a high preference for this technique in care giving for depression, schizophrenia and mania [31].

Compared to the general population, the PSMIs are the subject of unfavourable prejudice on many levels and in various areas of life.

In the area of access to work, a review of the literature situates from 20 to 40% the ratio of activity of people suffering from schizophrenia in national surveys. The same source claims on the basis of four studies carried out from 1994-1998, that the activity ratios of PSMIs were largely lower than those of the general population [32].

In Europe, another review of the literature highlights this disparity with regard to schizophrenia and work. The activity ratios vary between 10-20% concerning people suffering from this disorder. In addition, the authors stress that the obstacles at recruitment include stigmatization, discrimination, the fear of losing benefits and lack of professional experience [33]. In spite of progress and the opening of training structures for PSMIs, their access to certain training channels and degrees remains discriminatory as shows an evaluation of the legislation and practice in the USA [34].

Access to care represents a great challenge to families and close relations of PSMIs and shows two contradictory developments according to the economic

levels and the financing of the health sector. On the contrary, forced psychiatry in certain countries of the North, PSMIs' inaccessibility to care is a public health concern as well in 'wealthy' countries and 'poor' countries or in economic transition.

With a population of 44 million inhabitants, South Africa counts 429 acknowledged psychiatrists, 56% of whom work in the private sector and in the agglomerations of the big towns Cape Town and Gauteng (Johannesburg-Pretoria). The rural sector only has 5.6 % of the psychiatrists which results in inaccessibility to technical care skills [35].

The inaccessibility to housing appears in many situations as resulting from discrimination against PSMIs. The latter get up to 30% of the obstacles to housing as the second most significant area of discrimination in their life as a study undertaken from 1999 to 2002 with 1824 PSMIs in five American states reveals [36].

The great vulnerability of PSMIs is more noticeable in their sexual and private lives. While the prevalence of sexual abuse is estimated at 15-30 % in the female population in general, it is on the other hand situated at 25-77% among the women suffering from mental illnesses [37] due both to their inability give evidence of aggression, but also and likely due to the effects of medicines administered to them.

Beyond the coherence of the method and congruence of its results, this study suffers from three significant limits which refer to the sample's size and the generalization of its conclusions. Firstly, let us bear in mind that attacks on

the human rights of PSMIs rest upon a range of economic, political, legal and cultural factors which, in their demonstration and intensity are far from being similar in different national and local contexts and health systems. From this point of view, it is advisable to keep in mind that many of our respondents come from Africa where the weight of traditions, including in health systems, the limitations of resources and the role of communities in care giving to PSMIs cannot be neglected in studies and actions for the promotion of mental health. The fight against violations of human rights in the area of mental health requires identifying causes, determinants and risk factors for the populations concerned. PSMIs' unawareness of their rights and the lack of HPs' training in human rights call for the implementation of specific training programmes either in their general training course, or in various forms of continuous training.

Another requirement in the fight remains that of taking into account of the overall nature of the violations of human rights and the effects on mental health. The aggravation of social inequalities and the precariousness in which increasingly broader layers of populations live including in wealthy countries remain fundamental determinants of mental health but also of rights to care, dignity and life for PSMIs.

In spite of their limitations, the results of this study open interesting prospects for research and actions for the protection PSMIs' rights.

The modes of expression, accounts and especially the effects of infringements of the rights of PSMIs on the therapeutic course, the stay's duration, the costs and rehabilitation constitute interesting research thematics able to contribute to the development of action plans for the rights of PSMIs within and outside of care institutions.

Lastly, dialogues between social groups for the defence of the rights of PSMIs and HPs deserve to be promoted and supported at local and national levels in order to assess the needs for the protection of the rights of PSMIs, to elaborate and implement national plans for the protection and promotion of the rights of PSMIs.

Conclusion

This study aimed to find out the views of HPs about the existence, the causes and factors of social, economic and political practices which undermine the rights of PSMIs in comparison to the general population and 'normal' patients.

The results obtained show that according to HPs, PSMIs' rights are more violated than those of 'normal' patients and the general population within as well as outside of care systems.

The most frequent practices concern the use of coercion, contention, forced administration of medicine, seclusion and locking patients up.

Compared with the general population, many attacks on civil and political rights (non-discrimination, the right to meet, freedom of opinion, freedom to marry and found a family, and the right to participation) and economic, social and cultural rights (rights to education, housing, healthcare, access to and management of property) affect PSMIs more.

The unawareness of PSMIs and their close relatives of their rights as well as the lack of training intended for HPs constitute the major causes of the emergence and recurrence of these practices.

The acknowledgement of the existence of these practices, the identification of their causes and risk factors can contribute to the elaboration of policies and action plans intended for the protection and promotion of human rights in the area of mental health.

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Table I

Views of the practices violating the human rights (regularly or systematically) according to health professionals (n=76): comparison between psychiatric and somatic patients.

Practices violating human rights in the area of care	**Responses in terms of percentage "regularly or systematically"**		p values
	Psychiatric patients	Somatic patients	
1. Locking patients up	**82.9**	42.1	< 0.001
2. Unfounded diagnosis	**72.3**	48.7	< 0.005
3. Contention	**80.2**	35.5	< 0.001
4. Seclusion	**84.2**	61.9	0.001
5. Invasion of privacy	**75.0**	54.0	< 0.01
6. Inhuman treatment	65.7	40.6	< 0.01
7. Rationing/refusal of care	**68.4**	55.2	n.s.
8. Abandoning patients	**72.4**	52.6	n.s.
9. Physical violence and blows	**76.3**	22.3	< 0.001
10. Electric shocks	40.8	5.3	< 0.001

Table II

View of the practices violating human rights (regularly or systematically) according to health professionals (n=76): comparison between psychiatric patients and the general population.

Practices violating fundamental social, economical, political and cultural rights	**Responses in terms of percentage "regularly or systematically"**		p values
	Psychiatric patients	General Population	
1. Forced prostitution	36.9	46.1	n.s.
2. Forced marriages	**44.8**	**63.1**	**<0.05**
3. Impediments to marriage/family life	**80.3**	**56.6**	**0.001**
4. Annulment of marriage	50.0	44.7	n.s.
5. Attack on freedom of religion	64.4	50.0	n.s.
6. No access to education	**84.2**	**51.3**	**<0.005**
7. No access to certain trainings	67.0	48.7	n.s.
8. Slave system	**55.3**	**29.0**	**0.001**
9. No access to work/posts	**77.6**	**57.9**	**< 0.01**
10. Expropriations	56.5	42.1	n.s.
11. No access to property	48.0	35.5	n.s.
12. Exploitation for scientific means	**65.8**	**42.2**	**< 0.005**
13. No access to bank accounts or credit	**76.3**	**47.4**	**< 0.001**
14. Attack on freedom of expression and opinion	**76.4**	**46.0**	**< 0.001**
15. Attack on freedom of association and demonstration	**71.0**	**44.7**	**0.001**
16. Forced exiles and exclusions	**60.5**	**35.5**	**<0.005**
17. Restrictions on political participation	**43.4**	**25.0**	**<0.05**
18. Psychiatrization for political aims	38.1	34.2	n.s.