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Presentation of the publications by Dra. Ángeles Roig Moliner, Coordinator of the Technical Conference

This is the presentation of a set of essential texts that delve deeper into the United Nations document A/HRC/29/33 prepared by Rapporteur Dainius Pūras which deals with Human Rights and Mental Health. The texts deal with the works presented at the Canis Majoris Foundation's 5th Technical Conference in January 2019 and, subsequently, published to their full extent in the Foundation's 4th edition of the Annals Magazine. Presented below are summaries prepared by the authors referring to their full length article but to a much greater extent than those that are customarily offered before the article itself. As already stated in the previous issue, the editors consider that these extensive abstracts in English facilitate virtual editing given the Foundation's commitment to immediately placing them on the website in the form of a booklet.

As was perceived in the debates held at the Conference, the topic of Human Rights in the theory and practice of Mental Health at the present time, are not as current nor have as much consensus as it may seem. Despite the undoubted advances, there is still much to do and not only in the daily clinic, but also in the theory itself, as is seen in our authors articles.

We begin with the theme of CHILDREN due to Dr. Dainius Pūras specialization and the importance of this in the PREVENTION of Mental Health problems being highlighted in the text, specifically in reference to bullying.

On the CHANGE OF PARADIGM, as advocated by the report, all the papers, in one way or another, bear relation with it. The proposal for a change in Mental Health practices, the presentation on the exercise of citizenship, the crossroads between medicalization and justice and the impact that the Psychiatric Reform had in our country from the viewpoint of Human Rights, all addressing the paradigm shift from diverse angles.

Subsequently, three articles that address different aspects of the report are presented:

1. The first proposes an approach from the NGO sector (non-governmental organizations).
2. The second is an appeal to the report as a whole addressing it from a different perspective.
3. The third raises several questions about psychiatry and current Mental Health as a result of the assumptions and demands outlined in the report.

The contributions are reflected in the works of the Doctors;

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In our opinion these collaborations constitute a set of essential texts providing an in-depth analysis of the United Nations document A/HRC/29/33 as prepared by Rapporteur Dainius Pūras.

Title:

About Foundations in Spain and its relationship with research, development and innovation

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Keywords: Foundations; R+D+i; private funding; The Big Opportunity.

According to law 50/2002 of December 26, a foundation is an organization that has been constituted without a profit motive and that, by the will of its founders, will have a lasting impact on its heritage to the realization of general public interest purposes . In Spain, this sector represents an important source of funding for biomedical research as well as another type of research of an exclusively technological nature.

Although there are different management models of foundations dedicated to R + D + i, (Research, development and innovation) in Spain, the predominant model has been the financing of research projects developed by third parties in public research centers, outside the control of the foundations themselves. This article analyzes the state of the art and proposes a new model, called The Big Opportunity, whose objective is to establish new forms of action based on criteria of efficiency and effectiveness.

In Spain, the total number of active foundations has been maintained in a constant manner in the last 10 years with a figure, to date, of 4,892 active foundations. As indicated above, the foundations develop different management models that are translated into numerous activities, a analysis of these allows us to conclude that most of the foundations dedicated to scientific research in Spain are operational foundations, that is, they execute their own programs In addition, these foundations do not have their own research centers-laboratories, but instead go to a third party (mainly public R + D + i centers) for the development of these programs.

In this article we ask ourselves if this is a good strategy for the strengthening of the R + D + i sector in our country, understanding that the current model represents a perfectly valid resource management model, but is lacking in control over what is being done, which in turn has its problem regarding the reliability and validity of the results obtained in the laboratories, as previously indicated by the prestigious journal Nature three years ago.

Nonetheless, we can not remain in the mere analysis of the facts or in the criticism of the

current model. Once the general framework is established, it is necessary to present proposals that go in the direction of improvement of what we now believe does not work. We understand that it is not a simple task; multiple factors converge that make it difficult to meet the objectives that I will propose below. The conflicting interests (something more and more frequent within the Third Sector), the different management models of the foundations, the high cost in the hiring of specialized personnel (which in many occasions frustrates the projects of this type of entities), the difficulty to find spaces where to develop the research activity (I will touch on this point later), the endogamic nature of Spanish universities and, within the scope of self-criticism, the scant motivation on the part of the foundations to do something different within the parameters of effectiveness and efficiency, which obliges us to be creative and propose realistic solutions.

For this reason in this article we present a new model that we have called The Big Opportunity, which is structured in the following central concepts:

1. Identifying the strengths and weaknesses of the current funding system of R & D+i by private foundations.
2. To present a new model, based on the above mentioned analysis, which includes a series of common strategies.
3. Establishing mechanisms to evaluate the impact of this new model on R & D+i .
4. Enhance the model (if the assessment is satisfactory).

Title:

Mental health: the exercise of citizenship

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Keywords: Citizenship; deinstitutionalization; United Nations Convention; obstacles quality rights.

The recognition and exercise of full citizenship for people with mental health problems in the different contexts of social life has been full of obstacles. One of the biggest obstacles was the development and expansion of psychiatric asylum institutions throughout the nineteenth century and part of the twentieth century, which represented a form of exclusion from social life.

It is in these psychiatric asylum institutions of the nineteenth century, where psychiatric knowledge was to develop in addition to the appearance of psychiatry as a medical discipline. The social and political power of the time placed the formulation of how these problems should be addressed, in the hands of the aforesaid professionals. However, at that time, and, influenced by Christian movements, a proposal was developed, one which by today's standards would be considered paternalistic, this being the so-called "moral treatment" which promoted a strategy of separation for people with mental health problems from what was considered to be the "morbid" environment of the new cities, which sought to promote discipline, work and good treatment as bases for recovery in the context of psychiatric institutions.

However, there is another aspect to highlight in the nineteenth century, this being the development of a normative framework on psychiatric internment. That century saw an important demographic growth in the countries that were becoming industrialized, which in turn entailed an increase of the interned population in psychiatric institutions as well as the development of the first psychiatric laws (like the French one of 1838) which included the regulation of internments for the most part as involuntary, although in some countries these were enacted by means of a judicial order and in others through a governmental order (Aparicio, V. & Sánchez, A.E., 1997).

This situation was to be maintained during the first half of the 20th century, even when the care structures were expanded along with the development of community mental health centers. The first psychiatric units in general hospitals were developed. The sixties saw a

revolutionary change with the impulse of the deinstitutionalization movement, which was generated by those considering psychiatric hospitals as sterile institutions not conducive to the recovery of people with mental health problems, and at the same time promoters of stigmatization, isolation and social marginalization, as well as being institutions that make citizenship status impossible for inpatients. Deinstitutionalization presented a rupture of these closed scenarios. This phenomenon was linked to that which was known as “antipsychiatry” Franco Basaglia's thoughts concurred with those of Foucault on the role played by psychiatrists who favoured the isolation of people with mental health problems for the maintenance of social order. Basaglia's thoughts also concurred with Goffman's on the functioning of asylums as total institutions. Basaglia made an epistemological leap by placing that line of thought into daily practice and breaking ground in favor of the deinstitutionalization movement. By altering the scenario, the deinstitutionalization movements opened grounds for the expectation of the full exercise of citizenship by those who had been excluded and placed in asylum institutions.

The community scenario and citizenship:

This new community scenario opened the possibility for the empowerment of people with mental health problems to exercise their rights, however, in this scenario there continue to be social obstacles that hinder this exercise. There are myths (Gostin, L., 2009, pp. 25-31) that are maintained over time and are difficult to eradicate. One of these is the danger posed by and for people with mental health problems, this being the most persistent and most difficult to eradicate. The other myth is disability, which boils down to considering that these people are not competent to make decisions. This last myth has hindered the exercise of civil rights.

It must be remembered that Marshall (Moreno, L., 2000) points out that the development of citizenship in capitalist societies began in the eighteenth century with the recognition of civil rights, just as the French, English or North American revolutions did. In the nineteenth century, political rights are recognized, such as the right to vote and in the twentieth century it extends to the social rights of the welfare state. For people with mental health problems, in many countries, these rights start to be won in the 21st century. However, this development of citizenship is what has been called the formal or political-legal dimension, but there is another informal or socio-cultural dimension "more practical and day to day, which implies certain attitudes and behaviors acquired through socialization, it refers to how people are expected to act as committed and competent members of the community" (Oosterhuis, H., 2018, p.518-519). The exercise of citizenship in both dimensions needs to be based on the quality of the dignity of the people, an essential attribute in social interaction hence it "is in human relationships that dignity, in its full sense, is discovered" (Soyinka, W., 2005, p.101).

The United Nations Convention as the basis for empowerment:

The Convention on the Rights of Persons with Disabilities and its Enforcing Protocol that were adopted on December 13, 2006 at the United Nations Headquarters in New York was

an important step for the empowerment of these people in their claim to be full citizens. It points to a paradigm shift in attitudes and approaches towards people with disabilities. The complexity lies in the application of the principles of the Convention in the daily lives of people with disabilities. The obstacles are many and varied. The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest possible level of physical and mental health, in its 2017 report (UN, 2017) speaks of three major obstacles caused by the predominance of the biomedical model, the asymmetries of power and the biased use empirical data in mental health.

A) The predominance of the biomedical model: the rapporteur points out that this is a model promoted by the pharmaceutical industry and official psychiatry, considering it to be a reductionist model and the basis of what we are faced with. This being a "chemical imbalance" that has not been confirmed with the amplitude with which it had been presented. The adequate response is considered to be the biopsychosocial model that broadens the view towards other factors such as psychological and social factors, thereby creating the opportunity for new effective and low-cost interventions for part of the mental health problems encountered.

B) Asymmetries of power: the rapporteur proposes a redistribution of power in the area of clinical research and public policy. He considers that power is currently concentrated on biological psychiatry and the pharmaceutical industry. These asymmetries in the clinical setting lead to a favoring of paternalism and patriarchal visions in the relationship between professionals and users of mental health services and fosters distrust from users.

C) The biased use of empirical data in mental health: Scientific controversy is increasingly frequent on information and data on the efficacy of certain psychotropic medications. In this field, once again the pharmaceutical industry influences the research lines of health centers thanks to its financial power and its interests. This strategy has modulated the scientific discourse with biases on the efficacy or adverse effects of drugs, seeking the highest economic profitability and the use of the most expensive drugs, despite these not being the most effective.

Sensitive issues in daily practice:

We will present some of the most sensitive issues in our environment that show how the path to reaching the full exercise of citizenship is still however, a long one.

Involuntary treatment for people with mental health problems in Spain are regulated only in the case of hospitalization, but not in the outpatient setting. On involuntary commitment there have been many debates and publications, especially from the legal point of view since the 1978 Constitution that led to the repeal of Law of 1931. Initially this issue was regulated in the 1983 Civil Code reform (article 211), but subsequently modified in art. 763 of the Civil Procedure Law of January 7, 2000, indicating that judicial authorization is required for internment and in case of urgency, it must be communicated to the court within 24 hours and the court is to ratify or deny the internment within 72 hours. Nonetheless, this

modification according to the Constitutional Court in ruling 132/2010 required the status of Constitutional Law, as it is a limitation of freedom (Recover, T., 2018). In spite of the absence of a Constitutional Law, the Constitutional Court has been advancing through other sentences subsequent to that date and has specified several aspects of involuntary internment in requiring that "the judicial resolution that authorizes it, must guarantee the rights of the interned person and therefore it must be personalized. Appropriate to the specific situation and concrete state of the personand can not be resolved by a predetermined, standard resolution "(Recover, T., 2018).

When we enter the daily practice of healthcare services, we see that there are weaknesses in the procedure of involuntary commitment from the perspective of the protection of rights. There are countries that have improved their procedure by indicating that any medical report calling for internment must be made by two psychiatrists.

The second weak point of the procedure is about the interned persons exercising their right to representation and defense. The Ethics and Legislation Committee of the Spanish Association of Neuropsychiatry (AEN) pointed out that in healthcare practice it was exceptional that this right be exercised (Roig, A., et al., 2012).

The third weak point is the judicial control of the internment within the establishment. In my personal experience I have seen cases of people with more than 6 months of internment in a psychiatry unit of a General Hospital whose judicial follow-up was purely bureaucratic and standardized.

On the other side of the coin regarding involuntary treatment is the so-called "Involuntary Outpatient Treatment", (Tratamiento Ambulatorio Involuntario, TAI in Spanish), which has been the subject of a long-standing controversy between detractors and defenders. There have been proposals to regulate it but these have not been consolidated, although their application is being carried out in some Spanish provinces, such as Gipuzkoa, Barcelona, Valencia, Alicante, Murcia, Asturias, ... (Cañete, C. et al., 2012) under the principle of "who can do the most can do the least" (Portero, G., 2010). This principle coincides with the criteria of the World Health Organization to always apply the least restrictive alternative (WHO, 2005). Some suggest that its regulation is not necessary because it is inherent and generic in article. 9 of law 41/2002 Regulator of Autonomy of the Patient (González, O., 2006).

At the beginning of this section I pointed out that a second sensitive issue was that of coercion. In the Cartagena Manifesto, promoted by the Spanish Association of Neuropsychiatry (AEN), in 2016, coercion is defined as "... the use of power, force or threat to get a person who is being assisted to do or stop doing something against their will ... "(AEN, 2017). It is an issue that enters fully into what is stated in article 15 of the Convention on the rights of persons with disabilities in relation to the protection against torture and cruel, inhuman or degrading treatment or punishment, which says " No person shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. In particular, no one will be subjected to medical or scientific experiments without their free

consent" (UN, 2006). It considers that coercion represents traumatic psychic suffering and that the discourse that sustains it must be transformed, hence it can be eradicated. To this end, it proposes a series of measures, the most important being the following:

- Culture of working with "no" coercion.
- Training of professionals in therapeutic relationship practices.
- Establishment of adequate registration systems for coercion.
- Redesigning of hospitalization spaces and their organization.
- Not to deem these practices as treatment.

I believe the biggest problem is in the hospital units that with 40% of involuntary patients gather people with serious mental health problems in spaces that are often not adapted to this type of situation and without a therapeutic atmosphere. Sometimes, community health teams do not have adequate strategies to address people with more severe mental disorders, especially when those people are initially reluctant to follow a therapeutic program.

Quality rights: an instrument for evaluation

The Department of Mental Health of the World Health Organization created "Quality rights" initiative, which is a quality and human rights instrument based on the 2006 United Nations Convention, specifically in the following articles:

1. The right to an adequate standard of living and social protection (Article 28, CDPD).
2. The right to enjoy physical and mental health of the highest possible level (Article 25, CDPD).
3. The right to exercise legal capacity and the freedom and security of the person (Articles 12 and 14, CDPD).
4. Protection against torture and cruel, inhuman or degrading treatment or punishment, as also against exploitation, violence and abuse (Articles 15 and 16, CDPD).
5. The right to live independently and to be included in the community (Article 19, CDPD).

The virtue of this instrument is that it is done through direct observation in the mental health facilities themselves, through interviews with users, family members and professionals. It also includes the review of the documentation on standards and protocols of these establishments. The evaluators are alien to the centers and are composed of professionals, users, family members and people in the field of human rights protection. Reports are made that include the information collected and proposals to correct or improve the protection of human rights.

Title:

Invocation and Fundament in reference to a document produced by the United Nations Organization

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Keywords: Psychiatric Epistemology; A/HRC/29/33; body and mind.

Walter Benjamin already pointed out that there is no document of culture that is not at the same time a document of barbarism. This affirmation of the German thinker not only extends to historical patrimony, but to those documents which, to a greater or lesser degree, advance societies. The creation in 1945 of the United Nations, the Universal Declaration of Human Rights in 1948 and the publication of a whole series of documents emanating from its work, constitute an wide array, suffice the forming of a framework for progress. Included in document. A / HRC / 29/33 , which we are going to consider and which is in fact, a text of proposals and invocations, where each of these in turn present a compromise, this being the shadows of "manifest barbarism" in events such as immigration, wars, and, for example, the mistreatment of women and children.

In order to broaden the scope of the arguments put forward by the Rapporteur's text, it seemed important to order them throughout a series of sections that are profoundly related and which, in turn, in our opinion, it becomes essential that we pause to reason our position and / or criticism of the work we are analyzing. Therefore, they should be read as a complement to the statements made by Dainius Puras, who is an expert Rapporteur as has been verified in previous documents on the importance of Mental and Emotional Health in early childhood; (A / HRC / 70/213), in adolescence (A / HRC / 32/32) and finally another referable to the right of everyone to the enjoyment of the highest possible level of physical and mental health (A / HRC / 35/21). To the extent that the Rapporteur refers to public authorities, it is important to frame his calls within a correct interpretation of the State and Civil Society, given that these would be responsible for executing the various proposals. In relation to the State, it should be noted that at present it forms a conglomerate that responds to diverse economic, social and cultural interests where contradictions create a series of barriers that hinder the programmatic advances proposed by the Rapporteur. It is often forgotten, and the document is no exception, that today there is a form of globalization that is accompanied by a hierarchy of states and, therefore, these difficulties present a very notable difference.

In our opinion, the Rapporteur does not sharply differentiate these religious, social and cultural barriers, or even political policies, and focuses his critical efforts on other aspects that are undoubtedly important, but very much in need of debate and that are present in the psychiatric discourse: "Predominance of the biomedical model", "Asymmetries of power" and the "Biased use of empirical data in mental health" (UN-HRC, 2017, 18-29). These are aspects that would be corrected through rigorous analysis of what the State and the Civil Society represent, and to whose organizations of users of Mental Health and alternative therapy to which the Rapporteur appeals with the self-declared intention of transforming the dominant biomedical psychiatric panorama.

Our reflections, once the problems of the State and Civil Society are clarified, focus on those points that are more directly related to the paradigmatic aspects and to the extent that the Rapporteur appeals to psychiatrists as leaders of the welfare practices, to which these are directed. We must warn that they are a series of insights that detect some debatable points and have a limited depth of reflection, among other reasons, due to the nature of the work itself.

We commence from a perspective of two sets of questions that are conceptually very related: those derived from the practice of Psychiatry and, on the other hand, those derived from the presence and absence of a Psychopathological theory as the basis for Mental Health intervention. We considered it essential to point out what the sense and meaning of the Psychiatric Institution in any of its forms, including those which it adopts in the so-called psychiatric units in general hospitals conceived as places of seclusion. We must not forget that the discourse of Psychiatry itself is, in a certain way, expression and configuration of the dominant social values, which demand a continuous demarcation; In this sense, we do not radically differ with that offered by the Rapporteur, although we do differ in the way he understands the process of healthcare transformation, specifically when proposing Deinstitutionalization. The latter is, for us, a dialectical work - in the line of Franco Basaglia - that should lead to a greater self-awareness of internees and care personnel and, in no case, should be understood as a mere alternative process carried out mechanically. Regarding Psychopathology, we commence with a complaint, considering them ideological, of those Psychiatric Theories that claim to be based on ateoricity, as is the case of the Operational Classifications sponsored by the American Psychiatric Association (APA).

In our original work we pause in order to take an extended focus, on the body-mind relationship, examining the implications of Dualistic theories on such renowned scientists as Cajal, Flechsig or Eccles observing that this dualism, regardless of whether the advances of neuroscience are rigorous, leads, with regard to considerations such as the psychic, to ideological, religious or metaphysical approaches. The advances of science in relation to these problems of the mind-psyche binomial should be understood and framed within Monist theories of phylogenetic evolution, considering that mental aspects emerge in this same evolution; although it is true that, at a given time, they have different, although complementary, development laws hence their methods of study must also be diverse. In this sense, human thought, the highest degree of psychic evolution, must, in the field of Mental Health and in the scheme of the dual therapeutic relationship, achieve advances in

meaning and, therefore, the biopsychosocial becomes a concept, in my opinion, one that is empty of content.

Returning to one of the main axes of our reflection - the transformation of the biomedical paradigm into a biopsychosocial paradigm - we must call attention to certain aspects if we want to delve deeper into the meaning of these two words. To begin with, it is not very clear what the Rapporteur understands by biomedical model; we suppose that it refers to the biological aspects of illness and everything related to the body and excludes other aspects of psychic and social order. This conceptual approach seems wrong to us in the extent that the biological, when referring to the human being, encompasses the psychic, and as we have previously stated, the question lies in the fact that physical and mental realities require differentiated methodologies of study and intervention. This reflection is complemented by another that tends to focus on the alternative paradigm, the latter being the biopsychosocial, whilst being simultaneously postulated as an alternative to the former. Although the biopsychosocial denomination has trumped in the last third of the 20th century, it must be revised epistemologically given that it entails certain contradictions when this paradigm becomes effective in the field of Mental Health.

The contradictions to which we refer in the previous paragraph derive from two theoretical sources that converge at the end of their approach; on one hand, the so-called biopsychic component presents the characteristics duly noted in the previous paragraph and, on the other hand, the social factors, that are very evident in the field of Mental Health, must be added if we wish to be faithful and rigorous with this field, to the fact of the significance that is, in short, the procedure that should govern the practice of Mental Health operators. This does not exclude that these same social factors be subsidiary of other discourses such as, for example, those which are political or legal. It is precisely the meaning which is the true paradigmatic alternative and to it we must submit, let us reiterate, any formulation of the patients or of social groups as a whole.

Title:

About two proposals for change made more than 30 years apart

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Keywords: Institutional psychiatry; Clinical practice evaluation; Disability and human rights; Reforms in mental health; Recommendations; Historical comparisons.

It has been my intention to relate the document on the rights of people with mental health problems presented by Dr. Dainius Pūras in 2017 to the Human Rights Council of the United Nations, with the old *Report for Psychiatric Reform* of 1985, which was elaborated by a Technical-professional commission for the then Minister of Health and Consumer Affairs of the Government of Spain, Ernest Lluch.

Despite the time period elapsed between the publication of both documents, there are related aspects: both have considered that a "change of course" is needed in the attention to mental health and, at the same time, they have presented comparable proposals, as if, in some aspects, time had stopped. With a time difference of 30 years, they have been brought together in both cases with historical circumstances especially favorable for change and with the same objective: to undertake a global rethinking of mental health care.

While this allows me to reclaim the Spanish Report today, despite the insufficient knowledge (and recognition) that it had at the time at an international level. This is how we would remember it in Toledo, in 2005, a senior WHO official, Matt Muijen, referring to two of its main and contradictory aspects: the modernity and validity of its proposals - twenty years after its drafting -, together with its influence on the development followed by mental health in Europe. What is surely attributable to a certain homeland provincialism together with a limited sensitivity to mental health policies in the international arena, especially since the stalemate suffered by the "Mental Health Strategy", approved by the Interterritorial Council of the national health service in December 2006, which had been promoted by the first government of Rodríguez Zapatero from the 2005 Conference of European Health Ministers in Helsinki on mental health.

Looking back, Spain, in full Francoist repression, did not undergo the advances in favor of human rights as per the Charter of the United Nations and the Universal Declaration of Human Rights, although after the death of the dictator, the approval at the Thirtieth World Health Assembly for the objective of "Health for all by the year 2000" and the extension of

primary health care at the Alma-Ata (USSR) Conference in 1978, not being specific proposals on mental health, there were to have a great impact on the new generations of mental health professionals, inside and outside of Spain, to which we should add the antipsychotic movements and in favor of the deinstitutionalization of the mentally ill of the 70s, nourishing all this intellectually the reforms that would give rise to the Report of the Ministerial Commission for the Psychiatric Reform of 1985 and the General Law of Health of 1986.

Some of those past debates have been rekindled by the Special Rapporteur when proposing, for example, to integrate mental health into primary care or referring to the negative impact that the use of certain diagnoses of discriminatory and segregating potential continues to have, such as the well-known case of the pathologization and supposed treatment of homosexual behavior.

Since the 80s, more specific developments have taken place in the international arena, with two strategic and complementary objectives, one of assistance in favor of the universalization of mental health services and another focused on promoting the rights of people with mental disorders, obviously two key issues in our 1985 Report.

Despite this, the 2017 "Report on the right of everyone to the enjoyment of the highest possible level of physical and mental health" prepared by Dainius Pūras, when reviewing the process followed throughout these years, criticizes the evolution followed in certain aspects by mental health policies in our century, something that also affects our public actions in this area.

The Dainius Pūras document has revealed insufficiencies and deviations in mental health policies that are already consolidated, while the Spanish Report started from a new political situation in the country, from the recognition of a general delay in mental health care in relation to the European context and the need felt by a majority for a profound change in the general organization of the health system with respect to how it had been structured during the dictatorship. It included some clear objectives: to extend the protection of mental health, to integrate its organization in the whole of health care and to recover the civil rights of the mentally ill patient imprisoned indefinitely in psychiatric institutions.

Dainius Pūras sets his critical eye on the exaggerated influence of a **reductionist bio-medical model** that, relying on the power of **academic psychiatry** and **the pharmaceutical industry**, has dominated clinical practice, policies, research programs, medical education and investments in mental health, its influence being key, therefore, in what happened within the sector throughout all these years. For Dainius Pūras, sensitivity to the discrimination of the mentally ill has been lacking, the scientific basis has been questionable, the research interested and biased, a non-rational use of psychotropic drugs has been promoted, a certain degree of authoritarianism has been maintained in the clinical relationship, forgotten the role of the environment in the development of mental disorder and promoted, finally, a continuous growth of (supposed) psychic disorders in need of treatment

Consequently, it will consider indispensable to regain the balance between the exaggerated influence exerted by the current biomedical approach on clinical practice and the therapeutic relationship itself, bring the different interventions to the community level and count on their development with the active participation and support of all parties involved. In addition to gaining prominence for mental health within health policies, take into account both promotion and prevention, integrate mental health into primary care, guide spending towards sectors that respect the rights of the sick, change medical training and research and call the participation, finally, of professionals and users, these will be some of its main recommendations.

Issues, undoubtedly had been the subject of special attention and concern for the drafters of the Spanish report

At the time of the differences, largely due to the times in which both reforms take place, it is necessary to consider a greater specification of the healthcare assistance measures and organizational proposals put forth in the Spanish Report, except in the safeguarding of human rights of the mentally ill, a matter that has undergone important modifications since the formal recognition of the rights of persons with disabilities in 2006.

Furthermore, the special importance given by the Spanish report to the role of the territory (regionalization and welfare zoning) when it comes to organizing services for the population, or prioritizing the universalization of the health system and which, having already passed more than six decades, must be considered solved in today's Europe.

There is greater specificity in the Spanish Report, finally, when establishing limits to the sanitary action regarding the protection of people's mental health: "psychiatric attention can not include the set of needs and factors that configure mental health and the well-being of people, because many of them do not depend on health action but on factors of a general nature ". The 2017 Report has been, in this sense, much more optimistic.

It should be noted, on the other hand, that there is an existing coincidence in both reports, this being their "lack of obligation" or non-obligatory nature when putting their proposals into practice. In the case of the Püras Report, it is the Member States - that is, the governments - that are responsible for developing them according to their own considerations and priorities. The same would happen with the Spanish Report, including the principles of action on the matter that was to be collected one year later in the Health Law: the different CCAA (regional governments) being responsible for developing the said proposals to a greater or lesser degree and counting on the cooperation and leadership of the Ministry of Health. The prestige and technical quality of the Report will also affect its greater or lesser development, so it would be advisable not to forget, finally, that the Public Report can not and should not be above criticism, being able to sustain a somewhat simplistic vision of the current biomedical model, which sometimes seems to confuse with the banality of the "drug-psychiatry" that has invaded a large part of our clinical practices, or because of its excessive confidence, in my opinion, in the capacity change of a certain generalized "psychologization" of mental health practices or, finally, by the doubtful viability

of some of its supposedly "health-related" proposals that would require, however, changes of great importance in the public policies of governments for possible implementation. Nonetheless, in any case, it should be said in favor of the Püras Report that by putting on the table the "feet of clay" that could be sustaining some of the achievements of European psychiatry through all these years, it has reopened a debate about where, at the present time, attention to mental health should go in the part of the most developed world on the planet.

Title:

Narcotherapy and human rights. A crossroads between Health and Justice

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Keywords: Post Traumatic stress; narcotherapy; psychoactive drugs; human rights.

In the present work we try to validate narcotherapy as a coadjuvant and catalytic tool for psychotherapeutic intervention in mental disorders and in particular in cases of post-traumatic stress which, in my opinion, is one of the mental alterations that entail immense suffering for those affected by it, precisely because it offers persistent and obstinate symptomatology which is very difficult to relieve.

We believe narcotherapy to be the use of a drug, that does not have healing purposes per sé but intervenes as a coadjuvant of the psychotherapeutic action in that it is like the catalyst of a biochemical reaction if the catalyst is or is not present, the reaction is or is not given or is not given in time.

The use of psychoactive drugs is probably a practice linked to man's own evolution and possibly one of the causes of his socialization, there is no doubt that with the priority objective of survival, for which food is essential, humans find themselves with a significant variety of plants and vegetables that, in addition to offering energy nutrients, produce collateral effects which alter their moods, conscience and knowledge, and which are undoubtedly key to their use for healing, ceremonial, recreational and even hunting purposes. Among these are the psychoactive drugs that have been, and still are, in many cultures of the planet, the approach to communal and curative integration.

With the discovery of antipsychotic drugs, interest in psychedelic and psychoactive substances increases, as occurs with the use of Lysergic acid diethylamide (LSD-25) both for clinical diagnosis and for treatment, in addition to others such as psilocybin, mescaline, methylene dioxy amphetamine (MDA) and methylene dioxy methamphetamine (MDMA).

Results and constancy confirm that these types of drugs do not have curative properties per se, but when consumed by the patient within a controlled framework during the psychotherapeutic session, they can produce a catalyzing of the emotional experiences which favors the therapist's intervention thereby greatly helping the patient to overcome the

psychic traumas of different mental disorders, this therefore being the basis of narcotherapy. MDMA is psychoactive in doses between 75 and 125 mg, with the effects appearing between 30 and 60 minutes later, reaching their peak of activity somewhere between 2 and 3 hours after intake and cease to have effect in 6 hours. MDMA does not produce alterations at a perceptual level although it does stimulate a significant emotional experience accompanied by euphoria in which feelings of affection and empathy increase considerably. It maintains lucidity, blurs possible neurotic fears and favors sincerity and interpersonal communication, thereby making it an adequate candidate in narcotherapy.

We also discuss how the use of narcotherapy is complicated, given that it has to be done with absolute respect for the patient's human rights and in turn circumvent the laws in place where it is applied.

The fundamental purpose of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens. If it is considered undeniable that every society needs laws to achieve its objectives, therefore mental health legislation should be no exception to any other legislation.

People with mental disorders are, or may be, particularly vulnerable to abuse and violation of their rights. Legislation that protects vulnerable citizens (which includes people with mental disorders) is a reflection of a society that respects and cares for its people.

In both high and low income countries, the stigmatization of people with mental disorders has persisted throughout history and has manifested itself in the generation of stereotypes, fear, shame, anger and rejection or elusion. . Violations of human rights and basic freedoms, and the denial of civil, political, economic, social and cultural rights to those suffering from mental disorders are a common occurrence around the world, both in institutional settings and in the community.

Physical, sexual and psychological abuse is a daily experience for many people with mental disorders. In addition, these people face an unfair denial of employment opportunities and discrimination in access to services, health insurance and housing policies.

According to the objectives of the United Nations Charter and other agreements, international human rights constitute one of the fundamentals for mental health legislation, thereby identifying the problem and where the treatment is thus guaranteed.

It is very difficult to precisely define what constitutes the limit of what should be considered as involuntary treatment and even much more difficult is the incorporation of a drug as a therapeutic adjuvant but it is no less difficult with the informed consent of its use in a voluntary treatment.

That is why in narcotherapy, in its practice, not only, the use of a drug is not widespread but it seems to open up with difficulty and almost as a novelty, when in the history of man it appears linked to its evolution and its own existence.

Title:

New paradigms in mental health for the 21st century: Prevention and vulnerability. The diagnostic fallacy of disability. The child as a subject and his/her place in the clinic in Child Mental Health

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Keywords: Prevention; vulnerability; disability; pathologization; symptom in children's mental health; trauma; resilience; empowerment.

A reflection is made about the new paradigms in Mental Health for the 21st century with respect to three themes: I) Prevention and vulnerability; II) Fallacy of disability and III) The place and function of the child in child mental health: the child as a subject. Concepts and paradigms that as canonical are sometimes admitted as formulations without questioning, debate or reflection.

Regarding prevention, it is based on what is understood by prevention and if possible, mental health prevention specifically, other than a false mimicry of the preventive medical model (vaccines, diets, prophylaxis etc.), or mental normative hygienism.

Prevention in mental health is confused with what really is the primacy of the rights that correspond to public and welfare policies, as reflected in the Report of the UN Rapporteur on Mental Health.

The fundamentals and foundations that account for prevention in mental health and the predictive, preventive and homologous nature of physical processes can be possible in mental processes. The physical processes are linear, mechanical, measurable and quantifiable from cause to effect and have in themselves their own code of innate and deterministic development.

In mental processes, in subjectivity, there are no ideal developments, nor anything that has its own code, they are random, uncertain, contingent, unpredictable and unforeseeable. Subjectivity is born from the experience of the link, which makes each subject unique, having a particular experience and distinct from others.

In the preventive mental health model, we cannot mechanically apply prevention as if dealing with a viscera or an organ. We can measure and enumerate neurons, but we cannot measure

or quantify kindness, beauty, love, tenderness, etc., the result of the activity of these neurons. The mental state is an emerging phenomenon of the brain that has specific properties different to it, which are framed in its own parameters, models and specific knowledge.

Regarding the concept of vulnerability, it opens up to two conceptions of different dimensions and applications. It is not limited to the generalized idea of vulnerability as fragile or anomalous and unhealthy. It is understood as what is constitutive of the human being, incompleteness, prematurity of being, helplessness, as a reconstructive and creative capacity. It is this constitutive lack, its incompleteness, its dependence on the other, which makes it open to desire, to know, to search, to fill the void and forge a singular existence. This dimension of vulnerability means not pathologizing, nor "traumatizing" any shocking event (catastrophes, death, grief, accidents, suicide, etc.). Not to restrict and inhibit all risks and uncertainties, which entails annulling the capacity for adaptation and autonomy, creativity and learning and building defense and freedom mechanisms.

The diagnosis of disability and the biomedical paradigm of understanding the disabled body, deficit or impairment is questioned. New paradigms are proposed in this regard and the recognition of functional diversity, neurodiversity, characteristic of the human condition as a form of non-stigmatization nor marginalization.

The biomedical paradigm of disability refers to a vision of the disabled body that identifies its deficits, impediments, as a body-thing, timeless and an unhistorical body. An anatomical body, without intentionality or desire, whose reference would be the corpse to dissect. This dysfunctional and unproductive machine-body of the so-called disabled person is excluded from the verification and production practices, stigmatized and marginalized.

The prefixes that dominate in the diagnoses (sub- minus- dis-) refer to the norm = subnormal; to the valid = invalid, to the able = disabled. This constitutes the norm, the validity, the order, the function, as instruments of normalization, discipline and regulation as forms of power and social control.

The social paradigm of the so-called disability, de-medicalizes and de-biologizes the discourse on disability, opening a different line of understanding and addressing the issue as functional diversity. They are not so much physical, sensory dysfunctions, etc. those that generate disability, but what the social system implies as exclusion, exploitation, stigma and prejudice.

Finally, the role and place of the child as a subject in child mental health is raised. Not to understand that the child is the subject of his story, is to relegate him to being a timeless object, without the ability to feel and desire, to exclude him from his historical and social being.

We must value and take into account the plot of stories that interweave the child's place, family history, school, the environment, etc. But you have to give the child his place, which allows one to build one's feelings, story, discomfort, desire, history. The vital facts, the events, when narrated are vital facts inscribed in a biography, in a story.

We have to construct a narrative with the child, a first-person story, integrated into their family and social history. The interpretation is of the subjective experience with the child, not of the data of the child but the child themselves, turned into a mere interrogation or questionnaire. It is not necessary to create a narrative, while collecting items, that attempts to square the discomforts and the story in a diagnosis or label more appropriate to the taxonomy of plants and animal species.

There is a current tendency towards the pathologization of all behavior of the child that does not fit the norm, or, that it implies discomfort or problems of his daily life. Also to confuse the symptom with illness, and fall into the intervention of the furor sanandi and normalizer before any conflict, or psychic or relational problem.

Pathologizing behaviors means that computer schemes of good or bad behaviors are replaced by brain, genetic or mental disorders, thus nullifying the responsibility and freedom to respond to their actions, replacing it with the rhetoric of diseases and therapies.

This pathologization of the child's behaviors and discomforts, leads to the current situation paradox in which they are no longer naughty, capricious, rebellious, distracted, cheeky, disobedient, restless, undisciplined, etc; now they are ADHD, negative , defiant, bipolar, autistic, etc.

In this pathologization of all behavior, the child is excluded from having the ability to be and from the expression of their psychic suffering and how they manage and confront life, adversities, discomfort, anguish, learning and relationship issues, etc.

Before any problem of the child, we must assess not only what is missing, the deficit or the disorder, but also what it has, the rich areas of life that underlie the entire process. Not focusing only on the disorder or deficit, but knowing how to value and focus on the potential and capacity for reconstruction and resilience.

Title:

New views on the right to health

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Keywords: Human rights; mental health; right to health special rapporteur; public health; United Nations.

This article takes the first report prepared by the current bearer of the United Nations mandate regarding the Right to Health as its object of analysis. The objective has been to scrutinize its contributions in order to assess the global impact and its applicability to our environment. The most relevant points and the weaknesses found at a conceptual and strategic level along with elements to be incorporated within the mandate are exposed, and the dissemination of the rapporteur's work is encouraged as a way of enriching their work in the line of participation of the population in public health decisions.

The report of the Special Rapporteur on the *right of everyone to the enjoyment of the highest attainable standard of physical and mental health* is the first issued by the current bearer of the United Nations mandate for the Right to Health, Special Rapporteur Dainius Pūras.

Special Rapporteurs (*specialrapporteur*) are appointed to act on behalf of United Nations as independent experts. The rapporteurs or mandate bearers are selected from among a set of volunteer candidates according to criteria of expertise, experience in the field of mandate, independence, impartiality, among others. The authority responsible for their appointment is the Human Rights Council of the United Nations. Special rapporteurs are mandated to examine, supervise, advise and publicly report on problems related to Human Rights (HR).

The *Report of the Special Rapporteur* is based on a guiding axis that is the framework of the Right to Health. Around this framework, the Special Rapporteur articulates those that, in his opinion, constitute the priority issues on the public health agenda at a global level: primary care as a care axis, mental health as a requisite for health, rights of people with disability, life cycle (well-being in childhood, sexual and perinatal health, role of the biomedical model in mental health, relationship between violence and health, active participation and empowerment).

This first report of the Special Rapporteur proposes a rethinking of the way of understanding health and disease, which aims to be a revulsive to the current prevailing paradigm, thus reclaiming the relationship between social determinants and the health and disease conditions of both populations and individual.

In order to enhance the scope of their work , the Rapporteur appeals to the legal framework of the Universal Declaration of Human Rights, as its predecessors of mandate center its work around the framework of the Right to Health, and elevates it to a requirement of the first order to which all UN member countries and signatories of the DUDDHH would be bound. This would make it possible to force the states to ensure the health of their citizens, for which the need to carry out adequate supervision and accountability is defended. The framework of the Right to Health implies abandoning utilitarian-type health policies, activating the necessary institutional resources to make way for a more egalitarian policy within countries with a more liberal tradition.

Probably the second main axis of the report by Rapporteur Dainius Pūras has to do with the markedly preventive approach that structures its draft mandate. Throughout his first report he repeatedly states that, in order to guarantee the right to the highest possible degree of health, it is essential to adopt measures of special protection for the most vulnerable segments of society. He also points out that this vulnerability is accentuated in certain stages of life.

That is why in its section of areas of special interest it highlights issues such as the equitable distribution of economic resources, the fight against discrimination of people affected by HIV / AIDS, the defense of the LGBT collective, the attention to reproductive health and of women, health care during childhood and adolescence, the rethinking of restrictive measures regarding contraception and addictions, or the need to guarantee equitable access to medicines.

The Rapporteur also highlights the defense of primary health care level as one of the mainstays that allow a more appropriate redistribution of resources. Primary care is the gateway to health care for the most vulnerable groups of the population and their care work tends to be better aligned with community initiatives than those at the specialized level. That is why primary care is claimed as an institution with a social cohesion effect, with an enormous preventive potential due to its potential effect on the health of the most vulnerable sectors.

On the other hand, it points out the role of violence as a transversal element with great capacity to violate the right to health of people. This would be a problem largely underestimated due to epistemologically wrong approaches, focusing on an individual and short-term analysis unable to point out the deep and lasting repercussions that this has on the health of the victims, sometimes transmitted from generation to generation.

It puts the accent on the need to fight for the health of the people, bearing in mind the asymmetries of power, the hierarchies that sustain unjust practices and policies, the empirical

evaluation of the measures adopted by the states, the unavoidable rendering of accounts, the promotion of good practices identified as well as the work to favor the active and informed participation of the populations in the decision making that is relevant to them.

From the point of view of the rapporteur, the search for full well-being is, in short, an ethical requirement of the first order, and not a simple "invitation" to its fulfillment, which corresponds to the States, but in which its inhabitants must be called to active and co-responsible involvement. It would be a matter of being able to fight for this well-being without making excessive use of the restricted view of health, as there is a risk of medicalizing aspects of human existence that do not correspond to the field of pathology, but to that of the always complicated relationship with each other.

The achievement of all these objectives implies the active participation of all the agents, the adoption of training and sensitization measures, organizational and management measures, the inclusion of commissions, preventive and monitoring bodies, which guarantee their correct compliance, and that everything exposed is not reduced to a mere declaration of intentions.

In short, the document promotes the awareness and participation of other sectors (political, economic, social and cultural), from a policy approach, under the guiding principle of human rights and with the collaboration of society, collectively or individually, which can also be implemented through the empowerment of people. Although all of this constitutes an ideal framework from which to advance towards the maximum state of physical and mental health of the population, our work has consisted mainly in submitting to critical analysis the global approach proposed initially by the rapporteur, in order to estimate the global impact of his contributions as well as their applicability in our environment.

Title:

The forgotten aspect of prevention. The need for an integral vision in the care of child and adolescent disorders

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Keywords: Prevention in Mental Health; paradigm of simplicity; reductionism; interdisciplinarity; Quaternary prevention.

INTRODUCTION

Despite the impulse that has been given to Mental Health attention in our country since the 1980s, especially after the enactment of the General Health Law, serious deficiencies in planning and assistance in this field persist, especially in the Mental Health care aimed at children and adolescents. The report by the United Nations special rapporteur, Dairius Pūras (UN-HRC, 2017,73/75) makes special mention of the need for prevention, which at present can be considered as an overlooked and even forgotten subject.

A judicious policy in Mental Health should contemplate prioritizing programs of psychosocial protection of children and young people, with extensive educational and health coverage.

FLAGRANT OVERSIGHTS IN MENTAL HEALTH CARE AND HEALTH PROBLEMS IN THE CHILD-YOUTH POPULATION

The possibility of detecting disorders and risk factors in the first period of life is more closely linked to the quality of gynecologists, neonatologists, pediatricians, psychiatrists and adult psychotherapists than to the direct action of child and adolescent mental health service recipients, on condition that the problems are detected at the initial level of care. To highlight two factors that will act as a source of iatrogenesis:

- The lack of adequate training of the initial level of care in Child and Mental Health
- The lack of organization of a functional network of services that allows the exchange of knowledge and actions in the resolution of these disorders right from the beginning.

We have an extensive bibliography on the detection of risks during pregnancy and early

childhood, with studies that also include the effects that social changes have on frequent parenting modes and their impact on child development. (Masson, O., 1987, Berger, M., 1992 and 2003, Barudy, J., 1998, Cyrulnik, B., 2002 and 2005). Disregarding these social changes leads to multiple errors and omissions. The lack of a comprehensive vision by gynecologists and professionals who deal with early childhood, focusing attention only on biological evolution, outside family and social avatars, prevents the management of new risk situations in this age period.

We point out a regression even in the attention to parenthood, when contemplated from an integral perspective. While in the decade of the 1980s there were different preventive programs aimed at pregnancy and parenthood, the preparation for current delivery is reduced to physical aspects and a dogmatic and pendular transmission of the criteria that characterize at all times what good parenting should be. Often interventions that skew the context, represent iatrogenic actions that favor anxiety, guilt and insecurity, especially for mothers. Protocols are introduced without taking into account the context in which pregnancy, childbirth and parenting occurs.

SECONDARY PREVENTION

Symptoms are still considered as attributes of the person at a given moment. Professionals are rarely capable of evaluating the quality of the father-mother-baby relationship or rarely can they detect dysfunctions in them, prior to symptoms appearing in the baby in the form of withdrawal, arrest in psychomotor development, psychosomatic symptoms, and/or others. These visions and reductionist interventions are, at best, ineffective, and more often the cause of iatrogenesis.

The factors most linked to the failure of interventions in the initial period of life are:

-The lack of comprehensive training of professionals, who tend to deal with the attention to the problems of the first period of life with fragmented and reductionist knowledge.

-The lack of coordination between the professionals involved and between the different levels of care, made even more alarming when we face high-risk situations, where it is necessary to take measures to protect the child.

THE LACK OF POLITICAL INTEREST FOR PSYCHOSOCIAL PREVENTION CONSTITUTES A CENTRAL IATROGENIC FACTOR FOR A LARGE PART OF THE CHILD-YOUTH POPULATION

Children born in situations where high-risk conditions already exist, present developmental disorders within the first days of life, these being physical, cognitive and socio-affective. If left untreated, in time, these disorders worsen and in many cases become irreversible.

A healthy political option would institute regular peri-natal detection of psychosocial risk situations as exercised for somatic risks and would also ensure continued care for children and families in need. Preventive interventions of this type are much less expensive than the expenses generated by secondary and tertiary measures implemented by the communities to try to cure the sick or to incarcerate criminals. In contrast, these prevention programs that are inexpensive and extremely profitable from an economic, psychological and somatic point of view are usually discarded. Consider, among others, the contributions of medical teams such as that of Professor Papiernik, who has demonstrated as statistically significant, the possibility of reducing, through simple accompanying measures during pregnancy, the incidence of premature births and children of low weight, for example. The success of his guide comes from including social factors such as the mother's work pressure during pregnancy as social risk factors, in addition to strictly biological findings.

ON THE CONSEQUENCES OF DIAGNOSES BASED ON UNIDIMENSIONAL PERSPECTIVES

If the issue of diagnosis in Mental Health is very complex in general terms, in the child it is even more worrying to establish a diagnostic label, an act that will not only configure the expectations of the environment towards the child, it will also contribute in the construction of his own image, and his self-esteem. Classifications such as DSMIV, DSMV (even more controversial) or ICD 10, based on consensus established at a given time, and not exempt from pressures upon their establishment, do not provide comprehensive assumptions of the genesis of the problems and are often a source of iatrogenesis.

The view of diagnosis being the eclosion of something internal (genetic, biological ...) or external (crisis caused by adaptation to an adverse environment or circumstance ...), obviates a holistic view of the more complex disorder, considering it to be the result of interaction between an individual, with their potential and their evolution, and an environment to which they must adapt.

The absence of a procedural vision of the disorder, which tends to be set as if it were a still photo, is especially serious during childhood and adolescence.

The symptoms, seen at the same time as adaptive behaviors and as a protest against adverse situations for the development of the individual, can only rely on the abilities that the child or adolescent has at a given moment. The responses to suffering will vary depending on that potential. A superficial look can only see that these are new disorders to which new diagnostic labels may be possible.

ON QUATERNARY PREVENTION

There is a growing interest in the iatrogenic consequences linked to unnecessary and/or inappropriate therapeutic measures. Both the hyper-diagnosis and the multiplicity of

treatments, the results of which, are not only insufficiently contrasted in large populations, but are also ineffective or even harmful in the specific case being treated, are also sources of iatrogenesis, which require rigorous attention.

This does not exclude the fact that neglect in care is still a relevant factor that cannot be overlooked: the economic and professional cuts imposed since the economic crisis that began in 2008 have only increased the deficiencies in assistance and training that existed beforehand. This lack of resources has not led to a decrease in hyper-diagnoses or to a better selection of treatments, on the contrary, these continue to prevail, as noted in the rapporteur's report, where it is noted that these measures are medicalized prevailing over the bio-psychosocial concerns (UN-HRC-2017, 6).

IN CONCLUSION

The approval of the 2030 Agenda for Sustainable Development includes objectives in different points related to Mental Health and the promotion of such. It is an opportunity for the different actors who are most directly involved (at a political, institutional, associative and professional level ...) to provide data that contributes towards establishing a diagnosis of the current situation, as well as to propose what initiatives should be carried out at different systemic levels in order to contribute toward better Mental Health of the population, framing it as Integral Health which is a right of all citizens.

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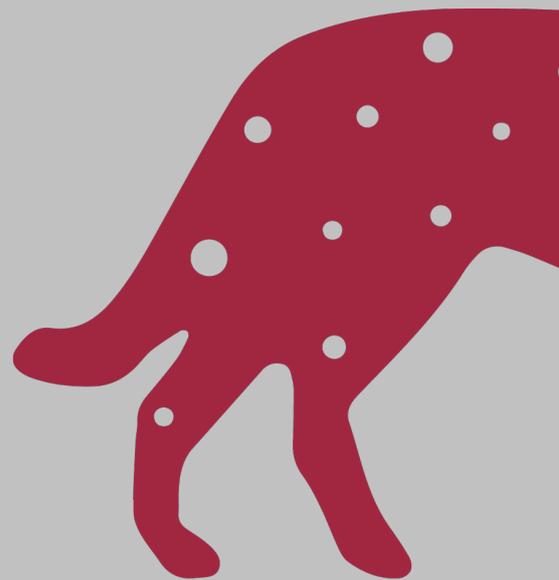
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