ORIGINAL ARTICLE

Communication with Health Personnel and Human Rights: A Perspective from People with Mental Disorders

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Abstract Mental health care has focused on participation, which, in addition to improving recovery processes, constitutes a tool to defend the human rights of people with mental disorders. For this participation, communication is a fundamental element. The objective of the present research was to analyzed the perception of the human rights and communication with healthcare personnel in care processes, from leaders of mutual aid groups or support groups in various contexts of Colombia. It is expected that the generated information can contribute to the evaluation of the quality of mental health services from a human rights and health participation perspective, in contexts similar to the one being analyzed. A qualitative approach has been used, which takes information from six leaders of support groups for mental health, in four regions of Colombia. Said information was analyzed through a thematic analysis, contrasting with the vision of the researchers and with the current theory. It is found that the subject of communication was made up of categories such as *Previous ineffective treatments* and *Perception of a violation of dignity.* Communication barriers are pointed out, such as attitudes of mental health professionals, but the influence that the health system and social and political barriers can have on the same communication is recognized. From the perception of leaders of mental health support groups, it is concluded that it is necessary to improve aspects of communication in health personnel. In addition, clinical mental health care could also be a space for the promotion of human rights.

Keywords Mental Health · Health Communication · Patient Rights · Communication Barriers · Physician–Patient Relations · Human Rights

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Introduction

Mental health is a fundamental human right for all people, therefore, it requires a rights-based approach (Patel et al., 2018). Human rights must be considered in two senses: mental health as a right in itself, and mental disorders as situations where human rights

can be violated (World Health Organization, 2012). Throughout the world, individuals with mental disorders experience a low quality of care, as well as violations of their human rights (Rusch et al., 2011).

In addition to evaluations of mental health services from the perspective of individuals, other key elements have been described to ensure that strategies are effectively delivered to those in need. Some of these elements include respecting the uniqueness of the individual, promoting autonomy and informed decision-making, advocating for rights, recognizing and respecting dignity, and fostering collaborative relationships and effective communication (Gill et al., 2024). In this regard, the Convention on the Rights of Persons with Disabilities (2006) considers access to information as a fundamental element in terms of rights. It emphasizes the importance of overcoming language barriers to improve the quality of life for individuals with mental disorders.

Some analyzes on the perception of the quality of mental health care pointed out deficiencies in most of the countries, and an association with human rights abuses such as torture, forced restrictions, and mistreatment in communication. Effective communication between people with health problems and clinical staff is critical to improving health (Patel et al., 2018). As components of this communication, the following ones have been highlighted: empathic listening, the effort to understand people's needs, to reduce anxiety, to respond to concerns and to give hope (Clark et al., 2021). In many cases, arriving at categorical diagnoses can be easily achieved, but getting people to trust their treating professionals and change harmful lifestyles is more complex (Decety, 2020). This is why deeper relationships with clinical staff have been associated with significant benefits for people with health problems and even for the health staff themselves (Agudelo-Hernández et al., 2024).

When offered a choice, most people living with mental disorders prefer psychosocial therapies to pharmacological options, where they argue trust in health professionals and validation of their dignity in the clinical act as reasons (Rodriguez del Barrio et al., 2014). In addition, pharmacological and psychological interventions can often be used simultaneously in a way that can reinforce their individual effects: both must contain key communicative elements to achieve the best effect (Hernández et al., 2024; Rodriguez del Barrio et al., 2014; van Ginneken et al., 2021). A

better relationship with health personnel is associated with better awareness of how to seek help, reduced stigma against mental illness, improved mental health outcomes, and increased use of mental health services (Agudelo-Hernández et al., 2024; Ibrahim et al., 2019; Jawad, 2020; Knopes & Dégale-Flanagan, 2023).

Therefore, it should be noted that people with mental disorders are at greater risk of having their human rights violated, both at the outpatient level and in psychiatric hospitals (United Nations, 2006; Gill et al., 2024). As a necessary complement to quantitative research, phenomenological approaches should be used in current strategies to improve communication between health personnel and people with mental disorders, in order to prevent coercive practices and promote human rights as part of the health intervention process (Gooding et al., 2020). Support groups or mutual aid groups have been settings where the need to align recovery goals towards hope, healing, empowerment, and connection has been highlighted (Agudelo-Hernández et al., 2024; Kelly et al., 2019; Picco et al., 2018). These settings are where the greatest initiatives emerge to advocate for the rights of people with mental disorders (Agudelo-Hernández & Rojas-Andrade., 2024).

The Present Study

Based on the above, it is highlighted that communication is the cornerstone of the relationship with people with mental disorders in all health settings. This communication aims to create a good interpersonal relationship, to exchange information, to promote human rights and to make decisions related to treatment. Despite the aforementioned, in Latin American contexts, gaps in access to comprehensive care, implementation issues of group or community mental health services and limited participation of individuals in the design of care processes and decision-making in mental health have been identified (Agudelo-Hernández & Rojas-Andrade, 2023). In this sense, the objective of the present research was to analyzed the perception of the human rights and communication with healthcare personnel in care processes, from leaders of mutual aid groups or support groups in various contexts of Colombia. It is expected that the generated information can contribute to the evaluation of the quality of mental health services from a

human rights and health participation perspective, in contexts similar to the one being analyzed.

Methods

Qualitative study, which considers the reciprocal interaction of multiple factors in communication between people with mental health problems and health professionals. The qualitative approach allows us to understand the perceptions and experiences of the actors, emphasizing the meaning and significance that they give to their behaviours and their lives within the framework of social interactions. This approach allows for a deep and nuanced understanding of social dynamics from the perspective of the actors themselves, emphasizing the importance of their context and lived experience.

Process and Participants

For the selection of the participants, mutual aid groups or support groups were selected. The sample was selected by convenience, since these groups collected the perceptions of those who have been actively involved in the defense of the rights of people with mental disorders. As inclusion criteria, it was required that the individuals participate in a support group or mutual aid group related to mental health, have authorization from the other members of the group to share group experiences, and sign the informed consent. Psychiatric diagnoses were not taken into account directly in the interviews. These were not elements that influenced the selection of the focus group, although all had a diagnosis given by a psychiatrist.

Although the selection of the territories where the groups are located was based on the availability to participate in the study, it is important to highlight that each territory has its own contextual specificities. The department of La Guajira presents factors such as high rates of multidimensional poverty and migration, Bogotá presents the best indicators of implementation of mental health services, particularly community services, Risaralda and Caldas present the highest indicators of suicidal behavior in the country, in addition to a described genetic risk for mental disorders (Agudelo-Hernández & Rojas-Andrade, 2023). At the time of the study, these support groups were made up of 40 people from Risaralda (self-help group for rural women), 35 people from Caldas in urban areas (support group for young people), 20 people in Caldas in the rural area, 25 people from the indigenous community, 27 people from the department of La Guajira (support group for suicidal behavior) and 43 people from Bogotá (support group for adults).

The people who participated in the focus groups (n = 58) were between 18 and 58 years old (M = 32.5). This took place in the last quarter of 2022. 12 women participated in the Risaralda group, 8 young people from the rural area of Caldas (five men and three women), 10 young people from the urban area of Caldas (seven men and three women), 15 adults from the department of La Guajira (10 women and five men) and 13 adults in Bogotá (seven women and six men).

Six focus groups were carried out as a data collection technique through a semi-structured group interview, which was based on the theme proposed by the research team. The following steps were taken for the groups: defining an objective, selecting participants through a call made to the support groups registered with the Ministry of Health of Colombia, analyzing the registered participants to guide the development of survey questions, selecting moderators based on their proximity to the groups, scheduling the meeting at the group meeting place, signing the informed consent on the day of the meeting, conducting the session with an explanation of the research and the objectives. Finally, a summary of the conclusions was provided and the report was presented to the group, in addition to expressing gratitude by the research team.

The focus group was facilitated by a community psychiatrist who was previously known to the participants through academic processes focused on mutual aid and community rehabilitation. The questions were formulated according to the categories ordered according to the objective of the study: How has your experience been in the health services you have attended? How has communication with health professionals been in these services? How have human rights been addressed in these care processes?

Analysis

The systematization and analysis of the data was carried out simultaneously with the field work, which made it possible to make adjustments to the techniques, delve deeper into the topics and investigate

in greater depth in search of emerging themes. The field work was carried out until data saturation was reached. In the context of qualitative research, this means that information continued to be collected until no new themes, patterns or insights emerged in the data. Saturation is an indicator that the phenomenon under study has been thoroughly explored and that enough information has been collected to fully understand it. It is a point at which adding more data does not add additional value or offer new perspectives on the topic being investigated.

For the evaluation of the data collected, an approach focused on thematic analysis was chosen. Initially, the interviews and focus groups were transcribed verbatim from recordings, which were authorized through the signing of the informed consent. Subsequently, the data were coded and categorized using Atlas Ti software, version 23, grouping the categories according to their intrinsic characteristics and content, and then reaching a consensus on the codes. This process was carried out by people independent of the development of the focus groups. During the structuring phase of the analysis, an endogenous interpretation perspective was adopted, based on the internal analysis of the data, as well as on the previously defined categories and those that emerged during the study, which were integrated with relevant theories and findings from previous research.

To ensure the validity of the results obtained in the research, a triangulation process was implemented. This process involved comparing and contrasting the data collected through different techniques, participants and groups involved in the study. Additionally, the project design, the category system used and the advances achieved in the field were subjected to evaluation by experts in the field. This step was carried out with the aim of enriching the perspective of the study and improving the applied research methodology. The discussion on the advances achieved and the results obtained was also extended to the participants of the groups involved.

Ethical Considerations

The study was adapted to the recommendations for biomedical research of the Declaration of Helsinki of the World Medical Association. It was approved by the community through its governor and by the Ethics Committee of the [masked], through the CBE022/2022 act. The names of the participants have been changed to protect confidentiality.

Results

The topic *Communication with the treating health personnel* unifies the categories of *Previous ineffective treatments* and *Perception of a violation of dignity* (See Table 1).

According to the first category, a perception of the ineffectiveness of the classic treatments (pharmacological and psychological) is pointed out, people understanding this efficacy as an excessive duration of the process or an iatrogenic effect, for which they decide to abandon the treatment. Similarly, in the interviews, it is expressed characteristics of coldness and excessive distance in the relationship between health personnel and people who need mental health services. This is reaffirmed by Cristian, a 25-year-old man:

> It turns out that I was in various psychological processes like five or six more or less and I lost count. [The treatment] It should not be oriented on this side, this is not working for me, so what I do is leave the process.

This statement sparked two related comments. Catalina mentioned, "Some doctors seem tired, angry, impatient… as if they don't enjoy what they do, and as a patient, you feel like it's your fault." Mariana also added, "The ones who attend to you focus on typing on the computer, they do that very well, but they don't know how to comfort, look into your eyes, give meaning to the pain."

For this reason, it has been essential to incorporate psychoeducational processes into psychological and psychiatric treatments before they begin. However, knowledge about the illness and effective treatments are not only one part of the equation, since it is also important to consider affective aspects, the psychosocial impacts of mental disorders. As referred to by Cristian himself: "In a process, it is not enough for me to say, take these medications and that's it. (…) What a psychologist from my insurance is going to do is to give me advice". Jaime responded to the previous comments, saying:

Table 1 Configuration of factors that influence on the communication from people with mental problems

Topic	Categories	Definition	Representative quotes
Communication with the treating health personnel	Previous ineffective treatments	Perception of previous pharmacological and psychological treatments. Their contribution to improving, maintaining or aggravating the mental health problem	It turns out that I was in various psychological processes like five or six more or less and I lost count. [The treatment] It should not be oriented on this side, this is not working for me, so what I do is leave the process. [CC_2] But if you add human relationships, trust, understanding, closeness, things you find in a support group, that consultation will be better, more effective… and then nobody wastes their time. [JC_6]
	Perception of a violation of dignity	Included in this code are all citations that explicitly or implicitly mention the approval of professionals and their expert judgment in the diagnosis, treatment, and general management of mental illness	You don't need to be tied up to take away your wings, sometimes they say painful things to you, they take away hope, like the pain you feel will be forever, irremediable… that leaves us reduced. [CB_10] When I was hospitalized, I felt like a monster, like one of those witches who were tied up and burned for thinking differently. In my case, it was because I felt so much anguish. [MC_6] Regarding tying someone up or sedating them with medications, we know that it goes against their rights, against their dignity. But not being listened to, not having our culture respected, as Cristian just mentioned, even if it's not physically violent, it also harms us. And it's a systematic, structural harm, not the kind you can easily report, which makes it very serious. [JC_6]

Going to the doctor for mental health sometimes doesn't fix anything; those types of consultations can be ineffective. We know that medications alone often don't work, so what does? Psychotherapy combined with medication works a little better. But if you add human relationships, trust, understanding, closeness, things you find in a support group, that consultation will be better, more effective... and then nobody wastes their time.

"They may know a lot, but if they don't know how to empathize, in mental health, knowledge is not enough… Healthcare professionals should come to the [mutual aid] group", says Mariana. In this sense, this may be a reason for ineffective treatment and the

appearance of discourses associated with criticism of the duration of treatment, even considering the negative impacts of these approaches. Jaime illustrated it in his case:

> I started to think, I have to do something for myself because I have had two or three interviews with a psychiatrist and a psychologist and well, I see that this really is a salute to the flag, it is a band aid on my problem, and it seems even to me counterproductive, saying this with respect for the professionals. But that of not talking to a person for five, 10 minutes and well, take this medicine, and that is all, I think that's not for me.

To that, Heidy adds, "They are superficial, transactional relationships. If I have an infection, that kind of relationship may work, but if it's the soul that hurts, what good will it do?". Cristian adds:

> In indigenous communities, we understand mental illnesses as spiritual disharmony. In some communities, they do seek Western medical help for this, but if they encounter what the companion mentioned, where there is no spirit, then how can we help to harmonize?.

Catalina, 27 years old, refers: "Not everyone is willing to help you in this way. I have gone through many professionals, there is always a condition relation with the appointment setting or money, and going to the appointment does not mean that it would work". Later on, Heidy opened up the discussion that formed the second category, *Perception of a violation of dignity*. She mentioned:

> Well, when there is more empathy in the professionals, and at least they listen, the treatment is useful. There are some professionals in any area, psychologists, doctors, whoever, there are many who do not do things with love, I don't know, it seems that they do it as if was only a routine because I know friends who go to the insurance psychologist and, apart from the fact that it is very difficult to get an appointment, it does not help them very much because they are not treated well.
>
> You don't need to be tied up to take away your wings, sometimes they say painful things to you, they take away hope, like the pain you feel will be forever, irremediable… that leaves us reduced.

To that, Mariana added:

> When I was hospitalized, I felt like a monster, like one of those witches who were tied up and burned for thinking differently. In my case, it was because I felt so much anguish... I wanted to run away, and I was confused, I didn't know what was happening. All I saw were people hovering over me, nobody explained anything to me. I passed out, and when I woke up, I could only move my head. I still didn't know what was going on... If it was necessary for them to tie me up, although I don't think it was, at least if they had explained why they were doing such a horrible thing, I wouldn't have felt so bound, not just physically but emotionally.

Jaime mentioned: "Perhaps it was a procedure, there may be an explanation, but if they don't explain it and see you as a crazy person, it sounds violent. The worst part is that Mariana's story is an everyday occurrence for people in the group". To this, Heidy responded, "And being tied up is also done with medications. There is a medication called haloperidol, which some professionals refer to as a pharmacological straitjacket. I've heard this from several professionals during hospitalizations". Later, Jaime said:

> These perceptions are generated by not communicating effectively with people in the clinics, by not explaining things properly. You need trust, and a good face in who you are going to tell your problems, this is needed to feel comfortable, feel intimacy, and tell the sadness. Although this is not entirely the fault of psychiatrists and psychologists, I know that they force them to have 15-minute interviews, that is very little to build intimacy. In addition, that is also why many look ugly and are tired, and they infect you with that bad temper and that tiredness, not only when you are sad, but also when something hurts.

These situations, beyond a diagnosis, could speak of individual situations that are suffered in a unique way and that must be addressed considering all possible aspects of an existence. Therefore, the application of these principles does not depend on a diagnostic code. In words of Mariana: "The psychiatrist only

gives me pills, I think the only thing that matters to him is that I don't want to kill myself, he doesn't care about my problems or what happens to me or what I feel".

In general, health professionals appropriate broad understandings of mental health, oriented towards integrated care and not exclusively linked to the absence of disease. As Cristian points out, when asking if he agrees with the treatment his indigenous community receives in terms of mental health:

> In my community, noises were heard at night, some young people did not want to fish, they had a hard time getting up, they refused their parents' care, they cried for hours. Given this, the leader of the settlement directed the young people, their mothers and fathers, to consult the nearest western doctor. They followed the recommendation. When consulting the professionals, they did not find any problem: he has nothing, there is no disease, they said. As indicated in the community, if you do not find problems in the western doctor, you should go the Jaibaná or traditional doctor. When there is no illness from the doctors, there is a spirit of death that must be fought with the help of the Jaibaná, our traditional doctor. But since my community is displaced by the armed conflict, we don't have a Jaibaná… So, what path was left?: evil has no solution, there is no hope.
> Two weeks after the first consultation, a 17-year-old boy committed suicide, he was also our translator. Another one, in a 14-year-old girl, sister of the first, another one in a 16-year-old boy, an expert fisherman, another one in a 15-year-old girl, mother for a few months, another one in an 18-year-old boy, assistant in the popular school. All one to two weeks apart... And all because they couldn't communicate.

As Mariana pointed out: "They [Health professionals] think that everyone who suffers from depression has the same path or the same medicine, that happens a lot with psychiatrists and psychologists". To that, Jaime added:

> Regarding tying someone up or sedating them with medications, we know that it goes against their rights, against their dignity. But not being listened to, not having our culture respected, as

Cristian just mentioned, even if it's not physically violent, it also harms us. And it's a systematic, structural harm, not the kind you can easily report, which makes it very serious.

Discussion

Recognizing mental health as a fundamental human right for all people is a key principle in the reformulation of mental health. A better relationship between people with mental health problems and health personnel has important benefits, including reinforces the dignity of people with mental disorders by promoting their human rights (Bhugra et al., 2017; Gill et al., 2024; Knopes & Dégale-Flanagan, 2023; Meier et al., 2018). Therefore, the present study aimed to analyze the perception that some people with mental disorders have of communication with the treating health personnel. Indeed, the study considers specific perceptions that are anchored in their context and provides guidance for political practice in light of these findings.

It is emphasized how effective and sensitive communication with healthcare personnel validates and helps realize the right to an adequate standard of living and social protection, the enjoyment of the highest attainable standard of physical and mental health, freedom and security, protection against inhumane and degrading treatment, and inclusion in the community (Gill et al., 2024). Although they carry out initiatives within their support or mutual aid groups to advocate for their rights, provide emotional support, and even address economic needs (Agudelo-Hernández et al., 2024), they acknowledge the importance of healthcare services and professionals in the path to recovery.

A perception of the ineffectiveness of the classic treatments (pharmacological and psychological) is pointed out, people understanding this efficacy as an excessive duration of the process or an iatrogenic effect, for which they decide to abandon the treatment. Similarly, in the interviews, it is expressed characteristics of coldness and excessive distance in the relationship between health personnel and people who need mental health services (Ibrahim et al., 2019; Grassi et al., 2015; Wei et al., 2015). It has also been described that the perception that people with medical problems have of empathy or negative emotions

in health personnel, cause neurobiological changes in the brain regions related to pain, decreasing it when a positive attitude is identified and increasing it in the opposite case (Decety, 2020; McDonagh et al., 2019). Most people who come to clinics display a dynamic mix of characteristics between anxiety, anger, and sadness, in addition to previous trauma experiences. Other needs in people who go to health services, are hope and understanding on the part of health personnel to stop living with prolonged uncertainty or with the inevitability of decline (Hernández et al., 2024 Picco et al., 2018).

Group-based disadvantage was found to be a significant and under-researched health challenge, especially in low- and middle-income countries (Agudelo-Hernández & Rojas-Andrade, 2023). It found that poverty, stigma, and marginalization intensify health problems and can make health care systems unwelcoming and unresponsive to group needs, hampering policy implementation and putting human rights at risk. For reasons such as those reinforced by the focus groups, the need to improve the continuity of care as a mechanism to improve communication has been emphasized (Hernández et al., 2024).

As can be inferred from the quotes mentioned by the people in the support and mutual aid groups, an understanding of mental disorders beyond biology or psychological mechanisms is sought (Agudelo-Hernández & Rojas-Andrade, 2023). Just as reports of frustration with care in this category have been reviewed, other studies focused on health personnel members also express frustrations in their professional practice, since they do not identify feasible possibilities of improvement in people who seek support in their care experience, which led them to feel exhausted (McDonagh et al., 2019). These professionals pointed out that the main actions should be oriented towards education, security and housing. As mentioned in the interviews, especially with Cristian, there are factors that also cross communication, among them, forced displacement, lack of housing. As some participants mention, the "medicalization" of certain everyday situations that do not constitute a psychopathological process could be driven by other commercial interests that hinder the recovery of individuals (Kelly, 2018).

As recommendations, as reported by people with mental disorders in this research, improving communication in mental health clinical practice has a positive impact on recovery processes. In the same way, seeing people as active agents of their lives and holders of rights, and not as simple recipients of information, mobilizes communities to recover other rights, such as housing, education, employment (Meier et al., 2018). It would promote social inclusion and equity for the enjoyment of the highest possible level of physical and mental health, which is a right of all (United Nations, 2006).

Basing the clinical act on human rights and communication is urgent in terms of public health (Meier et al., 2018). The WHO has proposed QualityRights as a strategy aimed at improving the quality and effectiveness of services (WHO, 2012), which offers virtual training (https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training). Which entails preserving the dignity of individuals with mental disorders, providing accepted and relevant care, ensuring that the quality of care improves in all areas, including the promotion of mental health, prevention, treatment, and rehabilitation in primary care, as well as in community residential facilities, outpatient settings, and inpatient care (Gill et al., 2024).

As limitations, the bias of the sample chosen by convenience through the Ministry of Health is recognized, since many mutual aid groups, sometimes due to their foundations, operate without being registered in government systems (Agudelo-Hernández & Rojas-Andrade, 2023). Quantitative analysis is also required to determine the impact that communication problems and lack of human rights among health personnel could have on health systems. As highlighted by the present study, communication with healthcare personnel significantly influences this situation, and the perception of individuals with mental disorders becomes a key element in identifying and assessing human rights in the quality of services. Future studies could take an ecological approach, delving into the communication style of professionals, the characteristics of people with mental disorders, and other sociodemographic factors that influence the provision of services.

In conclusion, human rights in mental health as a specific focus in clinical practice guidelines. In order to shift from a reactive approach to a participatory one, based on group and community decision-making, it is necessary for treatments to go hand in hand with education on civil rights, opportunities for

participation in shared interests, and interaction with other individuals who have lived experience. This analysis points to the need to reinforce training and education on mental health in health professionals, to improve the attitude of the staff, to increase awareness among professionals of all the communicative elements that people have, beyond spoken language, as well as working for policies that improve the influencing factors in the delivery of mental health services. Similarly, it is necessary to inquire about people's perception of their own mental health processes.

Declarations

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