

ADVOCACY FOR MENTAL HEALTH



World Health Organization, 2003

“Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development.”

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This module is part of the WHO Mental Health Policy and Service guidance package, which provides practical information to assist countries to improve the mental health of their populations.

What is the purpose of the guidance package?

The purpose of the guidance package is to assist policy-makers and planners to:

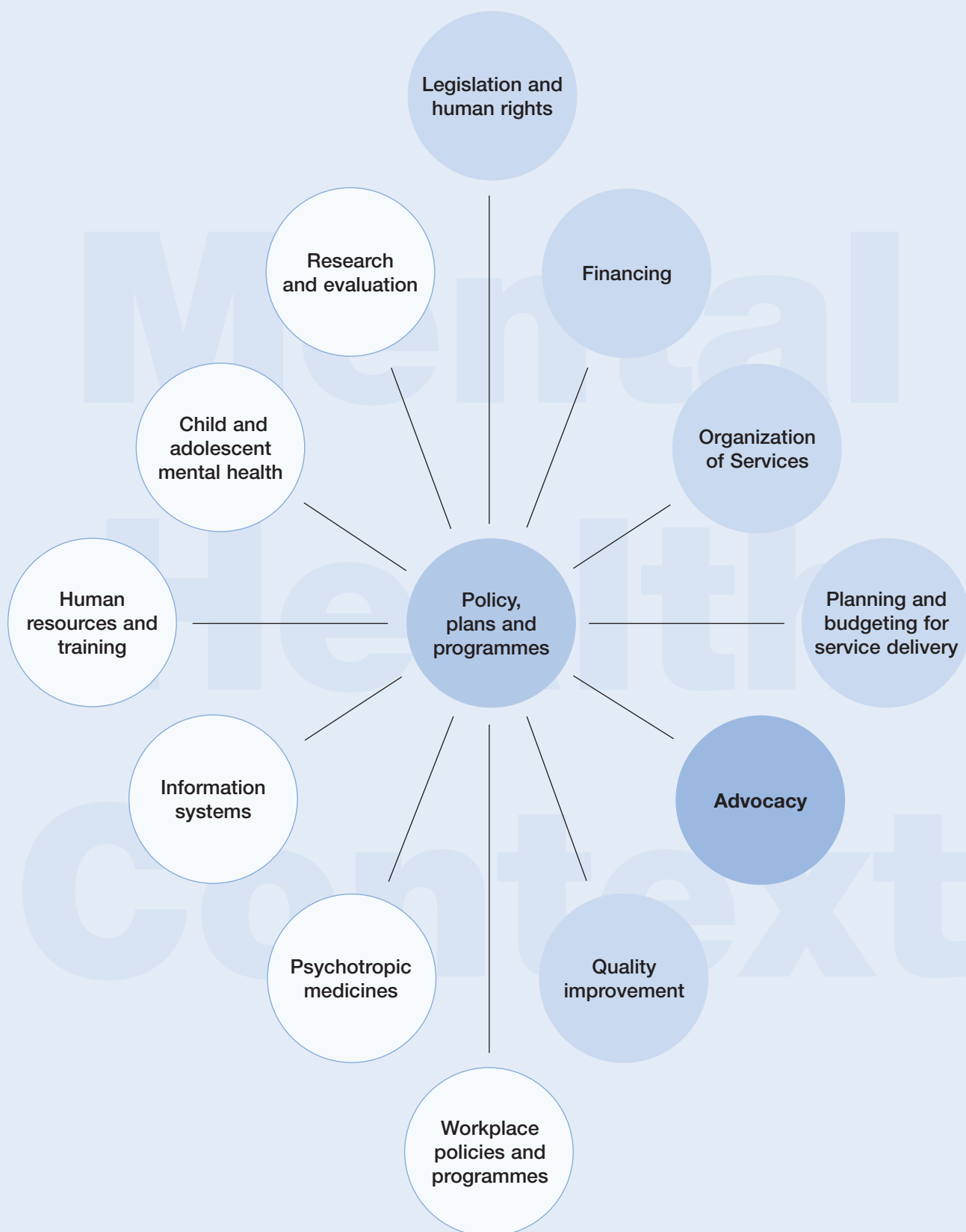
- develop policies and comprehensive strategies for improving the mental health of populations;
- use existing resources to achieve the greatest possible benefits;
- provide effective services to those in need;
- assist the reintegration of persons with mental disorders into all aspects of community life, thus improving their overall quality of life.

What is in the package?

The package consists of a series of interrelated user-friendly modules that are designed to address the wide variety of needs and priorities in policy development and service planning. The topic of each module represents a core aspect of mental health. The starting point is the module entitled The Mental Health Context, which outlines the global context of mental health and summarizes the content of all the modules. This module should give readers an understanding of the global context of mental health, and should enable them to select specific modules that will be useful to them in their own situations. Mental Health Policy, Plans and Programmes is a central module, providing detailed information about the process of developing policy and implementing it through plans and programmes. Following a reading of this module, countries may wish to focus on specific aspects of mental health covered in other modules.

The guidance package includes the following modules:

- > The Mental Health Context
- > Mental Health Policy, Plans and Programmes
- > Mental Health Financing
- > Mental Health Legislation and Human Rights
- > Advocacy for Mental Health
- > Organization of Services for Mental Health
- > Quality Improvement for Mental Health
- > Planning and Budgeting to Deliver Services for Mental Health



● still to be developed

The following modules are not yet available but will be included in the final guidance package:

- > Improving Access and Use of Psychotropic Medicines
- > Mental Health Information Systems
- > Human Resources and Training for Mental Health
- > Child and Adolescent Mental Health
- > Research and Evaluation of Mental Health Policy and Services
- > Workplace Mental Health Policies and Programmes

Who is the guidance package for?

The modules will be of interest to:

- policy-makers and health planners;
- government departments at federal, state/regional and local levels;
- mental health professionals;
- groups representing people with mental disorders;
- representatives or associations of families and carers of people with mental disorders;
- advocacy organizations representing the interests of people with mental disorders and their relatives and families;
- nongovernmental organizations involved or interested in the provision of mental health services.

How to use the modules

- They can be used **individually or as a package**. They are cross-referenced with each other for ease of use. Countries may wish to go through each of the modules systematically or may use a specific module when the emphasis is on a particular area of mental health. For example, countries wishing to address mental health legislation may find the module entitled Mental Health Legislation and Human Rights useful for this purpose.
- They can be used as a **training package** for mental health policy-makers, planners and others involved in organizing, delivering and funding mental health services. They can be used as educational materials in university or college courses. Professional organizations may choose to use the package as an aid to training for persons working in mental health.
- They can be used as a framework for **technical consultancy** by a wide range of international and national organizations that provide support to countries wishing to reform their mental health policy and/or services.
- They can be used as **advocacy tools** by consumer, family and advocacy organizations. The modules contain useful information for public education and for increasing awareness among politicians, opinion-makers, other health professionals and the general public about mental disorders and mental health services.

Format of the modules

Each module clearly outlines its aims and the target audience for which it is intended. The modules are presented in a step-by-step format so as to assist countries in using and implementing the guidance provided. The guidance is not intended to be prescriptive or to be interpreted in a rigid way: countries are encouraged to adapt the material in accordance with their own needs and circumstances. Practical examples are given throughout.

There is extensive cross-referencing between the modules. Readers of one module may need to consult another (as indicated in the text) should they wish further guidance.

All the modules should be read in the light of WHO's policy of providing most mental health care through general health services and community settings. Mental health is necessarily an intersectoral issue involving the education, employment, housing, social services and criminal justice sectors. It is important to engage in serious consultation with consumer and family organizations in the development of policy and the delivery of services.

Dr Michelle Funk

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ADVOCACY FOR MENTAL HEALTH

1. What is advocacy and why is it important?

1.1 Concept of mental health advocacy

The concept of mental health advocacy has been developed to promote the human rights of persons with mental disorders and to reduce stigma and discrimination. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations.

Advocacy in this field began when the families of people with mental disorders first made their voices heard. People with mental disorders then added their own contributions. Gradually, these people and their families were joined and supported by a range of organizations, many mental health workers and their associations, and some governments. Recently, the concept of advocacy has been broadened to include the needs and rights of persons with mild mental disorders and the mental health needs and rights of the general population.

Advocacy is considered to be one of the eleven areas for action in any mental health policy because of the benefits that it produces for people with mental disorders and their families. (See Mental Health Policy, Plans and Programmes.) The advocacy movement has substantially influenced mental health policy and legislation in some countries and is believed to be a major force behind the improvement of services in others (World Health Organization, 2001a). In several places it is also responsible for an increased awareness of the role of mental health in the quality of life of populations.

The concept of advocacy contains the following principal elements.

1.1.1 Advocacy actions

- > Awareness-raising
- > Information
- > Education
- > Training
- > Mutual help
- > Counselling
- > Mediating
- > Defending
- > Denouncing

1.1.2 Drawing attention to barriers for mental health

In most parts of the world, unfortunately, mental health and mental disorders are not regarded with anything like the same importance as physical health. Indeed, they have been largely ignored or neglected (World Health Organization, 2001a). Among the issues that have been raised in mental health advocacy are the following:

- lack of mental health services;
- unaffordable cost of mental health care through out-of-pocket payments;
- lack of parity between mental health and physical health;
- poor quality of care in mental hospitals and other psychiatric facilities;
- need for alternative, consumer-run services;
- paternalistic services;
- right to self-determination and need for information about treatments;

- need for services to facilitate active community participation;
- violations of human rights of persons with mental disorders;
- lack of housing and employment for persons with mental disorders;
- stigma associated with mental disorders, resulting in exclusion;
- absence of promotion and prevention in schools, workplaces, and neighbourhoods;
- insufficient implementation of mental health policy, plans, programmes and legislation.

1.1.3 Positive mental health outcomes

There is still no scientific evidence that advocacy can improve the level of people's mental health. However, there are many encouraging projects and experiences in various countries, including the following:

- the placing of mental health on government agendas;
- improvements in the policies and practices of governments and institutions;
- changes in laws and government regulations;
- improvements in the promotion of mental health and the prevention of mental disorders;
- the protection and promotion of the rights and interests of persons with mental disorders and their families;
- improvements in mental health services, treatment and care.

1.2 Development of the mental health advocacy movement

The mental health advocacy movement is burgeoning in Australia, Canada, Europe, New Zealand, the USA and elsewhere. It comprises a diverse collection of organizations and people with various agendas. Although many groups join together to work in coalitions or to achieve common goals, they do not necessarily act as a united front.

Among the groups involved in advocacy are consumer and "survivor" organizations and a range of nongovernmental organizations. In several countries, advocacy initiatives in favour of mental health and persons with mental disorders are supported and, in some cases, carried out by governments, ministries of health, states and provinces.

In many developing countries, mental health advocacy groups have not yet been formed or are in their infancy. There is potential for rapid development, particularly because costs are relatively low, and because social support and solidarity are often highly valued in these countries. Development depends, to some extent, on technical assistance and financial support from both public and private sources.

WHO, through its regional offices and the Department of Mental Health and Substance Dependence, has played a significant role in supporting ministries of health all over the world in mental health advocacy.

1.3 Importance of mental health advocacy

The emergence of mental health advocacy movements in several countries has helped to change society's perceptions of persons with mental disorders. Consumers have begun to articulate their own visions of the services they need. They are increasingly able to make informed decisions about treatment and other matters in their daily lives. Consumer and family participation in advocacy organizations may also have several positive outcomes.

2. Roles of different groups in advocacy

2.1 Consumers and families

Opinions vary among consumers and their organizations about how best to achieve their goals. Some groups want active cooperation and collaboration with general health and mental health services, whereas others desire complete separation from them.

Consumer groups have played various roles in advocacy, ranging from influencing policies and legislation to providing help for people with mental disorders. Consumer groups have sensitized the general public about their cause and provided education and support to people with mental disorders. They have denounced some forms of treatment that are believed to be negative. They have denounced poor service delivery, inaccessible care and involuntary treatment. Consumers have also struggled for improved legal rights and the protection of existing rights. Programmes run by consumers concern drop-in centres, case management, crisis services and outreach.

The roles of families in advocacy overlap with many of the areas taken on by consumers. However, families have the distinctive role of caring for persons with mental disorders. In many places they are the primary care providers and their organizations are fundamental as support networks. In addition to providing mutual support and services, many family groups have become advocates, educating the community, increasing the support obtained from policy-makers, denouncing stigma and discrimination, and fighting for improved services.

2.2 Nongovernmental organizations

These organizations may be professional, involving only mental health professionals, or interdisciplinary, involving people from diverse areas. In some nongovernmental organizations, mental health professionals work with persons who have mental disorders, their families and other concerned individuals.

Nongovernmental organizations fulfil many of the advocacy roles described for consumers and families. Their distinctive contribution to the advocacy movement is that they support and empower consumers and families.

2.3 General health workers and mental health workers

In places where care has been shifted from psychiatric hospitals to community services, mental health workers have taken a more active role in protecting consumer rights and raising awareness for improved services. In traditional general health and mental health facilities it is not unusual that workers feel empathy for persons with mental disorders and become advocates for them over some issues. However, there can also be conflicts of interest between general health workers or mental health workers and consumers.

Some specific advocacy roles for mental health workers relate to:

- clinical work from a consumer and family perspective;
- participation in the activities of consumer and family groups;
- supporting the development of consumer groups and family groups; planning and evaluating programmes together.

2.4 Policy-makers and planners

Ministries of health, and specifically their mental health sections, can play an important role in advocacy. Ministries of health may implement advocacy actions directly so as to

influence the mental health of populations in general or consumers' civil and health rights in particular. They may achieve similar or complementary impacts on these populations by working indirectly through supporting advocacy groups (consumers, families, nongovernmental organizations, mental health workers).

Additionally, it is necessary for each ministry of health to convince other policy-makers and planners, e.g. the executive branch of government, the ministry of finance and other ministries, the judiciary, the legislature and political parties, to focus on and invest in mental health. Ministries of health can also develop many advocacy activities by working with the media.

There may be some contradictions in the advocacy activities of ministries of health, which are often at least partially responsible for some of the issues for which advocacy is possible. For example, if a ministry of health is a service provider and at the same time advocates for the accessibility and quality of services, it can be perceived as acting as both player and referee. Opposition parties may question the degree to which the ministry is motivated to improve the accessibility and quality of services. The facilitation of independent review bodies and advocacy groups may be a more appropriate solution.

3. How ministries of health can support advocacy

3.1 By supporting advocacy activities with consumer groups, family groups and nongovernmental organizations

Governments can provide these organizations with the support required for their development and empowerment. This support should not be accompanied by conditions that would prevent occasional criticism of government. The empowerment of consumers and families means that they are given power, authority and a sense of capacity and ability.

Principal steps for supporting consumer groups, family groups and nongovernmental organizations

Step 1: Seek information about mental health consumer groups, family groups and nongovernmental organizations in the country or region concerned.

- Task 1: Develop a database with consumer groups, family groups and nongovernmental organizations.
- Task 2: Establish a regular flow of information in both directions.
- Task 3: Publish and distribute a directory of these organizations.

Step 2: Invite representatives of consumer groups, family groups and nongovernmental organizations to participate in activities at the ministry of health.

- Task 1: Formulate and evaluate policy, plans, programmes, legislation or quality improvement standards.
- Task 2: Establish committees, commissions or other boards.
- Task 3: Take educational initiatives.
- Task 4: Conduct activities with the media.
- Task 5: Organize public events in order to raise awareness.

Step 3: Support the development of consumer groups, family groups and nongovernmental organizations at the national or regional level.

- Task 1: Provide technical support.
- Task 2: Provide funding.
- Task 3: Support evaluations of consumer groups, family groups and nongovernmental organizations.
- Task 4: Enhance alliances and coalitions of consumer groups.

Step 4: Train mental health workers and general health workers to work with consumer and family groups.

Step 5: Focus activities in advocacy groups.

- Task 1: Identify the principal features of consumer groups.
- Task 2: Identify the principal features of family groups.
- Task 3: Identify the principal features of nongovernmental organizations.

3.2 By supporting advocacy activities with general health workers and mental health workers

Advocacy actions targeting this group should aim to modify stigma and negative attitudes towards consumers and families and to improve the quality of mental health services and of the treatment and care provided.

Principal steps for supporting general health workers and mental health workers

Step 1: Improve workers' mental health:

- Task 1: Build alliances with trade unions and other workers' associations.
- Task 2: Ensure that basic working conditions exist for general health and mental health workers.
- Task 3: Implement mental health interventions for workers.

Step 2: Support advocacy activities with mental health workers

- Task 1: Train mental health workers.
- Task 2: Encourage community care and community participation.
- Task 3: Facilitate interactions with consumer groups, family groups and nongovernmental organizations.

Step 3: Support advocacy activities with general health workers

- Task 1: Define the role of general health workers in the field of mental health.
- Task 2: Train general health workers in mental health.
- Task 3: Establish joint activities with mental health specialists.
- Task 4: Set up demonstration areas.

3.3 By supporting advocacy activities with policy-makers and planners

The principal objective in respect of policy-makers and planners is to give appropriate attention to mental health on national agendas. This helps to enhance the development and implementation of mental health policy and legislation. The professionals in charge of mental health in ministries of health frequently start the advocacy process.

Principal steps for supporting policy-makers and planners

Step 1: Build technical evidence

- Task 1: Determine the magnitude of mental disorders.
- Task 2: Highlight the cost of mental disorders.
- Task 3: Identify effective mental health interventions.
- Task 4: Identify cost-effective interventions.

Step 2: Implement political strategies

- Task 1: Identify themes ranking high in public opinion.
- Task 2: Demonstrate the success of these themes.
- Task 3: Empower alliances among mental health advocates.

3.4 By supporting advocacy activities with the general population

The two following areas of advocacy for the general population can be identified.

- **Advocacy for mental health:** This type of advocacy aims to enhance and protect mental health in the daily lives of individuals, families, groups and communities.
- **Advocacy around mental disorders:** In this case, advocacy aims to improve the knowledge, understanding and acceptance of mental disorders in the general population so that people can recognize them and ask for treatment as early as possible.

3.4.1 General strategies for supporting advocacy activities with the general population

Ministries of health can support advocacy with the general population through public events and the distribution of educational materials such as brochures, pamphlets, posters and videos. Many advocacy activities require little or no additional funding. Professionals in ministries of health, and eventually higher decision-makers, can incorporate many advocacy activities into their daily work. They can reach the general population through the media, national meetings, professional seminars and congresses, and various public events.

3.4.2 Role of the media in advocacy

The following media strategies may be considered for the purposes of mental health advocacy by ministries of health.

- > Maintenance of a continuous working alliance with the media.
- > Raising of mental health issues in the media.
- > Production of news that is of interest to the media.

4. Conclusion

The implementation of some of the ideas presented in this module could help ministries of health to support advocacy in their countries or regions. The development of an advocacy movement could facilitate the implementation of mental health policy and legislation and populations could receive many benefits. The needs of persons with mental disorders could be better understood and their rights could be better protected. They could receive services of improved quality and could participate actively in their planning, development, monitoring and evaluation. Families could be supported in their role as carers, and populations at large could gain an improved understanding of mental health and disorders.

Aims and target audience

Aims

To provide guidance to ministries of health on the development of mental health advocacy in countries or regions.

Target audience

- Policy-makers and public health professionals in ministries of health (or health offices) of countries and large administrative divisions of countries (regions, states, provinces).
- Advocacy groups representing people with mental disorders and their families.
- General health workers and mental health workers.

1. What is advocacy and why is it important?

1.1 Concept of mental health advocacy

Mental health advocacy includes a variety of different actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations. The concept, which is relatively new, was initially developed to reduce stigma and discrimination and to promote the human rights of persons with mental disorders.

Over the last 30 years the needs and rights of persons with severe mental disorders have become more visible. Families and, subsequently, consumers developed organizations enabling their voices to be heard. They were joined and supported by a range of nongovernmental organizations, many mental health workers and their associations, and some governments. More recently, the concept of advocacy has been broadened to include the needs and rights of persons with less severe mental disorders and the mental health needs of the general population.

Advocacy is one of the 11 areas for action in any mental health policy because of the benefits that are produced for consumers and families. (See Mental Health Policy, Plans and Programmes.) The advocacy movement has substantially influenced mental health policy and legislation in various countries and is believed to be a major factor in the improvement of services in others (World Health Organization, 2001a). In several places it is responsible for an increased awareness of the role of mental health in the quality of life of populations. In many societies, robust support networks have been established through advocacy organizations.

Actions typically associated with advocacy include the raising of awareness, the dissemination of information, education, training, mutual help, counselling, mediating, defending and denouncing.

1.1.1 Barriers to mental health

The advocacy movement has developed in response to several global barriers to mental health. In most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health. Instead, they have been largely ignored or neglected (World Health Organization, 2001a).

Only a small minority of people with mental disorders receive even the most basic treatment. Many of them become targets of stigma and discrimination. Many communities are faced with factors that present risks to mental health.

Advocacy began with attempts to reduce stigma and promote the rights of people with mental disorders.

More recently, the concept of advocacy has been broadened to include promotion, prevention and less severe mental disorders.

Advocacy is one of the 11 areas for action in the development of a mental health policy.

Several actions have typically been associated with advocacy.

Among the barriers to mental health are the following:

- *Lack of mental health services.* For example, only 51% of the world's population have access to treatment for severe mental disorders at the primary care level (World Health Organization, 2001b). Moreover, the available treatment is not necessarily effective or comprehensive.
- *Unaffordable cost of mental health care,* including out-of-pocket payments, even in developed countries. For example, out-of-pocket expenditure is the primary method of financing in 39.6% of low-income countries (World Health Organization, 2001b).
- *Lack of parity between mental health and physical health.* For example, investments made by governments and health insurance companies in mental health are disproportionately small.
- *Poor quality of care* in mental hospitals and other psychiatric facilities.
- *Absence of alternative services run by consumers.*
- *Paternalistic services,* in which the views of service providers are emphasized and those of consumers are not considered.
- *Violations of human rights* of persons with mental disorders.
- *Lack of housing and employment* for persons with mental disorders.
- *Stigma* associated with mental disorders, resulting in exclusion (see Box 1).
- *Absence of programmes for the promotion of mental health and the prevention of mental disorders* in schools, workplaces and neighbourhoods.
- *Lack or insufficient implementation of mental health policies, plans, programmes and legislation.* More than 40% of countries have no mental health policy, over 30% have no mental health programme, and over 90% have no mental health policy that includes children and adolescents (World Health Organization, 2001b).

There are several structural and attitudinal barriers to achieving positive mental health outcomes.

Only a small minority of persons with mental disorders receive even the most basic treatment.

There is widespread stigma and discrimination against persons with mental disorders.

There is an absence of mental health promotion and of prevention of disorders.

Box 1. Stigma and mental disorders

What is stigma?

Stigma is something about a person that causes her or him to have a deeply compromised social standing, a mark of shame or discredit. Many persons with serious mental disorders appear to be different because of their symptoms or the side-effects of their medication. Other people may notice the differences, fail to understand them, feel uncomfortable about the persons affected and act in a negative way towards them. This exacerbates both symptoms and disability in persons with mental disorders.

Common misconceptions about people with mental disorders

People with mental disorders are often thought to be:

- lazy
- unintelligent
- worthless
- stupid
- unsafe to be with
- violent
- out of control
- always in need of supervision
- possessed by demons
- recipients of divine punishment
- unpredictable
- unreliable
- irresponsible
- untreatable
- without conscience
- incompetent to marry and raise children
- unable to work
- increasingly unwell throughout life
- in need of hospitalization

What are the effects of stigma?

- > Unwillingness of persons with mental disorders to seek help
- > Isolation and difficulty in making friends
- > Damage to self-esteem and self-confidence
- > Denial of adequate housing, loans, health insurance and jobs because of mental disorders
- > Adverse effect on the evolution of mental disorders and disability
- > Families are more socially isolated and have increased levels of stress
- > Fewer resources are provided for mental health than for other areas of health

How to combat stigma

1. Community education on mental disorders (prevalence, causes, symptoms, treatment, myths and prejudices)
2. Anti-stigma training for teachers and health workers
3. Psychoeducation for consumers and families on how to live with persons who have mental disorders
4. Empowerment of consumer and family organizations (as described in this module)
5. Improvement of mental health services (quality, access, deinstitutionalization, community care)
6. Legislation on the rights of persons with mental disorders
7. Education of persons working in the mass media, aimed at changing stereotypes and misconceptions about mental disorders
8. Development of demonstration areas with community care and social integration for persons with mental disorders

1.1.2 Positive mental health outcomes

Many advocacy initiatives have yielded positive outcomes in spite of the above barriers. Although no scientific evidence yet exists that advocacy directly improves mental health in populations, encouraging projects and experiences have been reported from various countries (Aranha et al., 2000; Levav et al., 1994; Dirección General de Rehabilitación Psicosocial, Participación, Ciudadana y Derechos Humanos, 2001; Walunguba, 2000; World Health Organization, 2001a, 2001b. M. Lopez, personal communication, 2002). Some of the outcomes associated with advocacy include:

- the placing of mental health on government agendas;
- improvements in policies and practices of governments and institutions;
- changes made to laws and government regulations;
- improvements in the promotion of mental health and the prevention of mental disorders;
- the protection and promotion of the rights and interests of persons with mental disorders and their families;
- improvements in mental health services, treatment and care.

There have been many encouraging advocacy experiences with positive outcomes.

Key points: Concept of mental health advocacy

- Advocacy is considered to be one of the 11 areas for action in any mental health policy because of the benefits that are produced for consumers and families.
- There are different types of advocacy actions: the raising of awareness, the dissemination of information, education, training, mutual help, counselling, mediating, defending and denouncing.
- These actions are aimed at reducing barriers such as: lack of mental health services, stigma associated with mental disorders, violation of patients' rights, absence of promotion, lack of housing and employment.
- Reducing these barriers can help by improving policy, laws and services, promoting the rights of persons with mental disorders, promoting mental health and preventing disorders.

1.2 Development of the mental health advocacy movement

The advocacy movement had its origins in a range of organizations that set out to encourage support for vulnerable groups in society. The early aims were to develop communities whose members were more able, competent and willing to speak on behalf of other persons and advocate for them. This required listening to the points of view of the vulnerable groups, respecting their wishes, protecting their interests and standing with them to defend their rights. Individuals who had been stigmatized, ignored and excluded by society were enabled to become active members of their communities (Citizen Advocacy, Information and Training, 2000).

The principles of advocacy are applicable to anyone whose rights and wishes are ignored or overruled. They have been applied to persons with intellectual disability, gay men and lesbians, the elderly, homeless people, children (especially those in care) and people in jail.

In the area of mental health, advocacy began many years ago when the rights of persons with severe mental disorders were defended, particularly those of people who experienced long stays in mental hospitals. Changes were promoted in the community at large so as to facilitate the social integration of people with mental disorders.

Over the past 30 years, families of people with mental disorders, and, subsequently, people with mental disorders themselves, have become increasingly involved in the advocacy movement, acting on their own behalf through their organizations. This has led to the emergence of the concept of **self-advocacy**, i.e. people's ability to act and advocate on behalf of themselves and their families. This concept is significant because it implies that people affected by mental disorders can act with a high level of motivation and an intimate knowledge of mental disorders. Such involvement can have a positive effect on the mental health of volunteers, through improved confidence, self-esteem, motivation and a sense of belonging.

In the last 15 years the concept of mental health advocacy has been broadened to encompass people with relatively mild mental disorders and the promotion and protection of mental health in the general population. Moreover, advocacy for the rights of every citizen to have better mental health is an attempt to achieve changes in the sociopolitical environment favouring the promotion and protection of mental health (World Federation for Mental Health, 2002).

In Australia, Canada, Europe, New Zealand, the USA and elsewhere the mental health advocacy movement is burgeoning. It comprises a diverse collection of organizations and people and a range of agendas. Although many groups combine to work in coalitions or meet common goals, they do not necessarily act as a united front. Some organizations are run by consumers who may have a comparatively positive view of the mental health system, whereas others are run by individuals who call themselves psychiatric survivors and can be more critical of the system and the use of psychotropic medications (Tenety & Kiselica, 2000).

The following categories of organizations have come to be associated with mental health advocacy:

- > consumer groups;
- > organizations of families and friends of people with mental disorders;
- > professional associations;
- > nongovernmental organizations working in the field of mental health;
- > a wide range of mental health associations, including consumers, carers, mental health professionals, technicians, artists, journalists and other people interested in mental health.

The advocacy movement had its origins in attempts to support vulnerable groups in society.

The principles of advocacy can be applied to anyone whose rights are ignored or overruled.

Self-advocacy is the ability of people to act and advocate on behalf of themselves and their families.

Advocacy also attempts to achieve changes in the sociopolitical environment in order to promote and protect mental health.

Governments and ministries of health in several countries also support, and in some cases carry out, advocacy initiatives in favour of mental health and persons with mental disorders.

In many developing countries, mental health advocacy groups are absent or incipient. There is potential for rapid development, particularly because the costs are relatively low and social support and solidarity are often highly valued in these countries. Development depends, to some extent, on technical assistance and financial support from both public and private sources (Ministry of Health, 2000).

Organizations in the mental health advocacy movement represent the needs of various groups: consumers, families, civil libertarians, politicians, health providers, psychologists, psychiatrists and other professional groups. Advocacy is thus driven by agendas with diverse, often conflicting, sometimes irreconcilable, differences between stakeholders. Nevertheless, in some countries the groups concerned have tended to form alliances in order to campaign with increased strength on some common themes. For example, “the National Alliance for the Mentally Ill in the USA, ENOSH in Israel and MIND in Britain” are active players in policy development (World Health Organization, 2001c p.21). They have developed initiatives to raise public awareness about mental disorders and act as pressure groups for the improvement of services.

International organizations with a strong commitment to mental health advocacy have also developed in recent decades. They are useful resources for developing countries, providing support for the formation of national advocacy movements. Among such organizations are the following:

- the World Federation for Mental Health, which has individual and organization members in many countries (World Federation for Mental Health, 2002);
- Alzheimer’s Disease International, is an umbrella group of 64 Alzheimer associations throughout the world (Alzheimer’s Disease International, 2002);
- the World Fellowship for Schizophrenia and Allied Disorders, with 22 national organizations and more than 50 smaller groups (World Fellowship for Schizophrenia and Allied Disorders, 2002).

WHO, through its regional offices and its Department of Mental Health and Substance Dependence, has played a significant role in supporting ministries of health to advocate for mental health. The Caracas Declaration of 1990, promoted by the Pan American Health Organization, is a good example of an international initiative that has had an impact in several countries. The Declaration was very influential on Latin American and Caribbean countries in advocating for the protection of the personal dignity, human rights and civil rights of persons with mental disorders (Levav et al., 1994).

Another example of successful international advocacy was the WHO initiative “Stop exclusion. Dare to care” (World Health Organization, 2001d). This was intended to combat stigma and rally support for more equitable care for persons with mental disorders, including the acceptance of mental health as a major topic of concern among Member States. Educational materials were distributed to national governments and health care organizations, which were invited to become actively involved in the development of appropriate mental health policies and services.

1.3 Importance of mental health advocacy

In several countries the advocacy movement has led to major changes in the way persons with mental disorders are regarded. Consumers have begun to articulate their own vision of the services they need and want. They are also making increasingly informed decisions about treatment and other matters affecting their daily lives.

In many developing countries, mental health advocacy groups are absent or incipient.

Despite discrepancies, advocacy groups have tended to form alliances so as to become stronger.

International organizations with a strong commitment to mental health advocacy have also developed.

In several countries the advocacy movement has led to major changes in the way persons with mental disorders are regarded.

Advocacy has helped consumers make their voices heard and to show the real people behind the labels and diagnoses. “Those who have been diagnosed with mental illness are not different from other people, and want the same basic things out of life: adequate incomes; decent places to live; educational opportunities; job training leading to real, meaningful jobs; participation in the lives of their communities; friends and social relationships; and loving personal relationships” (Chamberlin, 2001).

Advocacy has helped consumers around the world to make their voices heard and to show the real people behind the labels and diagnoses.

Consumer and family participation in advocacy organizations may also have several positive effects (Goering et al., 1997), e.g. decreases in the duration of inpatient treatment and in the number of visits to health services. There has been a reinforcement of knowledge and skills acquired through contact with services. Other possible beneficial effects of advocacy are the building of self-esteem, feelings of well-being, enhanced coping skills, the strengthening of social support networks and the improvement of family relationships. These findings were reinforced by the United States Surgeon General’s report on mental health (Department of Health and Human Services, 1999). Consumer advocates and consumer researchers participated in planning, contributing to, and reviewing sections of this report.

The positive impacts of advocacy include decreased utilization of services, improved self-esteem, greater well-being, and enhanced coping skills.

Because many barriers prevent people in most countries from gaining access to mental health services, advocacy represents an essential area for action in national or regional policy. (See *Mental Health Policy, Plans and Programmes*.) Advocacy can help the development and implementation of programmes on mental health promotion for the general population and on the prevention of mental disorders for persons with risk factors. It can also help with treatment programmes for persons with mental disorders and with the rehabilitation of persons with mental disability.

Advocacy can help the implementation of promotion, prevention, treatment and rehabilitation.

Moreover, advocacy by consumer groups, family groups and nongovernmental organizations can make valuable contributions to improving and implementing mental health legislation, and to improving the financing, quality and organization of services. (See *Mental Health Financing; Mental Health Legislation and Human Rights; Quality Improvement for Mental Health; Organization of Services for Mental Health*.)

The importance of mental health advocacy became evident at the ministerial round tables during the World Health Assembly in 2001, where health ministers agreed that raising the level of mental health awareness was the first priority. “Policy-makers in government and civil society should be sensitized about the huge and complex nature of the economic burden of mental illness and the need for more resources to treat mental illness” (World Health Organization, 2001c).

The importance of mental health advocacy became evident at the ministerial round tables during the World Health Assembly in 2001.

The ministers agreed that the stigma associated with mental disorders was a severe stumbling block because, among other things, it prevented people from seeking help (Box 1). Stigma can also have an insidious effect on health policy. For example, health insurers may deny parity for the care of persons with mental disorders. It was recognized that new technologies based on scientific evidence, many of them in the affordable range of most countries, were available.

WHO’s response to the ministers’ call for action was to propose a global mental health strategy (World Health Organization, 2001c). One of the four pillars of this strategy is advocacy for mental health at the international, regional and national levels. Through partnerships with governments, nongovernmental organizations and community groups, WHO is helping countries to develop their advocacy sectors. The objective is to place mental health on the public agenda, to promote a greater acceptance of persons with mental disorders, to protect their human rights and to reduce the pervasive effects of stigma. It is argued that less exclusion and less discrimination will help those afflicted and their families to lead better and more productive lives and encourage those in need to seek treatment.

Advocacy is one of the four pillars of WHO’s global mental health strategy.

Key points: Development and importance of the mental health advocacy movement

- First families and then consumers started to organize and make their voices heard. They have been joined by nongovernmental organizations, mental health workers and some governments.
- The concept of advocacy has recently been broadened to cover the needs of persons with mild mental disorders and those of the general population.
- Consumers are saying what services they need and are increasingly making informed decisions about treatment and other matters affecting their daily lives.
- Consumer and family participation in advocacy organizations may have several positive impacts.
- The need for mental health advocacy has been recognized by health ministers throughout the world and by WHO.

2. Roles of different groups in advocacy

2.1 Consumers and families

The consumer organizations that exist in many parts of the world have various motivations, commitments and involvement in mental health. These organizations range from informal loose groupings to fully developed and legally established associations. Some groups include consumers' families. In other cases, however, families have parallel organizations.

Generally, people with mental disorders tend to organize themselves as consumers, focusing on their relationship with health services or on mutual help through their shared experience of specific disorders. For example, there are groups of people with alcohol dependence, drug addiction, depression, bipolar disorders, schizophrenia, eating disorders and phobias. People with mental disorders can be very successful in helping themselves, and peer support has been important in relation to certain conditions and to recovery and reintegration into society (World Health Organization, 2001).

Opinions vary among consumers and their organizations on how best to achieve their goals. Some groups want active cooperation and collaboration with general health and mental health workers, while others want complete separation from them (Chamberlin, 2001). The latter groups are sometimes very critical of services, types of treatment and the medical model.

Consumer groups have played various roles in advocacy, ranging from influencing policies and legislation to providing concrete help for persons with mental disorders. They have sensitized the general public about their causes and educated and supported consumers. They have denounced some forms of treatment which are believed to be negative, addressed issues such as poor service delivery, poor access to care, involuntary treatment and other matters. Consumers have also struggled for the improvement of legal rights and the protection of existing rights. Programmes run by consumers cover drop-in centres, case management programmes, outreach programmes and crisis services (World Health Organization, 2001a). Other examples of consumer roles in advocacy are given in Box 2.

The roles of families in advocacy overlap with most of those described for consumers. Families are also organized in various ways, with informal and formal groups. In some developed countries they have created influential national associations. Families have a distinctive key role in caring for persons with mental disorders. In many places they are the primary care providers and their organizations are fundamental as support networks. In addition to providing mutual support and services, many family groups have become advocates, educating the community, increasing support to policy-makers, denouncing stigma and discrimination, and fighting for improved services. Examples of family roles in advocacy are given in Box 2.

Some consumer groups want active collaboration with general health workers and mental health workers, while others want complete separation from them.

Consumers have denounced treatments believed to be negative, poor service delivery and involuntary treatment.

In many places, families are the primary care providers and their groups are fundamental as support networks.

Box 2. Examples of consumer and family roles in advocacy*

- > Raising awareness about the importance of mental health and mental disorders for the quality of life of populations.
- > Information, education and training on consumer and family needs and rights, mental disorders and methods of combating stigma.
- > Contribution to the development, improvement and implementation of policies and legislation.
- > Involvement in the development, planning, management, monitoring and evaluation of services.
- > Counselling, mediating and defending other consumers and families through service utilization and treatment decision processes.
- > Developing support networks: mutual help for information exchange; emotional and instrumental support.
- > Denouncing poor access to and quality of services, violations of rights, and stigmatizing behaviours.
- > Denouncing socioeconomic and cultural conditions that have adverse influences on the mental health of populations.
- > Developing alternative services run by consumers and/or families.

* The examples are not specific recommendations for action.

2.2 Nongovernmental organizations

Non-profit, voluntary or charitable nongovernmental organizations have developed advocacy initiatives and provided different types of mental health services in various countries. Their interests range from the promotion of mental health to the rehabilitation of persons with disabling mental disorders. They are not necessarily focused exclusively on mental health issues, sometimes having a broader field of action (e.g. human rights and civil liberties).

These organizations can be professional, i.e. including only mental health professionals, or interdisciplinary, with members from diverse areas. Mental health professionals may work alongside persons with mental disorders, their families and other individuals. The organizations have the advantages of grassroots vitality, closeness to people, freedom for individual initiatives, opportunities for participation and humanizing aspects.

In accordance with their particular areas of interest, nongovernmental organizations can carry out many of the advocacy roles indicated in Box 2. However, their distinctive contribution to the advocacy movement lies in support and empowerment for consumers and families. Thus they:

- reinforce and complement consumer and family advocacy positions with the views of mental health professionals;
- train consumers and families in mental health issues and leadership;
- help consumers and/or families to create their own organizations;
- provide professional support to consumers and families at times of crisis (consumers and families working in advocacy are often exposed to high levels of stress that can precipitate crises);
- provide mental health services to consumers and families.

Nongovernmental organizations have embraced a range of advocacy issues.

One of the distinctive contributions of nongovernmental organizations is support and empowerment for consumers and families.

2.3 General health workers and mental health workers

As a rule, general health workers and mental health workers are less involved in advocacy initiatives than consumers, families and nongovernmental organizations. However, in places where care has been shifted from psychiatric hospitals to community services, mental health workers have taken a more active role in protecting consumer rights and raising awareness about the need for improved services (Cohen & Natella, 1995; García et al., 1998; Leff, 1997).

Workers in traditional mental health facilities can feel empathy for persons with mental disorders and can become advocates for them in respect of some issues. Mental health workers can experience similar discrimination and stigmatization to those experienced by persons with mental disorders. In many countries this is reflected in low wages. They may also benefit from the advocacy process and obtain improved working conditions.

Nevertheless, conflicts of interest can occur between mental health workers and consumers. Workers may feel threatened or held back in their demands for higher wages when consumer groups campaign for their rights to be respected or for improvements in mental health services. Sometimes general health workers or mental health workers may be targets for advocacy, e.g. in campaigns designed to raise awareness about stigma or denouncing violations of rights in services.

If duly sensitized about the needs and rights of consumers and families, general health workers and mental health workers can play many of the roles described above for nongovernmental organizations. Several specific advocacy roles can be assumed by general health workers and mental health workers.

- *Working from a consumer and family perspective*

The first step for general health teams and mental health teams in advocacy is to respect the rights of patients in daily clinical work. Issues such as informed consent, the least restrictive care alternative, confidentiality and review boards, have to be discussed with patients whenever it is relevant to their treatment. (See Mental Health Legislation and Human Rights.) Every mental health consumer should be unreservedly regarded as a citizen and should be informed and consulted about any clinical decision during the different stages of the treatment process.

- *Participation in activities of consumer groups and family groups*

In many countries these groups are not very well known by mental health teams and are even less well known by primary care teams. In order for workers to understand fully how consumer and family groups function they should participate in their activities, e.g. meetings, counselling sessions, rallies and mutual help.

- *Supporting the development of consumer groups and family groups*

Local health teams can help to accelerate the development of consumer and family movements. These teams should consider that part of their usual work consists of group activities with people who have mental disorders and their families. One aspect of consumer psychoeducation is the fostering of social support networks. These group activities are the seeds of future consumer and family groups, especially if the health professionals keep supporting them by providing encouragement, information, rooms for meetings and contacts with other groups.

- *Planning and evaluating together*

The most effective way to empower consumer organizations is to help them to contribute to planning their mental health services. In order to ensure that their views are taken into account these organizations should have representatives on local health boards that evaluate and plan mental health services. Family organizations should also have representatives on such boards.

Mental health workers can experience similar discrimination and stigmatization as consumers.

It is not infrequent to find conflicts of interest between general health workers or mental health workers and consumers.

General health workers and mental health workers can support consumer groups and family groups and participate in their activities.

2.4 Policy-makers and planners

Ministries of health and, specifically, their mental health sections, can play an important role in advocacy. They may implement advocacy actions directly, in order to improve the mental health of populations and meet consumers' rights. However, ministries of health may achieve similar or complementary outcomes by working indirectly through supporting advocacy organizations (consumers, families, nongovernmental organizations, mental health workers). Additionally, ministries of health should endeavour to convince other policy-makers and planners to focus on and invest in mental health. This may include the executive branch of government, ministries of finance and other ministries, the judiciary, the legislature and political parties. Ministries of health can also develop many advocacy activities by working with the media.

There may be some contradictions in the advocacy activities of ministries of health. Some issues that can be advocated are often also responsibilities, at least in part, of these ministries. For example, if a ministry of health is a service provider and at the same time advocates for accessible services of high quality, it can be perceived as acting as both player and referee. Opposition parties may question the ministry's motivation for improving the quality and accessibility of services. In a similar way, trade unions in the health sector may demand higher salaries and better working conditions if they are urged to improve care. Consumer and family organizations may turn against the ministry of health, blaming it for unsatisfactory access to and quality of mental health services.

Consequently, ministries of health should support the active participation of multiple stakeholders, ensuring that their different views can be expressed. It may be necessary to take the lead on some advocacy initiatives that are policy priorities, e.g. ensuring that consumers' rights are protected and that consumers' needs are met. Ministries of health can show how they are contributing to the mental health of populations and can invite all stakeholders to make contributions. In this process they have to keep a balance between playing too active and directive an advocacy role and being too passive and laissez faire. If ministries are too active they may inhibit the participation of consumers, families, nongovernmental organizations and other stakeholders. If they are too passive they may leave these advocacy organizations without enough support to survive in the face of more powerful interest groups.

One of the ways in which ministries of health can overcome these difficulties is to promote the formation of alliances of stakeholders for mental health advocacy. A clear understanding of the various interests and motivations of the stakeholders is very useful, helping to ensure that the alliances contribute towards strengthening all the parties involved, while maintaining agreement on key issues.

Within these general guidelines the final role of ministries of health depends mainly on the particular social, cultural and political characteristics of the regions or countries concerned. In any case, mental health professionals in ministries of health should listen carefully to advocates, ensure that they represent an important constituency, and make every effort to respond to demands or requests through the implementation of policy, plans and programmes.

It is desirable that the executive branch of government, the legislature, the judiciary and political parties should also play a role in mental health advocacy. The minimal initiative involves trying to meet some of the advocates' claims by supporting the actions of the ministry of health. Eventually, policy-makers and planners can be expected to discover that mental health needs are important for a large portion of the population and that many advocacy groups are pressing for change. At this point, mental health can be given due attention on the government agenda and initiatives can be taken in order to improve policy, funding, research and legislation. Among other sectors that should

Ministries of health can implement advocacy actions directly or through supporting consumers, families and nongovernmental organizations.

Ministries of health should support the active participation of stakeholders, ensuring that their different views can be expressed.

The promotion of alliances of stakeholders is a key method of strengthening advocacy.

The executive branch of government, the legislature, the judiciary and political parties should also play a role in advocacy.

respond to advocates' claims are those of finance, education, employment, social welfare, housing and justice. (See Mental Health Policy, Plans and Programmes.)

Key points: The roles of different groups in advocacy

- Consumers have played various roles in advocacy, ranging from influencing policies and legislation to providing concrete help for persons with mental disorders.
- The provision of care for persons with mental disorders is a distinctive role for families, particularly in developing countries. In their role as advocates, families share many activities with consumers.
- The main contribution of nongovernmental organizations to the advocacy movement involves supporting and empowering consumers and families.
- Where care has been shifted from psychiatric hospitals to community services, mental health workers have taken a more active advocacy role.
- Ministries of health and, specifically, their mental health sections, can play an important role in advocacy.
- The executive branch of government, the legislature, and other sectors outside health can also play a role in mental health advocacy.

3. How ministries of health can support advocacy

Figure 1 illustrates the multiple interactions between the different stakeholders involved in mental health advocacy. Ministries of health, or health authorities of smaller administrative divisions, can be important actors in the advocacy system. They can develop various initiatives in respect of different target populations.

Each ministry of health is also a target for advocacy activities carried out by other stakeholders represented in Figure 1. Furthermore, there are advocacy interactions inside the ministry of health between the mental health section and other health sections.

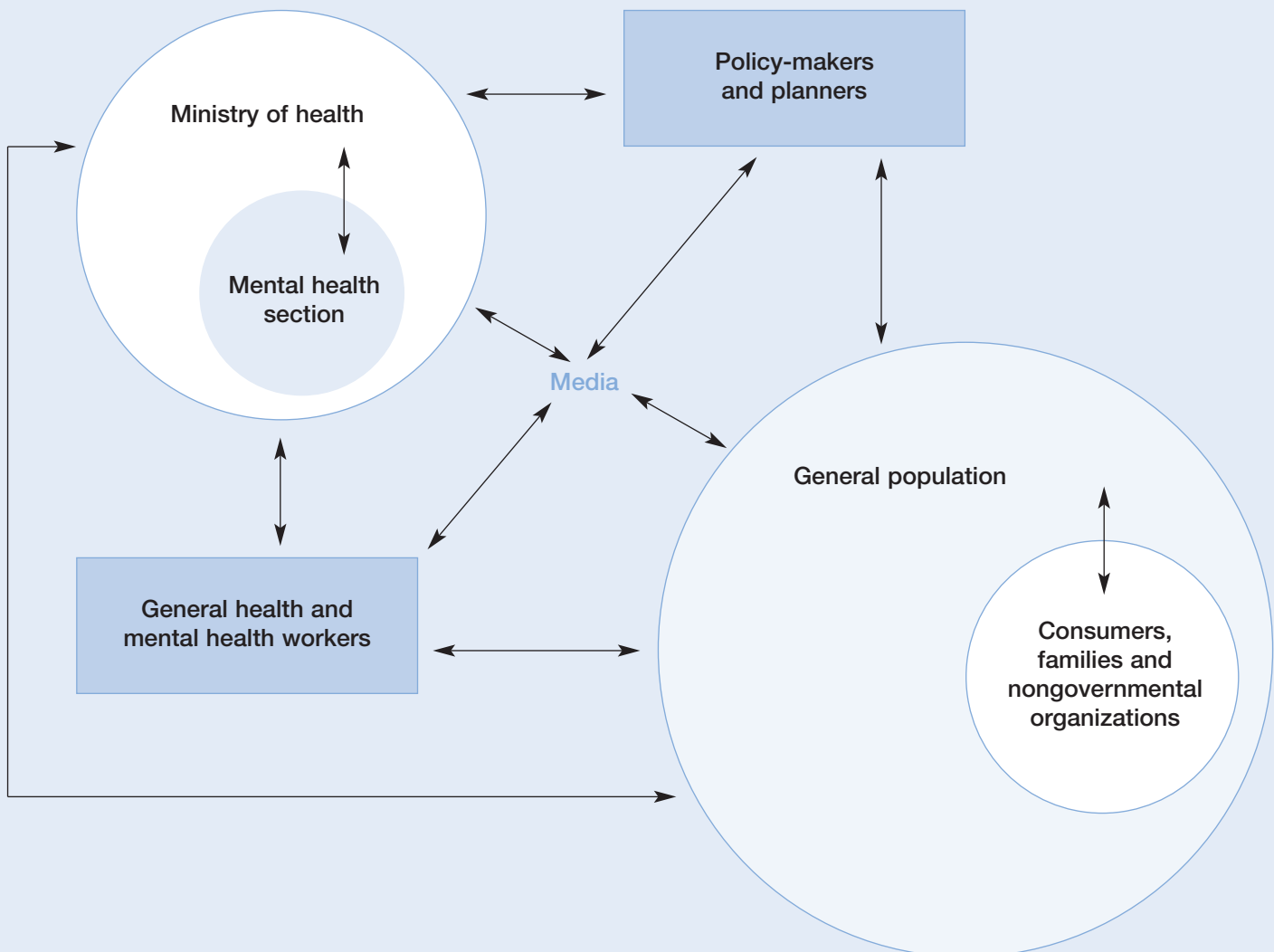
The arrows in Figure 1 illustrate the possibilities of reciprocal influences between stakeholders.

The particular circumstances in a country or region determine which stakeholders are the most influential. As a rule the most active stakeholders in the mental health advocacy movement are consumers, families, nongovernmental organizations, some organizations of mental health workers, and the mental health section of the ministry of health. The media, at the centre of Figure 1, are utilized by all stakeholders as an important tool for their advocacy actions.

The advocacy activities of health ministries with different stakeholders are described in this section, for which Figure 1 provides a frame of reference.

Each ministry of health is a target for advocacy activities carried out by other stakeholders.

Figure 1 Stakeholders in mental health advocacy



3.1 By supporting advocacy activities with consumer groups, family groups and nongovernmental organizations

As noted earlier, consumer groups, family groups and nongovernmental organizations play a fundamental role in advocacy. Accordingly, it is essential that governments provide these bodies with the support required for their development and empowerment. This support should be free of conditions that would prevent the advocacy movement from occasionally being critical of the supporting body, i.e. government.

The empowerment of consumers and families involves giving them power, authority and a sense of capacity in the following ways.

- One form of advocacy involves the **education and training** of consumers and families about mental disorders, treatment and the organization of services. They can be taught how to live with mental disorders in a controlled and balanced way and how to keep developing their talents and potential for personal power and recovery (Compton et al., 1999).
- **Counselling** can help people with mental disorders to defend their rights in various situations. This may include support from hotlines at times of emotional crisis or continuous support from mutual help or self-help groups.
- **Local initiatives** of consumer and family groups and nongovernmental organizations can be encouraged so that they have the power to advocate for themselves to health and welfare providers and the highest level of government.

Advocacy groups need independence from government in order to achieve their goals. While a good relationship and even financial support from government can be very useful to both parties, there is often a need for outside advocacy. History has repeatedly shown that governments can seriously violate human rights, including those of people with mental disorders. In many instances where this has happened the independence of nongovernmental organizations has been essential in enabling them to advocate for the rights of those affected and to promote change.

The extent to which governments should support and fund consumer and family groups and nongovernmental organizations should be carefully considered, especially by advocates. During the period of apartheid in South Africa there were essentially two types of nongovernmental organizations and advocacy groups - those that were subsidized by government and mainly supported government policies, and those that were in opposition. Most of those subsidized by the government agreed with its policies, e.g. in so far as treating Blacks and Whites in separate facilities was concerned. If they had advocated against these policies the government would have stopped funding and other support. As a consequence the nongovernmental organizations and advocacy groups in question would probably have disappeared.

Certain nongovernmental organizations and advocacy groups were established with the specific purpose of opposing the government in order to promote human rights. These groups received no government funding and the persons concerned put themselves at great risk. However, these groups ultimately held most sway in changing policies towards mental health and other aspects of human rights, and they assisted the post-apartheid government in drawing up policies and legislation which enhanced the position of people with mental disorders (M. Freeman, 2002, personal communication).

In most circumstances the picture is not as clear-cut as in the above example. Nevertheless advocacy groups should be careful not to lose strength by developing too close a relationship with government. In any event they should ensure that they develop sufficient financial and organizational independence in order to refuse government support that would compromise any positions they wished to adopt. From

The empowerment of consumers and families involves giving them power, authority and a sense of capacity.

Advocacy groups need independence from government in order to achieve their goals.

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the government standpoint it is important to work with advocacy groups that may oppose government policy and to try to understand their perspectives.

One way of including a range of advocacy perspectives is to invite advocacy groups to participate in the development of a new mental health policy. A communication strategy should be developed at the start of a reform process so as to keep all stakeholders, including advocacy groups, informed. Careful attention should be paid to their suggestions and their contributions to the new policy.

Principal steps for supporting consumer groups, family groups and nongovernmental organizations

The professionals in charge of mental health in ministries of health or health districts should consider the following steps:

Step 1: Seek information about mental health consumer groups, family groups and nongovernmental organizations in the country or region concerned.

In order to work with advocacy organizations it is essential to acquire basic information about them and their activities. Quantitative and qualitative information is required in order to plan strategies in support of their development. Such information helps to inform people about consumer groups, family groups and nongovernmental organizations close to their homes, thus facilitating access. However, care should be taken to respect the independence, integrity and privacy of these bodies.

The main tasks to carry out in Step 1 are as follows:

- Task 1:** Develop a **database** with consumer groups, family groups and nongovernmental organizations. It should include information on the names groups, their addresses and telephone numbers, contact persons, the numbers of members, the numbers of new members every year, affiliation to regional or national associations, and principal activities.
- Task 2:** Establish a **regular flow of information in both directions**. This means informing the relevant organizations of the activities of the ministry of health, e.g. with respect to policy, plans, programmes, guidelines, standards, resources and events. It also means receiving regularly updated information from the organizations about their activities.
- Task 3:** Publish and distribute a **directory of mental health consumer groups, family groups and nongovernmental organizations**. Mental health professionals and primary care professionals need this type of directory so that they can refer patients and their families to the groups. Moreover, the directory serves to publicize the groups for the benefit of consumers and families who may not belong to a group but are interested in joining.

Step 2: Invite representatives of consumer groups, family groups and nongovernmental organizations to participate in activities at the ministry of health.

The aim is to facilitate cooperative work with these bodies and allow them real participation in decision-making on policies and services. The participation of these groups at the central level of government also helps to model the behaviours to be followed at the local level of government and in local health teams.

Advocacy groups should be invited to participate in the development of new mental health policy.

Quantitative and qualitative information is required in support of the development of advocacy organizations.

The aim of this step is to facilitate cooperative work and allow participation in decision-making processes.

The main tasks to carry out in Step 2 are as follows:

- Task 1:** Invite key stakeholders to participate in the formulation and evaluation of policies, plans, programmes, legislation and quality improvement standards. For example, advocacy organizations can be represented on drafting committees and can be involved in the consultation process. (See *Mental Health Policy, Plans and Programmes; Quality Improvement for Mental Health; Planning and Budgeting to Deliver Services for Mental Health*.) It is always necessary to consider representation from the main national or regional consumer and family movements so that their points of view can be taken into account.
- Task 2:** Invite participation on mental health committees, commissions or other boards functioning under or with the support of the ministry of health. In particular, consumer and family groups should be represented on visiting boards for mental health facilities, where they can help to improve the quality of services and respect for human rights.
- Task 3:** Undertake educational initiatives. Any activity of this type should be performed in conjunction with the consumer and family movements, whether the aim is to promote the rights of people with mental disorders or to promote mental health. Consumers and family members are excellent collaborators in the development of audiovisual materials and the implementation of face-to-face and door-to-door activities.
- Task 4:** Arrange media activities. For news conferences, television shows, radio broadcasts or any other activity involving the media it is desirable to have help from a consumer or a family member. In general, consumers and families get their messages across more easily than professionals because they touch on emotional matters that they have experienced and that strike a chord with other people facing similar problems.
- Task 5:** Arrange public events in order to raise awareness. Events organized conjointly with consumers, families and nongovernmental organizations can attract larger audiences and help to validate these organizations in the eyes of the public.

Step 3: Support the development of consumer groups, family groups and non-governmental organizations at the national or regional level.

Consumer and family groups may be fragile. Many are at risk of disappearing, particularly in their first years of existence. Stigma and discrimination from society at large and the characteristics of mental disorders make survival more difficult than is the case with other social organizations. Consequently, the team in charge of mental health in the ministry of health should implement an active strategy supporting the development of consumer and family movements in the country or region concerned.

Social stigma, discrimination and the characteristics of mental disorders make survival difficult for some consumer groups.

The main tasks to carry out in Step 3 are as follows:

- Task 1:** Provide technical support. Consumer and family groups can be empowered if they receive knowledge and new skills. For example, they can benefit from learning about mental disorders and effective methods of prevention, treatment and rehabilitation. They also need information about the availability of resources for mental health and social affairs in their communities, and about current national

policy and legislation on mental health. Leadership abilities and group functioning are some of the most important skills that should be reinforced, since they can help the groups to survive and grow by themselves.

Task 2: Donate funds. In a developing country it is not enough to provide technical support from the ministry of health in order to keep consumer and family groups running. It may also be necessary to support them with resources such as a venue for meetings, professional counselling and office equipment. The ministry of health or another social sector can provide consumer and family groups with funds in support of their functioning. This can be arranged through a process of tendering for projects, which has the advantage of generating incentives to improve quality and the disadvantage of uncertainty about the continuity of funds in the future. Contracts or grants can also be given annually, with the advantage of continuity and the disadvantage of a lack of incentives to improve quality. A combination of the two procedures is likely to be the best solution. Both the advocacy groups and the ministry of health should ensure that the financial support does not create a conflict of interests or a means whereby the government can influence the groups.

Task 3: Support evaluations of consumer groups, family groups and nongovernmental organizations. Such evaluations can provide useful information on how these groups are contributing to the implementation of policy and legislation, the monitoring of human rights, the improvement of services and other advocacy issues. Best practices for consumer and family groups can be identified and used as models for the improvement of quality and the development of new groups.

Task 4: Enhance alliances and coalitions of consumer groups. The experience of countries with a high degree of development of consumer and family organizations has demonstrated that their power for individual or collective advocacy increases if they form large alliances or coalitions. They can also benefit from alliances with other advocacy groups. However, alliances also involve risks. Some organizations may need to compromise inappropriately, and continual conflict between members of an alliance can lead to stagnation because nothing effective happens. The team responsible for mental health in the ministry of health can facilitate the development of alliances by meeting representatives of different groups and collaboratively identifying common goals, agreeing on joint strategies and implementing actions.

Step 4: Train mental health workers and general health workers to work with consumer and family groups.

Cooperative work with advocacy groups requires health teams to be knowledgeable about their rationale and activities. It is necessary to relate to consumers and families in a non-authoritarian, collaborative way, to adopt an open-minded attitude and to have a willingness to learn from the wisdom of consumers and families. Additionally, special ethical issues arise from working with consumers and families. For example, there is a need to provide guarantees that patient care will not be compromised because of consumer or family criticism. Consumers who become advocates need protection because they may relapse under the stress produced by the advocacy activities.

An open-minded attitude and a willingness to learn from the wisdom of consumers and families is required of general health workers and mental health workers.

The main tasks in Step 4 concern training in the skills needed for work with advocacy groups. (See Section 2.3 for more details of these tasks.)

- Task 1:** Train workers in daily clinical work with reference to the consumer and family perspective.
- Task 2:** Train workers in participation in the activities of consumer and family groups.
- Task 3:** Train workers in supporting the development of consumer groups and family groups.
- Task 4:** Train workers in planning and evaluating together with consumers and families.

Step 5: Focus activities in accordance with the needs of advocacy groups.

The advocacy activities discussed above can be applied to a range of different groups. In order to be effective, ministries should go one step further. It is necessary to know the particular characteristics of the different types of groups in a country or region in some detail and to adapt strategies accordingly. It is important for ministries of health to recognize that advocacy groups are often diverse, always changing, sometimes contradictory and occasionally difficult to deal with. However, governments should not feel that they have to impose tidiness on these groups in order to make it easier to work with them.

The main tasks associated with the three types of advocacy groups are as follows:

- Task 1: Identify the principal features of consumer groups.**
In order to support consumer groups it is crucial to take cognizance of their main motivations for advocacy. These may include a desire for improved mental health services, respect for autonomy and rights, consultation about treatment options, involvement in the planning, delivery and evaluation of services, the creation of opportunities for meeting a sexual partner or finding a job, and so on. There are also important differences between consumer groups; each has its own identity, needs and interests. For example, persons with alcohol dependence may have needs that differ from those of persons diagnosed as schizophrenic.
- Task 2: Identify the principal features of family groups.**
Like consumers, families usually desire more and better services, but there may be significant differences between consumers and families regarding autonomy, human rights, sexual partners and independent life in general. These issues can be threatening for families because consumers' participation in advocacy organizations may lead them to take increased risks. This can arouse anxieties in the families concerned. Families may wish to have more information about mental disorders and their treatments, and mutual support in their role as carers. There are also differences between particular family groups. For example, the needs of families of persons with Alzheimer's disease differ from those of families of persons with intellectual disabilities.
- Task 3: Identify the principal features of nongovernmental organizations.**
There is a great variety of nongovernmental organizations devoted

Apart from general steps, ministries should also know the particular characteristics of the advocacy groups in countries or regions.

Advocacy groups are often varied, ever-changing, sometimes contradictory and occasionally difficult to deal with.

to mental health issues. Some are closer to consumers than to families, whereas for others the reverse is true. Others are focused on the needs of mental health workers. Nongovernmental organizations also work on specific mental problems, e.g. schizophrenia, violence against women, drug addiction, as well as on the promotion of mental health and the prevention of mental disorders. Mental health professionals in ministries of health and health districts need to know the main motivations and characteristics of all the nongovernmental organizations in their catchment areas in order to support their development.

Task 4: Balance the needs of different groups.

Throughout the process of endeavouring to understand the specific needs of advocacy groups it is important to appreciate that each group may have different requirements. It is crucial, for example, that consumers advocate for themselves in order that their particular needs be considered appropriately in the development and implementation of mental health policy, plans or programmes. Although families have traditionally campaigned for better services for their relatives with mental disorders, they do not necessarily understand consumers' needs as accurately as do the consumers themselves, e.g. in relation to informed consent for treatment, the avoidance of side-effects of medications, and the right to self-determination and autonomy. On the other hand, families have specific needs related to the emotional burden of being carers and providing support networks for persons with mental disorders. This can lead to conflicts of interest vis-à-vis consumers' needs.

In a similar way it is essential to balance the needs of consumers and families with those of professional providers. Advocacy groups are often based in treatment and rehabilitation centres, sharing with providers many issues that they seek to defend or denounce. However, conflicts of interest between them are inevitable and the encouragement of self-advocacy is crucial in this connection. Consumers, families and professional providers sometimes advocate conjointly. At other times they do so separately and on occasions they even advocate against each other.

Any conflicts of interest between advocacy groups should be taken into consideration.

Key points: How ministries of health can support advocacy with consumers, families and nongovernmental organizations

- Step 1: Gather and disseminate information about mental health consumer groups, family groups and nongovernmental organizations in the country or region concerned.
- Step 2: Invite representatives of consumer groups, family groups and nongovernmental organizations to participate in activities in the ministry of health.
- Step 3: Support the development of consumer groups, family groups and nongovernmental organizations at the national or regional level.
- Step 4: Train mental health workers and general health workers to work with consumer and family groups.
- Step 5: Focus activities in accordance with the needs of advocacy groups.

3.2 By supporting advocacy activities with general health workers and mental health workers

Advocacy actions targeting this group should aim to modify stigma and negative attitudes towards consumers and families and to improve the quality of mental health services and the care provided. Activities may include the dissemination of reliable information on, for example, the rights of persons with mental disorders, quality improvement standards for reinforcing good practices, and cost-effective interventions.

Quality improvement procedures are particularly useful. When consumers participate in quality improvement activities in health facilities they contribute their views on the needs of individuals with mental disorders and they speak out to defend their rights. This form of advocacy has helped to improve services in many places. (See Quality Improvement for Mental Health.)

Principal steps for supporting advocacy activities with general health and mental health workers

Step 1: Improving workers' mental health.

There has been growing concern about the mental health of general health workers and mental health workers. These workers are exposed to high emotional risks. They face stressful interpersonal situations and the danger of burn-out. It is important to take into account that the quality of mental health services depends, to a large extent, on the workers' mental health. For example, if health workers have episodes of depression they are likely to be less empathic and tolerant and may even act irritably towards persons with mental disorders who are under their care.

Moreover, if consideration is given exclusively to consumers' needs and due attention is not paid to the needs of general health workers and mental health workers, there could be resistance from trade unions to the advocacy policy of the ministry of health in question.

The main tasks for Step 1 are as follows:

Task 1: Build alliances with trade unions and other workers' associations.

It is necessary to understand the main needs of general health workers and mental health workers. The mental health policy and the advocacy strategies should meet at least some of their needs. For example, in some settings the closing down of psychiatric hospitals has shown that mental health workers can feel more satisfied with their jobs in community facilities (Cohen & Natella, 1995; Mexico, 2001), where they have more power to make decisions and express creative ideas and where they can receive positive feedback in the form of favourable changes observed in consumers.

Task 2: Ensure the provision of basic conditions for general health workers and mental health workers. In accordance with the needs detected during Task 1, efforts should be made to improve the working conditions requiring the most urgent attention before advocacy actions commence, e.g. improvements in the working environment, labour relations, and incentives.

Task 3: Implement mental health interventions for workers. In accordance with the needs detected during Task 1, some mental health interventions can be undertaken, e.g. workshops on interpersonal relationships, personal development and relaxation exercises.

Advocacy actions that target general health workers and mental health workers should aim to modify stigma and negative attitudes towards consumers and families.

The quality of the mental health services depends, in large measure, on the workers' mental health.

Step 2: Supporting advocacy activities with mental health workers.

Support for advocacy among health workers should begin with mental health workers because they are more likely than general health workers to understand the needs and aspirations of people with mental disorders. Once mental health workers are carrying out advocacy activities it is easier for general health workers to do so because they can then follow the example of their colleagues.

The main advocacy objectives for mental health workers are to reinforce their commitment to improve the quality of services, to respond to consumers' needs and to respect the rights of consumers. Mental health workers are frequently unaware of the power they have over people with mental disorders. If this power is not utilized appropriately it can have negative effects. For example, it can lead to dependency and institutionalization, or even worse to violations of human rights. It is also important to ensure that mental health workers do not stigmatize or discriminate against consumers and that they do not become stigmatized or discriminated against by society.

Advocacy for mental health workers should include shifting attitudes towards integrating mental health care with general health care. In some places there has been as much, if not more, resistance from mental health workers to an integrated approach as from other health workers. The main reason for this appears to be a perceived downgrading of status, i.e. work previously seen as highly skilled is done by any health worker instead of being reserved for mental health workers. There is also concern among mental health workers about whether they will have the skills for the broadened mental health functions that they may be asked to fulfil, e.g. in promotion, prevention and community care.

The main tasks for Step 2 are the following:

- Task 1: Train mental health workers.** Ministries of health should assist academic institutions to place increased emphasis on quality of care and consumer satisfaction in undergraduate and postgraduate training. Particular attention should be given to the training of psychiatrists, psychologists and psychiatric nurses in community mental health. This is important because of the strong influence of these professions on other mental health workers. The participation of organizations of consumers and families in the training of mental health workers should also be considered. This can help future professionals or technicians to improve their understanding of and empathy for consumers and their families.
- Task 2: Emphasize community care and community participation.** National or regional mental health policies should give special attention to community care because of the evidence of better clinical results and a higher degree of consumer satisfaction (World Health Organization, 2001a). Policies can specify that the active participation of consumer and family organizations would be encouraged. Such definitions issued by ministries of health help mental health workers to understand the frame of reference for their practice.
- Task 3: Interact with consumer groups, family groups and nongovernmental organizations.** Ministries of health can facilitate interactions with advocacy groups by encouraging the participation of these organizations in mental health facilities. The interaction between members of these organizations and mental health workers can help the latter to orient care towards consumer satisfaction and to respect consumer rights.

The main objectives for mental health workers are to achieve services of satisfactory quality and to meet consumers' needs and rights.

Advocacy for mental health workers should include shifting attitudes towards integrating mental health care with general health care.

Step 3: Support advocacy activities with general health workers.

The main objective of advocacy with general health workers is to incorporate the mental health aspects of care fully into their daily work. This includes the full spectrum of promotion, prevention, treatment and rehabilitation. Physicians, nurses and other members of health teams, particularly in primary care centres, should become more proficient and comfortable in the delivery of mental health care. A long history of stigmatization and segregation of mental health and mental disorders cannot be changed in a few years. In most countries the training and practice of general health workers remains oriented towards physical health. Many health professionals are unaware of the evidence in the literature of the burden of mental disorders and the cost-effectiveness of mental health interventions.

Physicians, nurses and other members of health teams should become more proficient and comfortable in the delivery of mental health care.

The main tasks for Step 3 are the following:

- Task 1: Define the role of general health workers in mental health.** Mental health policy should clearly indicate the role expected of general health workers. This should be done specifically for primary care workers, who carry out most of the promotional and preventive activities and treat most of the people with mental disorders.
- Task 2: Train general health workers in mental health.** Academic institutions should ensure that mental health is represented in undergraduate and graduate curricula to an extent consistent with its importance and the requirements of policy. Special consideration should be given to the place where the training is carried out. It is preferable for mental health training to be conducted at primary care centres and general hospitals that have incorporated mental health into their regular activities.
- Task 3: Initiate activities jointly with mental health specialists.** Regular visits of mental health specialists to primary care facilities have proved useful. They improve the abilities of general health workers to diagnose, treat and care for persons with mental disorders. They also help primary care workers to lose their fears and improve their confidence about dealing with persons who have mental disorders.
- Task 4: Develop demonstration areas.** Community-oriented demonstration areas can be helpful for incorporating mental health activities into primary care. (See Mental Health Policy, Plans and Programmes.) General health workers who are developing these activities can become excellent models for health workers from other places. Ministries of health can promote training practices for general health workers in these demonstration areas.

Key points: How ministries of health can support advocacy with general health workers and mental health workers

- Step 1: Improve workers' mental health: building alliances with trade unions, ensuring basic working conditions and implementing mental health interventions.
- Step 2: Support advocacy activities with mental health workers: training, community participation, interaction with consumer and family groups.
- Step 3: Support advocacy activities with general health workers: defining roles in mental health, training, joint activities with mental health workers, demonstration areas.

3.3 By supporting advocacy activities with policy-makers and planners

The principal objective in relation to policy-makers and planners is to ensure that mental health is given due attention on national policy agendas. This helps to enhance the development and implementation of mental health policy, legislation and services. Members of the executive branch of government, especially ministers of finance, are normally involved in decisions on the amount of funding to be invested in mental health. This group is crucial for policy implementation.

In many instances it is not easy to convince policy-makers to take decisions in favour of mental health. Policy-makers frequently have many other pressing problems, particularly in developing countries. However, during the ministerial round tables at the 54th World Health Assembly, ministers agreed on the importance of mental health for general health and human development and on the relative under-investment in this area (World Health Organization, 2001c).

The advocacy process is frequently initiated by the professionals responsible for mental health in ministries of health. Their first task is to make policy-makers aware of the importance of mental health and of cost-effective solutions. This should include not only the most senior managers but other colleagues as well. In competing for scarce resources it is very important to develop strategies for addressing the claims of colleagues.

If a minister of health or another high official becomes convinced of the importance of mental health he or she could become an advocate in this field, informing other policy-makers about the importance of mental health, e.g. the president or prime minister, other ministers and other high officials from other sectors, members of parliament, and other political leaders of the country or region in question.

Principal steps for supporting advocacy activities with policy-makers and planners

Step 1: Build technical evidence.

Evidence from epidemiological, public health and clinical studies can provide facts about mental health and mental disorders, thus helping to correct common misconceptions about these matters. The World Health Report 2001 (World Health Organization, 2001a) represents an excellent tool for advocacy with policy-makers and planners.

The main tasks for Step 1 are the following:

Task 1: Determine the magnitude of the problem of mental disorders.

Globally, data on the magnitude of mental disorders are becoming more available (World Health Organization, 2001a). There is useful information on the prevalence of mental disorders (e.g. 25% of the population develop one or more mental or behavioural disorders in their lifetime (p.23) and on mental health risk factors (e.g. between 16 and 50% of women have been victims of violence by their domestic partners).

The burden of mental disorders, i.e. disability-adjusted life-years, when available, is another important measure of the magnitude of mental disorders. It compares the weights of mental and physical disorders and demonstrates serious consequences in terms of premature mortality and disability. Since studies in these areas are, for the most part, too expensive for developing countries, information obtained in one country can be extrapolated to others that have similar cultural and social characteristics. (See Planning and Budgeting to Deliver Services for Mental Health.)

The principal objective in relation to policy-makers and planners is to ensure that mental health is given due attention on national policy agendas.

A minister of health could inform other policy-makers, e.g. a president, other ministers and other high officials, about mental health.

Evidence from epidemiological, public health and clinical studies can provide reliable facts that help to correct misconceptions.

In some settings, information on the magnitude of mental disorders is not necessarily convincing for policy-makers and planners, who may be in the habit of paying more attention to statistics on demands for services, e.g. numbers of people on waiting lists or for whom access to mental health services is denied. For this reason, it may be useful to supplement data on the current magnitude of mental disorders with information on the current demand for services. (See Planning and Budgeting to Deliver Services for Mental Health for guidance on the collection of demand data.)

- Task 2: Determine the cost of mental disorders.** Studies on the burden of mental and neurological disorders, i.e. on disability-adjusted life-years, can be translated into economic terms. Thus the problem is presented in a concrete manner for policy-makers and planners, i.e. every year a certain number of years is lost because of premature death or disability and this costs the country or region concerned a certain amount of money. Because of technical problems and the resources required, many developing countries would find it difficult to carry out studies on the cost of mental disorders. When feasible, however, such studies are a powerful tool. Moreover, figures on the costs of lost productivity because of depression or alcohol abuse may come to the attention of policy-makers and planners.
- Task 3: Identify effective mental health interventions.** Ministries of health should establish alliances with universities and other research centres in order to evaluate the effectiveness of mental health interventions in their countries or regions. Most of the evidence for effectiveness comes from developed countries. However, developing countries can benefit from meta-analyses of studies in other countries. This may require cross-cultural studies or simple evaluations verifying whether the results from developed countries are applicable to the populations of developing countries. It is also vital to conduct research into the effectiveness of mental health interventions that are culturally bound or specific to particular countries or regions.
- Task 4: Identify cost-effective interventions.** The most influential technical evidence for policy-makers and planners comes from studies on cost-effectiveness, which provide exact information on the health benefits obtainable from a certain amount of money. (See Planning and Budgeting for Service Delivery.)

Step 2: Implement political strategies.

Regardless of the technical evidence, many decisions relating to health are made for political reasons, particularly in some countries or regions. Policy-makers often make decisions on the basis of their public image, existing power struggles and support from the people. For this reason it is useful to identify the motives that can lead policy-makers to give priority to mental health.

The main tasks for Step 2 are as follows:

- Task 1: Identify themes ranking high in public opinion.** Every society has some themes that are considered priorities by the majority of the population at a particular moment. Policy-makers generally become more involved with these themes, which represent the people's principal needs, than with others. If the themes are properly dealt with the public

Policy-makers and planners often consider the pros and cons in terms of their public image, power struggles and support from the people.

image of policy-makers can improve and more popular support can be obtained. The professionals responsible for mental health in ministries of health should propose mental health strategies and interventions that can help to solve some of these priority problems.

Among the themes that can attract the support of public opinion are those relating to increases in the numbers of people committing suicide, especially if they are young, to adolescents abusing drugs and disturbing neighbours with violent behaviours and theft, and to persons with psychotic episodes who behave in bizarre ways or expose themselves or others to risks.

Task 2: Demonstrate that the themes can be successful. Policy-makers need to know that commitment to a particular theme will produce concrete positive results. For this reason, mental health professionals in ministries of health should present their proposals with a defined budget and expected results that can be quantified and made visible to the general population.

For example, proposals might be made to policy-makers in respect of a programme for: the treatment of depression in primary care, with screening for suicidal risk; a rehabilitation centre for drug dependence; or a community mental health team that would treat severe mental disorders in a defined population.

Task 3: Establish empowering alliances between mental health advocates. It is to be expected that policy-makers will be more inclined to support mental health if they are approached by large alliances of stakeholders, all advocating in the same direction. The mental health professionals in a ministry of health should help to build alliances that involve a range of mental health advocates. This increases power and the capacity to campaign for particular mental health issues with members of the legislature and the executive branch of government.

Key points: How ministries of health can support advocacy with policy-makers

- Step 1: Building technical evidence: determine the magnitude and cost of mental disorders and the effectiveness and cost-effectiveness of mental health interventions.
- Step 2: Implementing political strategies: identify themes that rank high in public opinion; demonstrate that they can be successful (with measurable and visible results); develop empowering alliances of mental health advocates.

3.4 By supporting advocacy activities with the general population

Two areas of advocacy for the general population can be identified, one related to mental health and the other to mental disorders. Although they represent the poles of a continuum and have common areas, in reality they address different aims and are supported by different stakeholders.

- **Advocacy for mental health:** This type of advocacy aims to promote and protect mental health in the daily lives of individuals, families, groups and communities. This means reinforcing protective factors like self-esteem, coping abilities, communication skills and social support networks. It also means decreasing risk factors, e.g. stress, alcohol, drugs, violence and poverty. The issues included in this type of advocacy are in part the responsibility of health policy. They also have a major component in the policies of other sectors, e.g. education, labour, social services, housing, justice and law enforcement. The principal stakeholders concerned with this type of advocacy are leaders or organizations involved in the principal arenas of the general population, such as neighbourhoods, workplaces and schools.

- **Advocacy around mental disorders:** One aim here is to improve the general population's knowledge, understanding and acceptance of mental disorders, so that they can recognize them and ask for treatment as early as possible. A second aim is that the general population should learn to interact with people who have mental disorders, without stigmatization and discrimination, so that full social integration can be achieved. The issues included in this type of advocacy are mainly the responsibility of the health sector, e.g. accessibility and the quality of mental health services. However, they also concern other sectors, e.g. integration with schools, work, social services and neighbourhoods. The main stakeholders for this advocacy are consumer organizations, family organizations and nongovernmental organizations.

Both of these forms of advocacy are needed in most societies. Through this process, ministries of health should always look for partnership and alliances with as many stakeholders as possible in order to advocate for those mental health issues that are most significant for the people.

It is easier to work on mental health advocacy with schoolchildren and employees in their workplaces than it is with less cohesive groups in the general population. This is because schoolchildren and employees share a common subculture and spend several hours together every schoolday or working day in the same place.

The general population can also be reached in neighbourhoods, where some social support systems operate and some spaces and activities are shared. Community leaders and key persons can be helpful for this purpose if properly trained, e.g. social workers, teachers, police, trade union officials, religious and neighbourhood leaders.

3.4.1 General strategies for supporting advocacy activities with the general population

Ministries of health can support advocacy with the general population through public events and the distribution of educational material, e.g. brochures, pamphlets, posters and videos. In a developing country with scarce resources for mental health it would be very unrealistic to attempt to carry out many of these expensive activities. However, the restricted and carefully targeted use of such methods can sometimes be useful.

Fortunately, many advocacy actions need little or no additional funding. The professionals in charge of mental health in ministries of health, and eventually the more senior decision-makers, can incorporate many advocacy activities into their daily work. When

Advocacy for mental health aims to promote and protect mental health in the daily lives of individuals, families, groups and communities.

Advocacy around mental disorders aims to achieve full social integration for people with mental disorders.

It is easier to work on mental health advocacy with schoolchildren and employees in their workplaces than with less cohesive groups.

they are formulating, implementing or evaluating mental health policy, plans and programmes, they can include a range of advocacy issues. These can have a direct impact on the general population as they are communicated through the mass media. Such activities can have a multiplying effect in each health district. Carried out continuously and consistently, they should have an impact on mental health teams and primary care teams, who can also influence the general population on these matters.

Many advocacy actions need little or no additional funding.

Advocacy issues should be also included in other regular activities of health ministries, such as meetings with representatives of other ministries and other sectors of society, as well as in training programmes for general health workers and mental health workers. Professionals in ministries of health have the advantage that their advocacy work is conducted before a national audience. They can reach this audience through the media, national meetings, professional seminars and congresses, and various public events. In all these activities, which are generally part of their daily functions, they can advocate for persons with mental disorders and for the mental health of the general population.

The professionals in charge of mental health in ministries of health can also advocate by playing an active role in formulating, approving and implementing **mental health legislation**. (See *Mental Health Legislation and Human Rights*.) It is necessary to have a clear picture of the legal mapping of mental health in the countries concerned so as to clarify the aspects of the law which need to be reinforced in order to protect consumer rights and implement promotional and preventive activities. Conversations with key persons in the health and/or legal systems are often necessary in order to sensitize them to these matters. As with policy, all of these activities related to legislation should be communicated to the general population nationally or regionally through the media and locally through the health districts and health teams.

Professionals working in ministries of health have the advantage that their advocacy work is conducted before a national audience.

3.4.2 The role of the mass media in advocacy

Mass media programmes promoting public health have been used successfully for many years. With regard to mental health, however, they are only in their formative stages. Attitudes and behaviours vis-à-vis mental health are complex, and studies of efforts in the mass media to alter them during the 1980s suggested that the results were limited. There have since been better results with carefully planned long-term educational campaigns targeted at specific audiences. For example, the broadcasting media have proved effective in destigmatizing and promoting the acceptance of persons with mental disorders (Austin & Husted, 1998).

The modification of public perceptions of mental disorders could promote policy changes favourable to the mental health of populations, and it is therefore necessary for ministries of health to implement continuous media strategies. In addition to fighting the stigma associated with mental health problems it is important to improve public opinion on the value of mental health and of interventions in this field. Moreover, it has to be remembered that in some countries the media can have a negative effect on perceptions of mental disorders, as has been demonstrated in the United Kingdom (Wolff, 1997).

In some countries the media can have a negative effect on perceptions of mental disorders.

It is useful to make a distinction between the various roles of the media, i.e. to inform, persuade and advocate, and the methods of using the media in mental health advocacy, e.g. education through entertainment, publicity and advertising.

The mass media can be used to inform the public, to persuade or motivate individuals to change their attitudes (thus leading to behavioural change) and to advocate for change in the social, structural and economic factors that influence mental health.

The role of the mass media in mental health can be to inform, persuade or motivate.

➤ **The informing or educational role** attempts to create awareness, knowledge and understanding of mental health issues in the community or in major subgroups of the community.

➤ **The persuasion or motivating role** attempts to alter individuals' attitudes and/or to encourage certain behaviours or actions through emotional arousal techniques. An important activity would be to reduce the stigma associated with mental disorders and to encourage individuals to adopt behaviours supportive of persons with mental disorders and disabilities.

➤ **The advocacy role** aims to achieve changes in the sociopolitical environment which would improve mental health. This could be done by re-framing public debate so as to increase public support for more effective policies in the field of mental health. This might also encourage community groups working on mental health to participate actively in the political process.

The three most common methods for using the media to address mental health issues involve advertising, publicity and education through entertainment.

Advertising can be useful for creating or increasing awareness of the value of mental health in people's everyday lives and of the existence of mental health services. It is also useful for neutralizing misconceptions about people with mental disorders and negative factors that influence the mental health of populations. Although this approach is expensive it is valuable for reaching large numbers of people in a short period. Furthermore, unlike media methods such as those involving publicity and entertainment, advertising messages and their exposure can be controlled.

Publicity involves the creation of news in order to attract the attention of the public to specific aspects of mental health, to promote involvement in mental health activities, or to frame issues and actions so as to achieve advocacy. With this method one has less control over the messages and their exposure.

Education through entertainment involves the placement of educational messages on mental health or other social matters in the entertainment media in order to promote changes in knowledge, attitudes, beliefs and behaviours. This may be achieved, for example, through television and radio (particularly soap operas), songs, music, comics and novels. This method has been successfully used to promote social and health issues in developing countries. It can make a valuable contribution to mental health advocacy.

Television tends to be the most extensively used medium, although radio is also used to reach local and rural populations. Education through entertainment is a particularly useful method for dealing in a non-threatening way with sensitive issues such as drug and alcohol abuse, gender violence, sexual practices, and the stigma of having schizophrenia or other severe and persistent mental disorders.

The following media strategies may be considered for the purposes of mental health advocacy by ministries of health.

➤ **Maintenance of a continuous working alliance with the media.** It is helpful to maintain a friendly relationship with media professionals by facilitating their work and giving them the information they seek. They frequently need to talk to mental health specialists in order to obtain background knowledge about news items. Consequently, good opportunities arise to learn about the culture and functioning of the media, to educate the media about mental health and to sensitize them about advocacy messages that have priority status in the country concerned at a given time. This strategy is particularly

The three most common methods for using the media to address mental health issues involve advertising, publicity and education through entertainment.

Television tends to be the most extensively used medium, although radio is also used to reach local and rural populations.

It is useful to maintain a continuous working alliance with the media.

useful for supporting the functions of the media, informing the public and persuading or motivating individuals to change their attitudes and behaviours in relation to mental health. Professionals with expertise in marketing, public relations and communications can be of great help to mental health sections in ministries of health.

➤ **Introducing mental health issues in the media.** Mental health professionals with special communication abilities may be identified and supported by ministries of health. Different abilities are required for appearing in a television show, speaking on the radio or writing a column for a newspaper or magazine. In most countries, radio can be an excellent medium for providing exposure to the subject of mental health because of its capacity to reach a large audience repeatedly and inexpensively. Although a single radio programme may not be as memorable as a single television show, radio permits a presenter to be heard regularly and to connect effectively with the public (Austin & Husted, 1998). This strategy is especially recommended for advocacy aimed at changing social, structural and economic factors that influence mental health. The method of choice in this case would be that of education through entertainment.

➤ **Producing news attractive to the media.** Most of the daily work of mental health specialists, whether of a clinical or preventive nature or concerned with public health, does not constitute news to media professionals and is not communicated to the general population. Something that mental health professionals find very interesting may be of no interest to media professionals. A working alliance between the two professions makes it possible to know more about the things that attract the attention of the media. The aim is to find common subjects that can serve the purposes of both parties. This can help to communicate mental health advocacy issues to the public, e.g. consumer rights and mental health promotion. The publicity method is the most appropriate for this strategy.

Mental health professionals with special abilities to communicate through the media may be identified and supported.

A working alliance between the media and mental health professionals can benefit mental health advocacy.

Key points: How ministries of health can support advocacy with the general population

- Two areas of advocacy for the general population can be identified: mental health (promotion and protection) and mental disorders (knowledge and acceptance).
- General strategies: advocacy through educational material, the internet, meetings, conferences, public events, policy and legislation.
- Mass media: maintaining a continuous working alliance with the media, introducing mental health issues (e.g. education through entertainment) and producing attractive news (e.g. publicity).

Box 3 gives examples of actions and issues that can be developed by ministries of health in order to support advocacy activities with the four target populations described in this section.

Box 3. Examples of how ministries of health can support mental health advocacy*

Target populations	Actions	Issues
1. Consumer and family groups and nongovernmental organizations Goal: empowerment.	Counselling on defence of rights. Education and training on mental disorders and treatment. Hotline for crisis intervention. Support to improve organization.	- Access and quality - Informed consent - Involuntary procedures - Confidentiality - Complaints and appeals - Mutual help groups - Civil rights - Disability pensions - Housing - Education and employment - Positive discrimination
2. General health workers and mental health workers Goals: improvement of service quality and respect for individual rights.	Incorporating consumers and families into the planning and evaluation of services. Training in human rights issues. Defending the rights of persons with mental illness. Helping workers to improve working conditions.	- Stigma because of mental disorders - Access and quality assurance - Community care - Incentives for general health workers and mental health workers - Resources for mental health services
3. Policy-makers and planners (executive branch of government, ministry of finance, other ministries, judiciary, legislature, political parties) Goals: improvement of mental health policy and legislation.	Dispelling myths. Interviews and meetings with key persons. Distributing printed and electronic documents. Visiting psychiatric facilities with policy-makers and planners. Inviting them to congresses and seminars on mental health.	- Mental health legislation - Resources for mental health - Equity for mental health - Burden of mental disorders - Cost-effective interventions
4. General population (including neighbourhoods, schools and workplaces) Goals: raising awareness, increasing knowledge and changing attitudes.	Educational materials: brochures, pamphlets, posters, videos, slides, multimedia, web sites, electronic bulletins. Face to face: conferences, workshops, group discussions. Public events: rallies, art exhibitions, parties. Policy and legislation. Media: news conferences, television and radio shows, newspapers	- Stigma because of mental disorders - Information about mental disorders and mental health services - Resources for mental health (e.g. parity with physical health) - Promotion of mental health and prevention of mental disorders

* the examples are not specific recommendations for action.

4. Examples of good practices in advocacy

4.1 Brazil

The Advocacy Office for Rights, Mental Health and Citizenship is a legal institution linked to the psychosocial rehabilitation programme developed in two outpatient mental health centres in the city of São Paulo. The Office is part of a joint collaborative programme between São Paulo University and the Public Health District. It has been working since 1997 with the aims of providing housing for people with serious mental disabilities and fulfilling the rights of persons who use mental health services. The principal methods are those of counselling and of mediation between these persons and the mental health service. This responds to the needs of persons with mental disorders living in the community and protects their health and civil rights (Aranha et al., 2000).

Comment: This is a good example of an institution that protects consumer rights in a developing country, where people with mental disorders who live in poor socioeconomic conditions are at comparatively high risk of being discriminated against, particularly if their own organizations are not yet powerful enough to defend them. This type of advocacy is also useful for producing changes supportive both of consumers' rights within mental institutions and of mental health workers in such settings.

4.2 Italy

As part of the psychiatric reform that followed Law 180 in 1978, a growing number of worker cooperatives in Verona, among other places, have become consumer-run enterprises. These cooperatives compete successfully with local businesses in the open market and provide work for persons with the most disabling and discriminated mental disorders. One of these cooperatives has become associated with a psychiatric self-help group and the Department of Mental Health in implementing a joint programme against stigma. Help is given to psychiatric service consumers to free themselves from the care system by promoting their initiatives and supporting their efforts to meet requirements for housing, work, social activities and entertainment. The results after five years are very encouraging (Burti, 2000).

Comment: In a developed country and within a process of comprehensive psychiatric reform, consumer organizations can become stronger. Not only can they protect the rights of persons with mental disorders but they can also support each other so as to satisfy some of their basic needs. These consumer organizations can go beyond immediate needs and attempt to produce cultural change in relation to the stigma of mental disorders in the community at large.

4.3 Uganda

The Uganda Schizophrenia Fellowship was formed in Kampala and fully registered with the National Nongovernmental Board. It comprises carers of persons with schizophrenia and allied disorders, families, friends, relatives and mental health workers. This organization is supported by the World Fellowship for Schizophrenia and Allied Disorders. The main initiatives involve home visits, counselling, health education (through seminars, psychodrama, music and poems), encouragement for persons with mental disorders to maintain their skills, and teaching them new skills in their communities (e.g. making mats and tablecloths). It has proved possible to decrease the stigma in the neighbourhoods where members live and to defend some of their rights (Walunguba, 2000).

Comment: The World Schizophrenia Fellowship is an excellent model of an international nongovernmental organization that can help developing countries to start advocacy groups. It is also an example of a mental health nongovernmental organization working with persons who have a particular disorder and including families, consumers, mental health workers and friends among its members.

4.4 Australia

The evaluation of the National Mental Health Strategy five years after its inception in 1992 demonstrated that the changes introduced for improving the rights of consumers and carers were among its more important achievements (Commonwealth Department of Health and Family Service, 1997). Among these innovations are the following.

- The establishment of formal entities to represent the interests of consumers (49% of public sector local mental health services had a formal consumer group by 1996).
- The allocation of funds to projects led by consumers and carers in order to strengthen their voice.
- The enactment of amendments to mental health legislation of most states and territories in order to protect the rights of people with mental illness.
- The inclusion of carers and consumers in all working groups dealing with national issues.
- The issuing of national standards for the protection of consumer rights in mental health services.
- The creation of a national media campaign to increase understanding of mental health and reduce stigma.

Comment: This is a case of a developed country whose government has a strong commitment to advocating for the rights of people with mental disorders. A comprehensive policy has allowed the participation of consumers in mental health services. This has led to financial support for their initiatives, laws to protect their rights, and education of the general population to reduce stigma.

4.5 Mexico

1. The Mexican Foundation for Rehabilitation of People with Mental Disorders is a non-governmental organization that began to function in 1980, pioneering the implementation of psychosocial rehabilitation programmes. It began its activities in psychiatric hospitals and extended them to the community. The Foundation developed the country's first community day centre for people with mental disorders and a community residence for former patients of psychiatric hospitals. It has denounced national and international institutions in relation to human rights violations in Mexican psychiatric hospitals and has promoted the formation of citizens' committees in these facilities. In 1999 and 2000 the Foundation joined forces with the National Secretary of Health to create the Hidalgo Model of Mental Health Services, a demonstration area in the State of Hidalgo with 10 small houses for intensive psychosocial rehabilitation and two halfway houses for social integration. This made it possible to close the state psychiatric hospital and to improve the quality of life of consumers (Dirección General de Rehabilitación Psicosocial, Participación, Ciudadana y Derechos Humanos, 2001).

Comment: This is an example of a local nongovernmental organization focusing on a particular subject, i.e. the rehabilitation of persons with mental disorders, and utilizing several methods for advocacy. It has denounced human rights violations, promoted consumer participation in mental health facilities, implemented pilot projects and provided community services. It is also an example of advocacy that has influenced policy-makers, leading to changes in mental health policy, the direct collaboration of members of a nongovernmental organization with government government, and the creation of a community mental health demonstration area.

4.6 Spain

When psychiatric reform began in Andalusia during 1984 there was no movement associated with families or consumers. Professionals assumed the leading roles in bringing about changes. Since 1987, however, family organizations have gradually developed, initially in Seville and later in the whole region. The Andalusian Federation of Family Associations was created in 1990. Their position in the reform process evolved from one of criticizing the closure of mental hospitals to that of supporting changes towards community care. The Federation played an important role in mobilizing public opinion. It influenced regional members of parliament and helped to create a foundation responsible for community services, i.e. housing, employment and recreation. It played a similar role in speeding up the implementation of new mental health services. The principal activities of family groups involve advocacy for persons with mental disorders, self-help programmes for families and the provision of some services for patients, namely social clubs and recreational activities (M. Lopez, personal communication, 2002).

Comment: This is another example from a developed country illustrating the important role played by family organizations. These organizations made the Government aware of the need for improvements in the quantity and quality of services. They also provided community services for consumers and families. The example also shows the importance of advocacy groups in a process of psychiatric reform, deinstitutionalization and provision of community services.

4.7 Mongolia

As part of a comprehensive national project for the reorientation of mental health services a programme was launched in 1999 by the Ministry of Health, with WHO support, to increase community awareness and reduce stigma and discrimination associated with mental disorders (World Health Organization, 2002). During the first year, interviews were conducted in order to determine the extent to which stigma and discrimination affected persons with mental disorders. Mental health workers felt that they were tolerant towards these persons but indicated that they would not like to live with them or let their children marry them. Some health workers and police officers were responsible for discrimination against people who were mentally ill and sometimes for their mistreatment. Among the poorer sections of the population there was a tendency to abandon relatives with mental disorders. In general it was felt that the transition to a market economy had caused a disproportionate burden on persons with mental disorders and that families' attitudes towards them had become more negative.

During the second year of the project a nongovernmental organization, the Mongolian Mental Health Association, was created with the support of a small amount of funding. It comprised psychiatrists, volunteers and representatives from other nongovernmental organizations. The Association has carried out a series of public education activities through newsletters and pamphlets explaining the basics of mental health for lay people. It has also participated in the activities of World Mental Health Day by launching a media campaign on mental health in the workplace, involving programmes and interviews on television and newspaper articles. A project has been developed to reorient the mental health services from specialist and hospital-based care to community-based services focusing on the promotion of mental health and the prevention of mental disorders.

Comment: This is an example of a country with a low level of mental health advocacy, where actions were started by the Ministry of Health as part of a mental health reform process with the support of an international agency (WHO). Evidence for advocacy was gathered through interviews and support was given for the development of a non-governmental organization concerned with advocacy. It is also an example of the types of advocacy activities that can be conducted with the general population through the distribution of educational material and by working with the media.

5. Barriers and solutions to supporting advocacy from ministries of health

Box 4 summarizes some of the main barriers that mental health professionals in ministries of health may face during the process of advocacy. Suggestions are made as to how these professionals might solve the difficulties. Further details of the barriers and solutions are given below Box 4.

Box 4. Examples of barriers and solutions to supporting advocacy from ministries of health*

Barriers	Solutions
1. Resistance to advocacy issues from policy-makers and planners. They consider that the defence of consumer rights or the plea for better mental health is either critical of their work or not relevant in the country or region concerned.	Formulate advocacy issues from a technical point of view, demonstrating that the defence of consumer rights and the improvement of mental health have positive health outcomes and cost-benefits.
2. Division and friction between different mental health advocacy groups. The conflict results in the advocacy groups losing strength and the ability to get their messages to the general population and policy-makers.	Help the different mental health advocacy groups in the country concerned to find common issues and goals. Facilitate the formation of large alliances or coalitions.
3. Resistance and antagonism from general health workers and mental health workers to advocacy for consumers' rights and better quality of mental health services.	Do not become involved in conflict with health workers' unions. Try to find common ground on advocacy issues, e.g. by establishing how working conditions would improve with the upgrading of the quality of services.
4. Very few people seem interested in mental health advocacy and proposals are not receiving support from the general population at the national or regional level.	Local actions are necessary. Implement pilot experiences or demonstration areas where advocacy proposals can be tested.
5. There is confusion about the theory and rationale of mental health advocacy. Stakeholders do not seem to believe the soundness of the ideas presented to them.	Organize a seminar on mental health advocacy in the country or region concerned with the participation of international experts and the main stakeholders.
6. Few or no consumer groups, family groups and nongovernmental organizations are dedicated to mental health advocacy in the country or region concerned.	Help to organize advocacy groups, identify and support stakeholders that have an interest in advocacy, and/or empower existing groups.

* the examples are not specific recommendations for action.

5.1 Resistance to advocacy issues from policy-makers and planners

Barrier: Ministers of health or other high officials sometimes do not support advocacy actions carried out by mental health professionals in ministries of health. They may consider that it is not the responsibility of these professionals to become involved in advocacy. They may be concerned that people would become more aware of their unsatisfied mental health needs and that the ministries would not have enough resources to meet them. They may also think that other health priorities are more urgent than mental health. In other instances, ministers of health may become active mental health advocates whereas other ministers or high officials in the executive branch of government may be resistant to the introduction of new policies or legislation or to the expenditure of more resources in this field.

Solution: In order to overcome these obstacles it is necessary to lobby the relevant government authorities. Professionals in ministries of health should have meetings with some of these authorities in order to explain the magnitude of mental health problems, the newest effective interventions and the economic return obtainable by investing in mental health. It should be stressed that building advocacy organizations is a way of encouraging people with mental disorders and their families to become self-reliant and is therefore cost-effective in the long term. The help of other key stakeholders in the lobbying process can make the message stronger. The distribution of printed and electronic documents may also be advantageous. Depending on the awareness of the authorities, messages can be reinforced by stressing either the problems, i.e. by increasing the visibility of violations of human rights in mental health hospitals, or the solutions, i.e. by drawing attention to successful pilot projects or demonstration areas.

5.2 Division and friction between different mental health advocacy groups

Barrier: Advocacy groups have different needs and interests and sometimes compete for access to resources or for the attention of policy-makers. For example, consumer groups differ in their relationships with mental health professionals, some being antagonistic towards them and others tending to work harmoniously with them. Consumer groups may have rivalries with family groups, and some initiatives of non-governmental organizations advocating for mental health may lead to competition with consumer and family groups for the same clients.

Solution: Professionals in charge of mental health in ministries of health should establish a dialogue with representatives of all groups involved in mental health advocacy in the countries or regions concerned. It is important to understand their needs, motivations and diverse methods of advocacy. Helping them to find common issues and goals can contribute to the formation of alliances and coalitions. Helping them to identify their similarities can give them more strength and power to advocate both with the general population and with policy-makers, without the loss of their identities.

5.3 Resistance and antagonism from general health workers and mental health workers

Barrier: Some of the mental health advocacy issues that have been discussed in this module may seem threatening to health workers. They sometimes fear that their needs will be neglected because the authorities are going to concentrate on improving the mental health of the general population, protecting the rights of consumers or improving the quality of mental health services. Health workers may be concerned about the prospect of being overloaded with extra work, blamed for human rights violations, changed in their job functions without proper consultation, or subjected to instability of employment.

Solution: It is crucial that mental health professionals in ministries of health maintain good working relationships with all the associations of general health workers and mental health workers, including trade unions and professional and scientific organizations. They should work in conjunction with as many of these associations as possible in order to define common issues and goals for the improvement of access, the quality of mental health services, consumer satisfaction and the working conditions of general health workers and mental health workers. Every possible effort should be made to build alliances between ministries of health and workers' associations with a view to mutual gains and, most importantly, gains for the mental health of the populations in question.

5.4 Very few people seem interested in mental health advocacy

Barrier: Sometimes it seems that mental health advocacy at the national level is achieving nothing and that the best arguments and speeches are completely unheard. When this is the case it is likely that other important problems occupy the attention of the leaders and social organizations in the countries or regions concerned.

Solutions: It is necessary to regroup, study the situation, examine experiences gained in other countries and prepare to raise the matter of advocacy again when the right occasion presents itself. Mental health and mental disorders are such important matters that they can be expected to re-emerge as matters of major concern.

These are times when the mental health professionals in ministries of health should implement local actions that can help to build knowledge, experience and evidence for advocacy. For instance, pilot projects in schools, workplaces or neighbourhoods can help towards the creation of advocacy actions, the raising of mental health issues (Box 3) and the evaluation of impacts on the people. If more resources and expertise are available a demonstration area for advocacy might be established with the involvement of several target populations and the participation of the main local stakeholders. Some of the media strategies described in Section 3.4.2 might also be tried in this connection.

5.5 Confusion about the theories and rationale of mental health advocacy

Barrier: Advocacy is a relatively new activity in the field of mental health and there is no general agreement about its meaning and practice. Consumers, families, health workers, ministries of health and other stakeholders have different understandings of the subject. The lack of agreement about the basic concepts of advocacy can sometimes delay progress in a country or region.

Solution: One way in which confusion can be overcome involves organizing a seminar on mental health advocacy in a country or region with the participation of international experts and the main stakeholders. Over the last few years, several international initiatives have been implemented by different organizations with the participation of representatives from ministries of health. They have fostered a common understanding of the need to protect the rights of persons with mental disorders and to promote mental health. There is now an international movement for mental health and a partnership of advocates from different countries.

The World Psychiatric Association's Programme to Reduce stigma and Discrimination because of Schizophrenia, is an international private initiative focusing on advocacy. Initiated in 1996, it aims to increase awareness and knowledge of the nature of this disease and the treatment options, to improve public attitudes towards persons with schizophrenia and to generate action for the prevention or elimination of discrimination and prejudice (World Psychiatric Association, 2000). The Programme is currently being implemented in several parts of the world and has already produced guidelines and audiovisual materials designed to help countries in launching their own experiences.

The World Fellowship for Schizophrenia and Allied Disorders is an international organization devoted exclusively to serious mental disorders. Twenty-two national family organizations make up the voting membership and more than fifty smaller groups are associate members. They provide direct services, run self-help groups, conduct workshops, produce educational materials, arrange conferences, advocate for better treatment and appropriate services, manage research funds and, consequently, influence government policies (World Fellowship for Schizophrenia and Allied Disorders, 2002).

5.6 Few or no consumer groups, family groups or nongovernmental organizations dedicated to mental health advocacy

Barrier: Mental health advocacy is comparatively difficult for professionals in ministries of health if there are few or no consumer groups, family groups or nongovernmental organizations dedicated to this matter in their countries or regions. In this circumstance the professionals are in a relatively weak position for lobbying policy-makers. Consumers and families, who have been the main force behind mental health advocacy where this movement is well developed, lack models on which to build their organizations.

Solution: In this situation, ministries of health should set priorities for advocacy actions on the basis of the available information about the main mental disorders and the policies and legislation in force in the countries or regions concerned. These priorities should be indicated to all health districts, mental health teams and primary care teams. Stakeholders interested in consumer rights should then be identified in order to negotiate joint projects oriented towards the formation of consumer groups and/or family groups with advocacy functions. Technical support and funding may be necessary.

If there are a few consumer organizations, family organizations, nongovernmental organizations or other advocacy groups in the countries or regions, the professionals in charge of mental health in the ministries of health should try to empower them by providing information, training and funding. The professionals can also support the evaluation of some of these advocacy groups by identifying best practices and disseminating them widely as models in the countries concerned. Another route to empowerment involves inviting representatives of the groups to participate in some ministry of health activities (e.g. the development and evaluation of mental health policy, plans, programmes or legislation).

6. Recommendations and conclusions

It is not easy to give recommendations that can be applied worldwide because of the diversity of social, economic, cultural and other realities. In order to systematize the information the following recommendations for action are given in accordance with the level of development of the advocacy movement.

6.1 Countries with no advocacy group

1. Set priorities for advocacy actions from the ministry of health, based on interviews with key informants and focus groups.
2. Draw up a brief document showing the priority mental health advocacy issues in the country (e.g. conditions in psychiatric institutions, inaccessible primary care services, discrimination and stigma against people with mental disorders). Support the document the country's policies, legislation, programmes or guidelines relating to these issues.
3. Disseminate the above document throughout the country via the supporting organization for mental health at the levels of health districts, community mental health teams and primary care teams.
4. Identify one or two psychiatric services with the best practices in the country and negotiate a joint demonstration project. This should involve the ministry of health and the psychiatric services. It should have the goal of forming consumer groups and/or family groups with advocacy functions. Technical support and funding are necessary.
5. Identify one or two stakeholder groups interested in the rights of people with mental disorders or in the promotion of mental health and the prevention of mental disorders. Carry out advocacy activities with them cooperatively on a small scale. These small projects can be used as a basis for attracting greater funding and for the expansion of advocacy activities in subsequent years.

6.2 Countries with a few advocacy groups

1. Empower the advocacy groups by providing them with information, training and funding. Focus on consumer organizations.
2. Carry out external evaluation of the advocacy groups, identify best practices among them and demonstrate them to the rest of the country as models.
3. Organize a seminar on mental health advocacy and patients' rights, inviting the advocacy groups and national and international experts on these matters.
4. Lobby the health minister and other health authorities so as to obtain explicit support for advocacy in mental health.
5. Conduct a small campaign, e.g. using radio and leaflets, in order to inform the population about the advocacy groups.

6.3 Countries with several advocacy groups

1. Maintain an updated census of the mental health advocacy groups, and particularly of the consumer groups, in the country. Periodically distribute a directory of these groups.
2. Invite representatives from advocacy groups to participate in some activities at the ministry of health, especially on the formulation, implementation and evaluation of policies and programmes. Try to disseminate this model to all health districts.
3. Co-opt representatives of consumer groups and other advocacy groups on to the visiting board for mental health facilities or any other board that protects the rights of people with mental disorders.
4. Train mental health and primary care teams to work with consumer groups.
5. Conduct an educational campaign on stigma and the rights of people with mental disorders. Try to incorporate issues about the promotion of mental health and the prevention of mental disorders.
6. Help advocacy and consumer groups to form large alliances and coalitions.

The implementation of some of these recommendations can help ministries of health to support advocacy in their countries or regions. The development of an advocacy movement can facilitate the implementation of policies and legislation on mental health. As a result the population is likely to benefit in many ways. The needs of persons with mental disorders will be better understood and their rights will be better protected. They will receive services of improved quality and will participate actively in the planning, development, monitoring and evaluation of the services. Families will be supported in their role as carers and the population at large will have a better understanding of mental health and disorders. Longer-term benefits include the wider promotion of mental health and the development of protective factors for mental health.

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Mental health advocacy / Various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations.

Health district / A geographical or political division of a country, created for the purpose of decentralizing the functions of the ministry of health.

Consumer / A person with a mental disorder who has been a recipient of mental health services. Synonymous terms are used in different places and by different groups of persons with mental disorders.

User / A term synonymous with consumer, used in some European countries.

Patient / A person with a mental disorder receiving medical forms of treatment.

Family / Members of the families of persons with mental disorders who act as carers.

Nongovernmental organization / A non-profit, voluntary or charitable organization that carries out advocacy activities and provides various mental health interventions, including promotion, prevention, treatment and rehabilitation.

Further reading

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