



Regional Meeting of the Global Forum for Community Mental Health

Jakarta, Indonesia, October 23 – 25, 2007

Summary Report

Brief Introduction on the Global Forum

The mission of the Global Forum for Community Mental Health is to provide a supportive network for all those interested in providing community mental health services. It provides a foundation for sharing information, providing mutual support, and a sense of belonging for consumers, carers, families and all who are interested in shifting mental health care from long-term institution to effective community-based care. The first meeting of the Global Forum for Community Mental Health was held in Geneva in May 2007 and was hosted by the World Health Organization.

The Regional Meeting

Given the enthusiasm expressed by participants of the Global Forum in Geneva, it was decided that regional meetings of the forum were in order so that better understanding of regional issues could be established and regional players could provide mutual support to each other. The expected outcome of the regional meeting was further strengthening of the forum's global initiative. This resulted in the first meeting of the forum being held in Jakarta, Indonesia on 23-25 October 2007. The convener of the meeting was WHO's Mental Health and Substance Abuse Department, while Christoffel Blindenmission (CBM) provided significant support. Other key partners were Basic Needs, the World Association for Psychosocial Rehabilitation and the UK Department of Health. There were individuals who offered immense support towards the establishment of the forum included S. Sashidaran and John Jenkins. The meeting in Jakarta was organized by WHO, Indonesia with active support from CBM, Indonesia.

The meeting was held over a period of three days, each day consisting of individual sessions that incorporated two lead comments to provide background and context and three or four speakers who shared experiences on the session topic. The session would then welcome comments by other participants.

For the programme of the meeting, see Annex 1.

For the list of participants, see Annex 2.

For the list of participants in the small group sessions, see Annex 3.

For the pdf copy of the presentations made in the meeting, see Annex 4.

Day 1

Subhash Salunke, WHO Representative to Indonesia, welcomed everyone and hoped that through this meeting, everyone could share regional and national experiences, and identify barriers and outline possible solutions for low and middle income countries. Yulizar Darwis, Director of Mental Health, Ministry of Health Indonesia, in his opening remarks stated that the majority of problems were found in the community, thus the response needs to be shifted from an emphasis in mental health institutions to community based interventions.

After brief self-introduction by each participant a short explanation on the Global Forum was given by Shekhar Saxena. The ten World Health Report 2001 Recommendations were reviewed and recommendation number three, “give care in the community”, was highlighted. In this situation, the drawback of bio-medical model is that it dismisses the social aspect to mental health care. An appropriate comprehensive long-term care should be provided within an optimal mix of services. This kind of models could be found in both rich and poor countries as attitude and willingness contributed more towards this model rather than money.

The objectives and themes of the Forum:

- To provide a supportive network for all those interested in promoting community mental health services and care for people with mental disorders, including the involvement of consumer and advocacy groups.
- To share selected experiences of regional and country activities concerning community mental health services and to derive some lessons.
- To discuss ways to identify and overcome the barriers involved in the strengthening of community health services in low and middle income countries
- To plan future activities of the Forum

It was realized that every objective could not be covered extensively during the meeting, but there was hope that this meeting would be the first of many to come in the ensuing years.

Session 1: Rethinking the role of the mental hospital

In the lead comment by Shekhar Saxena the 10 WHR-2001 Recommendations were reiterated. Despite WHO promotion, community mental health care was present in only 68% of countries, according to WHO Mental Health Atlas. In South East Asia, over 70% of mental health expenditures were spent on mental health hospitals. A vast majority of mental health resources in low to medium income countries are spent on mental health hospitals despite the clear evidence that this care is less effective, less cost-effective and often prone of violation of human rights.

The first speaker, Dr Peni Moi Biukoto from Fiji, gave a snapshot of Community Mental Health in his country. The main limitations were financial resources, human resources and monitoring and evaluation mechanisms. There were plans for the future to revise Mental Health legislation to include community mental health, formulate a mental health policy and advocate for national treatment guidelines. Fiji could not afford to limit itself to hospital-based clinical psychiatry and learnt some valuable lessons from this, chiefly that they had to be proactive in terms of policy-making and advocacy; community support was key; government and political support was crucial if community mental health care was to be long-term and sustainable.

This was followed by a presentation by Boonchai Nawamongkolwatana of Thailand, who looked at what could be done with less mental health resources and personnel in terms of community mental health care provision. The importance of having a good network in place and adequate training was underlined. Through this approach, a study conducted in Bangkok found that a patient with schizophrenia admitted three times a year spent 279.97 days more in the community between admissions after community mental health care services were established.

Eka Viora, the third speaker, from the Indonesian Directorate of Mental Health Care, spoke of Indonesia's current predicaments regarding mental health care provision such as centralized facilities that limit access for those who live in rural or more isolated areas. One of the main challenges was gaining support from practitioners, as there was concern that hospitals would see decreased revenues should services be decentralized, or community based. Possible solutions for Indonesia were outlined, such as establishing comprehensive mental health care services that are able to respond to specific patient needs, making psychotropics available at Primary Health Care facilities and General Hospital settings and adequate training for mental health workers to facilitate "decentralization" of services, thus making them more community- and patient-based.

Lourdes Ignacio, in her lead comments, stated that the challenge was to redefine the role of the mental hospitals. In some countries, if the mental hospitals were shut down, the patients would literally freeze or starve to death as patients were disjointed from the community and some had been institutionalized for up to 50 years. The mental hospitals play a humanitarian role from this perspective. Reflecting on several of the presentations, the need for mental health leaders to voice the need for community based services before policymakers was emphasized. Stigma, also created by mental health professionals themselves, need to be addressed in order to allow for responsive community based interventions. In several countries, such as Indonesia and the Philippines, the role of the traditional healer, a non-western concept, was one that contributes positively to community-based interventions.

There was a discussion that ensued, with all participants asked to comments on various points. It is recognized that input from consumers and NGOs is critical, as in the past it was sometimes overlooked. NGOs can play a vital part as they have financial and human resources, and do not have the bureaucracy that other organizations do.

It was noted that discussions should focus on community-based issues, not hospital based, and new resources in the community need to be found to aid with the social and economical aspects of the patients' needs. The role of relatives is vital in the success of community care as is proper training for everyone involved in the provision of care and services. Continuous support and training for community programs is needed to ensure that patients feel safe and comfortable. Mental hospitals can play a positive role. It was interesting to note that as bed occupancy reduces, they no longer receive the amount of funding, and therefore possibly unable to channel funds to community-based services.

The chairperson closed with several points: First, downsizing mental health hospitals can be done by stopping fresh admissions and creating community based alternatives. Second, mental hospitals need to improve the human rights situation and effectiveness of care. Third, existing mental hospital resources can be and should be allocated for community-based services.

Session 2: Policy and development of services

In this session, the two lead comments, by John Mahoney and Pandu Setiawan, provided a background on the levels of service paramount to comprehensive service delivery systems. Globally, there are 450 million people affected at any given time as a result of a rapid rise in mental ill health. The proportion of the global burden of disease attributable to mental, neurological and substance use disorders is expected to rise from 12.3% in 2000 to 16.4% by 2020. This burden will be keenly felt by developing countries and their vulnerable groups, such as impoverished people, those with chronic diseases and those exposed to emergencies. This burden represents human misery, disability and economic damages as well as immeasurable yet equally important burden shouldered by carers, relatives and communities who also suffer in consequence. Even without defined mental disorders, a diminished mental health should be seen as a something to be corrected, as a challenge to be taken by nations.

The first speaker, Chhit Sophal from the Cambodian Ministry of Health, presented how Cambodia has integrated comprehensive mental health care services into the public health care system through CPA (Complementary Package of Activities) delivered at 40 out of 69 Referral Hospitals; and MPA (Minimum Package of Activities) delivered at 16 out of 969 Health Care Centres.

C. Ramasubramanian, Professor and Head of Department at the Institute of Psychiatry, Madurai Medical College, shared his experience in developing "a community mental health project", deemed to be a success and warranting duplication of this model by the Tamil Nadu government in other districts. The project consists of four components: Awareness building, Identification and Assessment, Treatment and Rehabilitation. The program owes its success to its sustainability. Ultimately, beneficiaries are empowered through training, education, provision of medication and forming self-help groups that manage communal micro-enterprises, promotion of credit and savings cooperatives and

profit sharing. This has led communities to becoming self-sufficient, self-confident and economically independent. This project has also strengthened the Community Mental Health Program, gaining support from government, NGOs and civil society, and directly benefiting 2770 beneficiaries and 4000 caregivers.

The third speaker, Budi Anna Keliat from Indonesia, gave a short presentation on Community Mental Health Nursing in Indonesia that was started by WHO in 2005. Some brief comments were made with regard to training and accreditation for Mental Health Nursing in Indonesia, then finally a quick look at how it was implemented in Nanggroe Aceh Darussalam and North Sumatera during the period of 2005-2007. A total of twenty four districts received training. As a result, 614 nurses, 200 GPs, 2106 community leaders (cadres) and 343 villages were classified as ready to provide community based mental health nursing interventions. An external evaluation by Sydney University and Columbia University found 8106 patients were cared for. Its sustainability has been guaranteed through government funding in some districts, other donors have also committed to the program. NGOs, such as CBM has donated motorbikes for nurses to enable home care provision for patients who live in distant secluded rural areas.

The last speaker for the session, Wilfredo Reyes from the Philippines gave brief details of the Philippines' Mental Health Policy, enacted through Administrative Order Number 8 of 2001 in response to the Philippines' national mental health situation. The Administrative Order sets out to provide a better quality of life for all Philipinos through rational and ratified mental health responses leading to good quality mental health services throughout the country. This resulted in the outline/draft of the *Operational Framework for the Sustainable Establishment of a Mental Health Program* that established strategies consisting of four sub-programs for national reform, shifting towards a mental health system that emphasizes providing support for individuals in the community rather than an institutionally based system.

After the four speakers finished their comments, other participants were invited to comment on this topic. The major points emphasizes here were: needs for political will, needs for leadership in mental health, the forum should campaign for mental health community services policy and development, and WHO country offices could do more to get mental health services policy and development on the agenda.

There needs to be social science research documenting experiences and photographs to be used to advocate for mental health policies.

A question was raised on how these facilities and services can be mainstreamed without relying on external support. Without donor support in some countries, all the accomplishments will be rendered obsolete. The issue of funding is one that causes grave concern. The fear is when donors leave, programs will collapse. There needs to be great effort and thought put into sustainability and comprehensiveness of programs. Sustainability hinges on exploring community resources, and not depending on short term project funding.

Session 3: Services for chronic mental illness in the community

Chaired by Lourdes Ignacio, the context of this session is the lack of available services for people with chronic mental illness in the community. As most services are hospital based, identified providers of community based services for chronic mental illness from the Philippines, Vietnam and India have been asked to impart their experiences in establishing these services and sharing the outcomes of community-based projects undertaken.

During the lead comments, István Pátkai from CBM SEAPRO described criteria for success in treatment of chronic mental illness in the community: focus on priority conditions; focus on age groups; identification; assessment; treatment; follow-up and referral; family and community; work, employment and livelihood; self-care skills; quality of life; and networking and advocacy. Dr. Pátkai calls for education and training for mental health care workers and close collaboration with the Public Health System through various mechanisms in order to facilitate the ultimate goal: People with psychosis and their carers are empowered to advocate for themselves.

The previous statement was further developed by John Mahoney from the UK, giving Jaffna as an example of how community-based care can successfully facilitate the empowerment of those affected with mental illness.

The first speaker for this topic, Brother Manuel of the Holy Face Rehabilitation Centre for Mental Health in the Philippines felt that good treatment should be the shared responsibility of the centre, the family and the broader community. Their field team has five main clusters of tasks, broadly categorised into: home visits, screening of potential clients, evaluating clients' socio-economic status, admission and discharge. At present, they have four communities organised to provide community-based mental health care. They also identify community organisers, train them to provide comprehensive support and services, distribute information and education material and organize parish-based psychiatric rehabilitation.

The second speaker, Saeed Farooq, Associate Professor and Head Department of Psychiatry from the Post Graduate Medical Institute Lady Reading Hospital in Peshawar, Pakistan, discussed the benefits of an intervention for schizophrenia based on the principles of DOTS (directly observed treatment, short course) that was used in tuberculosis treatment strategy. This intervention was successfully piloted in Peshawar and will be replicated in other area. The challenge for mental health professionals lay in advocating schizophrenia treatment as cost-effective and not as charity.

Do Thuy Lan, Director of the Morning Star Center for Early detection, intervention, care and parental counselling for those with Intellectually Disabled Children from Vietnam. She gave some insight into Community Based Rehabilitation in Vietnam, through a chronological illustration of how Community Based Rehabilitation was established in

Vietnam, the seven disabilities it caters for, where facilities are located, how community based events and activities were conducted in support of CBR and listing donors and stakeholders involved.

The final presentation for this session was from India, delivered by Sudipto Chatterjee, a Consultant Psychiatrist. He illustrated the outcomes of CBR program in Pati sub district of Barwani in Madhya Pradesh, situated in a rural setting. The principles of the program included equitable treatment, combine effective low cost treatment, address stigma and discrimination and utilize local resources. This program was implemented through a multi tiered system. The outcome assessment involved 256 people with SMD being evaluated. The disability outcome found that on average, approximately 39% percent displayed marked improvement, and approximately 30% displayed moderate improvement.

In conclusion, it was stated that services can be delivered successfully in very low resource settings. What is needed is organization in terms of service delivery of these programs.

This session clearly underlined the effectiveness and benefits of self-help groups. Also, quality benchmarks are needed. Self-help groups could be very helpful. There is obviously a need to focus more on impact evaluations along with process assessments – look at results as well as how programs are implemented. There is a need to pool resources and evidence, as this will create a body of evidence that cannot be ignored. It was agreed that the first day bore highly fruitful results.

The first day ended with a welcome dinner held in honour of all the participants.

Day 2

The second day began with participants divided into 3 groups (see Annex 2). Each group was tasked with discussing lessons learnt and things that could be done to develop and enhance policy and practice in developing levels of mental health service. After a short coffee break, each group was asked to present the results of their group discussion during the plenary.

The first group, led by Christopher Underhill, looked at finding solutions for the shifting role of the mental hospital to one of a “hospital without walls”, where there was a continuity of care. Some of the solutions that they came up with were: reorientation, re-education and retraining of mental health staff; to create community budgets; using the term “consumer” instead of “patient” as this reduces stigma; using community volunteers; and working with donor agencies and NGOs.

The second group, chaired by Abdul Kadir, tackled the issue of filling in the gaps of policy and development levels of service. They felt that possible solutions for this

included, but were not limited to: changing the view of psychiatrist and shift of thinking; improving policy, program, plan and budget; identifying other partners to contribute funds; coordinate funding procurement; training for human resources; coordinate hospital-based and community-based services; and improvement of secondary care. Suitable financing mechanism needs to be found for the treatment of people with mental illness.

The last group (Andrew Mohanraj, Chair and Saeed Farooq, Presenter) grappled with the question “what steps would you take to establish service for people with chronic mental illness in the community where this kind of service does not exist?” A framework should be established in order to address this problem, encompassing the following steps:

- Defining chronic mental illness, such as psychosis, epilepsy, depression, alcohol/drug related problems and intellectual impairment.
- Define Target population
- Identify stakeholder – determine capacity of existing service providers and pathways of care
- Choose a Model of Care
- Decide on a ‘package’ that consists of:
 - Essential drugs (basic package), ensure sustainability
 - Guidelines
 - Define roles of service providers/stakeholder/family & consumer involvement/self-help groups
 - Advocacy/networking strategies
 - Appropriate resource materials
 - Capacity building of service providers
 - Ensure that is appropriate and sensitive
- Supervision and Impact Evaluation

Session 4: Community Development and Community Based Rehabilitation

István Pátkai, in his comments on Community Based Rehabilitation, mentioned that social and empowerment aspects of CBR were so often under-addressed. These two components are vital as there is huge stigma attached to mental illness, creating insurmountable barriers for mentally ill people to become an accepted member of society, thus rendering unable to access livelihoods and education, creating a vicious circle of mental illness and poverty.

The speaker from Indonesia, Dinarti, presented a project conducted in Bireuen District, Aceh that focuses on community income generation of people suffer from chronic psychosis. They trained 53 CMHN (Community Mental Health Nurses), 33 GPs and 556 Cadres to work in 96 villages. This project provided services and assistance to 1596 persons. This project illustrated how even in low resource settings, the community could come up with effective income generation activities, proactively provide services for those needing mental health services and identify people in the community who might potentially also need access to services, hence the term “alert villages”. Cadres are

volunteers, they are not paid, they work one or two days a week and they play a central role in this initiative.

The second speaker, Abdul Kadir from Malaysia, described his experience in Sarawak Mental Hospital that previously had the conditions of custodial type of care, high re-admission and overcrowding of wards. He found that the long-term patients – those who stayed for longer than 3 years – were those from the surrounding areas of the mental hospitals. Several initiatives were made: (1) Create a more conducive acute ward environment – providing private and individual rooms; (2) Assertive care at 2 levels: for those requiring more intense follow up and for those with less complex cases; (3) Early discharge with appropriate patient follow up; (4) Patient led rehabilitation activities – self help groups, sundry shops, cooperatives, education of families and public; and (5) Job placement. There are now more conducive acute wards, with individual patient care rooms and there are now 8 psychiatric care units available in General Hospitals.

Pastor Cucio from the Philippines looked at holistic services for internally-displaced people (IDPs). His project was triggered by a mudslide in 2004, whereby they started to work together with CBM to provide psychosocial services. The victims must be inspired to rise up above their tragedy until they are whole again. The first component in dealing with community mental health in disaster settings is providing basic needs: water, shelter, food etc. to establish a long term relationship with the affected communities. There needs to be integration: living amongst the people and staying with them in order to show them that they are there for the long term. The second component is partnerships with government sectors, INGOs, local NGOs, faith-based organizations and communities. The communities are then empowered through facilitating small support groups with an appointed carer/counsellor (a person from that community who has received appropriate training). There is an overall emphasis on community ownership.

Session 5: Special Presentations

The last session, chaired by Vijay Chandra, consisted of two special presentations, one by Basic Needs and another by CBM South-East Asia and Pacific Regional Office.

Christopher Underhill of Basic Needs explained that he set up Basic Needs seven years ago with the vision to ensure that basic rights and needs of mentally ill people are met. Basic Needs works in 8 countries and has initiated programs in another 3 countries. The mental health and development model utilized has five modules: Capacity Building, Community Mental Health, Sustainable Livelihoods, Research and Policy and Management & Administration. The unique aspects of the modules were that mentally ill people take an active part in research through setting down what they want the program to achieve and stabilised mentally ill-people are part of the steering committee, providing advocacy for policymaking.

The presentation from CBM was done by István Pátkai and Andrew Mohanraj. CBM (originally known as “Christoffel Blindenmission” in honour of its German founder) is a leading international non-governmental development organization specializing in the empowerment and inclusion of people with disabilities. In implementing their programmes, there are four models used: Model 1 – Integration into Community Based Rehabilitation (CBR); Model 2 – Integration into Primary Health Care; Model 3 – Specialist Community Mental Health Programs; and Model 4 – Post-Disaster Psychosocial Restoration.

The Indonesia Chapter of CBM, represented by Andrew Mohanraj, discussed their experience in providing psychosocial rehabilitation services in Aceh. Decentralization in Indonesia was a double-edged sword. Districts could independently embrace community mental health programs out of their own volition when there are no national policies in place. However, when there is national mental health policy if they wanted to disagree with that, they were well within their rights to do so.

CBM was praised for their involvement in community mental health in a number of countries, as well for their significant role in providing technical and financial support in establishing the Global Forum.

Day 3

Session 6: Consumer group movement and public education

Chaired by Christopher Underhill, the sixth session held on the third and final day of the meeting, further elaborated what many of the presentations discussed the previous day: patient led initiatives and consumer group movement, thus enabling successfully implemented community mental health programs and rooting firmly its sustainability.

Susan Teo Ai Lah from Malaysia discussed the “Malaysian Experience” concerning patient led initiatives. It was fully appreciated that consumers were the ones who knew best what they needed. To fully involve them meant they could have more interaction with society, empower them, and stabilized patients who were trained to deliver care meant more available manpower to assist on the ground. She discussed two initiatives: patient-led psychological education and a hospital canteen in Sentosa Mental Hospital, Kuching, managed by 12 long-term patients.

The stabilized patients were trained and were able to disseminate information to both in-patients and out-patients. This facilitates in promoting self-help groups amongst patients and families. On average, they provided information to 30 people a week. The canteen provides food services for hospital staff, visitors and patients. They run like any other enterprise, with weekly management meetings to discuss different issues. The employee (patients) are also the employer (patients). They make decisions from running day to day activities, purchasing and planning. In other words they are the 'think tank', they employ

2 cook who are not mentally ill and at the same time they are also earning a decent salary like anyone else and able to have savings, purchase assets and plan for holidays.

Sompong Kirksaeng from Thailand gave a brief overview on establishing the Association for the Mentally Ill. In broad terms, they aim to gain social acceptance through public campaign activities like encouraging consumers to enter in National Excellent Disabled Persons Competition, creating publications, radio programs and television programs; promoting wellness values amongst their members; engage with associated domestic and international organizations; promote research in all fields of mental health; and to protect the rights of mentally ill persons. Their activities to date revolve around three main clusters: encouraging and supporting patients in receiving quality treatment and rehabilitation; creating social acceptance through projects (such as campaigns) and involvement with other organisations' activities; and organizational strengthening.

Suchada Sakornsatian from the Department of Mental Health in Thailand presented a project undertaken from September 2007 through until March 2008. The objectives are: (1) To strengthen the network organizations to be able to carry out the useful activities to mentally ill and families; (2) To develop capacity of core group of network organizations to be able to have effective management skill; (3) To encourage existing organizations to increase new network organization; and (4) To promote and support the network to carry out activities according to strategic plan. There were two main target groups, 130 persons from 30 organisations and 400 persons from other NGOs/organizations that provide support and care for mentally ill. There were eight primary strategies that were implemented through three activity clusters: capacity building of core group, seminars to promote networking and coordination, and monitoring and evaluation; those are: (1) Seek financial support for implementation; (2) Develop capacity of network organization; (3) Coverage of strength network organization; (4) Cooperation among alliance; (5) Participation of community and society; (6) Know ledge distribution to patient, family members in order to change attitude; (7) Public relation to society; and (8) Participate in pushing forward the policy and legislation.

The last speaker from the Philippines, Violeta Bayato from CBM Philippines gave a short account of her "Philippine experience" in implementing a public education and anti-stigma campaign. It is believed that discrimination and ill-treatment of people afflicted with mental disorders has gotten worse with time. Included in this is the use of labels, which can assist yet hinder people from accepting certain conditions like mental illness. Word such as "mental" carries with it negative connotations compares to one such as "psychosocial". In accordance with this the issue of shifting from bio-medical approach to one that is weighted on addressing the social and causative aspects of mental health problems needs to be dealt with squarely.

The comments that were asserted after these presentations mostly centered around three main groups of issues: advocacy and public education for government sectors, stakeholders and communities to reduce stigma and ensure the protection of human rights of mentally ill persons and their families; greater involvement of people with mental disorders meaning empowerment and patient-based and patient-led approaches; and

decentralization of health care services and support to the primary and community level (placing more emphasis on the role of nurses, cadres and carers or in other words, non-medical personnel). All of these issues are either directly or indirectly linked and progress in one will benefit the other in the broader context.

There was also a suggestion for the WHO to create manual/teaching materials for psychoeducation, including also the rights and the legal implications of those rights as many people with mental disorders and their families are not fully cognizant of them.

The participants then were asked to break-up into their designated groups from the previous day. Each group was assigned a question to discuss:

- Group One: What are the barriers in starting or developing consumer group movement where there are none? What are the steps?
- Group Two: How do we include mental health and psycho social issues in community development? What steps can be taken?
- Group Three: What are innovative approaches in public education for mental health that can be used?

Plenary Session

This final session was chaired by Shekhar Saxena.

Group One Presentation:

Group one looked at two questions: what are the barriers to initiating consumer group movements and how are they overcome?

The barriers could come from different group of society: (1) Family: stigma, family underestimates patient's ability, fear of rejection by family, and cultural stereotypes; (2) Society: beliefs based on ignorance (mental health patients are dangerous and are not human), passive attitudes on the part of the family and community (allowing the government to bear full responsibility and leaving it to doctors and nurses rather than taking community-based initiatives); (3) Mental Health Care providers: superior attitudes of medical practitioners, looking at patients as statistics rather than individuals; compartmentalized service (a GP only focusing on medical treatment and refusing to address psychological issues as it is not their domain), culture of doctors and nurses (doctors give orders, nurses listen and obey), paternalistic cultures that exist, nurses hesitant to initiate any interventions, leaving it to psychiatrists; and (4) Government: low priority given to good mental health, mental health field lacks data/evidence - unlike clear-cut HIV data recording morbidity and mortality rates, lengthy bureaucratic processes to get proposals approved, and stereotypes also prevail as government officials are also part of society and community.

Several actions can be taken to overcome barriers, for instance: tackle labels present in our language in families and society, psychoeducation involving families and consumers working together with other stakeholders, patients and families treated as partners by mental health workers and professionals, psychosocial curricula in medical and nursing educational institutions and focus on teamwork between doctors and nurses, developing marketing strategies to raise awareness, one-on-one advocacy to promote awareness and advocacy for policymakers, and research should be conducted to support awareness raising.

Some participants looked at the need for a consumer group movement to be a political one, and the consumer group needs a consolidated voice to have political clout. There was also an opinion that leadership needs to be identified from inside the consumer group. Usually a doctor leads the movement at the outset as the consumers usually have very little experience. Consumer group movements are usually started through consumers and their families realizing their need for better information, respect, access to care etc. Eventually, they naturally progress to become a political movement.

The chairperson raised the issue of facilitation by professionals. He explained that some consumer associations refuse professional involvement absolutely. In some Western countries, professionals have been thrown out of their meeting for discussing their affairs. Ideally professionals should be involved but not dominate.

Another opinion was that a barrier to the consumer group movement is from the professionals themselves in wrestling to stay the absolute authority in the field. Some examples from Malaysia showed that consumer movements are controlled to a major extent by service providers and consumer led movements tend to fizzle out, whereas in Thailand there seems to be some success. These successes were important to be shared in a forum such as this Global Forum.

It is important to facilitate consumer movements at the outset; however, professionals need to remember that they need to step back eventually. The goal is to withdraw once facilitation is no longer needed and the consumer movement is able to operate fully independently; when they have reached the maturity.

Group 2 Presentation:

This group looked at community development in the broader definition of the word as this would provide the most benefits for consumers. They also looked at how community development could be linked to all potential beneficiaries, including vulnerable groups like women and children, ethnic and minority groups

Concrete examples were drawn on from different countries for how this could be done:

- Private sector involvement
- There is a need to acknowledge good work already done in improving community mental health communities by community mental health workers
- Integrate mental health activities into community support programs

- Involve community mental health program beneficiaries to participate in planning community mental health activities/programs
- Training of small group leaders in the field to provide psychological first aid how to listen to people who are suffering from stress
- Using family gatherings to educate people with mental health problems
- Training teachers in developmental approaches to working with children to better assist children in a classroom setting
- Training teachers to manage stress experienced by their students
- Identify stress factors such as unemployment
- Monitoring outcomes, not just clinical outcomes, but outcomes such as employment
- What is the scientific evidence
- Carers need to be strategically chosen – they are not paid - they can be community, religious and youth leaders. In countries like Indonesia, they are already involved in community development and can get things done.
- Community development - in Aceh, there are pilot projects to provide housing for the homeless as there are strong links between mental disorders and homelessness.
- Incest - advocacy for the impact of incest on mental health was needed. In the housing sector, there needs to be information disseminated regarding house designs that are conducive to good mental health (separate rooms etc).
- Development of manual linking community mental health and community development.
- WHO guidance document on mental health support and community development focusing on concrete action that can be taken. This document could be shared amongst participants.
- All the efforts being made by different countries should be shared as it was valuable learning. It could be done through the emails and the website, and the meetings also. Meetings could be held to discuss a specific topic if the need arose.

It was pointed out during discussion that instead of the term “vulnerable groups”, a term “a special-needs group” can be used as the term “vulnerable group” is problematic and sometimes considered inappropriate.

Group 3 presentation:

The main ideas generated in the presentation and during discussion included the following:

- Efforts should be contextually culturally and spiritually sensitive
- Consumer-led approaches necessary as ultimately, they are at the heart of all the initiatives and efforts
- Independent approach
- Art and music can be used to create awareness
- Utilising formal and non-formal education avenues: speaking at schools, and amongst youth groups in settings where there are schools with classrooms are not

- available. Involvement of accepted leaders to assist in raising awareness in communities.
- Appoint an ambassador, a spokesperson to articulate the importance of meeting the needs of consumers and their families.
 - Celebrities and legislators need to be influenced in propagating awareness
 - Programs highlighting best practices could be propagated in respective locations.
 - Impact measurement needed - such as narrative success stories
 - Simple and practical awareness raising models that are successful could be replicated in other settings
 - Traditional media could be used (for example traditional Balinese puppet theatre used to deliver messages).
 - Technology can be utilized - text messaging, weblogs etc.
 - Advocacy to reduce harmful messages and negative stereotyping in the mass media and film-making.
 - Radio programs developed by consumers to raise awareness - a successful example is a highly influential radio program in Nicaragua featuring different themes and music created by consumers
 - Not just commercial radio stations could be utilized, community radio stations can also be effective
 - Advertising locations/hotlines that provide support/counselling for people who have mental disorders
 - Collaboration with journalists and send them to mental health sensitivity/awareness training (there are organizations in America that provide this type of training).

In closing, the chairperson welcomed contribution of other materials not discussed in this forum that are related to mental health to be put on the forum website.

Relevant testimonies by consumers/patients/survivors should be made available in documented form. Some thought needed to be given to details such as anonymity and in which publications it would be featured in. In this case WHO would be happy to provide guidance.

Personal contact amongst the members, even visiting other programs and projects to observe directly, were encouraged. Firsthand observations would be highly beneficial to learning as long as it was feasible.

Opportunities of formal training to forum members should be explored and it will help if a list of organizational training needs could be generated.

Participants were encouraged to develop short proposal to develop assessment instruments and good practice projects to be considered for implementation.

Participants were then invited to provide final thoughts and comments individually. All participants voiced their gratitude at being invited to participate at the meeting and felt

they learned from each other during the 3-day meeting. Participants also noted that creating and maintaining the level of services was important, as was extending themselves to assist peers in other locations and countries.

WHO and CBM were also singled out for their role in facilitating and providing technical and financial support for the participants. The meeting organizers were thanked for all their efforts in successfully conducting the Regional Meeting.

Compiled by:
Andrew Mohanraj
Albert Maramis
Shekhar Saxena

ANNEX 1



Regional Meeting of the Global Forum for Community Mental Health Jakarta, 23 – 25 October 2007

Global Forum
for Community
Mental Health



PROVISIONAL PROGRAMME

Day 1: Tuesday, 23 October 2007

0800 – 0900	Registration
0900 – 1000	Opening Session <ul style="list-style-type: none">• Opening (Albert Maramis)• Welcome speech (Subhash Salunke, WR Indonesia)• Welcome speech (Yulizar Darwis, Director of Mental Health, Ministry of Health)• Introduction by participants• Background and objectives of the forum (Shekhar Saxena, WHO Geneva)
1000 – 1030	Photo session Tea/Coffee
1030 – 1230	Session 1 Rethinking the role of mental hospital Chair: Andrew Mohanraj <i>This session intends to discuss the “new” role of mental hospital within the community mental health movement. Comments will share various practices of mental hospital to answer this challenge.</i> Comments (10 minutes each): <ul style="list-style-type: none">• Peni Moi Biukoto (Fiji)• Boonchai Nawamongkolwatana (Thailand)• Eka Viora (Indonesia) Lead comments (10 minutes each): <ul style="list-style-type: none">• Shekhar Saxena (WHO Geneva)• Lourdes Ignacio (Philippines) Discussion
1230 – 1330	Lunch

1330 – 1530

Session 2

Policy and development of levels of services

Chair: Albert Maramis

The development of level of services is essential to complete the picture of service delivery system. Comments will focus on the role of policy and the development of various delivery systems.

Comments (10 minutes each):

- Chhit Sophal (Cambodia)
- Ramasubramanian (India)
- Budi Anna Keliat (Indonesia)
- Wilfredo Reyes (Philippines)

Lead comments (10 minutes each):

- John Mahoney (UK)
- Pandu Setiawan (Indonesia)

Discussion

1530 – 1600

Tea/Coffee

1600 – 1730

Session 3

Services for chronic mental illness in the community

Chair: Lourdes Ignacio

A service for people with chronic mental illnesses in the community is seldom available. In most countries the service is provided mainly by mental hospitals. Comments will share various practices of services for people with chronic mental illnesses in the community.

Comments (10 minutes each):

- Brother Manuel (Philippines)
- Saeed Farooq (Pakistan)
- Do Thuy Lan (Vietnam)
- Sudipto Chatterjee (India)

Lead comments (10 minutes each):

- István Pátkai (CBM SEAPRO)
- John Mahoney (UK)

Discussion

1800 – 2100

Welcome Reception

Day 2: Wednesday, 24 October 2007

0900 – 1030	Group discussion <i>Participants will be divided into 3 groups. Each group will discuss lessons learnt and things that we should do to improve policy and practice in developing levels of mental health services.</i>
1030 – 1100	Tea/Coffee
1100 – 1230	Plenary Chair: Shekhar Saxena
1230 – 1330	Lunch
1330 – 1530	Session 4 Community development and Community-Based Rehabilitation Chair: John Mahoney <i>This session intends to discuss practices in community-based rehabilitation and how partnership is developed.</i> Comments (10 minutes each): <ul style="list-style-type: none">• Abdul Kadir (Malaysia)• Dinarti (Indonesia)• Pastor Cucio (Philippines)• Erlinda Sianturi (Indonesia) Lead comments (10 minutes each): <ul style="list-style-type: none">• Christopher Underhill (Basic Needs, UK)• István Pátkai (CBM SEAPRO) Discussion
1530 – 1600	Tea/Coffee
1600 – 1700	Session 5 Special presentation Chair: Vijay Chandra Basic Needs: Christopher Underhill (Basic Needs, UK) (15 minutes) CBM: István Pátkai (CBM SEAPRO)/Andrew Mohanraj (CBM Indonesia) (15 minutes)
1900 – 2100	CBM Dinner

Day 3: Thursday, 25 October 2007

0900 – 1030

Session 6

Consumer group movement and public education

Chair: Christopher Underhill

Patients and families are important counterparts in therapeutic process and education to public at large. Comments will share experiences in developing consumer group.

Comments (10 minutes each):

- Susan Teo Ai Lah (Malaysia)
- Sompong Kirksaeng (Thailand)
- Suchada Sakornsatian (Thailand)
- Violeta Bayato (Philippines)

Lead comments (10 minutes each):

- Vijay Chandra (WHO SEARO)

Discussion

1030 – 1100

Tea/Coffee

1100 – 1230

Group discussion

Participants will be divided into 3 groups. Each group will discuss lessons learnt and things that we should do to improve policy and practice in developing community development/CBR programmes, consumer group and partnership.

1230 – 1330

Lunch

1330 – 1530

Plenary

Chair: Shekhar Saxena

1530 – 1630

Closing

1630 – 1700

Tea/Coffee

ANNEX 2

List of Participants **Regional Meeting of the Global Forum for Community Mental Health**

	Name	Address	Telephone/Fax/Email
1.	Dr. Chhit Sophal	Deputy Director, National Program for Mental Health, Ministry of Health, Cambodia Cambodia	Email: nmhp@online.com.kh Phone: +85512777218
2.	Dr. Peni Moi Biukoto	St. Giles Psychiatric Hospital, Suva, Fiji Islands	E-mail: pmbiukoto@connect.com.fj
3.	Dr. Sudipto Chatterjee	Sangath Centre Porvorim, Goa India	E-mail: sudipto_dr@yahoo.com.au
4.	Dr. Ramasubramanian	#643, K.K. Nagar Madurai – 625 020 Tamilnadu, India	E-mail: dr_crs@hotmail.com, dr.ramasubramanian@gmail.com Phone : 98430-58632
5.	Dr Abdul Kadir Abubakar	Department of Psychiatry, Hospital Sultanah Aminah 80100 Johor Bahru, Johor Malaysia	E-mail: ak_zak82@yahoo.com Mobile: +60-12 779 7717
6.	Mrs. Susan Teo Ai Lah	Department of Psychiatry, Hospital Sultanah Aminah 80100 Johor Bahru, Johor Malaysia	Email: susanteo20002000@yahoo.com Mobile: +60-12 849 5529
7.	Dr. Saeed Farooq	Associate Professor and Head Department of Psychiatry Post Graduate Medical Institute, Lady Reading Hospital, Peshawar, PAKISTAN.	E-mail: sfarooqlrh@yahoo.com Phone Office: 92-91-218690, 92-91- 9211430-40, ext. 3239, 3238 Clinic: 92-91-2568147
8.	Wilfredo Reyes	National Mental Health Programme National Center for Disease Prevention and Control Department of Health San Lazaro Compound, Rizal Avenue, Sta Cruz Manila Philippines	E-mail: wrr_psy@yahoo.com
9.	Mrs. Suchada Sakornsatian	Deputy Director, Mental Health Technical Development Bureau, Department of Mental Health Thailand	E-mail: chadakor@hotmail.com
10.	Dr. Boonchai Nawamongkolwatana	Director, Somdetchoapraya Psychiatric Institute of Psychiatry Klongsan District, Bangkok 10600 Tel. 66 2 4371298 Mob.6681 8766513	E-mail : boonchai82@hotmail.com
11.	Sompong Kirdsaeng	President, The Association for the Mentally Ill Srithunya Hospital, Tivanond Rd. Muang District, Nonthaburi 11000	Tel. 66 2 9689667 E-mail : AMI_DMH@hotmail.com

	Name	Address	Telephone/Fax/Email
12.	Dr. Do Thuy Lan	Director, Center for early detection, care and parental counselling for Intellectual Disabilities (Morning Star Centre) End of Vu Trong Phung Str., Nhan Chinh, Thanh Xuan Distr. Hanoi, Vietnam	E-mail: do_thuy_lan@yahoo.com, morningstarvietnam@gmail.com Phone: +84-903236633
13.	John Mahoney	Department of Health, England and WHO, Sri Lanka.	E-mail: mahoney@whosrilanka.org, johnmahoney@gmail.com Phone : +94 773171701
14.	Dr. István Pátkai	Christian Blind Mission (CBM), Southeast Asia & Pacific Regional Office, Unit 602 Alabang Business Tower, 1216 Acacia Avenue, Madrigal Business Park Alabang, Muntinlupa City, Metro Manila, Philippines.	E-mail: istvan.patkai@cbmseapro.org
15.	Christopher Underhill	New Initiatives in Mental Health and Development, Basic Needs 158A Parade, Leamington Spa, Warwickshire CV32 4AE, UK.	E-mail: chris.underhill@basicneeds.org.uk
16.	Dr. Shekhar Saxena	Mental Health: Evidence and Research, Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland.	E-mail: saxenas@who.int
17.	Dr. Vijay Chandra	Regional Adviser Mental Health, WHO SEARO	E-mail: chandrav@searo.who.int
18.	Brother Victor MANUEL	Holy Face Rehabilitation Centre P.O. Box 50 Tabiguian 4511, Tabaco City Albay, Philippines	Phone: +63-9064566695 E-mail: manongvic2000@yahoo.com
19.	Mrs. Violeta Bayato	Clinical Psychologist, Programme Officer (CBM – CMHP) Unit 602, Alabang Business Tower, 1216 Acacia Avenue, Madrigal Business park, Alabang, Muntinlupa City, Metro Manila, Philippines	Tel: +63 2 8090266 Fax. 8092362 Mobile : +63-9155677888 E-mail: violeta.bayato@cbmseapro.org
20.	Pastor Rolando “Dong” Cucio	Operation Compassion (OC) #88 Maningning Street Teachers Village Quezon City, Metro Manila Philippines	E-mail: operationcompassion@mydestiny.net oc.philippines@gmail.com Phone : + 63 2 4331818 + 63 2 4337807 + 63 9178640222
21.	Dr Lourdes Ladrigo-Ignacio MD	Professor of Psychiatry President-elect World Association for Psychosocial Rehabilitation Medical Center Manila Rm 318 Gral Luna St. Ermita Manila Philippines	E-mail: lulu115@ibahn.net, wapr_phil07@yahoo.com Tel/Fax : +63 2 5251767, +63 2 3713603 Mobile: +63 917 530 9650
22.	Drg. Syarifah Yessi	Aceh, PHO	Mobile: +62-813 70429217 E-mail:
23.	Dr. Cut Maneh	Provincial Health Office Aceh	Mobile: +62-811688579 E-mail: cutmaneh@gmail.com
24.	Dr. Erica Wheeler	Aceh, ADB, Team Leader Human Resources Development	Mobile: +62-81316243819 E-mail: ewheeler@adb.org

	Name	Address	Telephone/Fax/Email
25.	Dr. Hasta Yoga	Dept. Psychiatry Gajahmada University Mental Health Project, Meulaboh	Mobile: +62-81931084265 E-mail: hasthayoga@yahoo.com
26.	Mrs. Erlinda Sianturi-Simanjuntak	PEU WOE SEUMANGAT Jl. Geurutee No.2 – Blower Banda Aceh	Tel./fax: +62 651 41866 Mobile: +62-812 658 5691 Email: peuwoeseumangat@telkom.net erlinda_sianturi@yahoo.com.au
27.	Mrs. Budi Anna Keliat	CMHN Team Leader Faculty of Nursing, University of Indonesia Jakarta	Mobile: +62-8128100821 Email: budianna_keliat@yahoo.com
28.	Mrs. Dinarti	Poltekkes Jakarta 1 Jl. Wijayakusuma Raya 47 Jakarta	Mobile: 0816 1121238 Email: din_rh@yahoo.com
29.	Dr. Yulizar Darwis	Directorate of Mental Health Directorate General of Medical Care Ministry of Health Indonesia Jl. HR. Rasuna Said Block X - 5 Kav. 4-9, Jakarta Selatan 12950 Indonesia	Mobile: +62-8164530321 E-mail: yulizardarwis_keswa@yahoo.co.id
30.	Dr. Eka Viora	Directorate of Mental Health, Ministry of Health Jakarta	Mobile: +62-8161464070 Email: e_viora@yahoo.com
31.	Dr. Pandu Setiawan	Jejak Jiwa Jakarta	Mobile: +62-81553333467 Email: gpandu_stw@yahoo.com
32.	Dr. Suryo Dharmono	Dept. Psychiatry, University of Indonesia Jakarta	Mobile: +62-81511741411 Email: suryodhar@centrin.net.id
33.	Dr. Irmansyah	Department of Psychiatry Faculty of Medicine, University of Indonesia	Mobile: +62-81 6192 2023 Email: irmansyah@gmail.com
34.	Dr. Yuniar	Malang	Mobile: +62-81334455881 Email: yuniars035@yahoo.com
35.	Dr. Yulia	Surabaya	Mobile : +62 8563315181 E-mail : matursuksma_gusti@yahoo.com
36.	Dr. Andrew Mohanraj	CBM Indonesia	Mobile: +62-81 2699 3537 Email: mohanraj_1998@yahoo.com andrew.mohanraj@cbmseapro.org
37.	Asmara Wildani	CBM Indonesia	Mobile: +62-81361181330 Email: go_daffa@yahoo.com
38.	Dr. Albert Maramis	WHO CO Indonesia	Mobile: +62-815 895 9009 Email: maramisa@who.or.id; almarams@indo.net.id; amaramis@indosat.net.id
39.	Dr. Jusni Solichin	WHO CO Indonesia	Mobile: +62-81 673 3732 Email: solichiny@who.or.id
40.	Evi Fridayanti	WHO CO Indonesia	Mobile: +62-813 8216 0967 Email: fridayantie@who.or.id
41.	Reiko Abimanyu	WHO CO Indonesia	Mobile: +62-81 672 2898 Email: abimanyur@who.or.id

ANNEX 3

Group Discussion Regional Meeting of the Global Forum for Community Mental Health

Group 1	Group 2	Group 3
1. Albert Maramis	1. Abdul Kadir	1. Andrew Mohanraj
2. Brother Victor Manuel	2. Cut Maneh	2. Boonchai Nawamongkolwatana
3. Budi Anna Keliat	3. Do Thuy Lan	3. Eka Viora
4. Chhit Sophal	4. Erica Wheeler	4. Erlinda Sianturi
5. Christopher Underhill	5. Hasta Yoga	5. Irmansyah
6. Dinarti	6. Jusni Solichin	6. István Pátkai
7. John Mahoney	7. Lourdes Ignacio	7. Pandu Setiawan
8. Peni Moi Biukoto	8. Pastor Rolando Cucio	8. Saeed Farooq
9. Suchada Sakornsatian	9. Ramasubramanian	9. Susan Teo Ai Lah
10. Sudipto Chatterjee	10. Shekhar Saxena	10. Vijay Chandra
11. Suryo Dharmono	11. Sompong Kirdsaeng	11. Violeta Bayato
12. Syarifah Yessi	12. Yulizar Darwis	12. Wilfredo Reyes
	13. Yulia	13. Yuniar

ANNEX 4

List of Presentations Available in pdf Format

Session 1

- Peni Moi Biukoto (Fiji): *The New Role of a Mental Hospital: Fiji experience*
- Boonchai Nawamongkolwatana (Thailand): *Role of Psychiatric Hospital in Community Mental Health*
- Eka Viora (Indonesia): *Rethinking the Role of Mental Hospital*
- Shekhar Saxena (WHO Geneva): *Lead Comment*

Session 2

- Chhit Sophal (Cambodia): *Mental Health Services Delivery System in Cambodia*
- Ramasubramanian (India): *My Experience in Developing a Community Mental Health Project*
- Budi Anna Keliat (Indonesia): *Community Mental Health Nursing in Indonesia*
- Wilfredo Reyes (Philippines): *The Philippine National Mental Health Policy*
- John Mahoney (UK): *Lead Comment - Policy and Development*

Session 3

- Brother Manuel (Philippines): *Holy Face Rehabilitation Center for Mental Health*
- Saeed Farooq (Pakistan): *Public Health Intervention for Schizophrenia in Developing Countries – Learning from DOTS?*
- Do Thuy Lan (Vietnam): *Service for Chronic Mental Patients in the Community of Vietnam*
- John Mahoney (UK): *Lead Comment – Services for Chronic Mental Illness in the Community*

Session 4

- Abdul Kadir (Malaysia): *Towards a Community-Oriented Programme*
- Dinarti (Indonesia): *Alert Village of Mental Health in Bireuen - NAD*
- Pastor Cucio (Philippines): *Wholistic Community Development among Internally Displaced People*
- Erlinda Sianturi (Indonesia): *Community Development Based on Mental Rehabilitation in Aceh*
- Christopher Underhill (Basic Needs, UK): *Lead Comment*

Session 5

- Christopher Underhill (Basic Needs, UK): *Special Presentation to Regional Meeting of the Global Forum for Community Mental Health*

Session 6

- Susan Teo Ai Lah (Malaysia): *Involving Patients in Rehabilitation Activities: Kuching Experience*
- Sompong Kirdsaeng (Thailand): *The Association for Mentally Ill*
- Suchada Sakornsatian (Thailand): *Reinforcement to Strengthen Network Organization*
- Violeta Bayato (Philippines): *Public Education and Anti-Stigma Campaign: A Philippine Experience*