

APCMHD Project Meeting Delhi February 2011

Summary of Proceedings



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Introduction

The Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India collaborated with Asia Australia Mental Health to organise an International Conference and Workshop on Community Mental Health Development in New Delhi 17-19 February 2011.

Inaugurated by **Shri Ghulam Nabi Azad** Hon'ble Minister of Health and Family Welfare Government of India in the auspicious presence of **H. E. Mr. Peter Varghese** Australian High Commissioner to India Commonwealth of Australia, the three day event was co-hosted at National Institute of Health and Family Welfare. Assistant Vice Chancellor of the University of Melbourne, Professor Bruce Singh represented the University of Melbourne at the opening ceremony of the conference. The distinguished participants included representatives from the Asia Pacific Community Mental Health Development Project ([APCMHDP](#)), a network of mental health government officials, chief psychiatrists and research leaders from seventeen countries.

This partnership comes from a 5-year history of productive collaboration between Asia-Australia Mental Health (AAMH) and the Directorate General of Health Services of Ministry of Health and Family Welfare, Government of India. All participants were warmly welcomed to New Delhi to share real life practices, challenges and creative solutions. The conference opened with a symbolic lighting of the lamp, as a spark to fire and power to the work ahead.

H. E. Mr. Peter Varghese Australian High Commissioner said that the Australian Government was delighted to support the Community Mental Health Development conference and workshop. Australia considers mental health to be a significant issue, as the largest cause of disease burden in this country, and Australia is currently working across central, federal and state governments to progress important mental health reforms such as an increased emphasis on prevention and early intervention. His Excellency reiterated the importance of global reform efforts, and commitment to all citizens of the world. The Australian Government was pleased to offer support for Asia Australia Mental Health and the Directorate General of Health Services of Ministry of Health and Family Welfare through the Public Service Linkages Program and to contribute to the goals of increasing access and equal treatment for people with a mental illness.

Shri Ghulam Nabi Azad Hon. Minister of Health and Family Welfare Government of India wished the participants much success in the conference. The Hon. Minister outlined the Government's recent increases in spending and the launch of the National Mental Health Plan, now expanded to include the modernisation and upgrade of psychiatric departments and hospitals across 123 districts. Through the Government's support of postgraduate mental health programs and development of Centres of Excellence in mental health services, improvements can be made to our understanding of serious mental illness and availability of affordable and safer treatment for the community. The Hon. Minister expressed great pleasure at attending this conference, and welcomed the opportunity to collaborate with health leaders working in specialist services and with mainstreaming mental health services to find effective solutions to the increasing burden of mental illness. He wished everyone a bright future for the partnership.

Appearing in a video link-up, the inaugural Australian Federal Minister for Mental Health and Ageing, The Hon. Mark Butler said that the three day conference on "Building Partnerships in Community Mental Health" is a wonderful opportunity for leaders in mental health to meet with each other and exchange ideas on what needs to be done to improve mental health services in the region. Mr. Butler said that including mental health as part of a bilateral dialogue was indicative of a broad relationship between India and Australia.

The joint project in mental health has important implications for future education and knowledge transfer enterprise, and will build on the new linkages and collaboration in education and research in global health.

Asia Pacific Community Mental Health Development Project Meeting

Chaired by Dr. Chee Ng, Associate Professor, Director St. Vincent's Mental Health and Ms. Julia Fraser, Associate Director, Asialink, University of Melbourne.

The Asia-Pacific Community Mental Health Development (APCMHD) project has been established to explore diverse leading models or approaches to community mental health service delivery in the Asia-Pacific region. It aims to illustrate and promote best practice in mental health care in the community through use of information exchange, current evidence and practical experience in the region. The project is based on the work of an emerging network of mental health leaders from 17 countries or regions in the Asia-Pacific, working to build culturally appropriate mental health policy frameworks and workforce in the implementation of community mental health services. Such collaborative exchange based on local practices will help enhance regional solutions to challenges in building capacity and structures for community-based mental health systems in the future.



Since 2005, the APCMHDP has regularly met to develop understanding of the guiding principles for the development of culturally appropriate practices of community mental health care as well as foster collaboration within a network of key representatives from ministries of health and key organisations working in community mental health in the region.

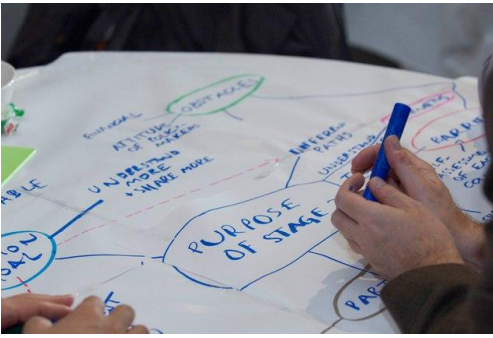
In Stage 1 of the project, this unique network contributed to a globally recognized joint publication titled 'The APCMHDP Summary Report'. This publication contains:

1. Context for countries in the Asia Pacific, including the demographic and cultural context, mental health policy, funding models, facilities and services, workforce (medical and allied health specialties), training and accreditation systems, and the role of private hospitals/ providers;
2. Each country's approach to the recommended mix of services by WHO and how other appropriate international policies are adapted to local situations;
3. Examples of best practice models of community-based services or care which include:
 - specific local and culturally adapted community services or community care model;
 - interaction with primary care and traditional healthcare;
 - Role of families, NGOs and community agencies;
 - Successes and difficulties or gaps;
 - Strategies to overcome gaps;
 - Inspiration and lessons learnt;
4. Implications of the findings for countries in Asia Pacific; and
5. The APCMHDP network vision for the long term goals in community care

The Summary Report was launched at the World Congress of Psychiatry in September 2008 and can be downloaded from the Asia Australia Mental Health website (www.aamh.edu.au).



In Stage 2, the APCMHDP continued to build and maintain a regional resource to facilitate the sharing of experience of real-life practices and solutions in the continuous evolution and development of different community mental health care models. This stage of the project focuses on developing a set of common principles of partnerships in community mental health, while also highlighting a best practice example of these partnerships across each country.



At the Melbourne meeting in August 2009, the group identified actions to address the major challenges to building robust community mental health services including conducting and prominently publishing research on the value of community mental health development, promoting anti-stigma campaigns, ensuring a whole of government approach, involving consumers and families more meaningfully, and developing clear communication strategies. Summaries of each meeting including the Melbourne meeting can be accessed from the Asia Australia Mental Health website (www.aamh.edu.au) on the publications page.

The second publication for the Asia Pacific Community Mental Health Development Project is underway with many authors mid way through their first or even second drafts of each country's contribution to the collaborative text. The workshop sought to explore the existing valuable partnerships in our regions and broaden our understanding of key principles required for building partnerships. At Taipei in 2009, the APCMHDP developed 10 key principles of good health partnerships. The New Delhi workshop explored these 10 principles further and looked at articulating the meaning of partnerships in our region. Themes and comments from these valuable discussions will be written up by AAMH for the introduction of our second publication.

Principles of partnerships for community mental health

1. Identify key stakeholders- It is important to involve the right people, and be inclusive rather than exclusive. There is a matrix to consider including multi-level (government, family), and multi-sector (social welfare, health, etc) and well as participation of the person living with a mental illness. Key stakeholders will vary across countries, e.g. some countries may have strong consumer groups, and others have a well-structured government presence, different climate, culture – these will determine key stake-holders. Identify where power lies to identify key stake-holders. Both consumers and families are important to improve health outcomes for the person living with a mental illness.
2. Common purpose and commitment among partners - partnerships are mutually beneficial. Shared long term goals in our partnerships include mental health recovery, and improved quality of life. Short-term goals may differ, but long-term partners will have similar goals.
3. Mutual respect between partners and appreciation of differences. Involving partners in planning from the very beginning is beneficial. There needs to be mutual respect between cultures and sometimes informal relationships are extremely important. Relationships can be personal, formal, informal; they can inspire confidence, and build up empowerment. Some relationships are able to be flexible, and allow informality.



The differences between partners can be a positive – it is important to appreciate difference.

4. Good communication- it is important to consider using multiple modes consistently and continuously. Communication needs to be done at the right time and the right amount.
5. Consumer focus – the partnership is to improve client outcomes and is often missed but imperative to involve consumers. The APCMHDP recognises that consumer focus in our region is very intertwined with family focus, as the basic societal unit.



6. Family focus- involve families. The Asia Pacific region recognises the higher priorities towards family, and the importance of health services to meet their needs. The family is the basic social unit in society. Ensuring a family focus can improve mental health, not only because the family are the primary carers who look after mentally ill, but they are a valuable part of the team because of their knowledge of the mentally ill. Supporting families can be valuable when a person becomes ill as well as earlier with mental health education about signs and symptoms. Supporting families during, treatment can prevent relapse. Support can be orienting where to get help, as well as family resilience and wellness, and must work with family beliefs and cultural perspectives. Definition of family should involve caregivers and individuals who may be considered extended family within the cultural context. Education should be provided to both the consumer and the caregiver and caregivers should be empowered to be involved in decision making. It is vital that services are be designed to involve families.



7. Oriented to recovery: this is more than treating symptoms. It is regaining of optimal functioning, and being part of society. Recovery oriented services involve the views of mentally ill and their experiences of the health services. Oriented to recovery will involve consumers in the process of getting help, getting back to school, finding employment, performing social functions and getting married. Social inclusion is a vital ingredient of recovery oriented services.

8. Partnerships within and across sectors- health, employment, housing, education. This is important as partners can have influence and can help deliver adequate services (e.g. in China 17 organisations delivering services together). Partners can develop win-win situations (with common goals). Partners can learn each other's language for their work and meet their needs, partners also include subsectors in government and should ideally reach joint funding, also need to list partners e.g. work with other traditional complementary medicines, village chiefs; Mental health care and promotion is a multi-sectoral effort (village commune, religious leaders, local governments); Mental health professionals cannot work alone; Educate our partners to recognise the socio-determinants of mental illness; Identify the roles our partners can do



9. Collaboration and coordination: work to share understanding, listening to each other, have common forums, coordination is a focal point of collaboration. It maximises resources, reduces duplication, reduce conflicts and brings partners together, taking the lead when necessary, then developing capability in key stakeholders; park your ego outside and engage in the recovery of the patient; patient centered care across sectors (health, housing, social etc); Mental health is the poorest resource; thus need to reduce duplication; Making sure everybody knows what they are doing; All partners must understand the whole process of care, then to break down into specific roles of each partner

10. Clear governance structures and accountability, clear roles of participating stakeholders, including fund-holding, partnership agreements, decision-making process: It allows sharing of work and partners are given the full picture. Improve trust, accountability for funding, better coordination and collaboration; Developing an agreement (e.g MOU, legislation, guidelines, regulations); Enabling partnerships to be developed from bottom-up via availability of funding grants or structures; Identifying clear governance and transparency of rules, but being flexible as well

Suggestions for the APCMHD Project and future focus areas – Workshop Discussion

In general discussions, the country representatives talked about the current experiences of participating in the Asia Pacific Community Mental Health Project. Some representatives were able to identify changes that had been a result of involvement in this project over the past few years. General comments included the value of global support and encouragement, and that the network provided support for influencing back at home. Many felt that they were able to learn from others as well as contribute their learnings, and the friendships developed from this group were also highly valued.

The network has been able to directly contribute to the Mental Health Gap Action Programme (mhGAP) of the World Health Organisation. mhGAP is WHO's action plan to scale up services for mental, neurological and substance use disorders for countries especially with low and lower middle incomes. The essence of mhGAP is building partnerships for collective action and to reinforce the commitment of governments, international organizations and other stakeholders. The network recognises the principles of mhGAP and that successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community.

The group also discussed the future of the project and how to keep the collaboration valuable to our region. Suggestions included:

- broaden to include NGOs, strengthen collaborations with general health services or
- Look at exploring local chapters to strengthen the regional links and ensure relevancy. The Pacific Island Mental Health Network (PIMNET) is a good example of sharing geographical, social and cultural ties working together and identifying regional priorities.
- Look at developing an Art in Mental Health arm of the network
- Focusing on Disaster mental health as an option was raised as a possibility given the rise of disasters throughout the region in the past decade, and the possibilities of further dangerous weather patterns emerging in the next few decades as Global Warming continues.
- Include layers of government such as central, provincial and local governments to ensure messages are understood more thoroughly and better communicated
- Continue to make reports available on the internet and expand resources available in the region including bringing in more partners



Discussions were also held about the focus for a third Stage of our project. More thoughts and final decisions will be made at the next meeting of the Asia Pacific Community Mental Health Development Project in Melbourne, 9-12 November 2011. The launch of the 2nd publication is being planned for this conference, with further plans to launch it in the region at a later date.



❖ **Australia – Ms Colleen Krestensen, represented by Ms. Margaret Goding**

The Australian Commonwealth Government has increased its role in mental health service delivery over the last 10 years, sharing responsibility with state governments, the non-government sector and the private sector. Since 2006, the Commonwealth has played a more significant and deliberate role in providing primary mental health care – to assess, prescribe, refer for talking therapies – and importantly to form partnerships with non-health services.

The Allied Psychological Services Initiative (**ATAPS**) commenced in 2003, and funds GP referral to short-term focused psychological strategies provided by an allied health professional. It enables better targeting of primary care services to hard-to-reach populations – children, rural, indigenous, youth. In 2010, the Commonwealth government used additional funding through ATAPS to provide primary care for children with mental illness and to offer proactive care for people who have been discharged from hospital after suicide attempts.

ATAPS is the vehicle for a medium-term primary mental health care response to disasters such as the Queensland floods and cyclones and the Victorian bushfires. The ATAPS partnerships provided a local platform to support the community, provide expert advice to schools, to offer training for health professionals and community leaders and to link with other services.

Through **headspace** the Commonwealth funds 30 integrated youth friendly shop-fronts across the country and a centralised centre of excellence. As it was found that only 25% of young people with mental illness in Australia access services for early intervention, these services were established to provide access for young people aged 12-25 years to primary mental health care, alcohol and drug counseling, vocational and social support. An independent evaluation of headspace in 2009 found 92% of young people reported improvements in their mental health and reduced levels of psychological distress.

❖ **Cambodia – Dr Sophal Chhit**

Substance abuse is recognised as a major problem in Cambodia and was identified by the Ministry of Health as a priority area to be included in the National Program for Mental Health. Reasons for this initiative were the co-morbidity of mental disorders and substance abuse, the similar intervention approaches to mental disorders and substance abuse, and the benefits of sharing human resources in mental health and substance abuse programs. Dr Sophal reported that the initiative had resulted in more resources for the mental health program in terms of technical and financial support, and better participation from all the key players. More political support had been given to the Mental Health Program from the Ministry of Health and a Mental Health Strategic Plan had been finalised.

Shared responsibilities, the mobilization of resources and increased coverage of services were important advantages of the partnerships. For clients and families, the initiative had increased the accessibility of services and improved health and socio-economic outcomes.

Dr Sophal highlighted some of the key lessons from the partnership initiative as the need for partnerships to be focused at both the management/policy maker level and at the implementation level for joint planning, evaluation,

and resource mobilization. Leadership, political commitment, time and opportunity, flexibility, mutual understanding, and coordination were all necessary for effective partnerships.

❖ **China – Prof. Liu Jin**

In China, developing mental health services has led to proactive partnership building. This deliberate process has been based on factors such as history, trust, communication, understanding of culture and sustainability. Some of the key findings have been the importance of a shared vision, of specific targets and the communication skills needed to adapt to each other as partners and practice our shared learning.

The China-Australia collaboration in Community Mental Health started in 2002. It was initially based on acquaintance and trust but needed additional communication and persistence to work together on mental health reform through the 686 Project. This working network was able to utilise the experiences in mental health reform of the Australian partners. The project worked to localise the international experience and promote the best local experiences.

Many services for people with mental illness were provided by different departments (Health, Civil Affairs, Disabled People’s Federation and Police) which operated relatively independently and lacked communication. At the beginning there was a lack of trust, and the different sectors were suspicious of each other. The partners encouraged each other and respected and allowed for cultural differences, which led to successful shared achievements.

❖ **India - Dr. D.C.Jain**

The Ministry of Health and Family Welfare, Government of India launched the National Mental Health Programme in 1982. The 2010 Revised District Mental Health Programme (DMHP) seeks to integrate mental health care into general health care services through short-term skill-based training for general health care staff. The training focuses on identification and treatment of common mental ailments with supervision and support from a mental health team based at District headquarters. Based on the Bellary Model, the community services were developed by NIMHANS (National Institute of Mental Health and Neuro Sciences) in the 1980s in partnership with the State Government and Local administration. Under the District Programme, services include specialized Mental Health Services, Training, MH Promotion in schools, colleges and Work places, Help-line, linkages with Primary and Tertiary Care, NGOs, and coordination & collaboration with other departments. The Community/Primary Health Center provides early diagnosis and treatment of common mental disorders, training, information, education, communication, referrals, and links with the community and schools through Sub-centers. The Sub-Centers provide Mental Health Promotion, and referrals to Primary Health Centers and Community Health Centers and include Health Workers, ASHA, VH&SC, AWW, NGO, PRIs.

Based on external evaluation as well as research and manpower development, future plans include the expansion of DMHP to all Districts of India. Keeping a focused approach on Community participation and involvement of NGOs/ civil society, ASHA, AWW, and other stakeholders, the District Program will seek to strengthen referral services and linkages with like-minded organizations and integrate with General health care at all levels.

❖ **Indonesia – Dr Irmansyah**

The Primary Health Center in the Tebet Sub-District, Indonesia provides a good example of the Directorate of Mental Health, Ministry of Health collaboration with community health care services. The Primary Health Center Profile includes Basic Health Services such as Emergency Unit, General Medical Clinic, and Mother and Child Health Clinic to an urban catchment with a population of 241,465. The center also includes GP+ services such as Dermatology, Dental, Pediatric, Acupuncture, Pulmonary, Methadone Clinic, and a Mental Health Clinic (Family and Adolescence Consultation Clinic).

The mental health services include the Mental Health Clinic as well as mental health promotion and empowerment of patients, families and community. It is self-financed and staff including GPs, GP plus, nurses and Community Mental Health nurses (CMHN) work within the mobile unit, consultation room and Aula (for family gathering and promotion about mental health. The issues to be addressed by this partnership include the need to improve the treatment gap - to increase mental health cases seen at the primary health center. The partnership aims to increase the priority in mental health programs, increase patients’ adherence to medication and reduce stigma and ignorance in the community. Evaluations show a marked increase of people attending the centre for both assessment and treatment for psychosis, substance abuse and other mental health issues.

Some of the challenges to this model include maintaining continuity in training to the health workers with a rotation of the GPs and especially for neurotic cases. The model needs to improve the network and referral system as there is a lack of referral from other clinics at Tebet Primary Health Care. Also, empowerment of patients and families are key issues to providing cost-effective care and following a pathway to recovery. The model needs to exercise creativity in finding financial support.

Future directions for this partnership include increasing the quality of service by developing collaboration with academic institutions and continuing training and mental health research. Plans are in place to increase collaboration with the private sector, with traditional healers, journalists (media) and NGOs. Scaling up Tebet's model at a national level has been discussed with at least 5 Primary Health Centers in Jakarta, who have adopted this model for their MH services. The Roadmap to "free restraint of people with MH problems" includes distributing free long-acting antipsychotic medication and further collaboration with other sectors.

❖ Japan – Dr Ryosuke Arakawa

Mental health has increasingly become an important health issue in Japan. In September 2009, an expert panel was held for 'Further Reform of Mental Health and Welfare'. This panel reviewed the 2004 Reform Vision which aimed at transforming hospital-centred mental health care to community-based care for people with mental disorders. This was done by developing community services and reducing psychiatric hospital beds. The review identified that the loss of quality of life and the socioeconomic costs from mental disorders are enormous, and that the support system for community life of the mentally disabled is insufficient. Many patients hospitalized under historical circumstances still remain hospitalised. All who are concerned, including government, regret that very long stays resulted from previous policies which emphasised hospitalisation. The Review Panel proposed new policy initiatives.

The Kawasaki Welfare Plan for People with Disability was instigated in 2006 throughout Kawasaki City, with a population of 1.42 million. The plan prioritised moving to community living from institutions, discharge from mental hospitals for people with social reasons and moving from sheltered work to competitive employment. The Northern Community Rehabilitation Center, in one of the 7 administrative wards of Kawasaki, explores the potential of collaboration between the public and private sectors. This includes the community mental health team (operating as a branch of the Mental Health and Welfare Center's community support section) and the private sector involved in the community support center, general consultations, and support.

For this plan and collaboration to be successful, the partners continue to look at a city in its entirety to determine which resources are needed where, and to be flexible in establishing resources in the appropriate areas. The partners depend on certainty from an administrative basis and financial support and continue to be guided by local or national policy.

❖ Laos – Dr Menorath Sing

Dr Menorath discussed a partnership project set up between local and international mental health experts. The primary purpose of the partnership was to build and strengthen the local networks and workforce. A key issue in Laos is a lack of trained mental health professionals. Currently they have only two qualified psychiatrists and one psychologist.

Dr Menorath discussed a number of challenges involved in the partnership project including dealing with concepts of community mental health, which is still relatively new in Laos. Further challenges were to develop open communication and collaboration across different sectors, language barriers, and a lack of leadership and resources.





❖ **Malaysia – Dato’ Dr Suarn Singh**

Partnership programs in Malaysia involve government agencies such as the Ministry of Women, Family Community Development as well as Non-government Organisations including Family Support Groups. These partnerships are guided by the 2008 Disability Act and the newly implemented Mental Health Act (2010).

The Family Support Group (FSG) Initiative commenced in March 2003 and was coordinated by the Family Health Division, Ministry of Health Malaysia (GO) and the Malaysian Mental Health Association (NGO). Regional family support groups were formed with the support of regional and local psychiatric departments. These groups looked to develop smart partnerships to provide promotion, prevention and recovery-oriented care for carers / individuals living with people with mental illness.

The four main functions of the Family Support Groups are emotional support, providing information and advocacy and education. The groups have created an equal partnership in the provision of care for the mentally ill as the care is now mainly in the community. This empowers the carers with knowledge, and minimises isolation so carers can support each other. The family education courses are customised to local culture in Malay, English and Mandarin. The Psycho-education courses were held initially in the Government facilities but over time, the courses are run by carers themselves.

As a result of this initiative, many regional FSG had registered as NGOs. Regional NGOs have united as affiliated members under a national group- MINDA Malaysia (established in 2006). The evaluation of the initiative highlights the empowerment of carers, who feel liberated when given an opportunity to be recognized, acknowledged, to speak and be heard. There was some initial resistance from carers regarding disclosure due to stigma and fear of discrimination. The diverse needs of carers at different stages of the family experiences can also create tensions in the partnership. The groups also identified a lack of champions for mental health due to the stigma attached to mental illness as well as a need for resources & funding for ongoing activities and administrative needs. Future plans include harnessing IT to further advocate the movement, more activities to reach out to more carers, and advocacy for non-discriminatory and equitable policies for the mentally ill. The smart partnership through the FSG in Malaysia has connected carers at both regional and the national level in a united force to improve the quality of life of carers, and mentally ill individuals.

❖ **Mongolia – Dr Oyunsuren Davaasuren**

Dr Oyunsuren provided an overview of some of the specific challenges for mental health in Mongolia such as ‘dzud’. ‘Dzud’ is a natural disaster related to extremely cold weather conditions and mainly affects the rural population of Mongolia who are herders. The effect of ‘dzud’ is a loss of livestock which is the main source of livelihood, and results in a range of biological, psychological and social consequences.

A community mental health project was set up partnering international, national and local NGOs, governors, local mental health services and other key stakeholders at a provincial level. Dr Oyunsuren shared some of the key lessons from the project, including the importance of professional training, providing psychosocial support through home visits as a better outcome, and the need to include mental health professionals in disaster management committees at the local level.

❖ Philippines – Dr Bernardino Vicente

Following an overview of mental health services in the Philippines, Dr Vicente described the experiences of building community partnerships in mental health. Partner organisations included provincial health and municipal officers, local government agencies, jail rehabilitation centers and some private groups. Primarily, the initiatives aimed at making mental health services more accessible by bringing them closer to the patients' place of residence. Some of the strategies used to improve community mental health services were a de-stigmatization campaign, psycho social processing, and post-graduate courses in mental health.

❖ Singapore – Dr Daniel Fung

Mental Health has been identified as extremely important to Singapore's health services for children and adolescents. Statistics show that mental illness is a leading cause of disease burden in disability adjusted life years (DALY's) for both 0-14 year age group and 15-34 year age groups. Singapore's Child Guidance Clinic has experienced significant increases in the demand for services in the past decade, although this increase may be due more to a better awareness of mental health in the community rather than an actual increase in mental health problems.

In developing local resources and rationalising care, it was identified that Mental Health Services, Educational Services, Paediatric Services and NGO's were all providing services to children within silos, with little collaboration with each other. As Mental Health is not solely a clinical issue but is also determined by psychosocial factors, it was determined that a Whole-Of-Government approach was needed to shape a social-cultural environment. The Ministry of Health together with the Ministry of Education and Ministry of Child and Youth Services/NCSS developed the REACH initiative- Response, Early intervention and Assessment in Community mental Health. This initiative aims to improve the mental health of children & adolescents in schools, provide training and support to school counsellors (FTSC) and general practitioners (GPs) and develop a mental health network in the community involving school counsellors, GPs and Voluntary Welfare Officers. This initiative involved 268 schools with a student population of 382,282 and trained 169 GPs and 4 Volunteer Welfare Officers. 25,310 students were seen by school counsellors, and 8052 calls received by Helpline which resulted in 685 cases referred to REACH and 329 referrals to the Institute of Mental Health.

Looking ahead for the next decade, the Child Guidance Clinics are planning to form a network with GP and VWO partners that ensures all regions in Singapore have access to the Community Mental Health Teams which is integrated with primary care providers such as schools, families, Community Social Agencies and Family doctors.

❖ Solomon Islands – Dr William Same

Dr. Same discussed initiatives in the Solomon Islands aimed at developing partnerships between national, provincial, and community organisations. Current partners included health and social welfare workers, families, community leaders, and police. The services provided incorporate counseling, mental health and drug and alcohol awareness.

Specific issues in the Solomon Islands concern geographical challenges and logistical supports such as transport, a lack of trained professionals, limited infrastructure to accommodate the increasing numbers of patients and rehabilitation needs, and mental health knowledge.

The partnership initiative was developed in response to a high readmission rate, and a range of psychosocial problems in the community concerning high school drop outs, unemployment, increased alcohol and substance abuse, family break downs and domestic violence. The advantages of going into partnership were seen as the sharing of resources and expertise, and increased service provision to meet community needs.

Key achievements have been the increased identification of new cases and the establishment of an improved referral process, increased participation from clients and relatives, and more collaboration between organisations. There appears to be a small reduction in readmission rates but there was no evaluation to support this. Evaluation was identified as an important activity that needed to be undertaken particularly in the early stages of the partnerships.

❖ Thailand – Dr Ittipol Soongkhong, represented by Dr. Amporn Benjaponpitak

Development of a partnership between religious organisations and mental health services has begun in Thailand. In a country with 80% Buddhist population, priests are powerful leaders for the community, and temples and

monks can influence villagers in terms of beliefs and attitudes, which can affect health care systems. The Department of Mental Health encourages patients to live in the community and believes that the idea of “Sending the patients back to the community” is the right approach. It was believed that the emphasis on prevention and promotion would be compatible with the beliefs of religious organizations in Thailand also.

The Government prepared the way for this partnership with the message ‘Contact-Connect-Cooperate’. A workshop was held with priests and community leaders to strengthen the capacity of both religious organisations and hospitals to establish mental health participation in both technologies and medicinal matters.

An example of successful partnership can be seen through Nakornrajsrima Psychiatric hospital. This hospital integrated mental health work in the community, following the Buddha teachings in order to cure chronically ill patients. They encouraged the community to accept patients and provided opportunities to become part of the community, give them work, warmth, and understanding. Finally the patients can go back to their families and resume some function with social acceptance.

This partnership has a number of strengths, including a strong community trust and belief in priests who are determined to help people sincerely; both health and non-health partnerships have the same goal; communities share the responsibility for participation; and the strong links and relationships between temple, hospital and community.

Future challenges for participation of religious organisations in mental health work include time constraints and sustainability. With the building of practical mental health technology, this model has the capacity to extend to other religious faiths such as Christianity, Islam, and others.

❖ **Vietnam – Dr Than Thai Phong**

The Community Mental Health Care Project (CMHS) is a major national programme that is being undertaken by the National Psychiatric Hospital No 1. Through this project, free treatment is provided for registered patients at the local community level, and a monitoring system has been established.

As a result of the support provided by the central government, Ministry of Health and local government, the structure of the community mental health network has been set up at a national level. A key outcome of the project has been improved cooperation and relationships between the different levels of service delivery.

The CMHC project has initiated public mental health education using multimedia approaches in the community, basic mental health training at the primary health level and psycho-education and rehabilitation in the community. There has been systematic monitoring and documentation of treatment and training in project and treatment management for staff.

Some of the challenges to the project highlighted by Dr Phong included the lack of a project budget, salary and incentives for staff to work at the community health level, and a lack of resources, such as transport. There were difficulties in establishing relationships between the small number of family support groups and health services and more social workers were needed to link patients to the community. There remains a lack of preventative and early intervention components in the programme and the overall mental health knowledge and literacy in the community remains low.

Future plans for the project need to include strengthening mental health training at the local level, policy reform to enhance community care (including the establishment of mental health laws), and increased collaboration with NGOs and community groups.



Appendix One: Participants in APCMHD Project Meeting in New Delhi, February 2011.

Title	First	Surname	Position	Organisation	Country
Dato' Dr.	Suarn	Singh	Chief Psychiatrist	Ministry of Health	Malaysia
Dr	Benjamin	Tan	Manager (Mental Health Policy) Primary and Community Care Division	Ministry of Health	Singapore
Ms	Marziyana	Abdul Rahman	Principal Manager (Community Mental Health) Primary & Community Care Division	Ministry of Health	Singapore
Dr	Daniel	Fung	Director, Child Psychiatry	Institute of Mental Health	Singapore
Dr	Oyunsuren	Davaasuren	Lecturer, Dept of Mental Health	Health Sciences University of Mongolia	Mongolia
Dr	Bernardino	Vicente	Director	National Center for Mental Health	Philippines
Dr	Than Thai	Phong	Vice-Chief, Community Mental Health Care Service Unit and Foreign Affair Unit	National Psychiatric Hospital no. 1	Vietnam
Dr	Do Huy	Hung	Director	Phu Tho Psychiatric Hospital	Vietnam
Dr	Irmansyah		Director, Directorate of Mental Health	Ministry of Health	Indonesia
Miss	Natalingrum	Sukmarini	Head of Evaluation, Community Mental Health	Ministry of Health	Indonesia
Mrs	Suyatmi	Diran	Head, Subdirector Community Mental Health	Ministry of Health	Indonesia
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Dr	Ittipol	Soongkhang	Deputy Director General, Department of Mental Health	Ministry of Public Health	Thailand
Dr	Amporn	Benjaponpitak	Director Bureau of Mental Health Technical Development	Ministry of Public Health	Thailand
Dr	William	Same	Director, Mental Health Services	Ministry of Health	Solomon Islands
Dr	Sopha	Chhit	Head	National Program for Mental Health	Cambodia
Dr	Jin	Liu	Chief of Executive Office	National Center for Mental Health China- CDC	China
Dr	Fujun	Jia	Director	Guangdong Institute of Mental Health	China
Dr	Menorath	Sing	Vice Rector	University of Health Sciences	Laos

Title	First	Surname	Position	Organisation	Country
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Dr.	R.K.	Srivastava	Director General Health Services	Ministry of Health and Family Welfare	India
Mr.	Sh. Keshav	Desi Raju	Additional Secretary Health	Ministry of Health and Family Welfare	India
Dr.	D. C.	Jain	Special Director General Health Services	Ministry of Health and Family Welfare	India
Dr.	Jagdish	Prasad	Additional Director General Health Services	Ministry of Health and Family Welfare	India
Ms.	Shalini	Prasad	Joint Secretary (Non Communicable Diseases)	Ministry of Health and Family Welfare	India
Dr.	D. C.	Jain	Deputy Director General	Ministry of Health and Family Welfare	India
Ms.	Sujaya	Krishnan	Director, National Mental Health Plan	Ministry of Health and Family Welfare	India
Prof.	Deoki	Nandan	Director	National Institute of Health and Family Welfare	India
Dr.	Jagdish	Kaur	Chief Medical Officer	Ministry of Health and Family Welfare	India
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For the full list of participants from India, see the International Conference Cum Workshop on Asia Pacific Community Mental Health Development 17-19 February 2011.					
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Prof	Bruce	Singh	Assistant Vice-Chancellor	University of Melbourne	Australia
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Mr	David	Paroissien	Program Manager	Asia Australia Mental Health	Australia
Ms	Julia	Fraser	Co-Director	Asia Australia Mental Health	Australia
A/Prof	Chee	Ng	Co-Director	Asia Australia Mental Health	Australia
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