AAMH
Asia Australia Mental Health

APCMHD Project Meeting Melbourne November 2011

Summary of Proceedings

.

Table of Contents

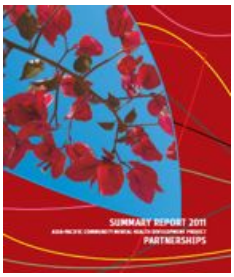
Over 100 delegates from seventeen participating Asia Pacific countries came together in Melbourne in November 2011 to launch *Partnerships 2011:* The Asia Pacific Community Mental Health Development Project's latest publication

The three-day Melbourne meeting opened with the inaugural Asia Pacific Art and Mental Health Symposium hosted by Asia Australia Mental Health and The Dax Centre, in partnership with the National Institute of Mental Health, Japan. An International Seminar in Community Mental Health Development, which included the launch of *Partnerships 2011:* Asia Pacific Community Mental Health Project Summary Report was held at St. Vincent's Health on the second day of the program. The final day's workshop hosted by Asialink, set the Project's agenda for the next triennium.

Asia Pacific Art and Mental Health Symposium

The symposium shared experiences and ideas about the role art can play in the promotion of mental health for communities globally.

In an open session, artists, carers and mental health professionals from the Asia Pacific region presented their models of working with art in mental health. A symposium highlight was the exhibition of numerous artworks brought by the international delegates displayed at the Dax Centre alongside the gallery's *Living with Psychosis* Exhibition.



Asia Pacific Community Mental Health Development Project Summary Report 2011: Partnerships

Authored by the mental health leadership of 17 countries in the Asia Pacific region, this latest publication from the APCMHD project documents best practice in building community mental health partnerships.

Brief History of the Project

Since 2005, the APCMHDP network has met regularly to build understanding of the guiding principles for culturally appropriate practices of community mental health care, as well as to foster a network of mutuality. The project has developed close collaborations between key representatives from Ministries of Health and peak bodies and mental health professionals working in community mental health in the Asia-Pacific region.

Stage 1: 2005-2008

Stage 1 published the globally recognized 'APCMHDP Summary Report'. This publication contains:

1. Context for 14 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.

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).

Stage 2: 2008-2011

The APCMHDP continued to facilitate the sharing of experience of real-life practices and solutions in the continuous development of different community mental health care models. Stage 2 focused 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. In Taipei in 2009, the APCMHDP members jointly developed 10 key principles to establish and maintain effective community partnerships. The New Delhi workshop of February 2011 further explored the 10 principles to better articulate what mental health partnerships mean for our region.

Authors from 17 countries contributed chapters giving best practice examples of partnerships for their individual contexts. The Editorial Board and Management Team synthesised the reports from past APCMHDP meetings to include in the Summary Report, complete with graphics and images from the mental health services and teams in the region. With the assistance of the Australian Department of Health and Ageing, St. Vincent's Health (Melbourne), Department of Psychiatry and Asialink, The University of Melbourne, Janssen-Cllag, Royal Australian and New Zealand College of Psychiatrists, World Psychiatric Association and World Health Organisation, this publication was launched in Melbourne November 2011.

"This volume has brought together examples of systems of health care that fulfilled their tasks while being respectful of the culture in which they operate. Each of them has a feature or features that are outstandingly good and can inspire others. Presented in one volume they make it easier for those who want to build their own system of care to create it - as one creates a mosaic composing it from many parts – by taking the best parts of many other systems put together and amalgamate them in a manner that responds to local needs."

Professor Norman Sartorius, President, Association for the Improvement of Mental Health Programmes, Geneva

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.

Day 1: Asia Pacific Art and Mental Health Symposium

The Asia Pacific Art and Mental Health Symposium was established for two reasons: to bring together art and mental health leaders from the Asia Pacific region to share experiences and ideas about the role art can play in the promotion of mental health; and to provide the foundations for the establishment of an Asia Pacific Art and Mental Health Network which will inspire and facilitate cross-cultural engagement, dialogue and exchange between art and mental health services and their respective communities.

Initiated by the Dax Centre and Asia Australia Mental Health (AAMH), the idea for the symposium grew out of the Asia Pacific Community Mental Health Development Project (APCMHDP) Network, which has been working collaboratively with mental health leaders from 17 countries to promote the building of community mental health in the region over the past six years. The development of a distinct network of art and mental health leaders was considered a valuable adjunct to the existing network, providing a broader means through which approaches to community mental health could be explored.

Consequently, the inaugural Art and Mental Health symposium was organised to coincide with the APCMHDP Network's 2011 conference in Melbourne, bringing together local and international mental health government officials, chief psychiatrists, researchers, art and mental health practitioners and organisations. Speaker presentations included:

- **Australia:** Keynote Lecture: "Art in Mental Health – opportunities for mental health promotion and overcoming stigma", Dr Eugen Koh, Director, *The Dax Centre*, Australia
- **China:** "Predicament of the Raw Art of people with mental illness in China", Mr Guo Haiping, Director, *Nanjing Natural Art* Centre, China
- **India:** "Art and Mental Health: The Different Interfaces", Dr Debasis Bhattacharya, Consultant Psychiatrist, India
- **Indonesia:** "Indonesia Community Care for Schizophrenia – Art Activities", Mr Bagus Utomo, Chairman, *Komunitas Peduli Skizofrenia Indonesia*, Indonesia
- **Japan:** Dr Tadashi Takeshima, Director, *National Centre for Neuroscience and Psychiatry*, Japan
- **Korea:** "Art and Mental Health", Prof Mee Yoo, Professor of Art Therapy, *Gyeonggi Provincial Mental Health Centre*, Korea
- **Taiwan:** "Art Therapy in Taiwan", Ms Shu Jen Lu, Art Therapist, *University of Taitung Counseling Centre*, Taiwan
- **Thailand:** "Art in Mental Health in Thailand", Mr Anupan Pluckpankhajee, Director, *Therapeutikum Thailand*, Thailand

Where the use of art in the context of mental health was more widely recognized in some countries than others, a common thread that ran through all eight presentations was that art, as a visual medium, has the potential to transcend many boundaries, not least the stigma that often surrounds mental illness.

The success of the symposium can be measured by the enthusiasm expressed by the international delegates at the ensuing workshop, and across the remaining two days of the APCMHDP Network conference. There was overwhelming recognition of the potential for art to be incorporated as part of a more holistic approach to community mental health. Its ability to help break down stigma and provide a platform for understanding and educating about mental health issues was also widely acknowledged. The support of key stakeholders and policy makers such as doctors, allied health workers, patients, artists and art therapists and government officials would be essential, however, for such a model of practice to be successful.

In turn, there was overwhelming support for the development of an Asia Pacific Art and Mental Health Network, particularly from those countries where the use of art in mental health is not widely recognized and/or supported. Such a network would help forge relationships between those already working in the field of art and mental health, and provide support and information for those trying to get established. The development of an on-line resource, such as a website, was noted as a valuable communication tool which could link individuals and organisations across the region and provide a virtual space for debate, discussion and the sharing of research, ideas and experiences. It was felt that the development of both online and traveling exhibitions could also serve as valuable educational resources, and that an annual symposium, again in conjunction with the APCMHDP Network conference, would be of benefit to all.

It is now anticipated that the growth and development of this network will be best facilitated by a series of meetings and conferences that will occur as satellite meetings alongside the established APCMHDP Network meetings, which occur annually around the region. These meetings, and other administrative aspects of this network, will be managed by a small secretariat based at The Dax Centre and will be directed by a steering committee consisting of representatives of AAMH, the Dax Centre and representatives of participating Asia Pacific countries. It is hoped that by establishing this network it will be much easier for communities within the region to learn more about this area, and that discussion and outcomes from the forums will make a significant contribution to Australian policy and practice in the area of art programs in mental health.

Day 2: International Seminar and Publication Launch

1 Professor David Castle

Asia Australia Mental Health, a consortium of St. Vincent's and the University of Melbourne was honoured to host the International Seminar in Community Mental Health Development in Melbourne, November 2011. . Professor David Castle, Chair of Asia Australia Mental Health, welcomed the audience of over 100 delegates from seventeen participating Asia Pacific countries to the seminar.

2 Mr Stephen Vale

Representing the CEO of St. Vincent's, Director Medical Services, Aged and Community Care, St. Vincent's, Mr Stephen Vale, spoke of the steady expansion of community mental health development and service in our region. Mr Vale, described St Vincent Hospital's support of this process through its involvement with Asia Australia Mental Health as an honour and a privilege.

2 Professor Susan Elliot

Deputy Vice Chancellor (Global Relations) University of Melbourne Professor Susan Elliott described the moral and economic imperative for communities to build new pathways to support the growing number of people who are affected by mental illness, and expressed the University of Melbourne's pride in being involved in the Asia Pacific Community Mental Health Development Project.

3 Professor Kwong Lee Dow

The University of Melbourne's Professor Kwong Lee Dow, the incoming Chair of Asia Australia Mental Health, applauded the Asia Pacific Community Mental Health Development network's focus on showcasing the strengths of each of the 17 partners. This, he said, would not only illustrate the skills and talents in the region but would also provide a source of inspiration for others across the region.

4 Georgie Harman

Ms Georgie Harman, First Assistant Secretary of the Mental Health and Chronic Disease Division, Australian Government Department of Health and Ageing, officially launched the Asia-Pacific Community Mental Health Development Project's Summary Report 2011. Ms. Harman conveyed the Australian government's pride in contributing to this important initiative, and stated how impressed she was by the range of innovative and inspiring projects that are happening across the region.

7 Dr. Irmansyah and A/Prof Chee Ng

Dr. Irmansyah, Director Mental Health, Ministry of Health Indonesia officially launched the publication on behalf of Asia Pacific countries. He said they were proud to be involved in such an inspiring project with friends from around the region.

8 Hon Jeff Kennett

Keynote Speaker

The Honourable Jeff Kennett AC
beyondblue Inaugural Chairperson:
23 years experience in Victorian Parliament, including as Premier of Victoria from 1992-1999.

Mr. Kennett warmly accepted the invitation to speak at the International Seminar on Community Mental Health Development. His keynote speech focused on the partnership between communities and mental health services.

For many years, Mr Kennett explained, mental health was not a priority for Australian governments. The widely accepted means of dealing with depression tended toward ignoring rather than confronting it. Today in Australia there is a more enlightened attitude to depression and mental illness, with all sides of government accepting that funding for mental health needs to be increased. This, Mr Kennett said, has come about due to a significant change in both public awareness and political action.

Beyondblue, the NGO that Mr Kennett chairs, was initially established to achieve five things. The first was to de stigmatise depression in the community as a whole, through a planned strategy that involved conversations with people around the nation, and educating politicians about the illness. Despite having a small population of between 22 and 23 million people, 800, 000 people suffer from depression each year in Australia, and a further 200,000 suffer a serious mental illness. Taking these figures into account, and the large number of people who care for those who suffer these illnesses, the number of people who have a personal interest in mental health issues can be placed at between three and four million. To a politician, this is a lot of votes. Beyondblue's success can be measured by the fact that it is a brand now recognised by 87% of the Australian public, and the amount of public discourse around depression today was inconceivable twelve years ago.

The second goal was to put together a body of research to try and understand more about the illness. From that research a major public education program – another aim of the organisation - has been developed. The program includes both print and electronic publications. Pamphlets, reports, websites and social media provide information to the Australian public and medical professionals. The fourth objective was to work with doctors, psychiatrists, psychologists and clinical nurses, who work at the front line of mental health, often under considerable pressure. The suicide rate of male doctors in Australia is twice that of Australian men; the suicide rate of female doctors is six times that of women in Australia. beyondblue works with medical professionals to try and encourage them to look after their own health. Finally, beyondblue set out to provide support to the carers of people suffering from depression, many of whom don't have sufficient information to know how they should be responding.


9 Hon Jeff Kennett and Professor Bruce Singl

Though a great deal has been achieved over the twelve years since the founding of beyondblue, Mr Kennett noted that there is still much to be done, particularly in the area of men's health. One result of raising public awareness of depression and mental health more broadly is that the demand for services has increased significantly. beyondblue estimates that Australia requires 600 extra psychiatrists to meet this demand, and it is unlikely this number will be achieved due a lack of training facilities, .

On a more positive note, Mr Kennett said that educating the public can offer hope and produce positive results over a relatively short period of time. Partnerships between the public and those professionally and clinically involved in mental health can be very powerful. Through such partnerships – with governments, individuals and organisations - beyondblue has achieved some wonderful outcomes, from public awareness to strong advocacy.

Discussion and Summary

Professor Graham Brown, Foundation Director of Nossal Institute for Global Health and Chair of Global Health in the Faculty of Medicine, Dentistry and Health Sciences at the University of Melbourne

Professor Brown commented that the day's presentations featured many inspiring examples of the ways in which people are working to make mental health and wellness everybody's business. He noted that the APCMHD project emphasized the building of supportive partnerships through the networks' own activities. The APCMHD project has created a network of support and advocacy, identifying applicable, evidence-based best practices. It operates under the recognition that in each country there are different cultural contexts, degrees of government involvement and levels of acceptance of mental illness. It was formed with an economic imperative, from a service perspective, moving to community development, mental health promotion and prevention. The importance of cultural context has been acknowledged again and again. It is central, complex and dynamic, and it needs to be understood and used. Other themes, Professor Brown noted, emerged repeatedly throughout the day: working with communities and community groups, building on community strengths, educating the community and training the workforce. Advocacy, Professor Brown said, is much needed within the profession - where old-fashioned ideas still exist - and in civil society.

10 Professor Graham Brown

In the initial stages, the Asia Pacific Community Mental Health Development Project was comprised of people who wanted to know more: now it is a forum for sharing ideas. As the partnership moves into its third triennium, the goal of collaborating to find and report better examples continues. Professor Brown emphasized the imperative of ensuring these examples are documented and submitted as peer-reviewed research articles from which everyone can learn.

A hospital is just one experience in a journey that involves families, the patients themselves, other relationships, the general practice and the district mental health system. Professor Brown noted the need to recognize that continuum. The hospital system is good for treatment, he said, but it is communities that can teach us more about care. Often we start with hospital services as the political imperative, but the continuum of care needs to be moved out into the community, by providing people with appropriate training. When talking about the importance of community level care it must be remembered that primary or rural healthcare needs to be backed up with relevant services. The training of health professionals to identify people with serious mental illness must be accompanied by mechanisms to deal with them, or else a community can lose heart.

Community education and mental health promotion needs to be enhanced and extended at all stages, from preventative programs to early intervention and early rehabilitation. It's incredibly difficult, from a public health perspective, he noted, to go from a pilot project to scale. Pilot projects are often dependent on individuals: the big challenge is taking them to scale, empowering communities to make health projects everybody's business. A whole-of-government approach is required. Too often in Australia mental health is spilt from other factors relating to it and only considered in terms of the health system. Frequently, however, it is the same people who are suffering from problems with drugs and alcohol, mental health, homelessness and poverty, and these problems shouldn't be dealt with in isolation. All sectors need to be engaged, from defense to education, and asked the question: what is your mental health policy?

The key challenges for global health, Professor Brown concluded, remain access; coverage; appropriate financing mechanisms and, above all, equity. These are the fundamental principles that underlie the Alma Ata-declaration, and there is an opportunity for mental health to be a champion in this context. A challenge for this group is how to take your advocacy to the next level. How can you get mental health onto the agenda of the numerous forums in

the region, such as APEC and ASEAN, in order to influence the broader agenda? Health was on the agenda at the recent UN General Assembly for only the second time in its history. The first time it was regarding HIV AIDS, this time it was non-communicable diseases. The challenge is to make mental health the next big priority.

Plenary Sessions: Best Practice Examples of Mental Health Promotion and Partnerships

Plenary Session 1: Best Practices of Asia Pacific Countries

Chaired: Professor Ian Everall, Cato Chair of Psychiatry, University of Melbourne.

Australia

Georgie Harman,
First Assistant Secretary, Mental Health and Chronic Disease Division, Department of Health and Ageing, Australia.

Over recent years the community mental health sector in Australia has been expanding its role in the delivery of a range of services for people who are living with mental illness, and their families and carers. A number of initiatives have been instrumental in the ongoing process of reform, and de-institutionalisation has been a major feature of this process. Better engagement of consumers and carers in the development, delivery and evaluation of mental health programs and services has increasingly been a key aspect of mental health care reform. The Prime Minister has appointed Australia's first dedicated federal minister for mental health, the honourable Mark Butler, MP, and in the last federal budget announced the $2.2 billion Delivering Mental Health Reform package. This package will provide more intensive and better coordinated support services, particularly for people with severe and persistent mental illness who have complex care needs. It will target support to young people, and to areas and communities that need it most, including Aboriginal and Torres Strait Islander communities, and socio-economically disadvantaged areas.

The package consists of 18 measures and spans four portfolios. A major feature is the creation of a national mental health commission for Australia, which will be established in the Prime Minister's portfolio and will report directly to the Australian parliament through the Prime Minister. Another major feature of the package is a commitment by the Australian government to work with the state and territory governments on a ten year roadmap for mental health reform.

Several key mental health promotion initiatives are currently operating in Australia. beyondblue works to increase the capacity of the Australian community to prevent and respond effectively to depression and anxiety. Together with other peak bodies, beyondblue recently held a national mental health stigma summit. The federal government has developed a training program for mental health first aid designed to improve mental health literacy and increase community support for people with mental illness. Later this year it will launch the National Survey of Mental Health Literacy and Stigma. R U OK Day, a national day of action, is the result of public, community and private partnership tackling the issue of mental health and suicide prevention. Another major policy initiative by the federal government is the move towards diversifying services offered so that they include online and telephone-based support, including a national mental health portal, a virtual clinic, and a central support service which will provide peer-to-peer support for mental health professionals practicing in the field.

Cambodia

Dr. Sophal Chhit
Deputy Director, National Mental Health Program

In 2005 the Ministry of Health, in collaboration with other partners, created a National Program for Mental Health to manage and implement activities for the development of mental health in Cambodia. The Ministry of Health's Health Strategic Plan 2008-2015 identified mental health and substance abuse as health priorities, proposing a community-based approach to health care.

The plan identifies two main aims for mental health service development: the expansion of coverage of mental health and substance abuse services to all hospitals and commune health centres across the country, and the improvement of the clinical skills and competency of the mental health workforce.

At present, mental health services are delivered through the primary health system and psychiatric services in general hospitals. Informal community mental health care is delivered by NGOs. Long-stay mental health care facilities and specialist services are not currently available.

The integration of mental health and substance abuse services into general health services is essential for reducing stigma and discrimination against people mental illness. It is also critical to improving financial and political support for the mental health system, and increasing participation from local communities and authorities. To this end, "No Health Without Mental Health" advocacy needs continue. Improved collaboration between multiple public service sectors is required in order to establish effective community-based intervention, which is currently fragmented due to a lack of guidance and standard operating procedures. Because of financial constraints, intervention is focused on mainly on medication, however the integration of substance abuse and mental health services has resulted in an improvement in funding for these services. Psychosocial intervention is currently performed by NGOs with small a coverage area, and remains the least developed area of mental health services.

China

Dr. Jin Tongling
Deputy Director, Division of Mental Health, China CDC, Ministry of Health

The 686 Program, managed by Peking University Institute of Mental Health, constitutes the largest mental health reform program in the world. Based on the Australian model, it is designed to provide seamless, patient centred, function oriented and multi-disciplinary mental health services in the community. An international advisory group oversees the program with experts drawn from Asia-Australia Mental Health. This partnership has worked to develop a new model for mental health care in China, drawing from the experience and avoiding the mistakes of the Victorian mental health system.

The China-Australia partnership has been given high priority by government at a ministerial level. The Ministry of Health has declared its full support for National Office of Mental Health Program and Asia Australia Mental Health, and draws on research generated by the partnership for the formulation of policy documents. Ministerial representatives have visited Australia and met with the Australian Governor-General, Quentin Bryce, and an International Advisory Committee has been appointed, including members of AAMH.

The rapid development of China's community mental health service over the past ten years is inextricably linked to the strength of its international partnerships, most particularly the partnership with Australia. Technical excellence and valid experience have been essential foundation stones for the success of these partnerships. Truly effective reform requires a deep appreciation of the cultural, socio-economic and political complexities of China and their impact on community mental health reform. The China-Australia collaboration in mental health, like all successful partnerships, needed from its infancy to create a way of working that could accommodate inevitable setbacks and "lost in translation" moments. The project partners now work as one team: a team that understands its strengths and needs and is focused on improving the lives of the most neglected in all populations - people with mental illness.

Plenary Session 2: Best Practices of Asia Pacific Countries

Chaired: A/Prof Chee Ng, Co- Director, Asia Australia Mental Health

Fiji Islands

Dr. Odille Chang
Senior Lecturer in Psychiatry, College of Medicine, Nursing and Health Sciences, Fiji National University

Community Psychiatric Nursing (CPN) was founded in 1996 in Suva, but remained hospital based, only servicing the Greater Suva area. A Day Centre was established in 1997 and operated until 2005. Several mental health advocacy groups have been formed, including the Psychiatric Survivors' Association (2004); Youth Champs for Mental Health (2007); Fiji Alliance for Mental Health (2010); Family Support Network (2011).

The Community Outreach Program was established in 2011 with funding support from AusAID, WHO and the Fiji School of Medicine. Staffed by registered nurses and medical orderlies, it has no allied mental health staff or doctor. Its focus is on "high risk" patients diagnosed with severe mental disorders.

In 2009 Fiji was granted an Award of Excellence by the Asian Federation of Psychiatric Associations (AFPA) for improving mental health through basic training. This followed the training of over 300 public health nurses and other staff between 2006 and 2009. AFPA has provided further training in child and adolescent mental health, and the Black Dog Institute has provided training in mood disorders. Additionally, clinical placements have been supported by St. John of God and St. Vincent's Mental Health. In 2009 community mental health outreach clinics were established in the Central, Western and Northern Divisions, and stress management wards were set up in three main divisional hospitals first half of 2011. The Fiji National University has set up a community mental health teaching clinic, and quarterly clinics are conducted by the IAP and IAPA. A Community Recreation Outreach project has been established in the in Central and Western divisions.

In recent years, the push to improve community awareness of mental health has been bolstered through various campaigns and events, such as the "Stop Stigma Against Mental Illness- Dare to Care" campaign, World Mental Health Day and Fiji Mental Health Month. The "5 A Day for mental health" campaign is soon to be launched, and the "6 Ss" campaign to decrease stress for children is being developed.

Future initiatives will see the establishment of community based multidisciplinary mental health teams, extending to the Western and Northern divisions. The recruitment of allied mental health staff and psychiatrists to support community mental healthcare is a priority, and the training of health professionals will continue. Additionally, the development of a Post Graduate Diploma in Mental Health is planned by the Fiji National University. Collaboration with Asia Australia Mental Health and the Royal Australian and New Zealand College of Psychiatrists will continue through the Pacific Public Sector Linkages Program.

Hong Kong

Dr. Eileena Chui

Consultant Psychiatrist, Department of Psychiatry, Queen Mary Hospital

Over the last decade there has been a move from hospital based treatment for people with mental illness to community-based treatment. The last two years have seen the establishment of the Personalised Care Program (PCP) in three pilot districts, and the Frequent Re-admitters Program, under which there has been an 82% reduction in hospital admissions and an 82% reduction in the average length of stay. 2011-2012 will see the roll-out of the Personalised Care Program to five other districts; the reform of the existing 24-hours hotline service to a mental health call centre; the establishment of a mental health intensive care team and the extension of the EASY (Early intervention and engagement) service to cover services for 15-64 year olds with first episode psychosis (FEP).

In 2010-11 there were 175,000 people with mental disorders in Hong Kong. 43,000 were categorized as having a severe mental illness (SMI), and 78,000 a common mental disorder (CMD). The Personalised Care Program aims to develop a long-term system of care to provide quality community mental health services for patients with SMI. This system will be recovery-focused, characterised by personalized care using a case management approach, needs and risk management and community partnership. The PCP is producing positive results. A comparison between a survey group of people in the PCP with a group in standard community care found significant improvement in total IP episodes, total LOS and total AED attendances in the PCP group.

The coming years will see the implementation of the New Community Psychiatric Services Model, including the roll out of the PCP program to all districts. 120 new case manages will be needed in the next year alone, and a further expansion of resources will also be required.

India

Dr. DC Jain

Deputy Director General of Health Services, Ministry of Health and Family Welfare

The provision of sustainable basic mental health services to the community and the integration of these services with other health services is a key objective of the District Mental Health Programme (DMHP). In 1996 community based services were introduced in four districts under the National Mental Healthcare Plan. Between 2002 and 2007 the services were rolled out to 100 districts across the country, and today there are community based mental health services operating in 123 districts. By 2017 it is proposed that all 642 districts in the country will be covered.

The District Mental Health Programme is a community based service model for the delivery of basic mental health care through existing primary health care services. Its broad aims include enhancing the capacity of district services for early detection and treatment of patients within the community; promoting public education and the reduction of stigma surrounding mental illness; and a continuation of the shift away from hospital treatment for people with mental illness towards treatment and rehabilitation within the community.

The DMHP provides clinical services, training for health care providers, counselling services, and information, education and communication (IEC) in vernacular languages. The DMHP strategy includes the management of common mental illnesses by trained medical officers, support and guidance from specialists and the detection of mental illness by peripheral health care providers. Another strategic component of the model is the promotion of community awareness to encourage people to seek early medical intervention.

The implementation of the DMHP has seen significant improvement in both care and satisfaction among users of its services. 60% of districts are able to provide mental health services at district level and 20% at primary level. There has been notable improvement in the knowledge and attitude of the community regarding mental illness in districts where the DMHP is operating. These successes can be attributed to the involvement of non-specialists in mental health services through short term trainings, the integration of Mental Health services with General health services at district level, and outreach services by DMHP staff.

Considerable constraints continue to impede the success of the DMHP, however. While there have been some improvements, poor community awareness regarding the nature and treatment of mental illness and a lack of community involvement in treatment services are prevailing problems. Limited treatment facilities, an insufficient skilled workforce, and the lack of coordination between various levels of administration and departments also constitute continuing challenges for the program.

Indonesia

Dr. Irmansyah
Director, Directorate of Mental Health, Ministry of Health

The primary health care mental health program in the district of Tebet has been adopted as a model by at least five other primary health care services in Jakarta.

2007 research found that 3600 people in Tebet suffered from severe mental disorders, and 35,000 from emotional problems. Psychosocial problems were also present, including the practice of pasung - the physical restraint and confinement of mentally ill people in the community. Prior to the program, primary health care resources in Tebet were limited to one general practitioner and one nurse, with a mental health hospital located 12 kilometres away. There was also a private hospital and psychiatric clinic. An increase in the demand for mental health services and limited funding presented the project with significant challenges.

Several strategies were put in place to meet these challenges, including mental health promotion and education in the community, and changing the name of the mental health hospital to the Family and Adolescence Consultation Clinic in an effort to reduce the stigma associated with its services. Partnerships were formed between families, community groups, NGOs, universities, national agencies and consumers groups. The mental health budget was increased, providing greater availability of psychotropic drugs and enhancing support for community activities.

These included community empowerment programs, hygiene and ADL training, and community forums. Mental health training and supervision was provided to health workers by the Provincial/District Health Office and Soeharto Heerdjan Mental Hospital.

Public knowledge and awareness of mental health has been greatly improved in Tebet following the program. Community acceptance has grown, and some patients have secured employment and become active contributors to their community. Additional development of the project will see further improvement in mental health needs assessment, including home visits for treatment evaluation, secondary consultation and support for community education activities. A sustainable mental health system in Tebet will require further continuing collaboration with academic institutions, a specialist supervision program, and the development of a case management system and a more systematic referral mechanism.

The successful improvement of mental health services relies on the variety, quality and continuity of support from all partners involved. Planning of mental health activities needs to be realistic, simple and doable. A formal partnership agreement, adequate budget and provision of resources, and ongoing training and support are critical for the continuity of the primary health care mental health program. The commitment, determination and enthusiasm of the small team behind the program have proved fundamental in improving mental health services.

Japan

Dr. Tadashi Takeshima
Director, Department of Mental Health Policy and Evaluation, National Institute of Mental Health

The 1990s saw a sharp increase in the rate of suicide in Japan, which in recent years has reached between 30,000 and 35,000 deaths per year. Suicide rates have risen particularly among middle-aged men and young adults, and there is a high rate of suicide among people living on welfare. Recent years have seen growth in the number of outpatients with mental illness, particularly mood disorders. There is a high rate of mental illness in homeless people, and there has been an increase in reported cases of child abuse.

Suicide prevention measures by local governments in prefectures and megacities have been enhanced significantly since 2002, with broad increases in budgets for suicide prevention, suicide prevention committees and cross-sectional government networks. Suicide prevention efforts since 2000 have taken place in three phases.

In the first phase the Ministry of Health, Labour and Welfare (MHLW) set a numerical target for the national suicide rate as part of the Health Promotion Project, and allocated a budget for suicide prevention. The Suicide Prevention Council issued a report in 2002, and in 2004 the MHLW published the Introduction of Treatment Guideline for Depression.

In 2005 the Upper House passed a resolution to put together a comprehensive strategy for suicide prevention, and the Suicide Prevention Liaison Committee (SPLC) was established, releasing a Report on National Suicide Prevention Strategy at the end of that year.

The third phase is comprised of actions that have been undertaken since the Basic Act on Suicide Countermeasures (BA) was passed in 2006. Since then there has been a significant increase in suicide prevention measures. These include the foundation of the Centre for Suicide Prevention, the establishment of the CSPI, the launch of the Project Team for Suicide Prevention and Mental Health and the establishment in 2010 of the Core Project for Suicide Prevention.

The next stage in the development of community mental health services is a revision of the CSPI. Draft proposals have been drawn up by working groups, which will be made available for public comment before being reviewed by experts from the WHO. Following the revision of the CSPI, the priority will be strengthening community mental health services for people with mental illness who are considered to be most at risk, and the further integration of community mental health services into the health system.

Plenary Session 3: Best Practices of Asia Pacific Countries

Chaired: Professor Helen Herrman, Professor of Psychiatry, The University of Melbourne

Korea

Professor Lee Young Moon
Chairman, National Mental Health Commission

Human beings are fundamentally social creatures, and the practice of both medicine and art is significantly influenced by socio cultural factors. The mental health system in South Korea has sought to emphasise the relationship between the practice of medicine and the healing potential of art. Most countries have a cultural relevance model, which preserves the existing social composition. Cultural sensitivity, as opposed to cultural diversity, acknowledges that the socio-cultural factors unique to every society significantly influence all aspects therein. There are two ways to understand culture. The etic approach seeks to understand a culture objectively, using standardised guidelines from an external culture. The emic approach is a more subjective method, using an independent value system bound to the culture in question. One affect of globalisation is that cultures have become self-aware, and it is therefore necessary to establish a balance between etic and emic views of cultural understanding.

South Korea's mental health system is centred on the cultural sensitivity model. An example of this basis is Mental Health Day, which takes place on the fourth of April. Four is an inauspicious number in Korea, so this date is considered the worst day of the year. Holding Mental Health Day on this date represents the stigma surrounding mental illness in South Korea.

The G-Mind structure– comprising of Green Mind, Global Mind, Great Mind and Good Mind - represents the different elements that make up the mental health system. 'G' refers to the Gyeonggi province, the largest in South Korea. Green Mind represents the saving of lives, including the Little Prince and Hope Village suicide prevention program, a provisional program adopted from the university of Hong Kong. Global Mind is the planning and evaluation division, and Great Mind consists of the rehabilitation and recovery program. Good Mind refers to the arts programs, including the mental health theatre and art festivals, which take place every year. Cultural events,

such as art, theatre and music festivals, can be even more effective than medicine. Following the cultural relevancy model in the implementation of mental health services has great potential to improve the future of people suffering from mental illness and of society as a whole.

Laos

Dr. Manivoe Thikeo
Mental Health Consultant, WHO Country Office

The community mental health promotion program was established by the World Health Organisation Country Office in collaboration with the Ministry of Health in Vientiane in 2011. The program was designed according to a top-down strategy approach, targeting policy makers, community leaders, NGOs and other bilateral organizations, with the goal of influencing policy change regarding mental health. Program objectives include an increase public awareness of mental health, improvement in the quality of mental health services to the community and enhancement of government interest in mental health capacity building and financing. It aims to create a community health network in which mental health practitioners can share knowledge and resources and access research, training and new treatment strategies from neighboring countries and international mental health communities.

Several positive outcomes have already emerged since the program's conception. The Ministry of Health has demonstrated increasing interest in mental health services, and WHO will be providing support for a mental health consultant position to work with the ministry in building mental health capacity. The MOH and WHO have joined with NGOs and other bilateral organizations in an initiative to provide mental health training for Lao doctors and services for children and adults in the remote areas.

Community mental health has only been very recently introduced to Lao PDR, and the challenges the program faces are substantial. In addition to the lack of funding, technology and resources for mental health services, there are very few mental health experts in the country, which has only two psychiatrists and ten general practitioners. A lack of leadership in mental health promotion proving a significant challenge, and the need for a cohesive vision for the development of community mental health services is apparent. As many members of the team do not speak English, the language barrier between them and international health advisors also poses a problem.

Looking forward, the community mental health promotion program will seek further support from and collaboration with the MOH, WHO, other NGOs and bilateral organisations and international mental health community. The integration of mental health care into primary health care services will be initiated with the provision of mental health training to GPs and other health professionals who work in provincial hospitals and at a community level. The program will also provide leadership training to its members and support their participation in international mental health conferences and workshops to exchange knowledge and lessons.

Malaysia

Dr. Toh Chin-Lee
Technical Advisor for Psychiatric Services (Chief Psychiatrist) Ministry of Health

Mental health care services in Malaysia are provided by the Ministry of Health, universities and the private sector. The Ministry of Health has sought to address the tension between hospitals and community health care through the development of hospital-based community psychiatry teams.

Community psychiatry teams based in psychiatric hospitals, and general hospital psychiatric units go out to homes and community mental health centres. They collaborate with people with mental illness, their families and key local figures, providing education regarding mental illness, medication, ADLs and early intervention. Community psychiatry teams also provide acute home care and patient follow up. They liaise with job placement services, assisting people with mental illness to find employment. The community psychiatry team initiative has produced notable results, including an increase in-patient and family satisfaction, increased quality of care, increased compliance, reduction in relapse and admissions, and less congestion in hospitals.

The Mental Health Act was passed in 2001, and implementation began in 2010. It outlines the laws and standards relating to mental health service provision in Malaysia, including psychiatric facilities, psychiatric nursing homes, community mental health teams and community mental health centres. The implementation of the Mental Health Act will take place in stages. All state and major specialist hospitals will be charged with the responsibility of establishing community mental health centres. Psychiatric nursing homes are to be set up under the jurisdiction of state hospitals. The ongoing challenge will be ensuring that this implementation takes place in compliance with the Mental Health Act.

Mongolia

Associate Professor Lkhagvasuren
Vice Director, Division of Strategy and Planning, National Centre for Mental Health

Since 1997, Mongolia has collaborated with the WHO to implement community based mental health care. In 2000 Mongolia adopted a Mental Health Law and 2002 formulated the First National Mental Health Program 2002-2007. This was followed in 2009 by the Second National Mental Health Program from 2010-2019. The Mongolian mental health system operates at the primary, secondary and tertiary care levels.

In 2010 the National Centre for Mental Health conducted a mental health promotion project to initiate the integration of mental health care into primary health care services. The program consisted of training for primary health care personnel in the early detection, diagnosis, and treatment of mental illness within the community. General practitioners, nurses and social workers from 24 sub districts of capital city participated. Results from the training indicate that the number of people with mental illness admitted to primary health care following the project was 3.7 times greater than in the previous year.

The Ger Project began in 2000. This psychosocial rehabilitation project operates out of community-based day centres in gers, which are traditional Mongolian portable tent-dwellings. In a sample period between 2004 and 2005, 349 people participated, undertaking living and vocational skills training. During this time, it was shown that the relapse of mental disorders among participants was reduced by 95%.

In 2009 and 2010, Mongolia was affected by a dzud, a natural disaster in which heavy snowfall and freezing temperatures make livestock grazing impossible. The National Centre for Mental Health delivered medical examinations, mental health assessment and psychosocial support to the population in affected areas. Further psychosocial support and mental health care service teams need to be included in future disaster management.

Though the mental health system in Mongolia operates a range of mental health facilities, the existing mental health system is still largely hospital based. Two percent of federal health expenditure is allocated to mental health in Mongolia. Of that two percent, sixty four percent goes towards expenditures for mental health hospitals. A move towards community care will require the increase and redirection of mental health funding towards community mental health facilities and the promotion of mental health in the community. Mental health care delivery will be enhanced through training and partnerships between primary health service representatives, governments, NGOs and other international organizations. Collaboration between the social welfare, housing, legal, employment and education sectors also needs to be improved.

Philippines

Dr. Ruth Bordado,
Medical Specialist, Public Health Unit, National Centre for Mental Health

The department of Mental Health was established in 1920, and consisted of one hospital with 300 beds. By the 1960s the average number of day and in patients had increased to around 8000, though this declined during the 1970s due to the introduction of psychotropic drugs. The authorized bed capacity for the National Centre for Mental health has been just over 4000 for the last 25 years, which remains above the average number of day and in patients.

The Discharge and Follow up Consultation Program (DFC) is an initiative of the National Centre for Mental Health, which operates in partnership with local governments, regional hospitals, non government units and the media to facilitate the transition of patients between hospitals and their communities. Through the program, the National Centre for Mental Health has provided hundreds of local doctors with training in the early detection and management of mental illness. Local governments have been responsible for the provision of transportation of patients and staff, and regional hospitals for the provision of beds. The media has played a role in the dissemination of information regarding mental health and the DFC program. The program has seen a significant reduction in congestion in hospitals. This is due in part to earlier diagnosis brought about by the training of local doctors, and also to the rehabilitation of thousands of patients into their own communities. Productive partnerships have been formed between hospitals and other agencies, however only those programs where local governments are in a position to provide financial backing can be maintained.

The continuation of the DFC program will see mental health training for the primary health care sector. Work will be undertaken towards educating

communities as to their role in the provision of care to people suffering from mental illness, and preparing them to undertake these responsibilities. Looking to the future, further budget allocation – including specific allocation for psychotropic drugs - is a priority for mental health services, as is the development of mental health legislation. The ultimate outcome of progress in healthcare in the Philippines will be universal healthcare.

Plenary Session 4: Best Practices of Asia Pacific Countries

Chaired: Margaret Goding, Associate Director, Asia Australia Mental Health

Singapore

Associate Professor Wong Kim Eng
Chairman, National Mental Health Professional Advisory Committee

In 2006 the Ministry of Health, in collaboration with public sector hospitals, voluntary welfare organisations and government agencies, formulated the National Mental Health Blueprint (NMHB). The aim of the Blueprint is to promote mental health and, where possible, to prevent the development of mental health problems and disorders. The policy also aims to reduce the impact of mental disorders. These objectives will be achieved through the integration mental health care into primary health care, an increase in human resources and improvements in research and evaluation.

A key public sector collaborator on the NMHB was the Institute of Mental Health (IMH), Singapore's only tertiary mental health institution, which represents the largest mental health professional workforce in the country. A broad range of programs underpin the NMHB in numerous areas, including primary health care, hospitals, prevention and early detection programs, community care and emergency care. Development in the primary care sector has seen the establishment of the Graduate Diploma in Mental Health, which offers training for general practitioners in providing treatment for patients with mental illness.

Overall, most of the projects have achieved their intended objectives. The adult Community Mental Health Team has recorded a reduction in readmissions, and shown improvement in the Global Assessment of Functioning (GAF) scale. People recovering from mental illness are being successfully placed in positions by the Job Club and the REACH (response, early intervention and assessment in community mental health) helpline has been established. Communication and integration between sectors continue to present challenges, however.

The Institute of Mental Health will continue to work towards a quality integrated mental health system that provides holistic, coordinated and integrated care across health, social and other related sectors. It seeks to provide patients, caregivers and the public with appropriate knowledge, information, skills and support to empower them, aiming to improve the network of care to enable integrated community living, maximize individual potential, and enhance access to mental healthcare.

Solomon Islands

Dr. William Same

Director, Integrated Mental Health Services, Ministry of Health Ministry of Health and Medical Services

The promotion of mental health in the community has become a central focus in mental health services in the Solomon Islands, where community mental health services are small and unorganised. Provincial Mental Health Coordinators have been appointed, and many nurses in the communities have been trained in mental health. There is still a 63% readmission rate to mental health institutions, however. Two models for the promotion of mental health are currently in place to provide services for people who have been discharged from hospitals. The first is founded on a community leader – client relationship. This is based on a religious attitude of caring for the unfortunate. The second model is supported by the Provincial Mental Health Coordinator and the Clinical Nurse Consultant, and involves families, carers, community leaders and rural clinic nurses.

The primary objective of the mental health services network is the creation of innovative services that promote recovery and social inclusion, building on the potential and strengths of the individual. Community participation and ownership will be integral to the achievement of these goals, helping to both de stigmatise mental illness and improve mental health awareness in the community. On a broader scale, mental health promotion and prevention aims toward the fostering of positive individual, social and environmental mental health determinants.

It is too early to see the real impacts of the program, which has just started in three pilot areas. Planning by families and communities has begun, and there has been good family and community collaboration in regard to rehabilitation activities in some areas. Community initiation of mental health promotion is beginning to take place, and a group of community leaders will be carrying out fundraising for mental health promotion in December.

The greatest challenge facing the program is ensuring its sustainability. This depends on mental health staff capacity and the availability of resources, particularly in geographically isolated areas. Support from Mental Health Services, whether it be technical support, knowledge sharing or outreach will also be a major challenge. Monitoring and evaluation mechanisms have to be put in place soon to inform future practice, before rolling out the program the whole nation. The future of the initiative will see further establishment of mental health services at a provincial level. There are plans to appoint a driver of the program whose sole duty is to drive expansion and development of the initiative. The training and continuing motivation of community leaders to participate is also very important.

Taiwan

Dr. Happy Kuy-lok Tan

Superintendent, Taoyuan Mental Hospital, Department of Health

In 1985 the government began to develop its mental health policy, improving the quality of care for psychotic patients through hospital accreditation every three to four years. The following year saw the introduction of the Psychiatric Network project, which increased the mental health budget and improved the supply and accessibility of mental health services. In 1987 the Division of Mental Health was established within the Department of Health. The Mental Health Law was implemented in 1990 and revised in 2007. The National Health Insurance network provides free treatment to all mental and psychotic patients, and offers partial coverage for people with other mental disorders.

From July 2012, as part of a program of government reform, a Department of Mental Health and a Bereau of Health and Social Welfare will be established.

Since 1985 the number of acute beds in psychiatric medical facilities has risen from 1200 to over 6800. The number of chronic beds have increased from 9800 to 1300, and the capacity of community day care has risen from 179 to 6700. Over the last fifteen years there has been a remarkable increase in community care facilities, particularly in community rehabilitation centres and half way houses. Community mental health programs are provided by the public and private sectors, or by individuals.

Taoyuan Mental Hospital was founded in 1934 as an asylum for inpatients only, it is presently a teaching hospital. There are fifty day beds for children with autism and developmental delays, and fifty day beds for adolescent care, provided for people suffering from schizophrenia, bipolar disorder, autism and intellectual disability. After patients are discharged from acute beds they go on to the day hospital or into the community, managed by mental health nurses.

The Methdone Maintainence Therapy services were initiated in 2006 by the Centres for Disease Control in response to increasing instance in HIV. The program has grown from providing 120 people with daily methadone services to 11,000 from over 100 sites across the country. In 2005 there were 2400 new cases of HIV in injecting drug users; the rate has now been reduced to 80 per year, a remarkable success. The rising rate of HIV contraction through homosexual contract is an increasing concern, however.

There has been a strong focus on mental health over the past 25 years, and in recent years on the Methadone Maintenance Therap program. Future efforts will be directed towards health promotion in the community, schools and workplace.

Vietnam

Dr. Truong Le Van Ngoc
Head of Non-Communicable Disease Unit of Administration Medical Services, Ministry of Health

In 1998 the National Community Mental Health Program (NCMH) was approved by the Prime Minister. The steering committee on NCMH program is formulated and headed by Vice Minister of Health, and Central Psychiatric Hospital 1 is responsible for its execution. The main approach of the program is to integrate mental health care into primary health care, and to date it has focused on the implementation of schizophrenia, epilepsy and depression management within the community.

The goal of the program is to increase the quality of mental health care services and intergrate this care into Commune Health Centres. Several positive outcomes have been achieved since the commencement of the program. The mental health system has been strengthened, and there is an increased awareness of mental health issues among both health workers and the broader population. The program has enjoyed increasing support from leadership at all levels, and has built the capacity of health workers, particularly psychiatrists. Services are provided for the poor and people in remote areas, as all provinces are covered by the program, allowing people to be treated in their communities.

There are very limited rehabilitation services for patients, however, and the program does not include social support. Health staff are overworked, and in remote areas there is limited mental health education due to lack of basic communication equipment. Non-drug treatments are not covered by the program, and there is an insufficient budget for health collaborators.

Several other challenges face the NCMH. There is a lack of collaboration between the Ministry of Health and other ministries. A mental health legislative framework is not fully developed, and current standard treatment guidelines on mental health are not sufficient and need to be revised. Facilities are poor, despite investment in Commune Health Centres, and the budget is limited. The mental health workforce is too small and insufficiently trained, and there are no qualified social workers. Within the community, stigma associated with mental health disorders remains an issue.

The development of a mental health law in Vietnam is essential to the progress of the mental health system. The development of national action plan on mental health for 2012-2020, and the establishment of a national task force on mental health are priorities. Additionally, mechanisms need to be put in place to attract medical professionals and students to mental health, and facilities require upgrading.

Day 3 Workshop: Setting Directions for Stage 3 of the APCMHDP network

Future Directions: Community Mental Health Promotion

Following formal meetings in 2011 in New Delhi (February) and Taiwan (November), and informal discussions throughout the year, the APCMHDP network members agreed to continue the collaboration into a third stage.

The final day of the three-day meeting included a facilitated workshop to discuss future directions for the third stage of the APCMHDP network. The day also included site visits to aged mental health, primary health, homeless, and youth and adolescent services.

It was decided that the focus and theme for stage 3 would be ***Community Mental Health Promotion***. The Melbourne meeting and workshop provided an opportunity for the network to begin exploring existing mental health promotion activities; to look at potential strategies and actions for mental health promotion in the Asia Pacific; and to explore how the network could support these initiatives over the next three years.

Existing Mental Health promotion activities

The first part of the workshop asked participants to look at what existing mental health promotion programs there were. In particular groups were asked to share what is currently being carried out well in their country in mental health promotion.

A number of themes emerged with some excellent exemplars of community mental health promotion. One of the themes that arose among a number of countries included the campaigns that used ***traditional media***, such as television, radio and print media for promoting mental health issues. One example of this was the Indian Government who uses these forms to communicate mental health campaigns. These campaigns were language and culture specific at the local and national level throughout India.

Other forms of ***non-traditional media campaigns*** such as the internet and web-based forms of communication were used particularly in Japan and Australia; In Cambodia, Government and NGO funding assisted with the development of t-shirts and a calendar that communicated various mental health messages; while in other countries such as Taiwan, the use of posters, home visits and training were used to distribute and disseminate information for campaigns.

Another theme of existing mental health promotion activities included programs in ***schools*** and ***workplaces***, particularly in Singapore, Japan, and Australia. Screening, counseling, referral, stress management, and education were key components of the programs.

One of the key themes to come out of this session from all countries in the Asia Pacific was the way existing community mental health programs are being leveraged to help build mental health promotion programs. Networks of volunteers are used in the Solomon Islands to communicate necessary messages via word of mouth; Cambodia, Fiji, India, Indonesia, Malaysia, Singapore and Taiwan all agreed that currently volunteer networks were critical to any mental health promotion activities. Cambodia in particular noted the opportunity to leverage their established methadone maintenance therapy program to communicate messages to the community. In Malaysia, primary health care clinics run by the Ministry of Health were used to deliver the "healthy mind" campaign, while Mongolia is running mental health promotion campaigns through their hospital system, focusing on overcoming resistance to community mental health from psychiatrists.

The use of art programs was also a common theme across a number of countries. Fiji discussed a program called the "Youth Champs for Mental Health", which used poetry, song and dance to communicate mental health messages to the community. Fiji also advocate for better mental health through using a book called "Fright or Light" that looks at lived experiences of mental health issues.

Other existing programs included the use of special events to bring focus onto mental health, such as World Mental Health Day. The Philippines have also carried out a National Survey in 2011 on the prevalence of mental health problems and disorders.

b) Mental Health promotion – what can be done?

The second part of the workshop asked groups to look at possible mental health promotion strategies and activities – what's possible. Suggested strategies were wide ranging, and culturally and country specific - however several themes emerged in the discussions as outlined below.

It emerged that a good community mental health promotion campaign requires an ongoing, targeted and frequent ***message*** that is practical, simple and non-threatening.

It was important to use existing ***influential people*** and networks, such as celebrities, politicians, sports people, and community leaders, for mental health promotion campaigns and initiatives. In particular, influential people with a history of mental illness or someone in their family are likely to be an authentic way of engaging new audiences about mental health issues. Targeted education and information for the influential people was also necessary. Examples included the use of the Governor General in Australia, and the First Lady of Fiji.

Further work needs to be done on ***partnering*** with other industries and sectors to reach a wider audience.

Exploration of non-traditional methods of community mental health promotion should be considered, including the use of social networking (facebook and twitter), mobile phones, and micro blogs.

Mental wellness programs need to be further developed in ***schools*** and ***workplaces*** from primary education to universities. ***Art programs*** and gallery spaces have proven to be extremely valuable and effective means of promoting mental health to the community – in particular the importance of culture through art in singing, dancing and storytelling.

Mental health campaigns need to be ***piloted*** first by trialing with a small group and then monitored and evaluated to ensure message is targeted and appropriate.

Current ***challenges and issues*** with community mental health promotion campaigns include that they are not targeted and are too spread out; there is no monitoring and evaluation; language is inappropriate or not targeted; campaigns are not done in partnership across sectors.

c) Future of the network – activities to support the APCMHDP

The final part of the workshop asked participants to discuss what particular activities would be needed to support this next stage of the network.

It was agreed that the network should continue to share experiences, ideas, challenges and support each other, by collaborating through resource sharing and inspiring creative ideas for community mental health development. This would continue to be based on *mutual respect, honesty and understanding*. It was also agreed that the network would continue to identify the strengths of each country in the areas of mental health promotion.

Suggested ways to support this included a virtual community and website; further workshops, field visits and maintain regular face-to-face meetings; disseminate good reading and resource materials; publish a third summary report focused on 'best practice' in community mental health promotion; share contact details and build a directory of people in the network; and support each other in technical management.

Conclusion

The leaders of mental health in 17 countries came together in Melbourne to inspire, support and continue to build a community aimed at improving community mental health services in the Asia Pacific. While the burden of mental health is often overwhelming, there are incredibly inspiring and effective models of community mental health throughout the Asia Pacific region.

Indeed, all countries are at different stages of the global movement from hospital based systems to a more community based one. As such, all countries require different strategies and approaches for mental health promotion that is culturally specific. However, what is clear from the meeting in Melbourne is that there are a common set of themes and principles in community mental health promotion, which are starting to be developed.

The network will be exploring these principles and themes over the next three years.

Comments from the APCMHDP Meeting

"It's my great honour to be invited and to share on behalf of my region. I appreciate very much the effort the AAMH Team has made to organize the Conference in an excellence way. I enjoyed very much the opportunities in sharing and learning from others."

"We are so excited and so proud being there during the whole sessions. We've learnt and inspired a lot from this seminar and workshop. We do hope that we could continue working in this group."

"Congratulations for grand success of events. Looking forward for further interactions with your team"

"Please extend my thanks to the rest of the AAMH Team for the opportunity to be part of the fabulous 3-day meeting."

"First of all, I would like to express my gratitude in giving me a chance to be a part of the seminar. I have learned a lot and made many friends."

"Looking forward to strengthen our future collaboration"

"I had a great time during the three days seminar and workshop. Thank you very much for your arrangement. I enjoyed the seminar, workshop as well as site visit."