Mental Health Literacy through Mental Health Literacy Advocacy

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Abstract

The story of a teenager who hanged himself in a cupboard some time ago has saddened the community. This case is only one in thousands or even millions of people out there, having life problems, not being able to support it alone and not knowing where to go to seek help. Eventually committing suicide or becoming a patient in a psychiatric hospital. Learning from the case of Rangga, who chose the path to end his life because he harbored family problems but had difficulty finding a way to express it to others, only to keep himself. Signs of psychological problems actually exist. However these signs have not been noticed as a serious problem, so there is no further action to help him. This situation is plural in ordinary people, because of the limited knowledge about mental health so it hinders the ability to recognize signs of disorder, when is the right time to get professional help and where the help can be obtained. This is a portrait of our current mental health. Another fact from the Ministry of Health report states that approximately 57 thousand people who have a mental disorder in Indonesia are moderate or have experienced shackling. The condition is also another piece of the reality concerning the disorganized mental health system. Health promotion and education has not been able to make the community have adequate mental health knowledge. The system has also not been able to provide services for all levels of society. Limited number of service providers and professionals, high costs and access to services are the main issues in the service system. It is urgent and important for policymakers in this country to pay attention to this issue.

Keywords: mental health literacy, mental disorder, interpersonal communication, advocacy

Introduction

Interpersonal communication is defined as communication that occurs between two or more people face to face. Meanwhile, according to Devito in his book “The Interpersonal communication: interaction that is carried out from person to person, is 2-way both verbal and non-verbal, by sharing information and feelings between individuals and individuals or between individuals in small groups. Interpersonal communication is communication between people face to face, both verbally and nonverbally. Interpersonal communication is the exchange of information, feelings or thoughts between humans (individuals) face to face (face to face), individuals with individuals (person to person), verbal non-verbal. Because the nature of the interaction is direct and immediate, interpersonal communication is at the core of all human relations ships [1].

Interpersonal communication processes are adversely affected by many mental health problems and in some cases may be risk factors for mental health problems. Four major interpersonal communication processes that play a role in mental health are highlighted: social skills deficits, communication deviance, expressed emotion, and lack of social support. The association between these interpersonal processes and schizophrenia, depression, anxiety, Mental disorders, substance abuse disorders, personality disorders, and loneliness are discussed.

Mental disorder is a new threat in the world health issues. WHO (World Health Organization) stated mental disorder as the cause of disability and malfunction of 450 million people. The number of sufferers in different parts of the world shows a significant increase each year. In 2002, the WHO reported about 154 million people had depression and 25 million had schizophrenia. Meanwhile, nearly 15 million people are addicted to illegal drugs, including drugs and alcohol abuse. In addition, the suicide rate reached 877,000 people, some of the perpetrators had links to mental problems [2]. Statistics also show an increase in the number of mental disorders in children and adolescents, it is stated that 1 in 5 children experience mental problems in the range of mild to severe. WHO recorded depression as the highest mental disorder for sufferers, reaching 350 million. While 60 million people live with bipolar disorder, 21 million people with schizophrenia and other psychotic disorders. Meanwhile, people with dementia reached 47.5 million people.

In Indonesia there was a decrease in the number of respondents with severe mental disorders based on the results of Basic Health Research (Riskesdas) in 2007 and 2013. The number of people with mental disorders decreased from 11.6% in 2007 to 6.0% in 2013. However, much of the data has not been able to be covered due to the limitations of detection systems and reported case in service centers. Basic Health Research in 2013 recorded 1,728 esponden with severe mental disorders. The highest prevalence of psychosis is in the Special Region of Yogyakarta (DIY) and Aceh, while the lowest is in West Kalimantan. DIY (Special Region of Yogyakarta) has the highest number, although this number is allegedly due to the early detection system which has started to run properly so that the number of reported cases is increasing. Community conditions also support an increase in the number of cases detected. People who are increasingly aware of seeking help from professionals, so that client data in health care centers is increasing. Therefore, in other areas where the numbers are still low, it does not mean there are no sufferers, but because of the awareness of treatment and affordability of services are still low. Nationally, the prevalence of mental disorders reaches 1.7 per mile, meaning 1-2 people out of 1000 population in Indonesia suffer from severe mental disorders. Referring to WHO, this number is classified as high.

Another portrait showing the darkness of mental health problems is the high number of sufferers experience shackling. Recorded in Riskesdas, the number of families with mental disorders who doing the shackling reaches 1,655 families or about 57 thousand people. The number of households living in rural areas (18.2 percent) increased by 14.3 percent and most lived in rural areas (18.2 percent) and also have the lowest economic level (19.5%). The method of shackling is not limited to traditional shackling (using wood or chains on the leg), but includes other restraints that restrict movement, isolation, and lock up the patient.

The numbers above are just the tip of the iceberg, the real number is certainly greater. This information system is expected to monitor the number and variety of cases that occur in puskesmas. SIKM data shows that the majority of clients who come to psychologist of puskesmas are indicated to have anxiety disorder, sleep disorder, depression, physical disorder with no obvious physical or psychosomatic cause, and also seen psychotic cases. For example, prominent case data from Sleman region over a two-year period of program implementation are presented in Table 1.

Table 1. Sufferers of Mental Disorder in Sleman

Types	**July-December 2010**	**January-November 2011**
Schizophrenia	191	575
Acute Psychosis	16	26
Depression	138	142
Bipolar	-	29
Depressive episode	138	193
Anxiety	586	1891
Severe stress	290	616
Somatization	440	1282
Neurotic	40	51
Sleep disorders	65	248
Psychological & behavioral factors (psychosomatic)	341	889
Growth Disorder	-	269
Behavior Disorder	-	223
Growth Disorder	-	252
Social Function Disorder	-	34

Source: annual report of CPMH (Center of Public Mental Health)

CPMH data shows a significant increase in all types of disorders. The number of people with anxiety disorders showed the highest number, with 1282 cases recorded in 2011. Meanwhile, patients who were indicated to have somatization or physical disorder with unclear causes, from 440 to 1282, and psychosomatic behavior from 341 to 889.

This condition is exacerbated by the lack of availability and access to mental health services in Indonesia. The service gap reaches 90%, it means that only about 10% of people with disorders get services from professional health workers. While 90% of others are not yet known for sure, it is estimated that they seek help from nonprofessional health workers.

Of course, these numbers will only serve as a sweetener for the statistical survey results if no steps are taken to help those with mental disorder who have potential for illness. Prevention, promotion and curation measures are certainly urgent to increase the rate of mental disorders. The availability of mental disorders services from the lowest levels in primary care, especially puskesmas, is very important to ensure community accessibility [3].

In all efforts to achieve better mental health there is a strong role to play, namely knowledge of mental health itself. Knowledge will help a person to recognize when he or she is having problems and it is time to need professional help from a professional health worker. One of the keys to successful treatment of mental disorders is early detection – early intervention, the faster it will be detected the faster the intervention can be given, the success rate of the treatment will increase. Therefore mental health knowledge that helps with early detection will play an important role in intervention. This knowledge of mental health is referred to as mental health literacy (MHL)..

Mental Health Literacy

Let us clarify what is actually meant by mental health literacy (MHL), whether it's just knowledge about various kinds of mental disorder or further more than that. Health literacy (HL) is heard more by the public than mental health literacy. Health literacy refers to knowledge of the various diseases, treatments and health services available. This literacy includes knowledge of various diseases, signs of treatment, the availability of various professionals and helpers [4]. For example, campaigns on dengue fever are very easy to find anywhere. As a result the community understands the signs of dengue fever attack, causes, prevention as well as where to get treatment. However, not so with MHL the term mental disorder itself is still unfamiliar, not to mention the different types of disorders, signs, causes and treatment. People already realize that mental disorders are a condition that is a non-physical disease in a sufferer. This condition has also been named or labeled by the common people with local terms, for example: insane people, crazy people, or in the local language called edan, sinting, lali jiwa, and so on. Society considers and gives the same term for all forms of mental disorders, for example society will still give the same term for people with schizophrenia disorder and children who have mental retardation, they used to call it "crazy".

The terminology of mental health literacy itself was introduced by Anthony F. Jorm in 1997 and is defined as knowledge and belief about mental disorders that help recognize symptoms, manage and prevent mental disorders. The broader and complete mental health literacy is described as the entire ability to gain access, the ability to understand and use information as a framework to promote and maintain mental health conditions. Based on these definitions, the definition of literacy will include knowledge and beliefs about mental disorders that can direct recognition, management and prevention capabilities involving the ability to recognize specific disorders from different types of mental disorders, knowing risk factors and causes, knowing how to perform self treatment, knowledge about the availability of professional assistance, attitudes that facilitate the introduction of appropriate help seeking behavior as well as knowledge of how to look for information about mental health. Briefly, there are several things covered in this definition of literacy:

1. Ability to recognize various mental disorders
2. Knowledge and beliefs about risk factors and causes
3. Knowledge and beliefs about personal intervention (self-help)
4. Knowledge and beliefs about the availability of professional assistance
5. Attitudes that facilitate the introduction of appropriate help-seeking behavior

6. Knowledge of how to look for information about mental health

For almost 10 years on the development of mental health literacy in Australia noted several important points: (1) mental disorders cannot be well understood by the public, (2) there is a gap in knowledge of treatment and intervention between the community and professionals, (3) there is a stigma in seeking help, as well as the ability to provide mental health first aid which is still severely lacking. In addition to these conditions, Jorm further added that the community also has a condition: (1) the lack of public knowledge on how to prevent mental disorders, (2) the inability to recognize when the disorder develops/arises, (3) inability to help seeking and availability of services and treatment, (4) effective knowledge of sell-help strategies for lighter problems and First Aid skills to help others with mental disorders.

Knowledge of MHL in Australia has increased throughout 1995 to 2011, characterised by a force of causative knowledge about schizophrenia, there is a belief that problems in childhood and genetic ancestry are the beginning of schizophrenia. Meanwhile the belief that mental disorders are a sign of weak character is starting to decline in society.

If the condition in the country where the mental health service system is the top priority still facing such problems, then what about Indonesia which is still very new to mental health issues as part of health policy? Of course, the study of MHL is still very limited, so it has not been able to provide a new view in policy in the government [5]. In Australia the concept of MHL developed and became an important study for stakeholders and policy makers took a long time since it became known to the public in 1997, so it is no wonder that the development is far ahead.

We may be worried that the condition of Indonesian people who still have low levels of education and have lower middle economic status will affect literacy conditions. However, it turns out that low socio-economic conditions and education levels do not affect literacy levels, but promotion and psychoeducation about mental health have a strong influence. Another affecting factor is the experience of having mental health problems and the experience of interacting with people with mental disorders (abbreviated to ODGJ). The experience will affect the flexibility in seeking help and change the view of the benefits of seeking some help. In addition to experience, the identification of views and perceptions of mental disorders based on locality is also a literacy factor. Our failure to understand this local perception will be an obstacle to the educational process.

Traditional society is not necessarily considered to have no knowledge at all. They may already have a system of knowledge about a mental disorder using the concept of belief they have. The local knowledge helps the community to recognize a disorder as a different condition, or a non-physical illness. The community has developed a knowledge system with its own use of local terms. In various studies on MHL, the difference in the term is also of particular concern. Differences in the use of terms in the medical world and lay terms in the community will influence MHL's improvement strategy. For example, rural and urban communities have different knowledge and beliefs about depression, the urban community prefers the clinical term depression rather than the rural community who prefer the term emotional stress as a more common term [6]. Traditional societies see mental disorders as

being caused by external factors, due to interference by spirits or due to magic or witchcraft. This traditional view, on the one hand, has a positive influence on the stigma against People with Mental Disorder (ODGJ), the community tends to accept them more positively.

Why this increase in MHL is very important in mental health, because it is believed that increasing literacy will be an effective strategy to facilitate early intervention for the mental health. Increasing literacy will encourage help seeking behaviour and improve help giving behavior.

Literacy as a Driver on Actualization of Help Seeking Behaviour

A qualitative study of the families and friends of suicide victims found the fact that family and friends were key to suicide prevention efforts. They play an important role in determining whether or not someone with suicidal thoughts will seek medical help. Some samples of victims were consulted in the last month and some were encouraged by friends/relatives to seek help [7]. Some who do not consulted are indicated to have a character who refuses help, but some of them refuse because no one around him is aware of the seriousness of the pressures/problems that are already in the clinical category. This fact shows that the seeking help behavior is related to literacy level, the higher the knowledge and understanding it will lead a person to seek help, both professional and nonprofessional.

Returning to the definition of MHL that has been explained previously, literacy includes knowledge of access to available assistance. Someone who has knowledge and is able to recognize signs of disorder is expected to seek help immediately from those without knowledge. However, to whom does a person seek help when they have a problem that interferes with their feelings or mental health? Of course the answer will be various. Some may seek help from closest people, family or friends, while others may have begun seeking help to counselors at school, psychologists or even psychiatrists. Age, education and gender will influence the chosen help. Some studies of adolescent behavior seeking help show that they tend to seek informal help rather than formal-professional. This informal help they get from friends or family when experiencing stress or psychological problems.

Mental health literacy greatly influences who a person will seek help from, whether to a professional or to an informal helper. Which parties will be asked for help in youth and adults also have a difference. If adults tend to make friends and religious leaders a source of help then school-age children and adolescents prefer parents, friends and teachers as a source of help.

Half of teenagers aged 11-18 years old in rural areas in Australia said they will seek help from counselors at school when they have mental problems. Meanwhile, teenage boys have a greater tendency to seek help from psychologists than teenage girls. This condition confirms that one of the obstacles for rural teenagers to seek help to a psychologist or psychiatrist is due to the limited access where as a large number of psychologists or psychiatrists are in urban areas, while it takes a quite a long time to achieve it.

The misuse of drugs and drugs causes permanent mental disorders in adolescents. Existing studies show there is a large gap between the number of people with drug abuse and seeking

help, very few seeking help. Literacy and service conditions are believed to affect adolescents experiencing drug abuse to seek professional assistance. For most teenagers in Indonesia, professional assistance is still the first alternative, especially parents, teachers and friends [8]. Therefore it is not wrong to think that youth mental health programs target key people around adolescents whether it is families, schools and peers as target groups. The strategy is believed to be more effective at improving literacy in adolescent groups.

Various other studies have also conducted assessments of how adolescents can identify or recognize various disorders. Half of adolescents were found to be able to correctly identify depression, and approximately 27.5% also did correct identification for anxiety, but unfortunately the tendency to seek professional help was still low. Another study found that girls have higher levels of boys in recognizing mental disorders in themselves. The results of further studies stated that it turned out that children began to be able to recognize mental disorder in their group during pre-school and began to develop identification skills as they developed.

The development of studies in adolescent groups shows different profiles, male students in the faculty of science, economics and philosophy have low literacy rates [9]. This study further reinforces that direct contact with the issue of mental disorders, both theoretically and practical activities are able to improve mental health literacy. Although high and low literacy levels do not directly affect acceptance and stigma against ODGJ.

The general public's beliefs about mental disorders will influence patterns of seeking help. For example, for communities that prefer socio-environmental explanations as the cause of mental disorders, believing that mental disorders are more caused by social factors then they believe that treatment must be able to affect the social level. So the community demands that the hospital provide answers to the social problems, if they are not able then the community is reluctant to use the hospital services. Similarly, with the view that mental disorders are a sin, psychiatric hospital is considered not to provide proper and effective treatment, so inevitably people will also not use services in psychiatric hospital (RSJ).

Access, Gap Services and Help Seeking Behaviour

What causes a person to be reluctant to seek help from a professional? Answering these questions of course we need to look at the condition of mental health services itself. If mental health service facilities are still minimal, geographically and the number of mental health professionals is very limited, it is certainly an obstacle for people to access services. How many psychiatrists, psychologists, clinical social workers, or the number of psychiatric nurses available in Indonesia today, is still far from ideal number [11]. In the field, there are currently only 51 psychiatric hospital in Indonesia and of course only in the city, while there are 9,655 puskesmas in all provinces, some of which have mental health services, have doctors who already have GP+, or CMHN nurses, mental health programs or psychologists, of course there are very few. This condition certainly exacerbates people's affordability for services, while the availability of professional personnel is a result of the increased intention to seek help.

The second problem is the limitations of mental health professionals. The number of formal health staff who receive education or mental health training is still very limited, and this is indeed a great homework for the government. Although the number of public health centers (puskesmas) is quite large, in 2013 there were 9,655 puskesmas in all provinces, with a ratio per 100,000 population of 3.09, but the staff of puskesmas who have a mental education background is still very few. Although in every puskesmas, there are already general doctors available, but our specialists are also limited, only 36,081 specialists in various fields are spread throughout the provinces in Indonesia. At the advanced service level, there are currently 51 psychiatric hospital with a total of 10,349 beds available as well. With a population of about 250 million, Indonesia has only 451 clinical psychologists or about 0.15 per 100,000 population, 773 psychiatrists (0.32 per 100,000 population), 6,500 psychiatric nurses or (2 per 100,000 population). Psychiatrists and clinical psychologists are only in urban areas, while the number of mental nurses is also still limited in psychiatric hospital, and very few are indeed educated as psychiatric nurses.

The third problem with regard to the accessibility of services is the limitations of the number of services and human resources. The fact that most people do not have access to mental health facilities due to geographical conditions which are very far from the facility, then the third problem that arises is the amount of costs which are doubled because there are costs beyond the cost of treatment that must be borne by the sufferer's family [12]. Transportation costs at the time of treatment and loss of income due to loss of working hours are also a calculation on the affordability of services. Some poor people have been helped through various social and health security provided by the government through Social Health Insurance (Jamkesos), Social Health Insurance for the Poor (Askeskin), or even now through BPJS (Health Insurance) to cover the cost of treatment. Unfortunately, there is no social security system which helps costs beyond the cost of such drugs. So, mental health services are still considered quite expensive due to the costs incurred from the distance and necessity while at the medical center which also requires a lot of money.

Currently, various parties have tried to narrow the gap in mental health services through various breakthroughs. One of the efforts is made at the primary service level in puskesmas, either through the provision of GP+ training to general practitioners, tiered CMHN training for nurses or through the provision of psychologist services. One of these efforts made by the Faculty of Psychology UGM is to cooperate with the Sleman Health Office to pioneer the placement of psychologists which was then expanded and managed by CPMH (Center for Public Mental Health). The Health Center Psychologist Program also gained reinforcement from the disaster of Mount Merapi, which by chance almost all areas in Sleman Regency were directly and indirectly affected, so in the condition of the disaster psychologists have a strategic role. Starting with Sleman Regency by placing a psychologist in each puskesmas, followed by Yogyakarta City government which also included puskesmas psychologist program in the local policy, was realized at the end of 2010 by placing 9 psychologists in 18 Puskemas in Yogyakarta city by working with CPMH. The development of psychologists in puskesmas has begun to develop into several other districts.

The existence of this psychologist service actually makes a big contribution to the provision of mental health services in the community, as evidenced by the high number of clients in each puskesmas and it can be handled properly.

The problem of low access and intention to seek help from general practitioners has led to delays in treatment for those with mental problems, not only in Indonesia. In a developed and prosperous country such as New Zealand, limited access is still a problem, where 82% of students in the junior high school who have significant mental problems do not seek help from a general practitioner. Therefore, various efforts to reduce this service gap deserve appreciation and support as a first step towards a mentally healthy society.

Stigma and Discrimination as Barriers

Some patients who went to the puskesmas when referred by the doctor to consult with a psychologist expressed their reluctance to see a psychologist because they were afraid of being labeled "crazy" or insane. They are also reluctant because they feel they do not have mental disorder. This condition is very common, when we visit a psychologist or even a psychiatrist, then people will ask if we have mental disorder, whether are we really insane so we need the help of a psychologist or psychiatrist [13]. The question will of course be very troubling when we ourselves feel very worried about getting stigma and discrimination as people with mental disorders (ODGJ). Based on various studies, it also confirms that the stigma against people with mental disorders is an important factor that influences this seeking-help behavior. Stigma has a significant influence on mental health-seeking help behavior, the higher the personal stigma then help-seeking behavior will also be lower. Reduced stigma in society is expected to improve help seeking behavior.

The stigma against people with mental disorders is also influenced by beliefs, beliefs or values in society which influence their beliefs in the causes and views of mental disorder itself. There is a traditional belief that mental disorders are caused by spirits, and sin will certainly develop a stronger stigma for sufferers. This stigma against ODGJ can be seen through the extent to which society has accepted ODGJ. For example, studies conducted in communities of a certain ethnic and religious background show that most women are afraid and unwilling to have a friendship with ODGJ. Other studies have also shown that some people believe that mental disorders are caused by punishment from God. It is predictable, when mental disorders are understood as a result of sin which gets punishment from God, then people will be so worried and afraid of getting labeled with mental disorders which also means being considered a "sinner". This label will certainly strengthen the social sanctions and discrimination of ODGJ in communities that still hold such views.

Education is important to improve knowledge about mental disorder and reduce stigma and discrimination against ODGJ. Campaigns aimed at reducing stigma and increasing knowledge about schizophrenia are also said to be able to minimize the possibility of harmful actions. Stigmatization significantly predicts a harmful response and low attitude to help. Nevertheless, the campaign must also pay attention to the needs and differences in characteristics of various social groups of the community. For example gender differences, men and women, the right form of campaign, according to its characteristics will influence

the result because it will be relevant to its needs. The selection of material that corresponds to a socio-cultural setting will also determine the extent to which the target group's acceptance of the content of the campaign.

Once again, it is emphasized that the increase in knowledge will increase the help seeking behavior psychological and its predictors, namely the attitude towards professional psychological assistance and a reduction in the social stigma of receiving professional assistance. Then the actual behavior of seeking professional help will be a very important indicator of an increase in literacy, between the two will be a mutually influencing cycle, where the actual behavior of seeking professional help itself will also continuously strengthen and improve literacy.

Choosing Strategies Towards Society of Mental Health Literacy

After discussing the various negative conditions that we face in the world of mental health, then it is time we moved to think on the positive side about the possibility of various efforts which can be made to improve public literacy [14]. The goal to be achieved is the ongoing effect on the behavior of seeking professional help and handling as early as possible. Various studies and programs in other countries have given hope to efforts to reach the society of mental health literacy. One of them is programs conducted through programs in Australia about initiation for depression problems or referred to as Beyond blue the national depression initiative and mental health first aid training, both programs have a pretty good impact.

Before developing a strategy, it is better if we recall the root problems around literacy, so there are several conclusions that can be obtained which includes:

1. The fact that mental disorders are not known and understood by society
2. The fact that there is a wide gap between the community and professionals about the belief in treatment
3. The fact that there is stigma is a barrier to help-seeking behavior
4. The fact that first aid skills are still severely lacking

Based on the facts, of course, the efforts made are directed at resolving the root of the problem. The big goal is of course towards a mental healthy society which will be achieved through improved literacy. The domino effect of increasing literacy is to narrow the knowledge gap between professionals and communities, reduce stigma and discrimination through increasibg the first aid skills.

Some conditions must be considered in an effort to improve community literacy, including the selection of strategies, target groups and appropriate educational models to ensure that the literacy will reduce stigma, improve the initial seek for professional assistance, target behavioral and promotive actions, and the absence of campaigns at every level of society. Selection of target groups, organizations that will be the basis of the program—whether it will be school or community based organizations and share the appropriate psychoeducation model; and do not forget to also consider the material and content. Mapping of target groups may use vulnerability-level criteria or strategic positions within the community. Vulnerable groups which can be categorized as priorities for example are groups of children and

adolescents who have high risk factors. While strategic groups are certainly groups that play a key role around youth. Meanwhile, another example is an example of the mhGAP program by WHO which targeting professional workers and vulnerable groups of mothers who are about to give birth because they are so vulnerable to postpartum depression so it is very important to be introduced about the disorder and its simple treatment.

The selection of material content from the campaign program is aligned with the characteristics of the target group to ensure its effectiveness. In addition, the content of education programs needs to weigh social and cultural conditions that encourage belief or that affect people's knowledge and choices towards professional assistance, treatment, and treatment methods for people with mental disorders [15]. For example, we need to consider how a particular religious community considers that reading the holy book will be a prevention or treatment for people with mental disorders, then the material will be more appropriate when doing self help based on religious knowledge so it will be more effective because it can parallel their beliefs.

The effectiveness of future interventions can be improved through the selection of mental health promotion with specific models thus making it easier to model the development of the program. Specifically targeted at the promotion of one type of disorder for example, such as the promotion of diabetes, dengue fever and others that target one of the specific diseases only. Similarly, mental disorders can target schizophrenia or bipolar disorder so they can focus and be targeted.

Furthermore, the material can also strengthen the understanding about symptoms of intervention, provide information on evidence-based treatments and be able to reduce barriers to seeking help especially reducing stigma. If the community MLH does not increase then it is very likely that there is incorrect information about the effectiveness of the service, in addition to the possibility that those people do not receive proper support from others in the community.

Proper psychoeducation will also be a powerful tool to counter the flow of inappropriate and misguided information. Because nowadays there is so much information circulating in cyberspace turns out to be wrong, while it is so easy for people to access that information, even then sharing it through various social media so that it has a tremendous viral effect. Information about mental disorders is obtained from the media. So it is very easy for society to be misunderstood even misguided in understanding distractions and seeking appropriate help. So no doubt, psychoeducation to increase literacy must also use information technology and target various social media, especially when we are going to target the younger generation.

Fighting for a Healthy Mental Community through Knowledge Advocacy

Efforts at the international level itself have been initiated by WHO through the Mental Health Gap Action Program (mhGAP) program in 2008, which was followed up by publishing the first mental health guide in 2010. Through this mhGAP program, WHO published a guidebook on governance such as treatment for people with mental disorders that are simple

and easy to learn and can be implemented by nonprofessional or non-specialized personnel, such as general practitioners, clinical organizers, and nurses. The term used is "low intesity psychological intervention", called "low intensity" because it refers to the use of specialists at a not-so-high level, for example using criteria: short, simple, basic, given by a professional psychology, as is common case in books and self-help programs.

Efforts at the national level – Indonesia also includes various levels, the top level is the elite or policy and the second level is the lower level or community. Both levels must be run parallel. One of the top level is through short cut policies, shortcuts to solve problems quickly. One of the things that is done is to reduce the gap of professionals and mental health specialists who become the real issue of human resources, then the Ministry of Health through tiered training for mental nurses or called CMHN (Community Mental Health Nursing) Program. In addition, general doctors are also given training called General Practioners Plus (GP+).

Each component in mental health services at the primary level has different but integrated tasks and functions. GP+ (General Practitioners plus) has a duty to diagnose mental disorders, provide medical procedures and plan rehabilitation for patients who have been discharged from the hospital. Meanwhile, CMHN or Mental Health Nurse has a function as to conduct training and supervision for mental health cadres to conduct screening or identification of mental disorders in the community. Likewise, the role of psychologists is very significant in conducting diagnosis, providing psychological therapy, rehabilitation even in the role of promotion and education which will spearhead the prevention efforts that are an important part in the effort to realize a mentally healthy society.

The second level to be advocated is of course the grassroots level itself, as the subject and at the same time the object of development. Communities must be strengthened to be empowered so that they are able to voice their rights and have the ability to find solutions for their environment. Community programs are also being initiated through Mental Health Standby Village (DSSJ) which is already under way in some locations, although it does not yet have a clear legal umbrella. For example, the launch of Mental health standby village (DSSJ) in Sleman Regency was conducted on November 29, 2012, there are nine villages spread across six sub-districts in Sleman Regency who are also pioneers of DSSJ, through the establishment of DSSJ in Sleman will further strengthen the strength of primary-health services, because psychologists will not work alone anymore, the absence of mental health cadres at the village level will be very useful in doing primary mental health services work. Meanwhile, mental health cadres are more likely to serve as part of the process of participation and empowerment in mental health services. One of the tasks of cadres is to assist in the screening process in the community through the detection of mental health problems.

The involvement of community mental health cadres has not been widely studied, however there have been a number of intensive studies to find solutions to the limitations of mental health workers in poor countries, as was done in India. The studies were conducted on intervention programs involving trained volunteers or mental health cadres and supervised by

mental health professionals or intervention programs involving the community in collaborative work.

Although there are still many pros and cons in the involvement of cadres in the mental health service system, due to the issue of knowledge and education is considered a lack of cadres. The reality exists that most cadres do not have a high formal education background or no one even has an educational background related to mental health, this condition sparked fears in some groups that cons to give the cadres a role. Efforts to bridge these conditions are carried out by providing training and supervision to cadres, so that cadres' capacity and skills can be improved. Training that has been well designed and adapted to the condition of the community will certainly determine the success of cadres in carrying out their duties. In the study, health cadres or referred to as volunteers trained five components of the program which include psychoeducation, adherence to management systems, rehabilitation of referrals to community agents and promotion of validity. Then, all five components are carried out by cadres with supervision from specialists. Granting raining to cadres is seen as the most important part of the cadre's work, as is the case in Kenya, Community Health Workers (CHW) are given adequate training to assist the Ministry of Health in providing assistance to people with HIV/AIDS, with the prevalence reaching 22% of the population and nearly 80% living in rural areas which do not have access to health services. Providing training to community health cadres is seen as a very effective step given the limitations of health infrastructure, especially in psychoeducation for sufferers and the public to prevent more severe problems.

Most of the results showed encouraging results due to the excellent cadre role and can provide significant results on improving intervention outcomes. For example, based on research conducted in three regions of India, it shows that the services provided by trained cadres and given assisted by professionals are surprisingly well received by patients and families. Strengthened by previous research which revealed that providing community intervention by engaging a cadre of volunteers proved effective and economical compared to the usual interventions. Meanwhile, the role of cadres in primary services in India in dealing with depressive and anxiety disorders commonly found in primary services. On the other hand, cadre involvement not only has a positive impact on improving services, but also reduces the cost of care that has a significant impact on patients and the state through declining hospital admission rates, lowering suicide rates, improving satisfaction with services, and reducing the number of drop out from these treatments and interventions is also cheaper. Evaluation of effectiveness and economic value through the empowerment of cadres in community interventions involving cadres proved effective and economical compared to the usual interventions.

Although research on mental health cadres is still limited, research on health cadres engaged in the area of HIV/AIDS treatment, cancer, and tuberculosis can also be used as a reference material in building the concept of developing mental health cadres due to the same condition in these cadres. Various studies which have been conducted about the involvement of cadres or volunteers in health programs have also shown effective and strategic results. For example, the program of counseling people with HIV/AIDS to consistently take anti-retroviral drugs

and perform treatment conducted by local volunteers in Zambia referred to as Adherence Support Workers (AWS) due to limited health staff resources turned out to be just as effective as counseling by Health Care Workers (HCWs). This study was also in line with data identified which revealed that community leaders who were given structured training and supervising (mentoring) in the field were able to play a major role in health care facilities especially in the provision of counseling and testing, and were found to be able to lower excessive burdens for health workers during this time. In line with studies also conducted in the involvement of local workers in the treatment of breast cancer programs, trained volunteers and English-Korean speaking in the Korean immigrant community in America by following up counseling for six months, turned out to be effective in increasing the number of women willing to perform mammography, clinical assessment of breasts and conducting periodic self-checking.

Conclusion

Jorm emphasized that there is strong data on an increase in mental health literacy in different countries. More people who have known different types of mental disorders, know where to get the right information and where to seek help and even know the various tretment for people with mental disorders in several countries. More encouraging results are a decrease in stigma and discrimination and increased acceptance of ODGJ in society. Therefore, health programs require the focus of public policy and community supervision so that all community members can empower each other to take steps to achieve a better mental health condition.

There must be programs at the elite level of government and policy makers and there must be programs at the grassroots level. The role of government elites and policy makers will certainly determine policies which make mental health issues mainstream in the health sector. So that every product of policy be it laws, government regulations or local regulations have a spirit of security and fulfillment of people's mental health rights. Of course this will require policy advocacy to be worked out together by all stakeholders in mental health. The role of psychology is a key in efforts to improve people's mental health, especially in the process of improving MHL as part of promotion and prevention. The existence of psychologists in primary services will be a strategic part of advocating at the elite and grassroots level.

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