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Evaluation summary

Supporting Community Mental Health in Indonesia

THE IMPACT OF OUR COMMUNITY EMPOWERMENT FOR PSYCHOSOCIAL HEALTH, LIVELIHOOD, AND EMERGENCY RESILIENCE IN YOGYAKARTA (CEPLERY) PROJECT IN INDONESIA, 2022–2024.

From 2022 to 2024, CBM Australia supported the Community Empowerment for Psychosocial Health, Livelihood, and Emergency Resilience in Yogyakarta (CEPLERY) project in Indonesia. The aim of the project was to improve the quality of life for people with psychosocial disabilities and their caregivers by enhancing mental health support through community-based rehabilitation, integrating mental health into local governance, and promoting inclusion and resilience.

The project took a multi-pronged approach, focusing on improving the knowledge, productivity, and engagement of people with psychosocial disabilities; fostering family and community support; getting local governments to commit to disability inclusion; and ensuring the coordination of mental health services. It also promoted policy development and raised awareness through public campaigns aimed at creating a more inclusive community for people with psychosocial disabilities.

"This program implemented by Yakkum is highly relevant... It focuses on empowering the community to recognise mental health issues as real problems, rather than something to be hidden, as was often the case before. It emphasises that addressing mental health issues should not stop at healthcare facilities, but also involves the family and surrounding environment."

-District Health Office

Front: Project participant Sugeng.

The project was implemented by Pusat Rehabilitasi Yakkum (PRY) and funded by CBM Australia through the Australian NGO Cooperation Program (ANCP). It was part of a multi-phase initiative that began in 2016 and ran for four years. Based on the successes and lessons of Phase 1, the project expanded in January 2022 with the launch of CEPLERY Phase 2, extending its reach to three additional sub-districts in Yogyakarta. In total, the project has supported 366 people with psychosocial disabilities and 363 caregivers.

2022–2024 ACHIEVEMENTS

The project played a significant role in meeting the needs and aspirations of people with psychosocial disabilities. Community-based rehabilitation (CBR) for mental health was established at the village level, with key elements, such as Self-Help Groups (SHGs), caregiver support systems, and the integration of mental health services into village governance, firmly in place. These elements formed a comprehensive support system, helping create an enabling environment for people with psychosocial disabilities and caregivers. The following provides a brief overview of achievements from January 2022 to June 2024. [1]

Integration into local governance:

Mental health priorities were embedded into local and provincial agendas, fostering a more inclusive, responsive, and resilient mental health system that can better serve people with psychosocial disabilities and their caregivers.

Through Village Development Planning Meetings (MUSRENBANGDes), mental health became an established part of community development agendas, signalling strong local ownership, enhancing sustainability, and helping normalise discussions around mental health.

1 The evaluation period from January 2022 to June 2024 may not fully capture the project's long-term impacts, such as policy changes and shifts in community attitudes toward mental health. This limits the assessment of sustainability and broader systemic impact.

By the end of 2023, three significant mental health policies were enacted on disaster preparedness, suicide prevention, and psychosocial rehabilitation across three districts and at the provincial level. These policies help to strengthen the institutional framework for mental health in the region, integrate mental health into broader governance and disaster management systems, and provide a formal mechanism for sustaining and scaling up psychosocial rehabilitation efforts.

"Before our collaboration with PRY, there was no attention given to people with mental health conditions. Now, with the treatment available, we are greatly helped. Since PRY became involved, both the sub-district office and the village head himself have started to pay attention."

- Mental Health volunteer

Engagement in Self-Help Groups (SHGs):

The establishment of SHGs in marginalised communities brought mental health support closer to those in need and embedded it within community systems. SHGs provided a support network for people with psychosocial disabilities and caregivers, and facilitated access to mental health and livelihoods training. This empowered people with psychosocial disabilities to self-advocate within their families and improved their and caregivers ability manage the disability. In several villages, SHGs were integrated into local governance, enhancing their ability to advocate for mental health resources.

"After joining the Self-Help Group, I received training on how to handle relapses. I also got training on sharing in public, which I used to feel insecure about. But, thank God, there was public speaking training where I learned to speak in front of many people."

- Person with psychosocial disability

Stakeholder training:

The project provided structured training that equipped project staff, village leaders, mental health volunteers, and health providers with the knowledge and skills needed to address the needs of people with psychosocial disabilities effectively.

Training for mental health volunteers enabled vital on-the-ground support, making services more accessible. Increased volunteer capacity, coupled with strengthened commitments from village government at the institutional level, was instrumental in advancing CBR for mental health.

Training for caregivers on early symptom detection, relapse management, and communication strategies increased their confidence and competence, improving the quality of care and fostering a more supporting family environment.

Gender-sensitive training reached 95% of SHG leaders, village authorities, and local government officials, helping meaningful participation for both men and women with psychosocial disabilities. It also led village governments to develop gender action plan, though gender-sensitive mental health governance remains limited.

Employment and livelihoods:

Secure, productive work can significantly enhance the quality of life and social inclusion of people with psychosocial disabilities. Through the project, people with psychosocial disabilities accessed training and start-up kits, and were introduced to livelihood activities such as duck farming, gardening, and batik-making (textiles dying technique). They also engaged in collective income-generating activities through SHGs, enabling them to contribute productively to their families and communities.

PRY is recognised as a resource organisation in community mental health:

PRY is no longer viewed solely as a resource for physical disability issues. Instead, it has become a go-to organisation for local government on community mental health.

Access to mental health services:

The project supported the provision of services to people with psychosocial disabilities in 13 public offices and the integration of mental health services in eight of the 15 targeted Primary Healthcare Centres.

74% of people with psychosocial disabilities accessed psychosocial services in the past six months, with most finding them accessible and the quality satisfactory.

The project addressed the need for consistent access to medication and psychological support for people with psychosocial disabilities by establishing mental health volunteers. These volunteers took on multiple roles, organising SHGs and conducting home visits, enabling substantial outreach in both new and established project areas without depending solely on project staff and professionals in psychosocial interventions.

Sustainability:

Sustainability was embedded into the project's approach, with village policies and budgets now supporting CBR components like SHGs, mental health volunteers, and livelihood initiatives. These efforts support the integration of people with psychosocial disabilities into communities and address their income needs. Given the challenges many face in securing formal employment due to mental health conditions and limited educational opportunities, these initiatives are essential for financial independence and community participation.

Right: Suprihatin has a cognitive disability and is the leader of a SHG.

Awareness and social acceptance:

Social support and community awareness were priorities for people with psychosocial disabilities and their caregivers. Mental health volunteers provided crucial support and community outreach, helping to reduce stigma and build understanding, while SHGs encouraged participation in social and community activities. Mental health guidebooks were distributed to government agencies and villages, and various media platforms were used to spread messages and reach wider audiences.

"Yes, it feels like my knowledge has expanded. You see, we used to just stay in our rooms, and sometimes we were afraid to meet people. Maybe with the Self-Help Group, we who are unwell can open up and find ways to live a more meaningful life...Yes, it feels like having companions, like we're strong together."

- Person with psychosocial disability

Empowerment and advocacy:

Through training and support, people with psychosocial disabilities were empowered to advocate for their needs. By the end of the project, 47% felt confident advocating within their families while only 31% felt confident advocating outside their families, indicating ongoing barriers in broader self-advocacy and confidence.

Left: Sugeng, seen chopping vegetables, has a cognitive disability and owns and operates a hair salon.

CHALLENGES	RECOMMENDATIONS
Group Activity Therapy: Sessions decreased to once per year due to limited therapists, reducing impact, particularly for those with acute symptoms.	**Enhance Structured Therapeutic Support:** Increase the frequency and consistency of group therapeutic sessions, especially for those with acute conditions. This could involve collaborating with universities.
SHG Participation: While high in established project areas, was limited in new regions, indicating the need for sustained engagement.	**Adapt Programming to Less Organised Communities:** In areas with lower levels of community organisation, prioritise foundational capacity strengthening by establishing core community structures like SHGs or Community Mental Health committees. Start with intensive training and awareness campaigns targeting local leaders to build trust and buy-in. Allocate more resources to outreach and mobilisation, using local facilitators to ensure engagement. This phased approach will gradually strengthen community structures to support and sustain mental health interventions.
Broader Community Education: Insufficient due to lack of structured public-facing education initiatives, limiting social inclusion and stigma reduction. Impact was further constrained by placing greater emphasis on mental health rehabilitation over broader promotion and prevention initiatives, which are essential for long-term attitudinal shifts and stigma reduction.	**Intensify Community Education and Inclusion:** Implement public education campaigns to promote accurate mental health information, engaging local leaders and influencers. Design community-wide initiatives such as community events, to foster dialogue and acceptance.
Livelihood Activities: Lacked sustainability and follow-up support, risking dependency and setbacks. Focused on people with stable conditions.	**Integrate Sustainable and Tailored Livelihood Strategies:** Strengthen livelihood support with sustainable elements like market assessments, ongoing mentorship, and skill development tailored to local context. Customise livelihood programs and use a phased approach to cater to people with varying levels of stability and functionality.
Indigenous Knowledge: Underutilised, despite potential to enhance rehabilitation with local resources and culturally-rooted approaches.	**Incorporate Indigenous Knowledge:** Integrate local traditions and cultural practices into mental health programs to enhance community-based rehabilitation and provide culturally relevant support.

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