

ORIGINAL ARTICLE

Mental Health Screening in North Sulawesi, Indonesia: Kessler 6 pilot data and needs assessment results from the LearnToLive Indonesian Health Initiative

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community mental health service, Indonesia, Kessler 6 screen, mental health, needs assessment (health services accessibility)

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Received 3 March 2015

Accepted 18 August 2015

DOI:10.1111/appy.12211

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Abstract

Introduction: Communities around the world are increasing their focus on mental health and substance use disorders. However, the struggle to identify and treat patients remains great. The sequelae of these disorders, including severe chronic disability and suicide, are significant, and its impact is felt most in lower and middle-income countries. In the rural and underserved region of North Sulawesi, Indonesia, there are limited data published regarding the prevalence of depression, anxiety, and other symptoms of psychological distress.

Methods: In order to characterize and quantify some specific areas of psychological distress, the LearnToLive Indonesian Health Initiative completed a retroactive review of Kessler 6 data from 697 people in rural communities of North Sulawesi.

Results: Our results demonstrate a rate of near 10% for psychological distress, particularly with anxiety and depressive symptoms. We also found that the village of Sapa scored higher on most of the subcomponents of the screen compared with the other villages in the study.

Discussion: While the Kessler 6 screening tool is not diagnostic, our results suggest significant mental health issues in need of further exploration and research. We found that these results exist in an environment with high stigma, limited education regarding mental illness, and limited outpatient services. The results from this analysis will hopefully guide future mental health education in the region and will ultimately assist in the development of the clinical infrastructure needed to effectively identify, treat, and manage mental health conditions.

Introduction

Mental health disorders are a large burden on overall health care. In 2012, the World Health Organization (WHO) published a report specifically highlighting the global impact of mental health and substance use issues on communities in developing countries (WHO, 2012). They presented information regarding suicide rates and the specific populations and countries most impacted. Part of their conclusion was a reminder that mental disorders reduce an individual's ability to function and can often lead to chronic disability and pos-

sibly suicide. In fact, not accounting for the additional risk of suicide, mental health and substance use is the fifth leading cause of disability globally (Ferrari *et al.*, 2014).

The Global Burden of Disease Study 2010 quantified the economic burden of noncommunicable diseases (Lozano *et al.*, 2012). The findings reflect a growing consensus among global health experts and economists that the largest source for future costs in health care will be mental disorders, one third of the global economic burden of noncommunicable diseases by 2030. In 2010, they accounted for approximately

7% of the total burden of disease versus 5% in 2000 and 4% in 1990 (Institute for Health Metrics and Evaluation., 2013). Taken together, the direct economic effects of mental illness (such as spending on care) and the indirect effects (such as lost productivity) already cost the global economy approximately \$2.5 trillion per year (Insel *et al.*, 2015). The forecast is continued rapid growth in the next 15 years. By 2030, the amount will increase to around \$6 trillion, more than heart disease and more than cancer, diabetes, and respiratory diseases combined (Insel *et al.*, 2015).

Financial constraints are a global problem, but in nations with smaller gross domestic product (GDP) providing resources to educate clinicians, to improve access to care, and to ensure evidence-based and current treatments can be especially challenging. Indonesia is considered a lower middle-income country with a GDP/capita of \$5,200, with 2.9% of its total GDP allocated to health services (OECD/WHO, 2014). Indonesia has less than one psychiatrist per million, and the country only has 48 mental health hospitals (OECD/WHO, 2014; WHO, 2011). In the region of North Sulawesi, there are only five actively practicing psychiatrists in private and public settings for a population of 2.3 million people.

Unfortunately, the overall burden of illness can be felt hardest in lower and middle income countries when there is significant disability related to illness, severely limited access to care, and clinical and financial resources are stretched thin. In the long term, the countries not proactively addressing mental health issues may face further hardship in the future based on associated potential physical illnesses and disability, as well as financial difficulties.

With the assistance of WHO mental health action plans, more countries are developing and passing legislation that addresses these important issues. Indonesia is one example, where dedicated mental health laws are evolving. A new national policy was passed in 2014 after 5 years of drafts and debate (WHO, 2014). Prior to this, Indonesia's policy on mental health was not firmly enforced, so there was little to improve quality, coverage, or community acceptance of people with mental health disorders.

Indonesian mental health: Review of literature

There are very limited published data on the prevalence of mental illness in Indonesia. It is quoted that 11% of the country is suffering from some form of a mental disorder (Vitelli, 2011). Several national studies completed over the past 20 years have attempted to quantify and qualify the types and preva-

lence of illness. The first was a national prevalence study done as part of the Indonesian Psychiatric Epidemiology Network. It was completed in the mid-1990s and looked at mental health problems in 11 cities within Indonesia (Directorate of Community Mental Health and Directorate General of Community Health Department of Health and Social Welfare, 2001). Another study, the *National Health Household Survey*, was organized by the National Institute of Health Research and Development in conjunction with the Ministry of Health in 1995 (Directorate of Community Mental Health and Directorate General of Community Health Department of Health and Social Welfare, 2001). A later national survey, *The Proportional Study of Mental Disorders*, was completed during 1996–2000. This survey was completed by the Ministry of Health in 16 cities around Indonesia. Data specific to the disability related to mental illness in Indonesia are also scarce, but one report estimates that neuropsychiatric conditions contribute to 10.7% of global burden of disease (WHO, 2011).

Most of the recent data regarding psychiatric illness have focused on the areas of Aceh (Musa *et al.*, 2014) or East Timor (Silove *et al.*, 2008), where recent natural disasters or political unrest have led to fertile grounds for research. However, given the diversity of the nation, the data are not always generalizable to some of the more rural provinces. Indonesia as a whole is a country of over 17,000 islands with over 350 separate cultural groups (Pols, 2006). The region of North Sulawesi is unique in that it is predominantly Christian and represents a part of the nation that has less economic resources as compared with the populated cities of Central and Western Java (i.e., Jakarta and Bali). To our knowledge, no research exists on specific psychological evaluations in rural communities, such as North Sulawesi, Indonesia, and there are no published data for mental illness rates and prevalence of psychological distress in this region.

LearnToLive Indonesian Health Initiative 2014

LearnToLive is an international humanitarian non-profit organization based in the US and Australia. LearnToLive has worked collaboratively with numerous communities in North Sulawesi since 2012. Conducting initial general health consultation during these visits revealed a clear need for psychiatric assessments based on observed and reported suicidal ideation, trauma, anxiety, and depressive symptoms.

We also learned of several suicides in the Siladen region, and one tragic event of a psychotic individual killing and injuring several members of his village in

Beringin. While these latter cases are the more extreme instances we encountered, a variety of psychosocial stressors, such as domestic violence, intergenerational pressures regarding westernization, financial insecurity, and poverty, were identified as some of the more common contributing factors for psychological distress. For people presenting with these symptoms, it was often noted that our interactions were the first they had ever had with a medical practitioner or specialist. Lack of access, either due to financial or geographic constraints, isolation or limited education, and stigma created barriers for local populations to receive assistance. For these reasons, the LearnToLive Indonesian Health Initiative was charged with the goal to complete an initial needs assessment in North Sulawesi in addition to our pilot study, investigating the psychological distress in the communities published here.

Methods

In early 2014, the LearnToLive team started working on its mental health initiative and the institutional review board approved research protocol. The purpose of this study is to assess the prevalence of psychological distress symptoms in rural and remote mainland and island populations of North Sulawesi, Indonesia. The sample population consists of subjects who voluntarily chose to attend the LearnToLive health clinics in the communities of Likupang, Sapa, Siladen, Bunaken, and Beringin, North Sulawesi, Indonesia. The patients participating at these clinics gave consent for the screening with the option to not answer any or all questions depending on their comfort level. Patients were additionally offered the opportunity to discuss specific concerns in a private or alternative setting if they felt uncomfortable or unable to discuss in the identified setting. As a means to protect patient privacy, no names were used on the forms documenting Kessler 6 (K6) responses.

This study is a retroactive chart review study using data collected via the K6 questionnaire screening tool, which was professionally translated into Bahasa Indonesian (Appendix I) as part of their routine intake assessment from July 26–August 15, 2014. All data were entered into an Excel file and subsequently inputted into Stata 12 (StataCorp LP, College Station, TX, USA). Descriptive statistics and cross-tabulations by location were run. Count (frequency), percentage, and cross-tabulation results are presented in Tables 1 and 2.

Twelve local translators, all educated to at least a tertiary level, surveyed the patients in a scripted interview based on the K6. All translators were employed by the LearnToLive medical team and provided with appropriate training to assist the medical team and the delivery of the K6 to the target population. Prior to the initiation of the clinics, orientation and training included an explanation of the study goals, the screening tool, and a description of the survey and translated documentation to assist understanding and interpretation. Scenario-based exercises and practice interviews were also undertaken. Training emphasized the necessity for an accurate presentation and completion of the K6 questions in a manner that was consistent and with minimal independent interpretation.

The Human Research Ethics Committee of Tulane University School of Medicine, the North Sulawesi Ministry of Health, and chiefs in the villages of Beringin, Bunaken, Likupang, Sapa, and Siladen approved the study. LearnToLive also has a memorandum of understanding with the North Sulawesi Ministry of Health and Division of Family Health that outlines the ongoing support for the Indonesian Health Initiative and its projects.

K6 screening scale

Initially developed for use in the US National Health Survey and the National Household Survey on Drug Abuse, the K6 uses psychometric methods to assess

Table 1. Frequency and percentage of Kessler 6 scores

	Location									
	Beringin		Bunaken		Likupang		Sapa		Siladen	
K 6 score	Frequency	Percent (%)								
Greater or equal to 10	15	14	17	11.8	30	14.9	45	22.5	4	9
Greater or equal to 13	10	9.3	9	6.2	16	7.9	31	15.5	2	4.5
Total	107	–	144	–	202	–	200	–	44	–

Table 2. Kessler 6 (K6) scores by location and response

K6 question		Location					Total
		Beringen	Bunaken	Likupang	Sapa	Siladen	
Nervous	Missing	1	0	0	0	0	1
	0	41	63	76	61	22	263
	1	38	50	59	67	11	225
	2	16	21	44	49	8	138
	3	11	9	17	18	3	58
	4	0	1	6	5	0	12
	Total	107	144	202	200	44	697
Hopeless	Missing	1	0	1	0	0	2
	0	63	86	114	104	29	396
	1	25	31	43	47	12	158
	2	9	17	28	30	2	86
	3	8	9	13	16	1	47
	4	1	1	3	3	0	8
	Total	107	144	202	200	44	697
Restless	Missing	3	1	4	1	0	9
	0	19	44	54	38	15	170
	1	43	48	61	57	10	219
	2	24	34	46	63	16	183
	3	13	11	24	30	3	81
	4	5	6	13	11	0	35
	Total	107	144	202	200	44	697
Cheer	Missing	1	0	1	1	0	3
	0	62	94	129	97	33	415
	1	25	24	38	51	7	145
	2	11	17	21	27	4	80
	3	7	9	9	19	0	44
	4	1	0	4	5	0	10
	Total	107	144	202	200	44	697
Effort	Missing	1	0	0	0	0	1
	0	45	65	94	73	24	301
	1	32	51	42	47	14	186
	2	17	17	48	42	5	129
	3	12	11	12	29	0	64
	4	0	0	6	9	0	15
	Total	107	144	202	200	44	697
Worthless	Missing	1	0	2	0	0	3
	0	70	110	130	110	29	449
	1	19	17	40	42	7	125
	2	5	11	18	26	5	65
	3	11	6	9	15	3	44
	4	1	0	3	7	0	11
	Total	107	144	202	200	44	697

Nervous, feeling nervous; Hopeless, feeling hopeless; Restless, feeling restless or fidgety; Cheer, feeling so depressed that nothing could cheer you up; Effort, feeling that everything was an effort; Worthless, feeling worthless.

prevalence of serious mental illness within a given population (Kessler *et al.*, 2002, 2003, 2010). It is specifically designed to evaluate symptoms consistent with cognition, behavioral, emotional, and psychophysical distress against the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM IV) criteria (Kessler *et al.*, 2003, 2010). The questions relate to common symptoms of distress, asking participants to assess how often, in the last 30-day period, they have felt (i) *nervous*, (ii) *hopeless*, (iii) *restless or fidgety*, (iv) *so depressed that nothing could cheer you up*, (v) *that everything was an effort*, and (vi) *worthless* (Kessler *et al.*, 2010).

Using standardized scoring, each question is measured on a scale of 0 (*none of the time*) to 4 (*all of the time*). A participant's score is the sum of all six questions. A threshold score of 13 is identified as the cutoff point indicating the potential for serious mental illness in this study (Kessler *et al.*, 2010; Prochaska *et al.*, 2012). Scores between 8 and 12 are indicated as "probable" markers of moderate mental illness, and thus a score of 10 or greater may be used to measure mild to moderate symptom prevalence (Kessler *et al.*, 2006). As reflected in our data review, scores between 10 and 13 have been quantified to indicate moderate nonspecific levels of distress, relevant for follow-up consultation and tracking.

The K6 was chosen for the mental health component of the LearnToLive Indonesian Health Initiative 2014 as it is a widely accepted and utilized tool in other population-based studies. Several international studies have identified consistent validity in cross-cultural settings in Africa (Baggaley *et al.*, 2007; Tesfaye *et al.*, 2010), Europe (Carrà *et al.*, 2011), and the Asia-Pacific region (Furukawa *et al.*, 2008; Patel *et al.*, 2008). It has also been previously validated in numerous languages worldwide, and therefore could be quickly adapted to identify pilot data in our clinical setting of North Sulawesi.

Our version was specifically translated into Bahasa in collaboration with our interpreting team using the standardized US English version. The community "forward only" method of translation has been evaluated as a technique by other research teams as an alternative to the standard "back translation" model when, as in our situation, the number of available translators is limited and when it can be pretested with native speakers (Maneesriwongul and Dixon, 2004). In our case, consultation with our interpreting team regarding various K6 translations was conducted in order to identify words and meanings that needed further clarification based on local dialectical understandings. We discussed these findings and finalized

our K6 version as a group. This technique, while not ideal, has been described in the literature as an accepted technique when the goals of the study are focused and not intended to produce comparative cross-cultural results (Maneesriwongul and Dixon, 2004). In addition to this, selection of the K6 allowed for a standardization of techniques across interviewers, with interviewers trained on administering the questions in a complete and nonjudgmental manner. This led to a systematic method of administering questions and recording responses, but also allowed for ongoing supervision of the interviewers to improve and monitor the quality of the interview. Efforts such as these can become critically important in multi-language studies (Small *et al.*, 1999).

Results

A total of 697 patients completed a K6 screen. Table 1 provides a breakdown of K6 scores by location. A total of 68 participants (9.8%) scored greater than 13, and 111 participants (15.9%) scored 10 or greater. Sapa had the greatest number of participants reporting a 10 or greater (22.5%) and a 13 or greater (15.5%). Siladen had the least positive scores (9.0%, 4.5%, respectively). We are currently unable to comment explicitly on the participation and refusal rate. However, in the previous 2 years, the LearnToLive Indonesian Health Initiative saw approximately 800 patients each year (including adults and children). Assuming similar patient numbers in 2014, it is likely that the K6 refusal rate was less than 15% of eligible patients.

Responses from the individual K6 questions are illustrated in Table 2. Responses regarding *restlessness and feeling fidgety* received the most affirmative responses (score of 3 or higher – symptoms experienced most or all of the time) and served as the highest positive screen in all the villages, representing 16.6% of all participant responses ($n = 116/697$).

Conversely, many participants reported never feeling any symptoms. About 38% reported never feeling *nervous*, 56.8% reported never feeling *hopeless*, 24.4% reported never feeling *restless*, 59.4% reported never feeling *so depressed that nothing could cheer them up*, 43.2% report never feeling *that everything required effort*, and 64.4% reported never feeling *worthless*. The symptoms of *feeling so depressed that nothing could cheer you up*, *feeling hopeless*, or *feeling worthless* received the fewest affirmative responses across all locations, present in 7.7% of responses ($n = 54/697$), 7.9% of responses ($n = 55/697$), and 7.9% of responses ($n = 55/697$), respectively.

Siladen showed the lowest positive screens in all areas but one. In Siladen, *feeling nervous* was reported at 6.8%, *feeling hopeless* was 2.3% of responses, *feeling restless or fidgety* was 6.8% of responses, *feeling so depressed that nothing could cheer you up* was 0.0% of responses, and *feeling everything was an effort* was 0.0% of responses. The village of Bunaken had the lowest positive of responses for *feeling worthless*, where it was reported at 4.2%.

By location, the village of Sapa had the greatest number of participants reporting a K6 of 10 or greater. Moreover, Sapa showed the highest percentage of individually reported symptoms of 3 or higher in all except one category. It had the greatest number of respondents *feeling nervous* (11.5%), *feeling hopeless* (9.5%), *feeling restless or fidgety* (20.5%), *feeling so depressed that nothing could cheer you up* (12%), and *feeling everything was an effort* (19%). This *restless and fidgety* response also represented the symptom most frequently reported by any site. The village of Beringin had the only other high response rate on one of the screened core symptoms: *feeling worthless*, 11.2%.

Discussion

Our pilot data demonstrate a substantial portion of this rural population reports experiencing distressing psychological symptoms. There are some unique differences reported in these neighboring communities. We also found specific symptom overlap in these five villages of North Sulawesi.

It was surprising to find variation between the five villages surveyed in this study. The village of Sapa had the highest rate of overall positive responses. During our fieldwork, we did not identify specific etiologies for the elevated responses and were surprised at the high number of positives in this community. Sapa has a comparative high level of economic stability, is well organized, and has not encountered recent natural disasters that may have triggered this. We propose that comorbid factors such as substance use, domestic violence, or increased levels of westernization may be factors that have not been accounted for in the K6 screen. Also, this high rate may be due to this village's active participation in the health initiative over the past several years and may reflect their comfort level with our clinic model.

The low number of positive screens found in Siladen was surprising because we expected to find a much higher rate. This community had several suicides over the year prior to this study, and therefore we considered we might find a continued high

response of reported distress. In discussions with the village chief, we found that domestic violence and trouble dealing with domestic economic disparities were particular stressors in the community. Limited employment opportunities within the village and ongoing exposure to and hosting of visiting tourists at the foreign-owned resorts may have also contributed to ongoing stressors, in an otherwise subsistence lifestyle. These issues, unfortunately, were not considered within the K6 screen.

The rates of the reported *feeling restless or fidgety* was quite an interesting finding. The idea that a physical complaint is a symptom of psychological distress is not novel, as somatization symptoms are more common in particular East Asian cultures as an expression for mood disorders (Marsella et al., 1973). It may be more acceptable to report a physical complaint as opposed to *hopelessness* or *worthlessness* for instance. Both of which were reported less frequently in our screens. Although recent studies by WHO show comparable rates of somatization in developing and developed countries (Gureje et al., 1997), the symptom of *restlessness* may be a more valid starting point for further psychiatric evaluation.

The pilot data presented here are the results of screen questionnaires that were given to a group of voluntary patients that self-selected to our outpatient community health clinics in August 2014. The patients who screened positive (K6 > 13) did receive psychiatric evaluation at the time of presentation to investigate the reported symptoms in detail and gather diagnostic clarity. Those results will be presented in a separate report, as this report is focusing on the pilot data regarding symptom clusters and its related psychological distress. We were able to achieve a high response rate in phase one of this project. Nevertheless, resource constraints prevented us from assessing for possible false negatives by additionally interviewing a random subsample of those who did not reach cutoff scores.

We did have several limiting factors that may be influencing the results listed above. All attempts were made to make the translated version of the K6 culturally relevant and easily understandable; however, our K6 was not validated for Bahasa Indonesia. We were dependent on a small group of qualified interpreters to administer a pretranslated K6, and we faced some difficulties with translations despite local translators, translated scripts, and training. Despite these hurdles, our translators were instructed to maintain to the script as close as possible and only provide more in-depth explanation when the patients were not able to understand the questions.

Several patients were simply unfamiliar with the western concepts of depression and anxiety. They frequently reported that “no one has ever asked me that before,” so an understanding of the questions may have influenced some of the responses. Our interpreters often were forced to explain or elaborate on the descriptors of depressed mood and anxiety. The interpreters often spoke of the difficulty to convey the symptoms of *nervousness* or *restlessness and fidgety*. This speaks to the potential differences in which the local culture expresses psychological symptoms. Interpreter recall, feedback, and elaboration of a patient’s responses did require careful interpretation and clarification. As mentioned earlier, the symptom of *restlessness and fidgety* may be as solely a physical symptom not associated with psychological distress and could be misinterpreted by our study group. We are aware and emphasize that the results described here are part of an initial pilot project and only apply to the specific group studied. Although our long-term goal is to have a broader study that allows for a cross-cultural comparison, the limitations of our tool presently prevent this type of investigation.

Another obstacle that we faced is possible underreporting. Our clinics were voluntary and patients were free to opt out of the mental health screening portion. Given that clinics were held in large, open areas with patients often surrounded by family, neighbors, and other members of their community, concerns about privacy and confidentiality could certainly have affected willingness to report symptoms. Even though our sense is that patients welcomed the chance to discuss their mental health concerns, some patients may have been uncomfortable disclosing symptoms in this setting. In traveling around these villages, we were asked to do home visits for family members whom the villages were concerned about. This could be another area of underreporting of the more symptomatic people in the community as they either chose not to or could not attend the clinics. As noted above, our cutoff score was predetermined at 13 as an indicator for serious mental illness. Patients who did not reach this score may not have been referred by clinicians during the health initiative clinics, potentiating the risk of not identifying mental illnesses in the moderate range of scores.

These surveys were also completed in various communities with diverse demographics, levels of employment and income, health status, and co-occurring substance use, so comparing the isolated farming village of Beringen with the tourist destination of Siladen and Bunaken might be difficult to generalize to the region of North Sulawesi.

Preliminary data in this limited pilot study demonstrate that there is a significant percentage of the population in North Sulawesi reporting psychological distress. The reported symptoms may represent early and developing mental problems or reflect more serious and persistent disability, but many of these reports come from people that have never been asked about such symptoms, and we think this population can benefit from early intervention, education, and treatment. We suggest a clear need for more thorough and structured population-based studies in this area of Indonesia. Our team also identified significant deficits in referral processes available to local communities. So, in an attempt to both identify areas of further research, we propose that there should be a concerted focus on access to care and care coordination in North Sulawesi, Indonesia.

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Appendix I

Translated Kessler 6 Bahasa Indonesian

Prakarsa Kesehatan Mental Tanggal:

Lokasi:

Pertanyaan-pertanyaan berikut diadaptasi dari K6 dan menanyakan tentang bagaimana perasaan Anda 30 hari belakangan. Untuk masing-masing pertanyaan, mohon lingkari nomor terbaik yang menjelaskan-seberapa sering Anda mengalami perasaan seperti ini.

Selama 30 hari belakangan, seberapa sering anda merasakan:	Tidak Pernah				
	Sama Sekali	Jarang	Kadang kadang	Sering	Selalu
A) Gugup?	0	1	2	3	4
B) tak ada harapan/Putus Asa?	0	1	2	3	4
C) Gelisah/Resah atau Tidak Bisa Tenang?	0	1	2	3	4
D) sangat depresi/tertekan sehingga tak satu halpun yang dapat membuat anda gembira?	0	1	2	3	4
E) bahwasanya sangat sulit untuk melakukan segala sesuatu?	0	1	2	3	4
F) tidak berharga/bernilai	0	1	2	3	4

Total:(penjumlahan jawaban yang dilingkari):

Catatan: Skor 13 atau di atasnya secara otomatis dikonsultasikan ke kesehatan mental.

Catatan untuk pewawancara: Semua kata-kata tebal dalam pertanyaan harus ditekankan dengan perubahan nada suara. Jika klien memberikan respon yang tidak termasuk di antara respon pra-penentuan, ulangi pilihan respon. Biarkan kotak isian kosong hanya jika pasien menolak untuk menjawab.

Q1a: Pertanyaan-pertanyaan berikut menanyakan tentang bagaimana perasaan Anda selama 30 HARI BELAKANGAN. Tentang seberapa sering dalam 30 hari itu Anda merasa GUGUP— apakah SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?

Q1b: Dalam 30 hari belakangan, seberapa sering Anda merasa putus asa— SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?

Q1c: Dalam 30 hari belakangan, seberapa sering Anda merasa gelisah atau tidak tenang: SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?

Q1d: Dalam 30 hari belakangan, seberapa sering Anda merasa depresi bahkan tak ada yang dapat menghibur Anda? SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?

Q1e: Dalam 30 hari belakangan, seberapa sering Anda merasa bahwa segala sesuatu adalah usaha: SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?

Q1f: Dalam 30 hari belakangan, seberapa sering Anda merasa tak berguna? SETIAP SAAT, SERING KALI, KADANG KALA, JARANG, TIDAK PERNAH?