Dissertation

Perception, Attitude, and Consultation of Community Health Workers in Indonesia Concerning Possible Patients with Mental Disorders

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Perception, Attitude, and Consultation of Community Health Workers in Indonesia Concerning Possible Patients with Mental Disorders

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Abstract:

Background:

Community health workers called *Kaders* have contributed to community health in Indonesia, like other developing countries. *Kaders* had mainly worked for maternal/child health, while their activity for community mental health just has been beginning. The aims of this study were 1) to know their perception and attitude toward possible patients with mental disorders, 2) to compare them in the *Kaders* trained for mental health with those in the untrained, taking years of *Kader's'* experiences into account, 3) to know who *Kaders* consult about the patients and whether it is associated with the experiences in actually meeting a patient with mental disorders, 4) to know *Kaders'* satisfaction with mental health training and opinion about mental health service, and 5) to examine the association of *Kaders'* health locus of control (HLC) with their background and the above consultant.

Methods:

In the five districts of Yogyakarta Special Province, Indonesia, 800 *Kaders* were invited to a self-administered questionnaire survey through collaboration with the Public Health Centers (PHC) in June to September 2013, and 619 (77.4%) anonymously responded. The questionnaire included questions on sociodemographic information, perception toward possible patients with mental disorders, consultation with the patients, experiences in mental health training, HLC, etc., for the above purpose.

Results:

The *Kaders* perceived the possible patients unlikely to recover and to able to make a decision, having a low risk for violence, but less serious, and less willing to spend time or socialize with them, compared with the general population in the US and Japan. Only 29.2% of the *Kaders* experienced mental health training. Although they were satisfied with the training, limited association of the training with the perception was observed, particularly among those with long experience of *Kaders*. If they meet a similar person, they intended to consult with PHC or community leaders. Only those in a district including a mental hospital tended to consult with the hospital. However, those who actually met possible patients seemed to be more optimistic toward the prognosis of the possible patients. In addition, the above perception, attitude, and consultation were partly associated with HLC, although the association was weak.

Conclusion:

Their perception and attitude may be affected by the fact that they rarely see the patients get recovery from treatment. Only limited efficiency of mental health training for the perception was confirmed, suggesting the need to revise program of the training, in order to improve the perception and attitude. That should include the need of treatment, causes, prognosis, and appropriate actions of treatment and rehabilitation for mental disorders.

Keywords: attitude, community health worker, consultation, health locus of control, mental health, Indonesia, perception

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Wardaningsih S, Kageyama T (2017) The correlation between demographic data of Kaders' to Health Locus of Control score and the opinion about mental health services in Indonesia. Advanced Science Letters, 23 (12), 12580-12583.

1. Introduction

Empowering community as a partner with public health service has been a method to activate community health program for at least 50 years (WHO, 2007b). In low- and middle-low- income countries, community health workers (CHWs) are common partners for a health profession. CHWs are usually the residents selected out of their community members by their communities, and help the communities to access to health services. They should be answerable to communities for their activities, and should be supported by the health system but not necessarily a part of its organizations and have shorter training than professional workers (WHO, 2007b). The importance of CHW has been emphasized by WHO for at least fifty years, and the World Health Report 2006 appealed working together for health engaging CHW for preventive, curative, and rehabilitation intervention.

In Indonesia, CHW called *Kader* has been worked for three decades. They are community health volunteers for general health of both urban and rural residents, particularly working in the field of maternal and child health (Zulkifli, et al., 2007; Iswarawanti, 2010) and also for health among the elderly (Suwarsono, 2010). They are important coworkers of health projects provided by Primary Health Center (PHC), a branch of local government. PHC is located in every sub-district including near 30,000 residences. In cooperation with *Kaders*, the nurses in PHC contact with the community directly and also work for case management

(Department of Health-Social Welfare Indonesia, 2001).

Mental health is an essential part of health, as the appeal “No health without mental health” by WHO, and WHO recommended in 2005 that every country should begin community-based mental health service. According to the WHO survey (WHO, 2009d), the prevalence rate of schizophrenia tends to be higher in Oceania, the Middle East, and Southeast Asia while Australia, Japan, the United States (US), and Western Europe show low prevalence rates. However, the reason for the regional difference remains unclear. Those who have mental disorders have some difficulties to deal with their condition, and often experience a low quality of life (QOL) (Prasetiyawan, et.al, 2006). Although their QOL can be increased by the support from the community, the negative experiences for community members to meet them are confounded by stigma and inappropriate access to mental health services. It is shown that QOL among the patients with mental disorders was rated good or very good by 90-92% of those who saw friends or family at least weekly, those who attended social or leisure events or facilities at least monthly, and those who felt they had at least three people that they could count on. In contrast, 72-79% of those with poorer social support rated their quality of life as high (Prasetiyawan, et.al, 2006).

Since awareness of the importance of mental disorders as a public health issue has greatly increased, and mental health has emerged on the policy agenda in many countries, these

countries have developed or revised their policies, programs, and legislation system related to mental health. However, the resources provided for the prevention, treatment, and rehabilitation in mental health has remained short, as is the case in Indonesia. One-third of countries belonging to WHO still have no special budget for mental health. As a result, many persons with mental disorders are not supported by appropriate facilities and infrastructures, and their human rights are not protected. The Basic Health Research (Riskesdas, 2007) conducted by the Health Ministry, Indonesia, shows that more than one million persons in Indonesia are at high risk of severe mental disorders, are receiving treatment in mental hospitals. The disability-adjusted life-years (DALY) of schizophrenia in Indonesia is nearly double that of Australia with 321,870. Although exact prevalence rate of depression is unknown, suicide mortality rate of patients with depression in Indonesia is 24 per 10^5 persons. Depression as one of most leading of disabilities is often undiagnosed and untreated.

In addition to the situations, stigma in community often prevents case-finding and treatment for those with mental disorders (Kaligis, 2011), as is already shown in the two studies among the general population in the US and Japan (Indiana Consortium for Mental Health Services Research, 1996; Yamazaki, et al., 2012). According to the results of two studies, discrimination against mental disorders was not so plain among the respondents in the general population, although they feel anxious and confused for having personal relationships with the

possible patients with mental disorders.

Since *Kaders* have done a good job in the field of community health, they are also expected to work great for community mental health. However, they began to work in the field of maternal and child health at first, and have an only short history for community mental health training. Their performance for mental health has not been confirmed except in limited areas. Although part of them have experienced mental health training, the efficiency of the training program has not been examined well. Since they are not the medical professionals, they do not need to determine medically correct diagnosis or treat the patients with mental disorders. It is important for them to perceive medical needs of possible patients, and to appropriately introduce them to the medical profession, e.g. PHC.

It is, therefore, necessary to clarify their perception and attitude toward possible patients with mental disorders, as shown in the study from the U.S. (Pescosolido et.al, 1996) and Japan (Yamazaki 2012). How do *Kaders* perceive the seriousness, ability, risk of violence and self-harm, and prognosis of the possible patients? How is *Kaders* willing to have social interaction with the possible patients? It is also important to know their primary consultation just after case-finding; namely, who do they consult about the possible patients. Since the above information has not been collected before the mental health training for *Kaders* has begun, the efficiency of the training program cannot be confirmed directly. So we first need to examine the difference

between the trained and the untrained *Kaders* through a cross-sectional survey. However, it should be considered that the above perception, attitude, and consultation may be associated with the difference in generation, educational background, the impression of patients a *Kader* actually met, or a *Kader's* health locus of control (HLC), which affect the understanding for the sources regulating their health (Wallston,1976). The cross-sectional data can provide the strength and weakness of *Kaders* to work for community mental health, which is useful information to argue the role of *Kaders* in community mental health and appropriate training about mental health in line with the Mental Health Act (2014) in Indonesia. This is also helpful to discuss the role of CHW in other countries.

Thus, the author decided to make an investigation of *Kaders'* perception, attitude, and consultation concerning possible patients with mental disorders in Indonesia. This was examined in consideration of their experiences, particularly the experiences in mental health training, and HLC. History of mental health training, which began after the earthquake in Indonesia, also should be taken into account. The aims of this study were as follows;

1) To know the *Kaders*' perception and attitude toward possible patients with mental disorders,
2) To compare the perception and attitude in the *Kaders* trained for mental health with those in the untrained, taking years of *Kader's* experiences into account,
3) To know who *Kaders* consult about the possible patients, and whether this or the perception

and attitude in 2) is associated with the experiences in actually meeting a patient with mental disorders,

4) To know *Kaders'* satisfaction with mental health training and opinion about mental health service, and

5) To examine the association of *Kaders'* HLC with their background and consultation as mentioned above.

2. Literature review

2.1 *Kader* as a community health worker and his/her mental health activity in Indonesia

History of *Kaders* in Indonesia is as follows. To overcome the problems of maternal and child mortality in Indonesia, Posyandu, which is an abbreviation of *Pos Pelayanan Terpadu* (Integrated Service Office), was established for each sub-district in the 1970s, and *Kaders* began to participate in health program provided through Posyandu (Iswarawanti, 2010). A PHC usually has several Posyandu, each of which is responsible for 100-150 residents. A *Kader* is chosen by each community according to Posyandu recruitment, being supported by community leaders. Since *Kaders* are volunteers to work in the community, there is no special requirement other than ability to read, physical health, their income, being a permanent resident in the local village, being active in the community, and being able to work as a volunteer in the community (Zulkfili, 2003). PHS held a mini-workshop (Lokmin in Indonesian terminology) every month to monitor and to evaluate the activities performed by Posyandu. PHC trains *Kaders* to improve and review their ability, throughout refreshing activity for each month, e.g. presenting new information on diseases and health, checking the number of working days and home-visiting as *Kaders*. The operating costs for all the activities are budgeted by a local government for each PHC (Departemen Kesehatan Republik Indonesia, 2014).

Some previous studies have shown successful performances of *Kaders* for the health care system in Indonesia; e.g. National Survey 2007 emphasized the importance of Posyandu

managed by *Kaders* as a public health tool. There are increases in health care coverage, especially for maternal and child health services, and also increases in improving the nutritional needs through health education, assisting health check-up, and finding cases with special health needs (Iswarawanti, 2010). Also, *Kaders* have played their roles well for the duties of public health care in the field of elderly health, involving the community in the health program, managing monthly meetings and reporting (Suwarsono, 2011).

2.2 Recruiting and training *Kader*s for mental health services

Mental health and behavioral disorders occur around the world, even in man and woman in the lifespan, among urban and rural area, in any economic situation. It is predicted that 450 million people around the world are distressed by some type of mental disorders, including behavioral disorders and drug addiction (WHO, 2001a). It is estimated that lifetime prevalence ranges from 12.2% to 48.6% and 12-month prevalence between 8.25% and 29.1% (WHO, 2008c). Community's perception of mental health varies across the culture, and there are various myths and beliefs regarding mental health (Arnault.DS, 2009).

Indonesia is a developing country and has not put the priority on the budget for mental health, whereas mental health is a huge problem in Indonesia. Mental health care in Indonesia is still far from the standard of developed countries. Many persons with mental illness have no access to mental health service. Primary health services do not give priority to mental health

matters. The skills of primary health clinicians are not quite good. The quality of mental health service in the hospital is poor, and conventional treatment like giving typical psychotics without other treatment is dominant. Among 2,404 public and private hospitals in Indonesia, only 27 have mental health services.

Only a part of public hospitals in Indonesia provides inpatient-unit services for those with mental disorders, although some of them have psychiatry clinic.

Since *Kaders* in Indonesia were primarily organized for maternal and child health, and also for health among the elderly, their role for mental health has not been stressed for a long time even in the above hard situation concerning mental health. It was an epoch-making event for Indonesia and *Kaders* to experience a terrible earthquake in 2005. The earthquake attacked Sumatra Island, and a vast number of residents suffered from tsunami disaster. Then, some mental health professionals of a non-governmental` organization began to work for helping the survivors from the tsunami disaster. They took initiative to develop a project to empower *Kaders* in mental health work (Keliat, et al., 2011a; Keliat, et al., 2011b). The pioneer *Kaders* were involved in mental health program of the non-governmental organization working in Nangroe Aceh Darussalam (NAD), a province located in Sumatra Island, Indonesia.

In the pilot project in NAD Province, mental health training was provided to *Kaders* (Good et.al, 2013). The training required three days; two days in a classroom and one day for

practicum in which they directly contacted patients with mental disorders in the community. The material of the training included definition of mental disorders, the signs and symptoms of mental health problems, how to detect mental health problems in community, treatment of patients with mental disorders in community, how to refer the patients to PHC, monitoring and evaluation of their activity, and to record them (Table 2.1).

Then, *Kaders* were behaved so as help PHC nurses' activities in the program. They have some duties such as finding possible cases with mental disorders, grouping them among the community, visiting their home, referring them to PHCs, motivating the community to attend to activities provided by PHC, and making documentation and reports to PHC (Keliat, et al., 2011a; Keliat, et al., 2011b). *Kaders* could help many patients and family suffering tsunami. According to the evaluation of NAD*, Kaders* detected 2,602 cases with severe mental disorders (mostly chronic psychosis) and treated them in cooperation with PHC teams. It can be provided with a vital link between the patients and PHC doctors (Health Service Executive, 2007).

Table 2. 1 Topic of Mental Health Training for Kader

Day 1	Day 2	Day 3
- Definition mental disorders - Sign and symptom of mental disorders - How to detect possible patient in community - How to categorize individual into three group healthy, risk and mental disorder - How to refer patients	- Home visit - How to supervise patient and family with mental illness - How to make community to attend psycheducation - Reporting - Monitoring and evaluation	Practice in community - Detection of individuals - Home visit

Although the efficiency of this training program for *Kaders* has not been quantitatively evaluated, the qualitative evaluation revealed that some patients were found among the population in NAD (Good et.al, 2013). As a result, the *Kaders* made an enormous contribution to the communities through assisting the nurses of PHC, and their activities were highly evaluated (Prasetyawan, 2006). This was the experience which introduced *Kaders'* potential in the field of community mental health.

Following the above achievement of *Kaders* in NAD, mental health professionals in

Indonesia began to apply similar mental health training program for *Kaders* to other provinces in Indonesia, in addition to previous short training on community health, in order to involve *Kaders* into community mental health program as volunteers to help PHC nurses. In the community health system in Indonesia, Primary Health Center (PHC) depends on *Kaders* as CHW, and *Kaders* play a role of facilitators for the community to reach health services (Iswarawanti, et al., 2010). The *Kaders'* performance has been particularly visible in the field of maternal and child health. In Indonesia, however, 90% of patients with mental disorders do not receive even basic mental health care (Armstrong, et al., 2011). *Kaders* are expected to take a role not only to help patients directly but also to indirectly affect the perception and attitude of individuals in community (Salve, et al., 2013).

The above idea appeared good because *Kaders* have quick access to a community, and can play a significant role in the community. However, the national budget for community mental health was minimal in Indonesia before the Mental Health Act was established in 2014, and about two-third of *Kaders* still remains untrained. As a result, *Kaders* have not shown their performance maximally for community mental health except some regions such as NAD (Suwarsono, 2007). According to the preparatory interview to PHCs in the present study, the mental health training program was recently modified (e.g. three days were reduced to two days), taking the financial limitation into consideration, while some PHCs autonomously

provided the training to *Kaders*. The national government therefore enacted the Mental Health Law in August 2014, which is expected to contribute to the spread of correct knowledge concerning mental disorders. However, the present study was conducted before the law was established.

2.3 *Kaders'* perception and attitude toward possible patients with mental disorders

In order to establish the community mental health program in a nation or area, it is important to know the knowledge, perception, and attitude toward mental disorders among people. Knowledge is the ability to generate an appropriate response (connection weight) to a particular input. Perception is awareness of the elements of environment through physical sensation as well as another physical sensation interpreted in the light of experience, e.g., meeting a patient. It signifies quick, acute and institutive cognition: appreciation, a capacity for comprehension (Encyclopedia Britannic, 2006). Attitude is a relatively continuous system of evaluative and affective reactions to the characteristics of a social object or class of social object, e.g., a person with a mental disorder, based upon and reflecting the evaluative concepts or beliefs to the characteristics (Das & Phookun, 2013).

People's attitude toward a patient diagnosed as mental disorder depends on their knowledge and perception toward mental disorders. Incorrect knowledge and perception are likely to develop the negative attitude toward mentally disordered patients. In the above context,

patients with mental disorders have double challenges in their life (Kure, 1918; Corrigan et.al, 2002). On the one hand, they have to struggle with their mental problem. On the other hand, they are challenged by the stereotypes and judgments that result from misconceptions and stigma about mental disorders. The quality of life among the patients with mental disorders can be affected by the opportunities such as good job, safe housing, appropriate health care and sociality with others.

The perception or view toward causes of mental illness varies from society to society. Thus, people with mental health problems have different names depending on the habit with the community (Teferra and Shibre, 2012; Stolovy, et al, 2013; Payne, 2012). According to the previous studies, beliefs on mental illness are based on a prevailing local belief system. Apparently, most of the attitudes and perceptions of people with mental disorders sometimes lack scientific reasons and this has an adverse effect on the search and compliance of treatment (Nsereko, et.al, 2011; Ventevogel, et.al, 2013). Several studies have shown that public confidence in mental illness is also a major factor causing stigmatization and labeling. The stigma of people with mental illness remains a significant barrier to positive outcomes across cultures and countries, which are associated with the threat of mental symptoms, intolerance to diversity, and inaccurate conceptions of mental disorder (Stier and Hinshaw, 2007; Gureje, et .al, 2005).

Community's perception is dynamic and tends to change as the awareness and education changes. Education and social media are the major factors which move the perception of the community to the scientific perspectives (Pescosolido et.al,1996). Globally, in developed and developing countries, people hold different explanation regarding mental illness, especially its causes and treatment option. A report of the behavioral risk-factor-surveillance system shows that 80% of the adult population in the US agree that mental illness treatment is effective, and the reminder either disagree or have no idea about that. However, only 35–67% of the population agreed that people are caring and sympathetic to the people with mental illness (BRFSS, 2012). In most parts of the world mental health, mental disorders are unfortunately not regarded as important as physical health (Sadik et.al, 2010). In fact, mental health has been neglected in many societies for a long time, which is crucial to the overall well-being of the societies. According to the previous studies, the above perception and attitude are partially affected by our personal background, e.g. age (Pescosolido et.al,1996; Yamazaki 2012). As for *Kaders,* experiences in mental health training may affect them.

Inappropriate perception toward mental illness in different communities contributes to low treatment seeking and stigmatization of people with the mental illness. As a result, they often go to hospitals after they have tried all other options and after the symptoms have got worse, and this, in turn, negatively affects the prognoses of treatment (Salve, et.al, 2013). Hence,

assessing community's perception is important to have an appropriate plan of health promotion and scaling up public utilization of mental health services, particularly in multiethnic and multicultural countries as the community's view of mental illness varies with culture. Studies in many different areas have shown that poor perception towards the mentally ill is mainly deep-rooted with sociodemographic and other various factors (Nsereko, et.al, 2011; Ventevogel, et.al, 2013; Sadik, 2013; Salve, et.al, 2013; Kabir, 2004; Crabb et.al, 2012; Girma et.al, 2013). Since there are few published studies (BRFSS, 2013) in developing countries, assessment of community perception toward people with mental illness has great value.

As for *Kaders*, their practice, e.g. primary behaviors for the possible patients with mental disorders, also may be affected by their perception and attitude toward mental disorders. According to a previous study, case-finding for them and their prognosis are often affected by the perception and attitude of society toward mental disorders, which depends heavily on their knowledge toward mental disorders (Salve, et al., 2013).

As already mentioned, perception and attitude toward mental disorders can be assessed, using a questionnaire including vignettes for neighbor persons with possible mental disorders (Pescosolido et.al, 1996; Yamazaki 2012). Since researchers need to specify the features of the persons with possible mental disorders to measure respondents' perception or attitude toward the persons, questions about some vignettes illustrating the persons are very useful. In the study

of the US (Pescosolido et.al,1996), a questionnaire which contained some vignettes was used to investigate the perception of the general population toward mental disorders. The questionnaire included five vignettes, those with depression, schizophrenia, alcohol dependence, drug dependence, and trouble with neighbors. The previous study in the general population in Japan also used the same tools (Yamazaki, et al., 2012). These researchers examined the knowledge about mental disorders, the perception toward possible patients with mental disorders shown in vignettes (e.g. prognosis), and attitude toward the patients (e.g. willing to work together). According to the results of the two studies, discrimination against mental disorders was not so plain among the respondents from the general population, although they feel anxious and confused for having personal relationships with the possible patients with mental disorders. The above reports show that these tools can be applied to the present study.

2.4 Health Locus of Control

According to Rotter's social learning theory, a person will be engaged in a goal-direction behavior only if he/she values the particular reinforces available and if he/she believes that his/her action will lead to these reinforcers in the situation (Wallston, 1976). The person will seek for the information around the issue that is threatening in his/her condition and choose the behavior that will influence his/her health. Based on the theory, the health belief model was developed and applied to health education and public health service. Health psychologists tried

to understand why the people often fail to utilize an advantage from health program and services (Rosenstock, 1990; Safarino, 2006; cit Shahed, 2008).

One of the important concepts in the above discussion is health locus of control (HLC) that refers to how individuals perceive the sources regulating their health (Wallston et.al, 1978). HLC is frequently measured as parameters of health belief to make planning for health education programs (Kuwahara et al., 2004). Although the HLC scale was at first developed by Rotter to measure internal and external locus of control, the classical concept of HLC was extended to Multidimensional Health Locus of Control (MHLC) in a later developed theory. MHLC measures health belief, using three dimensions, Internal HLC, Powerful Others HLC (e.g. physicians), and Chance HLC. For example, whether an individual seeks information and helps related to their health condition often depends on their Internal HLC, showing that the HLC influences the individual's expectation of health services (Wallston & Wallston, 1989). The three subscales of MHLC showed sufficient internal consistency (Cronbach's alpha = .56-.82) and test-retest reliability (r = .66-.73) both in the original version (Wallston & Wallston, 1989) and in the Japanese version (Kurihara, et al, 2000).

As above mentioned, HLC is often discussed in the context of health-related behaviors for self-care, and sometimes in relation to attitude toward mental disorders (Higashiguchi, et al. 1997). In the case of CHW, however, it is also probable that their HLC affect their helping

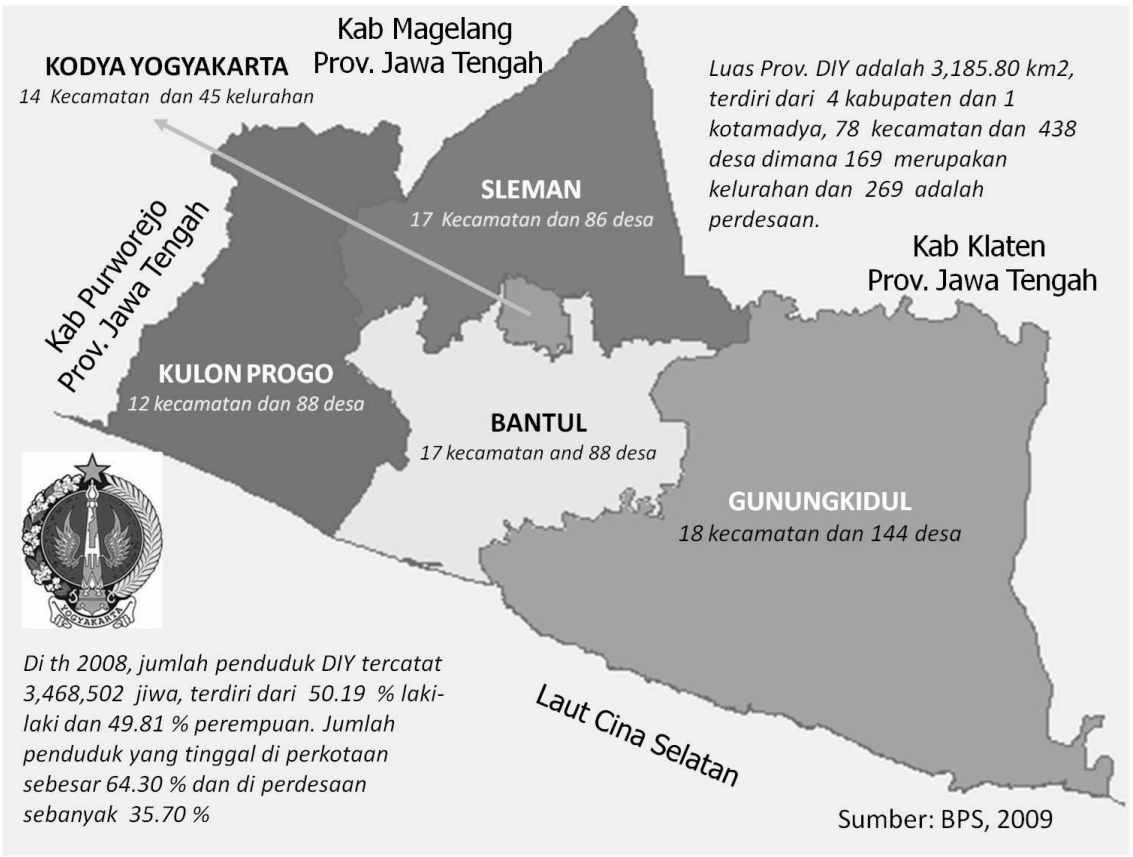
behaviors toward others with possible health problems. For example, the CHW with high Internal HLC may tend to stress self-help for their health, while the CHW with high Powerful Others HLC may tend to frequently consult PHC or doctors about the matters on health. The advantages and disadvantages of the tendencies depend on a case by case.

In addition to the direct relationship between *Kaders* and patients with mental disorders, *Kaders* are also expected to affect favorably to the perception, attitude, and support of community members toward the patients with mental disorders, which, in turn, contribute to the QOL of the patients with mental disorders. This effect may be associated with the HLC of *Kaders*. However, Suwarsono (2007) argued the roles and tasks of *Kaders* in actuating the community and pointed out that *Kaders* have not shown their performance maximally in this field. If this is true, it may mean that appropriate training is required for *Kaders* to favorably affect the community. Taking the above into account, it is important to examine the association of *Kaders'* HLC with their background such as experiences in mental health training.

3. Methods

3.1 Community health activity in Yogyakarta Special Province

The present study was conducted in Yogyakarta Special Province. The previous activity of community health in the study area was as follows. Yogyakarta Special Province, located on Java Island, includes five districts, Yogyakarta City (Kodya Yogyakarta), Sleman, Gunung Kidul, Bantul and Kulon Progo (Fig. 2.1). The area of Yogyakarta Special Province is around 3,185.80 km^2. The population size in 2012 was about 3.5 million. Among five districts, two (Jogja and Bantul) are in the urban area, while the others (Sleman, Gunung Kidul, and Kulon Progo) are in rural area. Only Sleman has a general mental hospital.



Source: BPS, 2009

Figure 3. 1 Map of Yogyakarta Special Province

Based on the policy of the Indonesian government, each district in the province is facilitated with Primary Health Center (PHC) to cover community health care. The number of PHCs in each district depends on its population size. The Province has 121 PHCs, 18 in Yogyakarta City, 21 in Kulon Progo District, 30 in Gunung Kidul District, 25 in Sleman District, and 27 in Bantul District.

Implementation of health program in Yogyakarta Special Province could not be separated from the Vision and Mission of Health Department of Yogyakarta Special Province, as follows: "Public Health Service which catalytically support reaching of the Province in high health status, as the health care center and health education that qualified and ethically" (Dinkes Daerah Istimewa Yogyakarta, 2013). The mission of Yogyakarta Health Department is as follows:

1. Preventing the increased risk of diseases and health problems
2. Providing health services equitably, good quality government and private
3. Increased health financing that enough to raise the status of public health
4. Improving the quality of education, training of health personnel and research health

In the case of Yogyakarta Special Province, the present study area, training for mental health has been provided in almost all PHC of Bantul and Sleman, but not in other three districts.

Even in the former districts, however, only part of *Kader*s has been given the opportunity for the training.

3.2. Participants and data collection of the study

To reach the aims previously shown, the author conducted a cross-sectional survey using a self-administered questionnaire for *Kaders* in the five districts of Yogyakarta Special Province, Indonesia, in June to September 2013 (Fig. 3-1).

The authors randomly chose 36 Primary Health Centers (PHCs) among the 53 PHC in the five districts in the province. However, the number of PHCs in each district was proportional to the population size of the district. Since each PHC has 25-30 active *Kaders*, more than 800 *Kaders* were chosen from the 36 areas.

Then, the author asked *Kaders* of these PHCs to participate in the present study. The inclusion criteria were being aged 18 or over, being able to read Bahasa (Indonesia language), and being active as a *Kader* for at least one year. The exclusion criteria were being inactive because of physical problems or living in the location far from PHC. The last exclusion criterion means that they could not join meeting at PHC every time and also that the authors or coworkers could not visit them in the research term. As a result, 800 *Kaders* were invited to the present study. They were 14.2% among 5,625 *Kaders* in the provinces (Health Service Executive, 2007).

Self-administrated questionnaires, accompanied with the paper showing the aim of this

research and ethical consideration, were distributed to the above samples when they got together to PHC meeting. They were informed that participation is based on free will and is related to no interest. After they anonymously completed the questionnaire, they posted it sealed in an envelope to a box prepared for this study at PHC. This posting was assumed by the presentation of informed consent. For the respondents living far from PHC, data collector visited the respondents to collect the questionnaire sealed in the envelope, if they are willing to respond. As a result, 619 samples (77.4%) were collected.

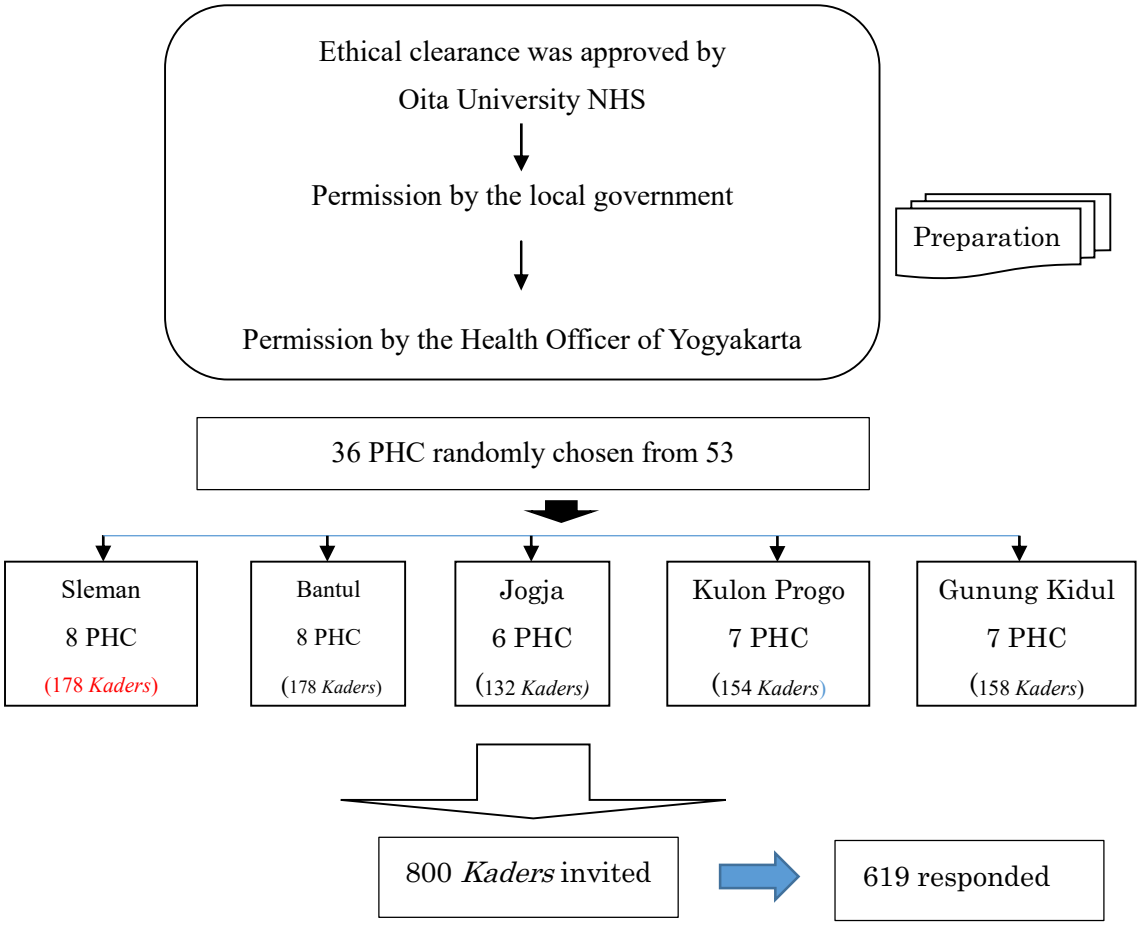


Figure 3. 2 Flow chart of recruitment of the participant

3.3 Ethical consideration

The researcher maintained the confidentiality of the respondents and explained the benefits of the research. The following procedure was approved by the Committee for Research Safe and Ethics of Oita University of Nursing and Health Sciences, Japan, and also permitted by the local government.

3.4 Questionnaire

The questionnaires used in the present study contained five parts (Appendix A).

3.4.1 Sociodemographic background

The first part includes sociodemographic variables, namely gender, age, marital status, ethnicity, education, the district where they live, occupation, and income, which were categorized according to the method in a previous literature (Dinas Kesehatan Daerah Istimewa Yogyakarta, 2011). Their age was categorized into 18-24, 25-34, 35-54 and 55+ years. Marital status was categorized into single, married, and widow. Ethnicity was categorized into none Javanese and Javanese. Education history was also categorized into ”high school or above” and “junior high school or below”, according to the common classification in Indonesia. Five districts were categorized into an urban area (Jogja and Bantul) and a rural area (Sleman, Gunung Kidul, and Kulon Progo). Occupation was categorized into a full-time job, part-time job, and housewife. Their income was categorized into Rp 0-950,000 (low income), Rp

950,000-2,000,000 (middle income), and more than Rp 2,000,000 (high income). Years of *Kaders'* experience were categorized into "less than ten years" and "ten years or longer", taking account of the history of Posyandu and mental health training for *Kaders*, as shown in 2.2.

3.4.2 Perception and attitude toward possible patients with mental disorders and consultation about the patient

The questions in the second part intended to know *Kaders'* perceptions and attitude toward patients with mental disorders, using three vignettes. In order to examine *Kaders*' perception toward possible patients with mental disorders, it is very useful to refer to the well-known methodology of previous studies (Pescosolido et.al,1996; Blumberg, 2009; Yamazaki, et al., 2012). In these studies, the researchers presented vignettes illustrating possible patients with mental disorders to the participants and asked their perception and attitude toward the cases in vignettes, and greatly succeeded in describing stigma and related factors in a community.

In the present study, three vignettes were used for the same purpose as the previous studies. The first one (Illustration 1) was developed by the author to ask perception and practice toward an individual who has schizophrenia-like symptoms, e.g. hallucination, disorientation, talking by herself, and a deficit of personal hygiene. The *Kaders* were asked who they will

consult about the individual. The possible multiple choices were society leaders, PHC, psychiatric hospitals, and alternative treatment.

Other two vignettes about schizophrenia and depression were taken from MacArthur Health Module of the 1996 General Social Survey (Pescosolido et.al,1996; Blumberg et al., 2009). The second vignette (Illustration 2, Schizophrenia vignette) presented an individual with schizophrenia-like symptoms (talking by herself, has the delusion, often do bizarre behavioral and sometimes act aggressively). The third vignette (Illustration 3, Depression vignette) represented an individual who has depression-like symptoms, e.g. lack of motivation, sleep disorder, desperate, and suicide ideation. Respondents were asked about the perception of the two vignettes as follows (Blumberg et al., 2009). A) For each vignette, *Kaders* assessed the seriousness of mental illness, using a question with three items (very serious, somewhat serious, not very serious, or not at all serious). However, the responses were categorized into a dichotomous variable (very serious and others) in later analysis. B) Possible causes of the above mental illness were asked using six items, and four-point responses to each item were grouped into dichotomous variables (very likely or somewhat likely vs. not very likely or not likely). C) *Kaders'* perception to the ability of the above two possible patients to make the decision about treatment and to manage money was assessed using two questions, and four-point responses to each question were categorized into dichotomous variables (very able or somewhat able vs.

somewhat disable or disable). D) *Kaders* assessed the possibility of violence in the above two cases to themselves and others using two questions, and four-point responses to each question were categorized into dichotomous variables (very able or somewhat able vs. somewhat disable or disable). E) *Kaders* also assessed the possibility for the persons to get improvement by themselves or by treatment using two questions, and four-point responses to each question were grouped into dichotomous variables (very likely or somewhat likely vs. not very likely or not likely). F) *Kaders* assessed how they are willing to move next door to, to spend an evening socializing with, to make friends with, to start working closely with, to have a group home for people like, and to become a family with the persons (definitely willing, probably willing, probably unwilling, or definitely unwilling). The data was manipulated according to a previous study (Blumberg et al., 2009).

However, concerning the perception and attitude toward the three cases illustrated in vignettes, no comparable data for CHW have been available from previous studies concerning the perception and attitude toward the three cases illustrated in the vignettes. The present data were therefore compared with that for the general population of Japan and the US (Blumberg et al, 2009; Yamazaki et.al, 2012). This was described in Discussion.

3.4.3 Experiences in mental health training

In the third part, the presence or absence of experiences in mental health training for

Kaders was asked. The fourth part included five additional questions about mental health service in the community. *Kaders* answered their opinion about budgeting and responsibility of the mental health service.

3.4.4 Health locus of control

One of the tools to measure health locus of control (HLC) is the Multidimensional Health Locus of Control (MHLC) (Wallston & Wallston, 1989; Kuwahara et al., 2004; Moshli et al., 2007). MHLC measures health belief, using three dimensions, Internal HLC, Chance HLC, and Powerful Others HLC (e.g. physicians). For the fifth part of the present questionnaire, the author newly developed the Indonesian version of MHLC through "forward-backward translation" process. Responses to every 20 items were scored into 1-4. By summing up the scores for every three subscales, HLC scores were calculated as follows: Internal HLC (item 1, 2, 6, 8, 12, 13, and 17), Chance HLC (item 4, 7, 9, 10, 11, 15, 16, and 18), and Powerful Other HLC (item 3, 5, 14, and 19).

The Cronbach alpha values for the three subscales (Internal, Chance, and Powerful Others HLC scales) of the new version were .67, 70, and .57, respectively. Although they were not so high, they were almost consistent with the English and Japanese versions (Wallstn & Wallston, 1989; Kurihara, et al, 2000).

3.5 Data Analysis

First, *Kaders'* perception and attitude toward possible patients with mental disorders (the second and third vignettes) were described by simple tabulation. The choice of consultants among *Kaders* when they meet the patients were also described. Second, the association of the personal background (e.g., years of *Kader's* experiences, geographical area, and educational background) with the experiences in mental health training was examined, using Fisher's exact probability method. If there is any difference between the trained and untrained *Kaders,* this was taken into consideration in the next analysis, because the variable may be a confounding factor. The perception, attitude, and choice of consultants were compared between the trained and untrained *Kaders*, using Fisher's exact probability test. If needed, the analysis was conducted after the classification according to the correlates with the training shown in the previous analysis, taking possible confounding or modifying effect into account. Third, the association of the perception, attitude and choice of consultants with the experiences in actually meeting possible patients with mental disorders were similarly examined. Forth, the satisfaction with mental health training and the opinion about mental health service were described. Finally, an association of HLC with the *Kaders'* background and the choice of the consultants was examined, using analysis of variance (ANOVA).

A significant level of statistical test was set as 0.05. The above statistical analyses were conducted, using SPSS ver. 17.

4. Results

A part of following results has been already published by the author (Wardaningsih & Kageyama, 2016; Wardaningsih & Kageyama, 2017).

4.1 Sociodemographic background of *Kaders*

Sociodemographic background of the respondents is summarized in Table 4. 1. Out of 619 respondents, 97.6% were Javanese, 97.6% were female, and 95.3% were married. The majority were middle-aged women and completed senior high school or upper education. Although 82.4% had no job, respondents had low income. Near half of them lived in rural areas, while 35.4% lived in Sleman province where a mental health hospital is located. More than one third had been *Kaders* for more than ten years. About 30% had training in mental health.

Table 4. 1 Sociodemographic background of *Kaders*[1]

Variable	Category	n	%
Sex	Female	604	97.6
	Male	9	1.5
Age	18-24 yrs	14	2.3
	25-34 yrs	130	21
	35-54 yrs	411	66.5
	55 yrs+	63	10.5
Marital status	Married	584	95.3
	Unmarried	29	4.7
Education level	Junior high school or below	198	32.4
	High school or above	418	68.3
Ethnicity	Javanese	604	97.6
	Non Javanese	8	1.3
Area	Rural	296	48.4
	Urban	313	51.1
Job	Present	109	17.6
	Absent	509	82.4
Income	Low	436	71.2
	Middle	130	21.2
	High	28	4.6
Years of *Kaders* experience	Short (<10)	384	62.8
	Long (>=10)	206	33.7
Training on mental health	Present	181	29.6
	Absent	428	69.9

N=619. Missing data was excluded in each tabulation.

[1] Published in Wardaningsih & Kageyama (2016)

4.2 Perception, attitude, and consultation for possible patients with mental disorders

The respondents' perception and attitude toward possible patients in the second and third vignettes are illustrated in Fig. 4.1 to 4.9. Near half of the respondents perceived, the symptoms shown in the two vignettes are serious (Fig. 4. 1 and 4. 2).

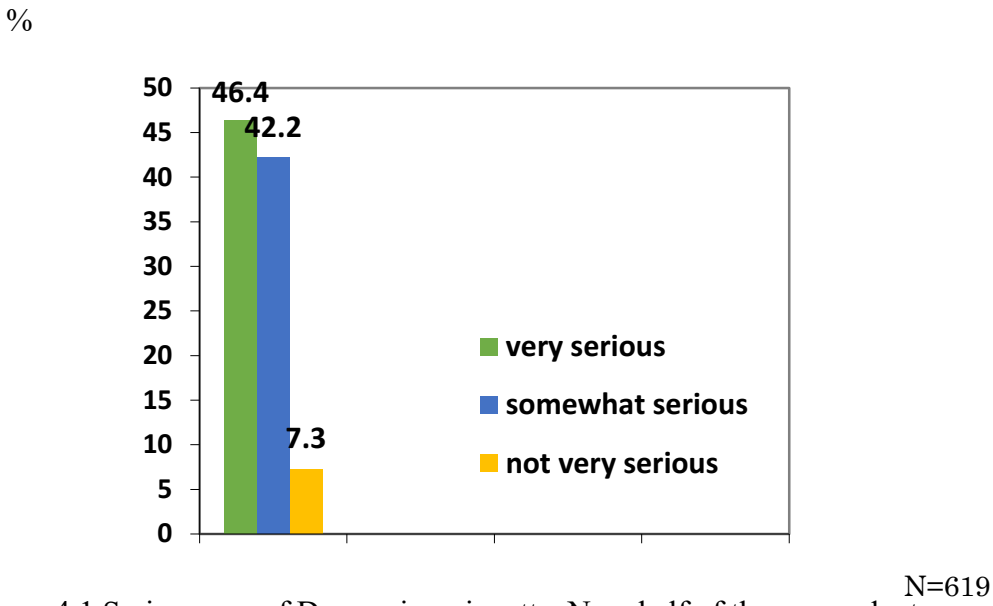


Figure 4.1 Seriousness of Depression vignette. Near half of the respondents answered that the person in Depression vignettes is very serious.

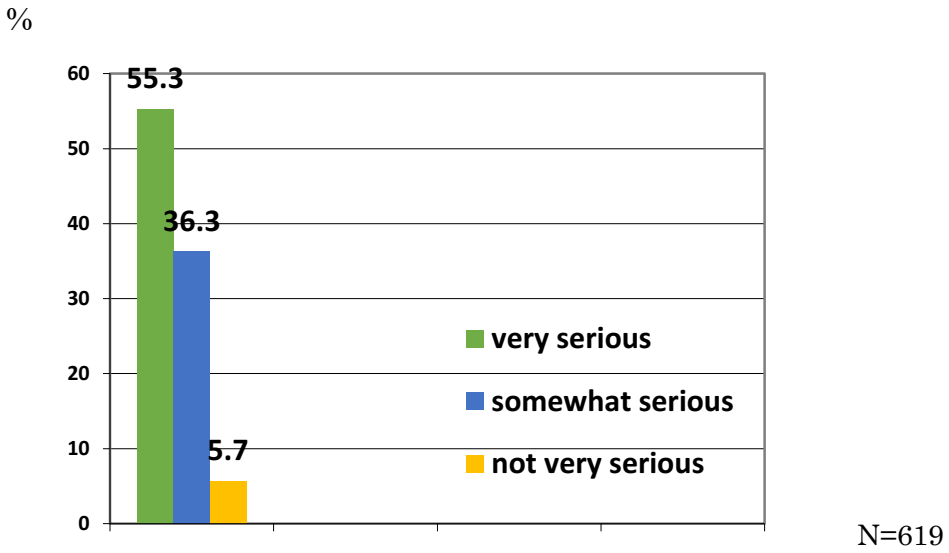


Figure 4. 2 Seriousness of Schizophrenia vignette. More than half of the respondents answered that the person in Schizophrenia vignettes is very serious.

Fig. 4.3 and 4.4 show multiple answers for possible causes of the presented symptoms. The *Kaders* tended to attribute the cause of depressive and schizophrenia-like symptoms to 'stressful', 'chemical imbalance', and 'bad character'. Quarter or one-third perceived the symptoms might be caused by 'God's will'.

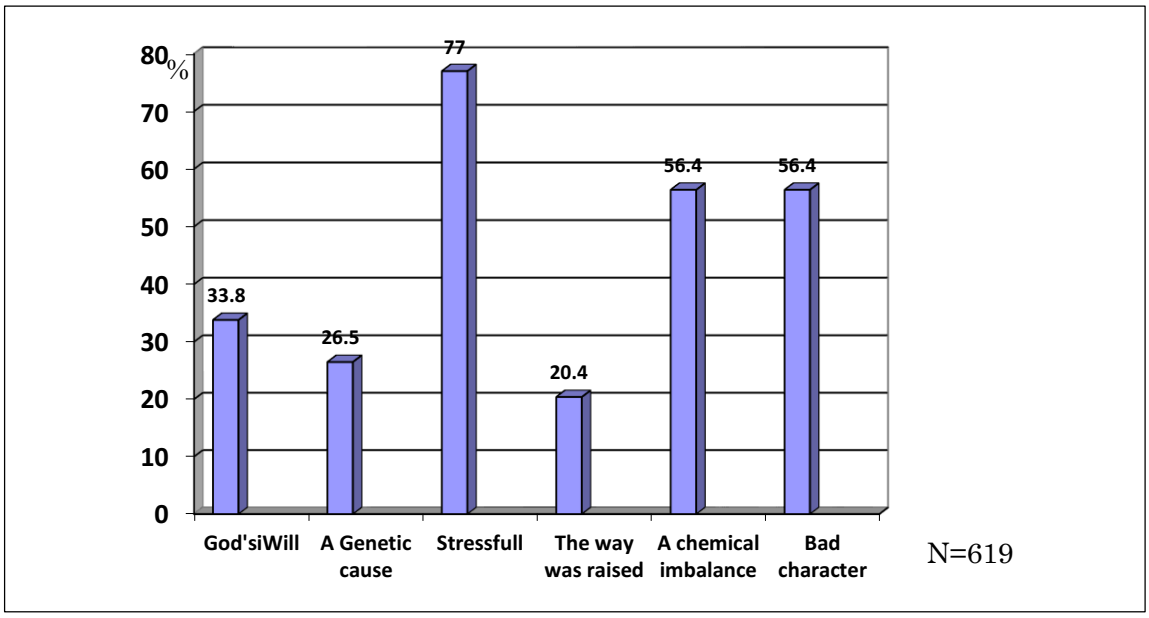


Figure 4. 3 Causes related to Depression vignette. Three quarter *Kaders* attribute the cause of depression to 'stressful', and a half *Kaders* assumed because of chemical imbalance', and 'bad character'.

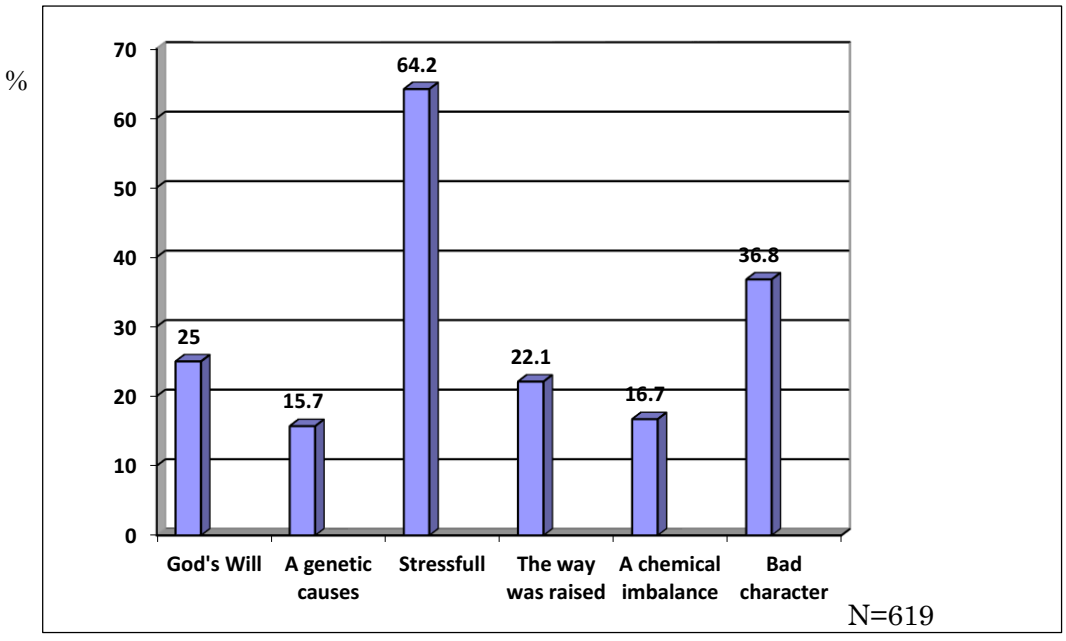


Figure 4. 4 Causes related to Schizophrenia vignette, More than half attribute the cause of schizophrenia to 'stressful'.

Fig. 4.5 and 4.6 show the multiple choices about problems related to the state described in two vignettes. The *Kaders* frequently perceived the depressive and schizophrenia-like symptoms as part of normal up and down.

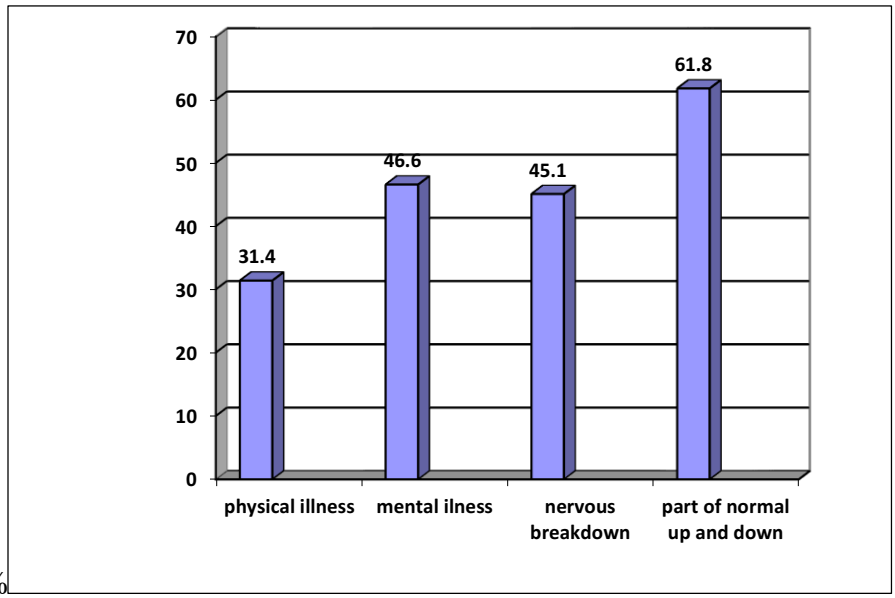


Figure 4.5 Background of mental health problems in Depression vignette. More than half of *Kaders* perceived that the depressive like symptoms as part of normal up and down the life. Near a half of them assumed because mental illness and nervous.

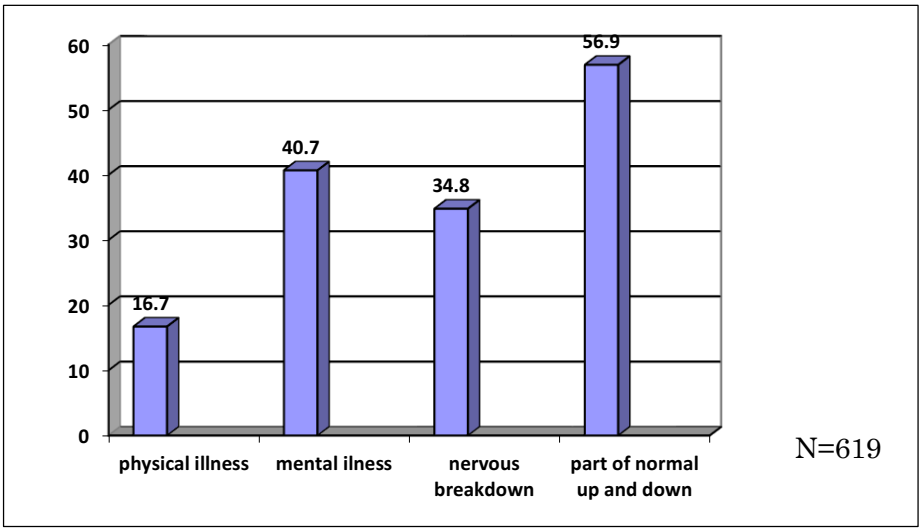


Figure 4.6 Background of mental health problems in Schizophrenia vignette, The *Kaders* frequently perceive the schizophrenia-like symptoms as part of normal up and down.

Fig. 4.7 summarizes the risk of violence to others and self-injury that the *Kaders* perceived for the second and third vignettes. The *Kaders* were, however, pessimistic for the two cases in the vignettes to make a decision about treatment and to manage money, in comparison with the previous reports (Yamazaki, 2012; Pescosolido B. A, et.al, 1996), as shown in Fig. 4.8. Almost two-third of The *Kaders* seemed to be pessimistic about the improvement of the depressive case (Fig. 4.9).

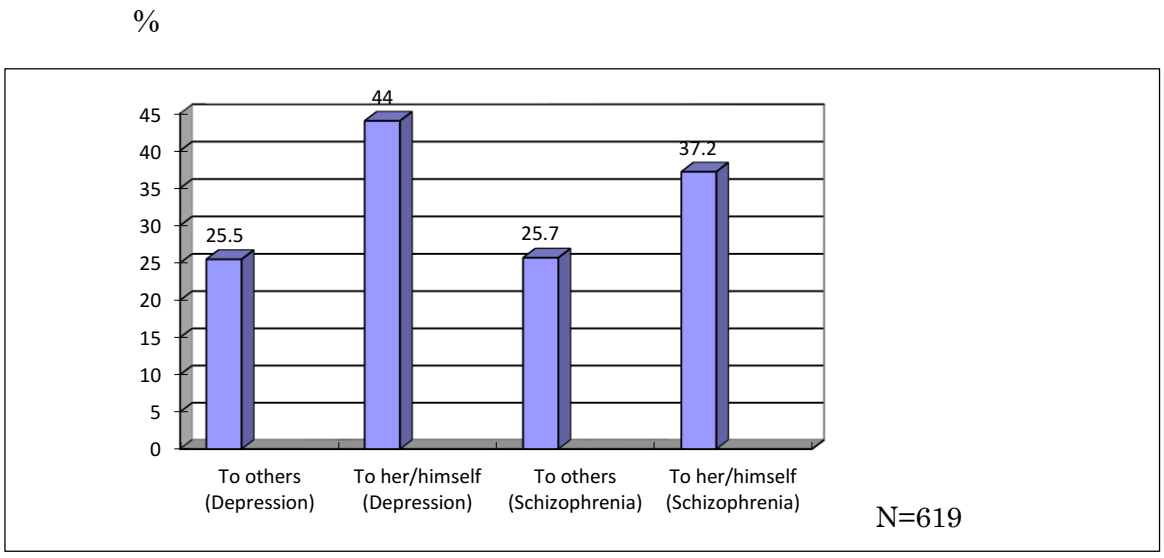


Figure 4. 7 Perception toward possible violence in Depression and Schizophrenia vignettes. Quarter of *Kaders* perceived that people with both of depression and schizophrenia have a risk of violence to others and self-injury.

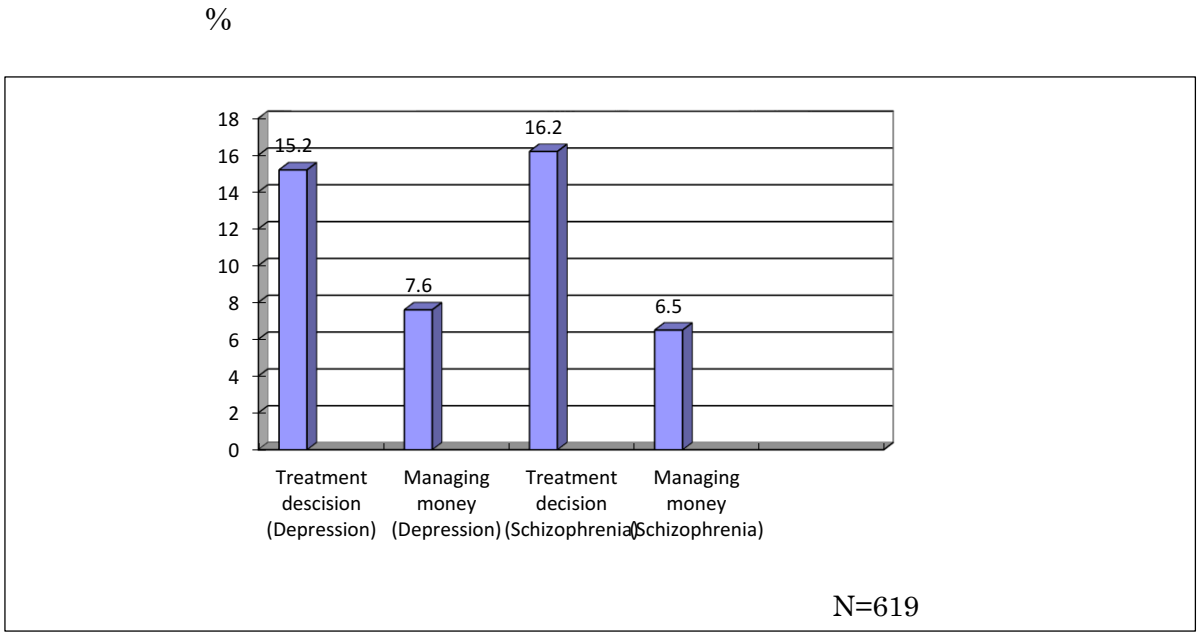


Figure 4. 8 Perception toward the ability to make a decision for treatment and managing money in Depression and Schizophrenia vignettes. *Kaders* more than two third seems pessimistic for depression and schizophrenia person to make decision about treatment and to manage money.

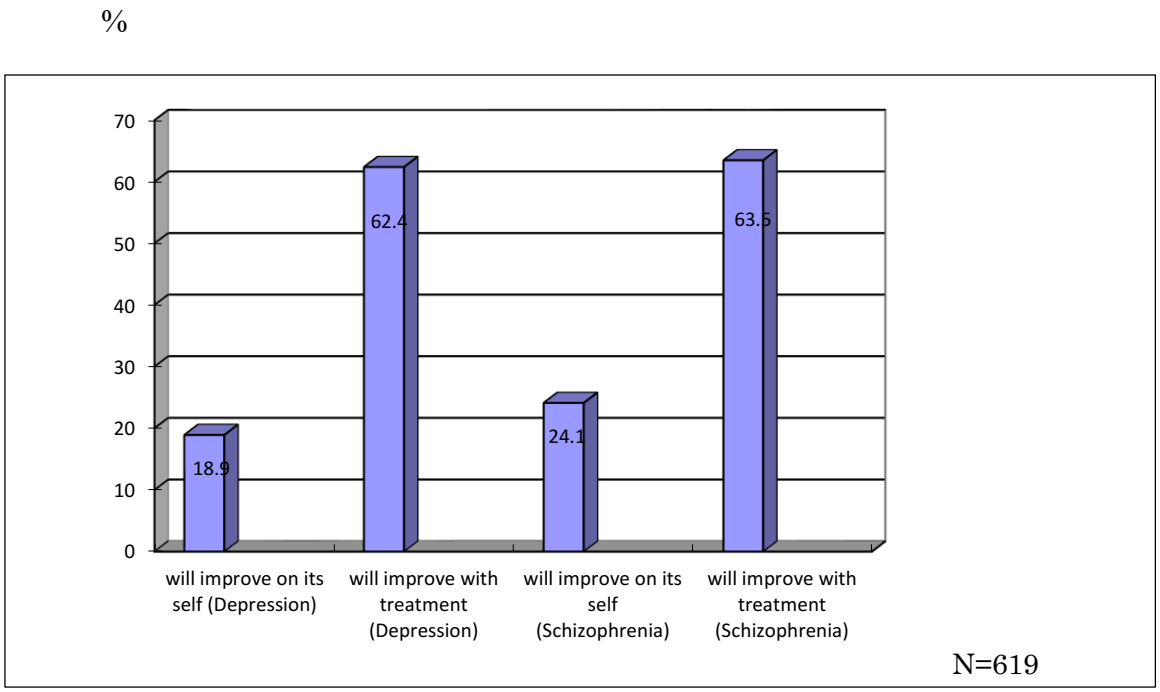


Figure 4. 9 How is likely situation to improve in Depression and Schizophrenia vignettes. Almost two third of *Kaders* were optimistic that person with depression and schizophrenia will be improved with treatment.

The *Kaders'* attitude toward the cases illustrated in the second and third vignettes is summarized in Fig. 4.10 and 4.11. Little difference was found between the two vignettes.

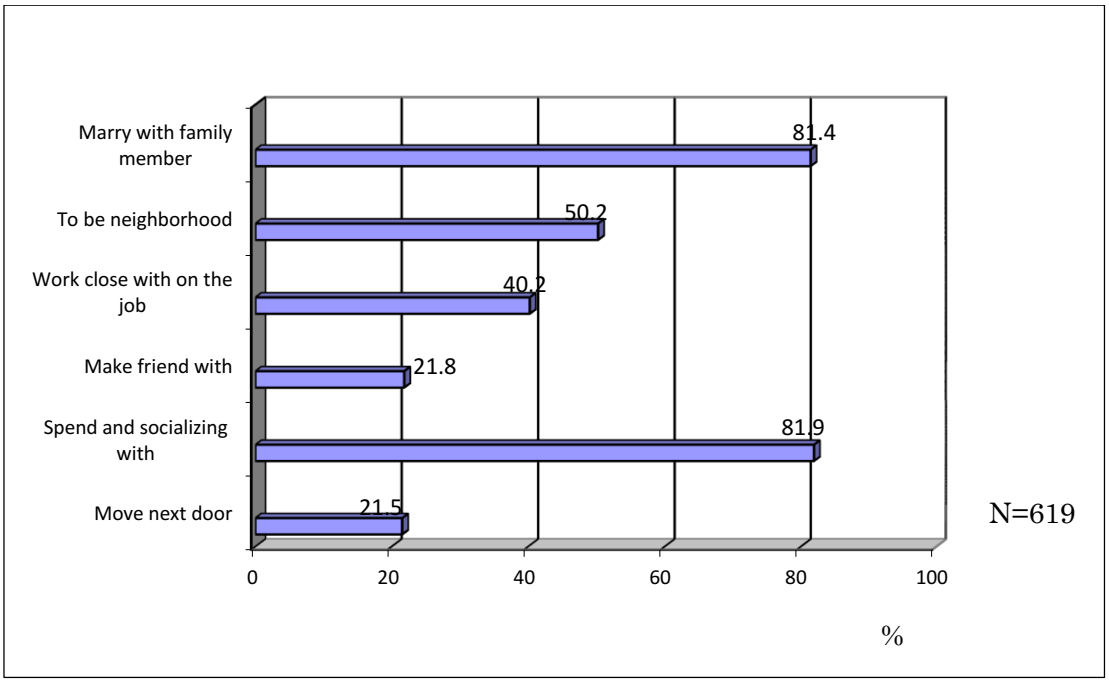


Figure 4. 10 Unwilling to interact with a person in Depression vignette. More than 80% of *Kaders* are unwilling to be a family of, or spend and socializing with a person with depression.

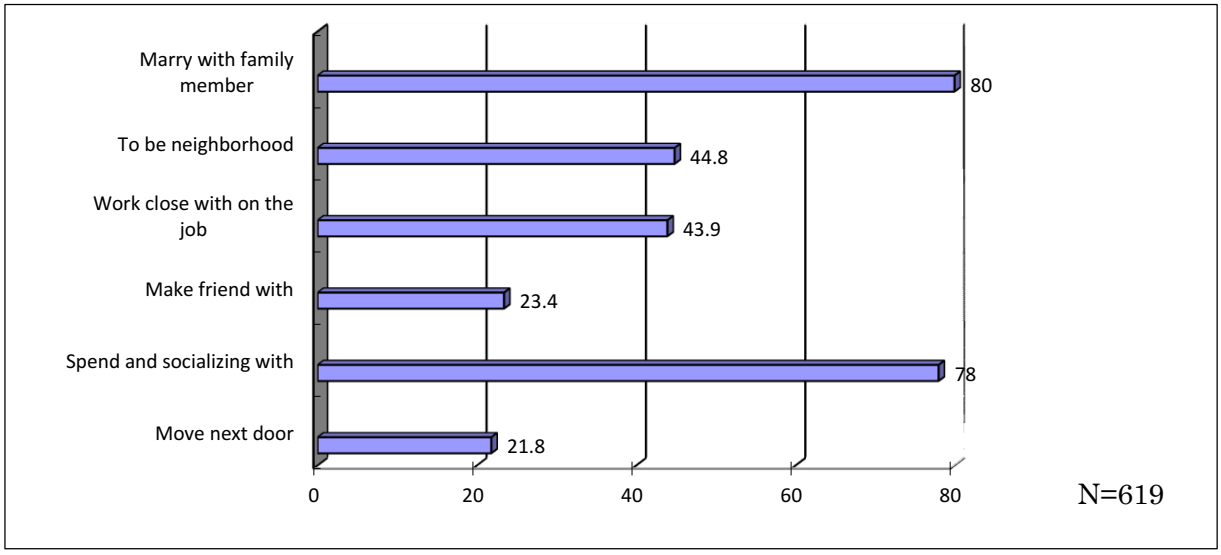


Figure 4. 11 Unwilling to interact with a person in Schizophrenia vignette. Nearest 80% *of Kaders* are unwilling to be a family of, or spend and socializing with a person with schizophrenia.

On the other hand, the *Kaders'* responses to the first vignette were as follows. Among the *Kaders*, 154 (24.9%) had met the similar cases to the vignette once or more times. Table 4.2 shows the responses to "who *Kaders* consult the case if they meet the case similar to the vignette". The most frequent choice was PHC, and community leaders were also their major consultants. It was rare for them to go to specialists of alternative medicine or leaders of religious/supernatural matters.

Table 4. 2 Who do *Kaders* consult about possible patients with mental disorders?

Consultants	N (%)
Community leaders	178 (28.8)
Family and friends	-
PHC or nurse or general physician (non-specialist)	253 (40.9)
Mental hospital (Psychiatrist)	178 (28.8)
Alternative medicine/supra-natural, religious leader	8 (1.3)
Police officer	-
Total	619 (100)

N=619, missing cases were excluded from tabulation.

4.3 Analysis for experience in mental health training

Out of the *Kaders*, 181 (29.2%) had the experiences in mental health training for *Kaders*. As shown in Table 4.3, this percentage was higher in the *Kaders* with long experience than in those with short experience. This percentage rate was slightly high in rural areas, where

the previous earthquake severely had affected people, but the difference was not significant. Other sociodemographic or personal background showed no difference between the trained and untrained *Kaders*.

Table 4. 3 Sociodemographic backgrounds of *Kaders* trained and untrained for mental health[2]

Variables	Items	Training		N (%)	*test*[1]
		Present (n=181)	Absent (n=438)		
Years of *Kaders* experience	Short (<10yrs)	83(23.0%)	295(78.0%)	378 (100%)	P<0.001
	Long (>=10yrs)	89(43.8%)	114(56.2%)	203 (100%)	
Area	Rural	100(33.2%)	201 (66.78%)	301(100%)	NS
	Urban	81(26.3%)	227(73.7%)	308(100%)	
Educational background	Low level	50 (25.5%)	146(74.5%)	196(100%)	NS
	High level	130(31.7%)	280(68.3%)	410(100%)	

N=619, missing cases were excluded from tabulation.

[1]Fisher's exact probability test

Sociodemographic variables (gender, age, income, marital status, ethnicity, occupation, or living area) did not show significant association with the perception or attitude toward the second and third vignettes. The experiences in mental health training with the perception toward the cases in two vignettes showed no significant association (Table 4.4). The years of *Kader*

[2] Published in Wardaningsih & Kageyama (2016)

experiences also showed no association with the perception. The experiences in the training or *Kaders* showed no association with the attitude toward the cases in vignettes.

Table 4. 4 Perception toward mental disorders by training or non-training in mental health[3]

Vignette	Variable	Items	Mental Health Training		*test*[1]
			Absent (n=438)	Present (n=181)	
Depression	The seriousness of mental disorder	- Serious - Not serious	375(93.9%) 35(6.1%)	165(93.8%) 11(6.2%)	NS
	Possibility for a patient to injure her/himself	- Possible - Impossible	370(90%) 41(10%)	165(93.8%) 11(6.2%)	NS
	Possibility for a patient to do something violent to others	- Possible - Impossible	307(78.9%) 82(21.1%)	135(79.9%) 34(20.1%)	NS
	Ability to make a treatment decision[2]	- Able - Disable	182(48.7%) 192(51.3%)	90(52.9%) 80(47.1%)	NS
	Ability to make a manage money[2]	- Able - Disable	116(30.6%) 263(69.4%)	52(30.4%) 119(69.6%)	NS
	How likely is that situation will improve by her/himself	- Possible - Impossible	247(62.7%) 147(37.3%)	118(67.4%) 57(32.6%)	NS
	How likely is that situation will improve by treatment	- Possible - Impossible	390(96.8%) 13(3.2%)	173(98.3%) 3(1.7%)	NS
Schizophrenia	Seriousness of mental disorder	- Serious - Not serious	388(93%) 29(7%)	170(96%) 7(4%)	NS
	Possibility for a patient to injure her/himself	- Possible - Impossible	330(83.3%) 66(16.7%)	146(83.9%) 28(16.1%)	NS
	Possibility for a patient to do something violent to others	- Possible - Impossible	295(73.8%) 105(26.2%)	131(75.3%) 43(24.7%)	NS
	Ability to make a Treatment decision[2]	- Able - Disable	197(46.4%) 228(53.6%)	91(51.1%) 87(48.9%)	NS
	Ability to make a Manage money[2]	- Able - Disable	140(35.9%) 250(64.1%)	63(36.8%) 108(63.2%)	NS
	How likely is that situation will improve by her/himself	- Possible - Impossible	227(57.8%) 166(42.2%)	95(53.4%) 83(46.6%)	NS
	How likely is that situation will improve by treatment	- Possible - Impossible	385(95.5%) 18(4.5%)	174(97.2%) 5(2.8%)	NS

N = 619

[1]Fisher's exact probability test

[2]Respondents who answer "don't know" are excluded from tabulation

Since years of *Kaders'* experience was associated with previous mental health training,

[3] Published in Wardaningsih & Kageyama (2016)

they were divided into long and short groups (Table 4.5). Then, the experiences in mental health training were associated with the perception of seriousness for the persons in both vignettes only among the long experiences group. Namely, the trained *Kaders* frequently perceived the two cases more serious than the untrained *Kaders*. No association of the experience with the attitude toward the cases was observed in both groups.

Table 4. 5 Association of mental health training with perception and attitude by years of *Kaders* experience[4]

Vignette	Variable	Yrs *Kaders*[1]	Short (10 yrs)			Long (>=10 yrs)		
		Training[2]	Absent (n=295)	Present (n=83)	*P* [3]	Absent (n=114)	Present (n=89)	*P* [3]
Depression	Seriousness of mental disorder	- Serious	262(93.6%)	70(88.6%)	NS	97(87.4%)	85(97.7%)	.01
		- Not serious	18(6.4%)	9(11.4%)		14(12.6%)	2(2.3%)	
	Possibility for a patient to injure her/himself	- Possible	261(91.6%)	76(93.8%)	NS	93(86.9%)	81(94.2%)	NS
		- Impossible	24(8.4%)	5(6.2%)		14(13.1%)	5(5.8%)	
	Possibility for a patient to do something violent to others	- Possible	220(82.4%)	67(84.8%)	NS	74(71.8%)	60(74.1%)	NS
		- Impossible	47(17.6%)	12(15.2%)		29(28.2%)	21(25.9%)	
	Ability to make a treatment decision[4]	- Able	135(52.3%)	47(61.0%)	NS	36(37.1%)	41(47.7%)	NS
		- Disable	123(47.7%)	30(39.0%)		61(62.9%)	45(52.3%)	
	Ability to make a manage money[4]	- Able	85(33.3%)	24(32.4%)	NS	26(24.8%)	27(30.7%)	NS
		- Disable	170(66.7%)	50(67.6%)		79(75.2%)	61(69.3%)	
	How likely is that situation will improve by her/himself	- Possible	220(82.4%)	67(84.8%)	NS	74(71.8%)	60(74.1%)	NS
		- Impossible	47(17.6%)	12(15.2%)		29(28.2%)	21(25.9%)	
	How likely is that situation will improve by treatment	- Possible	269(96.8%)	81(100%)	NS	102(96.2%)	83(96.5%)	NS
		- Impossible	9(3.2%)	0(0.0%)		4(3.8%)	3(3.6%)	

[4] Published in Wardaningsih & Kageyama (2016)

Schizophrenia	Seriousness of mental disorder	- Serious - Not serious	275(95.2%) 14(4.8%)	77(96.3%) 3(3.8%)	NS	95(87.2%) 14(12.8%)	84(95.5%) 4(4.5%)	.04
	Possibility for a patient to injure her/himself	- Possible - Impossible	237(86.5%) 37(3.5%)	65(81.3%) 15(18.7%)	NS	84(80%) 21(20%)	74(87.1%) 11(12.9%)	NS
	Possibility for a patient to do something violent to others	- Possible - Impossible	215(76.2%) 67(23.8%)	58(72.5%) 22(27.5%)	NS	66(66.7%) 33(33.3%)	66(77.6%) 19(22.4%)	NS
	Ability to make a treatment decision[2]	- Able - Disable	140(47.6%) 154(52.4%)	46(56.1%) 36(43.9%)	NS	45(40.2%) 67(59.8%)	43(48.9%) 45(51.1%)	NS
	Ability to make a manage money[2]	- Able - Disable	103(38.6%) 164(61.4%)	36(45.0%) 44(55.0%)	NS	30(28.8%) 74(71.2%)	25(29.4%) 60(70.6%)	NS
	How likely is that situation will improve by her/himself	- Possible - Impossible	159(58.9%) 111(41.1%)	51(60.7%) 32(39.3%)	NS	58(55.2%) 47(44.8%)	41(47.7%) 45(52.3%)	NS
	How likely is that situation will improve by treatment	- Possible - Impossible	266(96.4%) 10(3.6%)	83(100%) 0(0.0%)	NS	103(93.6%) 7(6.4%)	82(94.3%) 5(5.7%)	NS

N = 619, Respondents with no answer are excluded from tabulation.

[1]Years of *Kader* experience

[2]Experience in mental health training

[3]Fisher's exact probability test

[4]Respondents who answered "don't know" are excluded from tabulation

On the other hand, Table 4.6 shows the association of the experience to actually meeting case like the first vignette with the perception toward the second and third vignettes. The *Kaders* with the actual experiences perceived the second vignette less serious and more likely to improve by itself, and they also tended to perceive the third symptoms is able to manage money and likely to improve by itself.

Table 4. 6 The association of the *Kaders* experience in meeting a mentally disordered person with their perception toward possible patients[5]

Vignette	Variables	Items	Experience		P [1]
			Absent (n=326)	Present (n=276)	
Depression	Seriousness of mental disorder	- Serious - Not serious	287(89.9%) 32(10.1%)	255(94.8%) 14(5.2%)	.03
	Possibility for a patient to injure her/himself	- Possible - Impossible	285(89.6%) 33(10.4%)	251(92.6%) 20(7.4%)	NS
	Possibility for a patient to do something violent to others	- Possible - Impossible	238(77.8%) 68(22.2%)	206(81.1%) 48(10.9%)	NS
	Ability to make a treatment decision[2]	- Able - Disable	149(49.3%) 153(50.7%)	127(51.8%) 118(48.2%)	NS
	Ability to make a manage money[2]	- Able - Disable	95(31.1%) 210(58.9%)	73(29.4%) 175(70.6%)	NS
	How likely is that situation will improve by her/himself	- Possible - Impossible	180(58.1%) 130(41.9%)	186(70.7%) 77(29.3%)	.00
	How likely is that situation will improve by treatment	- Possible - Impossible	309(96.5%) 8(3.5%)	258(97.7%) 8(2.3%)	NS
Schizophrenia	Seriousness of mental disorder	- Serious - Not serious	297(92.5%) 24(7.5%)	264(95.7%) 12(4.3%)	NS
	Possibility for a patient to injure her/himself	- Possible - Impossible	257(82.4%) 55(17.6%)	220(84.6%) 40(15.4%)	NS
	Possibility for a patient to do something violent to others	- Possible - Impossible	242(77.1%) 72(22.9%)	184(70.5%) 77(29.5%)	NS
	Ability to make a treatment decision[2]	- Able - Disable	149(45.7%) 177(54.3%)	139(49.4%) 141(50.1%)	NS
	Ability to make a manage money[2]	- Able - Disable	95(31.1%) 210(68.9%)	108(41.9%) 150(58.1%)	.01
	How likely is that situation will improve by her/himself	- Possible - Impossible	158(50.8%) 153(49.2%)	165(62.9%) 97(37.1%)	.00
	How likely is that situation will improve by treatment	- Possible - Impossible	304(95.9%) 13(4.1%)	257(95.2%) 10(4.8%)	NS

N = 619

[1]Fisher's exact probability test

[2]Respondents who answer "don't know" are excluded from tabulation

[5] Published in Wardaningsih & Kageyama (2016)

Kaders felt satisfied with the contents of mental health training they received (Table 4.7). The majority of *Kaders* stated that it was well implemented. For example, the percentage of their opinion about training's theme, training's schedule, environment, speaker, the content of training and committee are around 50% or above.

Table 4. 7 *Kaders'* satisfaction with mental health training

Variables	Bad	Not bad	Moderately	Good	Excellent
Theme	4(2.2%)	55(30.1%)	21(11.5%)	68(37.2%)	35(19.1%)
Schedule	8(4.4%)	52(28.9%)	31(17.2%)	81(45.0%)	8(4.4%)
Environment or situation	3(1.7%)	31(17.2%)	39(21.7%)	96(53.3%)	10(5.5%)
Speakers	1(0.6%)	25(13.9%)	16(8.9%)	103(57.2%)	35(19.4%)
Content of training	1(0.6%)	28(15.5%)	16(8.8%)	87(48.1%)	49(32.6%)
Service of the Committee	2(1.1%)	26(14.6%)	26(14.6%)	110(61.8%)	14(7.9%)

N=181. Tabulated is only the *Kaders* who had been trained, and missing data were excluded from each tabulation.

Table 4.8 shows the *Kaders'* opinions for mental health service at the present time. More than half of *Kaders* expected the larger budget for mental health service. More than two-thirds of *Kaders* also hope that the government should be more responsible toward mental health services.

Their previous access to mental health service is also shown in Table 4. 8. Nearly half of the respondents had an experience that their relative or family has ever been hospitalized.

One-fifth of the respondents experienced the hospitalization of their family or close friends. Nearly half of them have other persons who have to get medical intervention. Most of them perceived more budget and the responsibility of the government are required for mental health service in Indonesia.

Table 4. 8 *Kaders'* opinion about mental health service in Indonesia[6]

Variable	Items	N	%
The budget for mental health services	a. spend much more	220	35.7
	b. spend more	159	25.7
	c. spend the same as now	90	14.5
	d. spend less	6	1.0
	e. spend much less	4	0.6
	f. can't choose	87	14.1
	g. no answer	37	6
The responsibility for mental health services should be on the government	a. Definitely should be	346	56.3
	b. Probably should be	155	25.0
	c. Probably should not be	77	12.3
	d. Definitely should not be	5	0.8
	e. Can't choose	16	2.6
	f. No answer	19	1.6
"I have a relative or family hospitalized because of mental disorder."	a. Yes	287	46.4
	b. No	295	47.7
	c. Not sure	20	3.2
(If yes to the above question) Relationship with a respondent	a. Family	54	8.7
	b. Close friend	87	14.1
	c. Others	132	21.3
	d. Won't say	18	2.6
	e. Don't know	21	3.4
"I have another person who has to get intervention."	a. Yes	305	49.3%
	b. No	59	9.5%
	c. Don't know	209	33.8%

N=619. Missing data were excluded from tabulation.

4.4 *Kaders'* Health Locus of Control

As shown in Table 4.9, the *Kaders* with long experience showed higher scores of powerful others HLC than those with short years. The respondents highly educated also showed

[6] Published in Wardaningsih & Kageyama (2017)

higher scores of powerful others HLC than those at a low level of education. The respondents who experienced mental health training showed significantly low scores of Internal HLC than those untrained, although years of *Kader's* experience was not associated with Internal HLC scores. The HLC showed no association with the perception toward possible patients with mental disorders. The *Kaders* who primarily consult possible patients (the first vignette) with mental disorders with psychiatrist showed low scores of Chance HLC scores. Other sociodemographic variables had no correlation with any of HLC scores. No other variables for *Kaders'* sociodemographic background associated with HLC.

Table 4. 9 The association of Health Locus of Control with *Kaders'* background and the persons they will consult[7]

Variable	Items	Health Locus of Control					
		Internal		Chance		Powerful others	
		Mean±SD	F^1	Mean±SD	F^1	Mean±SD	F^1
Years of *Kader*'s experiences	Short	27.10±5.64	1.45	21.06 ±9.12	0.11	25.76 ±5.88	5.42
	Long	26.49±5.73	(NS)	21.31 ±7.19	(NS)	26.96±5.94	(P<0.05)
Education	High	27.11±5.66	0.39	21.84±10.62	2.11	27.07±5.44	4.07
	Low	26.80± 5.65	(NS)	20.75 ±7.28	(NS)	25.94±6.74	(P<0.05)
Training for mental health	Present	26.17±5.410	3.59	20.68±7.286	0.586	26.13±6.245	0.11
	Absent	27.14±5.830	(P<0.05)	21.27±9.004	(NS)	26.32±6.532	(NS)
Consultation with	Community leaders	27.29± 5.44	1.38 (NS)	21.25±7.95	6.01 (P<0.001)	26.03±6.21	0.81 (NS)
	PHC nurses	27.14±5.91		22.23±9.84		26.70±5.65	
	Psychiatrists	26.35±5.64		19.30±6.79		26.00±7.65	

N = 619

[1]*F*-value for one-way ANOVA.

[7] Published in Wardaningsih & Kageyama (2017)

5. Discussion

5.1 Sociodemographic background of *Kaders*

Before the discussion on the above data, it should be discussed whether the respondents in the present study represent the *Kaders* in Indonesia. As demonstrated in Table 4.1, the majority of the respondents were middle-aged Javanese women with low-level education. Female generally tend to be more empathetic and more altruistic, compared with male (Andreoni and Vesterlund, 2001). Only people with high altruistic feature want to be *Kaders*. These competencies are favorable for *Kaders* to work in their community because they work with no salary, and sometimes have to spend their own money for transportation. The competencies could be sufficient to adapt to their work, although their income is not so high as shown in Table 4.1. Although the study area was limited to Yogyakarta province, the response rate was sufficiently high (77%). The result of this study can be a typical sample of *Kaders* in Indonesia if Yogyakarta provinces characterized by a representative province.

5.2 *Kaders'* perception and attitude toward mental disorders

It is expected that stigma toward diseases is less frequent in CHW such as *Kaders* than in the general population because CHWs know the causes, treatment, and prognosis of the illness to some extent. However, if CHWs have a negative view on mental disorders, they may

not be eager in detecting patients for treatment or may give up in assisting the recovery of patients. Concerning the *Kaders'* perception and attitude toward the second and third vignettes, no comparable data with the present study was available among CHWs in South-East Asia or medical professionals in Indonesia. Since two previous studies using comparable methods focused on the general population in the US and Japan (Indiana Consortium for Mental Health Services Research, 1996; Yamazaki, et al., 2012), the following comparison with them should be carefully interpreted.

In comparison with the general population in the US and Japan, the *Kaders* tended to perceive the situations in the second and third vignettes a little less serious (Figs 4. 1, 4. 2, 4. 5, and 4. 6), probably induced by stress (Figs 4. 3 and 4.4). The general population in the US who perceived that Depression and Schizophrenia were very serious was 53.6% and 79.2% respectively, while that in Japan was about 58.5% and 65.5% respectively (Pescosolido, et.al, 1996; Yamazaki, 2012). However, they appear to doubt the likelihood of recovery and the ability to make decisions for care and to manage money on the possible patients with mental disorders (Figs 4. 8, and 4. 9). They also perceived the lower risk of self-injury or suicide for these patients, compared with the general population in the US and Japan (Fig. 4. 7). In addition, they were less willing to spend time or socialize with the persons with depressive or schizophrenia-like symptoms in the two vignettes than the general population in the US. They

were also less willing to be neighborhood or family with the persons with schizophrenia-like symptoms than the general population in the US and Japan.

The perception of low risk of self-injury (Table 4.7) may reflect the low suicide mortality in Indonesia (WHO, 2014e) in Muslim background. The *Kaders'* perception to low risk of violence and self-injury for the two vignettes agrees with the fact that the *Kaders* perceive the two cases not so serious (Figs. 4. 1 and 4. 2). However, the *Kaders* perceived that the two persons are unlikely to recover and to able to make a decision (Fig. 4. 5), as if they think that the disability to make a decision is not a serious problem. One of the reasons for this may be the cultural background in Indonesia: family members in Indonesia are, in general, so close each other (Kurihara, 2000; Subandi, 2011) that they can be easily helped for decision by family members. This often helps patients, although it is sometimes likely to lead paternalism. On the other hand, the perception that the possible patients with mental disorders are unlikely to recover probably reflects the actual condition in Indonesia where the number of psychiatric hospitals and clinic is in short (Riskesdas, 2007). The *Kaders* have rarely seen the patients in the acute phase, as illustrated in the vignettes, who get recovery through treatment. Moreover, mental health training for *Kaders* appeared to have almost no influence on their perception toward mental disorders (Table 4.4): this will be discussed in more detail in 5.4. As a result, their perception of psychiatric treatment and recovery is likely to be affected by rumor or stigma,

remaining inconsistent or superficial. This may explain the fact that *Kader's* attitude toward the two vignettes was not so positive as a whole (Figs. 4. 6 and 4. 7).

5.3 Consultation concerning possible patients with mental disorders

If a *Kader* meets a person with health problems, they generally consult with the PHC about the case. This was similar to the possible patients with mental disorders in the first vignette (Table 4. 2). This seems good as the choice of non-professional CHW. PHC and *Kaders* are important components of community health system in Indonesia. PHCs depend on the community volunteers, and *Kaders* play a role of facilitators for the community to reach health services (Iswarawanti, 2010). Their second choice was consultation with community leaders. This seems reasonable in Indonesian and other South-East Asian cultures which encourage persons helping each other in a community (Subandi, 2011; Ito et.al, 2012). It was rare for the *Kaders* to consult these cases with the alternative therapist or religious leaders (Table 4.2), in comparison with the general population in the US and Japan. Although alternative therapy and traditional religion are still common in Indonesia, particularly in rural areas, consultation with them is so expensive in Indonesia that the *Kaders* will hesitate to access them.

The *Kaders* probably learned the above choices through their experiences in previous community health program. However, only the *Kaders* in Sleman district tended to consult the

patients directly with a mental hospital, in comparison with in other four district, probably because there was only one mental hospital has located in Sleman district. It should be pointed out that the Yogyakarta local government has not established systematic introduction system for patients with mental disorders that can be found by *Kaders* or PHC to the hospital, or systematic reference system for discharged patients from the hospital to community. These systems should be established as soon as possible.

5.4 Association of the perception and attitude with previous mental health training and meeting with patients with mental health disorders

The percentage of *Kaders'* who experienced mental health training was related to years of *Kader's* experience, but not to their living area or educational background (Table 4.3). Since opportunity of the training is not so frequent, *Kaders* with short experiences probably have not been given adequate opportunity.

It was surprising that mental health training for *Kaders* appeared to have almost no influence on their perception toward mental disorders (Table 4.4). However, if the *Kaders* were once categorized into two groups according to years of *Kader's* experience (Table 4.5), the difference in the perception between the trained and the untrained was significant only among the *Kaders* with long experiences. The old *Kade*rs without mental health training frequently

assess the situations in two vignettes less severe, although the situations might show the acute phase of mental disorders.

Why does the previous mental health training presently have limited effects on *Kaders*, regardless of *Kaders'* satisfaction with the training provided (Table 4. 7)? It is possible that the training is too short (usually two days or shorter) to affect their perception of mental disorders. In addition to the short period, the content of the training did not explain the etiology or treatment of mental disorders, but just their symptoms. According to Armstrong (2011), the 4-days curriculum which provides appropriate contents (introduction to mental health, mental health first aid, basic skill and mental health promotion-including stigma) to CHWs could improve their knowledge and attitude to the mental disorders. It also should be considered that the contents are accessible to young *Kaders* through media such as the Internet. They probably obtain the information for the seriousness of mental disorders in the opportunity other than mental health training by themselves. This may be another reason why the training appeared to have no effect on young *Kaders*.

On the other hand, whether a *Kader* had ever met the persons with psychotic symptoms illustrated in the first vignettes was partially associated with the views on mental disorders (Table 4. 6). It is interesting that the experiences seem to make the *Kaders* a little more optimistic toward the prognosis of the illustrated cases. This suggests that actual contacts with

the patients with mental disorders contribute to the reduction of *Kaders'* stigma better than the previous mental health training does. Crips et.al (2000) found that negative stigma depends not only on knowledge about mental disorder but also on massive campaign in a community, for example, to invite persons with schizophrenia to speak up about their experience. If *Kaders* can contact patients who recovered from mental disorders, this may be a good opportunity to reduce their stigma toward mental disorders. However, if they get too much optimistic about the prognosis of psychotic symptoms, they may fail to consult PHC nurses or doctors about the cases.

Taking the previous studies into consideration, the contents of mental health training for *Kaders* should include mental and behavioral symptoms showing the need of treatment, causes of severe mental disorders, and possible prognosis of the mental disorders. The training program also should include appropriate actions of treatment and rehabilitation for the mental disorders, the preventive measures against the mental disorders, and opportunity to contact with persons who recovered from mental disorders, if possible. These measures seem to be corresponding to *Kaders*' opinion to mental health service (Table 4.8), namely the national and local governments should take a more role for mental health. However, too much immense knowledge and terminology are not required. For example, schizophrenia is too complicated terminology for *Kaders.* In this context, Japan can provide a good example; to replace

schizophrenia with easier terms in Japanese (2006) was efficient to reduce stigma for patients with schizophrenia (Sato, 2006). It also may be effective to newly recruit young *Kaders*, because they are more accessible to collect information about mental health and able to continue to participate in the future mental health program.

5.5 *Kaders'* Health Locus of Control

In the present study, the HLC scores for Powerful Others were higher among the *Kaders* with long experience, and also among those at high education level (Table 4. 9). In contrast, the *Kaders* at a high level of education showed low scores for Powerful Others HLC and a little high scores for Internal HLC, probably because they have obtained scientific knowledge for health and medicine. In the case of some mental disorders, however, the causes of disease remain unclear where medical care is required; namely, dependence on powerful others such as professional nurses and doctors is not a wrong choice.

It was not surprising that HLC in the present study showed no association with the perception toward possible patients with mental disorders although the results of previous studies on the association are inconsistent (Higashiguchi, 1997). However, it was a new finding that those who consult a psychiatrist about the patient with psychotic symptoms (the first vignette) showed low scores of Chance HLC (Table 4. 9). They probably have common

knowledge that causes of psychotic symptoms are diseases which can be improved by treatment, and that is not coincidence. However, Chance HLC scores were not affected by previous mental health training, as shown in Table 4. 9. On the other hand, those who consult PHC nurses in the same situation did not show the same tendency. They appeared to ask the PHC nurses regardless of medical knowledge. Of course, it is not a wrong choice for *Kaders* to consult with PHC about possible patients with mental disorders. However, the association of HLC with the choice of consultants was not so strong.

5.6 *Kaders'* opinion about mental health service

Kaders' opinion about mental health services (Table 4. 10) seems to be related to the condition when the study was conducted. The Indonesia national government enacted Mental Health Act in August 2014. During doing the activities in mental health, PHC cooperates with the academic institution, i.e. school of nursing and medicine, particularly in budgeting. Thus, PHC sometimes finds difficulty in sustaining the program. Some *Kaders* complained of the difficulty of funding for transportation, probably because of their internal motivation (Djuhaeni, 2010) which comes from their responsibility as a helper in the community, but not from economic rewards.

5.7 Limitation of the present study

In the present study, direct information about *Kader's* behaviors, e.g. who do they actually consult about a possible patient with a mental disorder, and how do they help social participation among patients with mental disorders, were not available. Only the self-reported possible choice was examined. It also remains unclear whether their choice to consult a specialist with the possible patients was timely or not. If they failed to consult timely, these experiences would provide a valuable information to future training on mental health.

5.8. Implication

Since the present study was cross-sectional designed, we could not determine exact causal relationship from the correlation observed in our results. If a longitudinal study is conducted on their perception, attitude, and future behaviors as CHWs, more definite conclusion will be available. The comparison of the present data with the CHWs in other countries or other medical professionals in Indonesia will provide more interesting and suggestive discussion.

However, the mental health training for *Kaders* showed limited efficiency for their perception and attitude toward possible patients with mental disorders. As a result, their perception and attitude were partly pessimistic for prognosis of mental disorders. On the other

hand, the effects of actual experiences in meeting a possible patient with psychotic symptoms on the perception and attitude were also suggested. Their practice to possible patients with mental disorders was partly associated with their HLC; consulting behaviors with a health professional may be associated with the belief that mental diseases are not caused by chance but can be treated by medicine. These results implicated the need to revise the mental health training for *Kaders*, and also improve mental health law and policy in Indonesia to give sufficient budget for the training.

5.9. Recommendation

Regardless of some limitations, the obtained results show what should be changed in the future training program on mental health for *Kaders*. Based on the results, the role of *Kaders* and the training program for community mental health should be reconsidered. The national and local government sectors, which are responsible for community mental health program, should develop a suitable program for mental health training to satisfy the need for *Kaders* and communities. The nurses in PHC should equip *Kaders* with the knowledge about mental health and mental illness such as schizophrenia and depression in order that the *Kaders* correctly perceive the persons with mental disorders. It is particularly important to strengthen the motivation to face with a new issue, community mental health, among young, newly recruited

Kaders. Since some local governments in Indonesia have not established systematic introduction system for possible patients from the community to the hospital, or systematic referral system for discharged patients from the hospital to community, *Kaders* must be appropriately involved in these systems. It is also expected that the budget from the government provides incentives to the *Kaders* in their role, and increase the opportunity of mental health training for them. This idea is in line with the results of the study conducted by Djuheani (2010), which showed that incentive or reward affected motivation.

5.10. Conclusion

Only 29.2% of *Kaders* experienced mental health training. Although they were satisfied with the training, limited efficiency of the training for their perception of possible patients with mental disorders was confirmed, particularly among those with long experience of *Kaders*. They perceived the possible patients unlikely to recover and to able to make a decision, having a low risk for violence, but less serious, and less willing to spend time or socialize with them, compared with the general population in the US and Japan. This may be affected by the fact that they rarely see the patients get recovery from treatment. If they meet a similar person, they intended to consult with PHC or community leaders. Only those in a sub-district including a mental hospital, they tended to consult with the hospital. However, those who actually met

possible patients with mental disorders seemed to be more optimistic toward the prognosis of the possible patients. In addition to the above results, a part of the above perception, attitude, and practice was associated with HLC, although the association was weak.

These results suggest the need to revise the program of mental health training, in order to improve the above perception and attitude. That should include the need of treatment, causes, prognosis, and appropriate actions of treatment and rehabilitation for mental disorders.

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APPENDIX A

QUESSIONNAIRE IN ENGLISH

PERCEPTION, ATTITUDE AND EXPERIENCE IN CONSUTATION OF KADER TOWARD MENTAL DISORDER IN YOGYAKARTA AREA

A. SOCIODEMOGRAPHIC DATA

1. Gender : □○Male □○Female
2. Age : □○18 – 24 years old □○25 – 34 years old
   ○35 – 54 years old ○> 54 years old
3. Ethnicity :□ ○Javanese □○Non Javanese
4. Educational Background :□ ○Elementary School □○Junior High School
   □○Senior High School □○Graduated School
5. Marital status :□ ○Single □○Married □○Widow ○ Widower
6. District : ○Yogyakarta ○Bantul ○Sleman ○Kulon Progo ○Gunung Kidul
7. Family Income :□ ○< Rp. 650,000 □○≥Rp 650,000 – Rp 2,000,000
   ○ □> Rp 2,000,000
8. Occupation : □○House wife □○fulltime job □○part time job
9. How long have been cadre : _____ year(s)

B. EXPERIENCE AS A KADER

The following questions are related to the Community Mental Health. Health is a condition of a person not only physically fit but also mentally. While mental health is a condition where a person is able to adapt well

1. In the community where you live, whether you've met residents of the public who have behavioral symptoms speak to themselves, laughing themselves and not dressed appropriately, thinks he has the power that is not fair, or behaving strangely. That kind of symptoms have been happened during 3 years?
   a. Yes
   b. No
2. As a Kader, have you ever been to collect data directly to the public, to people who experience the above symptoms?
   a. Never
   b. Yes, I have ever. How many times in the last year? _____ (never, 1-3 times, 4-8 times, 9-12 times)

3. Where did you get the information from? (can more than 1 answer)
   a. Screening (from yourselves when you do visiting home)

b. From PHC

c. By patient themselves

d. From policemen/security member

e. From family

f. From other community member

4. If you visit or meet with families who have family members with symptoms, any questions that you ask your family. (can more than 1 answer)

   a. How old the patient

   b. When the sign and symptom detect first time by family?

   c. Sign and symptom recently

   d. Patient complaint about the patient

   e. Family complaint about the patient (for example: what is the difficulty to care the patient)

The following is an illustration that you've probably met in the community

c. Knowledge about Mental Disorder

The following questions is about previous vignettes. Please answer the questions base on your opinion and your own attitude

Problem often come up in life. Sometimes they are personal problems-people are very unhappy, or nervous and irritable all the time. Sometimes problems in a marriage-a husband and wife just can't get along with each other. Or sometimes it's a personal problem with a child or a job. I'd like to ask you a few question now about what you think a person might do to handle problems like this.

1. For instance, let's suppose you had a lot of personal problems and you are very unhappy all the time. Let's suppose you've been that way for a long time, and isn't getting any better. What do you think you'd do about it?

   a. Let it flow because I think someday the problem will be completed

   b. solving the problems by me because this is a personal thing

   c. solving the problems by sharing with others (relatives)

   d. Solving the problem by consulting with professionals

Illustration 1

Sumanto (25 years old), jobless, his education background is Senior High School. He lives with his mother who was 55 years old. Sumanto have symptoms of talking by himself, he thinks he has super strength. Accordingly, he often do bizarre behavioral and sometimes act aggressively.

He was healthy before graduated, and this condition was changed since 6 month ago.

2. What do you think about Mr. Sumanto's condition?

   a. Risk for Psychosocial disorder

   b. Mental Disorder

   c. Trans Disorder

3. According to illustration 1, if in your community, there are any a member of community who gets this symptom, what you will do?

   a. Keep silent

   b. Referring for him to public health center

   c. Exclude him from community

   d. Referring for him to community leader

4. What kind of criteria to refer the patient? (can more than 1 answer)

   d. Couldn't take care themselves

   e. Sleeplessness

   f. Endanger themselves

g. Endanger the other ones

5. Where do you refer the severe disorder case? (can more one answer)

   a. Community leader

   b. PHC Nurse

   c. Mental Hospital

   d. Alternative medicine/ supernatural

6. Have ever been referred the case like the previous care in the community

   a. Never

   b. 1-3 cases

   c. More than 3 cases

7. What is your difficulty to care of them?

   ○Family is not cooperative

   ○Assessing to Public Health Center or Health services

   ○Lack of knowledge about mental health problem

   ○Lack of interest of me about mental health problem

○ I don’t know because I haven’t had experience anyway

Illustration 2

Schizophrenia Vignette

Sri is a woman, who has completed senior high school. Up until a year ago, life was pretty okay for Sri. But then, things started to change. She thought that people around her were making disapproving comments, and talking behind her back. Sri was convinced that people were spying on her and that they could hear what she was thinking. Sri lost her drive to participate in her usual work and family activities and retreated to her home, eventually spending most of her day in her room. Sri became so preoccupied with what she was thinking that she skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, she was walking back and forth in her room. Sri was hearing voices even though no one else was around. These voices told her what to do and what to think. She has been living this way for six months

Next I’m going to describe a person-let call her Sri. After I read a description of her I’ll ask you some questions about how you think and feel about her. There no right or wrong answers. I’m only interest in what you think of Sri.

8. Please remember, there are not right or wrong answers to these questions. Please think about the person just described when answering this group of questions. First, how serious would you consider (Sri's) problem to be-very serious, somewhat serious, not very serious, or not at all serious?

a. 1 very able

b. 2 somewhat able

c. 3 not very able

d. 4 not able at all

e. don't know

9. In your opinion, how likely is it that Sri's situation might be caused by __very likely, somewhat likely, not very likely or not all likely?

	very likely	somewhat likely	not very likely	not all likely
a. Her own bad character				
b. A chemical imbalance in the brain				
c. The way (she) was raised				
d. Stressful circumstances in her life				

e. A genetic or inherited problem				
f. God's Will				

10. In your opinion, how likely is it that SRI is experiencing-very likely, somewhat likely, not very likely, or not at all likely?

	Very likely	Somewhat likely	Not very likely	Not at all likely
a. Part of the normal ups and downs of life				
b. A nervous breakdown				
c. A mental illness				
d. A physical illness				

11. In your opinion, how able is Sri to make her own decisions about the treatment she should receive;

a. very able,

b. somewhat able,

c. not very able

d. nor able at all?

12. In your opinion, how able is SRI to make his/her own decisions about managing his/her

own decisions about managing his/her own money-very able, somewhat able, not very able or not able at all

a. very able

b. somewhat able

c. not very able

d. not able at all

e. don't know

13. In your opinion, how likely is that SRI's situation will improve on its own – very likely, somewhat likely, somewhat likely, somewhat unlikely or not likely at all?

a. very likely

b. somewhat likely

c. somewhat unlikely

d. not likely at all

e. Don't know

14. In your opinion, how likely is that SRI's situation will improve with treatment – very likely, somewhat likely, somewhat likely, somewhat unlikely or not likely at all?

a. very likely

b. somewhat likely

c. somewhat unlikely

d. not likely at all

e. Don't know

15. How willing would you be (vignette) definitely willing, probably willing, probably unwilling, or definitely unwilling?

	Definitely willing	Probably willing	Probably unwilling	Definitely unwilling
a. To move next door to SRI?				
b. To spend an evening socializing with SRI?				
c. To make friends with SRI?				
d. To have SRI start working closely with you on a job				
e. To have a group home for people like SRI opened in your neighborhood				
f. To have SRI marry into your family				

16. In your opinion, how likely is it SRI would to something violent toward other people. Is it:

    a. very likely
    b. somewhat likely
    c. somewhat unlikely
    d. not likely at all
    e. Don't know

17. In your opinion, how likely is it SRI would to something violent him/herself. Is it:

    a. very likely
    b. somewhat likely
    c. not very likely ALLOWED DEFINITION: violent toward self: suicide, eating, wondering in traffic, self mutilation
    d. not likely at all
    e. don't know

18. Should SRI do any of the following:

	Should Do: (yes=1,No=5,DK=8)	Order
Talk to family and friends about it		
Talk to minister, priest, rabbi or other religious leader		
Go to a general medical sector for help		
Go to psychiatrist for		
Go to a therapist, or counselor		
Join a self help group where people with similar problems help each other		
Take non prescription medication, like over the counter sleeping pills		
Take prescription medication		
Check into a mental hospital		

Illustration 3

Depression Vignette

Supratman is a man, who has completed undergraduate school. For the last two weeks Supratman has been feeling really down. He wakes up in the morning with a flat, heavy feeling that sticks with him all day long. He isn't enjoying things the way he normally would. In fact,

nothing seems to give him pleasure. Even when good things happen, they don't seem to make Supratman happy. He pushes on through his days, but it is really hard. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy and out of steam. And even though Supratman feels tired, when night comes he can't get to sleep. Supratman feels pretty worthless, and very discouraged. Supratman's family has noticed that he has-n't been himself for about the last month, and that he has pulled away from them. Supratman just doesn't feel like talking

19. Please remember, there are not right or wrong answers to these questions. Please think about the person just described when answering this group of questions. First, how serious would you consider (Supratman's) problem to be-very serious, somewhat serious, not very serious, or not at all serious?
    a. 1 very able
    b. 2 somewhat able
    c. 3 not very able
    d. not able at all
    e. don't know
20. In your opinion, how likely is it that Supratman's situation might be caused by __very likely, somewhat likely, not very likely or not all likely?

	very likely	somewhat likely	not very likely	not all likely
a. His own bad character				
b. A chemical imbalance in the brain				
c. The way he was raised				
d. Stressful circumstances in his life				
e. A genetic or inherited problem				
f. God's Will				

21. In your opinion, how likely is it that supratman is experiencing-very likely, somewhat likely, not very likely, or not at all likely?

	Very likely	Somewhat likely	Not very likely	Not at all likely
a. Part of the normal ups and downs of life				
b. A nervous breakdown				
c. A mental illness				
d. A physical illness				

22. In your opinion, how able is Supratman to make her own decisions about the treatment she should receive;

a. very able,

b. somewhat able,

c. not very able

d. nor able at all?

23. In your opinion, how able is Supratman to make his own decisions about managing his own decisions about managing his own money-very able, somewhat able, not very able or not able at all

a. very able

b. somewhat able

c. not very able

d. not able at all

e. don't know

24. In your opinion, how likely is that Supratman's situation will improve on its own – very likely, somewhat likely, somewhat likely, somewhat unlikely or not likely at all?

a. very likely

b. somewhat likely

c. somewhat unlikely

d. not likely at all

e. Don't know

25. In your opinion, how likely is that Supratman's situation will improve with treatment – very likely, somewhat likely, somewhat likely, somewhat unlikely or not likely at all?

a. very likely

b. somewhat likely

c. somewhat unlikely

d. not likely at all

e. Don't know

26. How willing would you be (vignette) definitely willing, probably willing, probably unwilling, or definitely unwilling?

	Definitely willing	Probably willing	Probably unwilling	Definitely unwilling
a. To move next door to Supratman?				
b. To spend an evening socializing with SRI?				
c. To make friends with Supratman?				
d. To have Supratman I start working closely with you on a job				
e. To have a group home for people like Supratman opened in your neighborhood				
f. To have Supratman marry into your family				

27. In your opinion, how likely is it Supratman would to something violent toward other people. Is it:

a. very likely
b. somewhat likely
c. somewhat unlikely
d. not likely at all
e. Don't know

28. In your opinion, how likely is it Supratman would to something violent him/herself. Is

it:

a. very likely
b. somewhat likely
c. not very likely ALLOWED DEFINITION: violent toward self: suicide, eating, wondering in traffic, self mutilation
d. not likely at all
e. don't know

29. Should Supratman do any of the following:

	Should Do: (yes=1,No=5,DK=8)	Order
Talk to family and friends about it		
Talk to minister, priest, rabbi or other religious leader		
Go to a general medical sector for help		
Go to psychiatrist for		
Go to a therapist, or counselor		
Join a self help group where people with similar problems help each other		
Take non prescription medication, like over the counter sleeping pills		
Take prescription medication		
Check into a mental hospital		

d. Next, we would like to ask about mental health service

1. Earlier, we talked about various areas of government spending. Since we've been talking about the mental health area, please indicate whether you would like to see more or less government spending in the area of mental health care. Remember that if you say, "much more". It might require a tax increase to pay for it.

h. spend much more

i. spend more

j. spend the same as now

k. spend less

l. spend much less

m. can't choose

n. no answer

2. On the whole, do you think it should not be the government's responsibility to provide health care for persons with mental illness?

g. Definitely should be

h. Probably should be

i. Probably should not be

j. Definitely should not be

k. Can’t choose

l. No answer

3. Did you ever know anyone who was in a hospital because of a mental illness?

d. Yes

e. No

f. Not sure

4. (IF YES), was this a relative, a close friend, or just someone you didn’t know very well? If you don’t want to explain who is she/he, please answer (e). Don’t know

f. Family

g. Close friend

h. Other

i. Won’t say

j. Don’t know

5. Have you ever known anyone (other than persons mentioned above who was seeing a psychologist, mental health professional, social worker or other counselor?

a. Yes

b. No

c. Don’t know

2. Health Locus of Control

Each item below is belief statement about your medical condition with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement; the lower will be the number you circle. Please make sure that you answer EVERY ITEM and that you circle ONLY ONE number per item. This is a measure of your personal beliefs; obviously, there are not right or wrong answers.

1 = Strongly disagree (SD)	4 = Slightly Agree (A)
2 = moderatly disagree (MD)	5 = Moderatly Agree (MA)
3 = Slightly disagree (D)	6 = Strongly Agree (SA)

	Statement	1	2	3	4	5	6
1	If my condition worsens, it is my own behavior which determines how soon I will feel better again						
2	As to my condition, what will be will be						
3	If I see my doctor regularly, I am less likely to have problems with my condition						
4	Most things that affect my condition happen to me by chance						
5	Whenever my condition worsens, I should consult a medically trained professional						
6	I am directly responsible for my condition getting better and worse						
7	Other people play a big role in whether my condition improves, stays the same, or gets worse						

8	Whatever goes wrong with my condition is my own fault						
9	Luck plays a big part in determining how my condition improves						
10	In order for my condition to improve, it is up to other people to see that the right things happen						
11	Whatever improvement occurs with m condition is largely a matter of good fortune						
12	The main thing which affects my condition improves and the blame when it gets worse						
13	I deserve the credit when my condition is what I myself do						
14	Following doctor's orders to the letter is the best way to keep my condition from getting any worse						
15	If my condition worsens, it's a matter of fate						
16	If I am lucky, my condition will get better						
17	If my condition takes a turn for the worse, it is because I have not been taking proper care of myself						
18	The type of help that given by God or Supernatural how soon my condition improves						
19	The type of cure I receive from other people is what is responsible for how well I recover from an illness						

F. Finally, we would like to answer about training for kaders

1. Have you ever got the training especially about Mental Health?
   a. Yes
   b. Not yet

2. Do you think the training is important to you as a Kader?

   a. Yes

   b. Not too important

6. **Evaluation (for TRAINED KADER)**,please remark your opinion, score 1 – 5 is mean bad - excellence

Items for evaluation	1	2	3	4	5
a. Theme of Training					
b. Timelines					
c. Environment					
d. Completeness of materials					
e. Service of the committee					
f. Tools (instrument, handout)					
g. Mastery of the speaker					
h. Whole of the training					

APPENDIX B

QUESSIONNAIRE IN BAHASA

SURVEI PERSEPSI, SIKAP DAN PENGALAMAN DALAM KONSULTASI PADA KADER TERHADAP KESEHATAN JIWA

A. Silakan jelaskan secara singkat tentang diri Anda terlebih dahulu.

1. Jenis kelamin	□perempuan	□ laki-laki
2. Usia	□18 - 24 tahun	□25 – 34 tahun
	□ 35 - 54 tahun	□ 55 tahun atau lebih
3. Suku	□Jawa	□ selain Jawa
4. Pendidikan	□Sekolah Dasar	□ Sekolah Menengah Pertama
	□ SMU	□ kuliah
5. Status perkawinan	□single	□menikah
	□janda / duda	
6. Area tempat tinggal	□Yogyakarta □ Bantul □Sleman6	
	□Kuronpurogo □Gununkidul	

7. pendapatan rumah tangga

□ kurang atau sama dengan Rp 650,000

□ lebih dari Rp 650 000 s.d 2 juta rupiah

□ lebih dari 2 juta rupiah

8. Pekerjaan

□Bekerja penuh waktu

□ibu rumah tangga

□pekerjaan paruh waktu

9. Berapa tahun yang Anda dari menjadi seorang kader kesehatan _____tahun

B. Selanjutnya, pertanyaan tentang pengalaman Anda sebagai Kader.

Saya ingin bertanya tentang kesehatan mental masyarakat. Kesehatan seseorang dapat bermasalah, termasuk kesehatan mental serta kesehatan fisik. seperti yang Anda tahu, bahwa dapat dikatakan sehat jiwa bahwa pikiran adalah kemampuan seseorang dapat beradaptasi dengan baik terhadap lingkungan dan kesehatan.

1. Dalam masyarakat di mana Anda tinggal, apakah Anda pernah bertemu warga masyarakat yang memiliki gejala yaitu perilaku berbicara dengan diri mereka sendiri, tertawa sendiri dan tidak berpakaian dengan tepat, berpikir bahwa ia memiliki kekuatan yang tidak wajar, atau bertingkah aneh. Gejala semacam itu telah terjadi selama 3 tahun?

a. Ya

b. Tidak

2. Sebagai Kader, apakah Anda pernah untuk mengumpulkan data secara langsung di masyarakat, terutama pada orang-orang yang mengalami gejala-gejala di atas?

   a. Tidak pernah

   B. Ya, saya pernah. Berapa kali dalam setahun terakhir? _____ (Tidak pernah, 1-3 kali, 4-8 kali, 9-12 kali)

3. Dari siapa anda mendapatkan informasi tentang orang itu? (Anda dapat memilih lebih dari satu.)

   a. Skrining langsung (atas inisiatif sendiri ketika melakukan kunjungan ke rumah warga)

   b. Informasi dari puskesmas

   c. Dari pasien secara langsung

   d. Dari polisi atau dari petugas yang lain

   e. Dari keluarga pasien

   f. Dari anggota masyarakat

4. Sebagai seorang Kader, ketika sedang mengunjungi rumah tangga dengan orang-orang seperti di atas, apa yang akan Anda tanyakan? (Anda dapat memilih lebih dari satu.)

    1) Berapa umur pasien
    2) Sejak kapan tanda dan gejala diketahui oleh keluarga
    3) Tanda dan gejala saat ini
    4) Apa yang dikeluhkan pasien terhadap kondisinya
    5) Apa yang keluarga keluhkan terhadap kondisi pasien (coba

C. Berikut saya sampaikan beberapa kasus. Sebagai Kader di wilayah mungkin anda pernah menjumpai kasus tersebut. Ini bukan orang sungguhan, ada orang-orang yang mungkin sangat mirip dengan cerita yang ada didalam kasus berikut. Bahkan jika Anda tahu orang yang Anda miliki sangat mirip terjadi jika orang itu, ini hanya kebetulan saja

1. Terdapat bermacam-macam masalah dalam kehidupan. Kadang-kadang masalah pribadi, atau menjadi tidak bahagia, cemas, atau kesal pada sepanjang hari. Masalah perkawinan, mungkin terjadi saling tidak bekerja kadang-kadang. Kadang-kadang khawatir bahwa anak-anak dan, dengan cara bekerja kadang-kadang. Kami akan menanyakan tentang

bagaimana masalah seperti itu, atau pengobatan. Sebagai contoh, Anda memiliki banyak masalah, dan selalu khawatir. Anda keadaan seperti terus untuk waktu yang lama, masalahnya belum lebih baik. Pada saat-saat seperti itu, Apa yang Anda lakukan.

a. jalani saja, karena saya pikir suatu saat nanti akan berakhir

b. menyelesaikan masalah sendiri karena ini masalah pribadi

c. menyelesaikan masalah dengan konsultasi kepada teman

d. menyelesaikan masalah dengan berkonsultasi kepada tenaga profesional

Kasus 1

Bp.Sumanto (umur 25), pengangguran, pendidikan dan lulus dari sekolah tinggi. Dia saat ini tinggal bersama ibunya yang berusia 55 tahun. Sumanto sering mengatakan bahwa dirinya sendiri bahwa ia akan memiliki kekuatan super. Dia terlihat sering berperilaku agresif dan perilaku aneh. Dia sehat sebelum lulus dari sekolah tinggi, namun kondisi berubah dalam enam bulan terakhir.

2. Jika ada masalah pada Bp.Sumanto, apa yang Anda pikirkan?

a. kemungkinan gejolak psikologis dan sosial.

b. jiwa gangguan

c. Kesurupan

3. Jika daerah di mana Anda tinggal, ada kasus-kasus seperti di atas, apakah yang Anda lakukan

a. Membiarkan saja

b. Hubungi pusat kesehatan setempat

c. mengecualikan dia dari masyarakat.

d. hubungi pemimpin daerah.

4. Jika kondisi menjadi lebih serius, kepada siapa Anda berkonsultasi?

a. tokoh masyarakat

b. perawat di pusat kesehatan masyarakat.

c. psikiatri rumah sakit.

d. yang membuat doa kepada kehadiran supranatural atau pengobatan alternatif.

5. Untuk membawa orang ini dan berkonsultasi ke pusat kesehatan setempat, apa yang menjadi dasar (kriteria)? (Anda dapat memilih lebih dari satu.)

1. Jika dia tidak dapat merawat diri sendiri

2. Jika orang tersenut mengalami gangguan tidur

3. Jika mempunyai kecenderungan membahayakan diri sendiri

4. Jika mempunyai kesenderung untuk membahayakan orang lain

6. Adakah kasus seperti itu di daerah Anda tinggal atau pernah ada?

a. Tidak pernah

b. 1-3 kali

c. Lebih dari 3 kali.

7. Ketika Anda membantu kasus, apakah ada kesulitan seperti berikut?

(Anda dapat memilih lebih dari satu.)

○Keluarga tidak dapat bekerjasama

○mengakses pusat pelayanan kesehatan

○kurangnya pengetahuan tentang kesehatan jiwa

○kurang tertarik dengan tentang kesehatan jiwa

○ saya tidak tahu karena belum mempunyai pengalaman

Kasus 2

Supratman adalah seorang pria, lulusan sebuah perguruan tinggi. Selama dua minggu terakhir Supratman telah merasa hidupnya benar-benar jatuh terpuruk dan kacau. Pada saat dia bangun di pagi hari dia selalu merasa perasaannya datar dan berat, dan itu berlangsung sepanjang hari. Dia tidak lagi menikmati hal-hal seperti biasanya. Dia merasa tidak ada yang memberikannya kesenangan. Bahkan ketika hal-hal baik terjadi, mereka tampaknya tidak membuat Supratman bahagia. Dia mencoba melalui kesehariannya, tetapi hal itu sulit baginya. Tugas yang sepele menjadi sulit untuk dicapai. Dia merasa sulit untuk berkonsentrasi pada apa pun. Dia merasa kehabisan energi. Meskipun Supratman merasa lelah, ketika malam datang dia tidak bisa tidur. Supratman merasa tidak berharga dan sangat putus asa. Keluarga Supratman telah memperhatikan bahwa dia tidak seperti dirinya yang biasanya dan menjauh dari mereka. Supratman merasa malas berbicara

Selanjutnya kita akan mendiskusikan orang yang kita panggil Supratman tersebut. Setelah anda membaca kasus tentang dia, saya akan menanyakan beberapa pertanyaan tentang Supratman dan bagaimana yang Anda pikir dan rasakan tentang dia. Tidak ada benar dan salah dalam jawaban. Saya hanya ingin mengetahui apa yang Anda pikirkan tentang

Supratman.

8. Apakah anda pikir apa yang dialami oleh Supratman ini serius?

a) Sangat serius

b) agak serius

c) tidak terlalu serius.

d) tidak serius sama sekali

e) tidak tahu

9. Seberapa mungkin keadaan Supratman disebabkan oleh hal-hal berikut ini

	Sangat banyak kemungkinan.	Agak mungin	Tidak begitu banyak kemungkinan	Benar-benar tidak mungkin
a) disebabkan karena karakter dari orang itu sendiri				
b) ketidakseimbangan zat kimia dalam otak				
c) Pola asuh				
d) stress dalam hidup				
e) masalah genetik				
f) takdir Tuhan				

10. seberapa besar kemungkinan dia (Supratman) mengalami?

	Sangat mungkin	Agak mungkin	Tidak begitu mungkin	Sangat tidak mungkin
a) bagian dari naik dan turunnya kehidupan				
b) Gangguan saraf				
c) gangguan jiwa				
d) gangguan fisik (tubuh)				

11. Menurut pendapat Anda, seberapa mampu adalah Supratman untuk membuat keputusan sendiri tentang pengobatan ia harus menerima

a. sangat mampu,
b. agak mampu,
c. tidak terlalu mampu
d. tidak mampu sama sekali?

12. Menurut pendapat Anda, seberapa mampu adalah Supratman untuk membuat keputusan sendiri tentang mengelola keputusan sendiri tentang mengelola uang-sangat sendiri

a. sangat mampu
b. agak mampu

c. tidak terlalu mampu

d. tidak mampu sama sekali

e. tidak tahu

13. Menurut pendapat Anda, seberapa besar kemungkinan bahwa situasi Supratman tersebut akan membaik dengan sendirinya

a. Sangat mungkin

b. Agak mungkin

c. Agak tidak mungkin

d. tidak mungkin sama sekali

e. Tidak tahu

14. Menurut pendapat Anda, seberapa besar kemungkinan bahwa situasi Supratman akan membaik dengan pengobatan?

a. Sangat mungkin

b. Agak mungkin

c. Agak tidak mungkin

d. tidak mungkin sama sekali

e. Tidak tahu

15.Seberapakah kesediaan anda untuk …..

	Saya sangat ingin melakukan	Saya ingin berbuat banyak untuk itu	Saya mungkin tidak ingin melakukan	Saya sangat tidak ingin melakukan
a. untuk duduk disebelah Supratman				
b. Untuk bermalam bersamanya				
c. untuk berteman baik dengan Dewi				
d. Dia bekerjasama dengan anda dalam suatu pekerjaan				
f. Untuk memiliki tetangga dengan rumah kelompok bagi orang-orang seperti Dewi				
g. Dia menikah				

dan menjadi anggota keluarga anda				

16. Menurut pendapat Anda, seberapa besar kemungkinan itu Supratman akan melakukan tindakan kekerasan terhadap orang lain. Apakah ….

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

17. Menurut pendapat Anda, seberapa besar kemungkinan itu Supratman akan melakukan tindakan kekerasan dirinya sendiri. Apakah…

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

18. Haruskan Supratman melakukan salah satu dari berikut ...

Bicarakan dengan keluarga dan teman-teman tentang kondisi ini	Ya tidak tidak tahu
Konsultasikan dengan pendeta pemimpin agama, imam, atau pendeta	Ya tidak tidak tahu
mencari bantuan dari rumah sakit umum	Ya tidak tidak tahu
Pergi ke rumah sakit jiwa	Ya tidak tidak tahu
Pergi ke seorang terapis atau konselor	Ya tidak tidak tahu
Berpartisipasi dalam kelompok self-help untuk orang dengan masalah yang sama saling mendukung satu sama lain	Ya tidak tidak tahu
Minum obat bebas untuk mengatasi gangguan tidur	Ya tidak tidak tahu
Minum obat yang diresepkan dokter	Ya tidak tidak tahu
Dirawat di rumah sakit jiwa	Ya tidak tidak tahu

Kasus 3

Sri（30 tahun）adalah seorang wanita, lulusan SMA. Sampai tahun lalu, kehidupan Dewi berjalan dengan baik. Tapi kemudian, hal-hal mulai berubah, ia mulai berpikir bahwa orang-orang di sekelilingnya sedang membicarakannya dan tidak menyetujui setiap tindakannya. Sri meyakini bahwa ada orang yang memata-matainya dan bahwa mereka bisa mendengar apa

yang sedang dipikirkannya. Hal ini mengakibatkan Sri kehilangan dorongan untuk berpartisipasi dalam tugas yang biasa dia lakukan dalam keluarga dan tidak mau lagi berkumpul dengan anggota keluarga. Pada akhirnya dia lebih banyak menghabiskan hari-hari di kamarnya. Sri menjadi begitu sibuk dengan apa yang dia berpikir bahwa dia tidak lagi makan dan mandi secara teratur. Pada malam hari, ketika orang lain sedang tidur, ia berjalan bolak-balik di kamarnya. Sri mendengar suara-suara meskipun tidak ada orang lain di sekitar. Suara-suara mengatakan kepadanya apa yang harus dilakukan dan apa yang harus dipikirkan. Dia telah mengalami hal ini selama 6 bulan terakhir.

Selanjutnya kita akan mendiskusikan orang yang kita panggil Sri tersebut. Setelah anda membaca kasus tentang dia, saya akan menanyakan beberapa pertanyaan tentang Sri dan bagaimana yang Anda pikir dan rasakan tentang dia. Tidak ada benar dan salah dalam jawaban. Saya hanya ingin mengetahui apa yang Anda pikirkan tentang Sri.

Sekali lagi, tidak ada jawab salah dan benar dalam menjawab pertanyaan berikut, sampaikan apa yang menjadi pendapat anda.

19. Apakah kamu pikir apa yang dialami oleh Sri ini serius?

a) Sangat serius

b) agak serius

c) tidak terlalu serius.

d) tidak serius sama sekali

e) tidak tahu

20. Seberapa mungkin keadaan Sri disebabkan oleh hal-hal berikut ini

	Sangat banyak kemungkinan.	Agak mungkin	Tidak begitu banyak kemungkinan	Benar-benar tidak mungkin
a) disebabkan karena karakter dari orang itu sendiri				
b) ketidakseimbangan zat kimia dalam otak				
c) Pola asuh				
d) stress dalam hidup				
e) masalah genetik				
f) takdir Tuhan				

21. seberapa besar kemungkinan dia (Sri) mengalami?

	Sangat mungkin	Agak mungkin	Tidak begitu mungkin	Sangat tidak mungkin
a) bagian dari naik dan				

turunnya kehidupan				
b) Gangguan saraf				
c) gangguan jiwa				
d) gangguan fisik (tubuh)				

22. Menurut pendapat Anda, seberapa mampu adalah Sri untuk membuat keputusan sendiri tentang pengobatan ia harus menerima

a. sangat mampu,

b. agak mampu,

c. tidak terlalu mampu

d. tidak mampu sama sekali?

23. Menurut pendapat Anda, seberapa mampu adalah Sri untuk membuat keputusan sendiri tentang mengelola keputusan sendiri tentang mengelola uang-sangat sendiri

a. sangat mampu

b. agak mampu

c. tidak terlalu mampu

d. tidak mampu sama sekali

e. tidak tahu

24. Menurut pendapat Anda, seberapa besar kemungkinan bahwa situasi Sri tersebut akan membaik dengan sendirinya

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

25. Menurut pendapat Anda, seberapa besar kemungkinan bahwa situasi Sri akan membaik dengan pengobatan?

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

26. Seberapakah kesediaan anda untuk …..

	Saya sangat ingin melakukan	Saya ingin berbuat banyak untuk itu	Saya mgunkin tidak ingin melakukan	Saya sangat tidak ingin melakukan
a. untuk duduk disebelah Sri				
b. Untuk bermalam bersamanya				
c. untuk berteman baik dengan Sri				
d. Dia bekerjasama dengan anda dalam suatu pekerjaan				
e. Untuk memiliki tetangga dengan rumah kelompok bagi orang-orang seperti Sri				
f. Dia menikah dan menjadi anggota keluarga anda				

27. Menurut pendapat Anda, seberapa besar kemungkinan itu Sri akan sesuatu kekerasan terhadap orang lain. Apakah ….

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

28. Menurut pendapat Anda, seberapa besar kemungkinan itu Sri akan sesuatu kekerasan dirinya sendiri. Apakah…

a. Sangat mungkin
b. Agak mungkin
c. Agak tidak mungkin
d. tidak mungkin sama sekali
e. Tidak tahu

29. Haruskan Sri melakukan salah satu dari berikut ...

Bicarakan dengan keluarga dan teman-teman tentang kondisi ini	Ya tidak tidak tahu
Konsultasikan dengan pendeta pemimpin agama, imam, atau pendeta	Ya tidak tidak tahu
mencari bantuan dari rumah sakit umum	Ya tidak tidak tahu
Pergi ke rumah sakit jiwa	Ya tidak tidak tahu
Pergi ke seorang terapis atau konselor	Ya tidak tidak tahu
Berpartisipasi dalam kelompok self-help untuk orang dengan masalah yang sama saling mendukung satu sama lain	Ya tidak tidak tahu
Minum obat bebas untuk mengatasi gangguan tidur	Ya tidak tidak tahu
Minum obat yang diresepkan dokter	Ya tidak tidak tahu
Dirawat di rumah sakit jiwa	Ya tidak tidak tahu

D. Selanjutnya, pertanyaan tentang Perawatan Kesehatan Jiwa

1. Sebelumnya kita membicarakan tentang anggaran negara pada wilayah kesehatan jiwa. Mohon disampaikan harapan Anda menunjukkan apakah anda ingin pengeluaran pemerintah di bidang perawatan kesehatan mental lebih banyak atau kurang. Perlu di ingat, bahwa jika Anda mengatakan, "lebih", mungkin memerlukan peningkatan pajak untuk membayar untuk itu

   a. Menganggarkan lebih banyak

   b. Menganggarkan banyak

   c. Menganggarkan sama dengan sekarang

   d. Menganggarkan kurang dari sekarang

   e. Tidak bisa memilih

   f. Tidak ada jawaban

2. Apakah menurut Anda untuk memberikan pelayanan kesehatan kepada masyarakat tentang penyakit mental, dan bahwa hal itu harus menjadi tanggung jawab pemerintah?

   a. Pasti harus

   b. Mungkin harus

   c. Mungkin tidak harus

   d. Jelas tidak boleh

   e. Tidak dapat memilih

   f. Tidak ada jawaban

3. Apakah anda mempunyai kenalan yang pernah dirawat di RS Jiwa

   a. Ya (silahkan jawab nomor 4 dan 5)

   b. Tidak (Silahkan lanjut ke nomor 5)

c. Tidak tahu (silahkan lanjut ke nomor 5)

4. Jika “Ya”, apakah hubungan antara orang itu dengan Anda

   a. Keluarga

   b. Teman

   c. Selain itu

   d. Saya tidak ingin menjawab

   e. Saya tidak tahu

5. Selain mereka(kenalan) yang ada pada nomor 3, apakah Anda tahu siapa yang harus berkonsultasi dengan psikolog atau konselor lainnya, profesional kesehatan mental, atau pekerja sosial.

   a. Ya

   b. tidak

   c. tidak tahu

E. Sekarang saya bertanya tentang pendapat Anda tentang kesehatan secara umum.

Pertanyaan 1-19 berikut ini adalah pernyataan-pernyataan yang diyakini tentangan kesehatana. Pilihlah sesuai rentang 1-6 (*sangat setuju* sampai dengan s*angat tidak setuju*), silahkan menjawab dengan melingkari jawaban yang anda yakini. Tidak ada yang benar atau salah dari setiap jawaban, jadi jawablah sesuai dengan pendapat anda sendiri.

Pernyataan	Pilihan Jawaban					
	1	2	3	4	5	6
1. Jika kondisi saya memburuk, itu adalah perilaku saya sendiri yang menentukan seberapa cepat saya akan merasa lebih baik lagi						
2. Adapun kondisi saya, yang terjadi, terjadilah						
3. Jika saya melihat dokter secara teratur, saya kurang cenderung memiliki masalah dengan kondisi saya						
4. Kebanyakan hal yang mempengaruhi kondisi saya terjadi pada saya secara kebetulan						
5. Setiap kali memburuk kondisi saya, saya harus berkonsultasi dengan profesional medis terlatih						
6. Saya langsung bertanggung jawab atas kondisi saya semakin baik dan buruk						
7. Orang lain memainkan peran besar dalam apakah kondisi saya membaik, tetap sama, atau semakin memburuk						
8. Apapun yang tidak beres dengan kondisi saya adalah kesalahan saya sendiri						
9. Keberuntungan memainkan peran besar dalam menentukan bagaimana kondisi saya membaik						
10. Agar kondisi saya untuk memperbaiki, terserah kepada orang lain untuk melihat bahwa hal-hal yang benar terjadi						
11. Apapun perbaikan terjadi dengan kondisi m sebagian besar masalah keberuntungan						

12. Hal utama yang mempengaruhi kondisi saya membaik dan menyalahkan ketika semakin memburuk						
13. Saya berhak mendapatkan pengaruh pada kondisi saya, dengan apa yang saya lakukan sendiri						
14. Mengikuti perintah dokter untuk surat tersebut adalah cara terbaik untuk menjaga kondisi saya dari mendapatkan lebih buruk						
15. Jika kondisi saya memburuk, itu soal nasib						
16. Jika aku beruntung, kondisi saya akan lebih baik						
17. Jika kondisi saya mengambil giliran menjadi buruk, itu karena saya belum mengambil perawatan yang tepat dari diri sendiri						
18. Jenis bantuan yang diberikan oleh Allah atau Supernatural seberapa cepat kondisi saya membaik						
19. Jenis menyembuhkan saya terima dari orang lain adalah apa yang bertanggung jawab untuk seberapa baik saya sembuh dari penyakit						

VI. Terakhir, kami ingin menanyakan tentang **pengalaman anda sebagai Kader dalam mengikuti pelatihan kader kesehatan jiwa**

1. Apakah sebagai Kader, Anda pernah mengikuti training tentang Kesehatan Mental adalah ....
   a. Pernah
   b. Belum pernah
2. Apakah menurut Anda pelatihan tersebut penting bagi Kader?
   a. Ya
   b. Tidak

3. Pertanyaan ini hanya ditujukan bagi mereka yang telah menerima pelatihan, silahkan lingkari jawaban dengan memilih satu jawaban (berilah tanda melingkari dari hal yang harus dievaluasi dibawah ini)

Hal yang di evaluasi	Kurang baik (1)	Cukup baik (2)	Sedang (3)	Baik (4)	Sangat baik (5)
Isi pelatihan Jadwal pelatihan Lingkungan data, seperti teks. Panitia Handout Sebagai pelatihan kejelasan seluruh penjelasan					