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Unlocking mhGAP and family medicine potential: Strategic solutions for Indonesian mental health integration Extending

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Mental health has become a critical global concern in 2025, influencing individuals, communities, and healthcare systems worldwide. Recognizing its significance is essential for fostering well-being and resilience across all aspects of life. The World Health Organization emphasizes that mental health is a basic human right and essential for both personal growth and societal progress. It empowers individuals to handle life's difficulties, tap into their potential, learn effectively, perform well in their tasks, and make meaningful contributions to their communities[1]. Global threats to mental health today include economic and social inequalities; public health emergencies (including COVID-19); humanitarian emergencies (including conflict and forced displacement); and the climate crisis[2]. Mental health is closely linked to physical health. However, the relationship between mental health and physical disease tends to be neglected by communities as well as health care providers, specifically in Low Middle-Income Countries (LMICs)[3]. The vast majority of patients with mental disorder in LMICs have limited access to proper treatment [4]. In contrast, European region countries (EUR) report the highest rate of mental health treatment compared to other regions[5]. Undetected mental disorders increased the risky behaviors related to chronic diseases, in turn, people with chronic diseases are also prone to experiencing mental health issues [6-10].

In order to scale up the mental health screening and management at primary care level in low resource countries, WHO has developed the Mental Health Gap Action Programme (mhGAP). First published in 2010 and last updated in 2015, the mhGAP guideline, and its associated products including the mhGAP intervention guide, are now used in more than 100 countries and available in over 20 languages[11] It has been adopted by more than 100 countries globally[12]. Based on the WHO report, disaggregated by region, more than two-thirds of responding countries in the different WHO regions stated that guidelines for the integration of mental health into primary health care were available and had been adopted at the national level, with the highest percentage

in the Eastern Mediterranean Region (90% of responding countries) and the lowest in the African Region (66% of responding countries). Globally, the community-based outpatient mental health care was utilized less frequently than hospital-based outpatient facilities in all WHO regions. Only in The Americas and the European Region, numbers of community-based mental health outpatient visits were higher. This might reflect the centralization of care in hospital-based settings [13].

In Indonesia, the prevalence of severe mental disorders reported in Basic Health Survey (BHS) was 1.7 per 1000 population in 2013 [14]. In 2018, the prevalence of households having members with schizophrenia or psychosis was 6.7 per thousand populations. Bali Province has the highest prevalence of families having members with schizophrenia and psychosis in 2018 (11.1 per thousand populations). Meanwhile, the prevalence of depression was reported at 6.1 per thousand populations and mental emotional disorders at 9.8 per thousand populations [15]. Moreover, it is likely that the mental disorders in Bali still being underdiagnosed and undertreated due to lack of awareness in communities, stigma related to mental health issues, and limitation of the primary health care services, mainly in Community Health Centers (CHCs)[16].

Bali is the leading tourist destination in Indonesia, and has better access to health care compared to the other islands in eastern part of Indonesia. However, it still struggles to improve mental health care service at the primary care level. One of the main reasons that hinders mental health service delivery is the low capacity of general practitioners (GPs) and the health service to perform the mental health services. GPs and other health workers reported obstacles in conducting screening and management of mental disorders routinely in CHCs due to limited time to perform complete anamnesis and examination, uncomfortable examination rooms, inadequate supply of psychiatric drugs at CHCs, absence of practical diagnostic and management guideline[14]. Lack of training for the GPs also leads to lower confidence in integrating mental health services (MHS) in primary care routinely amongst program managers, GPs and other health workers [17]. A study of twelve general practices in the West of England, UK, revealed similar reason that GPs felt difficulties in handling patients with mental disorders, as they have to dedicate more time to care the patients and the GPs felt did not have adequate knowledge about efficacy of treatment, specifically for patients with personality disorders [18].

Improving the capacity of general practitioners (GP) and/or other medical staffs in primary care is beneficial to initiate early detection and treatment of mental disorders at the primary health care level [19]. The family medicine approach has been extensively applied in many other countries since family physicians (FPs) are the first line doctors who are able to screen early symptoms of mental disorders. This is particularly true in rural and underserved areas where psychiatrists are rarely available. In high income countries, for example in The Netherlands, cases of mental disorders can be detected earlier at the primary care service level by well-trained GPs/FPs, and treated in a collaborative way with other professionals [20]. A training program to improve the capacity of family doctors in Ontario, Canada, also showed that the number of mental disorder cases detection

increased [21].

A Systematic Review of mhGAP Implementation Globally has been published in 2021, found that most of mhGAP implementation studies were conducted in the African region (40%), South-East Asia (25%), Eastern-Mediterranean (7%), the America region (4%) and the European region (1%). The review reported that overall, after mhGAP-IG training, Primary health care (PHC) and community-based staff showed increased mental health knowledge and awareness, improved attitudes towards mentally ill and people living with mental health problems, improved attitudes towards psychiatry, more confidence in managing mental health problems in PHC, increased job satisfaction and interest in mental health training. Evaluations of the mhGAP-IG-based training highlighted trainees' satisfaction with the programme, which was generally considered useful, relevant and valuable. This study recommends that there is a need for filling gaps in the evidence base for under-studied regions and disorders, and to investigate the scale-up and sustainable integration of isolated interventions into long-term clinical practice [22].

In Indonesia, there has been limited implementation of mhGAP Intervention Guidelines in primary care setting. A study that in Yogyakarta, published in 2018, to determine the effectiveness of mhGAP training in improving the knowledge and skills of primary care physicians in diagnosing and treating depression in Gunung Kidul Area, reported that there was an increase in knowledge amongst primary care physicians in diagnosis of depression before and after intervention training modules, and that the training improved referral rates of depression cases from community health centers to district hospitals in Wonosari. It also revealed several challenges of primary care physician in providing MHS, for instance the lack of confidence in diagnosing and treating mental illnesses such as anxiety and depression. Other obstacles are the stigmatization of the patient, less coordination between segments of mental health and health services in primary care, and health workers in primary care who have not all received continuing education on mental disorders. The increase of the number of diagnosis for depression after undergoing training was reported, although it was considered not significant after being validated by the psychiatrist in the district hospitals [23].

The implementation of the WHO's mhGAP Intervention Guide within Indonesia's primary care settings remains relatively sparse, with the notable exception of a 2018 study conducted in Gunungkidul, Yogyakarta. However, the improvements were modest when assessed post-validation, suggesting deeper systemic challenges. Primary care physicians continue to face several barriers in delivering mental health services, including lack of confidence in diagnosing and treating conditions like anxiety and depression, persisting stigma, poor coordination between different health sectors, and limited access to continuing education. Collectively, these issues underscore the need for more widespread training, stronger support systems, and structural reforms to integrate mental health into primary healthcare across Indonesia. There are growing needs of coordinated policy reform and targeted action, for instance: expanding and institutionalizing the training program by adopting WHO mhGAP

Intervention Guide in GP's training; increasing funding support for infrastructure, logistics and capacity building; combating stigma towards mental disorders; and embed mental health in health policy design by ensuring the visibility of mental health in universal health coverage, public health check-ups, and NCD prevention strategies, with integrated care pathways.

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