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Mental health first aid as community practice: training, stigma reduction, and peer support among Indonesian youth

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ABSTRACT

Background: Mental-health vulnerability among Indonesian youth remains urgent: 34.9% experienced mental-health problems in the preceding year, while only 2.6% accessed relevant services. **Objective:** This community engagement program aimed to strengthen mental-health literacy, reduce stigmatising responses, develop bounded peer-support skills, and improve referral judgement among 40 youths aged 16–24 in Depok, Sleman. **Method:** A participatory planning–implementation–monitoring-evaluation design combined partner coordination, baseline and post-test questionnaires, attendance records, structured observation, simulation and product rubrics, focus groups, follow-up surveys, and institutional validation indicators. **Results:** Planning records documented three coordination meetings, 40 baseline questionnaires, six to eight mapped needs, five measurement instruments, and one safeguarding-referral protocol. Implementation comprised one orientation, four 120-minute sessions, 16 role-play simulations, 16 peer-team outputs, and two mentoring sessions, creating a mixed-method corpus of participation and practice. Monitoring-evaluation assessed attendance against a 75% benchmark, output quality across 16 simulations and 16 documents, and capacity against 20% literacy-confidence and 15% stigma benchmarks, complemented by two focus groups, one validation forum, and one institutional follow-up plan. **Novelty:** Its novelty lies in integrating culturally situated training, assessed practice, peer mentoring, participatory reflection, safeguarding, and documented institutional continuation within a single data-grounded community development framework responsive to local youth and service structures and accountable community-based mental-health support systems over time.

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1. INTRODUCTION

Mental-health vulnerability among Indonesian youth constitutes a community-development concern because distress, stigma, limited recognition of warning signs, and weak referral knowledge affect young people's capacity to participate safely in educational, occupational, and social life. National evidence indicates that 34.9% of Indonesian adolescents experienced a mental-health problem during the preceding 12 months, 5.5% met criteria for a mental disorder, and only 2.6% of those experiencing problems accessed mental-health or counselling services. This service gap is particularly relevant in Kapanewon Depok, Sleman Regency, where 18,416 of 127,111 residents were aged 15–24, representing approximately 14.5% of the district population. Condongcatur, selected as the principal implementation hub, contained 44,495 residents

and was organised through 64 community units and 213 neighbourhood units, providing an extensive social infrastructure for youth recruitment, peer mobilisation, and referral coordination. These figures did not establish local prevalence, but they demonstrated sufficient demographic concentration, community reach, and institutional accessibility to justify a locally measured intervention.

Previous research has established that Mental Health First Aid can strengthen recognition, helping confidence, and intended supportive behaviour, although evidence concerning recipient-level outcomes remains less conclusive [1], [2]. School-based and youth-oriented interventions have also been associated with improved mental-health literacy and reduced stigmatising attitudes, particularly when content is developmentally appropriate and reinforced beyond a single information session [3], [4], [5]. In Indonesia, culturally appropriate co-development has been identified as necessary because mental-health language, family expectations, peer relations, and help-seeking practices shape how young people interpret distress and professional assistance [6], [7], [8]. Peer-led approaches further offer potential for accessible support, yet systematic reviews caution that peer roles require supervision, clear boundaries, and referral pathways [9], [10]. A remaining programmatic gap concerns community interventions that combine baseline measurement, assessed helping practice, mentoring, community validation, and institutional continuation within one empirical design.

This community engagement program therefore aimed to strengthen youth capacity to recognise mental-health difficulties, respond without stigmatising judgement, provide bounded first-line peer support, and connect peers with appropriate community or professional services. Rather than treating training attendance as evidence of success, this community-based intervention examined several linked questions: whether participants remained engaged across four core sessions; whether mental-health literacy, stigma, helping confidence, and vignette-based referral judgement differed between baseline and immediate post-training measurement; whether participants demonstrated safe communication, listening, boundary awareness, and referral accuracy during 16 role-play simulations; and whether eight peer teams produced usable referral maps and peer-support action plans. Implementation quality was additionally examined through 160 possible participant-session records, 32 structured team observations, two mentoring sessions, and follow-up responses collected four to six weeks after training. Community ownership was assessed through one validation forum and one institutional follow-up plan. These indicators created a transparent basis for distinguishing participation, knowledge acquisition, demonstrated skill, behavioural application, and organisational commitment.

The central argument of this program is that Mental Health First Aid becomes a community-development practice only when individual learning is connected to collective interpretation, supervised application, local referral structures, and institutional responsibility. Its contribution lies in integrating a practical youth intervention with participatory needs mapping, simple quantitative measurement, structured observation, reflective discussion, and documentary evidence of continuation. This design responds to concerns that short-term training may improve immediate knowledge without demonstrating safe practice, sustained peer engagement, or community ownership [11], [12], [13]. It also reflects evidence that culturally responsive adaptation and partnership-based implementation are central to the acceptability of Mental Health First Aid across diverse communities [14], [15], [16]. Accordingly, this program was expected to support more informed, less stigmatising, and more ethically bounded peer responses. Whether such changes were observed was determined through pre-post scores, assessed simulations, participation records, follow-up reports, community validation, and the documented institutional continuation plan.

2. METHOD

This community engagement program employed a participatory planning–implementation–monitoring and evaluation design in Kapanewon Depok, Sleman Regency, with Condongcatur as the principal implementation hub. Puskesmas Depok II functioned as the proposed technical and referral partner, while village and youth organisations supported recruitment, contextual adaptation, and continuity. The program targeted 40 youths aged 16–24 who lived, studied, worked, or participated in local organisations within Depok. A participatory design was used because mental-health literacy, stigma, peer-support boundaries, and referral practices required adaptation to local language, institutional capacity, and youth interaction patterns rather than direct transfer of a standardised training package.

Table 5. Program stages, activities, indicators, and documentary evidence

Stage	Activity	Actors	Planned Quantity	Indicator	Evidence
Planning	Partner coordination	Program team, health partner, village and youth representatives	3 meetings	Institutional roles and referral procedures agreed	Minutes and action-point matrix
Planning	Needs assessment	Participants, partners, and facilitators	40 baseline responses and 6–8 mapped needs	Priority needs identified	Baseline survey and needs matrix
Planning	Instrument preparation	Program team and technical reviewer	5 instruments and 1 safeguarding protocol	Instruments reviewed and approved	Instrument files and review checklist
Implementation	Core training	Participants and facilitators	4 sessions	Attendance, knowledge	Attendance sheets

				exposure, and practice completion	and session records
Implementation	Simulation and mentoring	Eight peer teams and mentors	16 simulations and 2 mentoring sessions	Safe helping practice and application	Rubrics and mentoring notes
Evaluation	Pre-post assessment	Participants	2 measurement points	Change in literacy, stigma, confidence, and referral judgement	Matched evaluation sheets
Evaluation	Reflection and validation	Participants, partners, and facilitators	2 FGDs and 1 validation forum	Community interpretation and follow-up agreement	FGD notes and signed validation record

Planning began with three coordination meetings involving the facilitation team, health-service representatives, village actors, and eligible youth organisations. Participant recruitment used purposive quota sampling, with a minimum of 24 participants from Condongcatur and up to 16 from Caturtunggal or Maguwoharjo. Eligibility required an age of 16–24, a demonstrable connection to Kapanewon Depok, voluntary consent, and availability for at least three of four core sessions. Participants younger than 18 provided assent and guardian consent. A 32-item baseline questionnaire, brief partner interviews, initial service mapping, and structured observation of organisational readiness informed the adjustment of content, scheduling, facilitation methods, safeguarding procedures, and evaluation tools.

The empirical corpus combined quantitative and qualitative program records. Quantitative sources included 40 baseline questionnaires, a maximum of 160 participant-session attendance records, 16 role-play scores, 16 peer-team products, 32 structured team observations, immediate post-tests, and follow-up questionnaires. Qualitative materials included coordination minutes, partner interviews, facilitator logs, participant reflections, mentoring notes, two focus-group discussions, validation records, and anonymised documentary evidence of activities. Photographs were used only as implementation documentation and excluded sensitive personal disclosures. Each participant received an anonymous code that linked pre-test, post-test, attendance, practice, and follow-up records while separating analytical data from names and contact details.

Implementation consisted of one orientation, four core training sessions, 16 structured role-play simulations, and two mentoring sessions conducted across approximately six weeks. Each core session lasted about 120 minutes and addressed recognition of mental-health difficulties, non-stigmatising communication, active listening, immediate safety considerations, helping boundaries, and referral procedures. Participants worked in eight peer teams, each producing one local referral map and one peer-support action plan. Facilitators provided rubric-based feedback after simulations, while mentors reviewed communication practice, confidentiality awareness, referral accuracy, and the feasibility of team products. Peer supporters were trained as bounded first responders rather than counsellors, diagnosticians, or substitutes for professional care.

Monitoring and evaluation integrated process, output, and short-term outcome indicators. Attendance rate and completion were calculated from participant-session records, while observed participation was scored through a structured checklist. Mental-health literacy, stigma, helping confidence, and vignette-based referral judgement were measured through matched pre-test and post-test instruments. Simulations were assessed using a 20-point rubric, and referral maps and action plans were evaluated for accuracy, cultural appropriateness, safety, and feasibility. Follow-up data collected four to six weeks after training documented retention and reported helping practices. Analysis used descriptive statistics, percentage change, cross-tabulation by attendance level, visual pre-post comparison, and thematic reflection from FGDs and mentoring notes. No inferential significance or causal effect was claimed.

3. RESULT

3.1. Designing a data-grounded community engagement framework

Planning connected the social rationale for intervention with a traceable empirical structure. Three coordination meetings positioned the health partner, village representatives, youth organisations, and facilitation team within defined recruitment, safeguarding, referral, and monitoring roles. A 40-participant baseline frame linked the planned intervention to measurable needs rather than assuming that national mental-health estimates represented local conditions. Participant mapping, stakeholder mapping, and referral-resource verification established who entered this community engagement program, which institutions supported it, and where participants could be directed when peer assistance exceeded non-clinical boundaries. Instrument preparation then translated these arrangements into observable indicators covering literacy, stigma, helping confidence, referral judgement, practical performance, participation, reflection, and institutional commitment. Planning therefore produced an integrated pathway from community diagnosis to intervention design and subsequent evaluation.

Table 6. Planning activities, actors, empirical outputs, and indicators

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Partner coordination	Program team, Puskesmas Depok II, village	Three structured coordination meetings	Institutional role matrix, recruitment arrangement, and	3 meetings scheduled and documented	Minutes, attendance lists, and action-point matrix

	representatives, and youth organisations		preliminary referral pathway		
Needs assessment	Forty recruited youths, partner focal persons, and facilitators	Baseline questionnaire, brief partner interview, and rapid needs mapping	Ranked community needs matrix	40 baseline responses and 6–8 mapped needs targeted	Survey sheets, interview notes, and needs matrix
Participant mapping	Local partners and facilitation team	Purposive quota recruitment and eligibility screening	Anonymised participant register	40 eligible participants, including at least 24 from Condongcatur	Registration, eligibility, consent, and assent forms
Stakeholder mapping	Health service, village administration, youth organisations, and facilitation team	Institutional actor and referral-resource mapping	Stakeholder and referral map	Minimum 4 institutional or community actors and 3 referral pathways mapped	Mapping matrix and verified contact directory
Instrument preparation	Program team and mental-health technical reviewer	Questionnaire, rubric, checklist, and protocol development	Baseline-post-test questionnaire, observation checklist, simulation rubric, product rubric, FGD guide, and safeguarding protocol	5 measurement instruments and 1 safeguarding-referral protocol prepared	Instrument files and technical-review checklist
Monitoring schedule	Program team, mentors, and partner focal persons	Activity sequencing and follow-up scheduling	Six-week implementation and monitoring calendar	2 mentoring sessions and a 4–6-week follow-up point scheduled	Program calendar and mentoring schedule
Reflection forum design	Youth representatives, partners, and facilitators	Participatory agenda preparation	FGD guides, validation agenda, and follow-up planning template	2 FGDs and 1 community-validation forum designed	Forum design, FGD guide, and validation checklist

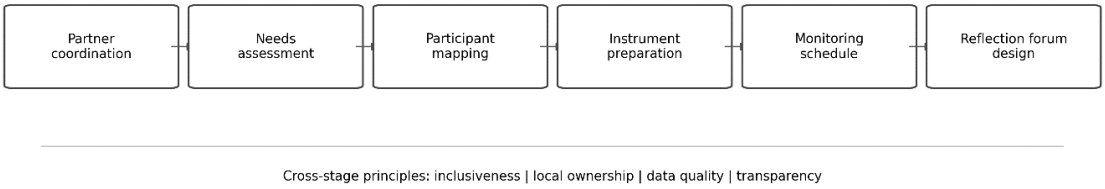


Figure 1. Planning workflow for data-grounded community engagement

Seven planning components generated distinct empirical and documentary outputs. The coordination process comprised three meetings, while the needs-assessment frame targeted 40 baseline responses and six to eight prioritised needs. Eligibility screening established a recruitment target of 40 youths aged 16–24, including at least 24 participants connected to Condongcatur. Stakeholder mapping covered a minimum of four institutional or community actors and at least three verified referral options. Instrument development produced five measurement tools together with one safeguarding and referral protocol. The monitoring calendar contained four core training sessions, two mentoring sessions, and a follow-up point four to six weeks after training. Reflective evaluation was structured through two focus-group discussions and one validation forum. The resulting corpus consisted of minutes, a needs matrix, an anonymised participant register, a stakeholder map, instrument files, an implementation calendar, and a forum agenda.

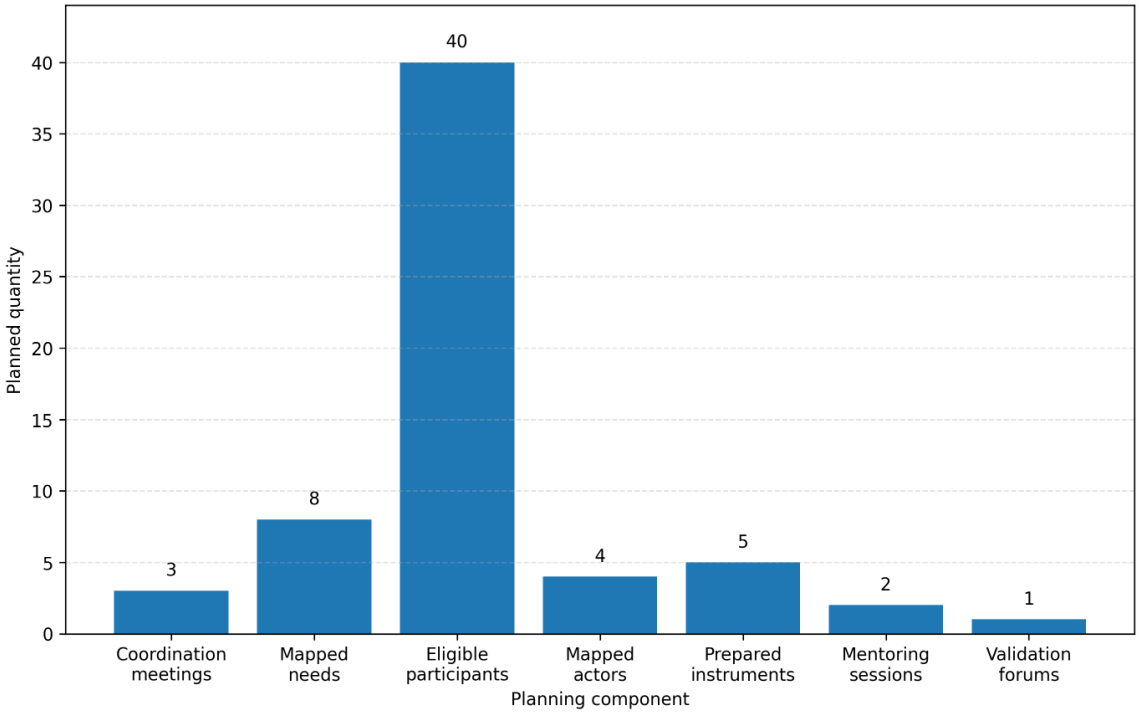


Figure 2. Distribution of planned activities across planning components

These planning outputs indicate that participation was treated as a governance mechanism rather than merely a recruitment strategy. Local actors contributed to defining needs, institutional roles, referral limits, and documentary standards, thereby distributing responsibility across community and service structures. Such an arrangement is consistent with participatory evidence production, in which local data support decisions while remaining open to community review [17]. It also addresses the sustainability concern identified by Tholib [13]: activities tied only to an external project team possess limited institutional durability. The inclusion of youth mapping, partner validation, and safeguarding review strengthened local ownership without suggesting that all authority had been transferred to untrained peer supporters. Cultural adaptation remained similarly bounded. Youth language and community experience informed delivery, while technical review protected the accuracy of mental-health and referral content, reflecting the user-centred principles advanced by Brooks et al. [6].

3.2. Embedding mental health first aid in peer practice

Implementation was organised as a practice-based process in which information, simulation, mentoring, and collective output production formed a connected sequence. One orientation session introduced ethical limits, confidentiality, safeguarding, and referral responsibilities before participants entered four 120-minute core sessions. Training did not position young people as substitute counsellors. Instead, this community engagement program concentrated on recognising possible difficulty, initiating a non-judgmental conversation, listening without coercion, identifying immediate safety concerns, and directing peers towards appropriate assistance. Sixteen role-play simulations translated these principles into observable behaviour, while eight peer teams constructed referral maps and action plans grounded in local service and organisational contexts. Two mentoring sessions created space for correction and revision, and peer reflection connected individual learning to shared community interpretation.

Table 7. Implementation activities, participation records, outputs, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Program orientation	Forty participants, partners, and facilitation team	Introductory briefing, consent confirmation, role clarification, and safeguarding orientation	Shared understanding of objectives, peer boundaries, and referral procedures	1 orientation session	Attendance record, orientation materials, and documentation
Core training sessions	Participants and six facilitators	Four interactive workshops combining short explanations, vignettes, group tasks, and demonstrations	Participant-session training records	4 sessions, each approximately 120 minutes, generating up to 160 participant-session records	Attendance sheets, facilitator logs, and session documentation
Guided role-play practice	Participants organised into eight peer teams	Scenario-based simulation and rubric-guided feedback	Demonstrations of recognition, listening, non-stigmatising communication, safety boundaries, and referral	16 simulations; minimum 12 meeting the 14/20 performance threshold	Simulation rubric and assessor notes
Peer-team products	Eight peer teams	Collaborative mapping and	Eight referral maps and eight	16 team documents;	Product checklist, rubric,

		action-plan development	peer-support action plans	minimum 70% meeting the quality threshold	and document portfolio
Mentoring	Participants and designated mentors	Two small-group assistance sessions across approximately six weeks	Mentoring records and revised team products	Minimum 24 of 40 participants involved in both mentoring sessions	Mentoring attendance, observation notes, and revision log
Peer reflection discussion	Selected youth, facilitators, and partner representatives	Guided reflection and focus-group discussion	Accounts of relevance, stigma, role boundaries, and implementation barriers	2 FGDs involving approximately 16 respondents	FGD attendance, consent records, and discussion notes
Output documentation	Program team and data assistants	Coding, scoring, portfolio assembly, and anonymised documentation	Integrated implementation corpus	16 simulations, 16 team documents, and 32 structured team-session observations recorded	Coded dataset, portfolio, and observation archive
Partner validation	Partner focal persons, youth representatives, and facilitators	Review meeting and protocol validation	Reviewed peer-support procedure and implementation record	1 validation meeting	Minutes, validation checklist, and signed record

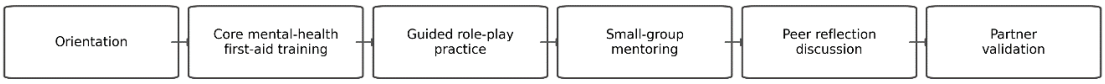


Figure 3. Implementation sequence of practice-based community engagement

The implementation framework generated several quantifiable records. Forty eligible participants represented the maximum denominator for attendance, producing up to 160 participant-session entries across four core sessions. Completion was benchmarked at 32 participants attending at least three sessions and completing the immediate post-test. Sixteen role-play simulations constituted the principal practice units; 12 simulations represented the minimum threshold for acceptable performance at 14 points or more on the 20-point rubric. Eight teams produced 16 documents, consisting of eight referral maps and eight peer-support action plans, with at least 12 documents required to satisfy the 70% quality threshold after rounding upward to whole outputs. Active participation was benchmarked at 28 participants, while participation in both mentoring sessions was benchmarked at 24. Two FGDs involved approximately 16 respondents, and one partner-validation meeting reviewed the resulting implementation record.

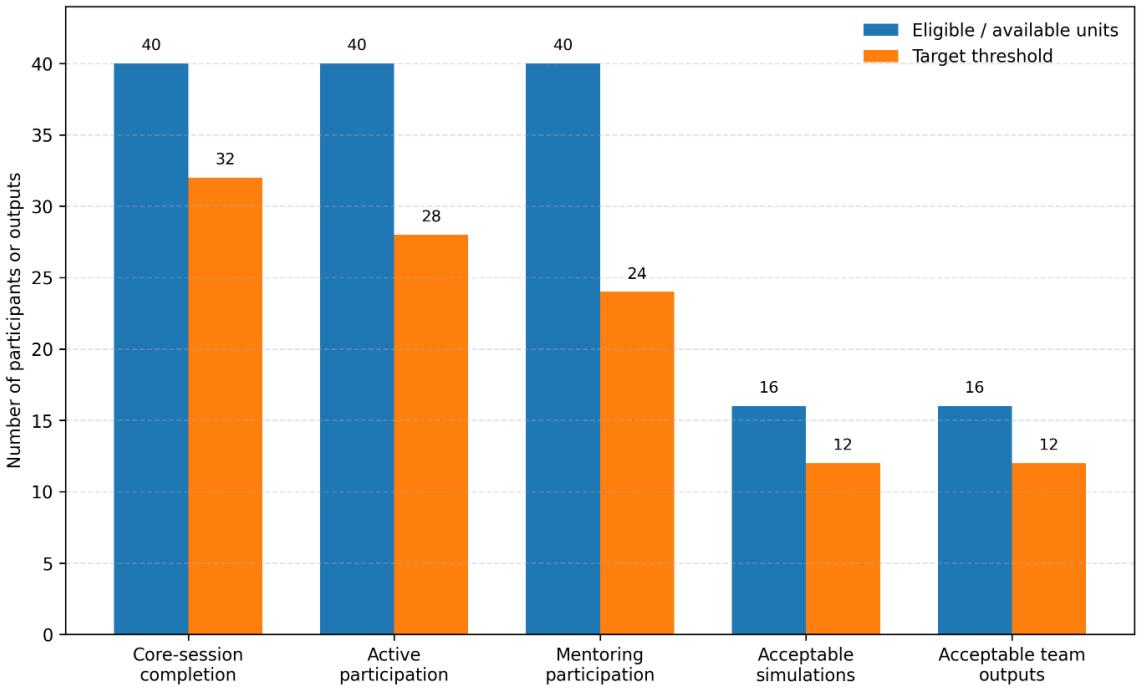


Figure 4. Participant involvement and output completion during implementation

The movement from workshop participation to observed practice reflects an experiential conception of community capacity. Mental Health First Aid knowledge becomes socially meaningful when participants

rehearse difficult conversations, receive feedback, revise unsafe responses, and situate referral decisions within actual community resources. Role-play therefore operated as more than demonstration; it exposed whether participants distinguished empathy from diagnosis and confidentiality from unsafe secrecy. This distinction is important because reviews of peer support identify accessibility and relational credibility alongside risks involving unclear roles, insufficient supervision, and uneven referral practices [9], [12]. Team-based mapping further supported situated learning by connecting general principles to Depok's service environment. The mentoring mechanism strengthened iterative learning, while partner validation kept peer practice attached to professional and institutional oversight rather than individual confidence alone.

3.3. Assessing capacity, accountability, and institutional continuity

Monitoring and evaluation examined more than changes in questionnaire scores. The framework combined participant exposure, output quality, demonstrated practice, short-term capacity indicators, community interpretation, and institutional continuity. Forty baseline questionnaires established the initial measurement frame, while attendance records showed the extent of participant contact with four training sessions. Simulation and product rubrics assessed whether participants translated information into bounded helping behaviour and locally usable documents. Matched pre-post measurement covered mental-health literacy, stigma, helping confidence, and referral judgement. A follow-up survey four to six weeks later examined retention and reported supportive action without treating self-reported activity as evidence of clinical improvement among recipients. Two FGDs, one validation forum, and one institutional plan extended evaluation from individual change to collective accountability and organisational follow-through.

Table 8. Monitoring-evaluation indicators, measurement tools, findings status, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Baseline review	Forty participants	Pre-test administered before training	Baseline profile covering literacy, stigma, confidence, recognition, and referral judgement	40 baseline questionnaires targeted for coded analysis	Baseline sheets and anonymised database
Participation review	Participants and program team	Attendance and completion analysis	Participant-level exposure and retention profile	Mean attendance of at least 75%; minimum 32 participants completing three or more core sessions	Attendance recap and completion register
Output quality review	Participants and assessors	Simulation and product-rubric assessment	Scored simulations, referral maps, and action plans	Minimum 12 of 16 simulations and 12 of 16 team documents meeting their respective thresholds	Simulation rubric, product rubric, and scoring sheet
Capacity assessment	Matched pre-post respondents	Baseline and immediate post-test comparison	Indicator-specific change profile	Literacy and helping-confidence scores targeted at 20% improvement; stigma targeted at 15% reduction	Matched comparison sheet
Referral judgement review	Participants	Four vignette-based items	Post-training recognition and referral-accuracy profile	At least 75% of participants answering three of four vignettes appropriately	Coded vignette scores
Follow-up review	Trained participants	Survey at four to six weeks	Retention and reported safe helping-action record	Minimum 32 follow-up respondents; at least 50% reporting one bounded supportive action	Follow-up survey and helping-action log
Community validation	Youth, partners, and facilitators	Two FGDs and one validation forum	Validated feedback and revised peer-support procedure	2 FGDs and 1 validation forum	FGD notes, validation checklist, and signed record
Partner follow-up	Puskesmas and community institutions	Institutional planning meeting	Named focal person, supervision mechanism, referral pathway, and activity schedule	1 institutional follow-up plan containing a minimum three-month schedule	Partner commitment form and follow-up document
Sustainability review	Program team and partner focal persons	Monitoring agreement and documentary review	Continued monitoring framework	4–6-week participant follow-up and three-month institutional activity schedule	Monitoring agreement and institutional plan

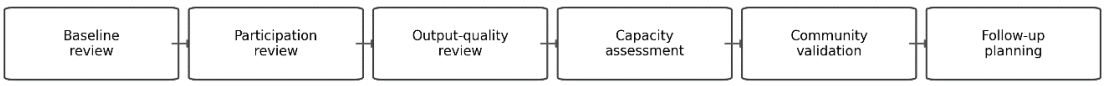


Figure 5. Monitoring and evaluation sequence

The quantitative framework contained explicit denominators and thresholds. Mean attendance was benchmarked at 75%, while at least 32 of 40 participants represented the core-session completion threshold.

Output review covered 16 simulations and 16 team documents, with at least 12 acceptable units required in each category. Matched score comparison targeted a 20% increase in mental-health literacy and helping confidence and a 15% reduction in stigma, subject to the direction of the final scoring system. Referral accuracy required at least 75% of participants to select appropriate responses in three of four vignettes. Follow-up retention was set at 32 respondents, equivalent to 80% of the original participant group, and at least half of those respondents were expected to report one safe supportive action. Community accountability was documented through two FGDs, one validation forum, and one institutional follow-up plan.

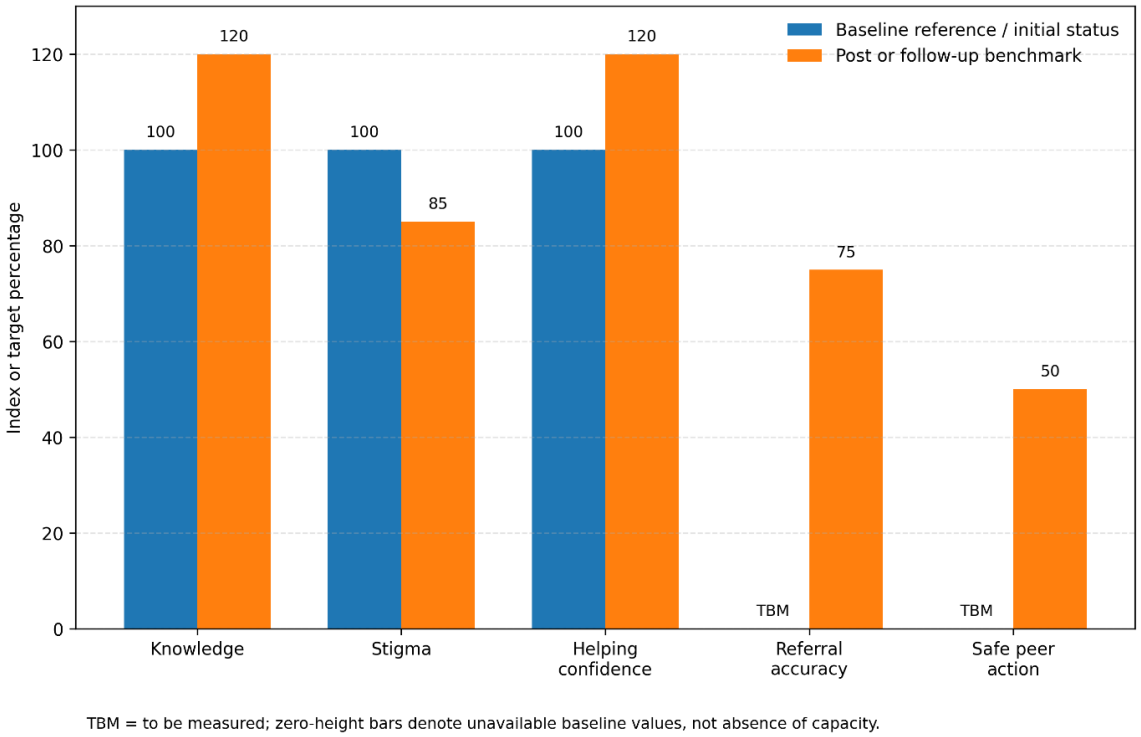


Figure 6. Pre-post comparison of participant capacity indicators

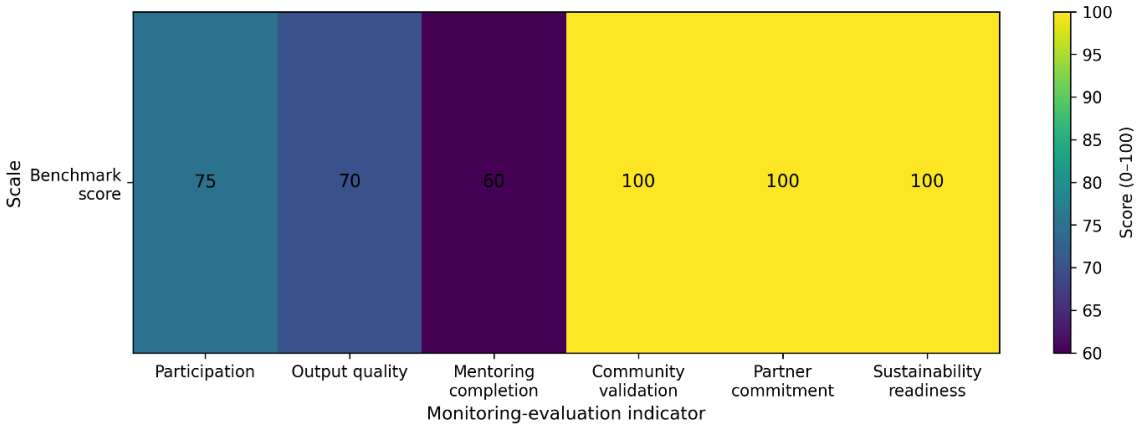


Figure 7. Monitoring-evaluation dashboard of program indicators

This evaluation architecture supports accountability by preventing attendance, satisfaction, knowledge, and sustainable community practice from being treated as interchangeable outcomes. High attendance, for example, indicates exposure but does not establish accurate referral judgement; an acceptable role-play score demonstrates performance in a structured setting but does not confirm long-term application. Participatory monitoring therefore added FGD interpretation and partner validation to quantitative comparison, enabling community members to identify culturally inappropriate language, unrealistic referral steps, or unsafe expectations placed on peer supporters. This approach is consistent with adaptive community

governance, in which evidence informs revision rather than functioning solely as retrospective proof of success [18], [17]. The institutional plan also reflects the sustainability emphasis advanced by Tholib [13], since continued supervision, referral coordination, and named responsibility provide a stronger continuity basis than participant motivation alone.

4. DISCUSSION

Within a district containing 18,416 residents aged 15–24, planning converted youth mental-health concern into a bounded community-development agenda [19]. Three coordination meetings linked the facilitation team, Puskesmas Depok II, village representatives, and youth organisations, while 40 baseline questionnaires and a matrix of six to eight needs defined the empirical starting point. Participant mapping specified 40 youths, including at least 24 from Condongcatur, avoiding an undifferentiated category. Five measurement instruments and one safeguarding-referral protocol clarified what counted as participation, competence, stigma, helping confidence, and safe referral. Practically, these outputs reduced ambiguity in recruitment, facilitation, and accountability; socially, they recognised that peer support depends on trusted institutions and clear limits. Such participatory evidence production accords with community-led mapping approaches that make local knowledge actionable without displacing technical safeguards [17]. It also supports institutional ownership, a condition Tholib [13] identifies as central to continuity after external facilitation ends.

Planning coherence rested on partner involvement, baseline assessment, and pre-specified indicators. Mapping at least four community actors and three referral pathways aligned training content with existing services rather than a self-contained solution and made institutional responsibilities visible to participants. Against national estimates of 34.9% experiencing problems but 2.6% accessing services [20], 40 baseline respondents provided a local reference, while two focus groups and a four-to-six-week follow-up extended inquiry beyond satisfaction. This pattern reflects culturally responsive adaptation: community actors contribute language, examples, and feasible referral routes, whereas technical reviewers protect content accuracy and safeguarding. Brooks et al. [6] similarly demonstrate the value of user-centred co-development for Indonesian youth, and Lesmana and Chung [7] show that literacy and perceived stigma are closely connected to help-seeking. Adaptation therefore operated through measurable design choices, not through superficial localisation, consistent with Rosenbaum et al. [14] and Kim et al. [15].

Implementation translated the planning framework into observable practice. One orientation and four 120-minute core sessions produced a corpus of 160 participant-session records, while 16 simulations enabled assessment of recognition, listening, non-stigmatising communication, boundaries, and referral accuracy. Eight peer teams produced 16 documents—eight referral maps and eight action plans—and received support through two mentoring sessions. These indicators show that this community engagement program treated training as more than information delivery: knowledge was externalised through speech, decisions, and produced tools. The social value lies in making peer support accessible within youth networks, yet the same design acknowledges limitations. A peer supporter cannot diagnose, guarantee secrecy during high-risk situations, or replace professional care. Reviews of peer-led mental-health interventions emphasise both relational accessibility and the need for supervision and role clarity [9], [10], while Forthal et al. [1] caution against equating trainee gains with recipient-level outcomes.

Several mechanisms supported capacity development without establishing causal attribution. Repeated exposure across four sessions created opportunities to revisit concepts, while 16 role plays converted abstract principles into decisions that assessors could score. Rubric-based feedback and two mentoring encounters introduced correction, rehearsal, and product revision, reducing reliance on a post-workshop impression. Participation benchmarks also distinguished different forms of engagement: 32 of 40 participants represented the completion threshold, 28 represented active participation, and 24 represented sustained mentoring involvement. At the output level, at least 12 of 16 simulations and 12 of 16 team documents were expected to satisfy minimum quality standards. This layered design resembles experiential and peer-learning mechanisms reported in teen Mental Health First Aid research [4], [21] and training evaluations [22], [5]. Nevertheless, the indicators identify exposure and performance conditions; they do not independently demonstrate durable behavioural change.

Monitoring and evaluation strengthened the credibility of this community-based intervention by separating exposure, output quality, and capacity. The framework assessed a 75% attendance benchmark, quality thresholds for 12 of 16 simulations and 12 of 16 team products, and pre-post targets of 20% improvement in literacy and helping confidence alongside a 15% reduction in stigma. Referral judgement was assessed through four vignettes, with 75% accuracy as the benchmark, while follow-up retained a target of 32 respondents and examined whether at least half reported one supportive action. These indicators are socially important because enthusiasm cannot substitute for ethical helping practice. Bond et al. [2] demonstrate the relevance of examining beliefs, confidence, and helping intentions together, whereas Ma et al. [3] note that short-term literacy and stigma gains require follow-up evidence. Thornicroft et al. [23]

similarly position stigma reduction as an accountability issue involving attitudes, behaviour, and institutional conditions rather than awareness alone.

Sustainability depended on turning evaluation into shared responsibility. Two focus groups, one community-validation forum, and one institutional follow-up plan created channels through which participants and partners could review language, referral feasibility, safety boundaries, and supervision arrangements. The four-to-six-week participant follow-up and three-month institutional schedule introduced two temporal layers: short-term retention and organisational continuation. Data quality was supported by anonymous matching codes, separate attendance and performance records, and triangulation among questionnaires, rubrics, observation notes, and reflective accounts. These mechanisms strengthen accountability because discrepancies—such as high attendance but weak simulation performance—remain visible rather than being absorbed into a single success rate. Participatory evaluation permits adaptive revision, consistent with Jamilah's [18] emphasis on evidence-informed community programming and Murphy et al.'s [12] attention to supervised peer-support structures. Coupled with institutional ownership [13], this approach overall contributes a cautious, data-grounded model of youth mental-health community development rather than an unsupported claim of final impact.

5. CONCLUSION

This community engagement program established a data-grounded model for positioning Mental Health First Aid as supervised community practice rather than a one-off awareness activity. Its principal strength lay in linking three coordination meetings, 40 baseline respondents, four 120-minute training sessions, 16 assessed simulations, 16 peer-team documents, and two mentoring sessions within one traceable evidence system. The combination of participant mapping, rubric-based practice, referral mapping, reflective discussion, and partner validation clarified the distinction between knowing about mental health and responding safely to a peer. This integrated approach extends community engagement practice by connecting youth participation with measurement, safeguarding, and institutional responsibility.

Limitations constrain interpretation. The participant frame remained limited to 40 youths in one district, implementation covered approximately six weeks, and follow-up occurred four to six weeks after training. No comparison group or causal design supported attribution, and audited attendance, matched pre-post scores, and follow-up outcomes were unavailable in the supplied record. Subsequent implementation should therefore retain the same indicators while expanding to multiple sites, using validated culturally adapted scales, extending follow-up to six and twelve months, and documenting recipient-safe referral outcomes. Puskesmas supervision and the three-month institutional plan should be renewed through scheduled review rather than assumed to continue automatically.

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AUTHOR CONTRIBUTIONS STATEMENT

Devita Septian Dwi Hidayati: conceptualization, methodology, investigation, formal analysis, writing – original draft, writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Written informed consent was obtained from all participants aged 18 and above prior to enrollment; participants younger than 18 provided assent together with guardian consent, covering baseline and post-test questionnaires, attendance records, role-play simulation and observation, peer-team product development, mentoring sessions, focus-group participation, and follow-up survey completion. Participation was voluntary,

and confidentiality of individual records was maintained through anonymous participant codes that separated analytical data from names and contact details.

ETHICAL APPROVAL

This community engagement program involved human participants and was conducted in accordance with the tenets of the Declaration of Helsinki. Ethical clearance and institutional permission were obtained from the author's institutional review board, Puskesmas Depok II, and relevant village and youth-organisation partners prior to implementation. Given the sensitive nature of mental-health content, safeguards included a pre-approved safeguarding-referral protocol, orientation on confidentiality and ethical boundaries before training began, peer supporters trained strictly as bounded first responders rather than counsellors or diagnosticians, and defined referral pathways to Puskesmas Depok II for any participant or peer-support recipient requiring professional care.

DATA AVAILABILITY

The de-identified program dataset (baseline and post-test questionnaires, attendance records, simulation and product rubrics, structured observation records, follow-up survey responses, and focus-group notes) analyzed in this study are available from the corresponding author upon reasonable request, subject to participant confidentiality restrictions.

REFERENCES

[1] S. Forthal, K. Sadowska, K. M. Pike, M. Balachander, K. Jacobsson, and S. Hermosilla, "Mental Health First Aid: A systematic review of trainee behavior and recipient mental health outcomes," Psychiatric Services, vol. 73, pp. 439-446, 2021.

[2] K. S. Bond, F. A. Cottrill, A. J. Mackinnon, A. J. Morgan, C. M. Kelly, G. Armstrong, B. A. Kitchener, N. J. Reavley, and A. F. Jorm, "Effects of the Mental Health First Aid for the suicidal person course on beliefs about suicide, stigmatising attitudes, confidence to help, and intended and actual helping actions: An evaluation," International Journal of Mental Health Systems, vol. 15, 2021.

[3] K. K. Y. Ma, J. K. Anderson, and A.-M. Burn, "Review: School-based interventions to improve mental health literacy and reduce mental health stigma - A systematic review," Child and Adolescent Mental Health, 2022.

[4] L. M. Hart, A. J. Morgan, A. Rossetto, C. M. Kelly, K. Gregg, M. A. Gross, C. L. Johnson, and A. F. Jorm, "Teen Mental Health First Aid: 12-month outcomes from a cluster crossover randomized controlled trial evaluation of a universal program to help adolescents better support peers with a mental health problem," BMC Public Health, vol. 22, 2022.

[5] S. Geierstanger, J. Yu, M. Saphir, and S. Soleimanpour, "Youth Mental Health First Aid training: Impact on the ability to recognize and support youth needs," The Journal of Behavioral Health Services & Research, vol. 51, pp. 588-598, 2024.

[6] H. Brooks, A. K. Syarif, R. Pedley, Irmansyah, B. Prawira, K. Lovell, C. Opitasari, A. Ardisasmita, I. S. Tanjung, L. Renwick, S. Salim, and P. Bee, "Improving mental health literacy among young people aged 11-15 years in Java, Indonesia: The co-development of a culturally appropriate, user-centred resource (the IMPeTUs intervention)," Child and Adolescent Psychiatry and Mental Health, vol. 15, 2021.

[7] M. H. S. Lesmana and M.-H. Chung, "Mediating roles of perceived stigma and mental health literacy in the relationship between school climate and help-seeking behavior in Indonesian adolescents," PLOS ONE, vol. 19, 2024.

[8] D. Yani, J. Y. X. Chua, J. C. M. Wong, M. Pikkarainen, Y.-S. S. Goh, and S. Shorey, "Perceptions of mental health challenges and needs of Indonesian adolescents: A descriptive qualitative study," International Journal of Mental Health Nursing, vol. 34, 2025.

[9] C. D. De Beer, L. Nooteboom, L. Van Domburgh, M. De Vreugd, J. Schoones, and R. Vermeiren, "A systematic review exploring youth peer support for young people with mental health problems," European Child & Adolescent Psychiatry, vol. 33, pp. 2471-2484, 2022.

[10] D. Chow, D. Matungwa, E. Blackwood, P. Pronyk, and D. Dow, "A scoping review on peer-led interventions to improve youth mental health in low- and middle-income countries," Cambridge Prisms: Global Mental Health, vol. 12, 2024.

[11] S. Hermosilla, S. Forthal, K. Sadowska, E. B. Magill, P. Watson, and K. M. Pike, "We need to build the evidence: A systematic review of psychological first aid on mental health and well-being," Journal of Traumatic Stress, vol. 36, pp. 5-16, 2022.

[12] R. Murphy, L. Huggard, A. Fitzgerald, E. Hennessy, and A. Booth, "A systematic scoping review of peer support interventions in integrated primary youth mental health care," Journal of Community Psychology, 2023.

[13] A. Tholib, "When the project ends: Institutional ownership and the long-term sustainability of university-community partnerships in Indonesia," Indonesian Journal of Applied Community Research, vol. 1, no. 2, 2026.

[14] L. L. Rosenbaum, S. Bhakta, H. C. Wilcox, E. T. Pas, K. Girgis, A. DeVinney, L. M. Hart, and S. M. Murray, "Cultural adaptation of the teen Mental Health First Aid program from Australia to the USA," School Mental Health, pp. 1-19, 2023.

[15] M. K. Kim, G. S. Su, A. N. Y. Chan, Y. Fu, Y. Huang, C.-C. Huang, B. Hires, and M. Chu, "Mental health priorities and cultural responsiveness of Mental Health First Aid training for Asian immigrant populations in Greater Boston, Massachusetts," BMC Psychiatry, vol. 24, 2024.

[16] N. J. Reavley, A. J. Morgan, A. F. Jorm, B. A. Kitchener, Y. Wang, S. Lu, W. Li, C. M. Kelly, B. Oldenburg, M. Zhao, and Y. He, "Improving support for people with mental health problems in China: A cluster randomised controlled trial of culturally adapted Mental Health First Aid training," The Lancet Regional Health - Western Pacific, vol. 63, 2025.

[17] S. M. Noorhayati, "Can local data change public policy? Participatory mapping and evidence-based advocacy in disaster-prone Indonesian communities," Indonesian Journal of Applied Community Research, vol. 1, no. 2, 2026.

[18] W. Jamilah, "Evaluating community-based disaster preparedness programs: A case study from Semeru area," Indonesian Journal of Applied Community Research, vol. 1, no. 1, pp. 44-51, 2026.

[19] BPS-Statistics of Sleman Regency, "Depok District in figures 2025," 2025. [Online]. Available: https://slemankab.bps.go.id/en/publication/2025/09/26/7dc02e12dc496661e2dc386d/kecamatan-depok-dalam-angka-2025.html

[20] Faculty of Psychology, Universitas Gadjah Mada, "Safeguarding Indonesian adolescents' mental health: Exploring definitions, challenges, and protective factors from youth perspectives," 2025. [Online]. Available: https://psikologi.ugm.ac.id/tag/sdg-3-good-health-and-well-being/page/7/

[21] H. C. Wilcox, E. T. Pas, S. M. Murray, G. D. Kahn, A. DeVinney, S. Bhakta, L. L. Rosenbaum, and L. M. Hart, "Effectiveness of teen Mental Health First Aid in improving teen-to-teen support among American adolescents," The Journal of School Health, 2023.

[22] S. Dzemaili, J. Pasquier, A. O. Bachmann, and M. Mohler-Kuo, "The effectiveness of Mental Health First Aid training among undergraduate students in Switzerland: A randomized control trial," International Journal of Environmental Research and Public Health, vol. 20, 2023.

[23] G. Thornicroft et al., "The Lancet Commission on ending stigma and discrimination in mental health," The Lancet, 2022.

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