

# Implementation of Mental Health Policies toward Indonesia Free Restraint

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## Implementation of Mental Health Policies toward Indonesia Free Restraint

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### Abstract

Mental health disorders are still one of the most prominent health problems in the world, including in Indonesia. There is still a misguided stigma and discrimination on people with mental disorders, so more than 56,000 of them experience restraint. This study aims to determine the efforts and review the implementation of Law no. 18/2014 about Mental Health until 2017. This is a policy study using literature review. Descriptive exploration is done using a policy analysis framework in the implementation phase based on Edwards III model. The unit of analysis is mental health policy in Indonesia. The results show that only a few local governments initiate special mental health regulations as well as more operational programs. Activities are still focused on curative and rehabilitative efforts. There has been prevention of deprivation through the 'Indonesia Free Restraint' program since 1977 but this has not gone well. The communication process encountered problems of unclear and inconsistent information. Moreover, not all local governments use the authority to regulate the mental health policy to mobilize resources. Law no. 18/2014 has not been implemented optimally. Not all implementers and policy targets are dedicated to direction of the Law. Neither not all aspects of mental health efforts have programs, Standard Operating Procedure and coordination governance. Conversely, optimal implementation can be done by introducing it as an element of primary health in basic health service.

### Keywords:

mental health; policy implementation; psychosocial; restraint; review

### Introduction

There is no health without mental health, but mental health problems have long been abandoned (WHO, 2013). According to World Health Organization (WHO), about 450 million people worldwide have mental disorders. Mental disorders account for 13% of the global

disease burden and are estimated to increase by almost 15% by 2030 (WHO, 2009). Globally the number of people with depression disorders is estimated to exceed 300 million by 2015. Almost all of these numbers suffer from anxiety disorders (WHO, 2017).

The WHO regional Asia Pacific (WHO

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SEARO) states the largest number of depression cases is found in India (56,675,969 or 4.5% of the population), the lowest in Maldives (12,739 or 3.7% of the population), while Indonesia make up 9,162,886 or 3.7% of the population (WHO, 2017). Based on the 2007 and 2013 reports of *Riset Kesehatan Dasar (Riskesdas)*, emotional mental disorders (depression and anxiety) are suffered by 11.6% and 6% of people over 15 years. While the weight mental disorder (psychosis) are found in 0.46% of sample in 2007, and 0.17% in 2013 (Ministry of Health, 2007, 2013; Putri, et al., 2015; Widakdo & Besral, 2013).

Based on studies from various sources, there are still cases of restraint in Indonesia. 14.3% of people with severe mental disorder who are restraint due to their condition (calculated from the 1655 households who have people with severe mental disorders). The methods used are traditional restraint (using wood or leg chains), restricting motion, isolation, including confinement, and neglect. The latest government data shows that there are about 18,800 people still being restraint. This shows the existence of violence against people with mental disorder in Indonesia (Ayuningtyas, et al., 2018; HRW, 2016; Ministry of Health, 2013).

The consequences of depressive and anxiety disorders in terms of lost health are huge. Depressive disorders led to a total of over 50 million Years Lived with Disability (YLD) in 2015. More than 80% of this non-fatal disease burden occurred in low-and middle-income countries. Globally, depressive disorders are ranked as the single largest contributor to non-fatal health loss (7.5% of all YLD). Anxiety disorders led to a global total of 24.6 million YLD in 2015. Anxiety disorders are ranked as the sixth largest contributor to non-fatal health loss globally and appear in the top 10 causes of YLD in all WHO Regions (WHO, 2017).

Every country is recommended to have a policy on mental health. About two third

of WHO member states have a stand-alone policy or plan for mental health, half of the WHO member states have a stand-alone mental health law. However, in many countries policies, plans, and laws are not fully in line with international human right covenants. Person with mental disorders and family members are not involved in policy/plan/law development (WHO, 2015).

Data could be detected from 12 different countries, covering single or multiple hospitals in most countries and complete national figures for two countries (Norway, Finland). Both mechanical restraint and seclusion are forbidden in some countries for ethical reasons (Steinert et al., 2010).

Indonesia have a stand-alone mental health policy or its plan since 2001, then the Mental Health Law in 2014 (Law No.18/2014) but its implementation is not yet optimal (WHO, 2014). Factors affecting the implementation include the diverse level of public understanding and the ability to access information, limited resources that is still centered on the island of Java, low budget for mental health programs because it has not been a priority, and disintegration in the primary service. There are still problems caused by stigma and human rights abuses in people with mental disorders. In fact, the burden of mental disorders is largely preventable with known and affordable treatments, but inadequate health systems limit progress (WHO, 2013).

Implementation of Law No.18/2014 is considered lacking, seen from the implementing regulations have not been made as mandated for no longer than one year since enacted in 2014 (Yusuf, 2015). Its impact is failure to reach the program target, with the worst are still found cases restraint. The law should be a policy to protect people with mental disorders from various discriminatory issues. This study aims to determine the effort as well as to review the implementation and achievement of Law No. 18/2014 about Mental Health until 2017.

### Theoretical Framework

Law is one of the public policy consists of written rules that serve as guidelines in the implementation of achieving goals. Analysis of health policy implementation requires approaches from various aspects to fully understand the issues (Ayuningtyas, 2015). Webster's dictionary define that the implementation is to provide the means for carrying out, to give practical effect to (cause an impact or effect on something). Implementation of policies relates to three things: the goals and objectives of the policy; activity or activity reaches the goal; as well as the results of activities (Agustino, 2008). Implementation of policies in the form of two choices of programs and formulation derivate policies/derivatives of the policy (Dwijowijoto, 2003).

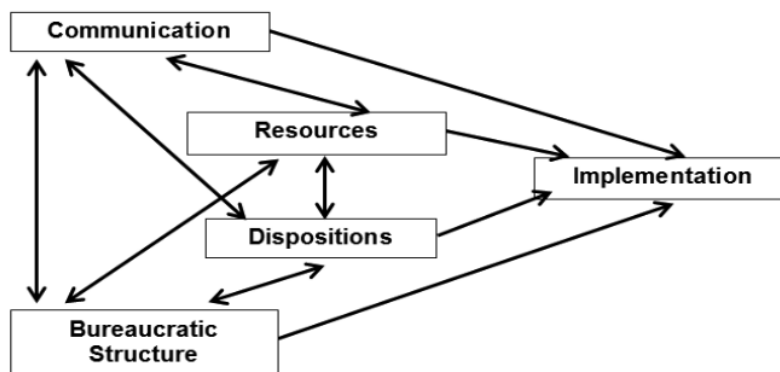
The approach to reviewing policy implementation is based on a model of public policy implementation by George C. Edwards III (1980), that policy implementation is a crucial process that closely with the formulation of policy, preparation and implementation planning to achieve the goal (Edwards, 1980). Evaluation of Edwards III implementation states four crucial variables in implementations that operate simultaneously and interact with each other.

Edwards III (1980) proposes a policy implementation model with a top-down perspective that consists of communication, resources, dispositions, and bureaucratic structure (see **Figure 1**). This model is one of the clear perspectives in analyzing policy implementation that starts with policy makers. This model is one of the clear perspectives in analyzing policy implementation that starts with policy makers. Communication means the ability to convey the goals and objectives of the policy to be known, understood and can be realized. Resources relate to **human resources, materials, and methods** to achieve the goals, objectives, and content of the policy. Disposition means attitudes possessed by policy implementors **such as commitment, honesty, communicative, clever and democratic**. The bureaucratic structure relates to organization or governance in realizing the goals and objectives of the policy (Edwards, 1980).

### Methods

This is a policy study using literature review, as a descriptive exploration on the application of Law no. 18/2014 about Mental Health in Indonesia. The policy analysis framework uses the Policy Development Cycle approach at the implementation stage

Figure 1.  
Factors Influencing Policy Implementation



Source: George III Edward (1980)

(Ayuningtyas, 2015). Analysis of policy using Edwards III model approach on Public Policy Implementation consists of the following aspects: communication, resources, disposition, and bureaucracy (Edwards, 1980). The analysis will explore on context, content, and actor (Ayuningtyas, 2015).

The unit of analysis in this research is a mental health policy in Indonesia. Main sources of information consist of government regulatory documents, books, WHO reports, government reports. Secondary sources of information consist of journals, and articles from electronic media using the keywords "mental health", "mental health policy", "implementation of mental health policy" and "restraint" as the main subjects of this study. Information obtained as data and findings are collected, managed, and reviewed critically.

## **Result**

### **Mental Health Policy**

Concepts and views on mental health and problems affect the handling from the policy to the actions taken (Siswanto, 2007). A mental health policy is the official statement of a government which defines the vision and details an organized set of values, principles, objectives and areas for action to improve the mental health of a population (WHO, 2011).

A mental health plan details the strategies, activities, timeframes and budgets that will be implemented to realize the vision and achieve the objectives of the policy as well as the expected outputs, targets and indicators (WHO, 2005). That can be used to assess whether implementation has been successful (WHO, 2005).

Mental health legislation, or mental health provisions integrated into other laws (e.g. anti-discrimination, general health, disability, employment, social welfare, education, housing, and other areas), may cover a broad array of issues (WHO, 2011). That are including access to mental health care and

other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (WHO, 2011).

The policy of laws governing about mental health in Indonesia is revolving. The first policy to attend is the Law on Mental Health No. 3/1966 passed and enacted in Jakarta on June 11, 1966 by President Soekarno. Furthermore, canceled through the ratification of Law No. 23/1992 about Health. This law applied for 17 years ago was replaced with Law No. 36/2009 about Health. In this law there is a chapter on mental health, as mandate for the government to establish a Government Regulation that regulates mental health efforts. However, the Government Regulation was never prepared.

The following considerations underlie the long road to the presence of Law No. 18/2014 on Mental Health:

- a. The State guarantees that every person lives physically and mentally prosperous and receives health services which are mandated by the 1945 Constitution.
- b. Mental health services for every person, and guarantees the right of people with mental disorders cannot be realized optimally.
- c. The lack of mental health services for every person, and not guaranteed the right of people with mental disorders resulting in low productivity of human resources.
- d. The regulation of mental health efforts in the current legislation has not been regulated comprehensively so that it needs to be regulated specifically in one law.

Law No. 18/2014 about Mental Health includes explanations of general provisions, mental health efforts, service systems,

resources, rights and obligations, mental health examinations, duties, responsibilities and authorities, community participation, criminal provisions, and other terms. In the Law No. 18/2014, article 2 states that mental health strengthening efforts must be based on justice, humanity, benefits, transparency, accountability, comprehensive, protection, and non-discrimination ones. The mental health efforts should include promotive, preventive, curative, and rehabilitative services. The promotive effort one's purpose is for eliminating the negative stigma in society and also increasing public acceptance of mental disorders.

Article 70 mentions about people with mental disorders' rights, they are entitled to protection from any kind of neglect, violence, exploitation, and discrimination. Article 80 states that the government is responsible for managing cases of abandoned mental disorders patients, or the ones whom vagabond tramp, threatening the safety of themselves or others, and the ones whom perceived disturbing the public. The government is obliged to provide rehabilitation to poor mental health patients whom helpless and destitute, have no families or relatives, and not knowing any member of family. The government, with local government, is also obliged to accommodate the ones whom have recovered or can controlled the symptoms yet have no family.

Article 85 in the Law No. 18/2014 states the roles that public could take. One role mentioned that public can take is in reporting immediately if there is people with mental health disorders that needs help, or if there is the ones whom experienced acts of violence. Article 86 states that any person who carries out any misuse, shackle, neglect, violence, and or tells any other person for the same things like shackle, neglect, violence or any other violation of human rights shall be liable to be punished in accordance with the laws and regulations. Article 90 states further explanation about the

Law No. 18/2014 implementation should be within one year of the enactment. The Law has been enacted since August 7<sup>th</sup>, 2014.

### **Implementation and Current Achievement of Mental Health Policy in Indonesia**

Implementation of Law No.18/2014 about mental health is carried out in accordance with all legislation related to mental health as long as it does not conflict with the provisions therein. It is mentioned in article 90 that the implementing regulations shall be decided no later than one year since enactment (UU-No.18/2014). However, until the commemoration of World Mental Health Day on October 10, 2015, article 90 is ignored. The draft such as the Presidential Regulation about Coordination of Mental Health Efforts has been missed from the time the regulation was written in the Act. There is no the implementation regulations stipulated by the President, the Government, nor the Minister as a further provision (Yusuf, 2015).

Likewise, in mental health facilities, it is mentioned in Article 52 that the Provincial Government shall establish at least one mental hospital or service facility for mental health no later than five years after the law is enacted (Articles 88 and 89). However, District Governments have varying levels of implementation in providing facilities and management of mental health resources (Yusuf, 2015). The mental health resources in Indonesia in ratio per 100,000 population are 0.29 psychiatrists, 0.18 psychologists, 2.57 nurses, and 0.05 social workers. This ratio is still smaller than those in Malaysia and Thailand, let alone United Kingdom. Maximum budget in Indonesia for mental health efforts is set at 1% of the total national health budget (WHO, 2014).

Currently in services field, number of mental health service facilities is increasing: 48 Mental Hospital and Drug Addiction Hospital located in 26 of 34 provinces. The number of *Puskesmas* that provide mental health services

is 4182 from 9005 *Puskesmas* (46.4%). Moreover, 249 (55.95%) out of 445 General Hospitals provide mental health service (outpatient and inpatient). Even 25 *Puskesmas* at D.I. Yogyakarta already have a clinical psychologist (Ministry of Health, 2015).

### **Restraint Handling in Indonesia**

Restraint treatments are universally agreed as human rights abuse. Indonesia also has a policy to prevent restraint i.e:

1. 1945 Constitution (UUD 1945) Articles 28G and Articles 28I.

Articles 28G, paragraph (2):

“Setiap orang berhak untuk bebas dari penyiksaan atau perlakuan yang merendahkan derajat martabat manusia dan berhak memperoleh suaka politik dari negara lain.”

Articles 28I, paragraph (1):

“Hak untuk hidup, hak untuk tidak disiksa, hak kemerdekaan pikiran dan hati nurani, hak beragama, hak untuk tidak diperbudak, hak untuk diakui sebagai pribadi di hadapan hukum, dan hak untuk tidak dituntut atas dasar hukum yang berlaku surut adalah hak asasi manusia yang tidak dapat dikurangi dalam keadaan apa pun.”

2. Law No. 39/1999 about Human Rights, Articles 9 and Articles 42.

Articles 9, paragraph 1, 2 and 3:

(1) Setiap orang berhak untuk hidup, mempertahankan hidup dan meningkatkan taraf kehidupannya.

(2) Setiap orang berhak hidup tenteram, aman, damai, bahagia, sejahtera lahir dan batin.

(3) Setiap orang berhak atas lingkungan hidup yang baik dan sehat.

Articles 42 (which regulates the rights of people with mental disabilities):

“Setiap warga negara yang berusia lanjut,

cacat fisik dan atau cacat mental berhak memperoleh perawatan, pendidikan, pelatihan, dan bantuan khusus atas biaya negara, untuk menjamin kehidupan yang layak sesuai dengan martabat kemanusiaannya, meningkatkan rasa percaya diri, dan kemampuan berpartisipasi dalam kehidupan bermasyarakat, berbangsa, dan bernegara.”

3. Law No. 36/2009 about Health, Chapter IX (Articles 147, 148, and 149)

Articles 147, paragraph (1):

“Upaya penyembuhan penderita gangguan jiwa merupakan tanggung jawab Pemerintah, pemerintah daerah dan masyarakat.”

Articles 148, paragraph (1):

“Penderita gangguan jiwa mempunyai hak yang sama sebagai warga negara.”

Articles 149, paragraph (1):

“Penderita gangguan jiwa yang dapat mengganggu ketertiban wajib mendapat pengobatan dan perawatan di fasilitas pelayanan kesehatan.”

Articles 149, paragraph (2):

“Pemerintah, pemerintah daerah dan masyarakat wajib melakukan pengobatan dan perawatan difasilitas pelayanan kesehatan bagi penderita gangguan jiwa yang terlantar, menggelandang, mengancam keselamatan dirinya atau orang lain, dan/ atau mengganggu ketertiban umum.”

4. Law No. 18/2014 about Mental Health (Articles 86).

“Setiap orang yang dengan sengaja melakukan pemasangan, penelantaran, kekerasan dan/atau menyuruh orang lain untuk melakukan pemasangan, penelantaran, dan/atau kekerasan terhadap ODMK dan ODGJ atau tindakan lainnya

yang melanggar hak asasi ODMK dan ODGJ, dipidana sesuai dengan ketentuan peraturan perundang-undangan.”

5. Law No. 19/2011 about Ratification of the Convention on The Rights of Persons With Disabilities (The Convention held on March 30<sup>th</sup>, 2007 in New York). In this convention, one of them regulates about the Rights of People with Disabilities:

“Setiap penyandang Disabilitas harus bebas dari penyiksaan atau perlakuan yang kejam, tidak manusiawi, merendahkan martabat manusia, bebas dari eksploitasi, kekerasan dan perlakuan semena-mena, serta memiliki hak untuk mendapatkan penghormatan atas integritas mental dan fisiknya berdasarkan kesamaan dengan oranglain. Termasuk didalamnya hak untuk mendapatkan perlindungan dan pelayanan sosial dalam rangka kemandirian, serta dalam keadaan darurat.”

The restraint handling has started since issued Decree of the Minister of Home Affairs No. PEM.29/6/15 date November, 11<sup>th</sup> 1977 which is addressed to all Governors about prohibition of restraint on people with mental disorders (ODGJ). However, based on reports from public and mass media, there are still many ODGJs being restraint. In 2010, Indonesia conducted the ‘Indonesia Free Restraint Programme’ through Directorate of Mental Health, Health Ministry (HRW, 2016; Ministry of Health, 2015).

Previously in 2010, the number of provinces that made efforts for case finding, release, and medical treatment on people restraint was only 12 Provinces from 33 Provinces. Furthermore in 2014, provinces participating in the Indonesia Free Restraint Program increased to 32. Currently, there are 5 Provincial Governments that have decided regulation about free-restraint i.e:

1. Qanun Aceh No. 4/2010 about Health, which contains the efforts to handling restraint in NAD Province

2. Governor Regulation No. 1/2012 about Handling Restraint in Central Java Province
3. Governor Regulation No. 22/2013 about Handling Restraint in West Nusa Tenggara Province
4. Governor Regulation No. 49/2014 about Implementation of Handling Free Restraint in Bangka Belitung Islands Province
5. Governor Regulation No. 81/2014 about Handling Restraint Guideline in D.I. Yogyakarta
6. Circular Letter of East Java Governor No. 460/11166/031/2014 about the release of people with schizophrenia from restraint.

There are already District Governments that create and run programs for handling of restraint, such as ‘Inovasi Bebas Pasung’ in Muara Enim District, ‘Inovasi MLM’ and ‘e-pasung’ application in East Java Province, and ‘Inovasi Desa Siaga Sehat’ in Indragiri Hilir District. Most of these programs basically involve community to actively report cases of restraint, also medical teams from Puskesmas or District Hospital to actively investigate. In addition, family role is also encouraged in treatment including in relapse (Suripto & Alfiah, 2016).

Indonesia Free Restraint Program in 2019 was also implemented by the Ministry of Social. Due to the great scale of the situation, the program’s deadline was extended from 2017 to 2019. Restraint still occurs due to low knowledge of family and community about mental disorders. The aim of the Indonesia Free Restraint is to prevent the ODGJ from experiencing restraint and re-restraint and obtaining medical and social rehabilitation to recover its social function (Yulianto, 2017). In addition, since 2016 began to provide information about people with disabilities and mental health and testing ‘Rumah Antara’ which is one alternative services that can be accessed by people with mental disability post medical rehabilitation (Yulianto, 2017).



### Evaluation of Implementation Mental Health Policy

We assessed the implementation of public policy using George C. Edwards III model approach. There are four crucial variables in implementation with top down perspectives that operate simultaneously and interact with each other, i.e communication, resources, disposition, and bureaucratic structure (Edwards, 1980).

#### Communication

Communication is process of delivering information by communicators to communicant consisting of dimensions of transmission, clarity, and consistency (Edwards, 1980). Information about mental health policy is important to be communicated to policy actors so the policy goals and targets can be achieved as expected. The transmission dimension requires information about the policy to be communicated to policy implementer, and the policy target group, and the parties involved directly or indirectly. The clarity dimension requires that information transmission process of policy be communicated clearly between communicator and communicant involved directly or indirectly. The dimension of consistency requires that information about policy is not different and unclearly among implementers, target groups, and parties involved in the policy.

Law No. 18/2014 provides comprehensive information on this. Since its enactment, the delivery of information from this Law is still limited. Information addressed to many parties: the legislative group that initiated this Law, the policy implementers in government, to community groups and individuals. The role of communication is important, starting from policy planning and implementation also. The figure of excellence in any party that is involved directly or indirectly with the Law is expected to build a continuous communication network. Communications from policy makers with

each District Government can be a leverage to optimize the implementation of a mental health policy.

#### Resources

Resources on policy implementation include policy instruments, budget allocations, human resources, authority resources, and health facilities. Its means that policy implementation requires a source of drivers and implementers that must be available starting from explanation to implement policy, authority, to completeness of facilities and infrastructure (Edwards, 1980). Resources play a significant role since the policy is planned to be implemented by the policy objectives.

Subject that is not exist in Law No. 18/2014 are a concern and comprehension. Thus, policy implementers and targets have not prioritized mental health affairs which resulted in ignorance and lack of awareness. Particularly central and regional policy implementers are responsible for providing resources to drive the implementation of the mental health policy. Starting from declaration of leadership commitment on the policy implementers, based on the authority for creating attention, comprehension and instruments of mental health handling. Budget support, facilities and infrastructure of mental health handling must be integrated with existing facilities for effective and efficient implementation.

#### Disposition

The Edwards III model defines disposition as the will, desire, and tendency of policy actors to actually implement and realize policy objectives (Edwards, 1980). This variable is related to the attitude of policy implementers in terms of the perspectives and behaviors in policy implementation. Hence, optimal implementation requires an agreement between the maker and the policy implementer to implement the policy according to its objectives.

The management of mental health should be understood as a fundamental need that is an essential part of overall health. Policy of mental health management is also as important as managing major health problems, especially as it concerns everyone's basic rights. Makers, implementers, and policy goals simultaneously play a role in the implementation of the mental health policy. However, not all implementers and policy targets have the dedication to realize the mandate in Law No. 18/2014.

### Bureaucratic Structure

Edwards III model states that policy implementation can be ineffective because of inefficient bureaucratic structures, including bureaucracy, authority sharing, relationships between organizational units. The main characteristics of bureaucracy are Standard Operating Procedure (SOP) and fragmentation. Absence of SOP can be an obstacle to the implementation of new policies that require new ways of working or new personnel types to implement the policy. The bigger policies, requiring change in the usual ways in an organization, its means the probability of greater SOP to inhibit implementation. The fragmented organizational structure can improve communication failure because the chance of instruction is distorted enormously (Edwards, 1980). The more distorted policy implementation, its more requires intensive coordination.

Bureaucracy as an element of policy implementers should be able to support policy that has been decided politically by doing good coordination. Implementation of policies with these variables is supported by procedures established as a benchmark of work through coordination on the dissemination of responsibilities of policy determination. Mental health management involves many sectors, not only the Ministry of Health. The main parties involved are the policy implementers of central and district governments that must

be well coordinated. Currently, not all aspects of mental health efforts have a program moreover SOP and coordination governance, and excellent programs are still limited.

### Discussion

Law No. 18/2014 states that each person and/or ordering others deliberately to restraint, abandon, violence or other acts that violate the human rights of people with mental disorders should be punished in accordance with provisions of legislation (Law No.18/2014). This is clearly a prohibition of shelter activities, but has not been fully implemented because there are still restraint in Indonesia.

The five action strategies identified by the Ottawa Charter remain today the basic blueprint for health promotion in many parts of the world. That are build healthy public policy, develop personal skills, create supportive environments, reorient health services, and strengthen community action (WHO, 2004). Then, health promotion politics involves advocating both individual and collectivist interventions for social change. We conclude that mental health efforts and policies are still far reaching social change thoroughly in Indonesia.

This leadership is poorly developed in many countries where mental health is concerned. Around 40% of countries do not have an explicit mental health policy, while around 33% have no mental health program let alone a policy, and around 33% have no specific drug or alcohol policy, two issues that are closely intertwined with mental disorders. In financial aspect, 33% of countries do not report a specific mental health budget within their overall public health budgets, 33% of countries allocate less than 1% of their public health budgets to mental health, and most of the rest allocate less than 5% to mental health (WHO, 2001).

Globally, only 1% of the global health workforce works in mental health, while 45%

of the world's population live in a country with less than one psychiatrist for 100,000 people. The median public expenditure on mental health per person is \$2 in low and lower-middle income countries and \$50 in high-income countries. Median number of mental health beds per 100,000 population is 5 in low and lower-middle income countries and 50 in high-income countries. About 90% of total service contact by people with mental disorders is through outpatient services (as opposed to inpatient service). Since 2011, 60% increase in beds available in general hospital psychiatric wards (WHO, 2015).

Global percentage of mental health prevention and promotion program types consist of: 55% mental health awareness, 2% material mental health promotion, 11% school-based mental health promotion, 4% parental/family mental health promotion, 5% violence prevention (women, child abuse), 9% workplace mental health promotion, and 8% suicide prevention. However, low-income countries do not have national suicide prevention strategy (WHO, 2015). This achievement showed that Indonesia is still far behind the more developed countries. Indonesia is still focused on the efforts of 'Indonesia Free Restraint' which is now implemented with the role of NGOs from within and overseas.

Similarly, approximately 173 million people diagnosed with mental diseases are also found in China, whereas 158 millions of them are untreated. The rate of physical restraints is significantly higher in China than in other countries. The psychiatric industry there has received inadequate investment and financial support. Mental health services reported an insufficient number of nurses serving a huge number of patients, resulting in their heavy workload. In addition, inadequate number of beds in psychiatric units makes the mental health service unable to meet the public demand. Therefore, nurses are prone to bodily restraint aggressive patients. Physical restraints

are frequently applied to psychiatric patients after admission (Ye et al., 2018).

On the other hand, the review of the medical literature reveals 21 peer-reviewed studies investigating the physiological or psychological effects of using a restraint chair on humans. This study reveals that the restraint chair poses little to no medical risk. Additionally, when used appropriately, the restraint chair alone carries little legal liability. With proper monitoring and adherence to set protocols, the restraint chair is a safe and appropriate device for use in restraining violent individuals (Castillo, et al., 2015).

Furthermore, the analysis on the implementation of mental health policy, requires approaches from various aspects to fully understand the issues (Ayuningtyas, 2015). Implementation of policies relates to three things: the goals and objectives of the policy, activity to reaches the goal, and results of activities. Factors of policy implementation that interact with each other are communication, resources, disposition, and bureaucratic structure (Edwards, 1980). These factors need to be assessed to determine the optimization of the implementation of a policy.

**Analysis of Communication;** Law no. 18/2014 it is known that there is still uncertainty and inconsistency of information due to the information spectrum and the extent of the parties involved. Therefore, the implementation effort is not optimal with indicators such as there has been no agreement on the derivative regulation for the implementation of this Law and there are still violations of *ODGJ* rights such as restraint by community. Dissemination of information about the mental health policy must continue to be done through programs and concrete actions that can be directly seen and felt by the target community.

**Analysis of Resource;** it is known that there is no derivative of regulation in accordance with the requirement of Article 90 of Law No. 18/2014, and not all District Governments have

specific regulations in mental health policy to mobilize resources. This condition shows that the resource is not yet optimal to support this policy. In addition, there is a gap preventing available mental health resources from accommodating service needs. Strategies on human resources for optimal implementation include increasing the number of psychiatry and other mental health professionals; identifying the involvement of various trained non-specialist providers; the active involvement of people affected by mental disorders.

**Analysis of Disposition;** relates to the attitude of policy implementers, Mental Revolution tagline be used as a momentum to maximize the human resources involved directly or indirectly in the management of mental health by creating a dedication and a good work ethic. Policy objectives can be generated by the spirit of change in positioning mental health as an important part of overall health and the realization of basic rights. These activities can be done simultaneously with the implementation of communication variables. Furthermore, true and clear information about Law No. 18/2014 can be transmitted together with determination of dedication and work ethic in its implementation.

**Analysis of bureaucratic structure;** Government through the Directorate of Prevention and Control of Mental Health and Drugs Affairs, Ministry of Health needs to establish a superior program for the implementation of every aspect of mental health efforts which is mandated in Law no. 18/2014. Promotional, preventive, curative, and rehabilitative efforts need to be operationalized into real programs supported by SOP and coordination governance with effective and efficient principles.

Implementation of an optimal mental health policy can be done by incorporating it as an element of primary health in basic health services. Implementation strategy can be focused on change and improvement of

behavior and practice on professional as well as human resources as executor of life health policy (Lau et al., 2015). Strengthening primary care by supporting equitable provision of health-related care for people with intellectual disability is a much needed step towards improving health outcomes among people with intellectual disability (Lennox, et al., 2015).

Research results in South Africa conducted with phenomenological design recommend that Psychiatric nurses should also facilitate the discovery of strengths of the family members through education for them. It is important because their strengths to limit relapses of mentally ill family member (Tlhowe, et al., 2017).

We need to learn a lot from the developed countries to address, the community needs for mental health care by moving from institutionalized to community care, building on the strengths of their social institutions. India has begun this process and made important progress. There is a need to continue the process by widening the scope of mental health interventions, increasing the involvement of all available community resources, and basing the interventions on the historical, social and cultural roots of India (Murthy, 2011).

## Conclusion

It is not a simple matter to achieve the expected mental health situation due to the involvement of socioeconomic and environmental factors related to behavioral aspects. Law No. 18/2014 about Mental Health has not been implemented optimally. Implementation efforts such as specific regulations and more operational programs have been implemented by few District Governments, not evenly distributed in Indonesia, and more focused on curative and rehabilitative efforts. What is more promotional and preventive efforts in the prevention of mental health is still minimal

The communication process experiences issues on unclear and inconsistency of

information due to the information spectrum and the extent of the parties involved. There is no implementing regulation and not all District Governments use authority in the regulation of mental health policies to mobilize resources. Human resources who manage mental health lack in number to accommodate the needs of services. Not all implementers and policy targets have the dedication to realize the direction in Law no. 18/2014. Not all aspects of mental health efforts have programs, SOP and coordination governance.

Recommendations for government to realize comprehensive mental health efforts include promotive, preventive, curative and rehabilitative actions. This policy needs to be operationalized into real programs supported by SOP and coordination governance with effective and efficient principles. Overall, the implementation of an optimal mental health policy can be done by integrating it as a primary health element in *Puskesmas*. Then, joint collaboration on the parties involved directly or indirectly in the management of mental health should be built to empower the community in handling mental health problems and eliminate negative stigma.

Dissemination of information about mental health policy must continue to be done through programs and concrete actions that can be directly felt by the community. True and clear information about Law no. 18/2014 can be transmitted together with determination, dedication and work ethic in its implementation. In addition, it can also raise the spirit of change in positioning mental health as an important part of comprehensive health and the realization of basic rights.

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