Challenges and Opportunity of Psychiatric Care in Indonesia

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Indonesia holds an important position among nations, geographically and social-politically. As an archipelago of over 17,000 islands that lies between two large continents and two great oceans, Indonesia is an ethnically and linguistically diverse country, with around 300 distinct native ethnic groups, and 742 different languages and dialects. Government expenditure on healthcare in Indonesia is about 3.1% of its total gross domestic product. Many psychiatric problems were to be expected could raise from such a diverse cultural population, but as a nation, Indonesia has struggled to thrive to a mentally healthy nation by striving to develop its own personalized psychiatric care. Psychiatry arrived in Southeast Asia in the late nineteenth century. Dutch colonialism brought psychiatry and psychology to the Dutch East Indies (Indonesia's name during Dutch colonialism). Mental health care policy of the colonial Dutch government in the Dutch East Indies was centered on the mental hospital, for custodial function. In the early 1950s, the new government of Indonesia took over full responsibility for mental health and mental health institutions, part of a larger policy of nationalization and centralization, with the director of mental health of the Ministry of Health in Jakarta functioning as the central agency for planning mental health services. In 2000s, there were new growing interest in modern psychiatry. This emerging interest has come to uprise since the growing cases of narcotics and psychotropic abuse among Indonesian youngsters. A renewed Mental Health Act was published in 2012. President Joko Widodo in 2017 declares a national alert and fight over drug problems, taking mental problem as a serious matter for the nation. In national strategic plan of Health Planning Guidelines for 2015-2019, there are seven aspects of Healthcare Development Program, including the Development of Mental Health Services. The target of this services is to increase the quality and access of mental health service and drug problems. We gave an example of Dr. Soeharto Heerdjan Mental Hospital, to describe rehabilitation programs for its psychiatric patients and drug abusers.

Key words: Indonesia, mental health services, psychiatry, mental rehabilitation

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Introduction

Indonesia as one of the nations in Asian region, since even before its independence in August 1945 holds an important position among nations, geographically and social-politically. As an archipelago of over 17,000 islands that lies between two large continents and two great oceans, even since before this pack of islands inhabited by various tribes exclaimed themselves one as "Indonesia" in 1928, this nation has been long favored by explorers. This area once called East Indies by the first European nations came to be an important region in trading since around the seventh century, when Srivijaya Kingdom and then later Majapahit Kingdom traded with China and India. Local rulers gradually absorbed foreign cultural, religious and political models from explorers of the early centuries, Hindu and Buddhist kingdoms flourished. Muslim traders and Sufi scholars brought the now-dominant Islam, while European powers brought Christianity drawn into its natural resources of people and cultures. Following three and a half centuries of Dutch colonialism, at times interrupted by Portuguese, British, and then Japanese rules, Indonesia secured its independence after World War II.

Indonesia is an ethnically and linguistically diverse country, with around 300 distinct native ethnic groups, and 742 different languages and dialects. The official language is Indonesian (also known as Bahasa Indonesia), a variant of Malay and borrows heavily from local languages such as Javanese, Sundanese, Minangkabau, etc. It has been some kind of a miracle that this multicultural dan mutiethnic country can survive over multiple periods of colonialism, and still united and rising up until now. In psychiatric point of view, Indonesia in its sociocultural complexity holds many potential conflicts and problems in its social interactions. The vast area including five main islands and thousands of minor islands adds more complexity to the scheme. In spite of so many differences in so many ways, Indonesian people hold their national awareness of its own motto: "Bhineka Tunggal Ika," which literally is "many, yet one," meaning "unity in diversity," all thanks to the spirit of this country's founding fathers.

Situated between the Indian and Pacific oceans, Indonesia is the world's largest island country, with total area of 1,919,440 square kilometers, which consists of land 1,826,440 square kilometers and water 93.000 square kilometers (Asian Center for the Progress of Peoples, 2007), and the population is 237,556,363 according to the 2010 Census (Statistics Indonesia, 2011). The average population density is 124 per square kilometers, but it is ranged from the density of West Papua Province eight per square kilometers to the density of Daerah Khusus Ibukota, (DKI, Special Capital Authority) Jakarta as the capital city of Indonesia 14,440 per square kilometers. Indonesia is the world's fourteenth largest country in terms of land area and world's seventh largest country in terms of combined sea and land area.

Government expenditure on healthcare in Indonesia is about 3.1 percent of its total gross domestic product. Every citizen is protected under Jaminan Kesehatan Nasional (JKN), a scheme to implement universal health care in the country which launched by Ministry of Health of Indonesia. It is expected that spending on healthcare will increase by twelve percent a year and reach USD 46 billion a year by 2019. Under JKN, all Indonesians receive coverage for a range of treatments through health services from public providers as well as those private organisations that have opted to join the scheme. The 2010 maternal mortality rate per 100,000 births for

Indonesia is 240. The main health problems are air quality, disease, child malnutrition, alcohol and smoking. Health outcomes have significantly improved in Indonesia since the 1960s. Life expectancy at birth is 70.8 years. The child mortality rate has declined from 220 per 1,000 live births in 1960 to 45 per 1,000 live births in 2007. It has been suggested that over a third of the children under 5 years old have stunted growth. More than 28 million live below the poverty line of USD 17 a month and about half the population have incomes not much above it. The malnutrition status has shown steady progress from 38 percent in 1990 to 25 percent in 2000. The rate of smoking is high and about 400,000 die each year from smoking related illnesses.

Past to Recent Years of Psychiatry in Indonesia

Psychiatry developed as a modern branch of medical knowledge in Western societies and arrived in Southeast Asia in the late nineteenth century. Dutch colonialism brought psychiatry and psychology to the Dutch East Indies as part of the development of European therapeutics in that part of the empire. Mental health care policy of the colonial Dutch government in the Dutch East Indies was centered on the mental hospitals for custodial function. Indonesian individuals were confined to mental hospitals only if they disturbed the social order and a physician declared them insane [1, 2].

Bauer and Smit in 1868 as physicians in charge of small hospitals in the Indies, conducted a survey on Java [3]. According to them, there were around 550 individuals in need of institutionalization in the whole archipelago. They found that about 300 of these individuals in pitiful conditions in military hospitals, prisons, or abandoned in the community. They recommended that two large mental hospitals be built. The first mental hospital was located near Buitenzorg (Bogor) and began receiving patients in 1882 (Bauer became the first medical superintendent). A second mental hospital opened near Lawang in 1902. Two additional mental hospitals were established near Magelang and near Sabang, on an island just north of Aceh. Both were opened in 1923. These large mental hospitals treated patients of both European and indigenous backgrounds, for European patient treatments included continuous baths, bed treatment, and open air treatment, and for indigenous patients there was agricultural work for the male patients. Physical restraint, chemical restraint, and isolation were rarely used [3].

Two other types of institutions were established by the Dutch colonial government: acute-care clinics and agricultural colonies. In the 1920s, several clinics (doorgangshuizen) for the treatment of acute cases for up to six months were established in a number of metropolitan centres. If treatment in these facilities was proved unsuccessful, patients were transferred to the larger mental hospitals. Because the existing mental hospitals were severely overcrowded, most of these institutions for short-term care functioned as additional mental hospitals rather than as clinics. These establishments were opened in Surakarta, Batavia (Jakarta), Palembang, Padang, Medan, Banjarmasin, Bangli (Bali), Makassar, and Manado. Mental hospital facilities in the Dutch East Indies were always inadequate, which led to overcrowding, poor care, neglect, and the placement of individuals with mental illness in prisons (Engelhard, in Pols, 2006). Most indigenous individuals with mental illness were tolerated in their communities; a few were placed in wooden blocks called "*pasung*" [2].

Independent Indonesia inherited four large mental hospitals (each housing over 5,000 patients), about 10 acute-care clinics in the major

cities, and an agricultural colony for chronic patients. During the years following independence, the Dutch psychiatrists were discharged, causing a reduction of 18 professional doctors for Indonesian psychiatry. By the 1950s, there were fewer than 30 practising psychiatrists in Indonesia. The national independence of psychiatry did mean that Indonesian psychiatrists could now distinguish themselves on their professional merits, rather than be recognized by their colonizers through a European/native distinction. The independence of psychiatry also allowed for new input and directions from other international sources. Indonesian psychiatry was now freed from its colonial entanglements and seemed to come under the influence of American psychiatry. In 1956, the medical department of the University of Indonesia became affiliated with the medical center at the University of California through a five-year teaching project funded by the American government. This resulted in a new psychiatric clinic in Jakarta and the introduction of somatic therapy and insulin shock therapy [1].

In the early 1950s, the new government of Indonesia took over full responsibility for mental health and mental health institutions, part of a larger policy of nationalization and centralization, with the director of mental health of the Ministry of Health in Jakarta functioning as the central agency for planning mental health services. As an expression of their loyalty to the nation, psychiatrists were legally obliged to work until 2 p.m. each day for the government health care service, which were paid very little. Only after this could they work in their own private clinics [2].

During the 1960s and 1970s, medicine in general and psychiatry in particular took new directions, especially when it came to outreach, with legislation laying the foundation for new, open-style hospitals. In the old, Dutch-style system, patients could be admitted only through court order or through certification by a physician, after which the patient's name would be placed at the bottom of a waiting list. The Mental Health Act of 1966 allowed patients to be admitted voluntarily through non-legal procedures [2].

Initially, mental hospital care remained largely custodial, with electroconvulsive therapy (ECT) and insulin coma therapy (ICT) available on a modest scale. In 1966, the Directorate of Mental Health propounded principles of prevention, treatment, and rehabilitation as the foundation of a system of comprehensive mental health care. During the 1970s and 1980s, the number of mental hospitals in Indonesia more than doubled, new forms of mental health care were developed, and a number of original research projects were undertaken. During this period, Indonesian psychiatry was presented as a model for other South East Asian nations. Unfortunately, during the 1990s, Indonesia's mental health care was declined because of reductions in government spending [1, 2].

In the years of 2000, there are new growing interest in psychiatry in such a modern term. This emerging interest has come to uprise since the growing cases of narcotics and psychotropic abuse among Indonesian youngsters. A renewed Mental Health Act was published on 2012. President Joko Widodo in 2017 declared a national alert and fight over drug problems, taking mental problem as a serious matter for the nation.

Psychiatric Epidemiology over Social and Cultural History and Background

A general outline of the history of psychiatry in Indonesia show that psychiatry's culture has been influenced by local social and cultural back-

grounds. During the twentieth century, two main articulations governed the relation between psychiatry and indigenous psychologies. Colonial and local psychiatrists had to develop a language for their new medical discipline, which meant not only incorporating foreign words into their native language but also drawing on the language of indigenous psychologies to construct a professional lexicon. Borrowing indigenous psychological terminology, they transformed the local discourse to fit their disciplinary concepts [1].

Dutch psychiatrists in the Indies elaborated on a number of mental afflictions specific to South East Asia that currently are designated as culture-bound syndromes. These are amok, latah, and koro (see van Loon, 1927 [4]; van Wulfften Palthe, 1935 [5]). Amok is the designation given to sudden violent outbursts in men that generally occur after extreme embarrassment, in which the individual attacks everyone and everything in sight, often with a lethal outcome. An attack can last several hours, after which amnesia occurs. Very few cases of amok were admitted to the mental hospitals because individuals with this disorder were often killed to prevent further bloodshed (for a critical view on amok see (Carr and Tan, 1976 [6]). Latah occurs mostly in older women, who, after being startled, imitate the movements of the individuals around them. They often express vulgar language as well. Generally, it was said that an attack of latah occurs after dreams with explicit sexual content (see also Winzeler, 1995 [7]). Koro is the fear that the penis will retract inside the pelvis and disappear [2].

There is little research on traditional, cultural, and spiritual views on the cause of mental illness in Indonesia, but there are a number of studies on mental disorders in disaster-affected communities or on restrained or confined people with mental illnes which indirectly show us that a cultural and spiritual aspect was the background of the treatment. Another indication is the popularity of traditional or faith-based healing shelters for people with mental disorders. In a study by the Department of Psychiatry, Faculty of Medicine, University of Indonesia, in Garut District, West Java, after the earthquake of 2009, people associated symptoms of mental disoders mostly with severe mental illness, i.e. schizophrenia: only a few understood that depression and anxiety are also mental disorders [8]. According to the people of Garut, causes of mental illness are life problems, illicit substances, birth-related defects, accidents, and also inbreeding. Other causes are supernatural forces, witchcraft, lack of education [8].

In 2007, Indonesia for the first time carried out a national survey on mental health. It was a part of the first Basic Health Research that was implemented by the National Institute for Health Research and Development. The Basic Health Research 2007 had two sets of questions on mental health. The first set was on severe mental disorder and it showed that the national prevalence of severe mental disorder (psychosis/schizophrenia) was 4.6 per thousand, with the provinces of DKI Jakarta (20.3 per thousand), Nangroe Aceh Darussalam (18.5 per thousand), Sumatra Barat (16.7 per thousand), Nusa Tenggara Barat (9.9 per thousand), and Sumatra Selatan (9.2 per thousand) being the five highest, and Maluku (0.9 per thousand) as the lowest. The second set of questions used the Self Reporting Questionnaire to cover mental emotional disorders (depression and anxiety). National prevalence for mental emotional disorders in the age group > 15 years old was 11.6 per cent. The "*pasung*" rate in people with severe mental disorder is 14.3 percent or about 57,000 cases [8].

Mental disorders and drug abuse also relate to self-harmful behaviors, such as suicide.

According to a report from Indonesian Police Main Headquarters in 2012, the suicide rate is around 0.5 percent of the 100,000 population, meaning that there are about 1,170 reported suicides have been reported within a year. The priority for mental health promotion is to develop Community-based Mental Health Efforts whose spearhead is the community health center (Puskesmas) and works with the community, preventing the increasing number of mental disorders [9].

Data obtained from the National Narcotics Agency (BNN) survey and the University of Indonesia's Center for Health Research in 2008 revealed that the prevalence rate of drug users is around 1.9 percent of the total population of Indonesia, with an age range of 10 to 60 years. In just three years, the prevalence has been increased to 2.2 percent. This number means that about 4 million Indonesians are listed as drug abusers in recent years [11].

Training and Education of Psychiatric Medical Personnel

During the twentieth century, psychiatry was naturalized in Indonesia (and other Southeast Asian countries) and integrated into the national health care system. In the post-independence period, most Indonesian psychiatrists received training at Western universities and brought the knowledge back with them to their home country. In 1851, (School ter Opleiding van Indische Arsten [STOVIA, School for the Education of Indies Physicians]) was established in Batavia (Jakarta). In 1920, with the part-time appointment of F. H. van Loon, who taught psychiatry and neurology, psychiatry officially became part of the medical curriculum. Teaching was adversely affected by the absence of a psychiatric clinic. For in-class demonstrations, patients had to be brought from Grogol, which was about 20 kilometers away. The hospital next door to the medical school refused to open a psychiatric ward, on the conviction that the sick and the insane ought not to be treated in the same premises. In 1927, STOVIA was transformed into a medical faculty which admitted both Europeans and Indonesians; the degree it offered was equivalent to those awarded in the Netherlands. A chair in psychiatry and neurology was established and was occupied until 1942 by van Wulfften Palthe [2].

During the Japanese occupation (1942-1945), the medical school was run by the occupation forces. For the first time, Indonesian physicians participated in teaching. During the struggle for independence (1945-1949), a number of Indonesian physicians ran an underground medical school parallel to the re-established Dutch medical faculty. After the transfer of sovereignty to Indonesia December 27, 1949, most of the teaching staff at the Universityof Indonesia and 18 Dutch psychiatrists left Indonesia. In 1950, Fakultas Kedokteran (Faculty of Medicine) was founded as part of the University of Indonesia; medicine was taught according to the model established by the Dutch. Slamet Imam Santoso became the first professor of neurology and psychiatry (for a biography see Oemarjati, 1992 [12]). Santoso was later involved with the establishment of the Department of Psychology to make more psychotherapists available in Indonesia (see Santoso, 1959) [13].

In 1961, neurology and psychiatry became established in two different departments at the University of Indonesia medical school and R. Kusumanto Setyonegoro became the chairman of the department of psychiatry (a position he had held until 1972). In 1961, there were about 32 psychiatrists in Indonesia (Kelman, 1968 [14]).

After visiting the USA as part of the association of the University of Indonesia medical school with University of California at San Francisco (UCSF), Kusumanto came to advocate a holistic-eclectic approach, which emphasized biological, psychological, and social factors in the etiology of mental illness (Setyonegoro, 1965 [15]), which became the basis of psychiatric thinking in Indonesia. In 1967, Kusumanto introduced a structured three-year residency training program in psychiatry (which was extended to four years in 2000). [2].

Postgraduate education in psychiatry has been available to Indonesian psychiatrists on a limited scale in the USA, Canada, the UK, and the Netherlands. One initiative deserves special mention. From 1972 to 1973, the University of Hawaii medical school organized a training program in community child psychiatry in collaboration with the University of Indonesia medical school (McDermott and Maretzki, 1975 [16]; McDermott et al., 1974 [17]). Five psychiatrists spent a year on Hawaii for advanced training; after returning they established child psychiatry as a sub-discipline. Currently, there are 35 child psychiatrists in Indonesia. This project was followed by an anthropologist as well, who made a number of observations about the specific requirements of the mental health care system in Indonesia (Maretzki, 1981 [18], 1981 [19]). In 1972, the Society for Indonesian Neurology, Psychiatry, and Neurosurgery was established; in 1983 this society was dissolved and the Indonesian Psychiatric Association (Ikatan Dokter Ahli Jiwa Indonesia) was founded [8].

Research and Neuroscientific Approach in Psychiatric Care

One of the first physicians to write extensively on the psychology of the indigenous population of the East Indian archipelago was J. H. F. Kohlbrugge, a physician who spent 13 years on Java around the turn of the twentieth century. Kohlbrugge worked as a physician on Java 1892-1899 and 1901-1906. According to Kohlbrugge (1907) [20], the lack of mental development of the Javanese (and other ethnic groups in the colonies) was due to the pervasive presence of animism and superstition, which held it in a tight grip. In addition, the oppressively hot climate deterred hard work and impeded intellectual development. Kohlbrugge argued that the Javanese were highly suggestible, emotional, erratic, and child-like. The complete lack of individualism, an intrinsic laziness, the inability to plan ahead, the lack of development of rational abilities, and the strongly present emotions, meaning that Javanese society would only develop slowly. Kohlbrugge warned that Western education would erode indigenous culture, causing social problems, anomie, and the formation of a discontented urban class which had lost its cultural roots. He recommended that the colonial government limit itself to maintaining law and order, and that the psychology of the Javanese be studied to aid the formulation of an appropriate colonial policy, suitable to the nature of the psyche of the indigenous population [2].

The idea of such uncivilized version of Indonesian people evoked strong protests from Indonesian physicians, who expressed their opinion through the Society for Indigenous Physicians and the Indonesian Society (a group of Indonesian students in the Netherlands). Its journals published a coherent and well-argued critiques. They argued that the investigation of Indonesian individuals with mental illness should be conducted by physicians who speak their language and who are aware of their cultural conventions. They also protested against the generalization of findings based on a small group of patients in mental hos-

pitals to the whole population of the Dutch East Indies. They questioned that generalizations could be made about the over 300 different ethnic groups of the archipelago. And, lastly, they questioned whether comparisons between a generalized "East" and "West" would be meaningful [2].

From 1975 to 1982, the Directorate of Mental Health was appointed as a collaborative center of the World Health Organization–South East Asia Regional Office. During this time, many innovative research projects were undertaken. The first community-based mental health survey to ascertain the prevalence of mental illness in the population, based on a sample of 100,000 individuals, was undertaken in 1983. It was concluded that the prevalence of the major psychoses was 1.44 per thousand population. A comparison with groups of individuals suffering from schizophrenia in London demonstrated that Indonesian patients suffered more from over-activity and less from delusions of persecution, visual hallucinations, and depression, illustrating the significance of cultural factors in determining the symptoms of the major mental illnesses [2].

A second research project was focused on traditional healing with respect to mental health problems in Indonesia. Because there are only a limited number of physicians and an even smaller number of psychiatrists in Indonesia, most people consult traditional healers (*dukun*) rather than physicians when they are confronted with mental health problems. In some areas up to 80 percent will visit traditional healers or religious representatives before consulting physicians. Surveys were conducted in several provinces (Salan, Mustar, Bahar, Sosrokoesoemo, and Thong, 1982 [21]; Setyonegoro and Roan, 1983 [22]). As a result, a policy of co-existence between traditional healers and regular physicians was proposed. Unlike public health initiatives with traditional midwives, no attempts have been made to educate traditional healers about the nature of mental illness or to make them part of the mental health care system. Nevertheless, it is now understood that both groups are not operating in competition [8].

In Indonesia, research in general has not been a priority for some time. Even in academic institutions only small numbers of research activities have been done. Some factors that contribute to this situation are limited grant resources, inadequate facilities, weak coordination between departments and un-stimulating reward for researchers. In psychiatry, especially in schizophrenia the situation is even worse. Only small numbers of researches have been conducted and mostly done by individual researchers. Some research got support from international grants and collaborative partners. Some areas of research are (A) the biology of schizophrenia, genetics and drug clinical trials; (B) clinical aspect, duration of untreated psychosis and neuro-cognitive aspect; and (C) social aspect, pathway of health-seeking behavior, burden of family of schizophrenia, stigma and mistreated of patient with schizophrenia [3].

Some political changes, especially in decentralization policy, currently happen. Academic institutions get more autonomic status. Most of the academic institutions at present try to put research as one of their main priorities. Facilities, such as access to internet library, are improved. In addition to regular grant resources, some local governments can also support research activities. Hopefully this could be a better environment for research activities. In addition to some research activities that have been done, research on the basic epidemiology data and on innovation clinical and social approaches for schizophrenia are considered the foci of our research on schizophrenia in the future [10].

Community and Government Supports in Mental Healthcare

As in the past, and still today, the indigenous response to people suffering from madness has depended on how disturbing their behavior has been to others, and this is no less true today in various Indonesian communities. Villagers care for those who are silently mad, although teasing, especially by children, is common. Aggressive and violent individuals who lash out at people (but do not run amok) might be locked up and held in stocks (*pasung*) until they calm down. The family might also turn to local healers called "dukun" or "orang pintar." If the patient does not recover, the family will collect money and send the afflicted to a hospital, invariably far away, for treatment. Similar attitudes prevailed from colonial era of Indonesia. Since madness is generally an affair of the family and the village, the increase in the number of patients brought to the mental hospitals in Indonesia reflected local society's greater involvement with and dependence over government's mental healthcare service [2].

Twenty years after its independence, Indonesia developed its own mental health law, Law Number 3/1966 on Mental Health. This mental health law contained only 14 articles within seven chapters, and mostly deals with treatment and hospitalization of people with mental illness. Indonesian Law Number 36/2009 amending Law Number 23/1992 about Health, reserved one chapter containing eight articles on mental health (Articles 144-151) that covers the objectives and scope of mental health program, whose is the responsibility and what are the responsibilities for public information and education on mental health, treatment of mental illness, rights of people with mental illness including homeless people, and forensic psychiatric examination. In 2014, the new mental health law was published and stated that a comprehensive and integrated mental health program is highly important [9].

The practice of *pasung* towards people with mental illness can be found all over Indonesia. *Pasung* in Indonesian language refers to the physical restraint or confinement for criminals, crazy and dangerously aggressive people. In its development, the term *pasung* was narrrowed down to those with mental disorders in the community. Furthermore, *pasung* is not only about physical freedom but also something to do with rights to access health services that will improve the function of people with mental disorder. Some studies in lndonesia have shown that the act of *pasung* was initiated by families to protect the patient, family, and community from the violent behavior of people with severe mental disorder (schizophrenia); most of them are 20-30 years old, male, with the duration of being in *pasung* between a few days to more than 20 years. More than 76 percent of them had once been in contact with the health service but could not continue their treatment for various reasons, one of which was low quality of the health service. Acknowledging the impact of *pasung* on physical, occupational, social and humanitarian aspect of care, the government of Indonesia announced the *Pasung*-free Indonesia Program on World Mental Health Day, October 10, 2010. This program was meant to free people with mental disorder from the act *pasung*, and to prevent *pasung* and re-*pasung* [8]

Until 2013, people's awareness of the importance of having health insurance has been low, as shown by the percentage of out-of-pocket health expenditure which was 75.1 per cent in 2012 (The World Bank, 2014). The risk of catastrophic expenditure in this situation is high, especially for people with severe mental illness who tend to

move downwards in their socioeconomic status. Therefore, a good health finance system needs to be developed to share the risks and to protect people. At first the government of Indonesia organized obligatory health insurance schemes for civil servants, retirees, veterans, and private sector employees with health and labor insurance ran by Perseroan Terbatas Askes Persero and Perseroan Terbatas Jamsostek Persero, while securing the premium of the poor and nearly poor with two insurance product: the Jamkesmas (National Social Health Insurance) and Jamkesda (Provincial Social Health Insurance) [8].

In national strategic plan of Health Planning Guidelines for 2015-2019, there are seven aspects of Healthcare Development Program one of which is the Development of Mental Health Services. The target of this services is to increase quality and access of mental health service and drug. Indicators of achieving these goals are: (A) Percentage of Health Service Facilities (Fasyankes) Recipient Beneficiary Institution (IPWL) active drug addicts by 50 percent; (B) Number of districts/municipalities with Puskesmas that provide mental health efforts of 280 districts/municipalities; and (C) Percentage of Regional General Hospital Referral that organizes mental health services/psychiatry by 60 percent [9].

Along with the progress and development of science and technology in the field of medicine, especially psychiatric or psychiatric science, necessary guidelines or reference work of quality and should be accounted morally and materially. The government has made aframework that may serve as a guide in providing services and care to patients with mental disorders in government and private hospitals and other health facilities in Indonesia.Work guidelines are useful to avoid errors in acting so as to cause harm not only to the patient but also to all health practitioners. In addition, in providing services and care to the patient, a psychiatrist should always uphold the nature of humanism, professionalism, morally responsible, uphold medical ethics, social ethics and national ethics. National Guideline for Mental Health Service published by Ministry of Health in the decree of the Minister of Health of the Republic of Indonesia number HK.02.02/MENKES/73/2015 about National Guidelines of Mental Health Service as a guidance on standard operating procedures in patient care that a psychiatrist must know and operate in conducting optimal, professional and accountable health service activities [9].

In 2014, the Indonesian government has issued a Joint Regulation on Narcotics Addiction and Narcotics Abuse Treatment to the Rehabilitation Institution. Referring to Law No. 35 of 2009 on Narcotics and Government Regulation No. 25 of 2011 on the Implementation of Reporting Netters Narcotics Report, this is the legal basis for efforts and measures to save drug users. The drug users are no longer placed as criminals or criminals by reporting themselves to the Reporting Recipient Institution (IPWL) which was inaugurated since 2011. Currently, there are 274 IPWLs in all over Indonesia from various institutions including Puskesmas, Hospitals and Medical Rehabilitation Institutions, either governmental or private [11].

Mental Rehabilitation Service of Post Hospitalized Patients

Mental disorder leads to disruption of the ability of the people with psychiatric problems to play a meaningful rôle in the family and community environment, therefore necessary handling/service. Psychosocial rehabilitation is a service in

the form of strategies that facilitate the opportunities that exist in individuals with mental health problems so that it can function optimally in the environment by developing its capabilities and can adapt to changes in the environment (WHO, 1995) [10].

The main objective of the rehabilitation program is to improve the quality of life and independence of the patients in their social environment. In Dr. Soeharto Heerdjan Mental Hospital, the psychiatric rehabilitation program cope of services includes [10]:

Symptom management

- Training patients to recognize signs and symptoms to prevent the possibility of relapse
- Training patients to recognize and overcome sequelae
- Helping empower patients to overcome illness and can re-control their life

Medication management

- Teaching patients to understand the treatment
- Teaching patients to understand and assess drug effects and side effects
- Teaching them how to seek information and consult with health professionals related to the drugs they use

Basic conversational skills

- Teaching patients how to speak systematically
- Exercising effective communication (verbal and non verbal communication, daily conversation, etc.)

Community re-integration

- Teaching the patients how to reintegrate in the society after returning home
- Training patients with skills for self care, housework, financial management, using public transport, social interaction, self-employment
- Helping patients to get a job or self-employed
- Inviting patients to visit banks, markets and other public places

There are many kinds of activities available for rehabilitation therapy program, such as:

- Opening activities, morning meetings, afternoon meetings
- Educational therapy: English class, administration, computers, remedial, etc.
- Occupational therapy: cooking, hairdressing, sewing, handicraft, plantation, mug making, screening, etc.
- Music therapy: single organ, band, music, choir, karaoke, etc.
- Self-employment training: RH mobile, RH garden, RH corner, RH cleaning service
- Relaxation therapy (Biodanza, Reki Ling Chi, etc.)
- Sports (gymnastics, gym, etc.)

The rehabilitation program for drug abusers by BNN guidelines includes three stages that must be undertaken. First, the stage of medical rehabilitation (detoxification) is the process of addicts to stop drug abuse under the supervision of a doctor to reduce withdrawal symptoms (*sakau*). The second stage, the non-medical rehabilitation stage with various programs at the rehabilitation, such as therapeutic communities program, 12-step program and others. Then the last stage is the advanced stage of development which will provide activities according to interests and talents. In addition, addicts who have successfully passed this stage may return to society, either to go to school or to return to work [11].

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