

NATIONAL MENTAL HEALTH POLICY

2001 – 2005



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DIRECTORATE GENERAL OF COMMUNITY HEALTH
DEPARTMENT OF HEALTH –SOCIAL WELFARE
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FOREWORD

In the period of 2001-2005, we are facing a very dynamic changes in social situation and government policy, as part of the interaction between national political transition and globalization process. In this fully fluctuating period, there is a strong need of policy and direction, which could be used as a reference or guideline for dealing with the changes effectively and efficiently. Our main problem is how to make the limited resources which will be allocated for the greatest benefit of the community.

In this context, we are very pleased to appreciate the initiatives and tremendous efforts of the Directorate of Community Mental Health in the development of National Mental Health Policy for 2001-2005, as a reference and guideline for setting up the yearly Mental Health Program, which is in line with the direction of National Development Program for Health Sector (Propenas) for 2000-2004.

At this very good moment, we would like to express our gratitude to all of the participants, who has already involved very much in this policy development. We are hoping that all of your effort and exertion could provide the greatest benefits, not only for the Ministry of Health and Social Welfare, but also other related agencies and particularly for community organization that have plunged into mental health activities. At last, certainly they would have positive impact on the promotion of community mental health status as a whole.

Having a good works and hoping for the healthy and prosperous Indonesia. May God Bless You.

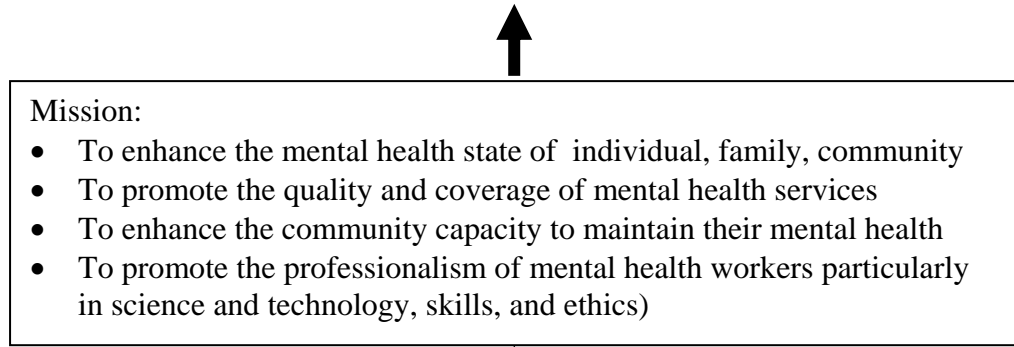
Jakarta, 20th March 2001

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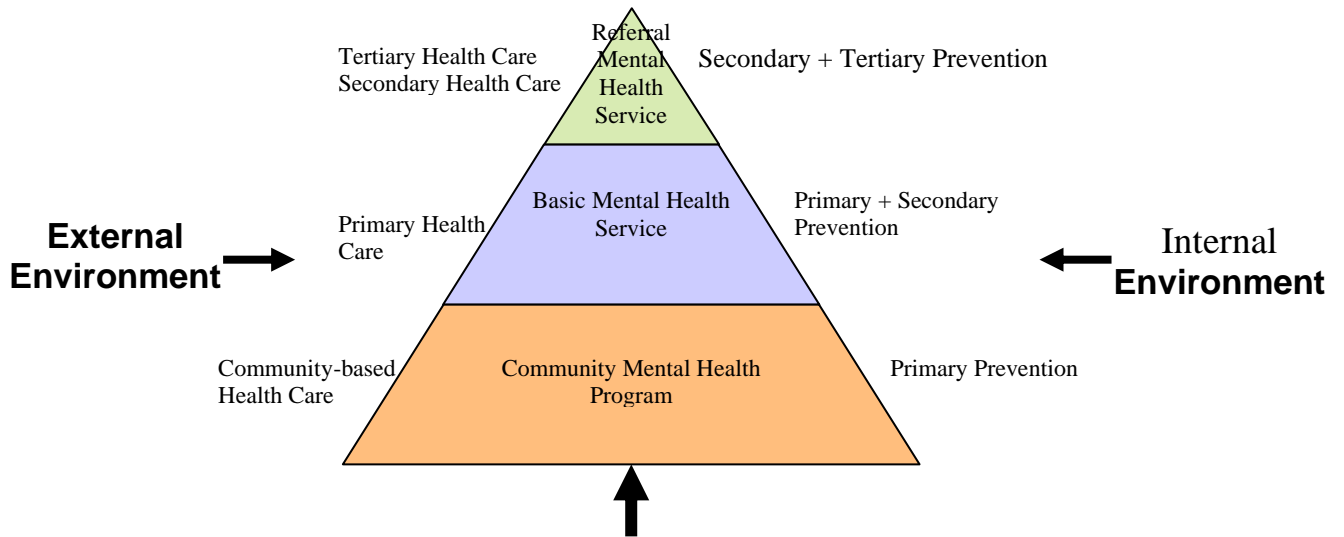
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THE VISION OF MENTAL HEALTH DEVELOPMENT

HEALTHY INDONESIA BY THE YEAR OF 2010



Comprehensive and Integrated Mental Health Programs



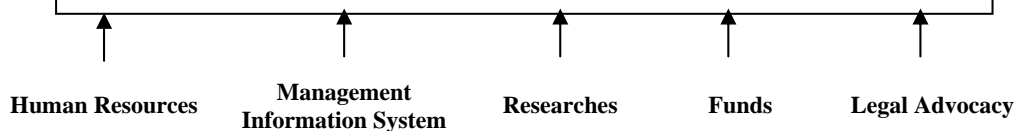
MENTAL HEALTH PARADIGM

Basic Concepts: Mental Health = Integral Part of Health
(Psychiatry + Health Law No.23 / 1992)

Health = State of Physical, Mental, and Social Well-being
→ (Socio-economically) Productive Life

Mental Health related to Human Rights, Quality of Human Resources, Social-Welfare

MANAGEMENT OF MENTAL HEALTH RESOURCES



Comprehensive and Integrated Mental Health Program

Level	Provider	Setting	Target	Activities
Community Mental Health Program (Participative Principle)	From, for and by community (Health Promoting Cadre)	Integrated Service Center Youth Consultation Center Narcotic Consultation Center NGO Service Center	Community Groups (High Risk Groups)	Primary Prevention <input type="checkbox"/> Health Education <input type="checkbox"/> Health Promotion <input type="checkbox"/> Specific Protection
Basic Mental Health Services (Integrative Principle)	General Practitioner Psychologist Counselor	Community Health Center School Health Clinic Marriage Counseling Center Medical Clinic/Center General Practice Clinic	Individual	Secondary Prevention <input type="checkbox"/> Early Detection <input type="checkbox"/> Prompt Treatment <input type="checkbox"/> Continuing Care
Referral Mental Health Services (Specialistic Principle)	Psychiatrist Clinical Psychologist Medical Specialist	Dept. of Psychiatry of General Hospital (out-inpatient) Mental Hospitals Drug Dependence Hospital Psychiatrist Practice	Individual	Tertiary Prevention <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Treatment Program <input type="checkbox"/> Disability Rehabilitation

CHAPTER I

INTRODUCTION

1.1. The Background

The direction of Health Development Policy in the five years forward had been formulated in the Law No.25 / 2000 regarding to the National Development Program (*Propenas: Program Pembangunan Nasional*) for 2000-2004, which is based on Broad Outlines of the National Policy (*GBHN: Garis –Garis Besar Haluan Negara*) for 1999-2004 that had been determined by the People Consultative Assembly *TAP MPR No.IV / MPR / 1999*. The policies are :

1. To enhance the quality of human and environment resources which support each other based on the healthy paradigm approach, by setting the priority on health promotion, prevention, medical care, and rehabilitation, starting from the period of reproduction until elderly;
2. To promote and to maintain the quality of the institution and health services through the empowerment of human resources continuously, and providing infrastructure and facilities for medical care, including the availability of medicine that accessible by the community;
3. To promote the quality of the population through controlling the birth, alleviating the mortality rate, and enhancing the quality of Family Planning Program;
4. To combat the drug abuse and trafficking systematically, including hazardous substance, by implementing the strongest sanction to drug producers, dealers and abusers.

In line with the national direction and policy as formulated in the *GBHN*, the Ministry of Health of Indonesia has developed *Health Development Plan that leads to Healthy Indonesia 2010 (RPK 2010)* in 1999, in order to make the development in the health sector could be directed purposely, comprehensively, integrated and continuously.

To clarify the strong will and commitment on reforming the implementation of development plan in health sector, the government has proclaimed “*National Development Movements with Health Approach* ” on 1st March 1999.

However, in facing the period of 2001-2005, there have been a lot of policy changes on governance. One of the changes that mostly influence the health sector is *Decentralization Policy* as formulated on Laws No.22 and No 25 / 1999, as well as Government Regulation No.25 / 2000, whose operational matter in the health sector is fully entrusted to autonomic territory (District / Municipal Government), while the central government (Ministry of Health) is only competent on regulation, facilitation, and standardization of the health programmes.

In the community that has been exposed with various social-political changes caused by reformation in every aspect of life, it occurs a new awareness about democratization, the development of civil society, respect on human rights, and social justice. Such situation also provide a new perspective in the health sector, particularly the health is perceived from human rights perspective, equality in gaining good quality of health services, insurance scheme for health care, the allocation of funds for health development programme as investment in human resources development, etc.

In facing the situation of *prolonged monetary crisis*, as well as the limited funds of the government, it appears new policies on regulating and down-sizing health organization in every level, which in turn will effect toward the health provider, the management of various health programme. In this situation, priority setting in health program becomes the central of concern, and also serves as reference in managing the institution, manpower, financing the and infrastructure .

All the above changes needs further review and reformulation of national mental health policy for the coming period of 2001-2005.

1.2. The Objective of Policy Making

- To serve as a reference in setting up yearly National Mental Health Program for the period of 2001-2005 which has taken into account the current changes and trends, either in national, provincial, and district level, or related mental health institutions (education, research, information system, inter-sector & inter-discipline cooperation)
- To enhance the partnership and the synergy of all potential and available resources through an integrated concept and perception of mental health into national health

system, so that they could achieved high efficacy and efficiency in mental health programmes.

- To become the baseline and reference for evaluation in making the next (2005-2010) *National Health Development Program* in general, and particularly for the next *National Mental Health Policy*, so that it will be more purposeful, comprehensive, integrated and sustainable policies.

1.3. The Approach and Basic Principle

The approach and basic principle in setting up the policies are :

- The continuum of the previous and future of National Mental Health Program and Policy (*continuity & sustainability*)
- The integration of National Mental Health Policy and “*Healthy Indonesia 2010*” *National Health Policy (integrated into general health system)*
- Including local (province and regency / town), national, and international perspectives (*global perspective*)
- Solving the problems which are related to the current strategic issues (*problem solving oriented*)
- Using health system which consists of sub-system of health programmes and sub-system of health resource management (*system approach*)
- Referring to the model of “*Comprehensive and Integrated Mental Health Programs*“ which includes *Community Mental Health Program* as the base, supported by the *Basic Mental Health Services*, and intensified by *Referral Mental Health Services*, that integrated as a whole unity (*comprehensive and integrated mental health care*)
- The analysis is done by taken into account the allocated resources and available capacity, the effective and efficient process, and the expected results that are related to the existing needs (*mental health economics analysis*)
- The implementation of mental health science and technology for mental health care and program should be based on the proven results and appropriate to the condition in the community, and making the benefits of it (*evidence based mental health*).

CHAPTER II

ANALYSIS of SITUATION and TRENDS

2.1. Current Situation

2.1.1. Community Health Status

Community Health Status is influenced by the interaction of *four factors*, namely: environment, behavior, genetic and health services. Generally, the community health level is evaluated by using indicators, such as mortality rate, morbidity rate, nutrient state, etc. The indicators of community health level, which have been achieved until right now, are: (Resource: *Indonesia Health Profile, 1998*)

- Life Expectancy : 64,2 years old
- Infant Mortality Rate : 71 per 1000 live birth
- Child Mortality Rate : 59 per 1000 live birth
- Maternal Mortality Rate : 373 per 100.000 live birth
- Crude Death Rate : 7,5 per 1000 population

2.1.2. Community Mental Health Status

The community mental health status is evaluated from several indicators such as morbidity indicator (prevalence or proportion of persons with mental disorders or psychological distress syndromes in the population at the particular time period), and disability indicator (the lost of productive days because of mental disorders or psychological distress syndrome in the population at the particular time period), which is commonly noted as DALYs (Disability Adjusted Life Years) lost, regarding as one of the “disease burden” measurement.

The Mental Health Household Survey (SKMRT: *Survai Kesehatan Mental Rumah Tangga*) which had been done in the population of 11 cities around Indonesia in 1995, by Indonesian Psychiatric Epidemiology Network (led by Prof. Dr Ernaldi Bahar, Ph.D), has suggested that the prevalence of mental health problems is ***185 per 1000 adult household population***. It meant that in every household (by estimating the number of adult household population was 185 million and every household had 5

members), there was at least one who suffered from mental health problems and needed mental health services.

To get the information about the proportion and types of mental health problems derived from the adult household population as suggested above, the Directorate of Mental Health, Ministry of Health, had executed “*The Proportional Study of Mental Disorders*” in 16 cities around Indonesia (Medan, Jambi, Pekanbaru, Bandar Lampung, Bogor, Bandung, Semarang, Yogyakarta, Magelang, Malang, Surabaya, Denpasar, Banjarmasin, Samarinda, Ujung Pandang, Manado) during 1996 - 2000, by using the CIDI (Composite International Diagnostic Interview) psychiatric epidemiology instrument developed by WHO. For every city, 100 respondents of adult household (18-65 years old) were selected by *Central Statistic Agency* (BPS: Badan Pusat Statistik) of the city, using SUSENAS (national social-economic survey) sampling frame. The 1600 respondents were interviewed by the mental health workers who had got three day training for using the CIDI. The study had found that ***the proportion and type of mental disorders*** are:

- Classified as “Mental Addiction” diagnostic type : 44,0 %
- Classified as “Mental Capacity Deficit” diagnostic type : 34,0 %
- Classified as “Mental Dysfunction” diagnostic type : 16,2 %
- Classified as “Mental Disintegration” diagnostic type : 5,8 %

The above sequences could describe the priority of mental health problems for adult household population, and it would be taken into account for the development of mental health program and providing type of services, so that it could be matched between the need and supply. Hence, there must be a priority setting for mental health programme, in order to maximize the utilization of available limited resources.

Regarding to *the magnitude of mental health problems*, either for child or adult population, could be shown from National Health Household Survey (*SKRT: Survei Kesehatan Rumah Tangga*) in 1995, which was organized by National Institute of Health Research and Development (*Badan Penelitian dan Pengembangan Kesehatan*) Ministry of Health, by using the sample frame of *SUSENAS–BPS (Badan Pusat Statistik)* 65.664 households were selected as national representative samples. Its finding indicated that the ***Prevalence of Mental Disorders*** (diagnostic codes F00-F99) ***per 1000 households*** were as follows :

- Adult Mental Disorders (over 15 years old) : **140 /1000**
- Child Mental Disorders (5-14 years old) : **104/1000**

(Prevalence over 100 per 1000 households have been judged as **priority public health problem**)

The prevalence rate of various Adult Mental Disorders (over 15 years old) were :

- Psychosis : 3/1000
- Dementia : 4/1000
- Mental Retardation : 5/1000
- Other Mental Disorder : 5/1000

There haven't any study yet about the *Disability of Mental Disorders* done in Indonesia. The data available now is from *World Bank Study* in several countries, either developing or developed countries in 1995, which indicated that **8,1 %** from "**Global Burden of Disease**" caused by **mental health problem**, a higher number than tuberculosis (7.2), cancer (5.8), heart disease (4.4), malaria (2.6). This magnitude of burden indicated the high priority of mental health problem among the community health problems in general (*the magnitude and importance of a priority problem in public health*).

From the aspect of social welfare and quality of community life, the status of Community Mental Health could be evaluated by using *Human Development Index (HDI)* as an available indicator that developed by United Nation Development Program (UNDP) every year. By the year 1999, Indonesia was listed at rank of **105 over 180 countries in the world** .

There are three domains, which are evaluated on HDI, namely: health (as the first sequence), education (as the second sequence), and economy (as the third sequence). These three domains are inter-dependent and inter-related each other in determining the level of quality of life and social welfare of the community. Therefore, **the allocation of health budget** in National Budget (*APBN: Anggaran Pendapatan dan Belanja Negara*) becomes one of the health policy indicator. During the fifty-year independence of Indonesia, the allocated budget for health development programme *has never exceed more than 3,0 – 3,5 % of National Budget* (whereas WHO determines minimal 5 % from national budget). In developed countries, health and education funds are still the

prominent priority, frequently around 30 % - 40 % from National Budget (*APBN*) or State Budget (*APBD: Anggaran Pendapatan dan Belanja Daerah*). Mental Health Development Programme as an integral part of health development programme receives *the least* allocated funds from the health sector, although in the of Health Development Policy and Program, mental health is one of the priority program in increasing the level of social welfare and quality of community life (mental health is one of the top priority program in Healthy Indonesia 2010).

2.1.3. The Coverage and Facility of Mental Health Services

At the beginning of first Five-Year Development Plan (*Pelita: Pembangunan Lima Tahun*), the Directorate of Mental Health was founded in the Ministry of Health, Republic of Indonesia, with the task of developing mental health program and policy in Indonesia. Through the mental health program during the first *Pelita* till the sixth *Pelita*, mental health service network had been established throughout Indonesia, which could reach out by all of the community level, consists of Primary Health Center – District General Hospital – Provincial State Mental Hospital / General Hospital Psychiatric Unit – National State Mental Hospital / Drug Dependence Hospital. The development of Mental Health Services from one *Pelita* to other *Pelita* went on continuously, spread over the country (based on equality principle), enhancing the service quality and upgrading human resource capacity, with the objectives of enhancing individual, family, and community mental health level which enable them to live productively and harmoniously.

The thirty three State Mental Hospitals around Indonesia with *8.150 beds* functioned as the referral centers for specialistic care of the mental health cases and the centers for the development of community mental health programs within the particular catchment area. The capacity to better functioning was developed systematically and continuously by the National Mental Health Program. This was included National Drug Dependence Hospital in Jakarta functioned as the central referral of Narcotic and Psychotropic abuse cases and transfer of knowledge and skills. The national mental health program covers the renovation of the available mental health service facilities, the building of new one in the provinces which don't have it before, supplying the mental health man power and enhancing their technical and managerial capabilities.

The various community mental health problems and mental disorders are served with *multi-sectoral approaches*, which need cooperation and cross-referral services between related agencies. The coordination of these community mental health services had been established by Community Mental Health Advisory Board (BPKJM: *Badan Pembina / Pelaksana Kesehatan Jiwa Masyarakat*) in Provincial level, that had been spreading out over the country.

The fundamental changes in mental health service during the first *Pelita* till the sixth *Pelita* are:

- Mental health services, from "custodial care" into "medico-psycho-social care".
Using a more sophisticated equipments and methods, either for diagnostic purposes or therapeutic intervention, could enhance the *quality of the service* and *mental hospital image*.
- Setting of treatment, from "isolative" (inpatient) into "extra-mural" (outpatient).
The development in psychiatric nursing science enables many behavioral and social interventions, which support the patient's treatment progress.
- Approach, from "clinical-individual" into "social productivity" (*community mental health*).
The advancement in the behavioral and social therapeutic intervention, such as occupational therapy, token economy, enable the patient live productively in his social-cultural environment.
- The focus of mental hospital care, from in-patient to out-patient (*de-institutionalized*)
The progress in psychopharmacology enables the use of a selective and rational psychotropic medication (effective, safe, efficient), so that the average of length-of stay (ALOS) in hospital becomes short and could be continued as out-patient care.
- The establishment of Mental Health Service Network, the network of: Primary Health Center – District General Hospital – Provincial State Mental Hospital / General Hospital Psychiatric Unit – National State Mental Hospital / Drug Dependence Hospital, are used as either referral cases or transfer of science and skills, even for the mental health information centers.

Currently, Indonesia has 33 State Mental Hospitals with *8150 beds* spread over the 24 provinces and 1 Drug Dependence Hospital with *50 beds* in Jakarta, which function

as the referral center for specialistic care of mental health cases and the center of community mental health programme with its catchment area. Of course, the mental health care facilities for serving and reaching by all of the Indonesian people with amount of 202 million are obviously not fulfilled. Hence, the utilization of other health facilities, such as General Hospital and Primary Health Center which are spread out evenly in every outlying place of Indonesia, as well as the participation of District / Municipal Health Officials in the community mental health programmes, are highly recommended. Therefore, the recruitment of psychiatrist for General Hospital or Provincial Health Office should be considered. Training the general practitioner of Primary Health Center should be considered by taking into account the relevant and appropriate materials and training methods with the local situation and condition. This is very important to be considered since around 28 % patients of the Primary Health Center showed the signs of mental health problems and the doctors missed around 80 % of the cases; thus they are not treated well. Actually, a simple and effective treatment method to recover them and can live productively in the society is available. Right here, we can obviously see the gap between the essential drug list which covers psychotropic medication (DOEN) and the availability of psychotropic drugs in primary health centres. A control and supervision toward a relevant tackling and application of the psychotropic drug supply in the field is highly required.

Besides that, the supply of the *psychotropic drugs* in some Primary Health Centers and General Hospitals are still very limited and not based on essential drug list (DOEN), whose policy is commonly came from the District / Municipal Health Officials.

The reasons came out were because of under-reporting of the cases.

2.1.4. The Development of Mental Health Manpower

At the beginning of first *Pelita*, only 6 (six) psychiatrists worked at State Mental Hospital. During the five *Pelita*, this situation has changed, and it became 110 psychiatrists at the end of the fifth *Pelita*. This amount has just fulfilled the minimal need of State Mental Hospital. At the end of sixth *Pelita*, the psychiatrist who worked at State Mental Hospital was 145 over the 202 million populations. The ratio of psychiatrist per population was about 1: 1,5 million (compared with Japan 1: 100.000). If the standard is applied to that every Class A of State Mental Hospital should have 7 (seven)

psychiatrists and Class B of State Mental Hospital should have 4 (four) psychiatrists, then the amount of the current available psychiatrists should be 190. This meant that the minimal need for State Mental Hospital has just achieved *76 % of the standard*, and It hasn't covered the needs of Department of Psychiatry for the psychiatric education and the development of sub-specialization in psychiatry.

If we take the ratio of psychiatrist per person with mentally ill, based on the prevalence of *1:1000 population*, then for the 202 million populations, the ratio will be about *1 psychiatrist for 1400 mentally ill persons*. To fulfill the needs of the psychiatrist right now, a breakthrough in psychiatric education system and the ways of recruitment, as well as its career development, should be considered urgently.

The mental health workers of psychiatric nurses, who worked at all of the State Mental Hospital currently, was about *1.769*. This meant that the ratio of psychiatric nurse per patient, based on the prevalence of mental disorder *1: 1000 population* over the 202 million populations, was *1 psychiatric nurse for 114 patients*. The standard, which has been determined for State Mental Hospital, is 3 (three) nurses over every 5 (five) beds. Thus, for the current 8.150 beds capacity need 4.890 psychiatric nurses. This meant that the nurse manpower that worked at State Mental Hospital has just achieved the minimal requirement and has just fulfilled *36 % of the standard amount of psychiatric nurses for State Mental Hospital*. The problems in psychiatric nurse education should be managed systematically and substantially, either for State Mental Hospital or Community Mental Health setting.

The distribution of manpower that involved in mental health programs, such as psychiatrist, general practitioner, psychiatric nurse, general nurse, psychologist, social worker, occupational therapist or other therapist, *has not yet been spread evenly throughout the country*. Most professionals were still concentrated in Java Island, while for the outer part of Java; it's still difficult to gain or to recruit the above professional. The improvement of recruitment system and distribution of professionals in the mental health field should be managed continuously, so that the mental health services could be provided effectively and efficiently.

2.1.5. Community Participation and Private Partnership

Until now, the involvement of community and private in the mental health field is still *quite rare*. The awareness and concern of community and private is *very limited*

either. This is because of ignorance or resistance in participating of mental health programs. *Stigma*, that mental health frequently related to “crazy people” or “abnormal”, is still quite prominent, instead of mental health as part of the health, and plays an important role in creating the welfare and enhancing the quality of life of community. Therefore, a political will from the government to provide an extensive and intensive information to the majority of the community should be available, so that the community could aware, concern and in turns could care about and actively participate in bringing out the mental health programs to the community.

The mental health problems in community are very broad and complex; including not only the obvious mental disorders but also various psychosocial problems, even the problems related to quality of life and harmony of living. These problems are not able and possible to be managed by the mental health professionals solely, but an extensive cooperation between various related sectors and departments, also community participation and private partnership, are highly required. Moreover, it is very relevant to our community condition right now which is covered by total crisis, including monetary, economy, moral-ethic, education, occupation and the opportunity to get better future. Inter-sectoral preventive measure should be managed integratedly and continuously, so that the problems will not create a deep impact on the community mental health state.

The problems, which should be examined carefully, are so called the “standardization” of Non Governmental Organizations (LSM: Lembaga Swadaya Masyarakat) who are involved very much in mental health care and services. The needs of supervision and evaluation mechanism, and the information system that could support and empower them. Therefore, the socialization of mental health programs managed by LSM or private institution, and the coordination of inter-program, inter-sector, inter-LSM / private, and among the prominent figures in the community, are highly recommended.

2.2. Trends

2.2.1. External Factor

The intensive and extensive of *Globalization* process, which causes the increase of all inter-countries communication and information flow in the world, gives an impact on the rapid changes of social and cultural values in Indonesia. This condition needs adaptive capacity and high coping skills, despite of supportive environmental condition

that conducive to the development of adaptive social and cultural values. Such conditions are highly susceptible toward stress, anxiety, emotional conflict, narcotic-psychoactive and other addictive substance dependence, deviated sexual behavior, and other psychosocial problems. All of these cause the increase of health service demand related to above problems, as well as the increase of community mental health programs in preventing the impact and deteriorating of the above problems, especially toward the greatest vulnerable groups (for example children under five, adolescent, adult productive age, and elderly) and in the big cities as part of major public health problems.

The transition from agrarian to industrial community by the globalization process, as well as the demographic transition from young-aged population to elderly, followed by intensive urbanization process, encourages the impetus of *epidemiological transition of health problems* : from dominated by infection disease to degenerative disease, cardiovascular disease, cancer, metabolic disorder, traffic accidents, and various mental health problems which manifested in narcotic-psychoactive and alcohol dependence, HIV / AIDS related to sexual behavior, the trauma from violent behavior, either domestic or public, etc.

From political side, *an increase demand for democratization and social justice* from the community, as the result of the previous achievable development programs, particularly in the education level and social-economic welfare, which provide critical views toward the government and political situation, as well as increasing the awareness of their rights as a citizen. On one hand, it reflects the progression of community living standard, on the other hands, it creates more conflicts between the community and government (vertical) or between various groups in community (horizontal). Such situations are vulnerable for various traumatic violent experiences among the community and have impacts on the community mental health state.

2.2.2. Internal Factor

The increase of education level and standard of community life, influenced by the rapid development of communication technology, has changed some of the community appreciation toward the health issues . In line with this progression, there are an increasing demand for better quality of health service and health care, but on the other hand *the health providers still fight for various resource limitation*. Such condition

is susceptible with various problems that exist in the health services, for example laws claim toward institution and health service provider. *Health funding system* is still unclear, while health service provided by government is still very limited. As the result, the occurrence of private health services institution with various competitive advantages, which concerned more to economic calculation rather than to social consideration, could not be holding out. Such situation will discriminate the right of every citizen to gain the accessible and equitable health services, specifically in the field of mental health services. Health Laws No.23 / 1992 has underlined the community rights to health, and the task and responsibility of the government in promoting health and providing health care. For Mental Health, it still needs further details of Governmental Regulation in providing a more powerful legal base for the development of mental health programme.

2.3. Strategic Issues

By analysing the above trends of external and internal factors, some strategic issues could be formulated as follows:

- There is a quite wide gap between the increase of mental health problems in the community and the availability of mental health service facilities, as well as the community mental health programs (Gap between the existing morbidity and available services and programs), despite the facts that the development of science and technology in mental health have been proven in dealing with various mental health problems (mental illnesses are treatable and mental well being is achievable).
- The Community Mental Health Program is still very low priority within the agenda of both National Health Development and National Development Plan. This is related to the high mental health stigma in the community or among the health professionals themselves, despite the facts that the manifestation of mental health problems are frequently covered from social, economic and criminal issues.
- The funding system in the mental health service is still neglected extremely. The insurance health scheme still strongly discriminate against mentally ill patients in general, and especially for the poor and chronically ill population.
- The centralization of administration and management of mental health programs cause less flexible in applying to the local or particular community group needs for mental health services.

- There is still no mental health regulation, which provides powerful legal base for mental health programs, this is with reference to Health Laws No.23 / 1992. Especially in fighting the stigma and protecting the human rights of mentally ill persons, supporting community participation in mental health.
- The amount of Psychiatrists, who are the “focal point” in community mental health programs, are still very low, as well as its distribution are spread out unevenly. Their competency in managing community mental health program and decision making are still required to be improved continuously.
- The problems of regulating and supplying psychotropic drugs based on the community needs, and rational use of psychotropic medication for the professionals.

CHAPTER III

BASIC POLICY

3.1. The Concept and Paradigm of Mental Health

3.1.1. Definition of Mental Health

Definition of “*health*”, which has been existed till now and basically refers to the preamble of WHO Constitution in 1948, noted that: “*Health is a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*”. Based on this, Laws No.9 / 1960 determines health as a condition which includes physical, mental, dan social state, and not merely the absence of disease, deformity, and infirmity. The above definition then has developed further and has changed accordance to situation, condition and necessity. In Laws No.23 / 1992 regarding to health, which exists until now, mentions that “health” is ***a state of complete physical, mental, and social well being, which enable everyone to live productively, either social or economic context.***

Referring to above definition of health, then a human being is always viewed as a whole unity of the *physical* (organo-biologic), *mental* (psycho-educative), and *social* (socio-cultural) elements, which is not emphasis on *disease*, but rather to *quality of life* which consists of *well-being* and *social-economic productivity*. So, it implies that ***mental health*** is an integral part of health and the main element of the existence of quality of life of human being as a whole unity.

Section 24 of Health Laws No. 23 / 1992, stipulated that Mental Health Programs are performed in order to achieve ***mental health*** optimally, either intellectual or emotional aspects.

Glossary of WHO-World Health Report 2001 noted that:

- *Mental Health is state of Well-being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*
- Achieving mental health and maintaining it consists of two functions. One is about *preventing and treating mental disorders*, and the other is about *fostering or promoting mental health and well-being*.

World Federation for Mental Health, in its campaign at “*World Mental Health Day*” on 10th October 1993 where Indonesia also took part and proclaimed by the President of Republic Indonesia, defined the characteristics of people with good mental health as follows: 1) They feel good about themselves, 2) They feel comfortable with other people, and 3) They are able to meet the demands of life.

Referring to the above definition and description of characteristics, the concept of mental health can be formulated as follows:

Mental Health is a state of *mental well being* that enable for *harmonious and productive life*, as an unity part of one’s quality of life, by concerning to all aspects of human’s life.

A *mentally healthy persons* has the characteristics as follows :

1. They realize fully their own abilities,
2. They are able to cope with the normal stress of life,
3. They are able to work productively and to meet their demands of life,
4. They are able to make a contribution to their community,
5. They feel good about themselves,
6. They feel comfortable with other people.

3.1.2. The Scope of Mental Health Problem

The scope of mental health problem is broad and complex, which relates each other with all aspects of human’s life. By referring to Health Laws No.23 / 1992, and the science of Psychiatry that develops rapidly, mental health problem could be classified as:

1. *Mental and Behavioral Disorders*, defined as a change of mental and behavioral process that causes an impairment of its function, which could create a psychological distress for the individual and / or a disability in performing his social-role. The classification of these mental and behavioral disorders are standardized in PPDGJ-III (*Pedoman Penggolongan Diagnosis Gangguan Jiwa Di Indonesia*, third edition) or Chapter F00-F99 of ICD-10.
2. *Psychosocial Problems*, defined as psychological distress burden that occurs as the result of social problems (Section 24, the explanation of Article 2, Health Laws No.23 / 1992). For example, street-children problem, social violence trauma, refugee / internally displaced persons, elderly problem, etc.
3. *Harmony of Human Development and Enhancement of Quality of life*, defined as psychological problems that related to the meanings and values of human's life. For example, the impact of a chronic disease that causes disability on quality of life, euthanasia problem, healthy re-settlement policy, etc.

3.1.3. “Core” Profession in Mental Health Services

In every community, the professionals related to mental health programs are very diverse and broad, it depends on the social context and the existence of formal health institution. All could take roles till a particular competent level and should be appropriate to the existing conditions.

Generally, the “core” profession in mental health services could be differentiated into who are involved in “*mental health care*” (all workers who take part in promoting mental health at the community and family level) and “*psychiatric services*” (formal personnel in health services, ranges from Basic Health Services to Referral Specialistic Health Services).

The formal “core” of mental health workers includes: Psychiatrist, Neurologist, Psychologist or Clinical psychologist, General Practitioner or Family Physician, Public Health Specialist and Health Services Manager, General Nurse or Psychiatric Nurse, Psychiatric Social Worker, Professional Counselor, Pedagogist, Occupational Therapist, Speech Therapist, and Physical Therapist.

3.1.4. Mental Health Development Paradigm

Referring to the concept of mental health, the scope of mental health problem, as well as the development paradigm in general health, the mental health development paradigm could be formulated as follows :

- Mental Health is *an integral part of health*, as stipulated in Health Laws No.23 / 1992 (Section 1, Item1) and Constitution of WHO – 1948.
- *Health is a fundamental human rights*. The United Nation’s Universal Declaration of Human Rights states that everyone reserves the right to achieve a good health life-standard (a probable highest achievement of his physical and mental health), including health care and the rights of providing insurance while sick. Health Laws No. 23 / 1992, Section 4, stipulates that everyone has an equal rights in gaining optimal health level, and Section 5 stipulates that everyone is obligated to take part in protecting and promoting his individual, family, and their environmental health level. Meanwhile the government just regulates, facilitates and supervises the health program implementation (Section 6). The government’s task is to provide an evenly accessible and affordable health programs and services by the community, as well as the providing of health services for the poor people could be guaranteed (Section 8). Moreover, the government has a responsibility to augment the community health state (Section 9).
The allocation of the governmental budget for mental health programs should actually referring to the government’s task and responsibility, not based on the economic consideration only. The expense for the most community needs (social cost) should be considered as the main emphasis.
- The Mental Health Programs are implemented for gaining an optimal mentally healthy people, either intellectual or emotional (Section 24). It means that mental health plays the most important role in upgrading *the human resources (productivity)* and enhancing the *quality of life (welfare or mental well being)*. Therefore, the funding for mental health program should be pointed as *human investment* that contributes to give an opportunity to live productively and prosperously, which becomes the task and responsibility of the government in protecting human rights for their citizens.

- **Three Constructs of Mental Health Motto**

Referring to the above mental health paradigm, the new mental health's motto, whose own 3 (three) paradigm, could be formulated as follows:

1. *To achieve a mental health is a Human Rights*
2. *Mental Health determines the quality of Human Resources*
3. *Mental Health creates community welfare*

3.2. The Vision of Mental Health Development

“Toward Healthy Indonesia 2010 Through Comprehensive and Integrated Mental Health Program”

The vision of health development in Indonesia is **Healthy Indonesia 2010**, a discription of Indonesian community in the future that would be achieve through health development, which is characterized by *healthy life style in the healthy environment*, whose own a capability to reach the qualified *health service* equally and evenly, as well as to achieve the highest *health level*, in all of the region of Indonesia.

The comprehensive and integrated mental health program is a holistic concept in mental health effort, which consists of *aspects*: medical, psychological, dan social-cultural, *types*: preventive-promotive, curative, and rehabilitative services, and *stages*: Community Mental Health Programs (participative), Basic Mental Health Services (integrative) and Referral Mental Health Services (specialistic).

3.3. The Mission of Mental Health Development

The Mental Health Development Plan for 2001-2005 gets the mission as follows:

- *To maintain and to enhance the Mental Health Status of Individual, Family, Community, and their Environments.*

One of the mental health development missions is to facilitate the supportive environmental condition, which could enhance the mental health development since conception until elderly.

This program reflects in all aspects of life starting from family, school, working atmosphere, housing, etc. Mental health program is held by empathizing toward the unique of the individual, the existence of social-cultural values, humanity, and the respect on personal, family and community dignity.

Mental health problem can create behavior that cause the around individual and others in a high risk. Individual, family and community expect that their mental health could be maintained; even they expect that the laws will protect them.

The laws will be an important issue to insure and to protect the individual, family and community rights, that must be appropriate to the community expectation and need, that need of protection from their experience of mental health problems and disorders either. Despite that, it also requires laws that manage the rights, duty and protection toward mental health service providers.

- ***To develop and to increase the quality, equality and accessibility of mental health services, along with the other welfare or humanity services.***

Mental health services have main characteristics: (a) could be achieved and fulfill the various needs of the patients and their community environment, (b) could be performed integrated and comprehensively, including acute or long term services, (c) could be done gradually and continuously in comprehensive services, (d) could be performed by utilizing all the potency of government, community, and private institution.

The providing of mental health services need to highlight the high-risk groups toward certain mental health problems (i.e. child and adolescent problems, narcotic and psychotropic dependent, adults with work stress, and psycho-geriatric problems in the elderly) and specific groups that require certain mental health services (i.e. street-children, prisoners, violence victims, minority groups) that are in highly variation as regarding with the specific area conditions and situations.

- ***To facilitate the community capacity in creating their mental health***

Community attitude toward mental health influence the consequence of mental health problems/disorders in individual and family. In general, community knowledge about mental health is still limited. Therefore, information about mental health, the way to prevent and to get treatment toward various mental health problems /disorders are highly recommended. Hence, the community could create supportive attitude and behavior, as well as could active participation in mental health programs.

It is important to have the continuity and sustainability of programs in increasing the participation of community and the partnerships with the private services to help the creation of supportive environment, which could support mental health development, as well as to increase the ability of self-help, the advocacy, the empowerment through information, opportunity to take participation in the funds and to make decision in the mental health programs, so that the autonomy of community lead to mentally healthy could be created.

- ***To increase professionalisms of mental health providers through the development of science, technology, skill, and professional ethics.***

The effectivity in the mental health services depends on the availability of trained professional providers continuously. Nowadays, the distribution of the mental health service professional is not evenly distributed; most of them are concentrated in the big cities. The government needs to assure and manage the availability of trained professional providers so that the distribution is evenly appropriate with the needs in certain region and accessible to all community levels.

The complexity of the community mental health problems to date and in the future need professionals that provide the more specific skill in the psychiatric services (i.e. child and adolescence psychiatry, social psychiatry, psycho-geriatrics, forensic-psychiatry, industrial psychiatry, etc). The mental health workers who provide mental health care and rehabilitation of mental disorder, health administration, the management of mental health institution, need to be improved in their professionalism continuously. Therefore, mental health education centers are highly required that are supported with appropriate facilities and infra structure, effective institutional management, and qualified human resources with mastery of the knowledge and the very latest mental health technology.

3.4. The Objective and Target of Mental Health Development

Based on the Broad Outlines of the National Policy (GBHN) 1999-2004 pertaining in health sector, the objective of health development is to increase the awareness, the will and the ability to get good health for every person so that an optimal health level could be achieved through the creation of community, nation and country of Indonesia which is characterized by their inhabitants that live in healthy behavior and environment, as well as to have the ability to access good quality of health services equally and evenly, and to have optimal health status in all regions throughout Indonesia.

Mental health program as the integral part of health and essential components in the creation of welfare and quality of life, is persistently referring to the objective of health development as *the general objective*. The *specific objectives* for mental health development as follows. :

The main *objectives* of policy on Mental Health Development are :

- To increase the community mental health state of Indonesian people as the part of the community health state
- To prevent the expansion of various mental health problems in the community.
- To minimize the impact of psychosocial problems and mental disorders on the individual, family, and community life.
- To protect the basic human rights of individuals who experience mental disorders
- To facilitate mental health workers in upgrading their professionalism and the development of science and technology in mental health.

The main *target* of policy on Mental Health Development are :

- The comprehensive and integrated mental health programs (a whole unity of community mental health program, basic mental health services and referral mental health services)
- The autonomy of community participation and private partnership
- The implementation of mentally healthy behavior
- Management of health development program (planning, executing, evaluating and monitoring of mental health programs)

- The development of mental health manpower
- The increasing of community mental health state (by lowering the prevalence and incidence of mental disorders, minimizing the burden of mental disorders on the the individual, family and community)

3.5. The Strategy of Mental Health Development

- Advocacy of *Public Policy* that support the mental health aspects of community life

The Development Program in all fields must provide positive contribution toward community mental health state. This could be achieved with the support of the public policy that appropriate to mental health principles, such as the policy of housing complex that provide social facilities (place for children playing, sport place for adolescence, social activity for elderly, etc), in every district or municipal that have “social and cultural activity center”, in every school that have library, appropriate sport field to accommodate student creativity, etc. In the programs to increase community mental health state effectively and efficiently, the promotive and preventive measure toward the various mental health problems will be taken as a priority rather than the curative and rehabilitation efforts.

- To increase the quality and amout of *Centre for Psychiatric and Mental Health Education* for mental health workers

The quality of mental health workers highly determines the success of mental health programs and mental health resource management. The qualified mental health worker is the one who is able to follow the advancement and to master the very latest knowledge and technology in mental health, and to give high respect to the moral values and ethics in performing their professional tasks. Psychiatric and mental health education institution strategically takes roles in creating qualified mental health workers. Therefore, the quantities or qualities of those institution should be increased, through determining the standard of mental health worker’s competency needs, providing the training and skills are based on those competencies, and accreditation and legislation of psychiatric and mental health education institution.

- Integrate the funding of Mental Health Service into Government Social Insurance Scheme (JPKM)

In the view of the physical side of the distribution health facilities, either Primary Health Center or General Hospital and Mental Hospital, as well as the other health facilities, we can claim that the distribution has already spread evenly throughout the Indonesia. However, we confess that the physical distribution above is still not really complete followed by the increasing of quality of services and the accessibility and affordability by all level of community. The availability of health service funds system through Community Health Insurance Scheme (JPKM: Jaminan Pemeliharaan Kesehatan Masyarakat) highly support in increasing the quality and affordability as mentioned above.

JPKM Funds should cover all mental health services, not like health insurance scheme that prone to refuse the claims of treatment for mental health services.

- “Decentralization” of mental health program in the District / Municipal level.

In line with the decentralization policy of the government services at the District or Municipal level, and because of the variation of existing resources in each District or Municipal, and the occurrence of specific mental health problems, then mental health programs in every District or Municipal should be developed by local health office with the support and empowerment from Provincial Office or Central Government.

- Establishing the inter-sectoral cooperation and private partnership

The mental health program is highly related with various policies come from outside the health sector, hence the co-operation that have been done during this time must be increased with more effective ways, especially in increasing the partnership of private sector in curative and rehabilitative services.

- Community empowerment through education and information about mental health integrated into the general health program.

Method and material of mental health education must be relevant to the specific community needs (relevancy), by using the existing social-cultural resources in the community (social-cultural setting), and could be understood easily by the community (contextual communication).

CHAPTER IV

OPERATIONAL POLICY

4.1. Policy on Community Mental Health Program

- 4.1.1. Policy on community mental health program is based on *participative principle* with the scope of *Primary Prevention (health education & specific protection)* and specific attention to *Life Cycle* and *Social-Cultural Setting*.
- 4.1.2. The creation of mentally healthy behavior in the community could be done through *the mental health education programs to the community*, especially the education of child-rearing practices based on mental health principles (the stage of child and adolescence's growth and development) that could be integrated into mother and child health program (BKIA), the education of family welfare that could be integrated into marriage counseling services (BP₄), and the perpetuation of cultural and moral values in the school education that support the child mental health.
- 4.1.3. The program for enhancement of *community participation and private partnership* is directed to empower NGO (LSM or Private Organization), so that they are able to motivate the autonomy of the community in gaining mentally healthy state, especially in the assistance to identify mental health problems and the existing resources in the community (social supporting system), to perform service standardization of NGO (LSM or Private Organization), and to increase community knowledge about mental health through local cultural media.
- 4.1.4. *Public policy* that was issued by central or local government must not contradict to the community mental health principles, and must have positive consequences toward community mental health state. For this matter, it needs a continuous and persistent monitoring toward the existing or the coming public policy issued by the government, as well as an active participation in advocating to the people representative assembly (DPR/DPRD) and central or local government.

Specifically in the policies related to social facilities in housing, and the regulations that support mental health in all social settings (work places, public places, markets, schools, printed or electronic medias, social gatherings)

- 4.1.5. The capacity of *mental health counselors* in all community setting must be increased periodically with sound planning, especially in increasing the skills of teachers who are in charge of student counseling (BP) and marriage counselors (BP4) .
- 4.1.6. The community groups with *high risk and susceptibility* toward mental health problems must get high priority in the community mental health programs.
For example, social conflict refugees, violence victim population (mental and sexual), street-children, jobless psychotic persons, susceptible female workers, school withdrawal adolescences, etc.
- 4.1.7. *Provincial and District or Municipal Health Officials* must be empowered in managing mental health programs for their each region referring to the decentralization policy, both related to institutional and human resources, and substantial and technical aspects of community mental health programs.
- 4.1.8. The role of *Provincial and District Government* must be sensitized and promoted in facing community mental health problems, and setting up intervention to decrease its consequence toward community welfare, especially in performing Community Mental Health Advisory Board (*BPKJM*) as one of local institution that involved in community mental health programs.
- 4.1.9 *The prevention of additive substance abuse programs* must get high priority because of its very big impact on community welfare state. The government, along with the community, must pay high attention to these matters, especially in the way to identify target group and its usage settings, to develop method and campaign material relevant to the target group and its usage settings, and to facilitate the participation of their peer groups as their motivators and counsellors.

4.2. Policy on Basic Mental Health Services

- 4.2.1. The policy on the basic mental health services is based on the *integrative principle* with the scope of *Secondary Prevention* (early detection, prompt treatment, disability limitation) and specific attention to *Private Institution* and *Non Health Institution*.
- 4.2.2. The scope and quality of *basic mental health services in Primay Health Center* must be improved continuously, not only to support the quality of primary health care in general, but also to improve the community mental health state. Especially in improving the training method for doctors working at the Primary Health Center, to renew the guidelines for mental health services in the Primary Health Center, to revise the methods of early detection of mental cases in Primary Health Center, to activate the early detection programs for the child development that performed along with the mother and child (KIA) program, to increase the usage of essential drug list (DOEN) for psychotropic medication, to perform a reciprocal referral system from and to the Primary Health Center, and to provide a greater portion for the mental health programs in the stratification of PHC.
- 4.2.3 The participation of *General Practitioners / Private General Hospital / 24 hour's Clinic* in the basic mental health services must be increased continuously. Therefore, a special training for the general practitioners above is required, as well as a guideline for treating the psychiatric cases relevant to the existing problems and the available resources.
- 4.2.4. The participation of *the company / industrial doctor* must be improved in dialing with mental health problems that pertaining with the work, especially by inserting the mental health subject matter in the refreshing course for Company Hygiene and Health (Hiperkes: Hygiene dan Kesehatan Perusahaan) and Safety (K3 : Kesehatan dan Keselamatan Kerja).
- 4.2.5. *Health care funding system* that include in Community Health Insurance Scheme (JPKM: Jaminan Pemeliharaan Kesehatan Masyarakat) should also

support the increasing of quality and affordability of basic mental health services as the realization of Human Rights. Hence, all claims on mental health cases should be included in the JPKM funding system.

4.3. Policy on Referral Mental Health Services

4.3.1. Policy on the referral mental health services is based on the *specialistic principle* with the scope of *Tertiary Prevention* (specific diagnostic and treatment, and comprehensive rehabilitation) and specific attention to *Technology Screening* and *Profession Standardization* in mental health services.

4.3.2. There is urgent need to reposition the role and function of *State Mental Hospital, Psychiatry Unit of Government or Private General Hospital*, and the development *mental health service networks* that includes District or Municipal level, Provincial and National level, in order to support the basic mental health services and community mental health programs (*Health Promoting Hospitals*). The above policy should be ruled out immediately by the Ministry of Health and Social Welfare (Directorate General of Medical Services), along with government policy on decentralization.

4.3.3. There is urgent need to reposition the role and function of *Drug Dependence Hospital*, and the development of national service networks against the narcotic and psychotropic abuse and dependence, in order to support the basic mental health services and community mental health programs to deal with the narcotic and psychotropic problems. The above policy should be ruled out by Ministry of Health - Social Welfare (Directorate General of Medical Services), along with the government policy on decentralization.

4.4. Policy on Management of Mental Health Resources

4.4.1. Policy on management of mental health resources is based on the *management of health administration principle*, with the coverage of *Health Security & Accountability* (equity, quality & efficiency) and specific attention to *Good Governance Policy* and *Mental Health Budget*.

- 4.4.2. **Laws protection**, toward the rights of patient suffering from mental disorder and mental health workers who provide the mental health services, is highly required. This need can be adopted in the Mental Health Regulations as the further description from Health Laws No.23 / 1992 .
- 4.4.3. Government policy in the health sector must include the supplying of various **professional mental health providers** in an appropriate amount with the need of various mental health programs. Therefore, a postulated developmental mental health resource program that integrated with the other health provider is highly required, as well as the planning of supplying mental health provider along with the provincial and local government and professional organization, and the performing of mental health education and training by using a long distance communication technology (internet).
- 4.4.4. The role and function of **Professional Psychiatric Education Center** as the central of excellence for the development of science and technology, and mental health research should be improved systematically and well planned. Therefore, the “National Board of Psychiatrists”, who performs a blue print for the development of professional psychiatric education center, is highly recommended.
- 4.4.5. There are urgent needs to provide **advocacy for the Provincial and District or Municipal Government** in succeeding the decentralization policy, especially in managing the policy and mental health program at Provincial and District or Municipal level. This need must regard to National Mental Health Policy as the National Health Policy Subsystem (Healthy Indonesia 2010) and Government Decentralization Policy.
- 4.4.6. Mental health programs should be supported by the **Development of Mental Health Information System** which must be able to provide timely and accurately information for the need of planning, executing and evaluating the terms of mental health programs, in all level of health administration. Therefore, a good cooperation, with both Center Data and Health Information and Institute of

Health Research and Development, Ministry of Health - Social Welfare, is highly recommended.

CHAPTER V

PLAN OF ACTION

Based on the basic and operational policy above, then a priority activity for 2001 till 2005 has been planned as follows:

1. Year of 2001:

- Review the concept, the planning, the organization, and the policy in the mental health sector, referring to the government decentralization policy and reorganization of the Ministry of Health and Social Welfare.
- Socialize and established the commitment of the “*stake holder*” involved in the mental health programs from the central till the regional office.
- Develop the models for “*District Mental Health Program*”

2. Year of 2002:

- Setting up the Mental Health Regulations by involving the entire “*stake holder*” in the field of mental health programs, by referring to the very latest development situation.
- Re-construct the education institution for mental health workers, supported by the increasing of the human resource capacities and skills through the use of far-distance communication technology, with the involvement of professional and private organization.
- Increase the participation of Non Government and Private Organization in the mental health programs, through a communication and dialog forum continuously.

3. Year of 2003:

- Evaluate the models for “*District Mental Health Program*” and the implementation for other District or Municipal by increasing the roles and functions of the Provincial Health Official and District or Municipal in mental health programs.

- Establish the setting of the community mental health programs (households, work places, public places, schools, etc) by preparing the guidelines and required materials in order to improve the community mental health state of the groups in their settings.

4. Year of 2004:

- Socialize “District Mental Health Program” for the province with the appropriate human resources, by performing workshops that involve all related officials in the District or Municipal with the readiness of the materials and methods that have been tested their reliability.
- Evaluate and re-organize the information system that involved in the decision making process, so that the monitoring of the mental health programs and the community mental health state could be supported.

5. Year of 2005:

- Evaluate all the policy in mental health programs by using valid and reliable indicators, and integrate them with the available health systems.
- Organize a National Mental Health Workshop as the forum for sharing experiences, by involving the entire “stake holder”, to determine forward programs as the continuity and improvement of previous one.

CHAPTER VI

CONCLUSION

By establishing the national policy on the mental health programs and services, creation of integrated and directed programs are highly expected, in order to achieve the objectives of health development in general dan specifically in mental health development

The success of the mental health programs is highly determined by the partnership and inter-sector cooperation, along with the entire components and the widely community participation, whereas the mental health sector is only act as the facilitator and “focal point”.

The ultimate objective to be gained is the healthy and welfare community, a state of complete physical, mental, and social well-being, and productive life either socially and economically.

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Administrative Staffs :

48. Supriyo, S.Sos	Secretary, Directorate of Comm. MH
49. Naman Suryadi, S.Sos	Administrative Staff, Dit.of Comm. MH
50. Nanang Sunardi	Administrative Staff, Dit.of Comm. MH
51. Teti Ratnawati, S.Sos	Administrative Staff, Dit.of Comm. MH
52. Agus Suyatno	Administrative staff, Dit.of Comm. MH