Indonesian Mental Health Reform: A case study of West Java, Indonesia

Emi Patmisari

Dissertation in partial fulfilment of the Doctor of Public Health

(Discipline of Public Health, Faculty of Health Sciences – Flinders University, South Australia)

Master of Nursing (Flinders University, South Australia)

Master of Clinical Nursing (Flinders University, South Australia)

Bachelor of Science in Nursing (Padjadjaran University, Indonesia)

Contents

Chapter 1 The rationale

1.1 Statement of the problem 1
1.2 Motivation behind the research 4
1.3 Research question, aims, and objectives 7
1.4 Structure of the dissertation 9

Chapter 2 Literature review

Introduction 11
2.1 Review process 11
2.2 An overview of contemporary mental health reforms 12
    Mental health reforms and the 'new public health' 12
    The advent of community-based mental health care 18
2.3 Mental health reforms in LMICs 24
    Indonesia and mental health issues 27
2.4 Bridging the gap strategies in LMICs 30
2.5 Public policy and mental health 32
    What is policy? 32
    The policy process 33
    Mental health problems and the policy agenda 35
    Mental health policy development 38
    Policy transfer 41
2.6 Policy analysis and mental health reform 44
    Policy analysis 44
    Health reforms and policy analysis 47
Summary 49

Chapter 3 Research design

Introduction
3.1 The research paradigm 52
3.2 Research methodology 52
3.3 Research methods 60
    3.3.1. Phase 1 Document analysis 62
        The selection of documents 63
        Sampling 64
    3.3.2 Phase 2 Interviews 65
        Sampling 68
        Interviews 71
    3.3.3 Data analysis 73
3.4 Quality and Ethics 77
    3.4.1 The quality of the research 77
    3.4.2 Ethical considerations 82
Summary 83

Chapter 4 The findings

Introduction 85
4.1 The roles of policy actors in West Java mental health reform 86
4.1.1 The supervisory team for Indonesian mental health reform 88
4.1.2 Mental health reform should not be shouldered alone 90
4.2 Bureaucrats' understandings of mental health reform policy content 94
4.2.1 What is mental health reform? 95
4.2.2 Understanding of mental health reform objectives 97
4.3 The Indonesian mental health reform policy process 101
4.3.1 Assumptions underpinning Indonesian Mental Health Reform 102
Local influences 102
Existing system failure 102
Scarce resources 103
Extent of the problem 104
Stigma 105
National reforms 107
Global influence 108
Best practice 108
International organisations 109
4.3.2 Understandings about the policy formulation process 110
Top-down processes 111
Institutional processes 112
Political processes 112
4.3.3 The expected impacts of mental health reform 113
Reducing health inequity 114
Increased awareness of society 114
Early intervention-recovery model 115
An overarching umbrella for the Indonesian mental health system 115
Better funding 116
4.3.4 How is policy communicated to the West Java government? 116
4.4 The context of the current mental health reform in West Java 119
4.4.1 The need for implementing mental health reform in West Java 120
4.4.2 Problem framing of obstacles to implementation in West Java 123
System level 124
Organisation level 134
Team level 143
Individual level 145
Summary 147

Chapter 5 Discussion

Introduction 149
5.1 Understanding West Java mental health reform 150
5.2 Civic philosophy 154
5.2.1 History of policy 159
5.2.2 Culture and policy 164
5.2.3 How policy is developed 172
5.3 Custodial role 178

5.3.1 Decentralisation 180
5.3.2 Reorganisation 182
The merger of two mental hospitals 183
The establishment of the BLUD 185
The new hospital accreditation 189
5.3.3 Resources 190
Policy and infrastructure 191
Mental health services 192
Funding 193
Community resources 194
Human resources 196
5.3.4 Organisational change 197
Leadership crisis 197
Resistance to change 199
Power distance 201
Conflicts 203
5.4 Civic organiser 206
5.4.1 Leadership 207
5.4.2 Readiness for change 210
5.4.3 Conflict management 213
5.4.4 Partnerships 214
Summary 218

Chapter 6 Research transfer and conclusion

6.1 Research transfer 221
6.2 Strengths and limitations of the study 226
6.3 Conclusion 228

References 235

Appendix 253

Declaration

I, Emi Patmisari, certify that this dissertation does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge it does not contain any material previously published or written by another person except where due reference has been made in the text.

Signed: Dated: 31 March 2014

Dedication

This is dedicated to a very special person in my life, my loving Dad, who sadly passed away on Friday, 24 January 2014. You were the best and the wisest man I ever knew who taught me many lessons and showed me many things. You did not tell me how to live, you lived and let me watch you do it. You lost everything just to make me win the battle. I miss you so much.

Acknowledgements

Studying overseas in Australia has presented me with many challenges beyond those of being a student. It would not have been possible to write this doctoral thesis without the help and support of the kind people around me, to only some of whom it is possible to give particular mention here.

First and foremost, I would like to thank Allah SWT, the almighty who has granted countless blessings, knowledge, and opportunity to complete this dissertation. I would like to thank the three most amazing people in this world, my parents and my precious daughter; you are my strength, my courage, and my hope. Without you all, I would never have had the ability and support to have completed this project.

I would like to thank my principal supervisor, Associate Professor Colin MacDougall, who provided his academic wisdom and patience to guide me through this process. I give thanks also to Dr. Samantha Meyer, my second supervisor, who gave me advice, encouragement, and understanding. Her help on this dissertation cannot be overstated. The good advice, support and friendship of my third supervisor, Professor Eimear Muir-Cochrane, has been invaluable on both an academic and a personal level, for which I am extremely grateful.

I would like to acknowledge the support of the International Student Services Unit, Flinders University and its staff, particularly, Jane Horgan and Elaine Kane, who provided me with indispensable help for completing my degree. I am most grateful to my dear friend, Associate Professor Lidia Mayner for providing me priceless advice and a shoulder to cry on during my gruelling submission schedule. I would like to thank Patricia Barkway and Robert Muller for your kindness, friendship and support.

Last, but by no means least, I would also like to thank all my colleagues and friends in Australia and Indonesia for their support and encouragement throughout.

Summary

Background: Mental health is a continuing health problem in Indonesia, the latest survey in 2007 stated that the national prevalence for mental disorders being at 116/1000. A strategy for the transformation of the mental health system, from a hospital-based mental health approach to one that is focused on community-based care, was firstly documented in the 2001 National Mental Health Policy. This policy, however, is not automatically translated into adequate delivery of mental health services at local government levels. It is not an easy task for ensuring the implementation of mental health reform within local levels, particularly in West Java province as the most populous province and the highest prevalence of mental health problems.

Aim: The aim of this study was to examine the meanings of mental health reform policy understood by the West Java bureaucrats.

Methods: Grounded by an interpretive paradigm, this case study was conducted by collecting information from primary and secondary sources that include interviews with 20 West Java bureaucrats and relevant policy documents.

Findings: The slow pace of mental health reform in West Java has been underpinned by complex interrelated factors. In West Java, there is much evidence to suggest that the problem is not the mental health reform policy itself, but rather the bureaucratic system and the lack of organisational capacity for supporting policy implementation. Rigid regulatory frameworks make the implementation difficult, and organisational barriers get in the way of good mental health service.

Discussion: Using Laris and MacDougall's trilogy model involving civic philosophy-custodial role-civic organiser role, it is clear that the values of bureaucracy, that is the civic philosophy, appear to be 'out-of-sight' in West Java, and the 'busyness' of the custodial role leaves limited space for manoeuvre as a civic organiser to engage with the West Java organisation's external partners to 'govern' mental health reform. The strategy proposed is to facilitate more on the public organisation's civic organiser role by emphasising four important aspects: leadership, readiness for change, conflict management, and partnerships.

Chapter 1: The rationale

Mental health has a continuing history of neglect across the globe (WHO 2009c). Despite the growing recognition of its importance to population health, both developing and developed countries show bias towards physical health, and especially mortality. Developed countries tend to give priority in health to non-communicable diseases that cause early death, namely cancer and heart disease, whereas developing countries prioritise infectious disease and reproductive and child health over those that cause disability, such as mental disorders (WHO 2009b). In recent decades, growing efforts in prevention and health promotion have seen mental health increasingly being acknowledged as an important public health issue. As a result, mental health has increasingly become a priority in the global public health and policy spheres. The contemporary public health approach has had a considerable influence on mental health reforms worldwide (Marmot & Wilkinson 1999).

This study presents an analysis of the Indonesian mental health reform through the eyes of West Java bureaucrats' by exploring their understandings of the policy actors (the roles of different stakeholders), and the content, process, and context of the reform in order to draw lessons that will be used to enhance the success of the ongoing mental health sector reform, particularly in West Java, Indonesia.

1.1 Statement of the problem

Mental health is a major health problem in Indonesia. Data from a national survey conducted in 1995 stated that the prevalence of mental disorders among children and

adolescents was 104/1000 and 140/1000 for adults. Meanwhile, the prevalence of psychosis was 3/1000, dementia 3/1000, mental retardation 5/1000, and other mental disorders at 5/1000 (MoH 2009). The latest survey in 2007 stated that the national prevalence for mental disorders was 11.6% (116/1000) (MoH 2012). Mental health services in Indonesia are mainly delivered as hospital-based services. A strategy for the transformation of the mental health system was initially documented in the 2001 National Mental Health Policy. This document outlines the transformation of the system from hospital-based to community-based mental health care.

Reform is recognised as being much needed, but this has proven to be difficult given the geo-political landscape, and the fact that access to resources is compounded by other health conditions being given priority. Administratively, Indonesia consists of 33 provinces, 399 districts or regencies, 98 municipalities, 67,711 sub-districts, and 78,609 villages spanning 3,200 miles, through more than 17,500 islands (Statistics Indonesia 2012). Each province has a different pace of development and different levels of resource availability. As a result, the implementation of mental health reform has been somewhat uneven across this vast territory. Consequently, a substantial reform of the national mental health system needs to be translated into a clear, creative, and sustained community mental health service platform at the provincial level. Since most care is institutionally based, the transition to community care requires greater resources, including funds that have not yet been made available in most provinces.

West Java province consists of 17 districts and 9 municipalities with a population density of 1,217 per km2. There are 1,039 Community Health Centres (CHCs) in

West Java, as the closest formal health service to the community, serving a total 43,826,775 people (Statistics Indonesia 2012). As mandated in the 2001 National Mental Health Policy, these CHCs are supposed to be the front-line in tackling mental health problems however, providing mental health services in the CHCs is undoubtedly a huge task. Under the decentralisation policy, in 2002, the West Java Government took responsibility for managing two psychiatric hospitals, which were then merged into one, known as the West Java Psychiatric Hospital (WJPH) in 2008. While West Java continues to battle with existing chronic health issues, such as a lack of resources for the health sector, limitations in the supply of health providers, inefficient funding and payment systems, ineffective planning for improving health outcomes, limited evidence linked to health performance, to name a few (Rokx et al. 2010), ensuring that mental health reform gets onto the provincial agenda creates additional burdens.

Ideally, under the decentralisation process, provinces, districts, and municipal governments develop their own plans and programs in order to respond to specific local issues in compliance with national policy objectives, strategies, and priorities. In practice, as elsewhere in many developing countries, local governments struggle with an unclear direction of change, as well as experiencing a dual dilemma of dealing with both pre-existing chronic problems, which require more resources, and a simultaneous burden of new emerging problems (Frenk 1994). It has been identified that continuing poor awareness, low prioritisation, and poor commitment by stakeholders are major barriers to the development of mental health services (Cassels 1995).

The West Java Provincial Government acts as both national policy implementers and as policy-makers. The government is fully responsible for ensuring the implementation of mental health reform within its area of jurisdiction and West Java bureaucrats, particularly those who work in the mental health field, are the main actors and promoters of this transformation. The knowledge of bureaucrats is understood to play a central role in decision-making and this suggests that their understandings and practical reasoning of policy language underpins their actions in the field (Pülzl & Treib 2007).

This study is the first ever conducted to closely investigate Indonesia mental health reform and to analyse the underlying mechanisms involved from the perspective of the bureaucrats involved. Given the aforementioned complexity of the problems facing West Java province, it is worthwhile to focus on the West Java case as the target population for this study. One strong point made by Hogwood and Gunn (1984), is that policy studies are conducted to understand the complexity of, the constraints upon, and the prescriptive ventures of policy-making because 'what you would change you must first understand' (p. 29). Hence, this study looks to generate a 'thick' understanding of mental health reform by exploring the meaning of mental health reform policy as understood by West Java bureaucrats.

1.2 Motivation behind the research

Soon after graduating from the Padjadjaran University with a Bachelor of Nursing in 1999, I worked at a private nursing academy as a lecturer. My two years of teaching experience taught me that teaching nursing students without a strong clinical background was just transferring theories from books to students. I decided to apply

for a government official position and passed as a registered nurse at the Bandung Psychiatric Hospital (BPH – now the WJPH).

My nine years of experience as a nurse clinician has enabled me to build my confidence, and clinical skills, and to determine the nature of effective communication with patients, care workers, and colleagues within a multidisciplinary team given the short periods of hospitalisation for mental illness cases (30 days was the maximum stay in the hospital for each period of hospitalisation). I worked not only with patients but also their families and found that mental illness is a time bomb that suddenly explodes, disrupting patients' lives and the lives of the people around them. Having dealt with everyday dilemmas, on the one hand, I knew what needed to be done to improve the situation, but on the other hand, my hands were tied in making it happen due to common issues found in government-owned hospitals, such as funding limitations, rigid regulations, and the lack of trained staff. I gained great experience dealing with such dynamic matters in practice during the early part of my career.

In 2004, I obtained a scholarship to pursue a Masters' degree in mental health at Flinders University. This was the moment when I expanded my horizons into a different world and a different way of seeing things. Equipped by such deep learning experiences in Australia, I returned to work at the BPH hoping, at least, to apply my updated knowledge and skills. A system change was never going to be easy as there were impenetrable barriers that I had to deal with. I started to question many things, how this could happen, why the system works as it does now, why it is difficult to change the system, and why people were so resistant to change. I felt as if I was the

outsider 'on the inside', who could only recommend alternative approaches or solutions, but unable to operationalise them. Although change is a crucial part of improvement, throwing an idea for a system change into such a rigid bureaucratic world was always going to be very painful and, because of this, most of us (myself certainly included) tended to shy away from it.

In 2009, I moved to a higher level in the provincial government to the Regional Development Planning Board (Bappeda), where all the proposed programs from all provincial organisations (including psychiatric hospitals) were reviewed and synchronised. I was no longer a clinician, yet my years of experience as a 'street-level bureaucrat' armed me well for every decision I made. In my new job as a health planner for the entire province, I was trapped in a tangled reality and exposed to even more barriers to change, including factors such as political-economic situations, and different actors with different interests. It is understandable, at this point, why mental health promotion and prevention programs have always been limited. Most people (bureaucrats) simply think that a psychiatric hospital is a place where insane people are treated, thus the most crucial thing to focus on is the supply of medication. This simple mindset, in fact, has a tremendous impact on the entire mental health system in West Java which, in turn, reflects the explanations for why the mental health system works as it does today.

Through my exposure to a variety of complex mental health issues in a bureaucratic world for over a decade, I have developed a passion for research to understand the issues through the collection of empirical evidence/data. My strong interest in mental health and public health policy motivated me to conduct research on the Indonesian

mental health reform policy. My dual roles in this study, as an insider as well as an outsider, have enabled me to look at the issues from a more balanced social justice perspective. As there is no country across the globe that is promoted as a mental health reform success story, this study provides valuable insight into the process of Indonesian mental health reform as a long-running saga involving the management of massive changes according to the country's own distinctive political-economic and socio-cultural characteristics. The results of these culturally-embedded forms of conduct bear out that it is not what is written in the policy documents or regulations that matter, but rather the implications of these regulations that are the key challenge, resulting in a wave of consequences that cause bureaucrats to be 'drowning in red tape'.

The research process begins with the conceptualisation of a research question which, for this thesis, involved a reflection on the problems that I experienced in the field. The next section details the research question, and the aims and objectives for this study.

1.3 Research question, aims, and objectives

As a baseline process, this study sought to answer the following question: How is Indonesia's mental health reform policy understood by bureaucrats at the provincial level in West Java? To gain a 'thick' understanding for answering this main research question, this study employs four overarching aims, these are, to:

1. Explore bureaucrats' perceptions of the policy actors who are significant to policy implementation

Objectives:

- Explore how the participants place themselves within the national mental health reform policy networks
- Identify how other relevant actors and stakeholders' roles also contribute to policy implementation in West Java

2. Identify their understandings of the policy content

   Objectives:

   - Identify what the bureaucrats know about Indonesia's mental health reform policy
   - Identify what they think about the assumptions underpinning reform in the Indonesian mental health reform policy
   - Identify their perceptions of the significance of mental health reform

3. Identify their understandings of the policy process

   Objectives:

   - Identify bureaucrat's perceptions about how Indonesia's mental health reform policy has been developed
   - Identify their perceptions about how Indonesia's mental health reform policy is transferred
   - Identify their perceptions of the need for mental health reform in West Java

4. Explore the changes in the system relevant to mental health reform in the West Java context

   Objectives:

- Identify their perspectives about any changes they see or experience in practice
- Identify the challenges they face in facilitating change
- Identify the impacts of mental health reform on their professional practice, the organisation, and the community

The study outcomes will provide a better understanding of specific constructs related to the mental health reform policy which can be applied to develop better actions and strategies to improve the quality of policy decisions and, more importantly, to improve the feasibility of the implementation of ongoing and future mental health care in Indonesia, particularly in West Java.

1.4 Structure of the dissertation

Following the introduction provided in this chapter, which includes the background to the research, the problem statement, the research questions, aims, and objectives, and the motivation behind the research, the structure of the dissertation is as follows: Chapter 2 presents the study's theoretical frame to elaborate upon public health and mental health reform, mental health reform in low middle income countries (LMICs), mental health reform and policy analysis, and Indonesia's mental health system, from the existing literature. Chapter 3 provides the study's research approach and methodology, as well as the process for the selection of the policy documents and interview samples and the coding and analysis strategy for each data type. Chapter 4 describes the results of the interviews which are organised into four headings based on the research aims: bureaucrats' understandings of the role of actors in Indonesian

mental health reform (Aim 1), bureaucrats' understandings of policy content (Aim 2), the Indonesian mental health reform policy process (Aim 3), and the context of current mental health reform in West Java (Aim 4). Chapter 5 provides a discussion of the findings using the civic-philosophy, custodial-role, and civic organiser lenses, outlined by Laris & MacDougall (2011), as a prescriptive model for supporting better West Java mental health reform outcomes. Chapter 6, the final chapter contains the details of the research transfer possibilities and the strengths and limitations of this study, as well as a concluding section on how the study has answered the research question.

Chapter 2: Literature review

Introduction

The purpose of this literature review is to provide an illustration of the issues at play in regard to the research question for this study – 'how is Indonesian mental health reform policy understood by bureaucrats at the provincial level in West Java?' Reviewing the literature on mental health reform is an expansive topic, using a critical analysis of the gaps in knowledge will refine the research question specifically in order to justify the choice of area of research and a framework to guide the research. This literature review aims to explore and interpret knowledge relevant to what is known about contemporary mental health reforms in relation to the New Public Health; what is known about mental health reforms in low- and middle-income countries (LMICs); the central theories that have been used to analyse health reform policy; and lastly, what is known about Indonesia and its mental health system.

2.1 Review process

The literature has been drawn from a variety of sources and is not limited to the research and theoretical development over the past few years, though recent works are emphasised. The themes contained in this literature review have been selected from a range of disciplines, for example mental health, public health, health policy, public policy, and public management and administration, because of their relevance to different aspects of this study. In an attempt to search for the relevant studies conducted in the field, a number of electronic databases were used, such as

PsychINFO, PubMed, ScienceDirect, Informit, ProQuest Central, SAGE Journals Online, Oxford University Press Journals, Journals@Ovid, and Google Scholar. In order to maximise the relevance of the search to the issue, especially in the Indonesian context, some Indonesian government official websites as well as World Health Organisation (WHO) were also used. Many WHO publications are used in this chapter, as it is widely agreed that in the health arena, the WHO is a source of authoritative knowledge. Furthermore, the WHO is referred to, by Sturdy et al. (2013), as a technocratic organisation, which uses technical expertise to define normative, universally-applicable standards on which to base health policy.

Apart from the use of electronic databases, contacting key informants and experts by email was also used to retrieve documents related to Indonesian mental health policies. The following key words were used for searching the databases: mental health reform, mental disorders, community mental health, and mental health service, mental health policy, health policy, health reform policy, policy development, policy formulation, government policy making, policy analysis, low-and-middle income countries OR LMICs OR developing countries, and Indonesia.

2.2 An overview of contemporary mental health reforms

Mental health reforms and the New Public Health

Mental health is increasingly being acknowledged as an important public health issue. Mental health-related conditions are among the most important causes of sickness, disability and, in some age groups, premature mortality, which in turn affects quality of life (Saxena et al. 2007). Marmot and Wilkinson (1999) argue that the principles

underlying the New Public Health, which is the recognition of equity, social and environmental factors, empowerment, and participation as basics in improving health in populations, have had a considerable influence on mental health reforms worldwide. In this section, I elaborate upon how the concept of the new public health is interconnected with the modern mental health care system.

Many studies have shown that health is influenced by a wide range of social aspects that go beyond the bio-medical paradigm. The Lalonde Report of 1974 was the first significant document to challenge the narrow approach of the medical model. This is regarded as a key in the development of what has become known as the New Public Health movement (Baum 2008, Hancock 1986, Terris 1984). Raphael (2009), the Canadian health policy and management scholar, highlights that the social determinants of health framework has been a powerful antidote to ‘the tyranny of the acute’. He further emphasises that only 15% of genetic and biological factors contribute to ill-health, while 60% of illness results from physical, social, and economic factors. The recognition of social determinants in public health policy is understood as an upfront investment to prevent larger amounts of money being spent on treatment and rehabilitation in the future. This economic argument has strongly driven public health movements (Raphael 2009).

Early paradigms of mental illness rely on individual variables that lead to a more bio-medical approach to the treatment of people living with mental illness. There are many contributing factors to mental disorders apart from biological factors. Thakker et al. (1999) proposes a constructivist model of mental disorder which describes multiple biological, psychological, and socio-cultural variables that determine the

level of an individual's mental health (Figure 2.1). Genetic factors and chemicals in the brain are among the biological causes of mental disorders. A study conducted by de Kloet et al. (2007), for example, shows that the susceptibility pathways underlying depression are influenced by genetic factors, and the vulnerability to psychotic episodes are linked to a hyperactive hypothalamic-pituitary-adrenal (HPA) axis and high levels of circulating cortisol. Harrison and Owen (2003) discovered that neuregulin, dysbindin, and RGS4 are among the genes responsible for schizophrenia, however, the case for each gene remains, to a greater or lesser extent, incomplete as there may also be other genes contributing to schizophrenia.

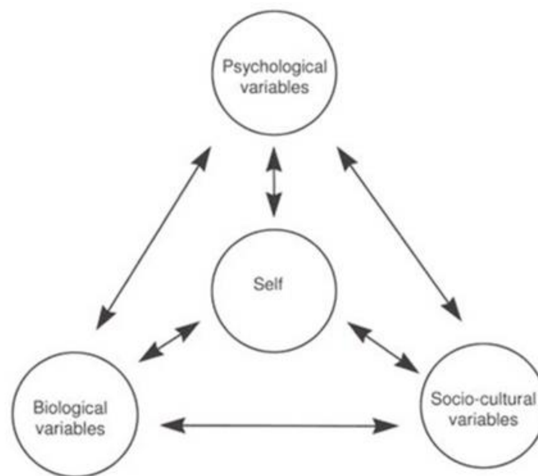


Figure 2.1 A constructivist model of mental disorders (*Thakker et al.1999)*

There are also specific psychological and personality factors that make people more at risk of having mental disorders. Akiskal et al. (1983) revealed that an introverted personality is a possible premorbid trait in primary non-bipolar depression, whereas extroverted, and related dysthymic temperaments, appear to be the precursors of bipolar disorders. On top of this, socio-cultural variables have been progressively recognised as risks to mental health for individuals and communities. Patel and

Kleinman (2003) state that rapid social change, stressful work conditions, discrimination, social exclusion, poverty, unhealthy lifestyles, occupation, access to health services, housing, and low levels of education are also associated with higher rates of mental illness.

Research on socio-environmental factors influencing schizophrenia indicate that it is more common among the lower social classes (Murray et al. 2003). Dalgard (2008) conducted a nationwide survey in Norway, surveying 12,310 people between 30 and 60 years of age. The study explored the mediating factors between social status and mental health. The results show that there is a social gradient in mental health, and the lower level of socioeconomic class, the higher the prevalence of mental illness. Whether these social aspects should be interpreted in terms of social causation or social consequence is still a topic of debate in the literature surrounding the social determinants of mental illness (Cohen & Minas 2008, Häfner & Heiden 1997, Piccinelli & Homan 1997, Sham et al. 1994), however, the evidence is robust enough to take effective action. This suggests that identifying the social determinants of mental health is important as it sets a direction for policy and methods of intervention.

Primary Health Care (PHC), as defined in the Alma-Ata Declaration, sets a standard for health care worldwide. Due to dynamic changes in society, there have been various modifications of the original idea of PHC, from only focusing on individual health, to what is now known as comprehensive PHC. Baum (2008) contends that selective PHC does not espouse the same philosophical principles as comprehensive PHC. In relation to mental health, comprehensive PHC stands in contrast to the early paradigms of mental illness, which relied on individual variables that lead to more

bio-medical approaches to the treatment of people with mental illness. The bio-medical approach to mental illness perceives the individual as requiring treatment and as 'the problem', which implies 'victim blaming' (Elder et al. 2009). This approach does little to address the social determinants of the person with a mental illness. Table 2.1 illustrates how the movement from selective to comprehensive PHC is interconnected with the transformation of mental health systems.

Table 2.1 The comparison of selective and comprehensive PHC in mental health

	Selective PHC	Comprehensive PHC
Approach, forms of evidence	Positivism, traditional epidemiology	Interpretivism/Constructivism, social epidemiology
Base of theory	Medical science	Social science
Focus	Individual	Collective
Locus of control over health	Medical profession as dominant	Communities, individual Multidisciplinary teams as dominant
Major aim	Mental illness eradication	Improvement in social and emotional wellbeing
Participation	Non-participation, limited engagement	Degrees of citizen power (partnership – citizen control)
Politics	Apolitical	Unavoidably engaged
View of health	Absence of disease, disorder	Positive health, wellness
Strategy	Curative, advanced technology, little attention to promotion and prevention	Prevention, promotion, curative, and rehabilitative Health through equity and community empowerment Multi-sector collaboration
Study	Psychiatry	Post-psychiatry, Social Psychiatry, Community Mental Health

Source: (Baum 2008, Bracken & Thomas 2001, Fusar-Poli et al. 2011, Hunter 1997, Keleher 2001)

Despite a long history of research on the social determinants of mental illness, people living with mental illness are still constrained to live lives that are shaped, in large part, by social isolation, ongoing stigma, and the denial of basic rights. Stigma towards the person with mental illness is pervasive and this marks not only those who

are ill (McColl 2007, Wahl 1999), but also their families across generations, as well as psychiatric institutions, psychotropic drugs, and mental health workers (Sartorius 2007). Stigma restricts people with mental illnesses from employment, education, and housing, which are essential for achieving life goals (Corrigan 2000). The available evidence strongly indicates that social exclusion is a major determinant of poor health, leading to limited access to health treatment and justice, and presenting almost impenetrable barriers to recovery (Burns et al. 2007, Huxley & Thornicroft 2003, Lundberg et al. 2008, Patel & Kleinman 2003, Webber & Huxley 2004). Stigma leads to low self-efficacy and low quality of life for the person with mental illness (Vauth et al. 2007), reluctance to invest resources into mental health care, discrimination in the provision of services, and low use of health facilities (Patrick et al. 2005). The WHO ties pervasive stigma to economic loss and disability associated with mental illness. In the USA alone, for example, such loss has been calculated to be as much as US$1458 billion per annum (WHO 2012).

A more comprehensive approach is needed to change the social, political, environmental, and economic determinants of illness in order to create better health for populations. The principles of comprehensive PHC in mental health include equity on the basis of need, affordable access to needed services, the sustainability of PHC services, and the empowerment of people alongside efforts to help them to become more self-determining (Baum 2008). The objective of applying a comprehensive PHC approach in mental health is for every individual to have the opportunity for growth, recovery, acceptance in their community, access to community-based and specialist services and supports of their choice, and to have a good quality of life (Bambra et al.

2010, Levin & Becker 2010, Marmot & Wilkinson 1999). The following section explores the historical context of mental health transformation and the debates surrounding the shift to community-based mental health services.

The advent of community-based mental health care

A series of reforms in psychiatric care can be traced back to the World War II era. After World War II, mental health reforms emerged in countries such as England and the USA, which was followed by Continental Europe and Scandinavia a little later (Archer & Gruenberg 1982, Novella 2008, Puckett 1993, Thornicroft & Tansella 2004). In the UK, asylums were the dominant resource for treatment of individuals with mental illness until the 1950s. The 1845 Asylum Act had a significant impact on the increase in the number of patients to over 150,000, which turned the institutions into 'museums of madness' (Turner 2004). A new Mental Health Act in 1959 initiated the closure of asylums in order to provide cheaper, non-hospital-based continuing care in the community supported by social services as part of the normalisation of stigmatised people.

For the second half of the 20th century, the term 'deinstitutionalisation' became popular, referring to the establishment of community care and the closure of beds in psychiatric hospitals, which has been considered to be an essential aspect of mental health reform in the west (Mills & Cummins 1982). The downsizing of psychiatric hospitals was the most visible implication of these reforms. In England, 130 psychiatric hospitals existed in 1970, being reduced to only 14 by 2000, whereas in Australia, there has been a ten-fold decrease in inpatient psychiatric beds over the last

4 decades (Glick et al. 2011). In Greece, between 1984 and 1996, the number of beds in public psychiatric hospitals decreased by 38% following a fivefold increase in community mental health service facilities (Madianos et al. 1999).

Gronfein (1985) underlines that the optimism about mental health reform was also backed up by advances in psycho-pharmacology. Since the 1950s, it has become gradually understood that prolonged hospitalisation can lead to the deterioration of patients' illnesses, and that it may also exacerbate the disabling effects of the illnesses, instead of curing them (Butler 1993, Rowe et al. 2011). New psychotropic medications have made it possible for psychiatrists to stabilize patients while they are living at home or in a community-based health facility. In the USA, these growing interests forced the government to build community mental health centres throughout the nation (Gronfein 1985).

The antipsychiatry movement emerged in 1967, criticizing the legal privilege of psychiatrists to compulsorily detain individuals with mental disorders (Berlim et al. 2003, Langsley 1980). Bracken and Thomas (2001) argue that various forms of antipsychiatry and critical psychiatry, between 1960 and the 1980s, have led to a growing number of clinical psychiatrists working outside of the hospital system with multi-disciplinary teams in community settings, while the 1990s was marked as the beginning of the 'post-psychiatry' era. Psychiatry took a leading role when it came to controlling madness; as Michel Foucault wrote, 'the language of psychiatry (has been) a *monologue* reason about madness' (as cited in Bracken & Thomas 2001, p. 1). The shift to community care signals a *dialogue* between psychiatrists and those who have experienced episodes of mental illness. The values within health care have moved

from paternalism, where the patients were expected to defer to the authority and wisdom of psychiatrists, to community participation and involvement (Bracken & Thomas 2001). Parallel to this movement, consumerism in health, which originates from western capitalism, has emerged, signalling that citizens have the right to make choices in health care (Aggarwal et al. 2010). In this sense, health care is thought of both as a right (that it is a need rather than a choice) and a commodity, the demand, supply, and cost of which should be governed by the market.

Extensive research has identified the superior outcomes, and the not so significant impacts, of community-based care in comparison to hospital-based services in a range of countries. With regards to the impact of community treatment on reducing readmissions and bed-days, Preston et al. (2002) found that although patients who were placed in community treatment demonstrated reductions in inpatient admissions and length of stay after one year, these improvements were no greater than those seen in controls who had not been placed in community treatment. Conversely, Rothbart et al. (1999) specified that the percentage of readmission patients who were managed in community treatment decreased over time. In this study, despite the fact that the number of hospital days increased, the total treatment cost per year per person was around 50% lower for the discharged patients receiving community services. Similarly, a study conducted by Dush et al. (2001) revealed that the average number of relapses was 50% lower for experimental participants who were managed by community teams, and the costs were 27% lower for the experimental group. A higher level of functioning was demonstrated for the experimental group, nonetheless there were no significant differences in clinical outcomes for both groups. The impact of

community services on patients' quality of life and level of functioning has been studied in many different settings and through a range of methods.

In Japan, Ryu et al. (2006) found that residents who remained in a community facility for 2 years demonstrated significant improvements in not only their psychiatric symptoms, but also their social functioning. Better life satisfaction and symptom improvement are also mentioned in Hobbs et al.'s (2000) findings, but there was no statistically significant change in their living skills. Bak et al.'s (2007) findings suggested that community treatment had a positive impact on symptom remission and quality of life of patients living in rural areas. In terms of service utilisation, research conducted by Issakidis & Andrews (2006) in Australia, revealed that being aged over 55 years or living in rural areas was associated with lower access to mental health inpatient units. Evidently, rural areas appear to be poorly served by mental health services and the facilities are not equitably located in the catchment areas, therefore it was seen to be more practical to focus on effective community services in rural areas.

Community treatment has been attested to have better outcomes due to the continuity of care. Honkonen et al. (2003) studied 3,257 schizophrenic patients who were transferred to community facilities after discharge by each district's psychiatric institutions. Three years after their discharge, the proportion of patients who had dropped out of treatment decreased and the psychiatric and somatic state of the drop-outs had improved. Community-based services are also associated with greater satisfaction based on two different studies by Younes et al. (2008) and Ruggeri et al. (2006) in France and the UK respectively. Greater overall quality of life outcomes and fewer unmet needs for patients treated in community settings for specific mental

illnesses and for specific populations have been found across the globe (Arvidsson 2005, Arvidsson 2009, Blumberg 2002, Cummings 2009, Gater et al. 1997, Rosier et al. 1998).

Despite the benefits, deinstitutionalisation has been the subject of serious debate. Although it has been positive for the majority of patients, it also has a number of severe shortcomings. Deinstitutionalisation was historically endorsed to reduce state funds for psychiatric hospitals by way of moving financial responsibility to federal funds, and was perceived as a neo-liberal action by governments (Chesters 2005, Habibis 2005, Henderson 2005, Mowbray & Holter 2002). Only later, the focus on improving and expanding the range of services and supports for those in the community has developed in recognition that medical treatment was insufficient. The history of deinstitutionalisation began with high expectations that community care would lead to fuller social integration; inopportunely, this has not been achieved. The concept of community care has become increasingly associated with neglect and lack of care, and a backlash of increasing risk management has developed, fuelled by public inquiries into homicides committed by individuals with mental illness (Turner 2004).

In practice, due to the lack of preventative initiatives and an underfunded community system, community care has become uncoordinated and disjointed which, in turn, has led to increased readmissions, with people needing more intensive treatment, as well as stimulating a rapid growth in the number of mentally disordered homeless individuals or those who have ended up in prison (Miller et al. 2011). Gerrand (2005) evaluated the success of deinstitutionalisation in Victoria, Australia. The success of

the program was due to the fact that alternative services that were comprehensive and locally accessible were established before the institutions were closed, yet the implementation of mental health reform was found to be more complex and costly than anticipated (Mechanic 1993).

It is also evident that people with mental illnesses felt that the 'open door' movement had no significant impact on their wellbeing. Davidson et al. (1995) and Lamb and Goertzel (1971) studied the experience of long-stay inpatients returning to the community. From the patients' perspectives, they perceived that there was no difference between living in hospital or in the community, as they felt impoverished, empty, lonely, and in despair, regardless of the setting. They stated that staying in the hospital was in fact more beneficial as it was a safe place away from their empty lives in the community (having limited social contacts), and they believed, beyond doubt, that they had better access to health care (Davidson et al. 1995, Lamb & Goertzel 1971). After decades of mental health reforms in the west, such as in Australia where major service gaps and poor experiences of care are still common, the mental health community reports little progress in implementing its key priorities due to lack of funding allocated for collaborative community care (Hickie et al. 2005, Rosenberg 2011).

In this section, I have presented an overview of the intersection of the 'new public health' concept and mental health as a paradigmatic grounding for understanding the basic principles of mental health reform for this research. By putting these two concepts together, it is clear that the gold standard of modern mental health care is nested in the public health system rather than in clinical psychiatry. A historical

review of the development of community-based mental health services is used to exemplify that radical transformation to community care comes with unintended outcomes. The following section highlights mental health reforms specifically in low- and middle-income countries (LMICs) to provide a contextual understanding proximate to the Indonesian situation.

2.3 Mental health reforms in LMICs

As discussed earlier, the rush towards community-based mental health care in many western countries originated from a complex mix of a strong radical grass-roots movement coupled with advances in psycho-pharmacological therapy and other evidence-based initiatives. The recognition of the global cost of mental illness has prompted mental health reforms in many western countries, resulting in the adoption of deinstitutionalisation and community-based mental health services as the preferred options (Hazelton 2005).

In LMICs, the concept of reform has become equally popular recently. In LMICs, the great majority of people with psychiatric conditions are already managed in the community, but with very few resources, including specialized professionals. In most developing countries, a few psychiatric hospitals were built mainly in the larger cities, with most being built in the colonial era. With the end of colonial rule, the psychiatric hospitals were taken over by the new governments (Mehryar & Khajavi 1974). In Pakistan, for example, there are only three psychiatric hospitals for over 40 million people. In Indonesia, there are currently 33 psychiatric hospitals covering more than 237 million people. In India, there are only about 25,000 psychiatric beds for a

population exceeding one billion, and Timor-Leste has no psychiatric hospital at all (Farooq & Minhas 2001, Hawkins & Tilman 2011, MoH 2010a).

Psychiatric hospitals in the developing world are ‘permeable’ institutions where family involvement is dominant in the care of patients. Farooq & Minhas (2001) have argued that, in developing countries, community-based mental health services do not even exist in the same sense as that which is practiced in western countries. The concept of so-called ‘community mental health’ is instead more akin to ‘primary mental health care’, and the western concept of ‘deinstitutionalisation’ is not well suited to developing countries (Farooq & Minhas 2001, Hawkins & Tilman 2011). This reflects the fact that mental health system reform in LMICs does not exist according to the same meanings and values as in western contexts.

As reported by the WHO (2011a), most LMICs’ expenditure on mental health is less than 2% of the health budget, with up to 90% going to psychiatric hospitals, while spending on mental health is less than 25 US cents per person in low income countries compared to US$2 per person per year globally. In general, psychiatric hospital systems have been less comprehensive in their coverage of populations in LMICs than in developed countries. In so doing, transforming the service into an integrated community-based care system in LMICs requires a massive effort to also move funding allocations in order to create innovative programs to achieve this aim. Merryman (2004) conducted a study on the factors that influence the adoption of mental health reforms in the District of Columbia. The results show that political factors were the most influential in the adoption of state mental health reforms specifically in terms of funding for innovative community programs. Bringing

together multiple funding streams with varying organisational structures, the negative social constructions of the population, and competition for scarce resources in the west has proven difficult, let alone in the LMICs.

The shortage of mental health professionals including psychiatrists, nurses, and psychosocial care providers in LMICs has been reported in the WHO Bulletin. Bruckner et al. (2011) have identified that, of the 58 LMICs sampled, it was found that all low-income countries and 59% of middle-income countries have far fewer mental health professionals. Cohen et al. (2011) reported that in countries such as Nigeria, the Philippines, and India, without any international funding, community mental health programs are unlikely to exist, and those that are struggle to be sustained. Although such funding is available, a lack of human resources is a huge challenge. Results from a case study in Abuja, Nigeria where there are no psychiatrists to which the program community psychiatric nurse can refer challenging cases, demonstrates that the retention and hiring of community volunteers to work in the mental health community centre is very difficult as they prefer to earn more money working as fishermen (Cohen et al. 2011). A lack of resources for mental health care is also reported in Ghana, based on a qualitative study interviewing a broad range of mental health stakeholders at the national, regional and district levels (Ofori-Atta et al. 2010). The findings show that there are insufficient numbers of mental health professionals, an aging infrastructure, widespread stigma, inadequate funding, and an inequitable geographical distribution of services. Post-war countries such as Bosnia Herzegovina and Kosovo rely on foreign aid to provide sustained community mental health services, but creating a balance between measured foreign

influence and the involvement of existing local structures in such difficult post-conflict situations has been reported to be problematic (De Vries & Klazinga 2006).

Indonesia and mental health issues

Indonesia is the fourth most populous nation in the world with total population of 237,641,326 people in 2010 (Statistics Indonesia 2011). Indonesia is grouped in LMICs based on the World Bank's classification. Indonesia has achieved substantial progress in overall economic growth, the national poverty rates have been decreased significantly, from 39.6% in 1976 to 12.5% in 2011 (Statistics Indonesia 2012). Life expectancy at birth is 69.4 years in 2011, above the average of lower-middle income countries but below the average of developing countries in East Asia and Pacific region. Based on the United Nations Development Programme's Human Development Report, Indonesia's Human Development Index (HDI), a comparative measure of three basic dimensions of human development: health, education and income, is ranked 124 out of 187 member states of the United Nations (with the HDI of 0.617), lags far behind neighbouring developing countries, such as Malaysia and Thailand, ranked 61 and 103 respectively (UNDP 2011). Countries with less human development tend to have greater inequality in the distribution of achievements across people in a society, thus larger losses in human development.

Mental health problems are well off the radar in Indonesia. Nevertheless, this is not exclusive to Indonesia, as Patel (2007) pins down, mental disorders are given the least attention globally on account of their low contribution to mortality. The majority of the research from Indonesia represents three mental health issues, post-traumatic stress disorder (PTSD), due to the 2004 earthquake-tsunami disasters and

humanitarian conflict, physically restrained individuals with mental illness (*pasung* cases), and the rising suicide rate. Irmansyah et al. (2010) carried out a quantitative study to examine the effect of the tsunami on the mental health of survivors in Aceh and Nias, revealing high rates of anxiety and affective disorders, and post-traumatic stress syndrome, in particular among women with lower levels of education, diminished resilience, high scores on disaster impact, and direct exposure to the disaster. Similar results were also found in a longitudinal study using different instruments conducted by Frankenberg et al. (2008), who found that post-traumatic stress reactivity (PTSR) scores were highest for women from heavily damaged areas, with scores declining over time.

Pasung, a cultural practice in which people with mental illness are physically restrained by families, occurs throughout the country. This is not a novel practice in Indonesia since it has been considered by many people as their only affordable option, due to insufficient funding for travelling to the nearest city for specialist care (Minas & Diatri 2008a, Puteh et al. 2011). Evidently, 60% of those people who were chained up had been given psychiatric care, but families were unable to continue the treatment. A similar study in Bali identified two major reasons why treatment was discontinued; their condition had not improved (65.2%) and financial difficulties (34.8%) (Suryani et al. 2011). From the Samosir Island cases, the duration of *pasung* ranged from 2 to 21 years, whereas from a study in Bali, the period ranged from 3 months to 30 years. The Ministry of Health estimates that there are between 10,000 and 26,000 victims of *pasung,* or other illegal restraint, across the country today.

A study conducted by Kurihara, examining mortality among people with Schizophrenia in Bali, revealed that the mean age at death was 33.3 years, and 90% of the deceased patients died from physical diseases while 10% were due to accidents (Kurihara 2006). It is concluded that patients and their families tend to reluctantly undergo, not only psychiatric treatment but also general physical treatment, which in turn increases the risk of death due to physical diseases. In the capital city of Indonesia, Jakarta, according to data from Jakarta's Social Agency, 239 people with mental illness in rehabilitation facilities died between October 2008 and May 2009 from acute diarrhea, anemia, or malnutrition, or a combination of the three illnesses (Minas 2009). It is reported in one of the shelters that out of 644 patients, 53 people died in 2007, 98 died in 2008 and 140 people died in 2009. The suicide rate in Indonesia is 8.10 for males and 3.68 for females per 100,000 population, although these figures were calculated after a significant increase due to the Bali bombings (Suryani et al. 2009).

As mental health problems continue to occur across the nation, in the last decade, the Indonesian government has made a significant effort to improve the mental health service system. The Ministry of Health has recently shifted its paradigm from a hospital- or institution-based mental health approach, to one that is focused more on community-based care and this issue has been ratified in the new mental health regulation (MoH 2009).

All of these examples in this section (2.3) imply that different social-political situations in different countries create different mental health problems as well as strategies to tackle these problems.

2.4 Bridging the gap strategies in LMICs

The gap between what is urgently needed and what is available to reduce the public mental health burden is still very wide in LMICs. Saraceno et al. (2007), have identified the greatest barriers to improving mental health care. First, the absence of mental health from the public health priority agenda affects spending on mental health care. The second barrier is the organisation of services, given the fact that, in LMICs, mental health resources are centralised in and near big cities and in large institutions. As a result, the organisation of the services tends to isolate people from vital family and community support systems; costs more than care in the community; and is associated with undignified life conditions, violations of human rights, and stigma. The third barrier to the development of mental health services is the complexity of integrating mental health care effectively with primary care services.

Mental health reforms in LMICs have focused on the integration of mental health into general health care, with the establishment of acute psychiatric units in general hospitals, efforts to incorporate mental health into primary care, and the implementation of a network of alternatives outside of psychiatric hospitals (WHO 2008b, WHO 2009a, WHO 2010). Learning from the past experiences of western countries, the closing of psychiatric hospitals without community alternatives is as dangerous as creating community alternatives without closing psychiatric hospitals (Barnes & Bowl 2001). The WHO has thus developed a model describing the balanced care of mental health services to be implemented, particularly in LMICs. This model proposes the integration of mental health services with general health care

(WHO 2009b). The integration of mental health services into primary care and general health, as the most feasible model of mental health services to be implemented in LMICs, is based on seven criteria: the burden of mental disorders is great, mental and physical health problems are interwoven, the treatment gap for mental disorders is enormous, primary care for mental health enhances access, primary care for mental health promotes respect for human rights, primary care for mental health is affordable and cost-effective, and primary care for mental health generates good health outcomes (WHO 2008a).

The message to arise from this section of the literature review is that mental health reforms in the developing world are primarily influenced by advice and consultation from the World Health Organisation (WHO). Most LMICs still suffer from a shortage of psychiatric beds in both general hospitals and psychiatric hospitals, thus the WHO's main recommendation on this issue is to integrate mental health into primary care. The development of strategies for improving the sustainability of mental health reform in the developing world is even more difficult as each country has experienced mounting problems, such as post-conflict situations, poverty, stigma, limited human resources, and inadequate funding. Providing community care for mental health creates an extra burden for most LMICs. The next section discusses the major public policy issues in relation to mental health reforms, which point to the importance of adopting a framework for policy analysis in this study.

2.5 Public policy and mental health

Shifting the locus of care from psychiatric hospitals to community care involves large-scale structural change in public policy and service provision (Aviram et al. 2007). This section explores the theoretical and conceptual background of the policy process and, in particular, how the issues come to be part of the public agenda, and how mental health reforms are issued in public policy. To begin with, it is beneficial to discuss the definitions of policy that arise from the existing literature.

What is policy?

Policy has a broad meaning. Searching for definitional clarity around policy can be misleading as the term is so widely used that it can often obscure meaning, and there is now a substantial literature on policy definition with the word being defined according to the authors' stances. For the purpose of my dissertation, the working definition of policy refers to 'courses of action taken by national, state, or local governments' (Scott & Baehler 2010). The 'public' component of 'public policy' is taken to suggest public-mindedness, or concern for the public interest, and implies the need for more participative policy-making (Hill 2009). It is also used to signal public sector ownership to implement the policies of elected governments. Public policy is generally associated with a course of action created by governments. Public policy can take the form of a law, a rule, a statute, an edict, a regulation, or an order (Howlett et al. 2009).

Policy can also generally be defined as 'an idea that we use in both the analysis and the practice of the way we are governed' (Colebatch 2009, p. 1). Bacchi (2009)

highlights that policies are highly complex, combining a range of proposals, thus producing more than one representation of a particular problem, and this problematisation involves an extremely complex set of interrelationships. Gauld (2005) defines health policy as the 'courses of action proposed or taken by a government that impact on the financing and/ or provision of health service'. From all the above definitions, governments are to be understood as the main actors in deciding the course of action for the public. Although it is clear in this study that government creates public policy, policy is not just about a product made by government. It is also the case that the construction of policy involves other stakeholders who have a significant role to play in terms of influencing which issues are seen as problems and worthy of being included on the policy agenda. It is therefore clear that, as Bacchi (2009) claimed, understanding policy means analysing how governing (governance) takes place and what the implications are for those who are being governed.

The policy process

The policy process can be simplified in a logical order, starting from the defining of problems, putting them on the agenda, then developing, adopting, implementing, and finally evaluating these problems (Jann & Wegrich 2007). These stages are then transformed into the so-called 'policy cycle' which emphasises feed-back (loop) processes between different elements of the policy process. Fischer et al. (2007a) claim that, under real-world conditions, policies are not developed in a vacuum; instead, new policies modify, change, or supplement existing policies. Moreover, policy processes do not have clear-cut beginning and ending features. The policy

cycle focuses attention on the generic features of the policy process rather than on specific actors or institutions, or particular substantial problems.

Problem identification and selection are inherently attached to the way a social problem is recognised and perceived. Agenda-setting is a selection process of diverse problems and issues, thus not all existing problems receive the same level of attention. Birkland (2007) explores how policy problems get on the government's agenda, and why other problems are excluded from the agenda, often creating political tensions due to conflict between competing actors who try to raise attention to particular issues. Adding to this, Howlett et al. (2009) point out that the mechanisms of setting problems into a formal political agenda are highly contingent, depending on a number of interacting factors, such as the policy environment and ideology. This implies that agenda-setting is far from a rational selection of issues, and that decision-making results from a bargaining process between diverse actors, the results of which are determined by the arrangement and power resources of the involved actors. Once the problems have been selected, alternatives for action are then formulated, followed by final adoption (the formal decision to take on the policy). During the implementation stage, there is no guarantee that action on the ground will strictly follow the policy-makers' aims and objectives (Hill & Hupe 2009).

Fischer et al. (2007a) argues that the intended outcomes of policy-making are to, at least, contribute to the reduction of problems, and assessment against intended objectives is part of the evaluation stage. As a result, policies and their intentions will often be changed, and their execution delayed or even blocked. Policies can be executed based on two major criteria. The first is due to a scarcity of resources,

including a lack of political support, while the second is due to the unclear spread of competencies between different actors (Howlett et al. 2009).

Mental health problems and the policy agenda

As mentioned above, the mechanisms for the setting of problems into a formal political agenda are highly dependent on multiple interacting factors, such as the policy environment and ideology, coupled with the complexity of political tensions between competing policy actors. Concerns about citizen participation and human rights protection of mental health service users has led the new mental health policy directions (Hazelton 2005). Mental health has not yet been given the priority it deserves in the global public policy agenda. The WHO (2008b) declares that mental illness has been a neglected element both in developed and developing nations. The developed world prioritises diseases that cause early death, such as cancer and heart disease, whereas developing countries tend to give priority to infectious disease and reproductive and child health. Patel (2007) argues that mental disorders are given the least attention globally on account of their low contribution to mortality.

Policy has an undeniable social dimension; this means that what is perceived as a problem in mental health policy is tied to specific social, political, and ideological contexts (Fischer et al. 2007a). Whether a policy problem is really a problem or not is an important part of the political and policy debate. The policy actors must persuade others that the problem exists or that the problem being cited is the real problem. Mental health problems in the context of public policy are often thrown into the 'too difficult to solve' category and thus are categorised as 'wicked' problems (Hannigan

& Coffey 2011, p. 225). Considering these 'wicked' policy problems that are not easily solved, mental health policies often have the following characteristics: the problems are not well defined; the solutions cannot be proven to be effective before implementation; no solution is guaranteed to achieve the intended outcomes; the efficacy of the solution is difficult to measure (Hannigan & Coffey 2011).

Mental health problems are not easily defined. Bacchi (2009) argues that a health concept is 'an abstract label'; it can be defined variously by different sources and thus can be hypothetically contested. The binary concepts of 'mental health-illness' or 'normality-abnormality' can be interpreted in different ways across cultures, and can be understood as cases of socially-constructed binaries that have changed over time (Rogers & Pilgrim 2010). Historically, the walls of the asylum have been a clear boundary to differentiate between the person with mental illness and the healthy, but today the limit of abnormality has changed in line with advances in psycho-pharmacology (Rose 2006). The shift to community care is viewed as part of the process of normalisation of the mentally ill to be part of daily community life, and that they should remain in the community, and be kept socially integrated including participating in work or vocational services and social activities (Brown et al. 1994).

A case study conducted by Aviram et al. (2007) reveals that getting mental health problems onto the policy agenda and into agenda setting processes is hampered by conflicts of interest and risk avoidance by major policy actors. These major risks are related to the inability to predict future demand for ambulatory services, uncertainty about future costs, and disagreements about the reliability and validity of data. Lack of a strong political commitment and a coalition supporting the reform, a financial

crisis in the health system, and social turmoil create a climate far from conducive to generating public interest in mental health reform. These findings tie back to Hannigan and Coffey's wicked problems, and the recognition that mental health is a wicked problem, and that it is impossible to cover every problem (Primm & Clark 1996). Primm and Clark (1996) further note that the issues underlying the problematisation of mental health are infinitely more complex than the solutions suggested in most public policies.

People with mental illnesses are vulnerable to abuse of their human rights, with the mentally ill being commonly labelled as the 'denied citizen' (Freshwater & Westwood 2006). People with mental illnesses have had only limited opportunities to participate in mental health services other than as passive recipients of health care (Browne & Hemsley 2008, Davidson et al. 2006). The raising of social inclusion and participation for the person with mental illness as key principles of mental health reform in the policy agenda is a contested topic. Studies from Australia, the United States, the UK, Canada, and Norway reveal that community participation is already endorsed in their government policies. However, in reality, it is evident that consumers are still battling to deal with tokenistic approaches (Bennetts et al. 2011, Elstad & Eide 2009, Grant 2007, Kidd et al. 2007, Robert et al. 2003, Tobin et al. 2002). It has also been shown that the attitudes of mental health professionals towards initiatives to enhance participation in health care remain variable (McCann et al. 2008). Rutter et al. (2004) conducted a study identifying health professionals' lack of willingness to work with individuals with mental illness who behave inappropriately or disruptively in professional settings. Due to the nature of mental illness, there are

times when people with mental illness are not fully in control of their behaviour, especially during their more acute phases. This was found to be one of the barriers towards active participation for the person with mental illness. Elstad and Eide (2009) studied people with mental illness and identified that they have low self-confidence and feel anxious about taking an active role in discussions and meetings. The existing research signals that in order to be actively and fully involved, people with mental illnesses have to fulfil what are quite often very high expectations for participation, the raising of issues, and attendance. However, because of the nature of mental illness, there is no guarantee that this is always possible.

Given this context which makes it difficult to have the full involvement of people living with mental illness, how can policy-makers ensure that community participation remains at the core of the policy development process? This is highly problematic as the policy process is not simply about linking a solution to a problem in a straightforward manner.

Mental health policy development

Mental health policy is defined as 'the official statement of a government conveying an organised set of values, principles, objectives and areas for action to improve the mental health of a population' (WHO 2011a, p. 17). Based on the Mental Health Atlas (2011) report, approximately 60% of countries have dedicated mental health policies, with the highest percentage in high-income countries, accounting for 77.1%, and the lowest in low-income countries (48.7%). Mental health policies are essential tools for increasing the availability, accessibility, affordability, effectiveness, and quality of

mental health care and services. The overall mental health care system is extremely complex, comprising many different agencies that inevitably interact with people with mental illness. Moreover, if mental health was integrated into general health services, this would mean that mental health policy would be incorporated into the overall national health policy, including the general health sector reform strategy. The WHO (2011b) states that national policy, plans, and programs are necessary in order to give mental health a high priority and to organise resources efficiently. Mental health policy does not automatically translate into adequate delivery of mental health services at the local level. Provinces, districts, and municipal levels can develop their own plans and programs in order to respond to specific local issues, in compliance with national policy objectives, strategies, and priorities.

Draper et al. (2009) conducted a policy analysis on the content of mental health policy and its development in South Africa. They found that the process of mental health policy implementation is hindered by the low priority given to mental health, varying levels of seniority of provincial mental health coordinators, limited staff for policy and planning, varying technical capacity at the provincial and national levels, and reluctance by some provincial authorities to accept responsibility for driving implementation. As the WHO (2011b) highlights, the construction of a national mental health policy takes one to two years for development, and five to ten years for implementation and to achieve change.

A step-by-step guide for mental health policy development has recently been published by the WHO (Figure 2.2). The first step is to gather information and data about the mental health needs of the population. The next step is to gather evidence

for effective strategies by visiting local services and reviewing the national and international literature. The third activity is to undertake consultation and negotiation to develop technical actions and resources. Exchange with other countries is the fourth step to learn about both the latest advances in more developed countries and about the creative experiences and lower-cost interventions in less developed countries. The fifth stage is to develop the vision, values, principles, and objectives. The sixth and final phase is the translation of the objectives of the mental health policy into areas for action and to identify the major roles and responsibilities of the different sectors (WHO 2011b).

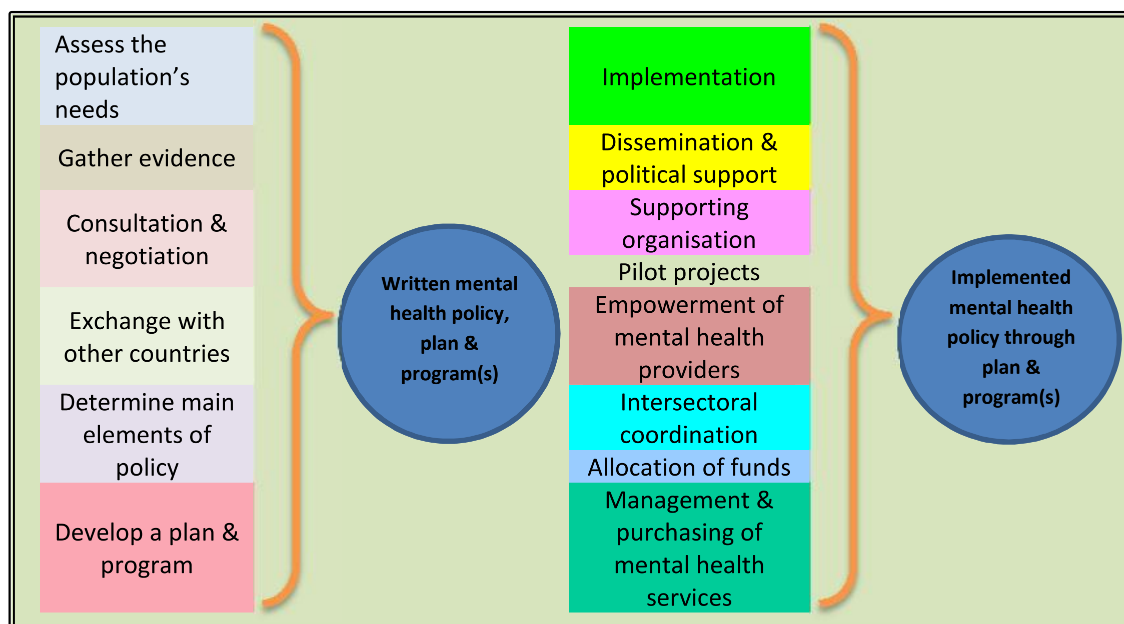


Figure 2.2 Developing and Implementing mental health policy model (WHO 2011b, p. 18)

The WHO recommends eight key points of mental health policy implementation, namely, dissemination and political support, support for organisations, pilot projects,

empowerment of mental health providers, intersectoral coordination, allocation of funds, management and purchasing of mental health services, and regulation.

Policy transfer

The WHO published the above model recently to target the 40% of countries that do not have mental health policies. This set of guidelines was developed by the WHO based on a collection of experiences from member countries that have been through the policy process by learning from the successes and failures experienced by each of them. Evan and Davies (1999) argue that it has been well-documented in the literature that policy-makers appear to be increasingly looking to other country's political systems for knowledge and ideas about institutions, programs, and policies, and about how they work in other jurisdictions. Taking for granted that no nation in the world can isolate its economy from global economic pressures and technological advances has made it easier for policy-makers to communicate with each other, to copy 'foreign' models, or to adopt what is regarded as 'best practice' elsewhere. This is not uncommon, especially if a government is searching for a quick fix to an urgent problem (Dolowitz & Marsh 2000). This process is known as 'policy transfer' which can be defined as:

> 'A process in which knowledge about policies, administrative arrangements, and institutions in one time and/ or place is used in the development of policies, administrative arrangements, and institutions in another time and/ or place' (Evans 2004, p. 10).

Globalisation and technological advances have provided a stimulus to the borrowing of policies and 'best practices' between and within countries (Dolowitz & Marsh 2000, Turbin 2001). Although policy transfer has been proven to lack an analytical

framework that would have an impact on understandings as it requires knowledge acquisition and utilisation, it provides a way of dealing with a problem quickly and at low cost (Newmark 2002, Wolman & Page 2002).

In developed countries, policy transfer has been a rational choice in evidence-based policy-making, but not in developing countries. However, in developing countries, international donors (e.g. developed countries who fund health reform in many economically unstable countries, or international organisations) are very powerful to influence policy change. International organisations are regarded as catalysts fostering the exchange and transfer of policy ideas, solutions, and problem perceptions between governments and beyond (Fischer et al. 2007a).

A study conducted in Bosnia Herzegovina and Kosovo reveals that foreign influence and the involvement of local stakeholders are needed to achieve sustainable mental health reform (De Vries & Klazinga 2006). Foreign influence has a stimulating effect on the initiation of mental health reforms, yet it can threaten the sustainability of mental health reform owing to a lack of local ownership of the new concept of community mental health and mental health care, many overlapping short-term mental health programs, and rapid change in health care systems.

A case study from Iraq shows that the Substance Abuse and Mental Health Services Administration (SAMHSA) and the WHO have been the primary facilitators in the reform of the mental health system since 2003 (Hamid & Everett 2007). The WHO's influence facilitated the adoption of the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) which includes six domains: the policy and legislative

framework, mental health services, mental health in primary care, human resources, public education and links to other sectors, and monitoring and research.

Mbatia and Jenkins (2010) conducted a study on mental health reform in Tanzania. The policy process was initiated and funded by the United Kingdom Department for International Development, and the WHO Collaborating Centre. The objective of the collaborative project was to: include mental health issues in relevant health policy instruments, offer treatment at the primary care level, have stronger referral and intersectoral coordination, and focus on rehabilitation and public education. They revealed that although successful in the short-term, initiatives funded by international donors are often discontinued and fail to disseminate sustainably across the country after donor funding comes to an end. In order to make programs sustainable, according to the study, there was an urgent need for a strong commitment from the national government for further decentralisation of mental health services in each of the local governments (Mbatia & Jenkins 2010).

This section has demonstrated the issues surrounding the policy process coupled with the 'wicked' mental health problems. The significance for my research is that numerous barriers exist, from the public policy perspective, to move persons with mental illness out of restrictive hospital settings and into community-based services. Although initiatives supporting greater participation for the person with mental illness in health care have been enacted in public policy, as seen in a number of Western countries, based on the evidence, the outcomes have not appeared to be satisfactory. Considering the strong knot of international influence around the development of mental health reform policy, particularly in the developing world, without the

acknowledgement of local contexts, it is unlikely that such reforms will be successfully implemented given the fact that mental health problems are tied into the nation's distinctive social-political contexts. The following section discusses the significance of policy analysis in mental health reform.

2.6 Policy analysis and mental health reform

Policy analysis

Dunn (1981) proposed the following definition of policy analysis: 'An applied social science discipline which uses multiple methods of inquiry and arguments to produce and transform policy-relevant information that may be utilised in political settings to resolve policy problems' (Fischer 2003, p. 1). Policy analysis explores how the interests, values, and beliefs of different actors shape policies, how problems are defined, how agendas are set, and how policy is formulated and re-formulated, implemented, and evaluated (Gilson & Raphaely 2008). The book 'The Policy Orientation', edited in 1951 by Lasswell and Lerner, marked a turning point in the history of policy analysis. Lasswell emphasised the role of 'knowledge *in* and *of* the policy process' as a fundamental principle in creating an applied social science. Later, in 1976, Rein called for a value-critical policy analysis that recognised the central role of social values, including the importance of taking seriously narrative story-telling about policy problems as opposed to a technocratic policy analysis that applies empirical technical methodologies, such as cost-benefit analyses and risk assessments (Fischer 2003). Social scholars argue that decision-making comprises a more complex process involving interaction and conflict resolution within and between actors.

Moving from this general perspective, analysis of the policy process involves an understanding of a complex social process (Birkland 2007).

There are a number of varieties of policy analysis, in general however, policy analysis can be divided into two major fields, analysis *of* policy to further understand policy, and analysis *for* policy to improve the quality of policy (Hill 2009, Hogwood & Gunn 1984). The origin of this classification can be traced back to Lasswell's depiction of policy sciences in which he proposes knowledge *of* the policy process and knowledge *in* the policy process. Analysis *of* policy (knowledge *of* the policy, known as 'policy studies') is pure, problem-oriented, and prescriptive, whereas analysis *for* policy (knowledge *in* the policy process, known as 'policy analysis') is applied, descriptive, and analytical (Gordon et al. 1993, Hogwood & Gunn 1984). Gordon et al. (1993) include policy advocacy, information for policy, and policy monitoring and evaluation as parts of a policy analysis typology. The current study is categorised as analysis *for* policy, specifically 'policy advocacy' for two reasons: the study is making an argument for a particular policy, and it makes recommendations that are aimed at policy-makers. Further, cutting across the distinction between 'analysis of' and 'analysis for' policy, are concerns with ends and means, together with authors who are concerned about both, but are not happy about separating them in this way. For this reason, in most of the policy research literature, these two approaches have not explicitly been separated as analysis 'of' or 'for' policy research, but rather were both regarded as policy analysis.

The discipline of policy studies has undergone a shift of perspective, from a focus on traditional government to one on collaborative governance. As Hill (2009, p. 3) points

out, public policy analysis stresses the extent to which government needs to be seen as governance. Governance is defined as 'the arrangements that societies agree upon between civil society, business, and government to address issues that are of collective interests, to solve problems or to create and draw on benefit' (Butterworth & Duhl 2011, p. 273). Governance theories have been increasingly used in policy research as these provide a valuable insight into the causal links between public choice processes, public management, service delivery, and citizen and stakeholder assessments and reactions (Robichau & Lynn 2009). Understanding governance involves a complex and continuous process of interpretation, conflict, and activity that produces ever-changing patterns of rule (Bevir 2010). In this sense, the best way to understand the notion of policy is by asking about its sources and how it operates, or in other words as Bacchi (2009) implies, by analysing how governing (governance) takes place and what the implications are for those who are governed.

Governmentality is influenced by Foucault's work which provides a framework for analyses of governance policy and practice. The governmentality approach is a tool to develop our understanding of the social and political conditions that shape contemporary world politics (Weidner 2009). Governmentality thus consists of capturing the way governments and other actors draw on knowledge to make policies that regulate and create subjectivities. As Colebatch (2002) argues, policy studies investigate the governments' way of thinking, what they do, and why they do it. Thus, the key assumption is that governments are to be understood in relation to how they coerce power in the process of deciding upon their courses of action. Colebatch further points out that governmentality seeks to interrogate problems and

problematisations. Problems do not exist in themselves. As part of the policy process, the ways in which situations come to be seen as 'problems' is an important part of this persuasive process and is important in the choice of solutions. Bacchi (2000) encapsulates policy as 'discourse' in which policy analysis is performed as a plan to identify 'constraints on change'. Put simply, discourse shapes the way issues are problematised into a conceptual framework that describes social processes.

Health reforms and policy analysis

Health sector reforms around the globe are politically problematic. Regardless of their level of economic development, all countries share the same goals of finding the best ways of organising to promote equity, effectiveness, and efficiency in health care. Frenk (1994) proposes four different drivers that have led to health sector reforms, namely, economic (a response to the devastating effects of economic crisis); political (the increased social pressure in demanding more from the health care system), ideological (for instance, conservatives versus liberals), and epidemiological (increases in morbidity and mortality). The prominence of health sector reforms in developing countries, as Cassels (1995) described, is grounded on three aspects: scarce resources are used inefficiently, people cannot access the health care they need, and services do not respond to what the people want.

Frenk (1994) claims that during the reform process, many developing countries struggle with an unclear direction of change, and they experience a 'double trouble' situation as they are still combating pre-existing chronic problems which require more resources and a simultaneous burden of new emerging problems. Getting reform onto the political agenda does not happen easily; change means dealing with conflicting

priorities, politics, processes, and power, and often, the most powerful health sector actors are satisfied with the status quo (Frenk 1994). Policy analysis is useful to inform strategic approaches for achieving such change and to implement change strategies. As well, it is important for understanding that the processes through which ideas, knowledge, interests, power, and institutions in decision-making are primarily concerned with public policy analysis (Gilson & Raphaely 2008). Policy analysis offers a comprehensive framework for thinking about health reform to understand the factors influencing the effectiveness of policy change. It is a well-established discipline in the developed world, yet its application in LMICs appears to be quite limited.

The most commonly used framework for health policy analysis in the LMICs is Walt and Gilson's analytical approach (Gilson & Raphaely 2008). Walt and Gilson (1994) provide a simple analytical model (Figure 3) that incorporates the concepts of context, process, actors, and content. The alternative frameworks are primarily focused on the content of health reforms, rather than on the process, which is more likely to be the reason why such policy implementation fails (Gilson et al. 2008). First, the context is the setting within which interventions are facilitated; it therefore shapes and is shaped by external stimuli such as policy. Second, 'policy is a process, as well as a product'; it draws attention to the course of action over time. Third, content refers to the object of policy and policy analysis and may be divided into technical and institutional policies. Finally, actors are individuals and members of interest groups or professional associations who are involved in the interplay of interests in negotiations and compromise.

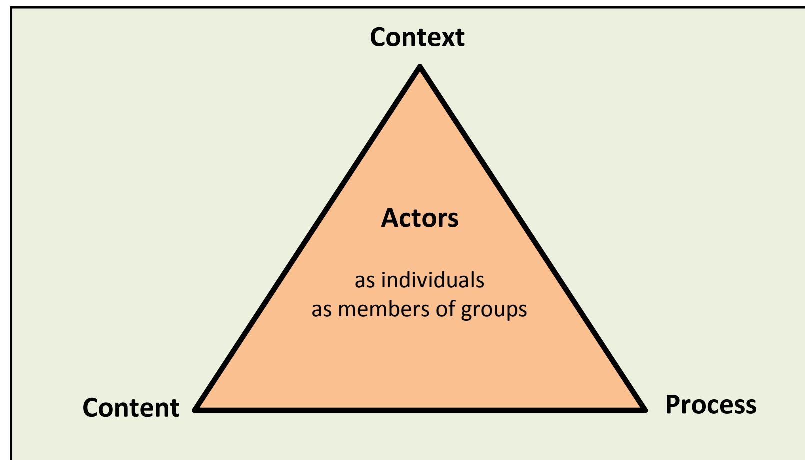


Figure 2.3 Analytical model for health reform policy analysis in LMICs

In reality, the interconnection among the dimensions can be explained as follows: actors are influenced (as individuals and members of interest groups or professional associations) by the context within which they live and work at both the macro-government level and the micro-institutional level. The context is affected by many factors such as the instability or uncertainty created by changes in the political regime or war; by neo-liberal or socialist ideology; or by historical experience and culture. The process of policy-making (how issues get onto the policy agenda, how they fare once there), in turn, is affected by actors, their position in power structures, and their own values and expectations. The content of policy reflects some or all of the above dimensions, including the objectives and aims, assumptions, values, and distributional impacts. Considering that policy analysis has been very limited in LMICs, this research is the first policy analysis on mental health reform conducted in Indonesia.

Summary

Through engagement with the literature in this chapter, I have pointed out the debates in the literature and identified problems remaining to be solved in relation to mental

health reform policy. I have also underpinned the framework that is used for conducting this research based on the key issues that are essential for conducting health reform policy analysis, particularly in developing countries.

In the first part of this chapter, the recognition of mental health as a public health priority, and the influence of the 'new public health' movement on mental health reforms were discussed. This is important ground upon which to support an understanding that mental health problems have moved beyond bio-medical issues, which is also influential in the shift of mental health services from being hospital- to community-based. The second part of this review discussed the contextual differences between mental health reforms in the developed world and in LMICs. It is evident that the drivers behind mental health reforms in western countries originated from a complex mix of a strong, radical grass-roots movement, coupled with advances in psycho-pharmacological therapies and other evidence-based initiatives, whereas in the developing world, there were no strong needs that emerged from the grass-roots, in fact, most influence has come from international agencies, such as the WHO. The third section identified that the process of developing and implementing mental health policy is mainly political. In order to move from a hospital- and physician-based tradition to a coordinated system with greater emphasis on community-based mental health care, mental health policy must be incorporated into the overall national health policy, including the general health sector reform strategy.

Considering the significance of Walt and Gilson's framework for conducting health reform policy analysis specifically in developing countries, their framework is used as a tool in my research for both data collection purposes as well as for the data analysis.

This framework has also led to the development of the specific aims for understanding mental health reform in Indonesia by exploring bureaucrats' perceptions of mental health reform policy content and process, as well as policy actors' roles relevant to mental health reform in the West Java context. In the following section, I will develop the study design and introduce the research approach, as well as the research methods used to gather the data using Walt and Gilson's framework.

Chapter 3: Research design

Introduction

In the previous chapter, I reviewed the relevant literature to provide background information and a justification of the research question. In this chapter, I describe the research design and methodology, which includes the research approach and methods, describe who participated and how they were selected, and also describe how the data were collected and analysed. This chapter is divided into four sections: (1) the research paradigm, where the interpretive stance for this study is justified; (2) the research methodology, which details why a case study approach is applied in this research; (3) the research methods, which describes the research design and covers the reasons for selecting the study site, sample, data sources, and data collection and analysis; and (4) quality and ethics, which covers how the quality of the research is elaborated in this study, the limitations, and an exploration of the ethical issues raised in, and by, this study.

3.1 The research paradigm

The rules and standards that guide a researcher's actions and beliefs in conducting research are generally referred to as a paradigm. Weaver and Olson (2006, p. 460) define research paradigms as 'patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished'. In order to clarify the structure of inquiry and

methodological choices, I discuss the research paradigm adopted for this study and how it informs the methodology and methods used in this thesis.

Over the last half century, a new research paradigm known as interpretivism has emerged to break away from the constraints imposed by positivist approach (Creswell 2005). The positivist paradigm, which uses hypothetical-deductive generalisations as its language of research, is based on a belief of a single truth, an objective reality that can be measured to construct truth, and therefore, that the result is independent and relatively outside of the control of the researcher (Crossan 2003). The paradigm places emphasis on the analysis of information using statistical analysis (Creswell 2005). This approach has limitations for use in the social sciences, as the complexity of the social world and the uniqueness of individual interpretation cannot be explained in just a few words or simplified by numbers (Denzin & Lincoln 2008b). Although deductive reasoning can still be used as part of the interpretive paradigm, a purely deductive approach alone does not account for the subjectivity of experience and subsequent analysis or explanation.

In this study, such inflexible principles associated with the positivism paradigm, based on rigid rules of logic and measurement, truth, absolute principles, and prediction (Weaver & Olson 2006), do not have the capacity to accommodate the investigatory aspects of this study that deal with the social and human experience. The interpretive paradigm, which supports the view that there are many truths and multiple realities, and which focuses on the holistic perspective of the person in the context of their social environment, is more congruent with the purpose of exploring bureaucrats' understandings in this study.

In shaping how the world can be viewed through the interpretive paradigm, Denzin and Lincoln (2008a) stipulate three principles, combining beliefs about ontology (the nature of reality), epistemology (the relationship between the researcher and the knowledge), and methodology (how to gain knowledge). The ultimate ontological standpoint is that truth or reality is no longer seen as a rigid entity owing to changes in phenomena over time, and how those phenomena are related to context (Crossan 2003). Thus, reality is multiple, subjective, and socially constructed by individuals. The epidemiological stance on the interpretive approach is that knowledge of reality gained through social construction focuses on the complexity of human sense-making as each situation emerges. Therefore, for the interpretivist, social phenomena must be understood in the social contexts in which they are constructed and reproduced through actions (Crossan 2003).

This study utilises the interpretive-constructionist paradigm to explore West Java bureaucrats' understandings of the Indonesian mental health reform policy. As these bureaucrats are the national policy implementers at the West Java province government level, their interpretations about mental health reform policy are constructed within their day-to-day working contexts, where they apply their interpretations towards the national policy to real actions and programs. To address the complexity of the different aspects of the situation in West Java, qualitative methodology is applied. This is the first study to explore Indonesian mental health reform. Qualitative research is used to describe and interpret phenomena about which little is known (Johnson & Onwuegbuzie 2004, Redmond et al. 2000). The

researchers interact with those being researched, resulting in deeper understandings of the meaning of people's experiences (Denzin & Lincoln 1994).

The social constructionist and interpretivist approaches structure qualitative research in particular ways. Qualitative research aims to elicit the contextualised nature of experience and action, and to generate analyses from the point of view of the people being studied. The most cited qualitative research definition is that it is:

> '… multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them' (Denzin & Lincoln 1994, p. 2).

Popay (2003) states that qualitative research transforms the world into a series of representations to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Accordingly, qualitative research aims to understand the meanings and experiences of people's lives and social worlds.

The focus of this study is on the Indonesian mental health reform policy. As discussed earlier in the literature review chapter, policy analysis is no longer grounded solely in the pragmatic-technocratic approach. Policy analysis was traditionally part of a rational planning and decision-making approach in the sense that it identified cost efficiencies and effectiveness, and risk assessment, for long-term necessity and feasibility (Fischer et al. 2007a). The interpretive philosophical approach was introduced into the field of policy analysis by Yanow (2000) to complement prior quantitative policy analytical techniques. The political science scholars argue that decision-making comprises a more complex process involving interaction and conflict

resolution within and between multiple actors which cannot be simplified by a pragmatic-technocratic approach (Fischer et al. 2007a).

The realisation that empirical technocratic policy analysis has lacked a sophisticated understanding of socio-political interrelations has led the post-empiricists to emphasise that public policy and politics need to be understood through socially interpreted understandings, and their meanings (Yanow 2007). Yanow (2000, p. 8) points out that 'interpretive approaches explore not only "what" specific policies mean, but also "how" they mean - through what processes policy meanings are communicated and who their intended audiences are, as well as what context-specific meanings these and other "readers" make of policy artefact'. Yanow (2000) goes on to say that:

> '… interpretative policy [implementation] analysis shifts the discussion from values as a set of costs, benefits, and choice points to a focus on values, beliefs, and feelings as set of meanings, and from a view of human behaviour as, ideally, instrumentally and technically rational to human action as expressive (of meaning)' (as cited in Pülzl & Treib 2007, p. 99).

A constructionist ontological stance assumes that policy is the product of social processes (Starks & Brown 2007, Yanow 1993). Thus interpretive-constructivist policy researchers place a strong emphasis on better understanding the world through first-hand experience and truthful reporting of actual conversations from insiders' perspectives (Yanow & Schwartz-Shea 2006). They employ one or more of three methods for gathering, accessing, and generating data: interviewing in a conversational mode, observing with whatever degree of participation, and the close reading of topic-relevant documents (Yanow 2000). The data collection methods used in this study are further detailed in the research methods section.

The interpretive approach has been selected for this study to identify subjective meanings and to transform them into a series of representations to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Guided by the interpretivist epistemology which views the world as constructed, interpreted, and experienced by people in their interactions with each other and with wider social systems, the focus of the interpretive-constructivist approach in this study lies on the interpretation of meaning passed on by policy actors, in this case, West Java bureaucrats. The research philosophy underpinning this study is interpretive which is based on the presupposition that mental health reform policy has the possibility of multiple interpretations, and that it is worthwhile exploring the meanings and interpretations that policy actors give to their understandings and actions.

3.2 Research methodology

In the developing world, it is evident that the outcomes of health reforms are largely determined by how bureaucratic agencies, public officials, and administrative routines respond to change (Cassels 1995). This present study is intended to understand mental health reform policy implementation which is embedded in a web of subjective meaning shaped by the bureaucrats working in West Java Province, Indonesia. As mentioned in the previous chapter, case studies were widely used in the existing research on policy analysis (Gilson & Raphaely 2008). This section highlights the significance of why a case study is used as the research strategy in this study.

Case studies are commonly used in qualitative research, although they can also be used as a method of inquiry employing a positivist epistemology and ontology (Stake

2008). Stake (2008) states that case study research is a choice of what is to be studied, with the researcher choosing to study *the case* regardless of the methods. Therefore, a case study is defined by interest in an individual case, rather than the methods of inquiry used. A case may be simple or complex, and may draw attention to the question of what specifically can be learned about a single case. As it only concentrates on one particular case or a single observation point to study a social issue or phenomenon, it has been criticised for two main reasons: the lack of representativeness, and a lack of rigour which is linked to the problem of bias, such as the subjectivity of the researcher (Hamel et al. 1993). These criticisms are not exclusive to case studies, as they are also the most conspicuous problems in any qualitative inquiry.

The most cited definition of the case study approach is proposed by Yin (2009, p. 17), as 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context especially when the boundaries between phenomenon and context are not clearly evident'. This implies that the case study approach is particularly useful in situations where contextual conditions surrounding the event being studied are critical, when the researcher has little control over events, and when 'how' or 'why' questions are being posed (Yin 2009). Case studies have long been used in organisational studies in the social science disciplines of sociology, industrial relations, and anthropology (Glick et al. 1990). Berg (1968) explains why case studies are suitable for, and sometimes the only method for organisational research. These are that they allow for the study of a particular piece of the puzzle that can provide insight into a huge complex system; organisational theory is still in the exploratory stage,

therefore the possibilities and value of carrying out investigations are limited; and some significant research objects and occurrences are rarely available, or are difficult to reach, for the researcher. West Java Psychiatric Hospital (WJPH) which is one of the research sites under investigation in this study, is a public organisation owned by the West Java Provincial Government (WJPG). It is best to apply case studies to capture a complex system of organisation, as Berg (1968) points out that applying case studies in organisational research allows the researcher to explore components of the complicated reality in which executives and other employers work.

The 'case' in this study is 'the mental health reform in West Java'. This study focuses on West Java province as a window into Indonesian mental health reform for the reason that, firstly, West Java is the most populous province in Indonesia with the highest prevalence of mental disorders (20%), and secondly, mental health reform is underway in West Java, and finally, I am a WJPG bureaucrat and have been part of the reform process. Thus, I am familiar with the problematic issues surrounding the mental health reform challenges. The specific interest of this study is the implementation stage of the national mental health reform policy at the provincial level. Pülzl and Treib (2007) claim that policy analysis rarely applies the whole policy cycle framework as an analytical model to guide the selection of questions and variables. To gain a better understanding of the policy process, policy scholars have increasingly turned their attention to the action of the implementers or lower-level actors, who are known as 'street-level bureaucrats' (Hill 2009).

Research on the implementation stage is perceived as a 'missing link' study in policy analysis (Fischer et al. 2007a). Although implementation of policies is not recognised

as a separate stage within, or element of, the policy process, focusing on the implementation stage is beneficial to a better understanding of the prerequisites, elements, and consequences of the policy process. Traditionally, policy implementation analysis is based on an implicit top-down perspective. A more contemporary approach focuses on the interaction between policy-related activities at different levels (local, regional, national, and international) and arenas (governmental, parliamentary, administrative, and scientific communities) of governance. In contrast to the top-down school where the implementation stage is seen as the hierarchical execution of centrally-defined policy intentions, the bottom-up camp sees local bureaucrats as the main actors in policy delivery and conceives of implementation as a negotiation process within networks of implementers (Fischer 2003).

Policy implementation is the most critical stage within the policy cycle as the action taken by provincial governments is not guaranteed to strictly follow the policy-makers' aims and objectives (Pülzl & Treib 2007). In other words, the actions are hardly ever perfectly controllable by policy objectives. In this light, a brief examination of what happens in the establishment of an apparent action as part of the WJPG's execution or enforcement of Indonesia mental health reform policy will be undertaken.

3.3 Research methods

A case study employs one or more of three methods for gathering, accessing, or generating data: interviewing in a conversational mode, observing with whatever

degree of participation, and the close reading of topic-relevant documents (Yin 2009). Using different data sources for case studies produces complementary data (Yin 2009). This study uses two data gathering methods: interviews and evidentiary material from relevant policy documents.

The primary data comes from interviews, especially with legislators and agency executives who are seen as playing a role in the shaping of policy. The interviews aim to understand how those who the researcher is talking to make sense of their lived experiences (Sadovnik 2007). Individual interviews are aimed at exploring rich, detailed, 'thick' descriptions of phenomena by encouraging provincial government officials to speak freely and understand the researcher's quest for insight into a phenomenon that the participant has experienced.

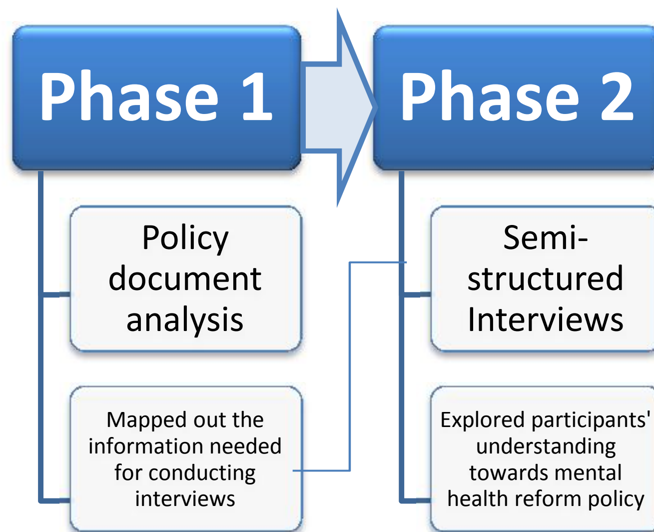


Figure 3.1 Phase 1 and phase 2 of data collection methods

The secondary source of interpretive data is gathered from policy documents. By examining policy documents, I was able to analyse the ways in which policy-makers'

or decision-makers' embedding of ideas about particular problems reflected and shaped mental health reform and policy intentions (Sadovnik 2007). This secondary data collection was conducted as the first phase of this study before conducting interviews for phase two, the primary data collection phase (Figure 3.1).

3.3.1. Phase 1 Document analysis

The purpose of the policy document analysis is to specifically target the policy documents that allow one to see the path of policy development over the decade (or so), and also to be able to clearly pull out the policy aims and objectives which represent the intentions of government. This is achieved through asking particular questions related to the content part of Walt and Gilson's framework, with the intention of formulating an interview schedule that would delve into the success of these government aims, objectives, and intentions. The development of the interview schedule, with the aim of eliciting such information, can only arrive at this through developing questions around content. Information about barriers, enablers, ethics, values, actors and so on, can only come from the informants, in response to the content. Therefore, the content part of Walt and Gilson's framework was used to construct the interview schedule with the aim of eliciting these other forms of information and knowledge about the mental health policy environment in Indonesia. As Walt and Gilson (1994) suggest, in the public health policy sphere, policy does not just consist of national strategy but also how it gets implemented by related stakeholders, and how it is put into practice on the ground by health care professionals, patients, and the wider community who are the object of the policy change. The understanding of policy document content is presented as a means of

addressing a number of issues in order to explore more about other overarching aspects in relation to policy implementation at the local level in West Java.

Documents that are classified as policy for analysis in this study include laws, and government decrees and regulations related to mental health reform issues. These documents were gathered initially by conducting web searches using keywords, both in English and Bahasa, an Indonesia language, such as: ‘mental health’, ‘policy’, and ‘Indonesia’, and secondly, by asking key informants during the interviews in particular, any related documents that they referred to as national and provincial policies.

The selection of documents

Three categories of policy documents were used in the analysis (Table 3.1). The primary documents were policy documents which outline policy for specific issues related to mental health and mental health reform. The policy documents included in the second category set the general policy for health. Under the third category are documents published by the West Java Provincial Government supporting national policies and the implementation of mental health reforms. All of these relevant policy documents were elaborated upon and discussed in conjunction with the findings from the interviews in Chapter 5.

Table 3.1 Policy documents related to Indonesian mental health

Category	Policy documents
1	▪ The 1897 Dutch Mental Health Law *Het Reglement op het Krankzinnigenwezenof.* ▪ The Mental Health Act of 1966 ▪ The 2001 National Mental Health Policy ▪ The 2002 Decree of the Ministry of Health ▪ The 2009 Decree of the Ministry of Health Republic Indonesia: Guidelines of Community Mental Health Implementation
2	▪ The 1945 Constitution of the Republic of Indonesia and Amendments to the Constitution ▪ The Health Law No. 23/1992 ▪ The Health Law 36/2009
3	▪ The Governor's Decree ▪ The West Java Development Plan 2008-2013 ▪ The WJPH Performance Annual Report

The documents used in this study are readily available from Indonesian government websites and official reports. Therefore, there was no ethics procedure required for accessing such documents. In this study, however, basic ethical considerations have been taken into account. For example, as Daly et al. (1997) claims, acknowledging the sources of data used is essential when analysing policy documents.

Sampling

The Indonesian government has endorsed a number of significant efforts to improve the mental health service system and to transform it into a more comprehensive and integrated community-based service in line with the 2001 National Mental Health Policy (MoH 2001). I used this policy document as the primary source of information for generating a number of key ideas for developing the interview guide in relation to the national mental health reform policy. A brief policy document analysis was essential as the first phase in this study to generate a summary description of the

mental health reform policy aims and objectives. The analysis of the remaining documents is elaborated upon in the discussion chapter.

3.3.2 Phase 2 Interviews

Yin (2009) sheds light on the importance of interviews as an essential source of information for a case study, because most case studies are about human affairs. He further points out that the strengths of conducting interviews for data collection are that they are 'targeted – focus[ing] on the case study topic' and 'insightful – provid[ing] perceived causal inferences'. Individual interviews are aimed at attaining rich and detailed, or 'thick descriptions', of phenomena by encouraging provincial government officials to speak freely and understand the researcher's quest for insight into a phenomenon that the participant has experienced.

This study used the in-depth interview method. In-depth interviewing entails asking questions, listening to and recording the answers, and then posing additional questions to clarify or expand on a particular issue (Patton 1990). Questions are open-ended and respondents are encouraged to express their own perceptions in their own words. In-depth interviewing aims to understand the beneficiaries' view of a program, and their terminology and judgments. There are three basic approaches to in-depth interviewing that differ mainly in the extent to which the interview questions are determined and standardized beforehand: the informal conversational interview; the semi-structured interview; and the standardized open-ended interview (Patton 1990).

In this study, the semi-structured interview was guided by questions that focused on policy content, the structural context, the policy actors, and the processes of decision-making (Table 3.2). Semi-structured interviews involve the preparation of an interview guide that lists a pre-determined set of questions or issues that are to be explored during the interview (Brinkmann 2009). Semi-structured interviewing is the best suited method for this study as it reflects an ontological position that is concerned with people's knowledge, understandings, interpretations, experiences, and interactions (Mason 2004). Although it is designed to focus on particular issues, there is no fixed range of responses to each question, thus it is very much a free-flowing two-way dialogue between the interviewer and the interviewee (Ayres 2008). The interview guide serves as a checklist during the interview and ensures that the same basic information is obtained from each person. Yet, there is a great deal of flexibility.

Table 3.2 Interview questions

Interview questions
▪ How do you know about the National Mental Health (NMH) policy on transforming mental health system? ▪ In your opinion what is mental health reform? ▪ What do you think about the key purposes of the reform? ▪ In your opinion what initiatives are needed to facilitate the reform? ▪ How do you think the reasons why our mental health system needs to be reformed? ▪ How do you think about problems with our current mental health system? ▪ How do you perceive the integrative system or community-based mental health as stated in the NMH policy? ▪ Do you think you have the influence over the reform initiatives? ▪ How well does the mental health reform address the wider needs of people? ▪ Who do you think was involved in the process of developing the NMH policy? ▪ How were they involved? ▪ How did mental health reform get into their agenda?

- **Who wants the MH reform?**
- **What do they want from it?**
- **Where do you think the influences come from?**
- **How do you perceive any changes happened in West Java MH system responding to the NMH policy?**
- **What do you think the responsibility and role of the governments in MHR are?**
- **What process is followed to implement mental health policies in the province? Is there any provincial mental health policy related to MHR? How is it related to the NMH policy?**
- **How do you think this reform will make mental health system more effective and better in West Java?**
- **What do you think will happen if West Java MH system does not change?**
- **How do you think about the constraints on reforming mental health system in West Java?**
- **What are the facilitators to the changes in West Java?**
- **How important is this reform for you?**
- **How do you relate the reform to your professional role?**

Language issues need to be taken into consideration, as these can impede the nature of the interviews (Liamputtong 2009). In order to facilitate a more free-flowing interview, it needed to be conducted in the Indonesian language as well as in Sundanese, a local language from West Java province. I speak both fluently. During the data collection process, I made field notes to remember and record the behaviours, activities, events, and other features related to the interviews. In these notes, I recorded all my thoughts, ideas, questions, and concerns as I was making my interpretations during the interviews. These were used as a supplement to the interview data, as Patton (1990) pointed out that field notes are intended to be read by the researcher to produce meaning and an understanding of the culture, social situation, or phenomenon being studied.

Sampling

Bureaucrats working at the WJPH are positioned as policy implementers for the policy-makers in the central government. Policy implementation consists of the everyday problem-solving strategies of street-level bureaucrats (Pülzl & Treib 2007). The theory about street-level bureaucracy, proposed by Lipsky (2010), highlights the dilemmas faced by street-level bureaucrats in implementing public policy. Within a public organisation, there are two groups of bureaucrats, the managers and the professionals. In the WJPH, the health professionals are situated as street-level bureaucrats who interact directly with citizens, who are, according to Lipsky (2010), often obliged to treat all citizens alike in their claims on government and, at the same time, to be responsive to the individual case when appropriate.

Lipsky's (2010) theory informed the selection of the key informants for this study, combining both groups, the managers and the health professionals in order to obtain a complete picture. It is expected that health professionals would have more knowledge than managers in terms of mental health care, however in this study, as the process of decision-making is complex, which stems from the interplay between power, knowledge, and values among actors, the managers are regarded as also having good knowledge of the mental health reforms. The perspectives of the managers are considered to be equal in value to the expert knowledge of health professionals. When this equal knowledge partnership is recognised, this has the potential to raise a wide range of key policy issues for consideration (Horsburgh 2003).

There is no gold standard for determining sample size in a qualitative study; what normally happens is that qualitative researchers seek to acquire profound information about a smaller number of people and cases (Marshall 1996, Patton 2002). Luborsky & Rubinstein (1995) point out that, in a qualitative study, the research participants are considered to be carriers and makers of meaning, which are more highly valued than such aspects as the size and diversity of the sample. They further specify that 'in practice, from 12 to 26 people in each study cell seems just about right to most authors' (p. 105). An appropriate sample size for a qualitative study can, however, be indicated through data saturation, when new categories, themes, or explanations cease to emerge from the data (Marshall 1996).

The primary source of data for the study was the face-to-face interviews. The interview participants were managers and health professionals who were selected according to their responsibilities in decision-making within West Java Province. All key informants were recruited from the WJPH. Of the 576 total employees in the WJPH, 42 of them are managers, 238 health professionals, and the remaining are administrative staff. For the interview phase, purposive or judgemental sampling was used. This is the best sampling design for the study objectives based on the judgement of the researcher when it comes to selecting the participants. This involved the researcher making a conscious decision about which individuals and which sites would best provide the desired information (Marshall 1996). In the Indonesian civil service system, employees are grouped into structural and functional positions. Structural positions are line management positions in the administration, whereas functional positions are career positions linked to specific professions. The health

professionals involved in this study were classified as being in functional positions e.g. medical doctors including psychiatrists and general practitioners, psychologists, nurses, social workers, and public health practitioners. In this way, it was expected that a comprehensive list of 20 participants comprising 10 managers (structural positions), and 10 health professionals (functional positions) were involved in the individual interviews.

Participant recruitment can be particularly challenging when the intended study participants are in a health care setting; this is due to the providers' time and workload constraints, lack of interest in the research topic, or ambivalence about the value and applicability of the research (Broyles et al. 2011). Successful recruitment of participants in health care settings is critically dependent on initial contacts made with the key administrative officer, who in this study was the Director, from a particular recruitment site (Patel et al. 2003). Establishing collaboration with the director of the WJPH in the recruitment process helped me to save time by avoiding unproductive visits to less-than-enthusiastic potential participants. Moreover, the Director is often an ideal collaborator in a recruitment process as they know exactly which participant positions, and their associated roles in the organisation, are the best fit with the inclusion criteria for the study.

By doing this, there was a potential risk; the participants may have felt obligated to participate in the study. To minimise the possibility of coercion, participants should be capable of choosing freely; they must do so voluntarily, willingly, without duress, and without being subjected to threats or the promise of a reward (Patel et al. 2003). Prior to the interviews, an information sheet was provided and consent forms were

voluntarily signed by the participants confirming their approval. Adequate time was also provided for the appointed participants to comprehend and give feedback (i.e. between the initiation and completion of the consent process).

Interviews

Twenty participants were appointed by the Director of WJPH. A letter displaying the appointees was then released to me by the WJPH Education and Training Unit. Equipped with this letter, I contacted the participants individually. I travelled to Bandung, West Java to conduct the interviews in person. I contacted them initially by phone and then made an appointment to meet them to explain the details of their involvement in the study, and to distribute the information pack. The participants were also given some time to think about their participation. Nineteen appointees were willing to participate after the information session, so these people were followed up to set up a time and place for the interview. One appointee was not sure whether she would be able to provide adequate information to answer the research questions and, on this basis, decided not to participate. Table 3.3 displays the participants' personal and professional characteristics.

Considering the length of time needed for the interview and their workload approaching the end of the year, many appointments were rescheduled. 10 interviews were conducted between November and December 2012, and the remaining 10 participants were interviewed in January and February 2013. The Director suggested a replacement for the participant who was not willing to be interviewed, yet I needed to wait until this person had finished her three months training in January 2013. The replacement agreed to participate and was then interviewed in February 2013, which

overall accounted for the total of 20 participants. An equal number of participants, 10 managers and 10 health professionals, were involved in this study as planned.

Table 3.3 Participants' profile

No	Position	Sex	Year of Birth	Years of Working	Highest Qualif	Years since highest Qualif	Time of Interview	Place of Interview	Length of Interview (h:m:s)
1	Structural	M	1965	27	Masters	3	Nov 12	Bandung	01:45:25
2	Structural	F	1962	31	Masters	3	Nov 12	Cimahi	01:29:47
3	Functional	F	1971	15	Masters	8	Nov 12	Cimahi	01:33:24
4	Functional	F	1967	22	Bachelor	6	Nov 12	Cimahi	01:06:23
5	Functional	F	1983	4	Bachelor	7	Nov 12	Cimahi	01:17:25
6	Functional	M	1976	12	Bachelor	5	Dec 12	Cimahi	01:29:22
7	Functional	F	1973	13	Masters	4	Dec 12	Cimahi	01:27:32
8	Structural	F	1964	26	Masters	5	Dec 12	Cimahi	02:10:47
9	Functional	F	1976	3	Bachelor	13	Dec 12	Cimahi	01:56:25
10	Functional	M	1980	13	Bachelor	2	Dec 12	Cimahi	01:29:58
11	Structural	F	1964	22	Masters	12	Jan 13	Bandung	01:09:35
12	Structural	M	1959	24	Masters	7	Jan 13	Cimahi	01:30:53
13	Structural	F	1966	6	Masters	7	Jan 13	Cimahi	01:15:05
14	Structural	F	1968	17	Masters	7	Jan 13	Cimahi	01:27:31
15	Functional	F	1966	21	Masters	5	Jan 13	Cimahi	02:18:33
16	Functional	F	1954	28	Doctorate	10	Jan 13	Bandung	01:08:08
17	Functional	F	1982	4	Bachelor	6	Jan 13	Bandung	01:17:54
18	Structural	F	1968	16	Masters	6	Feb 13	Bandung	01:11:41
19	Structural	M	1962	23	Masters	11	Feb 13	Bandung	03:32:49
20	Structural	M	1963	22	Masters	12	Feb 13	Bandung	02:55:17
								Total	33:33:54

There was some diversity in the composition of participants in this study, in terms of type of role, sex, age, highest qualification, and length of working (Table 3.3). The participants were aged between 29 and 58 with the majority of them being females and post-graduates. The duration of employment since their first placement as public servants varied from 3 to 31 years. The WJPH is headquartered in Cisarua, West Bandung Regency, and most of the interviews took place in the head office, while the remainders were conducted in Bandung, in a brand new building called Grha Atma, which is envisioned to be a community mental health center owned by the WJPH.

3.3.3 Data analysis

Data analysis is a complex and contested part of the qualitative research process. The information obtained from the interviews provides a basis upon which to carry out in-depth analysis. The recordings of the interviews were transcribed into written form so that they could be studied in detail, linked with analytic notes, and coded. Transcriptions need to be very detailed to capture every feature of the interview. Transcription involves close observation of data through repeated careful listening as an important first step in data analysis (Bailey 2008).

Unlike statistical data analysis, there are few formulae to guide how the researcher analyses case study interview data (Yin 2009). Walt and Gilson's framework shaped my data collection method, and therefore was also used in parallel to present and analyse the data in Chapter 4. The total duration of the 20 interviews was 33 hours and 34 minutes, producing 'thick' in-depth data. Familiarity with the data and attention to what is actually there can facilitate realisations or ideas which emerge during analysis, thus I conducted the entire process of transcribing, including translating the interviews into English. All the interviews were transcribed in full, and then repeatedly read, in order to gain a sense of the whole.

As I transcribed and translated all the interviews, a back-translation process was necessary to achieve rigour in the qualitative data. Brislin (1970) defines back-translation as 'translating from the target language (e.g. English) back to the source language (e.g. Indonesian) and the equivalence between source and target versions can be evaluated' (as cited in Chen & Boore 2009, p. 235). The back-translator should

be knowledgeable about both the original and the target language, truly bilingual and familiar with the area under study in the source materials (Chen & Boore 2009). One of my PhD candidate colleagues, who is from West Java and is also conducting policy research in West Java, was the back-translator for this study. The entire process of back-translation was approved by the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University.

A thematic analysis was used to interpret this large amount of data. Boyatzis (1998, p.1) defines thematic analysis as 'a way of seeing', interpreting a pattern or theme from the text and eventually incorporating it into the context of a theory or conceptual framework. Thematic analysis, which is driven by both theoretical assumptions and the research questions, provides a flexible method of data analysis (Braun & Clarke 2006).

The process of data analysis occurs in two primary ways: a deductive top-down theory-driven approach and an inductive bottom-up data-driven approach. A deductive approach means that the form of analysis is limited to preconceived frames, whereas in an inductive approach, the themes identified are strongly linked to the data which means that the process of coding occurs without trying to fit the data into a pre-existing model or framework. In this study, guided by an interpretive epistemology, I used both deductive and inductive approaches. Fereday & Muir-Cochrane (2006) outline a six step procedure for this hybrid approach using NVivo. These steps are: developing a coding manual, testing the reliability of the code, summarizing the data and identifying the initial themes, applying a template for the codes and additional coding, connecting the codes and identifying themes, and corroborating and

legitimating the coded themes. These steps were modified in this study, as I opted for manual management and coding of the data using Microsoft Excel to assist with the interpretation.

Table 3.4 Emerging themes related to the research objectives

Objectives	Coding No.	Emerging themes
To identify their understandings of what mental health reform policy is	1	A paradigm shift in mental health services
To identify their peceptions on mental health reform objectives	2	Integrated care, graded care, multisector collaboration, community empowerment, multidisciplinary approach, social determinants, government responsibility, accessible services, and Desa Siaga (Alert Village)
To identify assumptions underpinning Indonesian mental health reform	3	Local and global influences
To identify their understandings about the policy formulation process	4	Top-down, institutional, and political process
To identify their perspectives on the expected impacts of mental health reform	5	Reducing health inequities, increased awareness of MH, early intervention recovery-model, an umbrella for Indonesia MH system, and better funding
To identify how policy is communicated to the West Java government	6	Lack of dissemination from the MoH, source of bureaucrats' knowledge from: professional conferences/ colleagues; college; internal meetings; and self-learning
To identify the need for implementing mental health reform in West Java	7	The most populous province, the highest prevalence, concerns about homeless psychotics, prevalent pasung practice
To identify obstacles to policy implementation in West Java	8	System, organisational, team, and individual levels
To identify who should be responsible for implementing the reform	9	The reform should not be shouldered alone
To identify what capacities are required for mental health reform in West Java	10	Individual, organisational, and system levels
Other	11	Due to dearth of data, themes that emerged from this coding category were not presented in Chapter 4

During the data analysis phase of this study, I first organised the data into a separate spreadsheet for each participant. The second step was to develop a coding manual to organise segments of similar or related text, which was developed from the research question and the aims and objectives, according to Walt and Gilson's framework. 10 broad coding categories, based on 10 objectives, formed the coding manual. The third stage was testing the reliability of the codes. During this phase, I worked closely with my supervisors to code the transcripts using the predefined codes. The results were

discussed, and no modifications to the predetermined coding template were required, however, adding a new code was deemed to be necessary. One new category (number 11), classified as 'other', was included to organise the remaining data that did not fit into the initial 10 categories (Table 3.4). Table 3.4 demonstrates how the themes link to the research objectives, which also implies that the findings have answered the research question for this study.

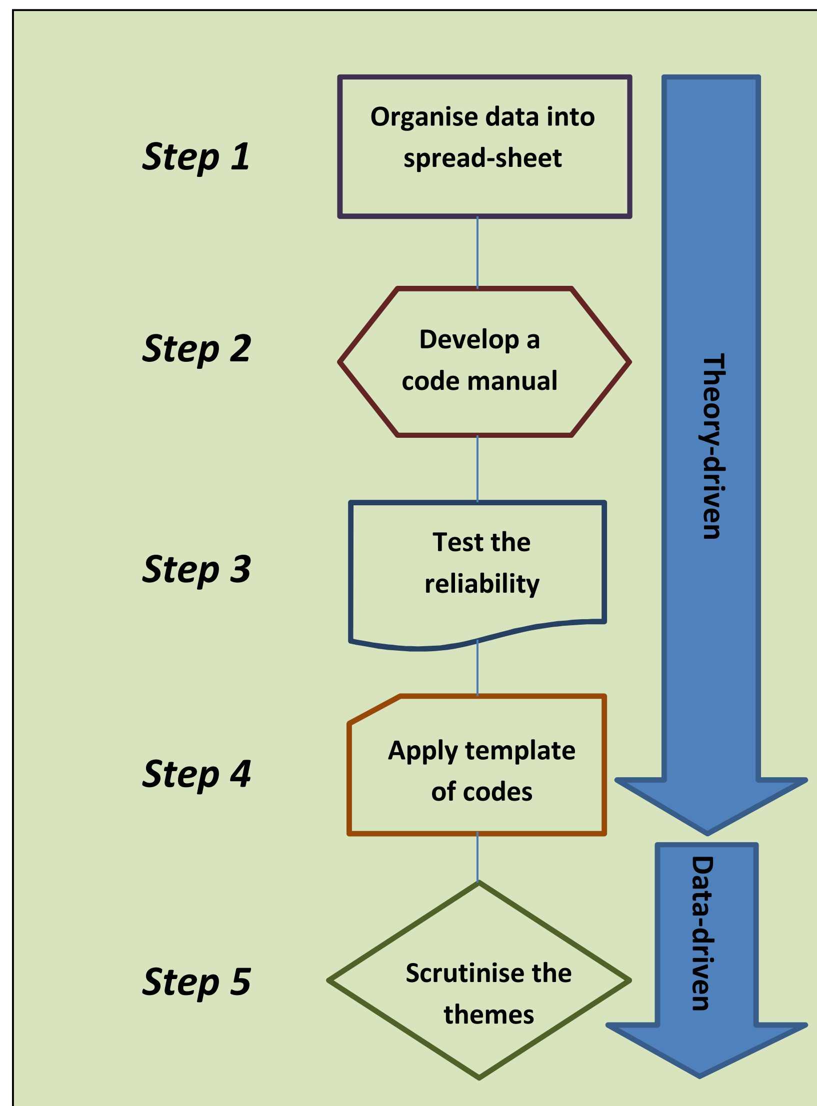


Figure 3.2 Data analysis process used in this study

The fourth step was to apply a template of the codes. In doing so, I applied the code numbers (1-11) to the text from each transcript for all participants. Until this stage, the process of analysis used a theory-driven approach, while the next stage applied a data-driven approach. The fifth step was to scrutinize the emerging themes that came from all units of text for each code number, and to sort out the data that did not fit. These emerging themes were then presented as the second order of subheadings in Chapter 4. Figure 3.2 illustrates the overall data analysis process followed in this study.

This step-by-step process of analysis is a method of demonstrating the transparency of how I formulated the overarching themes from the initial participant data. Although these stages of analysis may be considered to be a linear process that moves from preparation to reporting of results in a conceptual map, in practice, the analysis was carried out simultaneously at all stages in a backwards and forwards reiteration of data interpretation and analysis that enabled a continuous dialogue across the stages.

3.4 Quality and Ethics

3.4.1 The quality of the research

Unlike quantitative research where the researchers generally attempt to design, in advance, controls that will deal with both anticipated and unanticipated threats to validity, in qualitative research, rigour is more difficult to maintain, assess, and demonstrate. The issue of "quality" is part of a contested debate due to the nature of the knowledge produced by qualitative research. As Mays and Pope (2000, p. 51)

point out, ‘there are no mechanical or "easy" solutions to limit the likelihood that there will be errors in qualitative research’, however there are various ways of improving validity. Yanow and Schwartz-Shea (2006) proposed seven principles to improve the quality of research conducted based on the interpretive paradigm, which are grouped into ‘first-order’ and ‘second-order’ categories. The first-order principles include thick description, trustworthiness, reflexivity, and triangulation, whilst the second-order principles are informant feedback/ member checks, audit, and negative case analysis. These seven concepts are suggestive rather than definitive, and there is no consensus about the compulsion to use all seven concepts for assessing the quality of qualitative research.

‘Thick’ description refers to the presence in the research narrative of sufficient detail of an event, setting, person, or interaction to capture context-specific nuances of meaning (Yanow & Schwartz-Shea 2006). In other words, the researcher’s interpretation is supported by ‘thickly descriptive’ evidentiary data. This principle is in use in this study through clarity about the research setting, the participants, and the in-depth data collected from the participants. In interpreting and analysing the data, I also conducted historical or documentary analysis, as Yanow and Schwartz-Shea (2006) claim that the use of such analysis is important to obtain a nuanced portrait of the cultural layers supporting the researcher’s thick interpretation.

Research needs to be seen as trustworthy. Trustworthiness is ‘a way to talk about the many steps that researchers take throughout the research process to ensure that their efforts are self-consciously deliberate, transparent, and ethical’ (Yanow & Schwartz-Shea 2006, p. 101). Trustworthiness was introduced by Lincoln and Guba (1985),

who outline four criteria to establish the trustworthiness of interpretive research; credibility, transferability, dependability, and confirmability (Baum 2008, Liamputtong 2009). Credibility means that the research results can be trusted. This principle is used in this study as the research findings have been verified through field notes, recordings, thematic logs, and/ or transcripts. Transferability is confirmed by a logical, step-by-step display of the data, together with a simultaneous literature review, to ensure that the findings can be applied to other similar groups and later studies. The process of the research, including the choice of methods, must be clearly presented in detail to fulfil the requirements of dependability, while the interpretation of data needs to be objective which leads to confirmability (Liamputtong 2009). These three principles are applied in this study, as detailed in this chapter.

The term ‘reflexivity’ has now moved beyond what Lincoln and Guba (1985) initially referred to as a ‘reflexive journal’, implying a kind of diary in which the researcher, on a daily basis or as needed, records a variety of information about the self and the method. Reflexivity is not just about keeping a reflective journal. Maxwell (2009) points out that being reflective means being clear about the relationship between the observer and the observed, which is confirmed by Denzin and Lincoln (2008a) as part of demonstrating rigour in qualitative research.

A reflective approach was adopted in this study to emphasise that I, as a researcher, am not only a neutral observer but also an integral part of the generation of the knowledge. As stated in the introduction chapter, in this study I have dual roles both as an insider and an outsider. While the exploration of knowledge or evidence in the field was strongly influenced by the ‘insider’ role, the ‘democratizing process’ of

pulling out the evidence from the findings to generate new insights is predisposed by the 'outsider' role. Combining both roles allows researchers to mobilize their findings to have academic value as well as practical relevance, particularly for knowledge generation purposes (Avenier & Cajaiba 2012).

In the health research arena, the insider and outsider perspectives are balanced in order 'to make the strange familiar' and 'the familiar strange' (Allen 2004). This is in line with Yanow's viewpoint (2000) stating that the outcome of an interpretive policy analysis is a balanced perspective between 'stranger-ness' and 'insider-ness' where the researcher is able to move back and forth between seeing things as they are and as they are not. The insider status provides a privileged understanding of 'the fundamentals of what was going on', a prior knowledge of where to gather data, and a sensitivity to changes in the practices of the research participants, whereas the 'outsider' status was needed to construct objective knowledge that relies on the degree to which researchers can detach themselves from the prejudices of the social groups they study (Allen 2004). Acknowledging these dual roles contributes further to the demonstration of rigour in this study (Rose & Webb 1998). In addition, working closely with my supervisors in the analysis stage was a way of ensuring that I could view the data as an outsider.

Triangulation is 'a methodological approach that contributes to validity of research results when multiple methods, sources, theories, and/or investigators are employed' (Farmer et al. 2006, p. 377). There are four types of triangulation techniques, methodological, data, theoretical, and investigator triangulation. In this study, methodological triangulation was employed by using more than one data collection

technique involving in-depth interviews and document analysis. Data triangulation was conducted through the use of multiple data sources or participant groups (i.e. managers and health professionals). In terms of theoretical triangulation, different theories were adopted in this study as theoretical lenses to view the research findings and discussion. The patterns of relationships and interactions between policy content, context, process, and actors were based on Walt and Gilson's theory. Walt and Gilson's theory has provided useful 'maps' of the policy system, however, in order to move away from this descriptive phase to more prescriptive outcomes, Laris and MacDougall's framework (2011) was applied , as shown in the discussion chapter, as their framework on public organisations in health care is well suited to the West Java case. The final technique is investigator triangulation which entails the involvement of two or more researchers in the analysis stage. In this study, the involvement of three supervisors in the analysis phase ensured significant investigator triangulation.

Quality in qualitative research is heavily dependent on the individual skills of the researcher and is easily influenced by the researcher's personal biases and idiosyncrasies (Patton 1990). It is clearly impossible to deal with all validity threats, thus the main concern in establishing rigour is not in eliminating all such problems, but in understanding how a particular researcher's values and background are utilised and how these influence the conduct and conclusions of the study (Yanow & Schwartz-Shea 2006).

3.4.2 Ethical considerations

Ethical principles were applied in this research, based on the consideration that every individual has to be respected for their own dignity, and that they have the right to self-determine their participation in the research (Miller & Boulton 2007). It is the obligation of the researcher to honour the concerns of a person regarding their desire to participate. Although social research, ‘research that is intended to develop generalizable knowledge about social phenomenon including health-related issues’ (Burgess 2007, p. 2284), has a lower magnitude of physical harm, it does carry potential psycho-social risks, such as the potential damage to reputations.

Informed consent is a reasonable approach to acknowledge the involvement of research participants in a study, however this does not mean that this voluntarily agreed upon document will guarantee that the participants will be free from risk. There are three principles underpinning universally acceptable ethical conduct: ‘respect for persons’ by means of justifying participants’ autonomy, anonymity, and confidentiality; ‘beneficence and non-maleficence’ through maximising benefits and minimising potential disadvantage; and ‘distributive justice’ which concerns equal opportunity for the participants (Marshall 2007). In this study, the participants were provided with informed consent forms, including a statement of these three principles. The forms were voluntarily signed which confirmed their approval. Before the study commenced, this research was approved by the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University, project number 5881, to ensure

that the study met the most rigorous ethical, health, and safety requirements required by the university.

Although there is no such ethics committee for research conducted in West Java, the study was also planned to satisfy the West Java Provincial Government procedures for conducting research, including obtaining formal permission letters. An informed consent form and an information sheet about the study were also prepared. The consent form stated that the participants are guaranteed certain rights, agree to be involved in the study, and acknowledge that their rights have been protected. During this study, the participants can withdraw at any time. The interviews took place at the informant's workplaces or in a setting nominated as being convenient for the interviewees. The anonymity of the participants was protected and the responses kept confidential. While conducting the individual interviews with the selected participants, they were assigned fictitious names for use in the transcripts, which were also used for reporting the results. Before gathering the data, the researcher sought approval from the Head of the West Java Government Agency by sending a formal letter. All important documents regarding this study were sent to each participant involved in the study, so that potential participants obtained a clear picture of the purpose of the study and the details of their participation.

Summary

In this chapter, the philosophical and theoretical assumptions underlying the research methodology were reviewed. In addition, a discussion of the research design for the study was conducted. A summary of the chapter is presented in Table 3.5.

Table 3.5 Summary of the research design

Research paradigm	Interpretive approach
Research methodology	Case study
Research methods	Document analysis and Interviews
Case study site	West Java, Indonesia (West Java Psychiatric hospital)
Sample	West Java bureaucrats (10 managers and 10 health professionals)
Data analysis	Thematic analysis – a hybrid (deductive-inductive) technique
Theoretical framework	Walt & Gilson (1994) for conducting data collection, presenting and analysing research findings Laris & MacDougall (2011) for discussion which led to the prescriptive references for West Java

The discussion of the research paradigm and methodology led to the two phases of data collection, the document analysis as the first phase and the second phase of interviews. The second phase findings are presented in the next chapter.

Chapter 4: Findings

Introduction

In this chapter, I explicate the research findings for this study under four major headings that have emerged from the data. The data are organised according to four broad components steered by Walt and Gilson's (1994) framework for health reform policy analysis detailing actors, content, process, and context as stated also in the aims of this study. Walt and Gilson's model is considered as the best fit framework for use in this study due to its particular emphasis on capturing the 'messiness' of the policy process, and making sense of the interrelationship between the content of policy, and the contextual factors interpreted by policy actors. The aims of this chapter are to explore bureaucrats' understandings of the mental health reform policy *content,* the Indonesian mental health reform policy *process*, the *context* of the current mental health reform in West Java, and the role of *actors* in the mental health reform.

As illustrated in Walt and Gilson's triangle model (Figure 4.1), the *actors* are placed inside the triangle emphasising the policy actors as the focus of attention. For this reason, the roles of actors will be discussed in the first section of this chapter. Understanding the interrelationship between different actors leads us to the complex web of mental health reform policy implementation in West Java. In the second section, bureaucrats' understandings about the *content* of national mental health reform policy will be presented. The third section, *process*, looks at a number of objectives that detail the assumptions underpinning Indonesian mental health reform, the significance of the reforms, and how the policy is developed and transferred. In

the final section, the *context* of policy implementation in West Java, including the need for implementing mental health reform, and a number of problems and challenges as perceived by the bureaucrats, will be discussed.

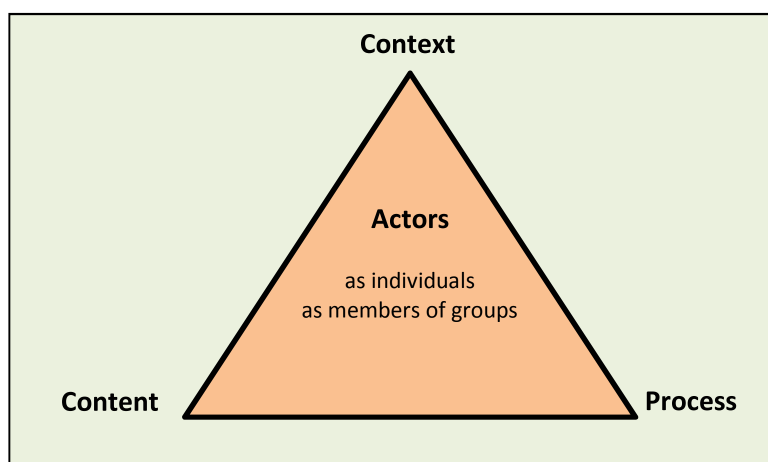


Figure 4.1 Walt and Gilson's triangle model (1994)

Throughout this chapter, the participants have been identified by their positions and by numbers associated with the quotations. Identification is also based on the Indonesian civil service system which groups employees' positions into two groups, *structural* and *functional*. Structural positions in this study are the heads of work units in the West Java Psychiatric Hospital (WJPH), whilst health professionals involved in this study were grouped as functional.

4.1 The roles of policy actors in West Java mental health reform

This section presents a description of how the participants place themselves within the national mental health reform policy networks, and how other relevant actors and

stakeholders' roles also contribute to policy implementation in West Java. The study participants' concerns about the roles of the different levels of government are clearly articulated in some of the interviews, as well as the idea that all levels of governments should play a role in mental health reform.

> *Mental health is the responsibility of all parties, governments and communities all together ... governments make policies, the government is also responsible for supervision, monitoring the continuation of the program ... (Functional-10)*

Figure 4.2 illustrates the role of each level of government, from the central government to local governments, as condensed from the interviews. The roles of the central government, in this case, the Ministry of Health (MoH) are those of being a policy-maker and a policy disseminator for local governments. The West Java Provincial Government (WJPG) is perceived as a coordinator of matters between districts (regencies and cities), and it is the district governments who are supposed to rule over the community mental health programs as they have the sole power and authority to plan, prioritise, and allocate resources for their people. A middle manager articulated these viewpoints:

> *'… the ministerial decrees are regulations that nationally bind … and become a legal base for regional and local agencies under that ministry ... there's regional autonomy, in which provincial and district governments should play an active role developing the implementation …' (Structural-1).*

The local governments are known as the 'executors' of national policy. Remembering that local government is made up of provincial and district government, the provincial government is the policy executor who facilitates the translation of the policy into programs, whilst the district government is the program executor where the policy

objectives are translated into actions to engage with the community in their jurisdictions.

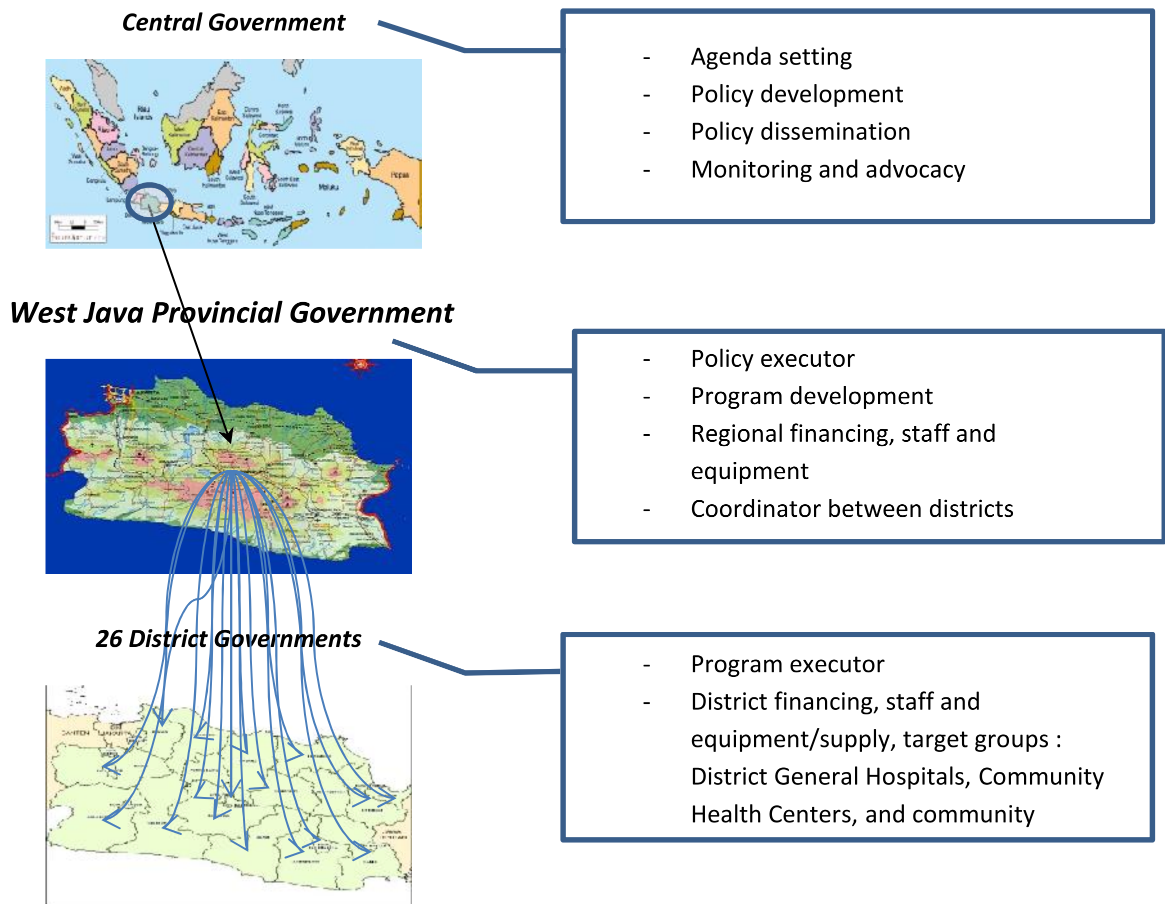


Figure 4.2 Different roles of governments as perceived by participants

4.1.1 The supervisory team for Indonesian mental health reform

From the West Java bureaucrats' perspective, mental health reform simply means a shift from hospital-based mental health services to community-based mental health care. How this change in perspective came about will be detailed in the next section. According to the participants, there is an ideal structure for organising mental health reform in Indonesia, a multi-sector supervisory team known as the TPKJM ('Tim Pembina Kesehatan Jiwa Masyarakat' - Community Mental Health Supervisory

Team). This supervisory team is based on the Ministerial Decree No. 220, signed by the Minister of Health in 2002. One functional commented on this, *'I think a team formation consisting of multi-sectorial agencies named TPKJM, we have that already, that's the ideal formation so far' (Functional-16).*

Figure 4.3 illustrates the appointed public organisations which are included in the membership of the TPKJM. The Directorate General of Public Health at the MoH is the coordinator in the central government, while the Regional and District Secretaries are responsible for organising community mental health at the peripheral local government levels.

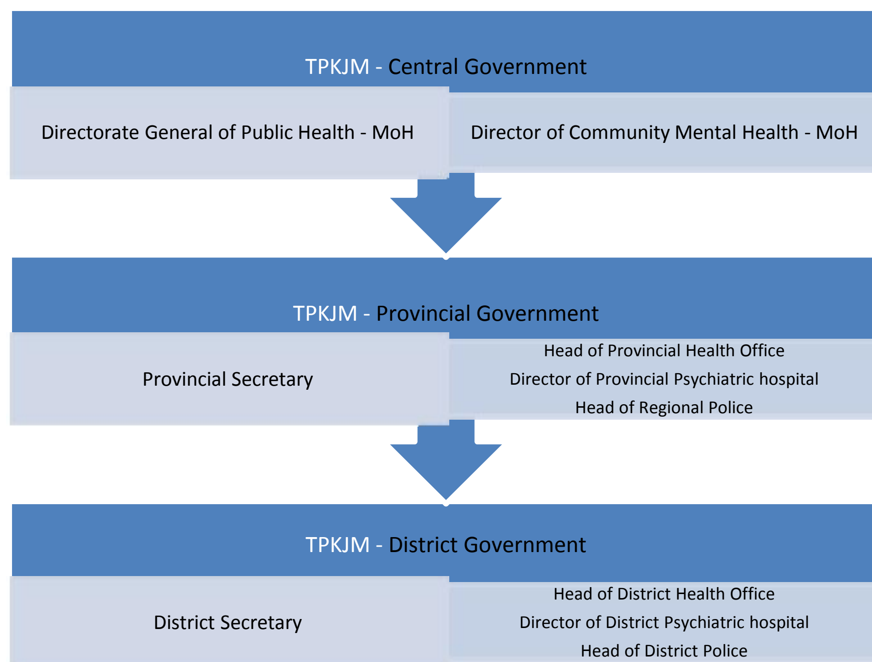


Figure 4.3 TPKJM organisational structure

In most of the interviews, the TPKJM is acknowledged as the best organisational structure for organising the reform, and the participants recognise that the TPKJM

policy was created long ago in 2002, however they question the existence of the TPKJM in the current period, with one functional seriously criticizing the provincial government for not doing anything, *'... the TPKJM structure is clear, it's a provincial government responsibility, I don't know where they are now, no-one acts as the initiator' (Functional-17).* Supporting this claim, a middle manager said:

> *'... actually the TPKJM concept is truly suitable, if it is executed right, it can be successful, but it's just a concept, sometimes even only on paper or it maybe no longer exists today ...' (Structural-11).*

This TPKJM aims to provide an overarching umbrella to establish the community mental health system implemented by the different levels of government, with their different targets. After the establishment of the TPKJM, the community mental health service was expected to be much better organised under the single direction of the supervisory team. The evidence shows that the TPKJM has not yet functioned as well as was initially expected.

4.1.2 Mental health reform should not be shouldered alone

The evidence from the interviews suggests that in West Java at present, the responsibility for mental health reform seems to be shouldered solely by the WJPH with no active involvement of other related agencies. This is due to the fact that all mental health funding allocated from the provincial budget is given to the WJPH. This means that the shift from a hospital-based to a more community-based system is entirely steered by the WJPH. Due to its function as a hospital which focuses on medical treatment, the WJPH had only limited capacity to network with other

responsible agencies, as mentioned by Structural-13, '… *as the hospital we cannot move freely ... that limits the expansion of its services to the public'*.

Within the provincial government, apart from the health office, mental health issues needs to be shared with other agencies such as the Social Office and the Social Service Bureau. *Structural-2* exemplifies this when referring to a community mental health issue related to homeless people with psychosis that needs to be tackled by other agencies as well:

> *'… would it be the health agency or the social agency or the social service bureau? We need to collaborate, for example, the social agency builds shelters, and we treat psychotic patients here in the hospital ...' (Structural-2).*

The findings about the various roles pursued by the agencies, leads to an incongruity in the role of the WJPH as the leading sector of community development programs. This view was expressed by Structural-19:

> *'If we are honest … this hospital is supposed to be a subsystem, only focusing on individual health, the leading sector for community mental health is the health office because they are responsible for public health affairs' (Structural-19).*

Apart from the networking issues with other agencies within the provincial government, the relationship between the WJPH and the MoH has also been problematic. Some participants also expressed concern about the lack of a 'nurturing' role from the central government towards the provincial governments. One senior structural participant provided an analogy, 'a parent-child relationship', depicting the expected relationships between the WJPH, the MoH, and the West Java Provincial Government (WJPG).

> *'… let me put it this way … the ministry is our mother, and the provincial government is our father, father gives us money, the ministry is our mother because she has given birth to us … all psychiatric hospitals in Indonesia, regardless of whether they are living with the father, are now still connected to the mother … although it's not easy to do so in reality' (Structural-19).*

Accordingly, as in an ideal family life, a mother, in this case the MoH, has more of a nurturing role. The mother (MoH) is more attuned to the child's (WJPH) specific needs than is the father (WJPG). *Structural-19* went on to say that the MoH should pay more attention to the process by monitoring the implementation, and that she should also provide feedback on whether or not the WJPH has fulfilled her expectations. Meanwhile, as a father, the WJPG tends to be more direct and is focused on technical and administrative issues, as he has given the children money to use. Interestingly, *Structural-19* expressed his concern that when the parenting styles are not blended effectively, the children can feel confused or conflicted with the different expectations of the mother and the father. Furthermore, the conflict can result in alienation, frustration, and depression, which is the type of malaise being felt within the WJPH at present. The WJPG is also perceived as having a lack of experience in managing hospitals, however this is also seen to benefit the WJPH as well:

> *'… the West Java government has no experience in dealing with organisations like a hospital, there are of course disadvantages for us, but if we look at the positive side, we are actually really benefiting, because whatever we ask of them, they always approve, especially for program funding' (Structural-19).*

In addition to the roles of public agencies, active involvement by the community also plays a crucial role in mental health reform. This viewpoint arose from an interview with *Functional-10, 'mental health is the responsibility of all parties, governments and communities all together'*. He further stated that mental health care needs to apply

the principle of: '*from the community, for the community, by the community',* although in practice implementing community participation as recommended in the policy is difficult. One senior functional mentioned that the barriers to the community's active involvement, in fact, come from health professionals.

> *'… frankly I am so confused. Why Pak Lili had to ask permission first just to give a talk about his experiences as a health cadre in another district … weird … we expect their active involvement in health care … but in fact, we hinder and complicate their active community participation … things are not that simple at the community level … contradictory … community participation is just the frill …' (Functional-16).*

Functional-16 goes on to suggest that an awareness raising program must first be implemented to target health professionals, in particular, those who work closely with the community in the CHCs.

This section highlights the different roles of the various levels of government towards the national mental health reform, as perceived by the study participants. From this standpoint, it is clear that there is an organising structure for achieving the desired changes in the mental health reform process in Indonesia. The participants acknowledge that mental health issues are the government's main responsibility. The reform process involves many parties, in consequence, consensus among the parties involved is required before the desired change can be achieved. In West Java, the reform process is perceived as being slow to progress due to a lack of compromise among the parties that it affects, thus it is felt that the reform has been organised solely by the WJPH. The findings suggest that mental health is everybody's business and that it cannot be shouldered alone, but must involve community participation as well. The next section will reveal further detail about the slow progress of reform

from the understandings of the policy actors toward the policy content, process, and context.

4.2 Bureaucrats' understandings of mental health reform policy content

In this section, policy content refers to the existing laws, regulations, and policies relating to Indonesian mental health reform. There is no uniformity in the responses that designate one specific policy regarding Indonesian mental health reform due to the absence of a national policy. Against this backdrop, the study participants had a range of perspectives about which policy is perceived to actually be a mental health reform policy, which in turn affected the way they interpreted it. There were, however, some related policies mentioned. The most common national policy related to mental health identified by the participants was Health Law No. 36/2009, a revised version of the 1992 Health Law. Although this policy was not referred to as a mental health reform policy, the principles contained therein were related to the general concept of change in the Indonesian mental health system, '... *mental health service delivery is specified in that law, basically that mental health services should be community-based' (Structural-1).*

Another participant stated that mental health policy has in fact existed for quite a long time, '… *the national policy on mental health is Mental Health Law No. 3/1966, and the new one, is now being discussed in IX Commission' (Functional-17).* Some of the participants stated that the existing laws do not mention in any detail what the Indonesian mental health system reform actually consists of, or how it operates, even

though the principles of change, transformation, and reform are detailed in the Health Ministry Regulation (*Permenkes 406/2009*). One participant commented that '... *it [Health Law 36/2009] doesn't say what community-based mental health service is … but in we can find it in detail in Permenkes 406 year 2009' (Structural-1).*

Due to the lack of a specific policy being acknowledged as the national mental health policy, one participant said that the MoH has never officially announced the reform policy, thus it is not known exactly when the reform had started in Indonesia, '*I've never heard of it, because to this day the transformation or mental health reform has not been announced officially' (Structural-11).* The bureaucrats' lack of awareness is influenced by their role in the organisation, '... *about reform policy and transformation of mental health, I honestly don't know, because I am grappling with the finance arena, so maybe I'm not following it' (Structural-12).* Although some participants are not aware of the existence of the mental health reform policy, they are able to explain the concept of mental health reform.

4.2.1 What is mental health reform?

The majority of participants agree that the content of the Indonesian mental health reform in question is a paradigm shift from the old to the new. Outlined in Figure 4.4 are the perceived shifts that serve as the fundamental principles of mental health reform along with a number of quotes to illustrate this.

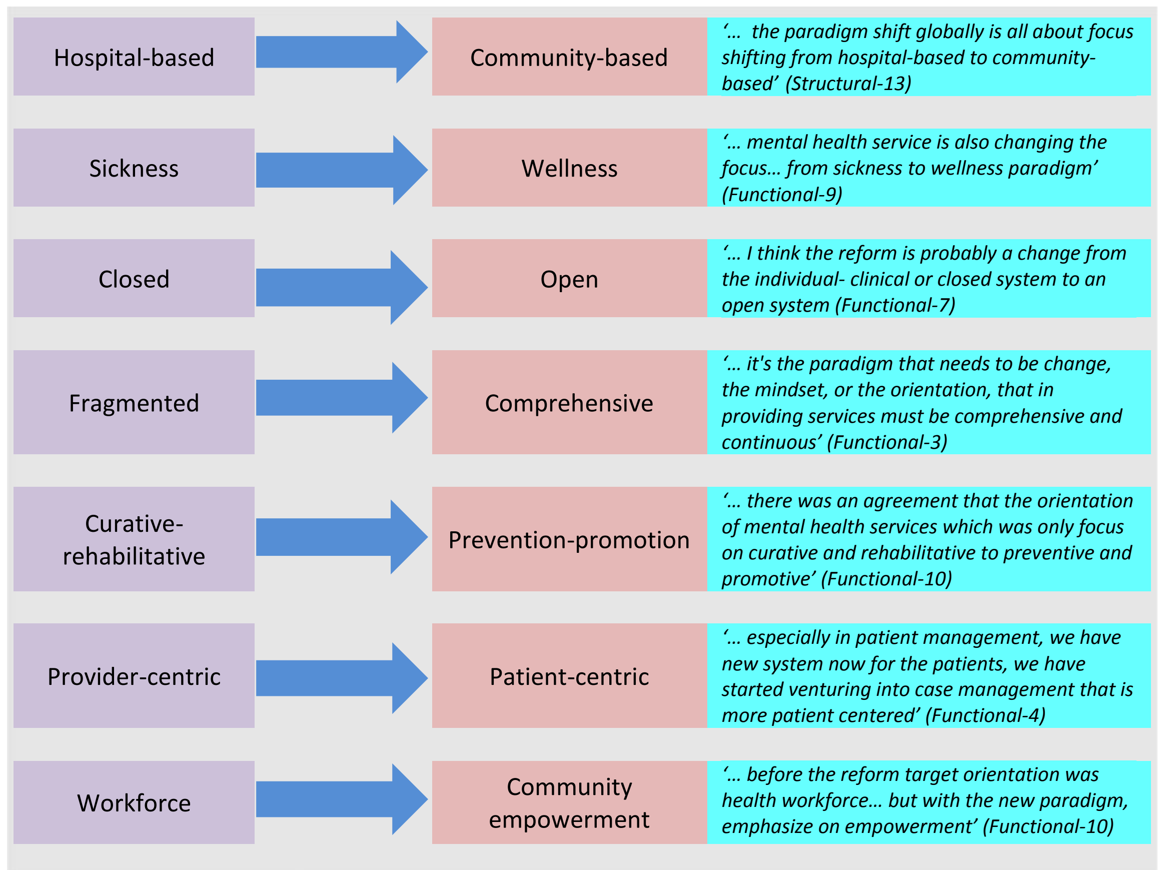


Figure 4.4 The paradigm shift in Indonesian mental health reform

In general, the shift is from a system that, in the past, was highly fragmented and provider-centric, with the hospital and the professional as the locus of control, to more patient-centered and community-based services. Most of the participants believe that the wellness movement places a greater emphasis on prevention, promotion, and comprehensive care. The target of system improvement does not merely focus on the sick, but also on '… *how to make the healthy stay healthy, and the sick more independent' (Structural-8)*. The suggestion here is that community mental health is a system that covers not only the mentally ill but also the health of the entire population.

In most of the interviews, the idea of reform is closely related to the community mental health movement, in fact the mental health reform is perceived as 'community mental health'. Various terms were used interchangeably for 'community mental health', in particular, by psychiatrists.

> *'… and also liaison psychiatry can be strengthened to support this community-based service … liaison psychiatry has been developing in recent years … become a hot topic now on our group website, we have a community psychiatry congress … so we have a special section in our professional organisation named community psychiatry section … it's been an emerging topic, we discuss things related to the development of community psychiatry' (Structural-13).*

As quoted above, they used terms such as 'community psychiatry', 'liaison psychiatry', or 'extra-mural psychiatry' during the interviews rather than using 'community mental health'. Thus, for them, mental health reform is linked to the development of community psychiatry in Indonesia.

4.2.2 Understanding of mental health reform objectives

There are different understandings among the participants about the reform policy objectives. The interview data demonstrate the ways in which the issues were finally identified, while the objectives that were set influenced the thinking on how the matter was to be dealt with. Figure 4.5 below describes the perceived objectives of mental health reform.

Figure 4.5 The perceived mental health reform objectives

There were nine ideas around the objectives of reform. Providing integrated and graded mental health care was among the perceived purposes of the reforms. According to *Structural-11*, '*integrated means that prevention, promotion, cure, and rehabilitation are an uninterrupted continuity*'. Adding to this, *Structural-13* mentioned that the purpose was to set up a system of graded care:

> *'… mental health services are provided as a system of graded services, starting from the lowest in the community, Puskesmas [Community Health Centre] … then up to district general hospitals, and the referral hospitals and at the top of the hierarchy is the psychiatric hospital … this strategy is effective to improve access … so in this way, people's needs can be fulfilled …' (Structural-13).*

Bringing health care closer to the home was identified as a way to improve access. Many participants ascertained that if the nearest community health centres were equipped with mental health care services, people would not have to go to a referral psychiatric hospital located in the capital city, often many miles away from their residences. Participants also recognised that another goal was the establishment of

multi-sector and multi-disciplinary collaborations, *'... to engage all the relevant sectors and to support each other through every layer of society'* (*Functional 3*). Another participant implied that '*the approach comes from a multi-disciplinary workforce'* (*Functional-5*). Community empowerment was also seen as an outcome of the reform to better maximize people's potentials. This was expressed as follows:

> *'... it's how we empower communities to collaboratively manage mental health, so we don't wait for them to come to psychiatric hospital or health care centers, but we are also as an officer in the center should be able to approach the community to see what potential there is in society that we can use to improve mental health' (Structural-11).*

The reform policy was interpreted as outlining both the local and central governments' responsibilities in providing community mental health services and facilitating community involvement. One of the strategies proposed in the reform policy was to form '*Desa Siaga'* [Village Alert]. The concept of *Desa Siaga* was clearly stated by *Functional-16*, '*… that in every village, people are actively involved in their own health care, so it's about active participation from the community',* whilst another participant emphasised that '… *the concept of 'Desa Siaga', health starts from the smallest unit of society, that includes mental health'* (*Functional-10*). The mental health reforms also highlight an increasing awareness that mental health is more than simply a medical issue, and that social factors are crucial to understanding the issue '… *we must consider other factors, most importantly social factors, mental disorder is not just a brain disorder, it's more complex than that' (Functional-10).*

> *'… we talk in a broader sense, which is not only focused on individuals who are sick, but on what is causing them to be sick, whether this is due to an unhealthy environment, or because of social conditions, a lack of knowledge, economic factors, and family and community factors' (Functional-17).*

In response to being asked what the objectives of mental health reform are, one functional argued that the essence of reform has been mistakenly implemented in practice. He further emphasised that community mental health is not simply any mental health care that goes on outside the walls of hospitals, and it is not just a transfer of mental health services that used to be provided in a psychiatric hospital to a Community Health Center (CHC), as he implied '… *but that's not Community Mental Health, it's just curative, a treatment that is transferred to the Community Health Center, hospital moves to CHC, it's a mini-hospital'* (*Functional-10*). He criticized the implementation of the integration program, where the psychiatrists from the psychiatric hospital go to the CHC once a month to examine the patients and give them medicine. Supposedly, he said, the task of the psychiatrists is to transfer their knowledge and skills to their colleagues who work at the CHC for mental health promotion and prevention, but not to examine patients. There is much conjecture around the direction of mental health reform, with some participants assuming that it is about 'closing down psychiatric hospitals'. The closing down issue is the reason for much of the debate, and in the process of being interpreted in a range of different ways, a number of conflicts of interest have emerged which will be further discussed in this chapter.

4.3 The Indonesian mental health reform policy process

This section outlines a way of looking at mental health policy development, starting from why such mental health reform is needed in Indonesia, to the way in which national policy is formulated and communicated to local governments. Some participants were not sure that their answers were particularly definitive, and many thought that they were not the appropriate person to be interviewed because they assumed that they are 'policy-implementers' who do not need to be acquainted with how mental health reform issues could become part of the national agenda. This was confirmed by one participant, '*... you should ask people working at the Ministry of Health ... not me' (Structural-13).* Many participants made it clear that their perceptions and understandings were primarily based on what they see in practice. It is understandable, considering their positions as local bureaucrats, that they are primarily preoccupied with the implementation process as part of their routine activities in the field. Thus, talking about what was going on in the policy process in the central government, in this case, the MoH, was apparently beyond their knowledge.

There were, however, a few people who thought that they were involved in the national policy-making process who had been invited by the MoH because of their expertise or due to their senior positions in the organisation, e.g. the director and vice-directors. An experienced participant, Functional-16, shared a story about how she became involved with the MoH because she was the only child and adolescent psychiatrist representing the West Java Government, '… *I was one of the writers for a book outlining the national guidelines for child and adolescent mental disorders; we*

also wrote other books on parenting skills, and child and adolescent mental health manuals'. The participants who had prior involvement with the MoH were more likely to be resourceful in answering a series of questions on national policy development. They tended to be more positive towards the relationship between the central government and the local government. The others were, to some extent, only speculating in giving replies to such questions, yet a number of diverse and interesting insights were expressed.

4.3.1 Assumptions underpinning Indonesian Mental Health Reform

The starting point for exploring participants' understandings of the policy process is to have a clear and detailed description of where the influences of reform come from and these are explored below.

Local influences

<u>Existing system failure</u>

Participants believe that the reform was prompted by the failure of the current system to tackle the complexity of mental health problems in Indonesia. The 'current system', which they refer to, is hospital-based care.

> *'… so they thought oh maybe it's time we should change yeah … to try a new approach because we've been running a hospital-based system for so long that cannot answer the mental health problems that developed in the field' (Functional-7).*
>
> *'... they found out that the number of mentally ill people is increasing … that the current system is no longer appropriate to deal with the complexity of the mental health problems in our society … the existing system did not work well … the results were not as expected' (Structural-13).*

The 'failure' in their frame of reference, was due to the existing service, at that time, being focused on fragmented medical care in the hospital system, at the same time neglecting the importance of the community in implementing care of the mentally ill, '… *treatment of mental disorders only focuses on the curative aspect, treating the sick who come to the hospital, and after being treated just saying goodbye' (Functional-3)*. A point made by a number of participants is that community involvement is 'a difficult thing' considering the cultural belief that make people, on the whole, act passively towards their own health care. A number of participants also discredited the government for their ignorance in facilitating such participation although they knew it was important. The government was also criticised for its unsuccessful efforts in providing accessible mental health care, stating that this '… *is as a result of the difficulty, or lack of success of the government in providing easy access for the public' (Functional-17).*

Scarce resources

There are three kinds of resources identified by the participants which are believed to be major driving forces for mental health reform, human resources, facilities, and funding. The shortage in the number of mental health professionals in Indonesia is primarily indicated by the limited number of psychiatrists. Psychiatrists are regarded as the most valuable resource within the mental health system, and the current paucity of psychiatrists across Indonesia is considered to be a major obstacle to providing care for people with mental disorders.

> *'… the number of psychiatrists compared to other specialists is not many … we have only around 700 psychiatrists in Indonesia … imagine only 700 psychiatrists for a population of more than 245 million (structural-20).*

Such thinking indicates a need to develop the capacity of other mental health professionals to deliver effective interventions to the community, '… *so psychiatrists deal only with severe cases ... mild cases can be handled by other health professionals' (Structural-1).* The indicator that is used to describe the scarcity of mental health facilities by the participants is the bed capacity available in psychiatric hospitals. This is exemplified by another participant:

> *'… because we cannot just rely on psychiatric hospitals; psychiatric hospital capacity is limited and people who come for treatment to a psychiatric hospital are chronic patients, the paradigm shift is expected to change this so that people are more aware of the signs and symptoms of mental disorders as early as possible, so they go to the nearest CHC before their mental illness get worse' (Structural-14).*

Financing is also perceived as a crucial building block of the mental health system. Without adequate financing, mental health policies remain only in the realm of good intentions. Structural-20 quantified the current budget allocations for mental health, stating that in terms of overall mental health spending, less than 1% of the government health budget (which is 10% of the overall national budget) is dedicated to mental health. For this reason, mental health reform is seen as essential to improving care.

Extent of the problem

Many participants consider that the magnitude of mental health problems in Indonesia led to the need for the national reform policy, as stated by *Structural-20*:

> *'… so what is underpinning this shift? My point of view is the magnitude of mental health problems in Indonesia …' (Structural-20).*

A number of participants talked about the prevalence and severity of mental illness, referring to the latest national survey *Riset Kesehatan Dasar* (Basic Health Research) by the MoH in 2007, as one of the prominent background documents for the reform. *Structural-20* confirmed that the national average for mental health problem prevalence was 11.6%. In addition to this, he further highlighted that '*30% of people who visited CHCs have mental and emotional problems',* meaning that '… *this is the core problem to be targeted by community mental health'*. Besides the prevalence data from the national survey, one participant raised a number of emerging social problems that are driving the reform:

> *'… the dynamic changes in our society nowadays are also influencing this service transformation, I mean people now are easily provoked by anger, crime rates are increasing, so they viewed the data, the evidence, the facts, and also the current issues in our society; all of this created the idea that the system needs to be fixed …' (Structural-13).*

Another participant thought that there was a supply and demand problem, '... *regulations are made due to the demands of the public or any problems that are found in the community so that the government facilitates the interests of community needs' (Structural-1).* This proposes that the policy was made to balance community demands and to determine what needs to be provided by government.

<u>Stigma</u>

The stigma of mental illness is comprehended as one of the most significant drivers of mental health reform. Participants assumed that the policymakers must have been

aware of this factor when they were identifying the issues that needed to be addressed during policy formulation. Given the culturally-embedded presence of stigma and the pervasive consequences of stigmatisation, stigma was voiced as a factor that added to a unique and troubling layer of mental health problems in Indonesia. *Functional-7* perceived that strong cultural beliefs around mental illness hampers professional help seeking:

> *'… because our culture is different … here we have shaman culture, supernatural culture, cultural-religious beliefs, etc., mental illness is associated with magic, sin, witchcraft or possession; eventually people don't go to the hospital, and don't seek help from health professionals … but they go to the shamans. After decades of unsuccessful attempts, they finally go to the hospital, with chronic conditions that are hard to handle' (Functional-7).*

To some extent, such beliefs were agreed to be the reason why '*most people still use non-formal institutions that provide treatment based on traditional and spiritual practices' (Structural-1).* Labelling people with mental illness as '*waste product*' was one of the examples of common stigmatisation in Indonesia, which in turn causes individuals with mental illness to become socially isolated. Moreover, some participants also suggested that inhumane practices such as '*pasung*' (shackling) in Indonesian society are still quite common. Participants also listed other language terms which are frequently used by lay people, describing people with mental illness as '*dangerous*', '*shameful'*, 'a *disgrace*', '*horrible*', '*scary*', and '*disturbing*'. According to *Structural-19,* the way people see psychiatric hospitals as a place for people with '*extreme*' or '*hard-core*' cases of mental illness such as schizophrenia, leads to the assumption that mild cases of mental illness are commonly considered to be social problems, thus non-health care institutions are the most reasonable choice for the initial treatment phase.

National reforms

Some interviewees argue that mental health reform cannot be separated from the national reforms. The economic crisis that hit Indonesia in the late 1990s was a good opportunity to initiate various changes in the health sector, including the elimination of various bureaucratic obstacles in efforts to increase efficiency; this also applied to the field of mental health. Mental health reform was denoted as an integral part of the National Health Development Plan which was initially implemented in 1999. In other words, broader national health reforms impacted upon the mental health system. This plan outlined the direction that the government would take over the following 10 years to achieve its vision of a 'Healthy Indonesia 2010', by shifting the old health development paradigm into what became known as the Health Paradigm. The Health Paradigm was a health development model which, in the long run, could be seen to push the community towards becoming autonomous in maintaining their own health through promotion and preventative care, and discarding the old health development paradigm which places priority on curative and rehabilitative health services. As *Structural-1* said:

> *'… that's not a new system after all … in the Indonesian health system we have had the four pillars of the health service system … promotion, prevention, cure, and rehabilitation … it's long been echoed by the Ministry, I am sure, but it's not long after the monetary crisis … they have a slogan 'Healthy Indonesia 2010' which represents a shift from the old health development paradigm into the Health Paradigm … yes … from a sickness-oriented to a wellness-oriented … paradigm' (Structural-1).*

As previously mentioned, the direction of reform in the Indonesian mental health policy was a shift away from acute care, hospital-based services towards community-based services. One structural participant considered that the 'community' component in the mental health system in Indonesia has long been articulated, at least since the 1970s, although the 'community' concept was not as well understood as it is in the present.

> *'… actually, the idea of community mental health has been around since the 70's in Indonesia … however, at that time … the context of service was still focused on the curative or treatment aspect … so … psychiatrists were not stationed only in the psychiatric hospitals, they also came to the district general hospitals to treat patients' (Structural-20).*

In addition to influence from the national reforms, at the same time, the Indonesian Psychiatry Association held a national conference pronouncing community mental health as the main focus of mental health system reform in Indonesia. However, the implementation of this concept did not show any encouraging results until the Aceh tsunami disaster. The case of Aceh became a successful example of how a community mental health model should be implemented in Indonesia, and this has also been documented in *Permenkes 406/2009*, the Ministerial Decree for community mental health.

Global influence

Best practice

There were also global issues that influenced the idea of mental health reform identified by the participants. As stated by Structural 1, '… *the concept of mental health reform was also influenced by developments in other countries'*. He argued that

site visits to countries that have advanced mental health systems, scientific studies, and international seminars were among the activities that facilitated policymakers in the decision-making process. This is in line with what *Structural-14* emphasised, that the study of literature and benchmarking have effectively provided the opportunity for an in-depth examination of significant positive or negative experiences that have occurred across the globe.

> *'… first is from the literature, then maybe from a comparative study they've been to other countries, for example to Taiwan, Australia, so maybe … they compared what happened in Indonesia with what is happening abroad, and they learned from the success of mental health services abroad … they evaluated why it is more successful there than here particularly in community-based systems …' (Structural-14).*

Driven by '*the complexity of our problems here in practice*', *Functional-7* thought that people in the MoH were trying '*to find solutions for our problems here … they found that in the literature and also in benchmarking studies'*. Many participants were conscious that the Indonesian mental health system was lagging behind the developed world, and in so doing, there was pressure to 'catch up' with developed countries, and to be part of the global governance of health.

<u>International organisations</u>

Some Indonesian psychiatrists worked closely with international organisations, such as the WHO, and were also members of the World Psychiatric Association (WPA). The drive for reform cannot be separated from the role of the psychiatrists; they initiated the emergence of these ideas, which eventually became enshrined in national regulations implemented throughout the country. A number of participants

emphasised this point, '… *we also have our colleagues, psychiatrists who work for the WHO also give much information about that' (Structural-13)* and '… *the role of the World Psychiatric Association (WPA) strongly influenced the development of community psychiatry in Indonesia' (Structural-20).* The PDSKJI [The Indonesian Psychiatric Association] was mentioned in several interviews for their role in bringing attention to issues and demanding policy action. The ideas of reform came from the convergent desire of psychiatrists to see a better overall mental health service system in Indonesia. Through their professional association, psychiatrists shared their knowledge and experiences. *Structural-20* argued that the reason why the PDSKJI had a special division of community mental health was because the WPA, at that time, had a new division called community mental health.

4.3.2 Understandings about the policy formulation process

Among the interview responses, there was unanimity that the ultimate decision to approve policies rests with the highest levels of government. Some participants said that they were not very good at describing how the policy was developed as it was not their specialty, with one participant commenting, '… *it would be more appropriate if the question was asked of policy-makers' (Functional-17).* However, knowledge of the policy process is important given that their main role is to work out the mechanics of how policy ideas can be translated into action:

> *'so when the cental government issued a policy, it should be clear … to make it easy for us to interpret the meaning and translate it into action at the local level' (Structural-1).*

There were mixed responses in relation to the policy-making process, however, in many interviews, the participants could identify a number of concerns related to the decision-making process, i.e. top-down, institutional, and political processes.

Top-down processes

Policy-making is framed as a top-down process, steered by the central government. There may be some input into recommendations from elsewhere, but the foremost authority in making decisions is the MoH. The MoH is critical in deciding which policy issues the government wishes to address and which have priority. In an in-depth interview, one bureaucrat claimed that the existence of a top-down approach is the most relevant strategy for Indonesian culture:

> *'the policy must start from the central government yeah, it would be more appropriate because we usually think … that which comes from above, would be more easily accepted …' (Functional-7).*

Gaining public input for policy recommendations is percieved as 'difficult' due to the bureaucratic nature of the governance system '*but if that comes from the public, until whenever … it seems that with the condition of society and the bureaucracy like this … it seems difficult' (Functional-7).* A senior structural participant felt 'excluded' from the arena of policy-making, '*… when they were formulating that policy … there was no hearing … without local government input … local government was not involved in policy formulation let alone the psychiatric hospital; we didn't even get a chance to share our thoughts on that policy' (Structural-20).* Another structural participant tried to analyse the current situation and make recommendations for

improvement, shedding more light on the bottom-up policy formulation pathways as an 'ideal-type' prescriptive model for how policy-making is supposed to be.

Institutional processes

Policy formulation in Indonesia is characterised as an institutional process, with ideas being passed through a formal bureaucratic procedure involving various formal institutions such as government offices, professional associations, and international organisations. As one official noted:

> *'… policy formulation was through institutional processes I think yeah … so it's not coming from an individual proposal yeah … so the proposal went through the PDSKJI and then they discussed it in the ministry … and apart from that, uhm we also have our colleagues, psychiatrists who work for the WHO also giving lots of information about that … so yeah I think they're all involved in policy formulation about this system shift' (Structural-13).*

This implies that there are no particular individuals who influence how policy is made, it is rather a process which is collaborative in nature. However, the main policy-makers in mental health are ultimately the MoH and the psychiatrists. According to another official, the process of policy-making is an internal affair, with the public, even educated people, not being invited to engage in a participatory process.

Political processes

Policy-making is seen as a political process encompassing different interests and being shaped by underlying power structures. This fact was echoed by one participant, '*… so why mental health is on their agenda, this is more political, and for the benefit of the few. It also looks this way because there's a psychiatrist who is very senior in*

the bureaucracy, so this person has the authority and the opportunity to create policy' (Functional-17). One junior participant voiced his negativity toward the policy-makers,

> '... *I know our government has never done a needs assessment or any kind of evaluation program whatsoever ... they suddenly make policy and suddenly throw out a slogan ... suddenly there's a budget for the program, which is not in accordance with the needs of the community' (Functional-10).*

He emphasised that political interests are always put in front of the public interest, with the government trying to show that it involves stakeholders, but that this is more lip service rather than genuine intent.

4.3.3 The expected impacts of mental health reform

In an attempt to explain the significance of Indonesian mental health, most of the participants appeared to agree on the idea of ensuring benefits for both the public and the government. However, a contrasting statement came from one young professional who thought that policy-related issues are simply about politics, and that the public interest is only a 'mantra' echoed by politicians. She openly spoke about the lack of impact for the general public, *'... the impact on the community is nothing, people don't care whether or not that policy exists' (Fuctional-17).* Others stated that a range of benefits accrue to the public, such as reduced health inequities, better understanding, and improved services. For the government, this policy is perceived as an 'umbrella' for covering all reform initiatives at the local level, including for better funding and for improving the awareness of bureaucrats on the issues under consideration.

Reducing health inequities

One major issue that arises in relation to the significance of mental health reform is the provision of accessible and affordable mental health care. In terms of reducing mental health inequities, one participant said:

> *'… of course to improve accessibility … hospital-based services are very limited, we are limited by distance, difficult to reach by the community from out of town … and also for affordability, most mental patients are in the lower socio-economic group … they cannot afford drugs, and they cannot even afford the travelling costs to get here, so these limitations must be handled … yes with this MHR' (Functional-5).*

Mental health care is supposed to be delivered through an integrated service system to provide more consistent quality care across the country, through which service gaps and the needs of specific populations can be addressed.

Increased awareness of society

People with mental illness are still the subject of powerful negative stigma and discrimination from the community. Although, the reform policy is not exclusively labeled as an 'anti-stigma' policy, the mental health reform is valued as an effort to improve people's understandings as part of actions to lessen stigma, '… *we change community perceptions about mental illness … we teach them what to do when they take care of their family members with mental illness, it's an effort for destigmatisation' (Structural-13).* In some interviews, there was a consensus that if people had better awareness, stigma would be reduced and, as well, people would not have negative perceptions towards those with mental illness. Social inclusivity is one of the oft discussed subjects by participants. For example Functional-7 stated, '… *so*

it's expected that the patients will stay in the community where they can be included and be more productive, and this will reduce stigma'. This would lead to greater acceptance of people living with mental illness in the community.

Early intervention-recovery model

High hopes were attached to the reforms with participants expecting that the reforms would be a watershed in strengthening the framework of promotion, prevention, and early intervention in mental health.

> *'... people can detect mental disorders so that early cases of mental disorders in the community will be immediately handled, and recovery will be more effective' (Functional-7).*

They assume that this systematic approach, as stated in the policy, which applies coordinated and integrated mental health services, will also strengthen the recovery process for people with mental illness.

An overarching umbrella for the Indonesian mental health system

The word 'umbrella' seems to be a common term used to depict how national policy is framed by bureaucrats' at the local government level, particularly in West Java. What is meant by 'umbrella' is the legal basis afforded to local governments for program implementation. As *Structural-1* said, '*... policies in Indonesia are made by the government, in this case the executive and legislature, which the central government issues and later passes down to local governments, so policy is an umbrella for a program to be implemented, because Indonesia is a Country of Law, so every activity must be based on rules'*. Another participant simply commented, '*... it*

should be an umbrella for the mental health system' (Functional-3). One participant added that the existence of mental health reform initiated by the central government is proof that the government has done something for the public, referring to what he said, '*… that is to convince the public that they are paying more attention to mental health ...' (Structural-2).*

Better funding

One of the key challenges to be faced is inadequate funding for mental health both at the national and local levels. This reform policy was supposed to have a positive impact on public budget allocations for mental health. Also, the alignment of mental health with physical health was part of the work that needed to be done by a range of stakeholders in the mental health field, as voiced by *Functional-17*, *'… I think mental health is as important as physical health, so it's expected that mental health would have better funding'*. Another high expectation attached to the policy by many of the participants was the hope that mental health would secure better funding as it deserves more, if not at least the equivalent, of the funding for physical health.

> *'… we can see that the budget for mental health used to be very small, but now it is getting better … both at the national and regional levels … however, although there has been an improvement, like I said earlier, the budget is still relatively small if you look at it … in comparison with the proportion of the total health budget' (Structural-20).*

4.3.4 How is policy communicated to the West Java government?

As has been previously outlined, national policies on mental health reform began to take shape around the late 1990s, with influences coming both from within the nation

and from abroad. The policy-making process was generally perceived as a linear top-down process. Owing to this, many participants involved in this study agree that once the mental health policies had been formulated, that it was important for the Ministry of Health to disseminate the policy to all stakeholders, including the health district offices and other partner agencies, and that the dissemination process should target key individuals in these organisations. They assumed that many policies fail simply because they are poorly communicated. The most common method of circulating policy information to local government was through meetings, with the MoH inviting relevant stakeholders to attend each meeting.

> *'… some meetings were organised by the ministry, who also issued some guidelines regarding the mental health community, particularly at the Psychiatric hospital, the Regional General Hospital, the community health centers and even at the community level' (Structural-20).*

However, this is, without doubt, only applied to a few people. They expected that those who attended the national meeting were able to disseminate information in their respective areas. In reality, too often the WJPH did not receive an invitation to attend the dissemination meetings. One structural participant provided details on why the WJPH was often excluded from national meetings:

> *'… and the least favorable for us, because geographically we are close to the ministry and we are also considered more proactive … often time we are excluded … so formally, the Ministry of Health has a direct coordination with the health offices … but not with us' (Structural-19).*

These dissemination problems were neither new nor unique in the government sphere; this situation was categorised as being very typical, '*it's a very classic problem yeah, I am sure because of their limited budget to gather all psychiatric hospital directors in Indonesia, so they invited only a few' (Structural-19).* This participant added that,

in his opinion, sometimes the selection of the invitees was based on the proximity to the people in the MoH, '*... depending on who the head of the mental health directorate is in the ministry, if he is well acquainted with us, we are often involved, but if he does not know us, goodbye!'*. Nearly all the participants were in doubt about whether there were specific national meetings about mental health reform policy. *Structural-14* noted that she was once invited to attend a meeting however the content was about a case study in the implementation of community mental health in Asia.

With relatively little dissemination from the MoH, other sources of communication were identified. The bureaucrats acquired their knowledge about mental health reform from: (1) professional conferences/ colleagues; (2) college; (3) internal meetings; and (4) self-learning. Apart from the MoH, policy information was frequently disseminated through professional associations. The *PDSKJI* (Indonesian Psychiatric Association) was considered to be the most active professional group.

> *'... they used to disseminate policies through professional organisations ... PDSKJI ... so yeah because they are ... the policy makers are psychiatrists ... and also members of PDSKJI ... so they inform us about it in our academic activities ... profession ... so we know about it' (Structural-13).*

Structural-13 added that only psychiatrists were exposed to the information, therefore if they did not make any move to spread this new information in their workplace, maybe nurses and other health professionals would never hear about it. Participants who were recently graduated professed that they gained their knowledge about mental health transformation in college. Some participants mentioned that there were a few attempts to spread information internally in the organisation, for example, in morning briefings or other meetings. The remaining participants stated that 'self-learning' from

a range of sources, in particular from the internet, was their only way of knowing and this may have been simply because of their curiosity or because it was part of their job. They also felt that the existing resources were often unreliable; for example, too often they could not find the information they were seeking on the MoH website.

> *'… they just throw out a policy and delegate authority to local governments … so we need to be smart enough to understand that policy, and it can be interpreted differently because they only give us general rules' (Structural-1).*
>
> *'… when I was given a task, I expect the leaders to provide insight and clear instructions about the tasks I need to accomplish, but I don't see this because among the leaders, there are also different perceptions, one says A, the other says B' (Functional-5).*

Given the fact that there was so little formal dissemination, and such a lack of diverse sources of information, it is not surprising that the bureaucrats have different levels of comprehension. The problem that arises is that the content of the policy is often interpreted and valued differently, hence creating a chaotic situation at the lower levels of the bureaucracy.

4.4 The context of the current mental health reform in West Java

The contextualisation of policy implementation issues in West Java is highly complex. Most key informants agree that mental health reform is difficult, and is perceived as a '*double-trouble extra-struggle*' situation by one senior structural participant, however he and several others said that it is not impossible. Mental health reform is underway in West Java, and there are both optimistic and pessimistic views on its progress. Some participants frame the teething troubles as inevitable natural challenges in the process of introducing a new concept or program. This is

exemplified by a comment from *Structural-14* who stated that, '*it's normal, only been here for two years, and it's hard because this is just the beginning, we are just about to change*'. An enlightening analogy was expressed by one functional, depicting the difficulties of mental health reform in West Java:

> *'… it's like a house, but it's an unfinished house, and located in the middle of a thick jungle … we don't know how to get there, the path does not exist, yeah … and to make a clear pathway there and shape the house, is something difficult to do' (Functional-10).*

Before addressing the challenges to implementation encountered at the provincial level in greater depth, it is useful to briefly review why the bureaucrats think that mental health reform is necessary in West Java.

4.4.1 The need for implementing mental health reform in West Java

In general, what the participants consider to be the reasons why West Java should implement the reform is similar to why Indonesia, as a whole, needs it, as described in Section 4.3.1 however there are some differences in the case of West Java. The ways in which the participants view the significance of mental health reform implementation in West Java are presented in Figure 4.6.

Apart from the obligation to implement the policies of the central government, the West Java Provincial Government also has a range of distinctive mental health problems, according to the participants. In view of West Java being the most populous and most densely populated province in Indonesia, some participants proposed that the scope of mental health problems in the region is now quite alarming.

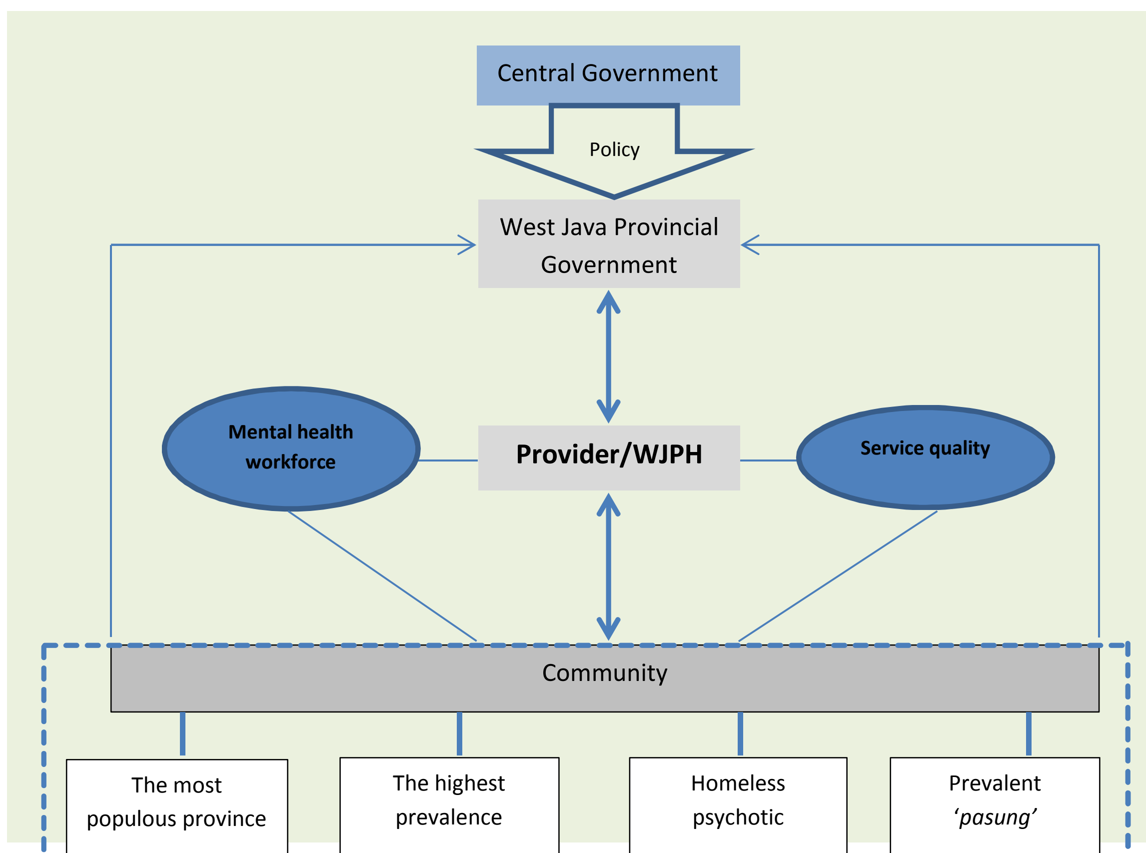


Figure 4.6 Situational analysis of why MHR is needed in West Java

The majority of participants acknowledge that, based on the latest epidemiological study, West Java has the highest percentage of mental disorders in Indonesia.

> *'… morbidity in West Java is the highest with 20%, that's higher than the national average which is only 11.6%, not including unreported cases' (Functional-5).*

Other worrying problems occurring in West Java are the escalating number of psychotic vagrants, and '*pasung*' cases. Although participants could not retrieve the exact data on the number of psychotic vagrants and '*pasung*' cases, as such studies

have not yet been conducted, they emphasised that there have not been any significant solutions to these problems.

> *'… what becomes my biggest concern now is about homeless psychotic people … we have not done anything yet about that problem … nothing, unable to solve that huge problem, it is getting more serious' (Structural-2).*
>
> *'… mental illness in our society is identical with schizophrenia, even though there is a psychiatric hospital, schizophrenics are still everywhere, on the streets, in the houses … and put them in stocks … do we have to provide 40,000 beds for West Java? That's impossible, so it is necessary to apply community mental health system' (Structural-19).*

Being the only government-owned psychiatric hospital in West Java was perceived as a burden by some participants, as though the entire mental health issue of West Java is dealt with 'alone'. This idea is certainly not without merit, and there were some suggestions drawn from the interviews to account for this. First, all regional funding for mental health goes to the WJPH, and secondly, mental illness is not considered to be a profitable commodity, so it is of no interest to the private sector.

> *'… the psychiatric hospital in West Java province is only the one, private psychiatric hospitals are very few … the private sector is less keen to open mental health clinics, we have more than 44 million people in West Java and they have poor access to mental health facilities … people with mental disorders do not have much choice … they are mostly of low socio-economic status; the government should strive for this … so the burden is all on us' (Structural-1).*

As a provider of mental health services, the WJPH is obliged to continuously improve its service quality. Many participants argue that the current quality of service is still far from satisfactory. It was mentioned by one participant that the services provided are not comprehensive and are only focused on treatment within the hospital. There is no continuity of care provided to patients after hospitalisation, apart from the patients obtaining their medications at the outpatient unit.

> *'... I can say that the quality of service here is not good ... when we look at the service provided is still not well-structured, not continuous ... rehabilitation services are also not satisfactory ... after-care service is not there yet ... after returning home they have no activity ... service quality overall is still not good ... (Structural-19).*

Functional-3 linked this unsatisfactorily fragmented service to the high rates of relapse in the hospital service, stating, *'... so the patient was treated, then he returned home, not long after, he was back in the hospital again, high relapse rate eventually'*. Furthermore, participants acknowledge that the existing mental health workforce is very few in number, thus it is not possible for them to engage in activities outside the hospital. A senior manager confirmed this, *'we have so many patients with so limited resources, so we need to reform the system ... it is very relevant' (Structural-20).* Many participants believe that the complexity of the mental health problems that exist in today's society must be accompanied by an increase in the ability of health workers to provide good quality services that meet community needs. Moreover, people have started to become increasingly critical, and have increased their expectations of, and demands upon, health service providers, and the public hospitals in particular, *'... society has high expectations, but we are not ready to accommodate high demand of services' (Functional-3).*

4.4.2 Problem framing of obstacles to implementation in West Java

Policies often have significant, unanticipated consequences during the implementation phase that may need to be addressed in order to move forward. The reality of making mental health reform happen is highly complicated, and the following discussion focuses on an understanding of the problems at hand from various perspectives and through various dimensions. The participants, with their varying perspectives, and

with differential access to information and resources in the process of framing the problems, tried to make sense of their experience, and to eventually reflect their preferred solutions to address the problems.

System level

Participants identified obstacles to implementation that arise starting from the larger policy system context. The extent to which policies are implemented is affected by circumstances that occur even before the policy is adopted. Most participants feel the presence of a gap in the implementation process, especially the gap between policy objectives and practice, as one participant stated, '… *if we look at its implementation in the field, it's still nothing, it is a good policy but the implementation at the bottom level is still nothing' (Strucural-18).* Some of the participants complained about a lack of clarity in technical procedures and the transformational steps to be made. One of the participants raised the issue of a national policy to support the idea of abolishing the practice of *pasung* under the banner of 'Abolish *pasung* in 2014'. She said that this policy would be difficult to implement because the support systems have not yet been put in place. On top of this, to find a case of *pasung* is very difficult as there is no accurate data on this and the case findings only rely on reports by community members or the media.

Decentralisation

Decentralisation should produce closer ties between the public and local government, however, this also means a rise in demands by the community with regard to improvements in the quality of mental health services. Bringing the services closer to

people's homes means that basic needs, such as sufficient services and medications, must be available in the nearest health care facilities, including in the district general hospitals and community health centres. This imposes a tremendous burden on district governments, in particular, due to the limited funding available for mental health to provide skilled mental health professionals and to supply psychotropic medications. Some of the participants complained about how difficult it is to coordinate these two crucial issues with the district governments, as one professional who also holds a structural position conveyed the fact that only a few types of medications can be found in the CHCs.

> *'… then I asked them, what medications do you have here for mental disorders? ... There are only a few types of drugs ... diazepam, Chlorpromazine, and luminal ... that's it, only three are available … I am just really sad to hear that' (Structural-18).*

According to *Structural-11,* the main reason why district governments cannot provide psychotropic medications is because mental illness is not included in the 10 most reported diseases at the CHCs.

> *'… I've asked this directly to the local authorities that a budget is needed for psychotropic medications. They said, we provide drugs based on the report, we provide medications for the 10 most reported diseases in the community health centers, and I finally know, everyone knows, mental disorders definitely are not in the top 10, because doctors at the CHCs never report cases of mental illness' (Structural-11).*

Another issue that arose from the interviews was in relation to decentralisation and regional autonomy and that this is a very difficult transition period for the West Java Provincial Government, '*then we started the regional autonomy, things were getting disorganised, poorly managed, during the transition process, we were like being in an old broken car with a lot of passengers' (Structural-20).* This implies that regional

autonomy led to new problems which impacted negatively on the mental health delivery system.

Problematic mindset change

Another theme to arise from the data was that people appear to hold on to the old paradigms for too long with the sickness-oriented mindset being very well-established in the Indonesian health care system, with West Java being no exception. The quotation below provides an example of how hard it is to change the fossilized mindset that sometimes, in practice, means that the application of promotion and prevention only results in educating sick people.

> *'The point is … our health care system still focuses on 1% of the population who are already sick, even though all central government policies state that health care should be more focused on public health, promotion and prevention, but not in reality … so it's more like we are educating sick people … fixing cracked glass is more difficult, better to take good care of the glass while it's still good … yeah that's the words' (Functional-10).*

Poor monitoring-evaluation

Additionally, many participants also felt that there is a lack of monitoring from the MoH on the implementation of these policies in West Java. There are no technical experts available to consult, let alone to evaluate the progress made by the West Java government. Furthermore, the WJPH has no obligation to officially report on the implementation to the MoH. The only method currently in place to evaluate the quality of the services is hospital accreditation conducted by the MoH, but the

evaluation indicators used at the time of accreditation were not set up to measure the extent to which hospitals have implemented and run national policies.

> *'… no-one supervise … no supervision in terms of service quality … I am responsible to the provincial government in terms of financial accountability … apart from that, I have no obligation to report the quality of the services … well … yes we have hospital accreditation … but that's only a one-time evaluation' (Structural-20).*

Workforce crisis

Under the current rules, local governments cannot recruit new employees when required because there is a centralized recruitment mechanism. One participant complained about this:

> *'… we cannot recruit new employees … although we need new professionals, and for us that's a very urgent need … but if there is no new recruitment, we cannot do anything, to recruit provincial civil servants there must be a system for that in place from the central government' (Functional-19).*

Due to the limited number of professionals, it is also problematic to expect hospital staff to do more in prevention and promotion activities outside the hospital than the examining of patients.

> *'… our workforce here is limited, we cannot let al.l the officers out there, busy coordinating or educating people outside but the hospital services would be undermined, there are times when patients have to wait 5 hours for a doctor's examination, it's not right …' (Structural-19).*

Clashing policies

The mental health reform journey in West Java cannot be detached from the larger political context. Massive changes in the Indonesian political and administrative systems have fundamentally influenced the mental health delivery system. One of the

impacts of the 'big-bang' decentralisation was that the West Java Provincial Government was given full authority over two psychiatric hospitals in 2001, which were previously owned by the MoH. Under the management of the West Java Provincial Government, the two were positioned as regional organisations, which were run parallel to other organisations, such as the Health Office, the Social Office, and others. These hospitals were finally merged in 2008, and became known as the WJPH based on *Peraturan Pemerintah* (Government Regulation) No. 41/2007, and reinforced by *Peraturan Daerah Provinsi Jawa Barat* (West Java Provincial Government Regulation) No. 23/2008. This merger led to unexpected and conflicting policies issued by two different ministries. The merger decision which was issued by the Ministry of Home Affairs (MoHA), and this clashed with the rules made by the MoH, which stated that the hospital should be located on one plot of land, and not in two different locations (one branch is in Bandung and the other is in Cimahi) under single management. One structural suggested that:

> *'… the decision to merge two hospitals under one management decision to combine the two psychiatric hospitals was not in accordance with the laws and regulations issued by the Ministry of Health … they say, it can't be two locations under one management … it's problematic when we are dealing with two different policies … issued by two different ministries … and both have their justifications … as a result … it left us in a state of confusion' (Structural-1).*

The data suggests that one of the main problems arising from the merger is related to hospital classification systems. Indonesian hospital types are classified according to MoH standards. There are three levels of specialised hospitals in Indonesia, types A, B, and C (A representing the highest and C the lowest), which are classified based on the standard of health services provided and patient facilities. Before the merger,

Cimahi Psychiatric hospital was classified as type B, whereas *Bandung* Psychiatric hospital was type A, and by merging these two, they could not automatically be classified as type A because with more facilities and resources being combined together, it needed to be thoroughly assessed by the MoH. In the meantime, the West Java Provincial Government made a clear statement that the WJPH was a type A psychiatric hospital, which was determined at the time of the merger decision. This created new problems, especially for the provision of health care to patients. The tariff standard provided to patients is different between type A and type B hospitals. Because the majority of mentally-ill patients use *Jamkesmas* (Public Health Insurance) organised by the MoH, the WJPH could not retrieve their insurance entitlements from the Central Government because of the hospital type not being confirmed. This was commented upon by *Structural-12*:

> *'… and now there's the governor's decree for Grha Atma … Psychiatric hospital in Bandung becomes a community mental health unit, it has already signed by the governor … This is problematic because there are policy conflicts … things like this … clash with the regulations … this needs to be quickly resolved as it would relate to the financial matter … licensing and classification problems have yet to be clarified' (Structural-12).*

Despite the fact that mental health problems are common, many participants feel that mental health has been marginalised in the health sector. They are concerned about the existing policies not keeping up with mental health reform, with one of the policies mentioned being part of the 'basic six' national policy. This policy is used as a legal framework for providing health services in the CHCs, which does not include mental health services as the main programs on offer. Based on participants' opinions, it is difficult for mental health care to be delivered in the CHCs, '*… mental health is*

not the priority, so that would be difficult because they cannot change the 'basic six' policy in which mental health is excluded' (Structura-20). There is a feeling of desperation from many participants as they realize that in order to bring mental health services closer to the people, they would first need to change this national policy.

Unorganised mental health system structure

The merger and streamlining of services were the two major strategies adopted by the government as part of the national bureaucracy reform. Aside from the merger of the two hospitals, the rationalization of the Provincial Health Office organisational structure was also very influential in how mental health is conducted in West Java. Initially, there was a special division for mental health, but it now no longer exists. Mental health is now positioned together with other specialised health services, such as eye health and dental health, with all being under the basic health division.

> *'… so that policy is about restructuring government organisational structure, like for example … the Health Office has a smaller number of divisions, I think it has gone from 32 structural positions to only around 20 now … that's definitely impacted negatively upon mental health … specialised health issues like mental health, eye health, oral health are gone … they are all under one division, a basic health division' (Structural-20).*

A senior structural participant was convinced that although the head of the West Java Health Office is acutely aware of mental health issues, this organisational streamlining restricts her from further developing mental health programs. This creates a missing link in mental health coordination between the MoH and the Provincial Health Office. It is assumed that because the West Java Provincial Government has a psychiatric hospital that all affairs related to mental health fall

under the full authority of the WJPH. The impact of this is significant, particularly in terms of mental health funding. All mental health funding sourced from the regional budget is allocated to the WJPH as a final point, '… *the budget for mental health programs in the health office is none, so all funding related to mental health goes to the psychiatric hospital' (Structural-1).* For this reason, all matters relating to mental health, including service transformation, is in the hands of the WJPH. Apart from the provincial budget as a source of funding, the WJPH can also use the state budget if it is available, but using this budget is perceived as being 'very risky' by a top manager:

> *'The psychiatric hospital can also get that from the central state budget, from the ministry, but in reality we fear to use these state funds, since they often don't have clear allotment and also the suitability with our program is unlikely. They poured in billions, but they restrict its use, for example, only for infrastructure, and it does not fit with our plans. Too often when we impose it, it's very risky for the mark-ups, corruption' (Structural-19).*

Adding to this, the participants said that, institutionally, the WJPH 'does not sit in a *comfortable* position'. The WJPH's position as a regional organisation is rather ambiguous. As a provincial government organisation, this hospital is bound by all the rules set by the Ministry of Home Affairs, and according to its function, it should have its main provisions directed by the MoH. Developing a system to reach the community is not easy. Some of the participants shared their reservations about transforming the system to being community-based if it is going to be steered by the WJPH. Their doubts are based on the rules applying to hospitals which state that the primary function of a psychiatric hospital is to provide mental health services to individuals, rather than taking care of the community. Many participants spoke confidently about their limited authority and the restrictions on going beyond individual mental health matters, with one stating that:

> *'… if we hold on to the existing rules, this is a constraint, meaning that as a hospital we have limited space, we cannot move freely … one example is that there is a law that regulates, the hospital must be present in one site, and this limits the expansion of our services to the public' (Structural-13).*

This led to the conundrum of uncertainty regarding the leading sector for organising mental health reform in West Java. Participants' views on this varied, for example, *Structural-2* said, *'… I don't know who should be the leading sector for this, I don't know who should be responsible for this, if not us who would it be?'* There is, however, an ideal structure for organising mental health reform. Interviewees talked about the TPKJM as the best solution for this. The TPKJM stands for the Tim Pembina Kesehatan Jiwa Masyarakat (Community Mental Health Supervisory Team) established by Ministerial Decree 220/2002. The participants recognise that the TPKJM policy was created long ago in 2002, but they question the existence of TPKJM in the present, with one functional seriously criticizing the provincial government for not doing anything, *'… the TPKJM structure is clear, it's a provincial government responsibility, I don't know where they are now, no-one acts as the initiator' (Functional-17).* A junior functional commented forthrightly about political influences regarding this perplexing situation:

> *'… but I see the role of psychiatric hospitals dominating the system here in this province, it has become the leading sector in community-based mental health, that's not really what it should be, I don't know why, maybe there is a particular interest, political interests, we have policy related to this, a multi-sectorial team TPKJM is responsible for community mental health, … but a lack of coordination has caused this to be left unorganised … oh well' (Functional-16).*

The difficulty in determining who is supposed to be the leading sector was also influenced by what is happening in wider society. As mentioned by a senior manager, everybody has their own roles in managing mental health issues. He said that, in

Indonesian society, mental health was indeed everybody's business in its own unique way. A cleric or a school teacher, for example, can handle mild cases, and mental health only becomes an issue if it is a severe mental disorder. He added that mental health issues can be seen as medical problems, education problems, religion-related problems, or social problems, and there are no clear-cut boundaries defining each of these types of issues, therefore it is not surprising that the leading sector has not yet been confirmed.

Another problematic situation depicted by participants is related to the new Hospital Act 44/2009 which has decreed that government-owned hospitals must become *BLUD* (Regional Public Service Board).

> *'... now all government hospitals must be BLUD ... it's impossible for a psychiatric hospital to become an enterprise ... we are dealing with poor people, 90% of patients are poor and are covered by 'Jamkesmas', and we are forced to make a profit ... that makes it even more difficult for people to access our services' (Functional-16).*

Although the primary purpose of converting public hospitals to *BLUD* was admirable, especially in terms of financial management autonomy to improve service quality, in some interviews, the participants were concerned about the impact of this policy on the mental health system. There are two major problems identified. The first is associated with the high cost of mental health care for the public, while the second concern is that of less income for the hospital.

Decision*-makers' lack of u*nderstanding

Many participants assume that the decision-makers make quick, effective decisions when faced with complex situations. It is recognised that the decision-making process

needs to be supported by sufficient knowledge in order to generate a possible course of action, to conduct an in-depth analysis of the constraints imposed by the situation, and to finally select the first course of action that is feasible. However, those who are positioned as decision-makers at the top level, especially in the West Java Provincial Government, are not considered to be knowledgeable in the health care administration and management field, with one participant stating that their lack of knowledge is one of the main reasons why such problematic situations occur.

> *'… the provincial government has no experience whatsoever in the hospital administration and management field … they don't know how to manage a hospital, they generalize that hospitals are the same as other organisations … so that's why they focus only on administrative stuff … they think a hospital is like an office … but it's not … to be able to manage a hospital, they need specific knowledge about health system, and specific policies and regulations' (Functional-16).*

This lack of mental health literacy among government officials was also identified as the underlying reason why mental health issues have always been marginalised.

The illustrations in this section are intended to portray the complexity of the issues surrounding general mental health system change and reform in West Java. The West Java mental health system is affected by many policies, standards, and rules that are not necessarily related to mental health. Conversely, the majority of participants are mindful that problems in one area will have a knock-on effect in other areas that create increasing systemic difficulties.

<u>Organisation level</u>

Change, in regards to this study, does not take place in a vacuum; instead, it occurs in the context of the organisational setting. Focusing our attention down to the WJPH as an organisation provides us with an understanding of how the participants interpret

problems in their workplace and, to a considerable extent, if the WJPH as the policy executor is 'reform ready'. A senior professional portrayed the WJPH as 'drown-ready' instead of 'reform-ready', a *sinking ship* in an ocean of reform.

> *'… we are now sailing on the sea and our boat will be sinking soon, now it is time for us to use a flare gun, we need help … there are people who just sit there and relax … just doing business as usual … they don't realize that this ship will sink … only a few people are aware that this ship is leaking … it's all up to the captain' (Functional-16).*

Leadership crisis

A 'sinking ship' was considered to represent the current situation of the WJPH as an organisation. This illustration was used to announce that there is a crisis of leadership in an organisation which has a mandate to carry out the task of mental health reform. There is only one issue that is considered to be keeping the organisation afloat, that it is a government-owned organisation. One participant stated:

> *'… this organisation, this psychiatric hospital is very weak, it all starts from the leader … I don't feel like I have a leader now, luckily we are a government institution, we still survive, still carry on otherwise we would collapse already' (Functional-3).*

The metaphor of 'being in a ship' was also alluded to in some of the other interviews. Another example of losing direction due to lack of leadership was voiced by a middle manager*, 'we are in the same boat, we are heading in one direction, but we paddle in different directions, not reaching the goal, the main point here is who will guide the boat?' (Structural-2).* A more considered perspective is put forward by a senior manager, claiming that being a leader in a government organisation is not easy because problems cannot be quickly resolved. Decisions must be made within the

bureaucratic process, not to mention the inherent rules applied that make it impossible to treat organisations as private organisations, '*if this was a private institution, then we could easily make a decision, but this is a public service institution, it's a big challenge to deal with that 'given' situation' (Structural-20).*

Unrealistic organisational vision

On the topic of leadership, many participants also stated that the quality of leadership can be seen from the vision of the organisation. From the participants' understandings, as an organisation, the WJPH should follow the direction set forth in their vision because this should serve as a source of guidance for the organisation's members. Thus, they perceive that the organisation's vision has been credited for the success of organisational leadership on the one hand, and blamed for the lack of organisational leadership on the other. Since a vision is viewed as being essential for organisational effectiveness, its articulation requires a sufficient degree of clarity, however most participants felt that their organisation's vision is neither clear nor realistic, with some feeling that it is no more than just a statement to pass the hospital accreditation process.

> *'… "to be a leading psychiatric hospital in Indonesia in 2015", I don't know where the emergence of that vision come from, is it merely a vision created just to pass accreditation? That is, for me, an impossible vision; to achieve this vision, we haven't done anything' (Functional-10).*

Others said that a vision is indeed a dream, but that it is very important that a vision be based on reality, and that it should be discussed and shared by members of the organisation. Again, different views were given by the managers, with one suggesting that, '*… actually we've done a bottom-up process for the vision and mission formulation, but yes it doesn't mean involving all employees but only the*

representatives of each group' (Structural-19). He went on to say that there is no standard to follow for assessing its consistency, for example, with national policy direction.

Funding issues

As previously revealed, most funding for mental health in West Java goes to the WJPH which means that regional funding remains focused on acute care and, as a result, a true continuum of care cannot be created. This also relates back to the idea that the reform in West Java is shouldered alone by the WJPH. The current mental health funding utilised by the WJPH is viewed as inefficient and ineffective in some instances. Regional funding is allocated mainly according to two major functions, infrastructure and service programs. Against a backdrop of the paradigm shift, the WJPH decided to 'do something new' through an infrastructure change by converting one location into a community center. A newly built community center (known as *Grha Atma*) in West Java signaled a significant bridge between the old and the new concept and, most importantly, this was recognised as a serious commitment from the provincial government towards mental health reform. As one participant commented:

> *'… we have good human resources yeah … good locations and support from government, big funding, and support from 'Bappeda' [Development and Planning Board] … to build that new building, they are very supportive' (Structural-2).*

At the same time, the WJPH also expanded its in-patient bed capacity in *Cimahi* by building new wards. This was perceived as a 'waste of money' by a functional participant who considered that building more acute-care facilities would not solve the problem.

'… so basically … just a waste of money ... it doesn't have to be like that, building as many hospitals as possible, is totally unnecessary, we are now building a new in-patient unit, expanding bed capacity, that's not the solution … are we going to provide 150 thousand beds according to what West Java needs? (Functional-10).

On the other hand, the development of inpatient facilities is perceived to be necessary because, until now, the WJPH has not had a special ward for children and adolescents, '*but we have no in-patient unit for children and adolescents, the ward has not existed until now, they are still mixed with adults' (Functional-4).* From an interview with *Functional-16,* it is evident that inefficient funding utilisation is due to poor planning, *'we are not doing something well-planned … all programs are just for symbolic purposes, for accessories, only to spend allocated funding'.* Apart from this, financial issues are believed to be closely related to infractions of the law if they are not strictly monitored. Thus, much attention has been paid to the administrative financing area, rather than to service innovation as the organisation's core business.

'So we devote most our time for that … therefore the health service part is often out of sight, I mean we are too busy to think about innovation in health care and to improve our service quality to the public' (Structural-20).

Resistance

In the process of moving from the "old way" to a more ideal integrated and balanced mental health care model, any form of change is believed to always meet some level of resistance, '*it has been challenged in many ways, many prefer the old paradigm, especially those who work in the hospitals' (Structural-1).* The degree of this problem

of resistance is considered to be more significant than the external problems, as one participant said:

> *'… the toughest challenge for reform is coming from the internal, the internal problems are more severe than the problems outside, rejection is greater than support … the change agent is one against a thousand' (Functional-17).*

The participants had tried to analyse why such resistance occurs in the WJPH. Some mentioned that the resistance can be quite mild, such as when it is due to a lack of understanding about the new paradigm. This can be overcome by simply learning about the new way. Others pointed out that the resistance can be intense and virtually unchangeable, requiring the strongest tools of cultural change to encourage the adoption of the new way. Those who are categorized as being highly resistant are driven by strong values and consider that the change will never be personally beneficial to them:

> *'… those who disagreed, as I mentioned earlier, are motivated by their mindset, especially from the medical staff, it's obvious because they are the sickness paradigm believers. When it is changed, they have to change their internal system automatically, and when it comes to their private interests, wherever possible they have to defend this for their own survival' (Structural-1).*

One participant noted that it is simply about one's own welfare and security, and that they would feel threatened if the hospital converted to a service orientation. This would raise two issues; firstly, their income would be affected, and secondly, no-one can guarantee that the new paradigm will provide better outcomes.

Power imbalance

A power imbalance was mostly attributed to the relationships between 'bosses and subordinates', 'seniors and juniors', and 'medical doctors and other health

professionals'. One of the subordinates depicted her leader as 'bossy' and that the boss did not properly delegate tasks that should be handled by subordinates, so it is not surprising that he felt overwhelmed, as if it all had to be done by himself. Different perspectives were articulated by the leader which conveyed that he had a bad experience of 'trusting' his subordinates in relation to financial matters:

> *'… I was called by the state attorney, I was intensively examined by the inspectorate and the Audit Board, in relation to the use of the budget and so on. I never knew how they used every cent of it, is it true that they spent money as they reported? I was overwhelmed by the negative feelings toward my staff, I started to sense a lack of trust' (Structural-20).*

Apart from the trust issue, the problems in dealing with subordinates are also influenced by staff characteristics. They spoke of a range of general characteristics in their employees, such as 'dependent', 'passive', 'unproductive', 'submissive', 'lack of attitude', and also 'lack of curiosity' as mentioned in the following statement, *'… the reason why they have a lack of knowledge is because employees here have no curiosity, so they tend to do technical things' (Structural-19).* Strong comments were also voiced by another top structural participant:

> *'… the way they always blame the top leader … they depend too much … no initiatives come from the floor … they are passive, those characteristics are also part of our organisational culture, they are all followers … and just complete their routines …' (Structural-20).*

As a consequence of this, the staff feel that their leaders tend to apply a 'favoritism' or a 'like and dislike' strategy, in the sense that only a few people are asked to be involved in certain tasks who are thought to be 'trustworthy' and 'capable'.

The power imbalance between senior and junior staff is also keenly felt, most markedly by junior employees. A working climate based on 'seniority' is thought to be one of the causes of low motivation and an apathetic attitude from the juniors. They consider themselves to be the 'younger generation' who are craving for change, having more up-to-date knowledge, energetic, idealistic, and creative. In contrast to the senior staff, they do not feel the distance between seniors and juniors, and tend to be more mindful of the larger structural problems. The '*ewuh-pakewuh*' [reluctant to be critical] culture was also identified by some participants, which confirms that this seniority issue has been overlooked by the leaders, a feeling depicted by a junior manager:

> '*… he could have said "I do not like what you do, you have to do this and that, if you do not like it, you may quit …" like that … but this will never ever happen yeah … you ask me why? ... Because we have ... "ewuh pakewuh" culture … that is feeling guilty towards the seniors if they did something like that' (Structural-14).*

A number of comments highlight how a form of power is practiced within the organisation and that it affects the way people work together to reach the same goals. One structural participant stated compellingly that the hospital is 'owned' by the medical service field only, as if there is no room available for other professionals to be equally responsible in providing care other than that which is ordered by the doctors. This creates an uncomfortable working atmosphere for those who are not medical doctors, '*... people become more comfortable to withdraw, better not to get involved, this ultimately pulls away this organisation as a whole system' (Functional-17).* Feeling uncomfortable due to the dominance of one professional group was also

expressed by one functional participant, and this, in turn, created a loss of commitment by individuals to achieving organisational goals.

> *'… now it seems that professional ego is still dominant … we are not blind, it's very dominant … because of this we are lacking in commitment … we work with people who have hearts and feelings … if one group demeans the others, she does not consider others as important as her own profession, there will be no harmony and will definitely cause an uncomfortable working climate here …' (Functional-7).*

Poor communication

In the interviews, some of the participants were also asked about the cause of their discomfort at work, which they thought to be barriers to change, with most of them confirming that poor communication is among the main problems. They believe that most messages are not clearly conveyed regardless of what the topics are. One functional participant argued that 'suspicion' is the main impact of poor communication, '… *only a few people who know, while there are 600 employees here who don't understand, employees become more suspicious, it's only for their benefit' (Functional-6).* He further specified that poor communication happens mostly between structural positions and employees, *'especially the structural positions, they do not have open communication, if there is any information they seal it'*. Another functional also agreed that poor communication is strongly felt by most of the WJPH's employees, '*probably because of poor communication, yes I think … communication between people here that really matters' (Functional-4).*

Team level

There is a widespread belief among the study participants that the values of the organisational culture are manifested within the team but also vice versa, that the team culture may direct organisational values. An interesting fact noted by one participant was that, based on the psychological assessments conducted not long ago for WJPH employees, it was found that most employees tend to be comfortable working in a team.

Lack of innovation-motivation

In undertaking the mental health reform mandate, the WJPH has attempted to form a special team created by a director's decree in 2011, which was later called the Community Mental Health Team (CMHT). In practice, the development of team norms does not take place in a vacuum, but is embedded in the wider organisational and system context. The CMHT was viewed by others as the team which had the task of developing and organising community-based activities specifically in the newly-built *Grha Atma*. A top manager expressed his opinion about the performance of the CMHT:

> *'… we have a multidisciplinary team, a community mental health task force here … but yeah … activities which they run have not shown anything significant yet … yes they've done such programs … but nothing innovative so far … it's interesting yeah … they are not taking any initiative … is like … a dead faint, they always rely on the top leaders' direction or initiation' (Structural-20).*

On the other side of the argument, the formation of the CMHT offers both positive and negative consequences. The positive consequences are that the WJPH has already committed to, and has focused on, mental health reform, while the negative

consequences are that the CMHT is viewed as being an exclusive group that nobody, other than the team members, gain benefits from, because there is no outlet for discussing related issues with people outside of the team. This is expressed by one middle manager:

> *'... If I am not mistaken, that program is under Dr. X's responsibility ... but I don't know what kind of activities are in the program, I don't follow that, and I am not included in that team too ... Would they have done something useful or not? ... I really don't know ... but yeah ... up until this minute ... I don't know how well the program goes' (Structural-2).*

In addition, there are no clearly defined goals for the team to achieve. The team members feel that they have no way of utilizing their individual potential and of pooling this potential towards achieving a common result, *'people here are willing to work hard, devote their time and energy for improvement, I was hoping to be a change agent, but looking at the conditions, and all that stuff, it's difficult' (Functional-5).* The members are more likely to work inefficiently due to a lack of motivation which comes originally from each individual and then contagiously creates an inefficient team performance overall. As one member confirmed, '*I finally arrived at that stage, no motivation, in the end ... just ignored it ... never mind, we just do our routine work' (Functional-5).*

Intergroup disharmony

Each individual is a part of various groups of teams, with each team being expected to work collaboratively with other teams. Intergroup harmony is seen as crucial to maintaining group conformity and commitment towards the organisational mission. Some of the participants articulated intergroup tensions in the WJPH, in particular,

conflict among divisions, professions, and different levels of management. A clear statement of this is made by one middle manager *'... to be honest, there is no good relationships here among the divisions, from the start until now, less harmony, yeah, no synchronization within the divisions' (Structural-2).* As well, intergroup disharmony is often seen in meetings. One participant characterised meetings as a fighting arena, *'... it becomes a habit in every meeting, they are very dominant, and make the meeting as a fight arena, in the end there's no decision made in a meeting' (Functional-3).* According to one structural participant, the disharmony is caused by poor communication and cooperation, *'... so I must say that their capacity in coordination and communication is ... kind of ... poor, yeah' (Structural-20).*

Individual level

This section is mainly about understanding individual level factors which influence reform, in this case, how individuals value themselves and others working in an organisation that is assigned to conducting mental health reform. There is a general consensus among the participants that people are motivated for change by a whole range of factors. Extracted from several of the interviews, these factors are: financial rewards, job security, moral responsibility, and obligation. These can be either a powerful ally or a genuine barrier to implementing change.

For some people, implementing change means extra financial rewards for the reason that it requires extra work. Government officials have a monthly salary and allowances which vary depending on their positions. One functional participant thought that her monthly salary is a reward for her routine chores on the ward. When

she is assigned to do home visits during work hours, she feels that the compensation does not compensate her for her hard work.

> *'… our sweat has dried up, and hard work was not paid accordingly, the rewards seem so unfair here … for example, we were given extra work, to drive the patient home, please prepare the compensation' (Functional-4).*

There is no question that pay is very important to most people. In fact, according to one senior functional, one of the reasons people are resistant to change is income insecurity. She cited the success of the community mental health programs in Aceh, because the Aceh government provided high wages for the psychiatrists who were also provided with special vehicles for their operations. Such benefits were perceived as a great force for change.

Another issue refers to a person's formal position within the organisation. Many participants argued that the current 'status quo' and uncertainty about the organisation's direction is also influenced by the individual's belief that the reform would endanger their position. Functional-3 clearly articulated her opinion about this issue:

> *'… it's a lie if people don't think about benefit for themselves … why work hard if there is no advantage for him, for whatever it might be, not only the material or money, yeah they need to secure their positions and always wanting for higher positions' (Functional-3).*

Security of position does not apply only to those who hold structural positions, but to professionals as well who from a different point of view, also feel that position security is very important.

> *' I don't want to get stressed because I try to change, I have to keep my position comfortable, so I don't want to create conflict, conflict makes me*

tired and depressed, I'm not enjoying my job here anymore then' (Functional-9).

Some participants brought up the idea of moral responsibility to serve people as a value that is ideally attached to being a civil servant. *Structural-19* commented on this, '*so the value of being a civil servant is mainly dedication, being a civil servant means serving people'*. He believes that many public servants dedicate their lives in service to the public. When they work from such a standpoint, nothing stands between the employees and the service user, apart from the provision of good quality service. Some people mentioned that reform is an obligation, a task that must be carried out regardless of one's personal values and preferences. According to *Structural-1*, there is neither negotiation nor bargaining in accomplishing the task of mental health reform. Instead, the tasks are part of his main responsibility in holding a structural position within the planning division.

Summary

The findings show that the slow pace of mental health reform in West Java has been underpinned by complex interrelated factors. There is much evidence to suggest that the problem is not the mental health reform policy itself, but rather the bureaucratic system and the lack of organisational capacity for supporting policy implementation, specifically in West Java.

Most of the participants assume that policy formulation at the national level goes through a range of logical steps, although they tend to regard themselves as inappropriate key informants on this matter. However, they were able to establish that

policy making is not conducted in a vacuum. There are many underpinning internal and external factors that contribute to the creation of policy. There has been an ongoing debate about which policy was actually regarded as the Indonesian Mental Health Reform Policy. The two policies, Health Law 36/2009 and *Permenkes* 406/2009, were mentioned as the basis of mental health reform in Indonesia.

From the participants' perspectives, the 'messiness' of policy implementation begins with the lack of policy dissemination from the central government to the local governments. This results in a range of differing perceptions and various understandings by the bureaucrats, which in turn affects the clarity of policy translation into real programs. The translation process is also in conflict with the existing state of affairs in the provincial government system. This creates a situation in which the practical implementation of the policy may be very different from what the policy had originally aimed for. Mental health service delivery is highly dependent on the public sector, thus actors who work in the public sector have a crucial role to play. Bureaucrats in the West Java Provincial Government are policy-implementers whose actions determine the success or failure of policy initiatives. A number of particularly useful issues were also revealed in the interviews, including the barriers to change, and the skills required to manage change.

Chapter 5 Discussion

Introduction

This chapter brings together the major insights that have come out of the data for this study and discusses them in the light of the theoretical perspectives from the literature. The previous chapter suggested that the mental health system in West Java is at an early stage of transition to a new paradigm, and in the course of implementing mental health reform, West Java faces many unique challenges. This discussion will illuminate the purpose of this study which is to develop an understanding of mental health reform in West Java, Indonesia. The study participants are the bureaucrats who (in this case study) act as national policy implementers at the provincial level. In this discussion chapter, I use the term 'West Java bureaucrats' to represent the study participants.

In the findings chapter, four major issues were revealed: the intricacy of the interrelationships between policy actors; the diverse perspectives on policy content; the 'messiness' of the policy process; and a range of contextual factors which are grafted onto a complex bureaucracy. These descriptive findings revealed that the slow pace of mental health reform in West Java is understood to be due to complex links of certain aspects of the bureaucratic system that connect root causes to unsatisfactory outcomes. This chapter provides a more detailed discussion of the findings moving from a descriptive concept into a prescriptive model as a suggested approach for improving the feasibility of ongoing and future mental health reform in West Java, Indonesia.

In the process of mapping the complexity and messiness of policy in West Java, an analytical lens proposed by Laris and MacDougall (2011) assists with framing the overall analysis for this study. They propose three distinctive characteristics that must be taken into account for public organisations to oversee healthy public policy; values – *civic philosophy*, administration – *the custodial role*, and intersectoral action – *the civic organiser role* (Laris & MacDougall 2011, p. 291). Other relevant theories in the literature are also called upon alongside the use of Laris and MacDougall's framework. The next section covers the summary of the key points about the policy actors, content, process, and context drawn from the data, which lead to a greater understanding of how Laris and MacDougall's analytical lens can act as a prescriptive model for supporting better West Java mental health reform outcomes.

5.1 Understanding West Java mental health reform

The meanings and understandings brought to policy are highly contested, particularly in a bureaucratic setting. As Bacchi (2000) argues, policy meaning is based on the interpretations of the actors involved which can be hypothetically contested, yet at the same time, also reflects the particular context of the real world setting in which the concepts inherent within the policy issue are framed. Reflecting back to the interpretive philosophical approach in the field of policy analysis, which has been applied in this study which infers that public policy needs to be understood through socially interpreted understandings and their meanings, the study not only explores what specific policies mean, but also how the actors are involved, through what process the policy meanings are shaped, and the context in which this happens. Table

5.1 provides an overview of the study findings. Reframing such subjective policy meanings will facilitate a clearer understanding of which factors and areas of improvement are important for sustainable mental health reform policy implementation at the provincial level to inform decision-makers, particularly in West Java, Indonesia.

Table 5.1 Overview of bureaucrats' understandings about policy actors, content, process, and context

Actors	• Mental health reform in West Java is shouldered alone by the WJPH although it is acknowledged that there are shared roles with other public organisations in different levels of governments as well as public involvement in implementing mental health reform. • The TPKJM (the supervisory team for Indonesia mental health reform) has not yet carried out the tasks as expected in the policy.
Content	• There was uncertainty about which policy is regarded as the mental health reform policy, however most of the participants referred to policy documents: Health Law 36/2009 and *Permenkes* 406/2009. • The reform was not strongly felt as the MoH has never officially initiated a 'mental health reform' policy. • The general content of mental health reform policy is about a paradigm shift, from the old paradigm (hospital-based) to the new (community-based care).
Process	• In the policy development process, influences were acknowledged as coming from both local and global forces. • The policy ideas were drafted through top-down, institutional and political processes. • The policy impacts were intended to reduce health inequity, increase awareness, establish early intervention-recovery programs, be used as a legal framework for implementation, and increase mental health funding. • Policy transfer from central to local governments was perceived as lacking which, in turn, created various interpretations.
Context	• Considering the complexity of mental health problems in West Java, which cannot be solved by the existing model, participants recognised the urgency of implementing the paradigm shift in West Java. • The 'devil-in-the detail' nature of policy implementation in West Java has been identified within four layers: ✓ System - *decentralisation, mindset, monitoring-evaluation, workforce, policies, structure, understanding* ✓ Organisation – *leadership, vision, funding, resistance, power, communication* ✓ Team – *innovation-motivation and harmony* ✓ Individual - *financial rewards, job security, moral responsibility, obligation*

The West Java Psychiatric Hospital (WJPH), as one of the public organisations (POs) owned by the West Java Provincial Government (WJPG), takes the utmost responsibility for carrying out mental health reform for the entire province. From Wamsley and Zald's (1973) concept about public organisations, it can be surmised that there are two major elements that define public organisations, ownership and funding (Rainey 2003). POs are owned by the government and receive most of their

funding from government sources, although they can also obtain funding from private sources (Rainey 2003). As the only public organisation which is fully funded for mental health matters in West Java, the WJPH is expected to be the leading actor in mental health reform. The evidence suggests that carrying out this reform is difficult due to the multilayered problems that abound specifically because of the never-ending simultaneous changes in public administration and management.

The new public management (NPM) has replaced the traditional model of public administration in an attempt to improve accountability, professionalism, transparency, citizen empowerment, the quality of services, and accessibility (Berry 2009). In relation to the NPM, while the WJPH assists in articulating public needs and identifying important although too often hidden needs and expressing a desire for their solution, the WJPH must also be responsive to promoting their own accountability and transparency in order to increase public trust, in addition to steering their collaborative partners in the governing of public matters. On top of this, the WJPH has to engage with the myriad of social values, and the bureaucrats in the organisation bear a responsibility to examine, understand, and interpret these public values to the best of their ability. This suggests that the WJPH is overloaded by ongoing system changes, which may be one reason why mental health reform appears to remain a long way off.

The above realities faced by the WJPH can be reframed using Laris and MacDougall's trilogy model. The three characteristics that are attached to public organisations emphasise how POs should operate to advance public health policy. *Civic philosophy* (values), *the custodial role* (administration), *and the civic organiser*

role (intersectoral action) need to be equally balanced to create a more supportive organisational environment to enhance the implementation of mental health reform (Figure 5.1). An organisational theory approach to the public sector is elaborated upon in this discussion chapter, as Christensen et al. (2007, p. xi) claims that 'one cannot understand the content of public policy and decision-making in public organisations without analysing the organisation and operational modes of the public administration'.

Considering the aforementioned characteristics as stepping stones, mental health reform in West Java can be explained as the consequence of an imbalance in the three aspects. Like three horses pulling a chariot, these forces, if coordinated and working together, provide a swift and exhilarating ride, however, if one of the forces is mismanaged or pulls against the others, the ride is bumpy and can end in disaster.

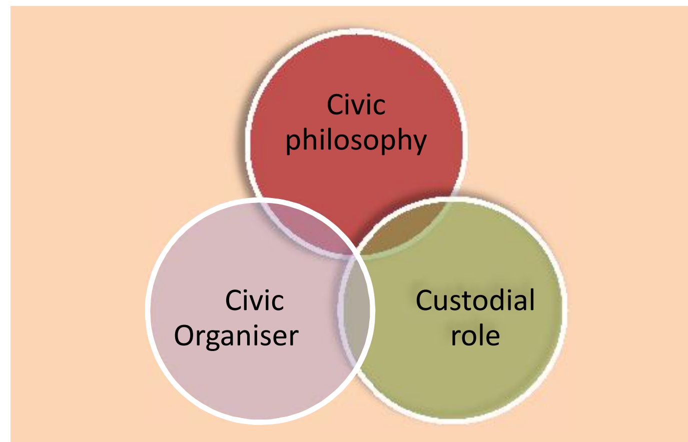


Figure 5.1 The three interlocking dimensions of Laris and MacDougall's model (2011)

The next three sections are based on each dimension of Laris and MacDougall's model. The civic philosophy section discusses the POs' responsibility to fulfill the

rights of people for a healthy life. In order to understand how human rights are included within mental health policies in Indonesia, a historio-cultural perspective, and the details of how policy is developed, are detailed in this section. In this civic philosophy section, the results of the policy document analysis are incorporated in a discussion supporting the historio-cultural aspects of policy, as well as mental health policy formulation. In the custodial role section, there are four subheadings: decentralisation, reorganisation, resources, and organisational change. These subheadings lead us to an understanding that the WJPH, as a public administrator, must engage with what its stakeholders expect, which includes comprehensive reorganisation and modernisation processes. The final section on the role of the civic organiser specifies the WJPH's core responsibility to influence the wider polity or society through exploring and developing partnerships with other agencies and groups in a way that leads to the idea of mental health reform being understood to be 'everybody's business'.

5.2 Civic philosophy

Civic philosophy is 'based on the rights and responsibilities of the organisation as a citizen committed to the health of the society – it often involves reframing health as a human right' (Laris & MacDougall 2011, p. 291). When health is viewed as a human right, it is the POs' social responsibility to fulfill the citizens' health needs by ensuring access to health care, promoting their active participation while engaging their autonomy, and applying the values of beneficence and non-malfeasance (Laris & MacDougall 2011). POs are formed to carry out tasks on behalf of society, and to

operate through public taxes; in this way, POs can thus be understood as tools or instruments for achieving equity (Christensen et al. 2007). This explains that, through an inborn trait, civic philosophy flows through the POs' bloodstream.

In relation to civic philosophy, West Java bureaucrats identify that mental health reform involves community empowerment, integrated and graded services, multisector collaboration, a multidisciplinary approach, the *Desa Siaga* (the Alert Village) formation, equity of access, and government responsibility. On a global basis, all reforms in the health sector are intended to offer better and more effective health services for all citizens and to achieve equity of access and of health outcomes (Bloom 2000, Cassels 1995, Roberts et al. 2008). This noble intention is based on the view that access to health care is a human right. While there have been national differences in how health reforms have been enacted, as a general rule, mental health reforms have emphasised the adoption of a process of deinstitutionalisation and community care, which is characterised by a greater concern for community participation, social inclusion, and human rights protection of mental health service users (Adams et al. 2009, Alarcon & Aguilar-Gaxiola 2000, Barkway et al. 2012, Berland 2001, Bouras 1995). By holding fast to the notion of human rights, a heroic belief in empowerment and greater community participation stands in contrast to earlier paradigms of mental health care, which relied on a more passive involvement approach based on bio-medical principles, often resulting in institutionalised care for the treatment of people with mental illness (Bunton 2008, Marmot & Wilkinson 1999).

In this study, the process of mental health reform in West Java is perceived as being difficult with several bureaucrats stating that it is a *double-trouble extra struggle* effort to achieve the desired policy outcomes. Many commented on the rigidity of the bureaucracy that limits the capacity of the system to achieve the proposed goals. Without thinking about the complexity of bureaucracy, mental illness, by itself, remains a subject of long-standing controversy, particularly in relation to human rights issues (Marzilli 2003). Historically, it is evident that people living with mental illness have not had sufficient rights, and have had only limited opportunities to participate in mental health services other than as passive recipients of health care (Browne & Hemsley 2008, Davidson et al. 2006). This has coincided with a long history of stigma surrounding mental illness.

A substantial body of literature confirms that stigma associated with mental illness is the most prevalent obstacle to the success of programs to improve mental health (Corrigan 2000, Corrigan et al. 2005, Lundberg et al. 2008, Sartorius 2007). People with mental illness are judged for being incompetent in their decision-making (Bjorklund & Pippard 1999). Adopting the principle of human rights and equality, having a mental illness should mean being able to do similar things to other people and to engage in all aspects of wider community life, and not being bullied, discriminated against, ignored, shut out or left out, or assumed to be disabled and lacking in skills, knowledge, wisdom and/or experience.

The findings show that stigma in Indonesian society is strongly inherent within the mindset of some West Java bureaucrats. One participant said that a person with mental illness is viewed as a *waste product*, thus social inclusion for people with

mental illness is indeed a goal to achieve. It is going to take a substantial effort by mental health advocates to be sure that the reform efforts address the needs of citizens. It is unfortunate that the situation of people with mental disorders in Indonesia is still far from satisfactory from a human rights perspective (Irmansyah et al. 2009a). Reflecting back to what commonly happens in Indonesian society, the '*pasung*' practice, a traditional practice where people with mental illness are shackled, restrained, and chained, is seen as a human rights violation. The MoH has recently endorsed a new policy to bring an end to the practice of *pasung* throughout the country. This program is known as 'Abolish *Pasung* 2014', and it is a 'no exception' policy, with the West Java Government also being obliged to implement this new policy.

This policy looks promising on the surface, although it must be remembered that each and every policy creates a wave of consequences in real-life settings. There are always unintended (and sometimes regressive) consequences of what are assumed to be progressive solutions to problems (Gerth & Mills 1958). One of the consequences of this *pasung* policy, for example, is that the West Java Psychiatric hospital (WJPH) has been overwhelmed by high public demand to treat all *pasung* victims in the hospital, with many being rejected, as stated in the findings '*... now we are overwhelmed by the case findings ... we couldn't fulfill their demands ...*' (*Functional-7*). In order to create an overall picture of Indonesian mental health reform, it is essential to look closely at the existing mental health policy in order to broaden our understandings about how problems are defined, to establish the origin, history, and

mechanisms of problem representation, and to understand how policy is formulated (Bacchi 2009).

Tracking back to how policy is developed, according to Michel Foucault's position, genealogy is 'the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles and to make use of this knowledge tactically today' (Meadmore et al. 2000). The unveiling of historical aspects allows us to understand the legitimating principles for what is appropriate to be included in policy, and how agendas are set that produce governing principles. Public policies are tied to specific historical contexts and are the means by which existing social relations are reproduced or contested, and of how different interests are served (Howlett et al. 2009).

The following section highlights the origins of the mental health system in Indonesia, leading to an exploration of how our mental health system functions as it does today. In this section, the results of the policy document analysis are also incorporated. The discussion demonstrates how mental health has embedded itself in distinctive ways in Indonesian society, and where the influences come from. This is revealed through a brief socio-historical overview of how the policies have developed over time. After all, history in a sense becomes culture. Policies are not developed in a vacuum; new policies modify, change, or supplement existing policies (Fischer et al. 2007). This also applies to the development of mental health policy in Indonesia, which can be traced back to when the first policy existed in the colonial era. Revealing the history of Indonesian mental health policy leads to an understanding that human rights related issues are deeply embedded within the ideals of civic philosophy, particularly in

relation to constructions of freedom, and the dignity of, and justice for, the individual, the family and the community. By looking at the historical perspective below, it will be shown that human rights has been, and continues to be, the most important element of mental health policy in Indonesia.

5.2.1 History of policy

Psychiatry was introduced to Indonesia by the Dutch (Porath 2008). The first hospital (a military hospital) was built near Batavia (Jakarta) in the 17th century by the *Verenigde Oost-Indische Compagnie* (VOC) for Europeans. Psychiatric patients were treated in a localised ward in this hospital, with therapeutic treatments being based on the European medical approach. Schoute (1937) stated that the only mental health policy which existed from 1638 to 1642 was an order to punish patients for disruptive behaviour (Porath 2008). When 'moral therapy' or 'talking treatment' was introduced in European countries, two physicians, Dr F. Bauer and Dr W. Smit, proposed that the Dutch government restructure the 'treatment of the insane' according to western principles, and to build a stand-alone psychiatric hospital in *Buitenzorg* (Bogor), providing custodial care through isolation from the rest of society (Porath 2008).

Not long after, the first psychiatric hospital was built and opened in 1882, followed by similar hospitals in Semarang, Surabaya, Malang, Lawang, and Magelang. In these hospitals, patients received modern therapeutic treatments and 'moral therapy'. Admission was by court order or through certification by a physician, as stipulated in the 1897 Dutch Mental Health Law *Het Reglement op het Krankzinnigenwezenof*. It was Willem Bosch (1798-1874) who recommended the idea of training 'native' health

care workers in the colonies. Later, he became the co-founder of the first school of medicine, *Dokter Jawaschool (*1927) in Batavia (known as the University of Indonesia), which trained native people in the basics of western medicine. In the 1940s, psychiatry was first taught in this medical school and medical students started to be sent abroad for their training. During World War II, European psychiatrists were discharged from their duties under Japanese occupation, and non-European doctors took over their responsibilities.

Following Indonesia's independence in 1945, less than 30 foreign psychiatrists were practicing in the country. In 1956, the American government funded a collaborative teaching project between the medical department of the University of Indonesia and the University of California (Porath 2008). This led to the psychiatric curriculum being aligned with that taught in the United States. Henceforth, Indonesian psychiatry was primarily influenced by American psychiatry and took new directions laying the foundation for new, open-style hospitals, and outpatient care. In the 1970s, there were 22 psychiatric hospitals in Indonesia. Hospitals still performed occupational, electroshock (ECT), and insulin shock therapy. During this period, the costly drug Chlorpromazine was prescribed on a limited basis and only for those who could afford it. Most psychiatric hospitals were in large cities, staffed by general practitioners, and there was only one psychiatrist, acting as director, for each hospital.

Viewing this historical timeline, the author suggests that Indonesia has been through several waves of identifiable mental health reform from the time of Indonesia's independence in 1945 to the present. The *first* wave of reform started in the 1960s, with Kusumanto (the father of Indonesian psychiatry, also the founding president of

the ASEAN Federation for Psychiatry and Mental Health) establishing the first private psychiatric hospital, 'the Dharmawangsa' Sanatorium in 1961 which started to provide mental health services other than the simple prescription of medications. In 1966, the Directorate of Mental Health ratified the first mental health policy adopting the three-fold principles of prevention, treatment, and rehabilitation as the foundation of a comprehensive mental health system (Pols 2006). This policy saw mental health being separated from general health, thus affording greater opportunities for the development of the mental health system. The Dharmawangsa Sanatorium was at the forefront of the first mental health reforms including, in 1968, publishing the first Indonesian Psychiatric Quarterly known as '*Jiwa'*. In 1972, the hospital also established a broadcasting station devoted to mental health education for the public.

Indonesia has acknowledged the practice of *pasung* in law for more than four decades. In accordance with Law No. 23, 1966 on Mental Health, patients with mental disorders must receive care and treatment at health care facilities. It is in this policy that the human rights of the mentally-ill were initially endorsed. The Minister of Home Affairs, letter number PEM.29/6/15, dated 11 November 1977 addressed to the Governors of the Indonesian Provinces, stated that mentally-ill people must not be shackled or restrained and that there should be awareness raising programs about mental health at all levels to be delivered by local governments (MoH 2012). *Pasung* is closely related to human rights issues. To date, Indonesia has ratified international covenants such as the UN Convention Against Torture (CAT) in 1998, the Convention on the Elimination of Racial Discrimination (1999), and the International

Covenant on Civil and Political Rights (ICCPR) in 2006 for such human rights protections (Irmansyah et al. 2009b).

In 1969, a comprehensive system of national mental health services was introduced integrating the already existing *Puskesmas* (Community Health Centers) (Pols 2006). Since then, psychiatric hospitals have become part of community mental health programs providing not only in- and out-patient services, but also consultation to general hospitals and engagement in public health education programs. In 1975, the Directorate of Mental Health was appointed as a collaborative centre of the WHO-SEARO. This collaboration initiated a number of research projects on the Indonesian health system, including a research project focused on traditional healing practices for mental health problems. As a result, the co-existence of traditional healers and medical doctors was acknowledged in the national policy. However, unlike the success story of collaboration between physicians and traditional midwives to decrease maternal and child mortality, there have been no attempts made to educate *dukun* (traditional healers) about their practices in healing mental illnesses (Pols 2006).

The *second* wave of reform started in 1992, when the 1966 policy was withdrawn and replaced by General Health Law No. 23. This was the watershed moment when mental health was integrated back into the general health policy. The *third* wave was initiated soon after the monetary crisis hit Indonesia in 1998. A strategy for the transformation of the mental health system was specifically documented in the 2001 National Mental Health Policy. This document outlined community mental health as a set of mental health programs to be initiated at the community level. Ministerial

Decree 220/2002 delineated a set of general guidelines for the formation of coordinating teams for the implementation of minimum mental health service standards at provincial and district levels. Unfortunately, years after this regulation was decreed, the application of this regulation has not been very encouraging in terms of transformation at the provincial and district levels.

Many of the study participants agreed that the turning point in the establishment of community-based mental health was the tsunami disaster in 2004. One participant confirmed that, prior to 2004, this was only a discourse and the implementation of the system was still minimal. West Java bureaucrats claim that the tsunami experience sparked mental health service reform in Indonesia, and this is also why Aceh's experience in the establishment of a community-based mental health system was written into the policy document as a benchmark for other provinces to follow (MoH 2009). Indonesia was the country most devastated by the tsunami which attracted international attention to tackle post-disaster mental health problems (Frankenberg et al. 2008, Irmansyah et al. 2010, Jones et al. 2007, Prasetiyawan et al. 2006). However, adopting the same ways of establishing community-based mental health as those developed in Aceh is rather problematic for West Java. The post-tsunami experience was successful due to the huge support and resources of government departments, non-government organisations, and international agencies. This issue is incorporated within some of the interviews in this study, and point to the idea that West Java bureaucrats perceive that different provinces have different resource levels, thus different strategies are able to be applied, however the national policy seems to generalise these differences.

In this study, West Java bureaucrats recognised that mental health reform was first initiated in Indonesia since 1966, and that the term *community* has also been linked with mental health since the 1970s. According to the participants, during the 1970s, psychiatrists were not only stationed in psychiatric hospitals, but they came to the district general hospital to treat patients. Some of the West Java bureaucrats acknowledged that the paradigm shift from a sickness- to a wellness-orientation was initiated in 2001. When the bureaucrats were questioned about which policy actually documented the Indonesian mental health reform, most of them mentioned the *Permenkes* [Ministerial Regulation] 406/2009: Guidelines of Community Mental Health Implementation, which outlines a detailed approach to the mental health care system, promoting a shift from an institutional to a community-based service. This policy specifies what has been enacted in General Health Law 36/2009, that the mental health system in Indonesia is community-based. As perceived by West Java bureaucrats, 2009 was the hallmark of the national mental health reform, which is regarded as the *fourth* wave of reform. From the author's analysis, this fourth wave is the first stage in the West Java government's implementation of the paradigm shift, as West Java now has a stand-alone community mental health center.

5.2.2 Culture and policy

Most of the study participants expressed that many people in Indonesian society hold a strong belief that mental illnesses are caused through spiritual-cultural means. Accordingly, most patients will be treated initially by religious teachers or native healers, and are often institutionalised in a particular setting along with others who need spiritual treatment. Indigenous healing practices have been used for a long time

by local communities to treat mentally-ill people (Kelman 1968) and, over time, a number of researchers from western countries have been interested in studying the cultural aspects of mental illness in Indonesia (Browne 2001, Hollan 2000, Horikoshi 1980, Ketter 1983, Lemelson 2003, Maretzki 1981). Based on Assan et al.'s (2009) study, the majority of people in rural areas, where most Indonesians live, often use traditional healers, although modern health care facilities are present, with the underlying reason being the high cost of modern health care, cultural beliefs, distrust, and distance. A senior psychiatrist interviewed for this study, said that in Indonesian society, mental health is indeed everybody's business in its own unique way, and a cleric or a school teacher, for example, can handle mild cases, while it becomes a medical problem if it is schizophrenia, or in 'extreme' or 'hard-core' cases. Thus, he added that mental health issues can be seen as medical problems, education problems, religion-related problems, or social problems, and there is no clear-cut boundaries defining each of these categories.

Despite the fact that Indonesia's mental health policies have acknowledged the human rights of people with mental illness since 1966, the *pasung* practice remains the preferred choice for families in taking care of the person with mental illness. This is consistent with a study conducted by Puteh et al. (2011) in Aceh, Indonesia, which revealed that most *pasung* patients had been previously treated in psychiatric hospitals, but that the treatment had been discontinued because either their condition had not improved or because of financial difficulties. These types of physical restraint practices have caused moral outrage not only in Indonesia, but in other countries as well. The WHO has noted that such practices represent an unresolved global crisis in

the mental health sphere (Drew et al. 2011). In Australia and New Zealand, for example, the practice of seclusion or restraint is still used in the clinical setting, and continues to be viewed as an accepted tool in the management of 'out of control behaviour' (Muir-Cochrane et al. 2002). The way it is practiced in Indonesia differs as there is a strong cultural context attributed to the practice.

Based on evidence from a number of studies that have scrutinized the *pasung* phenomenon in Indonesia, the methods of restraint used were securing of ankles in wooden stocks, chaining and tying the person by rope to immovable objects (e.g. a building or a tree), locking them in a confined space such as a cage or a box, and often a combination of confinement and restraint. Most of the ‘patients’ were males ranging in age from 18 to 69 years, and the duration of restraint ranged from 3 months to 30 years (Irmansyah et al. 2009a, Kurihara 2006, Kurihara et al. 2005, Minas & Diatri 2008b, Puteh et al. 2011, Suryani et al. 2011). The main reasons for restraint were to control aggressive behaviour and for safety reasons. The decision to apply *pasung* was mainly made by families, or community leaders in some cases.

An interesting fact from a study in Bali, Indonesia is that almost all *pasung* victims lived close to the community health centre, which at times was only as far as 150 metres away, with the furthest being 5 km (Suryani et al. 2011). Kurihara et al. (2005) studied the never-treated schizophrenic patients in Bali, finding that schizophrenic patients who had not committed any violent acts had not had any opportunity to receive medical treatment. The families in this study had taken all the subjects to a traditional healer, and sought help from psychiatric treatment only after violent behaviour was observed.

Drawing on the perspectives of the study participants, *pasung* is seen as a human rights violation in Indonesian mental health policy. In this respect, policy actors (both policy-makers and policy-implementers) tend to judge families for being inhumane and lacking a sense of social justice. Therefore, it is seen that the humane way for families to deal with the situation is to take the person with mental illness to the hospital because they should be medically treated. From another perspective, families believe that *pasung* is the most viable way to take care of their family members; in fact, that *pasung* keeps people safe who may be in danger of wandering the streets, it keeps the individuals with mental illness from being bullied by others, it helps to protect the individuals with mental illness from self-harming and violent behaviors, and most of all, the practice allows people with mental illness to stay close to their families where they can be easily monitored (Simanjuntak 2010). This suggests that there is a significant divide between the way that policy-makers govern mental health problems and the way in which the community handles these same issues.

In Indonesia, the great majority of people with psychiatric conditions are in fact already managed in the community, and their families play a significant role in taking care of them, considering the very limited resources available to the psychiatric hospitals and the fact that these institutions are mainly situated in large urban areas. Basically, people with mental illnesses have been kept integrated and within their local community. Similar to the development of alternative community services in the West, in Indonesia, native healing practices have long been used by local communities for treating people with mental illness which are intimately bound to their religious and cultural beliefs (Kelman 1968). The so-called psychotherapy,

moral-therapy, or talk-therapy which has been successfully developed and applied in the West, has also been part of alternative community services for a considerable time in Indonesia (Maretzki 1981, Porath 2008). Slamet Imam Santoso, the first Professor of Neurology and Psychiatry in Indonesia, who introduced western psychotherapy into the country, wrote an article in the American Journal of Psychiatry about the barriers facing the practice of psychotherapy in Indonesia. He revealed that terms such as 'schizophrenia', 'the unconscious', 'biology', and 'the mind' did not fit with the local parlance and understandings, as these terms could not be translated precisely into local languages (Pols 2006, Porath 2008).

Psychological experience is culturally alien to indigenous concepts and, even more incongruent is the fact that the majority of Indonesians hold strong religious beliefs. In Islamic society, for example, mental disorders are believed to be religious disorders as a result of a patient's inadequate religious faith (Horikoshi 1980). Accordingly, most patients will be treated by religious teachers, and are often institutionalised in a particular setting along with others who need treatment (Horikoshi 1980).

Farooq & Minhas (2001) argue that in developing countries, community-based mental health services do not even exist in the same sense as that which is practiced in western countries. It seems that although the policy-makers, who are predominantly psychiatrists, have knowledge about psychological experience being culturally alien to indigenous concepts and, even more, that the majority of Indonesians hold strong religious beliefs, these issues have not yet emulsified into national policies. Hence, due to insufficient research data presented in most Indonesian mental health policies, West Java bureaucrats believe that the policy objectives do not correspond to local

needs. Owing to the fact that the number of psychiatric hospitals which were built during the colonial era is very few, with a very limited bed capacity (MoH 2010a), the mental health care system in Indonesia can be regarded as being more community-based, where most care is provided by, and in, the community. There are also informal local institutions run by groups of religious healers offering treatment for people with mental illness.

Borrowing the term *a new age of confinement* proposed by Sociologist Nikolas Rose (2006), it is true that we are now living in the age of confinement. *Pasung* is intended to confine a person with mental illness in a wooden stock regardless of the way we view the case; we also confine people through the life-long expensive consumption of antipsychotic drugs, as we confine them through such frightening labels as schizophrenia for the rest of their life. Rose further argues that, historically, psychiatry was born in the asylum, with the walls of the asylum being a clear boundary to differentiate between the person with mental illness and the healthy, but today the diagnostic manuals are no longer relevant only within the walls of the asylum.

The limits of normality have changed; a multitude of conditions that are on the borders of normality, such as anxiety, panic, mild to moderate depression, or the disorders of childhood such as ADHD, are now included in the diagnostic manuals. The expansion of the use of certain psychiatric classifications and the treatment of those so diagnosed has resulted in much debate and controversy because of questions about undue pharmaceutical industry influence. This has opened the door for *disease mongering* which is defined by Moynihan et al. (2002, p. 886) as 'widening the

boundaries of treatable illness in order to expand markets for those who sell and deliver treatments' (Moynihan et al. 2002, p. 886), and for this reason these authors claim that prevention programs are in fact an empirical terminology for 'telling healthy people they are sick'.

The revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by the American Psychiatric Association (APA) has recently been critiqued for including premenstrual dysphoric disorder in the DSM-5 as a Mood Disorder (Cosgrove & Wheeler 2013). This is to say that the pathologising of a part of the menstrual cycle is an example of how scientific truthfulness becomes sacrificed to corporate gain. The absence of biological markers for psychiatric conditions makes psychiatry more vulnerable to industry influence than other medical specialties and industry has been able to co-opt the lack of biological markers to its own advantage (Cosgrove et al. 2006).

Despite the more positive implication that the expansion of such medical classifications is indeed an appreciation of an individually unique lived experience, the high cost of shifting to such a scientific medical model is unavoidable. Since premenstrual dysphoric disorder is now considered to be a mood disorder by psychiatrists, people who are diagnosed should now receive medical intervention (Cosgrove & Wheeler 2013). However, when the 'problem' is viewed from a different perspective, when people believe that such a mood disorder is simply part of the normal menstrual cycle, people will not seek professional help. This clearly shows how significant problematisation is in policy debate, as Bacchi (2008) argues that a focus on problematisations (rather than problems) can demonstrate the role they play

in governing processes, whether a problem really is a problem or not is an important part of political and policy debate and stakeholders need to persuade others that the problem exists or that the problem being cited is actually the real problem.

This phenomenon links back to the bureaucrats' perspectives, revealed in the findings, confirming that what they mean by community-based service, in practice, is bringing psychiatric medications closer to the community, thus the action taken is how to make standard psychiatric drugs available at the CHCs, despite the bureaucrats fully understanding that this 'solution' creates further issues. One example of this was revealed by the participants who said that no matter how good the GPs' knowledge and skills are in detecting early signs of mental illness, and the availability of a wide range of prescribed psychotropic medications provided by the CHCs, the utilisation of these resources remains low as people do not come to the CHCs for the treatment of mental illnesses.

The culturally-embedded belief that mental illness is not a disease that needs to be treated through medical intervention might be comprehended as one of the reasons. The well-known metaphor, 'we can lead a horse to water but we cannot make it drink' is a perfect picture for this phenomenon. This relates also to how different perspectives (between people and health professionals or decision-makers) about a mental health problem can have significant implications for the implementation of policy initiatives.

From the above discussion, it is clear that the clash of cultures in Indonesian mental health policy may be considered as the underpinning factor contributing to the gap

between policy-making and policy-implementation. In relation to these cultural issues, Suryani et al. (2011) states that although the adoption of a community-based system in Indonesian mental health policies may promote broader and more effective services in treatment and prevention, such policies may themselves fail should they not adopt a local cultural perspective.

5.2.3 How policy is developed

West Java bureaucrats perceive that Indonesia's mental health reform policy is created through a top-down, institutional, political process. This is not at all surprising considering that although Indonesia's democratisation has been focused on decentralisation since 1999, policy-making remains with the central government. Prasojo et al. (2007) explain that regional autonomy in Indonesia is nothing like that experienced by the federal state, as autonomy was given by the central government, and formed through law, and thus hypothetically, it can be removed again. This is further exemplified by the fact that some matters remain the permanent responsibility of the central government, including policy-making. One of the problems with policy-making is that the policies are not drafted through a process of building democratic consensus among the public therefore, the entire process occurs without public input, comment, or critique (Holtzappel & Ramstedt 2009). The policies are drafted and approved only within the MoH, or in cooperation with other government ministries. In so doing, it is possible that government officials may not identify or address pressing problems that can only be revealed through consultation with a wide group of stakeholders and community members (Datta et al. 2011).

In the Indonesian system, the drafting process is based on formal rules, as follows: *political,* drawing on the agenda proposed by the president (or other democratically elected leaders); *technocratic*, based on data generated through scientific methods; *participatory,* incorporating the views of interest groups or stakeholders, including those from the executive, judiciary, legislature, society, the private sector, and non-governmental organisations; *top-down*, centered on plans prepared by the president, ministries, and agencies; and *bottom-up*, founded on plans from the village, district, and regional levels (Datta et al. 2011, p. 6). However, based on Datta et al.'s study, these formal rules are too often incompletely applied, especially for the *participatory* and *bottom-up* rules. The more actors that are involved, the more vested interests arise which, in turn, often creates a policy gridlock. Policy gridlock means that every possible direction of change can be blocked by the interests of one group or another (Rosenau 1992). As a result, the entire policy process takes a lot of time. This has tended to result in an immature or imperfect government policy product which is unlikely to capture the real problems faced within society, thus lacking feasibility, which is evident in the results of this study.

Nevertheless, when compared to the era prior to decentralisation, the policy-making process is now no longer an exclusively executive affair, and has become more open, more pluralistic, and less top-down (Holtzappel & Ramstedt 2009). Traditionally, government has been seen as the master institution in producing public policy, whereas today many more actors are involved and government no longer has a monopoly in this area (Denhardt 2008, Weidner 2009). From the policy implementation scholars' perspective, the 'top-down' does not necessarily refer to the

‘top’ as in the hierarchical sense where the decision-makers have more power and a more legitimised role, but rather in the sense that what comes after policy formulation is the implementation process (Hill & Hupe 2009). This explanation may shed light on the idea that West Java bureaucrats’ perceptions about policy formulation are not overly skeptical in relation to top-down, institutional, and political processes.

Based on the interviews conducted for this study, mental health reform in Indonesia has, to a large extent, been driven by international agencies. This is not uncommon, as Milio (2001) points out that policy-making is driven by organisations and groups that have an interest in the outcomes. Moreover, in developing countries, international organisations are regarded as catalysts that foster the exchange and transfer of policy ideas, solutions, and problem perceptions between governments and beyond (Fischer et al. 2007). As the WHO echoed, it is evident that the treatment gap for mental disorders is significant all over the world, and that four out of five people with serious mental disorders living in low- and middle-income countries (LMICs) do not receive the mental health services they need (WHO 2008a, WHO 2009c), not to mention that LMICs are faced with extraordinary risk factors for mental illness such as poverty, conflict, stigma, disasters, co-morbidity and increased risk of injury, weak infrastructure, the lack of a specialist workforce, and low levels of investment (Patel & Kleinman 2003, Thakker et al. 1999). Apart from global pressures for Indonesia to provide effective, accessible, affordable, and equitable mental health services according to West Java bureaucrats’ understandings and predictions of why such mental health reform policy exists in Indonesia there are also influences that stem from the national situation. The bureaucrats mentioned a number of internal drives:

the lack of effectiveness of existing hospital-based services; the scarcity of resources including health care professionals, funding, and facilities; the magnitude of mental illness; stigma; and national reforms.

The objectives of mental health reform policies were understood by the West Java bureaucrats to be adopted strategies from other countries' 'best practices' to tackle mental health problems. West Java bureaucrats seemed very confident that the global influence is stronger than the local influences, and this is evidenced by the limited amount of national research data in the field that is applied to the policy-making process, and moreover, most of the data used was felt to be out of date. It has been well-documented in the literature that policy-makers appear to be increasingly looking to other countries' political systems for knowledge and ideas about institutions, programs and policies, and about how they work in other jurisdictions (Evans & Davies 1999).

Rudolf Klein noted, in discussing cross-national comparisons in health care, that there are no nations that can escape the bombardment of information about what is happening in other countries (Marmor et al. 2005). Globalisation and technological advances have provided a stimulus to the borrowing of policies and 'best practices' between and within countries (Dolowitz & Marsh 2000, Turbin 2001). This provides a way of dealing with a problem quickly and at a lower cost (Newmark 2002, Wolman & Page 2002). Despite the advantages, 'lesson learning', and 'policy borrowing' or 'policy transfer', have a number of limitations. For example, Stone (1999) points out that this process is not politically neutral, and thus the value of it lies in the policy-makers' power to influence policy choices, and also that domestic policy problems

cannot be dealt with effectively by using culturally-neutral policy solutions. This ties back to the above cultural section that elaborated upon Indonesia's context-specific issues, and more specifically, to the cultural issues inherent in policy-making that make it a rather challenging process.

As the West Java bureaucrats stated, the national policies are primarily focused on fixing the problem by suggesting a certain model of intervention without acknowledging causation and the wide disparity of resource availability across the different regions. Policies are not uniformly communicated to local governments, thus the West Java bureaucrats have a wide variety of understandings. Moreover, the depth of knowledge on policy depends on the participants' positions and roles in the organisation. The details of the content are not well-understood by the bureaucrats involved in this study and, more importantly, there was a lack of dissemination from the MoH regarding the policies.

Although some of the study participants were exposed to the policies, they were informed through a range of different sources. Of concern though, is the fact that the adoption of the information itself is a complex process which begins with an individual or organisation becoming aware of an issue and being interested in understanding it (Miyake 1986). The extent to which an individual or organisation becomes knowledgeable is somewhat dependent on the dissemination strategies applied (Greener 2002). It is acknowledged that personal, one-to-one contact with intended audiences are more effective in disseminating policy information, as is the facilitation of the utilisation of knowledge in practice such as through workshops and conferences (Dobbins et al. 2002).

The data suggest that the ways in which the policy-makers see the problems to be addressed in national mental health policies, and how the issues get onto the policy agenda, are highly contested topics. The absence of local concerns in the national policy may be the reason why the West Java bureaucrats perceived a lack of clarity in the national policy. Also, and perhaps most importantly, without a bottom-up process responding to local needs, the feasibility of policy implementation at the local level will be lessened. From a different viewpoint, policy-making is a complicated process involving a formal procedural bureaucratic process, and the application of formal rules of governing. The factors that inhibit or facilitate the process are equally complex. The issues underlying the problematisation of mental health in Indonesia are infinitely more complex than the solutions suggested in national policy. What is endorsed in Indonesian mental health policy is primarily still based on modern medical science; that is, to treat patients in health care facilities, and to get treatment from mental health professionals as early as possible. As explored earlier in this chapter, these clash with local traditional-cultural practices.

Returning to the civic philosophy, it appears that the value of governing society's mental health needs seems to be lost in policy. The contraction of civic philosophy in the government of mental health has been further exacerbated by the complexity of 'wicked' mental health problems by their very nature. Although there has been acknowledgement of the still strong stigma attached to mental illness, and how pervasive the human rights violations have been against people with mental illness, nothing thus far has been able to have a positive effect in lessening these ever-present issues. du Gay (2005) observes that the idea of the bureaucracy as a unique kind of

'moral institution' for the organisation of public affairs, has been largely discarded. Moral values have been replaced by the logic of modern bureaucracy, which in fact produces inefficiency, dehumanisation, and ritualism, with more paper work and a massive amount of formal rules which are too often conflicting and restricting (du Gay 2005). This partly clarifies why civic philosophy has become so distorted in public organisations. The following section examines the ideas of du Gay, that the value of bureaucracy has been lost as a result of the modernisation of bureaucracy.

5.3 Custodial role

The custodial role is the role of 'the responsible public administrator (or in some cases the administrator of a private enterprise with public or social goals)' to ensure that the organisation delivers what its stakeholders expect (Laris & MacDougall 2011, p. 292). Indisputably, POs are charged with administrative responsibilities, the foremost determinant of this is to uphold accountability to ensure that the organisation is trustworthy in delivering stakeholders' expectations. The building of public trust is among the major intentions of the modernisation of a bureaucracy. Public services have been the setting for persistent and complex arguments about bureaucracy (Clarke 2005). POs adhere to the classic Weberian characteristics of hierarchical organisation, such as delineated lines of authority in a fixed area of activity; action taken on the basis of, and recorded in, written rules; bureaucratic officials needing expert training; rules being implemented by neutral officials; and career advancement depending on technical qualifications judged by the organisation and not by individuals (Goodsell 2005). While recognising bureaucracy as the most efficient form of organisation,

ongoing bureaucratisation leads to bureaucratic monoliths, with bureaucracies being criticised for their complexity, inefficiency, and inflexibility, which are characteristics ill-suited to the demands of modern market societies (Clarke 2005). From the 1980s onwards, bureaucratic rationalisation has been the dominant organising logic of modernity in the developed world, and later in developing nations.

Despite the fact that modern bureaucrats attempt to eliminate costly, complex, inefficient, and inflexible bureaucratic procedures based on past practice, in reality the post (neo)-bureaucracy raises the same issues of accountability as the old. As Hopfl (2011, p. 30) points out, the problem is no longer being ‘not accountable’, but rather, the issue is one who is to be trusted? This skeptical view is indeed a real-life situation for the WJPH as a public organisation. Taking one example from this study, the growth of evaluative processes and systems to uphold accountability, such as inspection, audit, and performance measurement, has in fact lead to excessive bureaucracy and an over-adherence to rules and formalities, which in turn, creates more red-tape. Since efficiency is judged in simple quantitative terms, it is an extremely time-consuming and administratively burdensome way of operating. It is understandable, as Thomas and Grindle (1990) have argued, that in policy implementation, the implementers engage more in administrative activity rather than in politics, as in the decision-making process.

The WJPH operates within a political context in which it governs the use of public money. The use of such funds is rigorously monitored. As evidenced in the previous chapter, this pressure is greatly felt by the top managers; they must strictly monitor the utilisation of funding, at the same time as dealing with corruption and bribery. The

new regulation that stipulates that public hospitals must apply business-like management processes means that, for the WJPH, 'business' is obviously 'busyness' leading to mounting administrative tasks. The national strategy to change the status of public hospitals to that of autonomous hospitals, known as BLUD (*Badan Layanan Umum Daerah* – Regional Public Service Board), has contributed to even more 'busyness'. Although BLUD is based on the principles of efficiency and productivity in providing a good quality of health services to the public, the process has not been stress-free. In fact, most participants in this study do not understand what BLUD actually is.

In short, modern bureaucracy may provide benefits to some extent, but this can ultimately erode the value-principles of mental health reform. There are four issues identified from this study that underpin why the custodial role has been given the most attention and time in the WJPH which, in turn, eats away at the time devoted to developing a civic philosophy, these are decentralisation, reorganisation, resources, and organisational change.

5.3.1 Decentralisation

Decentralisation was one of the key elements of the implementation of the Primary Health Care (PHC) model, economic development, and a major strategy to achieve health for all, which were endorsed by the WHO (Saltman et al. 2007). Decentralisation in the Indonesian health sector implied that the MoH maintained the responsibilities of policy-making, long-term macro-planning, and monitoring. Local governments were given authority to undertake local planning, management of health

services, allocation of resources, financing, control of finances, supervision, monitoring, and evaluation (Kristiansen & Santoso 2006).

Decentralisation, which dominated much of the discussion on structural reform in the public sector after the monetary crisis in Indonesia in 1997-1998, has impacted greatly upon the West Java mental health system, with the two psychiatric hospitals being 'given' to the West Java Provincial Government (WJPG) in 2002. Decentralisation triggered, or was accompanied at the same time, by an administrative redesign. The 'giving away' of the psychiatric hospitals to provincial governments was also a consequence of the declining concern for mental health matters in the MoH, which was originally managed by the Directorate of Mental Health, down to the Division of Community Mental Health under the Directorate of General Community Health (Pols 2006). Throughout the country, the performance of psychiatric hospitals under provincial governments has declined as most of the psychiatric hospitals have been under-funded. In West Java, this period of darkness was likened to '*being in an old broken car with a lot of passengers*' by one study participant.

While it is important, the big-bang decentralisation process has tended to overwhelm most aspects of development, including of the mental health system in West Java. As voiced by the participants in this study, the process has been accompanied by inadequate supervision, and a lack of advocacy and monitoring from the previous owner (the MoH) to the new, the WJPG. As a new player in hospital administration and management, the WJPG has a dearth of experience in this area which is exacerbated by the lack of consultation. This has resulted in the management of

psychiatric hospitals in a similar way to other offices and bureaus which are grounded in the rigidity of hierarchical bureaucracies, a lack of control by managers over the day-to-day operations of their facilities, and an increased focus on administrative and financial accountability. Together with the very limited funding for psychiatric hospitals, these situations have led to the mental health services being conducted in a 'business as usual' fashion, just enough to serve the people who come in for treatment.

5.3.2 Reorganisation

Government Regulation no. 41, which was signed by the President on July 23, 2007, has forced the reorganisation of the mental health system. The structural reforms have been conducted through various forms of mergers. On a global basis, there have been sharp increases in organisational mergers and acquisitions over the last two decades as a result of global competition, rapid technological change, government deregulation, and demands for cost-cutting measures (Fischer et al. 2007b). The 2008 merger, however, was not achieved through combining two different locations into one, as this was ruled out by the hospital regulations decreed by the MoH which stated that a hospital must be situated at one site. This has forced the single site to be converted into a community mental health centre with a large state budget which was completed at the end of 2011. From the study findings, most of the participants confirmed that this newly-built facility has been a catalyst in declaring that mental health reform is on the move in West Java. Unfortunately, to function as a community centre, this facility has encountered an abundance of obstacles, mostly due to clashing national

and provincial government policies, and also as a result of the problematic human resource issues.

From the findings chapter, it is clear that unraveling the West Java situation is a never-ending story because, in the real world, the wave of consequences is always expected to continue. The ‘devil is in the detail’ is a perfect metaphor for mental health reform in West Java, emphasising the unforeseen details of policy consequences impacting upon a broader system all the way down to the individual level. In this study, the findings demonstrate that pressure from the central government to rationalise publicly-funded organisations steered the merger of the two psychiatric hospitals in West Java. It is unfortunate that the politically-driven decision to merge was not backed by a critical situation analysis which should have been conducted, particularly by the WJPG.

The merger of two psychiatric hospitals

The merger of the two psychiatric hospitals has been problematic, since the two differ in location, hospital classification, and most of all, in organisational culture. As a human resource manager in this study stated, the blending of the two different cultures was quite daunting. Before the merger, he stated that each hospital had found itself overwhelmed by a complex matrix of fragmentation and tensions, such as: between patients’ needs and government policies, and between professional interests and the emerging general management agenda. The merger policy was not a bargain, and did not even provide a take-it or leave-it option for each hospital. They simply had to adhere to the regulation, and the participants felt that they did not have the

power to negotiate or modify the decision. The impersonal and bureaucratic features of the merger procedures themselves produced frustration and anxiety (Shield et al. 2002). Apart from the employee-related issues, the merger was not thoroughly consulted with the MoH. Until the interviews were conducted (2013), the WJPH was still recorded as consisting of two separate provincial psychiatric hospitals in the MoH data system. Being an unrecognised organisation in the national government system has disadvantaged the WJPH in a range of ways, for example, they are unable to claim health insurance for poor patients who are covered by national budget funding. The above are only some examples of the tensions created by the merger which, in turn, are constructed by a number of other multi-layered issues.

Theoretically, such consequences could have been prevented if the merger decision had been withdrawn, not only for financial and legal reasons, but also in relation to the human factors involved, in this respect, the psycho-cultural issues. As Rottig (2013) emphasises, between 50% and 83% of mergers are unsuccessful due to failures in recognising psycho-cultural issues. Specifically in the health care system, the empirical evidence suggests that the success of hospital mergers is founded on an understanding of power structures, organisational value systems, and local cultures (Shield et al. 2002). A circular model for a successful organisational 'marriage' is proposed by Rottig (2013) comprising of three phases, the *dating*, *mating*, and *creating* phases. The dating phase is the assessment of cultural compatibility, hence the involved organisations will have an opportunity to socialise, interact, and assess whether their cultures are compatible. The second phase is an open, two-way cross-cultural communication among the involved workforces in their local organisational

environments. The final phase is an active engagement of key executives and managers (top-down approach) and the involved workforces (bottom-up approach) about cultural differences to create mutual trust, commitment, cooperation, and a common identity toward the combined organisation.

This is not to suggest that the WJPG must apply this three-step model to successfully merge the two psychiatric hospitals, but rather to analyse the taken-for-granted aspects which are needed for making such decisions. Mergers involve a difficult process with uncertain outcomes (Fischer et al. 2007b). The fact that human resource issues can actually cause a merger to fail is often underestimated. Hunt (1987) pinpoints that one-third of mergers fail within 5 years predominantly due to personnel factors. It has been 5 years since the 2008 merger, and the results show that the only reason that the WJPH appears at the surface is simply because it is government-funded, otherwise it would have been submerged, and large numbers of staff would have left immediately after the merger due to insecurity. From this point, although the merger decision has had a good impact in terms of effective and efficient public organisational performance, the implications for other issues, such as the human factors, are undervalued.

The establishment of the BLUD

Many participants in this study depicted the existing mental health reform situation in West Java as a 'sinking ship', representing the difficulties experienced by the WJPH as an organisation in responding to mental health reform tasks. Apparently, the WJPH is overloaded by ongoing system changes which began in the era of decentralisation,

and which were then followed by the merger. The load of the ship becomes heavier as all publicly-funded hospitals across the country must be converted into BLUD (a private-like organisation system) as legislated by the MoH in the new Hospital Act 44/2009. In this respect, the WJPH must become a regionally-owned enterprise. Participants commented, despite the advantage of improving service quality due to financial management autonomy, that this BLUD adds to the long ‘must do’ list that is inevitably attached to the WJPH as a government-owned hospital. The interviews in this study show that, although not everyone regards this as burdensome, especially the street-level bureaucrats, this has led to heightened frustration and anxiety for managers which has created new administrative tasks that take up a great deal of time, energy, and most of all, more paperwork.

In the past, public bureaucracy has come under much criticism for its reputation. Wæraas & Byrkjeflot (2012) list a number of images of bureaucracy or bureaucrats as summarised in the literature: an image of ill-spirited bureaucrats who try to figure out how to increase the regulation of citizens while extending their own malign influence; the lazy, procrastinating, and indifferent bureaucrat with no customer or service orientation, busy reading magazines, planning sailing trips, or buying and selling stocks; public organisations that are too big, wasteful, slow, unreliable, not sufficiently transparent, and inefficient; and public administration that is old-fashioned, obsolete, in need of drastic reform, and nightmarishly frustrating for those who are trapped inside it (p. 186). One of many ways to counteract these negative images is to modernise the public sector by relying on entrepreneurial and business-style models. Privatising the public sector is intended to create not only a more

responsible, accountable, and responsive government, but also to improve the public's impression of the government and to restore public trust (Wæraas & Byrkjeflot 2012).

While the proponents of privatisation enthusiastically introduce it into the public sphere, its legitimacy, ethical standards, and motivational foundations have been seriously contended, especially in the health service field (Gardner & Scheffler 1988, Shield et al. 2002). Indonesia today seems to be moving towards an entrepreneurial health care system based on the US model, where the responsibility of government is reduced and increasing market share is opened up to the private sector (Kristiansen & Santoso 2006). There are now increasing numbers of private hospitals and clinics across the country, especially in the larger cities. The high hopes of privatising the health sector are assumed to be promising for physical health, however, the world has been turned upside down for the mental health sector. In Indonesia, mental health is predominantly a public sector affair. The reason for this is not surprising, since it is obvious that mental health problems, which are in nature mostly long-term complex stigmatised diseases, are not profitable and marketable commodities. This may strengthen the fact that West Java's mental health problems are shouldered alone by the WJPH, as is evidenced in this study.

Based on the WJPH annual report, 76.82% and 63.80% of the total annual visits to inpatient and outpatient units respectively, are poor patients funded by public health insurance (*Jamkesmas*). The remaining patients are covered by civil servant health insurance and out-of-pocket payments (WJMH 2012). It is indeed unappealing for the private sector to offer mental health services, as the majority of patients are poor, the tariffs set under the insurance scheme for mental health-related diseases are too low,

and because of the lengthy procedure for claiming the bills from the insurance providers (in this case, the government, and the refunds are granted only if the funds are available).

The application of a business-like model in publicly-funded psychiatric hospitals tends to provoke great anxiety for mental health advocates. For the purpose of setting up the tariff in health insurance, mental illnesses are defined as short-term episodes, with a definite beginning, a definite end, a definite medical diagnosis, and a definite preferred set of treatments. In the Indonesian health insurance system, for example, the insurance coverage for a patient who needs to be hospitalised for an acute schizophrenic condition is 21 days of in-patient treatment whereas, in reality, there is a wide range of LOS (length of stay), between 50 and 90 days based on national records, and in West Java, an average of 33 days (WJMH 2012). The impact of this on service quality for patients is enormous, as one social worker in this study commented that patients too often have to be discharged and taken home, not because they have recovered but because of the 21-day treatment limit. The patients are forced to recover very quickly, and they frequently have no opportunity to take part in rehabilitation programs. In response to the limited number of in-patient days covered by insurance and the limited availability of beds, a program known as *dropping* has been implemented in which the Community Mental Health Unit programs send patients home for those who cannot be picked up by their families.

Likewise, within the West Java Provincial Government system, as mentioned by the interviewees, hospital performance is measured based on revenue; for instance, it is based on how much annual income the hospital brings in, or on how many

prescriptions are issued. Applying a business-like model infers that having more patients means gaining more income, and therefore it is appraised as having better hospital performance. This fact is, to a large extent, poles apart from the principle of the community mental health model which applies graded mental health services, and places psychiatric hospital treatment as a last resort.

The data suggest that the WJPH is in a state of indecision about whether to improve their hospital-based services for the purpose or gaining more income, or to move beyond this as a community mental health organiser. In doing the former, besides building a community mental health centre, the WJPH is also building more wards. As a result, there is a shortage of staff because the WJPH has extended its services despite utilising the same number of employees as previously.

The new hospital accreditation

The upcoming Joint Commission International (JCI) hospital accreditation process adds an even heavier cargo to the fully-loaded ship. Referring back to the importance of this as noted in the findings chapter, it has been very difficult for the WJPH to pass the national standard hospital accreditation, let alone to pass the international hospital accreditation which must be conducted in 2014. Until the data has been collected, the WJPH cannot be officially classified as an ‘A-Class’ Psychiatric hospital according to the MoH, whereas in the merger (different ministry) policy, the WJPH is already classified as an ‘A-Class’ Psychiatric hospital. To be granted the designation of a type ‘A’ psychiatric hospital, according to the national standard, the WJPH needs to recruit additional specialists, such as obstetricians, pediatricians, and others (MoH 2010b). It

is not an easy procedure to recruit new employees, because civil servant recruitment is governed by the central government. Thus, the WJPG and the WJPH have taken the initiative to hire a number of required specialists under contract. The logic of providing these (largely unneeded) specialist services for mentally-ill patients is questionable, and the money spent to hire them seems to be wasted, as based on the WJPH records of 2012, very few patients were referred to these types of specialists (WJMH 2012).

In the MoH's Strategic Plan 2010-2014, one of the indicators that has to be met is that Indonesia must have world-class hospitals (MoH 2010d, p. 32). Indonesian hospitals are internationally accredited by the Joint Commission International (JCI), a global accrediting agency from the USA. The decent intention of adopting this process is simply to enhance service quality, including patient safety in hospital, and moreover to ensure a level playing field for Indonesian public and private hospitals in the global healthcare services arena. Despite the fact that Indonesia has 1,800 hospitals, many wealthy Indonesians spend trillions of rupiah (the Indonesian currency) each year on medical treatment abroad (MoH 2010d). It appears that the policy decision to upgrade public hospitals to world-class is made on account of many upper-class Indonesians not being satisfied with Indonesia's health services.

5.3.3 Resources

Resources for mental health include policy and infrastructure, mental health services, community resources, human resources, and funding (Saxena et al. 2007). The following section discusses the general issues with these resources, especially in West

Java, which were perceived to be significant by the participants in relation to mental health reform.

Policy and infrastructure

Today, there are 33 government-owned and 16 private psychiatric hospitals in Indonesia, however not all provinces have psychiatric hospitals (MoH 2009). Of the 1,678 institutions classified as public hospitals, about 2% provide mental health services, and only 15 out of 441 general hospitals owned by provincial/ districts governments have psychiatric services. This data clearly shows that hospital beds are very limited, and the gap between what is urgently needed and what is available is still very wide. There are 244 public and private hospitals in West Java. Of these, 29 hospitals provide outpatient mental health services, while in-patient services are only available in two hospitals (Diskes Jabar 2012). There are also 1,039 CHCs across the province, however there is no data about how many provide mental health services (Diskes Jabar 2013).

Mental health policies and plans for their implementation are essential for the coordination of services and activities to improve mental health (Saxena et al. 2007). Law 22/1999 gave authority to the lower levels of government; this substantial devolution of political power sought to bring government closer to the people (Kristiansen & Santoso 2006). The WJPG now acts as both national policy-implementer and local policy-maker. The importance of formulating local policy was expressed by West Java bureaucrats in this study to incorporate mental health into

CHC programs. However, this must be done in collaboration with the district government as CHCs are under their jurisdiction.

Mental health services

Many participants commented on the combined community-based and hospital-based model, as a suitable form for the mental health system in Indonesia. Yet such a balance has only been successfully achieved in a few high-income countries, where financial resources have been matched by the political will to increase community care (Saxena et al. 2007). Although the WHO has endorsed the idea that large and centralised psychiatric institutions need to be replaced by other more appropriate community mental health services (WHO 2011b), the study participants believe that psychiatric hospitals are still very much needed in Indonesia. They placed emphasis on the idea that Indonesians' beliefs about the health system is that people come to health centres or hospitals only for medications, and thus accessibility to psychotropic drugs is the first priority. The managers and practicing psychiatrists in the sample stated that community-based initiatives would not be successful if atypical antipsychotic drugs were not yet available and accessible. This suggests that access to psychotherapeutic drugs is a precondition for community-based approaches to be successfully implemented. The ways in which this issue is problematised explains how the WJPH has set up programs to implement mental health reforms. Some of the participants stated that the ultimate goal of community mental health in practice is to provide psychotropic medications at the CHCs so that patients do not need to travel long distances to the capital cities simply to top-up their antipsychotic medications.

According to a number of psychiatrists who participated in this study, it is not possible for standard antipsychotics to be provided by the CHCs. The WHO has set up essential psychotropic medications to be available in the CHCs, such as chlorpromazine, fluphenazine, haloperidol, amitriptyline, carbamazepine, lithium carbonate, valproic acid, diazepam, and clomipramine (WHO 2005). Based on the participants' experience in the field, only a few CHCs actually provide psychotropic drugs, and only chlorpromazine, diazepam, and luminal are available. Despite the fact that 28% of patients admitted to the CHCs showed signs of mental health problems (Department of Health 2001), as stated by a number of participants, the GPs practicing in the CHCs were lacking in the confidence needed to prescribe psychotropic drugs to patients, particularly because these types of drugs have serious side-effects, and generally need to be prescribed by a psychiatrist. The lack of availability of psychotropic drugs in the CHCs and district hospitals is suggested to be because medications for mental illnesses are not categorised as 'important' as mental illnesses are not counted in the 'top ten' most commonly reported diseases, and moreover, mental health is not yet incorporated in the 'basic six' health services to be provided by the CHCs.

Funding

In West Java, mental health funding mainly comes from the regional budget and, at present, all the funding goes to the WJPH. Some of the participants noted that although health is funded to the tune of 10% of the regional budget, for mental health it is less than 1%. Others commented that there has been a significant increase in mental health funding in West Java and that the government is highly supportive of

mental health initiatives, and in fact, that the WJPH has been given a substantial budget. It is the planning and utilisation of this large amount of funding which has become the main concern for participants. The WJPH has limitations in relation to the development of community-based initiatives due to regulations that restrict a hospital to only having a focus on curative and individual health, rather than a concern with public health. The larger the amount of funding, the more difficult it is for the WJPH, as the focus of attention shifts more towards strict planning of the program and monitoring of funding usage. Funding is one of the essential factors that influence the adoption of innovative mental health reform (Merryman 2004, Merryman 2003), yet funding itself is not sufficient for ensuring successful reform efforts. It has been found that mental health services in Indonesia are mostly hospital-based in which 80-90% of the funding is going to psychiatric hospitals (Minas & Cohen 2007). This also explains why there are few efforts to promote mental health, little in the way of efforts to promote social inclusion and community-based services, and that treatment services are concentrated in urban areas and are often of poor quality, inaccessible, and unaffordable (Minas & Cohen 2007).

Community resources

Community resources consist of formally structured bodies such as non-government organisations; consumer and family associations; traditional and indigenous rehabilitation services; and informal resources of families, friends, and other social networks (Saxena et al. 2007). As stated by a number of participants, the community responds very well to mental health programs created by the WJPH however the problem stems from the health care professionals themselves. The WJPH has initiated

training programs for health cadres in the villages through a program known as the *Desa Siaga. Desa Siaga* was initially designed by the MoH to enable villages to provide basic health care services, safe water and basic sanitation services, and to undertake community-based disease surveillance, encourage healthy lifestyles, and use community empowerment to respond to health emergencies and natural disasters (MoH 2010c). According to the participants, the success of this program relies on the support of health professionals who work in the CHCs, and also from health agencies at the local government level.

Desa Siaga is a sort of community resource which helps with the establishment of connections between the individual and wider society. Community resources are regarded as mediating institutions, by Denhardt (2008), that serve the desires and interests of civil society and provide experiences that will better prepare those citizens for action in the larger system. In practice however, it is not yet clear what to expect from the community. The term 'community participation' was actually perceived as a slogan, yet such branding in public health interventions has the potential to provide high levels of message recognition (Hill et al. 2013).

Saxena et al. (2007) point out that people with mental health needs and their families tend to have few opportunities to participate in decision-making about treatment and that this is true in all countries, but especially in LMICs. Participants spoke about the frustration of the health cadres who want to perform well in their roles, being active volunteers, but are often unable to do so. One psychiatrist in this study mentioned that the active involvement of a health cadre in educating people about mental health is perceived to be 'breaking the rules' by most health professionals who are based in the

CHCs, as health education must be conducted by authorised health professionals rather than by lay people. Foucault (1978) implies that such ‘hegemonic power’ demonstrated by health professionals derives from their superior knowledge and ability (Laverack 2009). Community participation can only occur if there is a widespread willingness by health professionals to work through these concerns and to embrace consumers in mutually beneficial relationships (Lundberg et al. 2008, Morgan 2001).

Human resources

In terms of the data on the numbers of health professionals, in 1969 there were 6 psychiatrists working in State Psychiatric hospitals, and after 3 decades, the number had grown to 145 psychiatrists. This means that, in 1999, the psychiatrist-population ratio was 1:1.5 million. The number of psychiatric nurses working in State Psychiatric hospitals was about 1,769, or 1 psychiatric nurse for every 114 patients, in comparison to the ideal number of 3 nurses for every 5 patients. The distribution of health professionals such as psychiatrists, general practitioners, psychiatric nurses, general nurses, psychologists, social workers, occupational therapists, and other therapists, has not yet been spread evenly throughout the country, with most professionals still concentrated on the island of Java (Department of Health 2001, pp. 12-13). In West Java, the variety of mental health professionals working at the WJPH is perceived to be quite diverse, yet in terms of numbers they are still lacking. As identified by participants in this study, the major barrier for the WJPH in relation to human resources is the restriction on the recruitment of new employees which is under the central government’s authority.

5.3.4 Organisational change

As discussed earlier, high expectations have been attached to the West Java bureaucrats. They need to be attentive to more than the implementation of mental health policy as they should also attend to the market, political norms, community values, professional standards, and the needs and interests of civil society. As such, the WJPH is perceived to be a stressful working environment by its employees that were interviewed in this study. A supportive working climate plays an important role in the development of individual qualities, while an unsupportive environment conversely can contribute to poor mental well-being (Barkway 2006).

In the literature, organisational climate is defined as 'the prevailing atmosphere surrounding the organisation, to the level of morale, and to the strength of feelings of belonging, care and goodwill among members' (Mullins 2007, p. 730). Understanding of the organisational climate comes about, in part, through revealing employees' feelings and beliefs of what the organisation is about. The following are the most discussed themes based on the perceptions of participants in this study towards the unsupportive organisational climate which influences their work performance and their personal relationships.

Leadership crisis

Leadership is the most prevailing issue in all the interviews in this study, with many participants perceiving there to be a crisis of leadership in the WJPH. What is meant by 'leadership crisis' here is an organisation's leadership vacuum, so for example, there are leaders that have been nominated to be in such positions, but there is not

enough actual leadership in the WJPH. Excellent leadership is needed at all levels of an organisation (Northouse 2010), therefore, a perceived leadership crisis can have a significant impact on how an organisation functions. Leaders are often seen as the personification of leadership (Boin & Hart 2003). In public organisations, leaders are political-administrative leaders and their subordinates act within formal frameworks (Trottier et al. 2008a). Based on formal legal conditions, leaders have control over subordinate actors, and the subordinates generally accept this. Ideally, leaders have clear goals and an insight into diverse means and potential effects, including the ability to learn from experience as well as the ability and means to inspire subordinate actors to realise organisational goals (Christensen et al. 2007).

Considering the West Java situation as outlined in the previous chapter, the leaders face great challenges and experience pressures from both internal and external demands. Leaders working in the public sector face unique obstacles, mostly due to the nature of bureaucracy, procedural constraints, dealing with many different stakeholders, and dealing with increased employee and public expectations (Boin 2005). The pressures are felt at all levels with top managers stating that '… *being a leader in government organisations is not easy*', middle-junior level managers believing that there is no clear direction, and professionals stating that '*no-one makes wise decisions here'*. Many managers voiced their concerns about their *given* employees and that the civil servants they have are not what they need. A mirror-image perception of this *given* rule is also applied to the managers, as staff members feel the same about their *given* leaders. This is understandable because in the Indonesian civil service, civil servant recruitment (in terms of numbers of, and vetting

of, recruits) is under the authority of the central government, while the process of actually employing people is conducted at the local level.

The aforementioned situation mentioned above by both the leaders and the employees acts to restrict the choices and influence of both parties. The leaders have no choice or influence over who they employ, while the employees have no choice or influence over who leads them, because of the rigidity and rules imposed by the central government around recruitment. This as explained above, restricts choice, power and personal control over their own careers (McLeod & MacIntyre 2007).

Resistance to change

Change is an inescapable part of both social and organisational life as we are all subject to continual change of one type or another (Mullins 2007, p. 733). Resistance is a common phenomenon found in the change process and is to be expected, and yet it is difficult to pinpoint the exact reasons for this (Mullins 2007, Powell 2002). There is a broad consensus articulated by the West Java bureaucrats that mental health reform is perceived as a shift from sickness-oriented, hospital-based services to wellness-oriented, population-based mental health care. This suggests that the two are seen as mutually exclusive, nonetheless this dichotomous thinking constructs the formation of different 'champions'.

The findings suggest that West Java bureaucrats perceive that there are people who are keen to reform the system, and that there are people who constantly oppose change, but not all of these critics are overt in their resistance. Although the critics are only few in number, their power is perceived to be the strongest, and they remain in

stealth mode trying to derail change behind the scenes by using their ability to influence others. There are also the neutral bystanders and, in fact, the majority of employees belong to this group. They do not vocally oppose change, nor do they proactively get behind change. Instead, they simply go with the flow, not wanting to make any waves, and conducting 'business as usual'. A number of participants believed that doing 'business as usual' and remaining neutral gives them comfort and keeps them away from conflict.

In the theory of change literature, there is a risk of playing it too safe, when the level of urgency is not high enough, and thus the transformation process cannot succeed (Fernandez & Rainey 2006). As Laris & MacDougall point out (2011), when the so-called 'doing nothing' becomes a collective dominant paradigm this, in turn, shapes a stance that locks out any policy options to deal with West Java's worrying mental health problems, placing the reform objectives into freeze mode. It comes as no surprise that the spirit of mental health reform in West Java is in a *dead faint* state (stalled), as reflected in the findings of this study.

Typically, individuals seek a comfortable level of arousal and stimulation and try to maintain this state. It does make sense in relation to 'rationality theory' that people tend to act based on the calculation of the likely costs and benefits before deciding which actions to take (Laris & MacDougall 2011). In this study, this phenomenon is echoed by the sentiment of '*what's in it for me*', which refers to the rewards that one receives if they do the hard work to convey the reforms. This is also partly due to the reward system in the Indonesian civil service. The Indonesian government has not yet applied a 'performance-based' salary system, and instead offers the same salary

standard depending on the rank and position of the individual, regardless of performance (Tjiptoherijanto 2008). This proposes that people are likely to perceive that an increase in work should be accompanied by an increase in rewards, although some participants mentioned that the rewards are not just in terms of money, but also the recognition and non-materialistic support that they need.

Power distance

An organisation is not only a system with a hierarchical structure, but also an intricate system of power. In this study, there are three unbalanced power practices; between superiors and subordinates in management, between medical doctors and other professionals, and between senior and junior employees. In fact, those who perceive that they do not have power are those who are most likely to raise issues associated with power, regardless of who they are. For example, nurses feel powerless compared to medical doctors, while within the medical profession, a GP feels like an 'underdog' in comparison to a psychiatrist. Among psychiatrists, a junior psychiatrist has less power compared to a senior psychiatrist, thus although the top leader in an organisation is a psychiatrist, their formal position does not guarantee that they hold the most power as there are psychiatrists who are even more senior. This infers that power does not only reside at the top of an organisation, but that in one way or another, every single person has some power. As Foucault argues, 'power is everywhere', and is an everyday, socialised and embodied phenomenon, diffused and embodied in discourse, knowledge and 'regimes of truth' (Foucault 1982).

Power is defined as ‘control or influence over the behaviour of other people with or without their consent’ (Mullins 2007, p. 688). Power distance means ‘the extent to which the members of a society accept that power in institutions and organisations is distributed unequally’ (Westwood 1992, p. 373). Mullins postulates that power is an inherent feature of every decision-making process, and is central to the framework of order and system of command through which the work and activities of the organisation are carried out. There are many sources of power, however in general, power can be divided into legitimate (formal) power, which derives from an individual’s formal position in the organisation, and personal (informal) power which derives from the individual’s ability to influence people (Mullins 2007). Power becomes problematic, when it is not balanced. When a person or group has too much or too little power, team dynamics suffer and conflict is likely to arise (Erasmus & Gilson 2008).

In the mental health arena, Salhani & Coulter (2009) have argued that there will always be simultaneous and sequential micro-political struggles between psychiatrists and non-medical professionals. Likewise, micro-political struggles also occur within psychiatry itself, as the discipline remains divided between two visions. There is also a continuing struggle within psychiatry about its future role. This issue appeared to be the prominent topic discussed by health professionals other than psychiatrists in this study. Should psychiatrists be more like neurologists, examining patients, making diagnoses, and prescribing drugs? Or should they be more like psychologists, probing the inner workings of the mind and providing expert psychotherapy? Or should they practice in both ways? (Paris 2008).

Referring back to the mental health reform objectives, the shift to a community mental health system has placed psychiatrists in a position of uncertainty about how they should practice, especially in a multidisciplinary team. It appears as if the dominance of power that they practice in the field has left no room for other professionals to be equally responsible in providing care. A lack of power to change or affect a situation significantly diminishes motivation, causes poor job performance, and people who feel as though they have no control over their situation can easily become disengaged and unhappy (Erasmus & Gilson 2008). The ambiguity of power sharing in a multidisciplinary team is also influenced by the fact that the territory of psychiatry has expanded, placing the psychiatrists in a micro-political struggle, as Salhani & Coulter (2009) infer. There is a blurred distinction between mental health professionals who treat the 'hard-core' mentally ill and those who treat what were once termed 'neuroses' or mild cases (Rose 2006).

Conflicts

Many participants in this study perceive the burden of conflict within the WJPH. Conflict is an inevitable aspect of every organisation whenever two or more people interact (Gelfand et al. 2012). Deutsch (1973) defines 'conflict' as 'incompatible behaviour between parties whose interests differ' (Westwood 1992, p. 364). As identified in the results, conflicts occurs at different levels: *intra-individual* conflict, where a person experiences an internal conflict between their ideal to serve people but being unable to achieve this due to their position which restricts their role; *inter-personal* conflict, which is conflict between two individuals and is mainly due to personal differences; and *inter-group* conflict, which involves differences in group

interests. All of these types of conflict create emotions such as anger, frustration, aggression, dissatisfaction, fear, and insecurity, which in turn generate an unsupportive working climate in an organisation (Westwood 1992). Taking an example from the WJPH, although conflicts are felt, most people tend to stay away from conflict as a way to manage them. One of the participants in this study commented on the impact of conflict, '*I don't want to create conflict, conflict makes me tired and depressed, and I am not enjoying my job here anymore then'*. People fear what may happen if conflict were to be confronted. They are concerned that bringing up the conflict will only make matters worse, whereas in fact, unresolved conflicts make things worse (Notter & Blair 2004).

Conflicts are common issues, but what is interesting in the WJPH is that doctors who hold structural positions are also practicing doctors, thus they have hybrid roles in their daily work lives. They are caught in a web of street-level bureaucrats with conflicting orientations towards the public interest, and in their roles as managers who are trapped within a complex bureaucratic system. Dilemmas are their everyday business, and the policies delivered by street-level bureaucrats are most often immediate and personal, and they usually make decisions on the spot (Lipsky 2010). The problem is not necessarily the fact that conflict exists. It is how people deal with these conflicts, what happens when they are not resolved, and the potentially devastating impact of unresolved conflict in the organisation, that matter.

The culture of blame is rife in the WJPH. There is a quickness to point the finger which is a common problem, not only in public organisations, but also in everyday life. People are generally motivated to defend their positive image, thus a common

way to protect oneself is to blame other people or external circumstances so as to avoid the painful implications of an undesirable outcome (Fast & Tiedens 2010). It is in the public sector, especially in POs that deal with lots of inter-agency work, such as social and health services, that the culture of blame often obfuscates the real issues. Fast & Tiedens (2010) point out that blaming is contagious, and that its 'automatic' transmission leads to negative consequences in an organisation, such as creating an environment which is less psychologically rewarding for its members, is less conducive to learning and innovation, and less productive. In this study, a lack of common purpose or a clear sense of direction can also contribute to a culture of blame. This unclear direction has placed the top leader as the easiest victim to blame, because being at the top level is where the greatest pay, power, and prestige reside (Goodsell 2005).

In the WJPH, issues of trust and transparency compound the problem. Employees want to exist in a work environment that allows them to have clarity of thought of where the organisation is headed and where they can be forthright about its (and their) future. Leaders often feel the distrust of their staff due to a lack of transparency about their actions in regards to the utilisation of funding. This creates a *like and dislike* climate, where leaders eventually tend to choose employees who they trust and who can be trusted to carry out a particular task. Building a culture of transparency is a fundamental first step in achieving trust (Cofta 2007). Leaders who do not listen to employees, as well as employees who do not speak up, tend to aggravate problems, thus open communication is one of the key ingredients in promoting trust. Trusting relationships cannot be simply explained as a dyadic interaction between individuals,

rather these involve complex multidimensional social factors (Meyer et al. 2008). This is to say that without understanding what the complex determinants of trust are, it is not likely that a quick fix can be found for creating trusting relationships in an organisation.

5.4 Civic organiser

Being a civic organiser is about establishing a partnership and the organisation's capacity to be both a partner and a facilitator of partnerships (Laris & MacDougall 2011). As a civic organiser, the WJPH's core responsibility is to influence the wider polity, exploring and developing partnerships with other agencies and groups. As previously described, the custodial role has taken much attention and time, which leaves only limited space for the WJPH to engage with its external partners in governing mental health reform. Laris and MacDougall (Laris & MacDougall 2011) propose five preconditions which allow the role of an effective civic organiser: a shared achievable vision; an understanding-respectful-transparent working atmosphere; preparedness for change; conflict resolution; and trust. In the previous chapter, it is evident that all of these prerequisites have been perceived as being problematic according to the participants. This brings us to the supposition that the role of the WJPH as a civic organiser is deficient.

To be grounded in local realities, the five preconditions postulated by Laris and MacDougall (2011) are incorporated into the four characteristics identified, to dominate the WJPH working climate which leads to the leadership crisis, resistance to

change, power distance, and conflicts. I suggest that rather than signing up for macro-mental health system reform, as a leading sector in mental health reform in West Java, the WJPH must firstly proceed to rationalize the foundational concepts of the transformation within its own organisation, before trying to implement large-scale reform.

5.4.1 Leadership

The findings that emerge from this study are a powerful endorsement of the idea that leadership is a major catalyst for mental health reform in West Java. There are many different approaches to leadership and ways to practice it more effectively with the most prominent theory in public organisations being 'transactional-transformational leadership' introduced by Burns in 1976 (Boin & Hart 2003, Judge & Piccolo 2004, Northouse 2010, Sun & Anderson 2012, Van Wart 2003). According to Burns, transformational leadership, as its name implies, is a process that transforms people through an exceptional type of influence that moves followers to accomplish more than is usually expected. Transactional leadership, in contrast, focuses on the proper exchange of resources in terms of what leaders and followers can offer one another (Northouse 2010).

Bass (1995) has argued that transformational and transactional leadership do not represent opposite ends of a single continuum as mentioned by Burns. He claims that the best leaders are both transformational and transactional (Judge & Piccolo 2004, Trottier et al. 2008b). Trottier et al. (2008b) conducted a study based on Bass's leadership theory in the public sector, concluding that Bass's blended theory is the

best available and that it captures what government employees perceive to be effective leadership, although transformational leadership is considered to be slightly more important in the balance.

The majority of employees in the WJPH are staff while around 10% of the sample holds top leadership positions. This number is relatively similar to West Java bureaucrats in general; from a total of 12,984 employees, 1,484 hold structural leadership positions (BKD 2013). The leadership crisis in the WJPH is primarily attributed to the top leaders emphasising that the organisation suffers from a lack of *direction*, *results*, *support*, and *alignment* by the staff. Employees expect their leaders to have not only technical and managerial skills but also well-honed transformational competencies that emphasise the articulation of the mission and the vision, and who can inspire motivation. Meanwhile, in this study, the top leaders were more concerned about the high expectations of the organisation and they, as psychiatrists, also voiced that they were not well-trained in public administration and management. It seems likely that the pressure for results, mounting paperwork, devolution of authority, and the lack of confidence, to some degree, weakens the transformational leadership behaviors within the WJPH.

There is only one way to deal with a leadership crisis, and that is by enhancing the leadership capacities of the bureaucrats. Northouse (2010, p. 3) states that leadership involves *influence*. He further emphasises that it is crucial to understand the cultural value of leadership, as what he refers to as the Southern Asians, including Indonesians, express high scores on humane orientation and in-group collectivist leadership characteristics. Understanding these characteristics can improve the

leadership capacity of West Java bureaucrats. This collectivist nature is also in line with the WJPH employee assessment results that suggest that people are more comfortable working in groups. This collective culture is indeed beneficial for the WJPH if it is managed and directed properly by leaders who can turn single individual capabilities into remarkable collective accomplishments. An organisation is a remarkable social tool created by human beings to transcend individual limitations, thus when individuals work together collectively to achieve common goals, they are able to accomplish tasks that are far beyond the capacity of any single individual (Nilakant & Ramnarayan 2006).

Zand (2007) proposed the leadership triad theory, combining *knowledge-trust-power* for effective leadership. Triadic leaders *know* or can find out what should be done, they know how to gain access to the knowledge of others, and how to work with people to convert that knowledge into action. They earn *trust* by disclosing relevant information, sharing influence, competently using knowledge, and by applying fairness in their dealings with others. Triadic leaders use their *power* appropriately, and they know when they need to be directive or to delegate. Effective direction and delegation will ensure that the organisation's tasks can be equally shared among employees and be collectively accomplished for the best results. When health professionals complain about mounting administrative tasks, this means that the administrative staff members do not effectively carry out their tasks. The same rule also applies in health service quality improvement which would reach higher standards if those who were assigned to do so, would focus on their tasks. In real-life situations, a triadic leader rarely exists, with most people perhaps only having one

strong characteristic of the three, while others may have two characteristics, but it is far better to work together to combine all of the strengths.

5.4.2 Readiness for change

As noted earlier, to be an effective civic organiser, an organisation needs to be well-adapted to change (Laris & MacDougall 2011). Resistance to change was an interesting topic raised in almost all the interviews in this study. Employee resistance is the most frequent problem encountered by management when introducing change, therefore managing employee resistance is a major challenge for the initiators of change (Bovey & Hede 2001). In Bovey and Hede's (2001) study, the results showed that irrational ideas are positively correlated with behavioural intentions to resist change. This suggests that the human element, such as cognitive and affective processes, is more important than technical elements. This information can be used as an intervention strategy to guide management in developing a method for approaching resistance when implementing major change.

It is difficult to predict what will happen in a particular organisational environment (Mullins 2007). Typically, the problems are related to people and it may be difficult to predict how people in the organisation will react to change. The only certainty in a changing world is that change is absolutely unavoidable. Kurt Lewin's change model underlies all contemporary approaches to managing organisational change (Nilakant & Ramnarayan 2006). Lewin's model is based on the principle that in any individual, group, or organisation, there are two competing forces in operation, the force to maintain stability and the force for change. In order for change to happen, either the

forces of change need to be strengthened or the forces of stability need to be weakened. According to Lewin's theory, the step of weakening the forces of stability is referred to as *unfreezing* in his change model. Following this, the existing forces of change will ensure that the system *moves* towards a new state. Once the system has moved into a new state, it is *refrozen* in that state by the adoption of new habits, structures or culture (Nilakant & Ramnarayan 2006).

This change process needs to be understood by the organisation's members. Understanding the psychological stages that people go through in the midst of change allows people to know if they have managed a successful transition, or if they need to address additional problems. Without an accurate understanding of the change process, it is unlikely that they will know where to go, and what steps and rules to follow. As put forward by Anthony Giddens, rules act as *structure*, and structure provides people with a sense of security (Nilakant & Ramnarayan 2006). This is perhaps what the West Java bureaucrats feel about their response to mental health reform; they all have the willingness, desire, and obligation for change, but they have no idea of how they can organise this into real action.

Weiner (2009) claims that organisational readiness for change is a critical antecedent to the successful implementation of complex changes in the healthcare setting. He points out that the term *readiness* by itself connotes two words 'willingness' and being 'able'. This suggests that it is the *'able'*-ness which is missing in the WJPH. Organisational readiness for change is defined as 'organisational members' change commitment and change efficacy to implement organisational change' (Weiner 2009, p. 2). In the policy implementation game, which Weiner (2009) refers to as a 'team

sport', problems arise when some people feel committed to implementation but others do not. There are three conditions that underpin organisational members' commitment to implementing organisational change; because they 'want to', 'have to', or 'ought to', and the highest level of commitment happens when people have a 'want to' motive for change (Weiner 2009).

Given such a situation, the type of change management that applies in the WJPH case is about changing people's mindsets inside the organisation, and tuning this to the external environment. Change management involves a complex task however some very basic steps for the WJPH to be a change-ready organisation can be identified. These are: *first* and foremost to set up examples – employees at the WJPH rely on role models to turn to for direction, and leaders are expected to be the change agents. *Second* is to strengthen genuine and open communication – this is a vital tool in mobilising people for change by explaining to them why change is necessary, what the long-term effects of the change will be, and how employees will be personally affected by the proposed changes. The successful implementation of new programs depends on the top management's ability to disseminate information about the change, and to convince employees of the urgency of change. The public-management literature contains evidence of the importance of determining the need for change and persuasively communicating it through a continuing process of exchange with as many stakeholders and participants as possible (Lok & Crawford 2004). *Third* is to improve cross-functional collaboration which would be based on trust and a sense of ownership of common goals. The *last* step is to create a positive working environment that enables people to have faith in their own capabilities, and

to experiment, take risks and learn (Holbeche 2006, Nilakant & Ramnarayan 2006, Weiner 2009).

5.4.3 Conflict management

Conflicts, from both internal and external sources, are strongly felt by the individuals involved in this study. Within the context of organisational behaviour/ psychology, conflict and negotiation are joined together in a problem-and-solution accord (Imai & Gelfand 2009). People will have different cognitive interpretations of identical conflict episodes. For example, managers perceive conflicts to be concerned with individual rights and autonomy, whereas health professionals perceive conflicts to be concerned with violations of duties and obligations. Thus, from a practical point of view, a key to success in conflict resolution is through *negotiating* the value differences to be agreed upon, as an attempt to come to a shared understanding of the situation (Imai & Gelfand 2009). When two sides to a dispute are given the opportunity to understand more about the other party's viewpoints, then conflict is often lessened (Notter & Blair 2004).

Conflict theorists see society as being made up of different groups who have competing or conflicting interests, and some of whom would in fact be better off if others were to do less well (Imai & Gelfand 2009). Most conflict management approaches use a game theory perspective to achieve a state of equilibrium (Westhoff et al. 2012). Game theory is rooted in a mathematical approach. Nash's equilibrium assumption is used as a general principle in game theory, the term *negotiation* (in this context) being coined by Nash. According to Nash, a state of equilibrium will be

achieved if individuals (players) divide resources equally. At this point, no-one can improve his/her outcome unless all the other players also change their choices. This principle is also applied in conflict management, that although each individual is free to make a choice, to compete, or to cooperate, each one also receives a given payoff.

A wide variety of conflict management strategies has been uncovered in the literature, so it is perhaps not surprising that there are many distinct ways to manage conflict. In general, there are three conflict management styles: cooperation, competition, and avoidance (Gelfand et al. 2012). Cooperators prefer a proactive approach and easily engage in constructive negotiation and collaborative problem-solving, competitors are inclined to compete and dominate the conflict partner rather than negotiating open-mindedly, whereas avoiders tend to stay away from addressing conflict and tend to suppress the expression of conflict (p. 1132). Gelfand et al. (2012) studied the important role of leaders in conflictual cultures within organisations and found that leaders' cooperative conflict management styles were related to collaborative conflict organisational cultures, whereas leaders' avoidant conflict styles were related to avoidant conflict cultures. Conflict resolution depends on the leader's ability to handle conflicts in the organisation. In addition, employees will be more likely to be more cooperative and productive if they know that their grievances will be taken seriously by their leaders.

5.4.4 Partnerships

In the public health sphere, partnerships have become a catchphrase as a key capacity building strategy to improve population health status (Joss & Keleher 2011).

Partnerships are indeed a complex phenomenon involving a series of stages, involving many contextual and internal factors (Joss & Keleher 2011). In the field of governance, partnerships are the success formula for implementing government policies and initiatives (Geddes et al. 2007). Drawing on a general definition of *partnership,* according to the Merriam-Webster dictionary, it is 'a relationship resembling a legal partnership and usually involving close cooperation between parties having specified and joint rights and responsibilities' (Online dictionary 2013). There are important key points in this definition, *legal* – parties are contractually associated and have a formal status derived from law; *cooperation* – there is mutual benefit and a common effort shared between parties; and *specified* – responsibilities are set up and restricted to a particular individual, situation, relation, or effect. These three elements are requirements that need to be met for partnerships to happen. When one of these aspects is absent, it is likely that the essence of the partnership will be lost which may create a situation where the involved parties act as 'order takers' instead of as partners.

Figure 5.2 shows the partnerships which are needed to bring together each existing entity to ensure that mental health reform can happen in West Java. Indonesian mental health reform policies emphasise the importance of a multi-sectorial and multi-disciplinary approach to grapple with the complexity of mental health problems in society. However, the findings show that there are complex barriers blocking the way which make multi-stakeholder partnerships far too intricate. Considering the working climate of the WJPH, where conflicts are prevalent between individuals from different groups, partnerships need to be initiated at the individual level and then move up to

the inter-personal or group level. An example of this would be a nurse acting as a partner working collaboratively with a medical doctor, rather than as an *order-taker*. When groups are 'partnering', they create a conducive environment for an organisation to fulfill its tasks, both internally and externally (Holbeche 2006).

As part of its role as a civic organiser, the WJPH needs to initiate inter-agency partnerships, and together set up 'fair' rules so that each player has their own direction. The civic philosophy must be taken into account in setting up the fair rules and, in doing so, the outcomes will be successfully achieved when there is a workable partnership. This includes partnering with service users and the wider community.

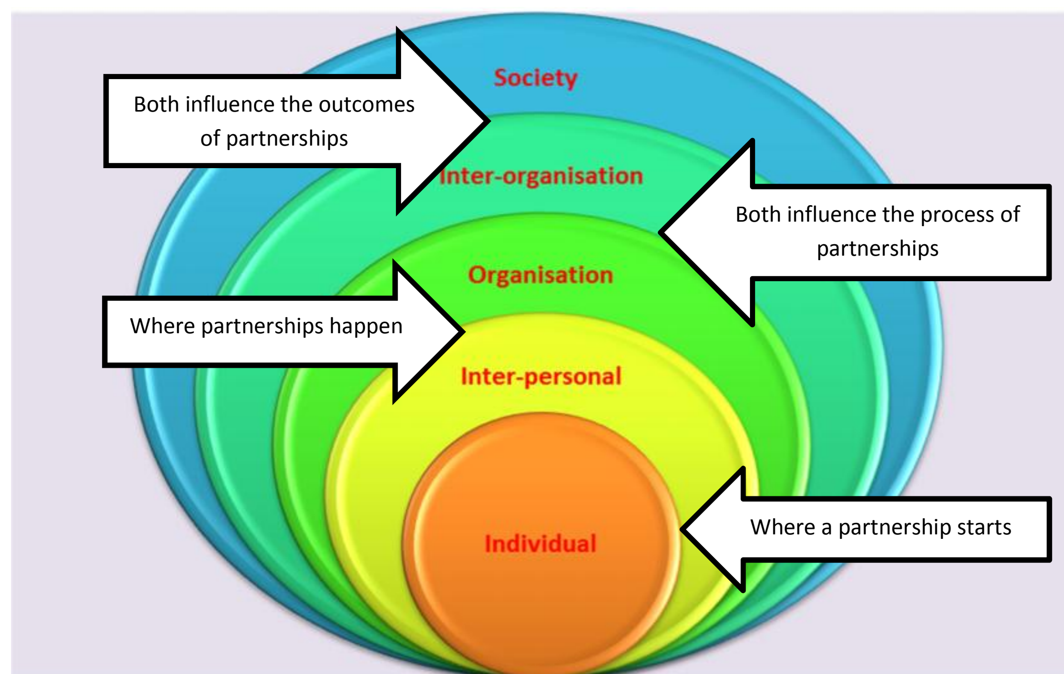


Figure 5.2 The contextual level within partnerships in West Java mental health Reform

The way of conceptualising the types of partnerships varies. For example, Carnwell and Carson (2005) propose four types: project, problem-oriented, ideological, and

ethical partnerships, while the four types according to VicHealth (2006) are networking, coordinating, cooperating, and collaboration (in Joss & Keleher 2011, p. 265). In a bureaucratic world, where the game played is formally structured and bounded by rules (which are too often highly restrictive), partnerships can never be equitably practiced.

Framing this into an example from the case of West Java, partnerships between the medical profession and other professions, between seniors and juniors, between leaders and subordinates, between structurals and functionals, between administration and the health service, between the health sector and other sectors, are very dynamic – however, neither can it simply be implied that partnerships are a *mantra* for everything to work perfectly. The process of partnerships is often restricted by attached regulations. For example, the WJPG has no direct authority to link with community groups, or to make antipsychotic drugs available in community health centers. All of this has to be conducted through the district governments which are usually restrained by their limited budgets. Partnerships are fundamentally based on the idea that no stakeholder acting alone has the sufficient funds, human resources, information, expertise, and/or authority to effectively overcome a particular issue, and therefore collective action is required for its success. Partners do hold different expectations for the potential outcomes from the partnerships. For example, an outcome of equilibrium will be achieved when the most mutually preferred outcomes for both parties can be generated, and such a process is facilitated through effective trust, commitment, and communication (Westhoff et al. 2012). The types of partnerships suitable for the case of West Java are cooperative and collaborative

partnerships, both allowing partners to collaborate while maintaining a balance between competing interests.

In the field of governance, partnerships are the success formula for implementing a number of government policies and initiatives (Geddes et al. 2007). Partnerships come to represent an effective element within the structures and processes of mental health reform governance in West Java based on the following considerations: *first,* partnerships are conditioned by the national policy context; there is an emerging need that the West Java provincial government must develop a more fluid set of institutional structures and relationships, and new relationships between the district governments, the market, and civil society. *Second,* there is a need to create local (provincial) policies detailing the national policy. These local policies are strongly conditioned by national trends, but will also respond in differing ways as a result of localities influenced by the history of past working partnerships and the character and capacities of the key partners. *Third*, as noted earlier, there is an organisational structure for organising community mental health to support mental health reform known as the TPKJM. The West Java government must detail the internal arrangements of the TPKJM at the provincial level including membership, leadership, structures and working practices, human and financial resources, and performance management.

Summary

The slow pace of mental health reform in West Java is understood to be due to complex interactions of certain aspects of the system that connect root causes to

unsatisfactory outcomes. This chapter provides a detailed discussion of the findings using relevant theoretical frameworks, which was followed by a discussion of a suggested approach for improving the feasibility of ongoing and future mental health reform in West Java. In Indonesia, mental health is organised through bureaucracy, and involves a rigid structure with many organisational levels. In bureaucracy, there are certain rules governing the way things can and cannot be done. Extremely large and highly complex public service systems have governed how mental health problems are managed in unique ways. Most mental health advocates, for example, know that psychiatrists, nurses, psychologists, and social workers must work closely together, but rigid regulatory frameworks make this difficult, and organisational barriers get in the way of good care.

Although policy actors have to act within the constraints of organisational routines and the structured interactions of politics and administration, they must be seen as essentially ‘agents’ that enact policy realities that structure and potentially change subsequent policy acts. Using Laris and MacDougall’s trilogy model involving *civic philosophy-custodial role-civic organiser role*, it is clear that the civic philosophy appears to be ‘out-of-sight’ in West Java while the custodial role leaves limited space for the WJPH to engage with its external partners to ‘govern’ mental health reform. In addition, the significance of public mental health to provide fair and equal access to all Indonesians has been lessened through various aspects of a modernised bureaucracy. The characteristics of *civic philosophy-custodial role-civic organiser role* are not mutually exclusive; in fact, they are interrelated, and each one must be congruent with the other two. Although in practice, systems rarely have perfectly

balanced loads, the more balanced that these three characteristics are in working together, the more supportive will be the organisational environment in advancing healthy public policy.

Chapter 6:
Research transfer and conclusion

In this final chapter, I present the details of the research transfer of the findings of the study, as a prerequisite of this doctorate dissertation was to design a knowledge transfer process for my research to be fed back to the West Java Provincial Government. Following this is an outline of the strengths and weaknesses of the study which lead to recommendations for future research. A conclusion on how this study has answered my research question is presented as the final part of the chapter.

6.1 Research transfer

The major purpose of this research has been to explore West Java provincial bureaucrats' perspectives on the national mental health reform policy. By providing a thorough analysis of mental health reform policy in West Java, this research has attempted to draw a clearer understanding of the relevant factors that influence mental health reform policy implementation as well as an identification of areas of improvement for facilitating successful mental health reform. The output is a research transfer to be used to inform decision-makers so that a more enlightened discussion of public mental health policy can occur and, as a result, that better policy will be adopted.

Ideally, public health research should produce transferable and actionable messages that can inform decisions about how to improve health care services, although not all

research should necessarily have an impact (Dagenais et al. 2009). The evidence from this study, on its own, does not provide an ample solution, a complete prescription for change, or an imperative for action.

> *'You can't find the solution of a problem in the solution of another problem raised at another moment by other people ... my point is not that everything is bad, but that everything is dangerous ... if everything is dangerous, then we always have something to do ...'*
>
> *(Foucault 1983, p. 231)*

Reflecting on Foucault's point, it is not possible to find a solution to a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognise. Mental health issues are often termed as 'wicked' problems, not in the sense of evil, but rather in terms of the problems resistance to resolution (Hannigan & Coffey 2011). On account of the complex interdependencies, efforts to solve one aspect of a wicked problem may reveal or create other problems. This current study is intended to yield 'ideas' that can enlighten stakeholders about issues arising from mental health reform policy implementation in West Java. Lavis et al. (2003) point out that decision-makers need more 'ideas' rather than more 'data' (as numbers are rarely used) to solve particular problems. This research provides an understanding of the unforeseen or unintended consequences of policy and will serve as a base for governments to 'think differently' about the complexity of these wicked problems.

Translating research evidence into practice means that there is a necessity to develop an organising framework to move from 'discovery' to 'delivery' (Catford 2009). How can research findings be transformed into knowledge that can bring about change?

Wilson et al. (2011) propose three practical phases for knowledge transfer to sustainable action: research, translation, and institutionalisation (Figure 6.1). The translation process comprises four steps: knowledge into products, dissemination, the decision by knowledge users to adopt, and practice. The research transfer for this study is guided by these four steps, and the following outline details the first two. The final two steps, *the decision to adopt* and *practice* represent an advanced formal process of coming up with recommendations of what stakeholders think will work. These recommendations will then be documented in a provincial policy that supports the national policy. This provincial policy will then be used to plan for more structured and effective implementation programs.

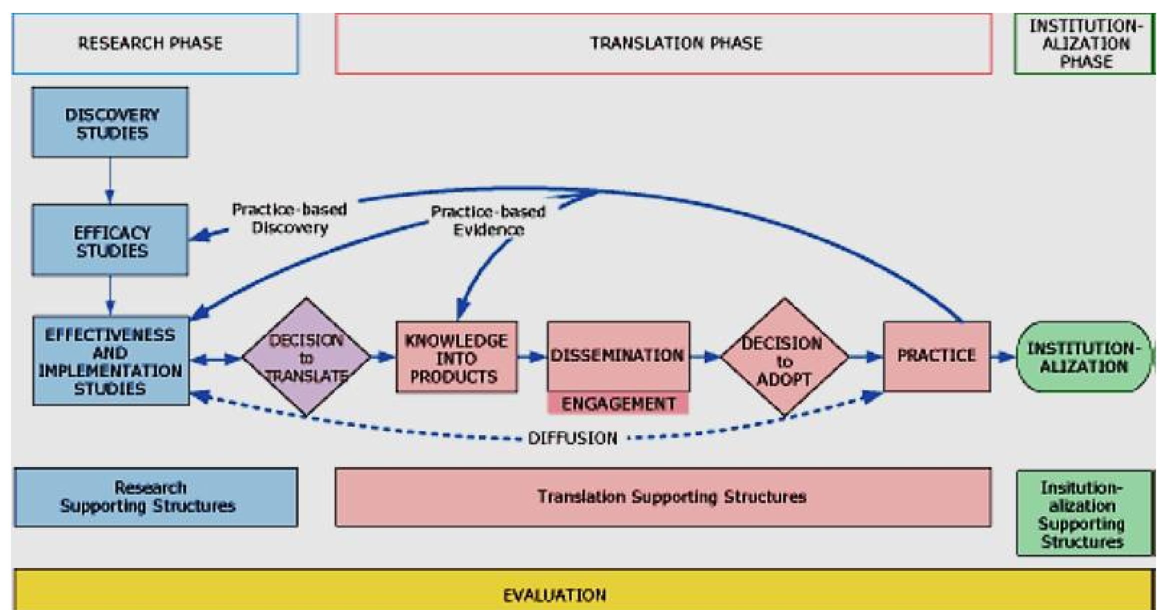


Figure 6.1 Knowledge to action framework for public health (Wilson et al. 2011, p. 2)

***Step 1* Knowledge into products**

Creating an actionable product based on existing research findings is the first crucial step in launching an evidence-based program, practice, or policy into widespread use. This can be achieved by documenting the key messages from research findings that will assist and support audiences or users in putting the research into practice. Nath (2007) highlights that policy briefing documents reveal the structure of the researcher's thinking on how things can be reconceptualised and what steps need to be taken as further actions. As part of this procedure, the findings of the present study will be written into a series of policy briefs based on the four major headings in the discussion chapter to stimulate future discussion. The *first* volume of policy briefs will be about the multiple meanings of the policy, the *second* volume will be about the civic philosophy, while the *third* and *fourth* contain information about the custodial and the civic organiser roles, respectively.

***Step 2* Dissemination**

Dissemination is defined as 'a purposeful and facilitated process of distributing information and materials to organisations and individuals' (Wilson et al. 2011). The purpose of dissemination is to increase awareness amongst the relevant groups who are in a position to translate research into policy or practice by engaging in active participation and collaboration with stakeholders. My position as a health program planner, and my close work with stakeholders from the lead agency related to mental health in West Java, may be beneficial in ensuring that the findings will be acted upon, and used in the program planning stages. This study also involved a number of

stakeholders as key informants which provides further benefits, as Nath (2007) and Lomas (2000) imply that successful translation can be achieved if there is a strong level of involvement of stakeholders from the start of the research process.

Within this dissemination process, there are some potential barriers which, in turn, create a mismatch between the intention to translate research into practice and the action that is actually taken, such as if stakeholders do not see the benefits of the study, or if they are busy with other work commitments. Some strategies to anticipate these potential barriers are disseminating the findings as soon as the study has been completed, and creating clear timelines for discussions (Nath 2007). The stakeholders have concerns that the researcher needs to respond to, and reporting back the findings to policymakers does take time.

The timeline for discussions in meetings and workshops with other relevant stakeholders will be further discussed with the WJPH after the first meeting involving the reporting back of the findings to the study participants. The first meeting with the participants is the beginning of a formal process of engaging with the findings, to provide them with the opportunity to reflect on these results, and then to get them to try to work through what they mean. Apart from meetings and workshops with relevant stakeholders, this study will be published in journals and also presented at external events and conferences, as these are resilient and broad-based dissemination tools.

6.2 Strengths and limitations of the study

This research has a number of strengths as well as weaknesses. Evaluating research quality helps researchers and research users to feel confident about the use of evidence in policy and practice (Boaz & Ashby 2003). As Popay et al. (1998) suggested, the quality of qualitative research is evidenced by whether or not the research participants' subjective meanings are illuminated. Subjective meaning was firmly grounded in this study, using the West Java bureaucrats' accounts as the core upon which all subsequent analysis and interpretation was based. It was the participants from the WJPH who were the primary stakeholders whose perspectives should be considered when seeking to improve mental health services in West Java. The perspectives of managers were considered equal in value to the expert knowledge of health professionals; this equal knowledge partnership is important in raising a wide range of key policy issues (Horsburgh 2003).

In order to be considered worthwhile, qualitative research must have adaptability towards, and responsiveness to, real circumstances as they exist (Popay et al. 1998). The evidence for responsiveness to social context and flexibility of design in this study were outlined in detail and clearly expounded in the methodology chapter (Chapter 3). It is extremely important to be completely transparent about what I was doing at each point in the research process, as qualitative research can be easily criticised, particularly in relation to research methods. This transparency and the tight design through the limiting of possible internal extraneous factors, allows this study to be transferable to other bodies of knowledge and to a range of different settings.

The strongest point of this study is how the research moved from a description of the data to an analysis and interpretation of the meaning and significance behind it, which was clearly detailed in the discussion chapter. The description of the findings was detailed enough to allow me or the reader to interpret the meaning and context of what was being researched. Thus, it is likely that readers will be able to attain a 'thick' description when interpreting the meaning and context of the findings. My dual roles, both as an insider and outsider in this study, have been beneficial in facilitating the mobilisation of the findings to have academic value as well as practical relevance, particularly for knowledge generation purposes. As this study was the first policy research conducted on mental health reform in West Java, Indonesia, it was also intended to contribute to policy debates relating to mental health policy, particularly in LMICs. This study provides a number of reflections on the complexity of policy implementation, which builds my capacity to make a difference in practice and, more importantly, which can be used as an evidence-base for improvement.

This study has a number of limitations. Understanding Indonesian mental health reform is a complex process which cannot be studied all at one time. The research question raised in this study was, without a doubt, a large question. The most obvious limitations are its cross-sectional design, and the fact that the data collection was confined to only a single public organisation under the West Java Provincial Government, the participants for this study were limited only to those who work in the WJPH. This means that this study was only a snapshot in time and thus it does not look at changes over a period of time. Therefore, a longitudinal study should be undertaken in the future to provide wider perspectives on the findings of the present

study. The involvement of other organisations as participants, both government and non-government organisations relevant to mental health reform in West Java, would provide a holistic picture to the given subject.

As well, the present study has relied largely on a sole researcher's perspective. Most public health research is conducted in teams, nevertheless the nature of many doctoral dissertations is that they are conducted by a lone researcher. If I were in a team, it would have provided more opportunities to get involved in comprehensive debates about various aspects of the study. Nonetheless, I used the supervisors' views for triangulation. This present study focused on understanding mental health reform which is a very broad issue. In doing so, it is likely that I missed some depth, however, as the big picture has been revealed in this study, the more specific issues can be studied in greater depth in the future.

6.3 Conclusion

This final section of this chapter brings closure to the research part of this process, 'the conclusion closes the door on the past before it opens doors into the future' (Lebrun 2007, p. 212). In a sense, when I finish this chapter, I begin a new phase of my practice. As a dissertation should 'bite itself in the tail', it has to close the loop that was opened in the introduction, so here I reflect on whether the research question has been answered and if the aims have been achieved.

This study set out to answer a question about how the Indonesian mental health reform policy is understood by bureaucrats at the provincial level in West Java,

Indonesia. The aims of this research were to explore bureaucrats': perceptions of the roles of policy actors; perceptions of the national mental health reform policy content; understandings of the Indonesian mental health reform policy process; and understandings of the changing process relevant to mental health reform in the context of West Java.

I reviewed the literature on public health and mental health reform, mental health reform in low middle income countries, mental health reform and policy analysis, and the Indonesian mental health system. It was at this literature review stage that I was enlightened by the issues, theories, beliefs, and the prior research findings, which guided my understanding of the people and issues I was going to research. Furthermore, it was Walt and Gilson's framework (1994), the well-known health reform policy analysis often used in the developing world, that strongly influenced the way I set up the strategy for developing the set of questions for the collection of the data. In order to answer the research question, a case study approach was used as a research strategy as it is the preferred strategy to use when 'how' and 'why' questions are being posed (Yin 1994). This study focused on the implementation stage of mental health reform policy at the provincial level and an interpretative-constructivist approach was used to understand the interpretation of meaning that was passed on by the policy implementation actors.

The findings were presented in accordance with Walt and Gilson's categorisation based on an analysis of policy actors, policy content, processes of decision-making, the structural context, and the roles of the policy actors. Gaining an understanding of mental health reform in West Java was indeed complex, nevertheless, the messiness

of the policy process and the intricacy of the interrelationships between policy content and a range of contextual factors in the implementation were revealed.

***Aim 1*. Understanding bureaucrats' perceptions about the roles of policy actors**

A description of how the participants place themselves within the national mental health reform policy networks, and how other relevant actors and stakeholders' roles also contribute to policy implementation in West Java was clearly articulated in the first section of the findings. West Java bureaucrats stated that all levels of governments should play a role in mental health reform. They were also concerned about community participation in supporting the success of policy implementation in West Java. The fact that the mental health reform is shouldered alone by the WJPH, as the only public organisation who is responsible for tackling mental health issues in West Java province, was based on the lack of other stakeholders' active involvement, particularly other government agencies in implementing the reform. Although there was an ideal organisational structure (the TPKJM) for establishing community mental health, as structured in the 2009 Ministerial Decree, no real action was performed by the TPKJM.

***Aim 2*. Understanding bureaucrats' perceptions about policy content**

There was much uncertainty about which policy is regarded as the mental health reform policy, however most participants referred to Health Law 36/2009 as specified in *Permenkes* 406/2009. The findings show that 'policy' is understood by West Java bureaucrats as a set of regulations documented and officially signed by the authorised governments, and 'policy' is perceived as an 'umbrella' for everything they do in

practice. The general content of the mental health reform policy is about a paradigm shift, from the old hospital-based paradigm to the new, community-based paradigm. Mental health reform was, therefore, strongly linked to the establishment of community-based mental health services in Indonesia. The development of this community-based model was initiated in West Java province, however most of the bureaucrats feel that the transformation process has been very slow. For some, they questioned whether or not community-based mental health is actually a reform considering the fact that community-based mental health, as an over-arching concept, has long existed in Indonesia.

***Aim 3*. Understanding bureaucrats' perceptions of the policy process**

In the Indonesian mental health reform policy development process, a range of both global and local influences were acknowledged. The mental health reform policy process in Indonesia can be traced back to the colonial era. The 1897 Dutch Mental Health Law *Het Reglement op het Krankzinnigenwezenof* was the first policy applied in Indonesia. Historically, Indonesia has been through several waves of identifiable mental health reform from the time of Indonesia's independence in 1945 to the present with the first wave starting in the 1960s. In 1966, the first mental health policy adopting the three principles of prevention, treatment, and rehabilitation was ratified, replacing the 1897 Dutch Mental Health Law. The second wave of reform started in 1992, when the 1966 policy was withdrawn and replaced by General Health Law No. 23. The third wave was initiated soon after the monetary crisis hit Indonesia in 1998. A strategy for the transformation of the mental health system was specifically documented in the 2001 National Mental Health Policy. The fourth wave in the

history of mental health reform began in 2009 when Health Law 36/2009 and *Permenkes* 406/2009 were initiated.

Meanwhile in Indonesia, the great majority of people with psychiatric conditions were in fact already managed in the community, and their families played a significant role in taking care of them considering the very limited resources available to the psychiatric hospitals. People in Indonesian society hold the strong belief that mental illnesses are caused through spiritual-cultural means; accordingly, most patients will be treated initially by religious teachers or native healers. The policy ideas which were drafted through top-down, institutional, and political processes and were based on modern medical science, appeared to be poles apart from the local traditional-cultural practices. This clash of cultures in Indonesian mental health policy may be considered as the underpinning factor contributing to the gap between policy-making and policy implementation. Moreover, the lack of communication between policy-makers and implementers has perpetuated the various interpretations of the policy objectives in practice.

***Aim 4*. Understanding bureaucrats' perceptions of the changing process of mental health reform in the context of West Java**

West Java bureaucrats acknowledged the urgency of implementing the paradigm shift in West Java, and they believed that the complexity of mental health problems in West Java which cannot be solved solely by the existing hospital-based model. The 'devil-in-the-detail' nature of policy implementation in West Java has been identified as happening within four layers: *System*, which involves issues such as

decentralisation, problematic mindset change, workforce crises, poor monitoring-evaluation, clashing policies, unorganised structures, and decision-makers' lack of understandings; *Organisation,* involving leadership crises, unrealistic organisational vision, funding issues, resistance, power imbalances, and poor communication; *Team,* with issues around lack of innovation and motivation, and group disharmony; and *Individual,* involving issues such as financial rewards, job security, moral responsibility, and obligation. It was strongly accentuated in the findings that mental health is everybody's business, yet it appeared that mental health reform in West Java was shouldered alone by the WJPH.

In the discussion chapter, the messiness of mental health reform in West Java was reframed. I did not simply present another data set showing issues that had already been shown in the findings, but instead, by using Laris and MacDougall's (2011) civic philosophy-custodial role-civic organiser framework, the discussion chapter presented a new and unique perspective by highlighting the unknown issues from the findings, which were supported by the additional facts, which shifted the descriptive data into a prescriptive strategy. It was evident that mental health is organised through bureaucratic means, through a wide range of structural and organisational levels. As well, within the bureaucracy, there are certain rules governing the way things can and cannot be done. Clearly, the values of bureaucracy, that is the *civic philosophy*, appear to be 'out-of-sight' in West Java, and the busyness of the *custodial role* leaves limited space for manoeuvre as a *civic organiser* to engage with the WJPH's external partners to 'govern' mental health reform in a way that leads to the idea of mental health reform being understood to be 'everybody's business'. The WJPH is left with only

limited choices, because organisations are swept along by events that are beyond the control of the bureaucrats. The strategy proposed is to facilitate the WJPH as a regulatory agency that must deal with externalities, focusing more on its civic organiser role by emphasising four important aspects which are grounded in the evidence from this study: leadership, readiness for change, conflict management, and partnerships.

References

Adams, N, Daniels, A & Compagni, A 2009, 'International pathways to mental health transformation', *International Journal of Mental Health,* vol. 38, no. 1, pp. 30-45.

Aggarwal, NK, Rowe, M & Sernyak, MA 2010, 'Is health care a right or a commodity? Implementing mental health reform in a recession', *Psychiatric Services,* vol. 61, no. 11, pp. 1144-1145.

Akiskal, HS, Hirschfeld, RMA & Yerevanian, BI 1983, 'The relationship of personality to affective disorders', *Arch Gen Psychiatry,* vol. 40, no. 7, pp. 801-810.

Alarcon, RD & Aguilar-Gaxiola, SA 2000, 'Mental health policy developments in Latin America', *Bulletin of the World Health Organization,* vol. 78, no. 4, pp. 483-490.

Allen, D 2004, 'Ethnomethodological insights into insider–outsider relationships in nursing ethnographies of healthcare settings', *Nursing Inquiry,* vol. 11, no. 1, pp. 14-24.

Archer, J & Gruenberg, EM 1982, 'The chronically mentally disabled and deinstitutionalization', *Annual Review of Public Health,* vol. 3, no. pp. 445-468.

Arvidsson, H 2005, 'Changes in the group defined as severely mentally ill: five years after the mental health-care reform in Sweden', *International Journal of Social Welfare,* vol. 14, no. 4, pp. 277-286.

Arvidsson, H 2009, 'Severely and persistently mentally ill - A changing group. Ten years after the 1995 Swedish mental health care reform', *Nordic Journal of Psychiatry,* vol. 63, no. 5, pp. 355-360.

Assan, JK, Assan, SK, Assan, N & Smith, L 2009, 'Health inequality in resource poor environments and the pursuit of the MDGs', *Journal of Health Management,* vol. 11, no. 1, pp. 93-108.

Avenier, MJ & Cajaiba, AP 2012, 'The dialogical model: Developing academic knowledge for and from practice', *European Management Review,* vol. 9, no. 4, pp. 199-212.

Aviram, U, Guy, D & Sykes, I 2007, 'Risk avoidance and missed opportunities in mental health reform: The case of Israel', *International Journal of Law and Psychiatry,* vol. 30, no. 3, pp. 163-181.

Ayres, L 2008, *Semi-structured interview,* SAGE Publications, Inc., Thousand Oaks, CA.

Bacchi, C 2000, 'Policy as discourse: What does it mean? Where does it get us?', *Discourse: Studies in the Cultural Politics of Education,* vol. 21, no. 1, pp. 45-57.

Bacchi, C 2008, 'The politics of research management: Reflections on the gap between what we 'know' (about SDH) and what we do', *Health Sociology Review,* vol. 17, no. 2, pp. 165-176.

Bacchi, C 2009, *Analysing policy: what's the problem represented to be?,* Pearson Australia, Frenchs Forest, N.S.W.

Bailey, J 2008, 'First steps in qualitative data analysis: transcribing', *Family Practice,* vol. 25, no. 2, pp. 127-131.

Bak, M, van Os, J, Delespaul, P, de Bie, A, a´ Campo, J, Poddighe, G & Drukker, M 2007, 'An observational, ''real life'' trial of the introduction of assertive community treatment in a geographically defined area using clinical rather than service use outcome criteria', *Soc Psychiatry Psychiatr Epidemiol,* vol. 42, no. pp. 125-130.

Bambra, C, Gibson, M, Sowden, A, Wright, K, Whitehead, M & Petticrew, M 2010, 'Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews', *J Epidemiol Community Health* vol. 64, no. pp. 284-291.

Barkway, P 2006, 'Creating supportive environments for mental health promotion in the workplace', *Contemporary Nurse,* vol. 21, no. 1, pp. 131-141.

Barkway, P, Mosel, K, Simpson, A, Oster, C & Muir-Cochrane, E 2012, 'Consumer and carer consultants in mental health: The formation of their role identity', *Advances in Mental Health,* vol. 10, no. 2, pp. 157-168.

Barnes, M & Bowl, R 2001, *Taking over the asylum,* Palgrave, New York.

Baum, F 2008, *The new public health,* Oxford University Press, South Melbourne.

Bennetts, W, Cross, W & Bloomer, M 2011, 'Understanding consumer participation in mental health: Issues of power and change', *International Journal of Mental Health Nursing,* vol. 20, no. 3, pp. 155-164.

Berg, C 1968, 'Case studies in organizational research and education', *Acta sociologica,* vol. 11, no. 1/2, pp. 1 -11.

Berland, A 2001, 'Mental health reform in British Columbia', *Administration and Policy in Mental Health,* vol. 29, no. 1, pp. 89-93.

Berlim, M, Fleck, M & Shorter, E 2003, 'Notes on antipsychiatry', *European Archives of Psychiatry and Clinical Neuroscience,* vol. 253, no. 958c304d-4f4e-bc5c-2a51-21aa7e75d7c6, pp. 61-68.

Berry, FS 2009, 'Government reform and public service values in democratic society', *in* Raffel, JA, Leisink, P & Middlebrooks, AE (eds.) *Public sector leadership: International challenges and perspectives.* Edward Elgar Publishing, Massachusetts.

Bevir, M 2010, 'Rethinking governmentality: Towards genealogies of governance', *European Journal of Social Theory,* vol. 13, no. 4, pp. 423-441.

Birkland, TA 2007, 'Agenda setting in public policy', *in* Fischer, F, Miller, G & Sidney, M (eds.) *Handbook of public policy analysis: theory, politics, and methods.* CRC Press, Boca Raton, FL.

Bjorklund, R & Pippard, J 1999, 'The mental health consumer movement: implications for rural practice', *Community Mental Health Journal,* vol. 35, no. 8128930f-658e-1333-4705-21aa7e78c032, pp. 347-406.

BKD 2013, *West Java officials,* Regional Public Service Board, Bandung.

Bloom, AL 2000, *Health reform in Australia and New Zealand,* Oxford University Press, South Melbourne.

Blumberg, S 2002, 'Crisis intervention program : An alternative to inpatient psychiatric treatment for children', *Mental Health Services Research,* vol. 4, no. 1, pp. 1-6.

Boaz, A & Ashby, D 2003, *Fit for purpose? Assessing research quality for evidence based policy and practice,* University of London, London.

Boin, A 2005, *The politics of crisis management: Public leadership under pressure,* Cambridge University Press, Cambridge.

Boin, A & Hart, Pt 2003, 'Public leadership in times of crisis: Mission impossible?', *Public Administration Review,* vol. 63, no. 5, pp. 544-553.

Bouras, N 1995, 'Mental health reforms in Europe', *British Journal of Psychiatry,* vol. 166, no. 2, pp. 262-263.

Bovey, WH & Hede, A 2001, 'Resistance to organisational change: the role of defence mechanisms', *Journal of Managerial Psychology,* vol. 16, no. 7, pp. 534-549.

Boyatzis, RE 1998, *Transforming qualitative information: Thematic analysis and code development,* Sage Publications. Inc, California.

Bracken, P & Thomas, P 2001, 'Postpsychiatry: A new direction for mental health', *British Medical Journal,* vol. 322, no. 7288, pp. 724-727.

Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* vol. 3, no. 1, pp. 77-101.

Brinkmann, S 2009, *Interviews: Learning the craft of qualitative research interviewing,* Sage Publications, Inc., Thousand Oaks, California.

Brown, L, Thomas, MD, Allen, DG & Gilchrist, LD 1994, 'Mental health reform: Client and family member perspectives', *Evaluation and Program Planning,* vol. 17, no. 1, pp. 81-92.

Browne, G & Hemsley, M 2008, 'Consumer participation in mental health in Australia: what progress is being made?', *Australasian Psychiatry,* vol. 16, no. 6, pp. 446-449.

Browne, K 2001, 'Ng(amuk) revisited: Emotional expression and mental illness in Central Java, Indonesia', *Transcultural Psychiatry,* vol. 38, no. 2, pp. 147-165.

Broyles, LM, Rodriguez, KL, Price, PA, Bayliss, NK & Sevick, MA 2011, 'Overcoming barriers to the recruitment of nurses as participants in health care research', *Qualitative Health Research,* vol. 21, no. 12, pp. 1705-1718.

Bruckner, TA, Scheffler, RM, Shen, G, Yoon, J, Chisholm, D, Morris, J, Fulton, BD, Dal Poz, MR & Saxena, S 2011, 'The mental health workforce gap in low- and middle-income countries: a needs-based approach', *Bulletin of the World Health Organization,* vol. 89, no. 3, pp. 184-194.

Bunton, R 2008, 'Public health and public involvement', *Critical Public Health,* vol. 18, no. 2, pp. 131-134.

Burgess, MM 2007, 'Proposing modesty for informed consent', *Social Science & Medicine,* vol. 65, no. 1, pp. 2284-2295.

Burns, T, DPhil, JC, Becker, T, Drake, RE, Fioritti, A, Knapp, M, Lauber, C, Rössler, W, Tomov, T, Busschbach, J, White, S & Wiersma, D 2007, 'The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial', *The Lancet,* vol. 370, no. 9593, pp. 1146 - 1152.

Butler, T 1993, *Changing mental health services: The politics and policy,* Chapman & Hall, London.

Butterworth, I & Duhl, L 2011, 'Healthy cities as a setting approach', *in* Keleher, H & MacDougall, C (eds.) *Understanding health.* Oxford University Press, Melbourne

Cassels, A 1995, 'Health sector reform: Key issues in less developed countries', *Journal of International Development,* vol. 7, no. 3, pp. 329-347.

Catford, J 2009, 'Advancing the 'science of delivery' of health promotion: not just the 'science of discovery'', *Health Promotion International* vol. 24, no. 1, pp. 1-5.

Chen, H-Y & Boore, JRP 2009, 'Translation and back-translation in qualitative nursing research: methodological review', *Journal of Clinical Nursing* vol. 19, no. 1, pp. 234-239.

Chesters, J 2005, 'Deinstitutionalisation: an unrealised desire', *Health Sociology Review,* vol. 14, no. -, pp. 272-282.

Christensen, T, Lægreid, P, Roness, PG & Røvik, KA 2007, *Organization theory and the public sector,* Routledge, New York.

Clarke, J 2005, 'Performing for the public: Doubt, desire, and the evaluation of public services ', *in* du Gay, P (ed.) *The value of bureaucracy.* Oxford University Press, New York.

Cofta, P 2007, *Trust, complexity and control confidence in a convergent world,* John Wiley & Sons Ltd, West Sussex.

Cohen, A, Eaton, J, Radtke, B, George, C, Manue, BV, De Silva, M & Patel, V 2011, 'Three models of community mental health services in low-income countries', *International Journal of Mental Health Systems,* vol. 5, no. pp. 3.

Cohen, A & Minas, H 2008, 'Mental Health Etiology: Social Determinants', vol., no. pp.

Colebatch, HK 2002, 'Government and Governmentality: Using Multiple Approaches to the Analysis of Government', *Australian Journal of Political Science,* vol. 37, no. 3, pp. 417-435.

Corrigan, PW 2000, 'Mental health stigma as social attribution: Implications for research methods and attitude change', *Clinical Psychology-Science & Practice,* vol. 7, no. 1, pp. 48-67.

Corrigan, PW, Kerr, A & Knudsen, L 2005, 'The stigma of mental illness: Explanatory models and methods for change', *Applied and Preventive Psychology,* vol. 11, no. 1, pp. 179-190.

Cosgrove, L, Krimsky, S, Vijayaraghavan, M & Schneider, L 2006, 'Financial ties between DSM-IV panel members and the pharmaceutical industry', *Psychotherapy and Psychosomatics,* vol. 75, no. 1, pp. 154-160.

Cosgrove, L & Wheeler, EE 2013, 'Industry's colonization of psychiatry: Ethical and practical implications of financial conflicts of interest in the DSM-5', *Feminism & Psychology* vol. 23, no. 93, pp. 1-15.

Creswell, JW 2005, *Educational research,* Pearson Prentice Hall, New Jersey.

Crossan, F 2003, 'Research philosophy: Towards an understanding', *Nurse Researcher,* vol. 11, no. 1, pp. 46-56.

Cummings, S 2009, 'Treating older persons with severe mental illness in the community: Impact of an interdisciplinary geriatric mental health team', *Journal of Gerontological Social Work,* vol. 52, no. 1, pp. 17-31.

Dalgard, O 2008, 'Social inequalities in mental health in Norway: possible explanatory factors', *International journal for equity in health,* vol. 7, no. e811d86e-33f8-0a44-ea3f-4e2fab97a29c, pp. 27.

Daly, J, Kellehear, A & Gliksman, MD 1997, *The public health researcher : a methodological guide,* Oxford University Press, Melbourne.

Datta, A, Jones, H, Febriany, V, Harris, D, Dewi, RK, Wild, L & Young, J 2011, *The political economy of policy-making in Indonesia,* Overseas Development Institute, London.

Davidson, L, Flanagan, E, Roe, D & Styron, T 2006, 'Leading a horse to water: An action perspective on mental health policy', *Journal of Clinical Psychology,* vol. 62, no. 9, pp. 1141-1155.

Davidson, L, Hoge, M, Merrill, M, Rackfeldt, J & Griffith, E 1995, 'The experience of long-stay inpatients returning to the community', *Psychiatry,* vol. 58, no. 1, pp. 122-132.

de Kloet, ER, DeRijk, RH & Meijer, OC 2007, 'Therapy Insight: is there an imbalanced response of mineralocorticoid and glucocorticoid receptors in depression?', *Nat Clin Pract End Met,* vol. 3, no. 2, pp. 168-179.

De Vries, AK & Klazinga, NS 2006, 'Mental health reform in post-conflict areas: A policy analysis based on experiences in Bosnia Herzegovina and Kosovo', *European Journal of Public Health,* vol. 16, no. 3, pp. 246-251.

Denhardt, RB 2008, *Theories of public organization,* Thomson Wadsworth, CA, USA.

Denzin, NK & Lincoln, YS 1994, *Handbook of qualitative research,* Sage Publications, Inc, Thousand Oak, California.

Denzin, NK & Lincoln, YS 2008a, *The lanscape of qualitative research,* Sage Publications Inc, California.

Denzin, NK & Lincoln, YS 2008b, *Strategies of qualitative inquiry,* Sage Publications, Inc., California.

Department of Health 2001, *National Mental Health Policy 2001–2005,* Department of Health-Social Welfare Republic of Indonesia, Jakarta.

Diskes Jabar 2012, *Data RSU/RS Khusus se-Jawa Barat yang diterima s/d Desember 2011,* Dinas Kesehatan Provinsi Jawa Barat, Bandung.

Diskes Jabar 2013, *Jumlah puskesmas di Jawa Barat,* Dinas Kesehatan Provinsi Jawa Barat, Bandung

Dobbins, M, Ciliska, D, Cockerill, R, Barnsley, B & DiCenso, A 2002, 'A Framework for the dissemination and utilization of research for health-care policy and practice', *The Online Journal of Knowledge Synthesis for Nursing,* vol. 9, no. 7, pp. 1-12.

Dolowitz, DP & Marsh, D 2000, 'Learning from Abroad: The Role of Policy Transfer in Contemporary Policy-Making', *Governance,* vol. 13, no. 1, pp. 5-23.

Draper, C, Lund, C, Kleintjes, S, Funk, M, Omar, M, Flisher, A & Consortium, MHRP 2009, 'Mental health policy in South Africa: development process and content', *Health Policy and Planning,* vol. 24, no. 7, pp. 342-398.

Drew, N, Funk, M, Tang, S, Lamichhane, J, Chávez, E, Katontoka, S, Pathare, S, Lewis, O, Gostin, L & Saraceno, B 2011, 'Human rights violations of people with mental and psychosocial disabilities: A unresolved global crisis', *The Lancet,* vol. 378, no. 1, pp. 1664-1675.

du Gay, P 2005, *The value of bureaucracy,* Oxford University Press, New York.

Dush, D, Ayres, S, C, C, Worthington, G, Gabriel, R & Chinney, T 2001, 'Reducing psychiatric hospital use of the rural poor through intensive transitional acute care', *Psychiatric Rehabilitation Journal,* vol. 25, no. 1, pp. 28-35.

Elder, R, Evans, K & Nizette, D 2009, 'Psychiatric and mental health nursing' in Elsevier Australia, Chatswood, N.S.W.

Elstad, TA & Eide, AH 2009, 'User participation in community mental health services: exploring the experiences of users and professionals', *Scandinavian Journal of Caring Sciences,* vol. 23, no. 4, pp. 674-681.

Erasmus, E & Gilson, L 2008, 'How to start thinking about investigating power in the organizational settings of policy implementation', *Health Policy and Planning,* vol. 23, no. 5, pp. 361-368.

Evans, M 2004, 'Understanding policy transfer', *in* Evans, M (ed.) *Policy transfer in global perspective.* Burlington, VT : Ashgate, Aldershot, Hants, England.

Evans, M & Davies, J 1999, 'Understanding Policy Transfer: A Multi-Level, Multi-Disciplinary Perspective', *Public Administration,* vol. 77, no. 2, pp. 361-385.

Farmer, T, Robinson, K, Elliot, SJ & Eyles, J 2006, 'Developing and implementing a triangulation protocol for qualitative health research', *Qual Health Res,* vol. 16, no. 3, pp. 377-394.

Farooq, S & Minhas, FA 2001, 'Community psychiatry in developing coountries -- a misnomer?', *Psichiatric Bulletin,* vol. 25, no. 1, pp. 226-227.

Fast, NJ & Tiedens, LZ 2010, 'Blame contagion: The automatic transmission of self-serving attributions', *Journal of Experimental Social Psychology,* vol. 46, no. 1, pp. 97-106.

Fereday, J & Muir-Cochrane, E 2006, 'Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development', *International Journal of Qualitative Methods,* vol. 5, no. 1, pp. 80-93.

Fernandez, S & Rainey, HG 2006, 'Managing successful oganizational change in the public sector', *Public Administration Review,* vol. 66, no. 2, pp. 168-176.

Fischer, F 2003, *Reframing public policy: Discursive politics and deliberative practices,* Oxford University Press, New York.

Fischer, F, Miller, GJ & Sidney, MS 2007a, *Handbook of public policy analysis: theory, politics, and methods,* CRC Press, Boca Raton, FL.

Fischer, P, Greitemeyer, T, Omay, SI & Frey, D 2007b, 'Mergers and group status: the impact of high, low and equal group status on identification and satisfaction with a company merger, experienced controllability, group identity and group cohesion', *Journal of Community & Applied Social Psychology,* vol. 17, no. 3, pp. 203-217.

Foucault, M 1982, 'The Subject and Power', *Critical Inquiry,* vol. 8, no. 4, pp. 777-795.

Foucault, M 1983, 'On the genealogy of ethics: An overview of work in progress', *in* Dreyfus, HL & Rabinow, P (eds.) *Michel Foucault: Beyond Structuralism and Hermeneutics.* The University of Chicago Press, Chicago.

Frankenberg, E, Friedman, J, Gillespie, T, Ingwersen, N, Pynoos, R, Rifai, U, Sikoki, B, Steinberg, A, Sumantri, C, Suriastini, W & Thomas, D 2008, 'Mental Health in Sumatra After the Tsunami', *American Journal of Public Health,* vol. 98, no. 9, pp. 1671-1679.

Frenk, J 1994, 'Dimensions of health system reform', *Health Policy,* vol. 27, no. -, pp. 19-34.
Freshwater, D & Westwood, T 2006, 'Risk, detention and evidence: humanizing mental health reform', *Journal of Psychiatric and Mental Health Nursing,* vol. 13, no. 3, pp. 257-259.
Fusar-Poli, P, Bruno, D, Machado-De-Sousa, J & Crippa, J 2011, 'Franco Basaglia (1924--1980): Three decades (1979--2009) as a bridge between the Italian and Brazilian mental health reform', *International Journal of Social Psychiatry,* vol. 57, no. 1, pp. 100-103.
Gardner, LB & Scheffler, RM 1988, 'Privatization in Health Care: Shifting the Risk', *Medical Care Research and Review,* vol. 45, no. 2, pp. 215-253.
Gater, R, Goldberg, D, Jackson, G, Jennett, N, Lowson, K, Ratcliffe, J, Saraf, T & Warner, R 1997, 'The care of patients with chronic schizophrenia: A comparison between two services', *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences,* vol. 27, no. 6, pp. 1325-1336.
Gauld, R 2005, *Comparative health policy in the Asia-Pacific,* Open University Press, Berkshire.
Geddes, M, Davies, J & Fuller, C 2007, 'Evaluating local strategic partnerships: Theory and practice of change', *Local Government Studies,* vol. 33, no. 1, pp. 97-116.
Gelfand, MJ, Leslie, LM, Keller, K & de Dreu, C 2012, 'Conflict cultures in organizations', *Journal of Applied Psychology,* vol. 97, no. 6, pp. 1131-1147.
Gerrand, V 2005, 'Can disintitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review,* vol. 14, no. 3, pp. 255-271.
Gerth, HH & Mills, CW 1958, *From Max Weber: Essays in Sociology,* Oxford University Press, New York.
Gilson, L, Buse, K, Murray, SF & Dickinson, C 2008, 'Future directions for health policy analysis: a tribute to the work of Professor Gill Walt', *Health Policy and Planning,* vol. 23, no. 5, pp. 291-293.
Gilson, L & Raphaely, N 2008, 'The terrain of health policy analysis in low and middle income countries: a review of published literature 1994–2007', *Health Policy and Planning,* vol. 23, no. 5, pp. 294-307.
Glick, WH, Huber, GP, Miller, CC, Doty, DH & Sutcliffe, KM 1990, 'Studying changes in organizational design and effectiveness: Retrospective event histories and periodic assessments', *Organization Science,* vol. 1, no. 3, pp. 293-312.
Goodsell, CT 2005, 'The bureau as unit of governance ', *in* du Gay, P (ed.) *The value of bureaucracy.* Oxford University Press, New York.
Gordon, I, Lewis, J & Young, K 1993, 'Perspectives on policy analysis', *in* Hill, M (ed.) *The policy process.* Harvester Wheatsheaf, London.
Grant, J 2007, 'The Participation of Mental Health Service Users in Ontario, Canada: A Canadian Application of the Consumer Participation Questionnaire', *International Journal of Social Psychiatry,* vol. 53, no. 2, pp. 148-158.
Greener, I 2002, 'Understanding NHS Reform: The Policy-Transfer, Social Learning, and Path-Dependency Perspectives', *Governance,* vol. 15, no. 2, pp. 161-183.

Gronfein, W 1985, 'Psychotropic drugs and the origin of deinstitutionalisation', *Social Problems,* vol. 32, no. 5, pp. 437-454.
Habibis, D 2005, 'Epilogue: the mental health reform cakewalk: moving forwards backwards', *Health Sociology Review,* vol. 14, no. 3, pp. 306-312.
Häfner, H & Heiden, W 1997, 'Epidemiology of schizophrenia', *Can J Psychiatry,* vol. 42, no. 2, pp. 139-51.
Hamel, J, Dufor, S & Fortin, D 1993, *Case study methods,* Sage Publications, Inc., Newbury Park, California.
Hamid, HI & Everett, A 2007, 'Developing Iraq's Mental Health Policy', *Psychiatric Services,* vol. 58, no. 10, pp. 1355-1359.
Hancock, T 1986, 'Lalonde and beyond: Looking back at "A New Perspective on the Health of Canadians"', *Health Promotion International,* vol. 1, no. 1, pp. 93-100.
Hannigan, B & Coffey, M 2011, 'Where the wicked problems are: The case of mental health', *Health Policy,* vol. 101, no. 1, pp. 220- 227.
Harrison, P & Owen, M 2003, 'Genes for schizophrenia? Recent findings and their pathophysiological implications', *Lancet,* vol. 361, no. pp. 417-419.
Hawkins, Z & Tilman, T 2011, '"The family is the clinic, the community is the hospital": Community mental health in Timor-Leste', *Australasian Psychiatry,* vol. 19, no. Suppl 1, pp. 95-97.
Hazelton, M 2005, 'Mental health reform, citizenship and human rights in four countries', *Health Sociology Review,* vol. 14, no. 3, pp. 230-241.
Henderson, J 2005, 'Neoliberalism, comunity care and Australian mental health policy', *Health Sociology Review,* vol. 14, no. 1, pp. 242-254.
Hickie, IB, Groom, GL, McGorry, PD, Davenport, TA & Luscombe, GM 2005, 'Australian mental health reform: time for real outcomes', *Medical Journal of Australia,* vol. 182, no. 8, pp. 401-406.
Hill, M 2009, *The public policy process,* Pearson Education Limited, Essex, England.
Hill, M & Hupe, P 2009, *Implementing public policy,* Sage, London.
Hill, PS, Goeman, L, Sofiarini, R & Djara, MM 2013, ''Desa SIAGA', the 'Alert Village': the evolution of an iconic brand in Indonesian public health strategy', *Health Policy and Planning,* vol. 1, no. 1, pp. 1-12.
Hobbs, C, Tennant, C, Rosen, A, Newton, L, Lapsley, H, Tribe, K & Brown, J 2000, 'Deinstitutionalisation for long-term mental illness: a 2-year clinical evaluation', *Australian & New Zealand Journal of Psychiatry,* vol. 34, no. 3, pp. 476-483.
Hogwood, BW & Gunn, LA 1984, *Policy analysis for the real world,* Oxford University Press, London.
Holbeche, L 2006, *Understanding change: Theory, implementation and success,* Elsevier, Oxford.
Hollan, D 2000, 'Culture and Dissociation in Toraja', *Transcultural Psychiatry,* vol. 37, no. 4, pp. 545-559.
Holtzappel, CJG & Ramstedt, M 2009, *Decentralization and regional autonomy in Indonesia : implementation and challenges,* ISEAS Publishing, Singapore.
Honkonen, T, Karlsson, H, Koivisto, A, Stengard, E & Salokangas, R 2003, 'Schizophrenic patients in different treatment settings during the era of deinstitutionalization: three-year follow-up of three discharge cohorts in

Finland', *Australian & New Zealand Journal of Psychiatry,* vol. 37, no. 2, pp. 160-168.

Hopfl, HM 2011, 'Bureaucratic and post-bureaucratic accountability in Britain: Some skeptical reflection', *in* Clegg, S, Harris, M & Hopfl, H (eds.) *Managing modernity: Beyond bureaucracy?* Oxford University Press, New York.

Horikoshi, H 1980, 'Asrama: An Islamic psychiatric institution in West Java', *Social Science & Medicine. Part B: Medical Anthropology,* vol. 14, no. 3, pp. 157-165.

Horsburgh, D 2003, 'Evaluation of qualitative research', *Journal of Clinical Nursing,* vol. 12, no. 1, pp. 307-312.

Howlett, M, Ramesh, M & Perl, A 2009, *Studying public policy,* Oxford University Press, Ontario.

Hunt, JW 1987, 'Hidden extras: How people get overlooked in takeovers', *Personnel Management,* vol. 19, no. 1, pp. 24-27.

Hunter, E 1997, 'Mental health: is this a public health issue?', *Australian and New Zealand Journal of Public Health* vol. 21, no. 6, pp. 648-656.

Huxley, P & Thornicroft, G 2003, 'Social inclusion, social quality and mental illness ', *The British Journal of Psychiatry,* vol. 182, no. 1, pp. 289-290.

Imai, L & Gelfand, MJ 2009, 'Interdisciplinary perspectives on culture, conflict, and negotiation', *in* Bhagat, R & Steers, R (eds.) *Cambridge handbook of culture, organizations, and work* Cambridge University Press, Cambridge.

Irmansyah, I, Dharmono, S, Maramis, A & Minas, H 2010, 'Determinants of psychological morbidity in survivors of the earthquake and tsunami in Aceh and Nias', *International Journal of Mental Health Systems,* vol. 4, no. 1, pp. 8.

Irmansyah, I, Prasetyo, Y & Minas, H 2009a, 'Human rights of persons with mental illness in Indonesia: more than legislation is needed', *International Journal of Mental Health Systems* vol. 3, no. 14, pp. 1-10.

Irmansyah, I, Prasetyo, Y & Minas, H 2009b, 'Human rights of persons with mental illness in Indonesia: more than legislation is needed', *International Journal of Mental Health Systems,* vol. 3, no. 14, pp. 1-10.

Issakidis, C & Andrews, G 2006, 'Who treats whom? An application of the Pathways to Care model in Australia', *Australian and New Zealand Journal of Psychiatry,* vol. 40, no. pp. 74-86.

Jann, W & Wegrich, K 2007, 'Theories of the policy cycle', *in* Fischer, F, Miller, G & Sidney, M (eds.) *Handbook of public policy analysis: theory, politics, and methods.* CRC Press, Boca Raton, FL.

Johnson, RB & Onwuegbuzie, AJ 2004, 'Mixed Methods Research: A Research Paradigm Whose Time Has Come', *Educational Researcher,* vol. 33, no. 7, pp. 14-27.

Jones, LM, Ghani, HA, Mohanraj, A, Morrison, S, Smith, P, Stube, D & Asare, J 2007, 'Crisis into opportunity: setting up community mental health services in post-tsunami Aceh', *Asia Pac J Public Health,* vol. 19, no. 1, pp. 60-68.

Joss, N & Keleher, H 2011, 'Community development and partnerships', *in* Keleher, H & MacDougall, C (eds.) *Understanding health: a determinants approach.* Oxford University Press, Melbourne.

Judge, TA & Piccolo, RF 2004, 'Transformational and transactional leadership', *Journal of Applied Psychology,* vol. 89, no. 5, pp. 755-768.

Keleher, H 2001, 'Why primary health care offers a more comprehensive approach for tackling health inequities than primary care', *Australian Journal of Primary Health,* vol. 7, no. 2, pp.

Kelman, H 1968, 'Indonesian Psychiatric Services', *Transcultural Psychiatry* vol. 5, no. pp. 206-210.

Ketter, T 1983, 'Cultural stylization and mental illness in Bali', *Transcultural Psychiatric Research Review,* vol. 20, no. -, pp. 87-106.

Kidd, S, Kenny, A & Endacott, R 2007, 'Consumer advocate and clinician perceptions of consumer participation in two rural mental health services', *International Journal of Mental Health Nursing,* vol. 16, no. 3, pp. 214-222.

Kristiansen, S & Santoso, P 2006, 'Surviving decentralisation?: Impacts of regional autonomy on health service provision in Indonesia', *Health Policy,* vol. 77, no. 3, pp. 247-259.

Kurihara, T 2006, 'Excess mortality of schizophrenia in the developing country of Bali', *Schizophrenia Research* vol. 83, no. pp. 103-105.

Kurihara, T, Kato, M, Reverger, R, Tirta, IGR & Kashima, H 2005, 'Never-treated patients with schizophrenia in the developing country of Bali', *Schizophrenia Research,* vol. 79, no. -, pp. 307- 313.

Lamb, HR & Goertzel, V 1971, 'Discharge mental patients - Are they really in the community?', *Archives of General Psychiatry,* vol. 24, no. 1, pp. 29-34.

Langsley, DG 1980, 'The community mental health center: does it treat patients?', *Hospital Community Psychiatry,* vol. 31, no. 12, pp. 815-819.

Laris, P & MacDougall, C 2011, 'Organisations, power and health promotion ', *in* Keleher, H & MacDougall, C (eds.) *Understanding health.* Oxford University Press, South Melbourne.

Laverack, G 2009, *Public health: Power, empowerment and professional practice,* Palgrave Macmillan, Basingstoke England.

Lavis, JN, Robertson, D, Woodside, JM, McLeod, CB & Abelson, J 2003, 'How can research organizations more effectively transfer research knowledge to decision makers?', *The Milbank Quarterly,* vol. 81, no. 2, pp. 221-249.

Lebrun, J 2007, *Scientific writing: A reader and writer's guide,* World Scientific Publishing Co. Pte. Ltd, Singapore.

Lemelson, R 2003, 'Obsessive-Compulsive Disorder in Bali: The cultural shaping of a neuropsychiatric disorder', *Transcultural Psychiatry,* vol. 40, no. 3, pp. 377-408.

Levin, B & Becker, M 2010, *A Public Health Perspective of Women's Mental Health,* Springer, New York.

Liamputtong, P 2009, *Qualitative research methods,* Oxford University Press, Melbourne, Australia.

Lipsky, M 2010, *Street-level bureaucracy: Dilemmas of the individual in public services,* Russell Sage Foundation, New York.

Lok, P & Crawford, J 2004, 'The effect of organisational culture and leadership style on job satisfaction and organisational commitment: A cross-national comparison', *Journal of Management Development,* vol. 23, no. 4, pp. 321-338.

Luborsky, MR & Rubinstein, RL 1995, 'Sampling in qualitative research : Rationale, issues, and methods', *Research on Aging,* vol. 17, no. 1, pp. 89-115.

Lundberg, B, Hansson, L, Wentz, E & Björkman, T 2008, 'Stigma, discrimination, empowerment and social networks: a preliminary investigation of their influence on subjective quality of life in a Swedish sample', *Int J Soc Psychiatry,* vol. 54, no. 47, pp. 47-57.

Madianos, M, Tsiantis, J & Zacharakis, C 1999, 'Changing patterns of mental health care in Greece (1984-1996)', *Eur Psychiatry,* vol. 14, no. pp. 462-467.

Maretzki, TW 1981, 'Culture and psychopathology in Indonesia', *Transcultural Psychiatry,* vol. 18, no. pp. 237-258.

Marmor, T, Freeman, R & Okma, K 2005, 'Comparative perspectives and policy learning in the world of health care', *Journal of Comparative Policy Analysis: Research and Practice,* vol. 7, no. 4, pp. 331-348.

Marmot, M & Wilkinson, R 1999, *Social determinants of health* Oxford University Press, New York.

Marshall, MN 1996, 'Sampling for qualitative research', *Family Practice,* vol. 13, no. 6, pp. 522-526.

Marshall, PA 2007, *Ethical challenges in study design and informed consent for health research in resource-poor settings,* World Health Organization, Geneva.

Marzilli, A 2003, *Mental health reform: Point-counterpoint,* Chelsea House Publishers, Philadelphia.

Mason, J 2004, *Semistructured Interview,* SAGE Publications, Inc., Thousand Oaks, CA.

Maxwell, JA 2009, 'Designing a qualitative study', *in* Bickman, L & Rog, DJ (eds.) *The SAGE handbook of applied social research methods.* SAGE Publications, Inc, Thousand Oaks, CA.

Mays, N & Pope, C 2000, 'Assessing quality in qualitative research', *British Medical Journal,* vol. 320, no. 7226, pp. 50-2.

Mbatia, J & Jenkins, R 2010, 'Development of a mental health policy and system in Tanzania: An integrated approach to achieve equity', *Psychiatric Services,* vol. 61, no. 10, pp.

McCann, TV, Baird, J, Clark, E & Lu, S 2008, 'Mental health professionals' attitudes towards consumer participation in inpatient units', *Journal of Psychiatric and Mental Health Nursing,* vol. 15, no. 1, pp. 10-16.

McColl, L 2007, 'They just don't care: the experiences of mental health consumers in a Queensland bush community', *Australian e-Journal for the Advancement of Mental Health (AeJAMH),* vol. 6, no. 2, pp. 9p.

McLeod, RH & MacIntyre, A 2007, 'Indonesia: democracy and the promise of good government' in ISEAS Publishing, Singapore.

Meadmore, D, Hatcher, C & McWilliam, E 2000, 'Getting tense about genealogy', *International Journal of Qualitative Studies in Education,* vol. 13, no. 5, pp. 463-476.

Mechanic, D 1993, 'Mental health services in the context of health insurance reform', *Milbank Quarterly,* vol. 71, no. 3, pp. 349-364.

Mehryar, A & Khajavi, F 1974, 'Some implications of a community mental health model for developing countries', *International Journal of Social Psychiatry,* vol. 21, no. 1, pp. 45-52.

Merryman, M 2004, 'Review of Factors that influence the adoption of innovative state mental health reform', *Administration and Policy in Mental Health,* vol. 31, no. 5, pp. 429.
Merryman, MC 2003, 'Factors that influence the adoption of innovative state mental health reform', *Dissertation Abstracts International Section A: Humanities and Social Sciences,* vol. 64, no. 1-A, pp. 300.
Meyer, S, Ward, P, Coveney, J & Rogers, W 2008, 'Trust in the health system: An analysis and extension of the social theories of Giddens and Luhmann', *Health Sociology Review,* vol. 17, no. 2, pp. 177-186.
Milio, N 2001, 'Glossary: Healthy public policy', *J Epidemiol Community Health,* vol. 55, no. 1, pp. 622-623.
Miller, T & Boulton, M 2007, 'Changing constructions of informed consent: Qualitative research and complex social worlds', *Social Science & Medicine,* vol. 65, no. 1, pp. 2199-2211.
Mills, MJ & Cummins, BD 1982, 'Deinstitutionalization reconsidered', *International Journal of Law and Psychiatry,* vol. 5, no. 3–4, pp. 271-284.
Minas, H 2009, 'Mentally ill patients dying in social shelters in Indonesia', *The Lancet,* vol. 374, no. 9690, pp. 592-593.
Minas, H & Cohen, A 2007, 'Why focus on mental health systems?', *International Journal of Mental Health Systems,* vol. 1, no. 1, pp. 1-4.
Minas, H & Diatri, H 2008a, 'Pasung: Physical restraint and confinement of the mentally ill in the community', *International Journal of Mental Health Systems,* vol. 2, no. 8, pp. 1-5.
Minas, H & Diatri, H 2008b, 'Pasung: Physical restraint and confinement of the mentally ill in the community', *International Journal of Mental Health Systems,* vol. 2, no. 1, pp. 1-5.
Miyake, N 1986, 'Constructive interaction and the iterative process of understanding', *Cognitive Science,* vol. 10, no. 1, pp. 151--177.
MoH 2001, *National Mental Health Policy,* General of Community Health Directorate, Jakarta.
MoH 2009, *Pedoman pelayanan kesehatan jiwa komunitas,* The Ministry of Health Republic of Indonesia, Jakarta.
MoH 2010a, 'Indonesia health profile', viewed 1 May 2011, http://www.depkes.go.id/downloads/profil_kesehatan_2009/index.html.
MoH 2010b, *Klasifikasi rumah sakit,* The Ministry of Health Republic of Indonesia, Jakarta.
MoH 2010c, *Pedoman umum pengembangan desa dan kelurahan siaga aktif,* The Ministry of Health Republic of Indonesia, Jakarta.
MoH 2010d, *Strategic Plan 2010-2014,* The Ministry of Health Republic of Indonesia, Jakarta.
MoH 2012, *Basic Health Research* [Online]. viewed 20 May 2012, http://www.depkes.go.id.
Morgan, LM 2001, 'Community participation in health: Perpetual allure, persistent challenge', *Health Policy and Planning,* vol. 16, no. 3, pp. 221-230.
Mowbray, CT & Holter, MC 2002, 'Mental Health and Mental Illness: Out of the Closet?', *Social Service Review,* vol. 76, no. 1, pp. 135-179.

Moynihan, R, Heath, I & Henry, D 2002, 'Selling sickness: the pharmaceutical industry and disease mongering', *BMJ,* vol. 324, no. 1, pp. 886-892.
Muir-Cochrane, EC, Holmes, C & Walton, JA 2002, 'Law and policy in relation to the use of seclusion in psychiatric hospitals in Australia and New Zealand', *Contemporary Nurse,* vol. 13, no. 2-3, pp. 136-145.
Mullins, LJ 2007, *Management and organisational behaviour,* Prentice Hall, Essex.
Murray, R, Jones, P, Susser, E, Van Os, J & Excerpt, M 2003, *The Epidemiology of Schizophrenia,* Cambridge University Press.
Newmark, AJ 2002, 'An integrated approach to policy transfer and diffusion', *Review of Policy Research,* vol. 19, no. 2, pp. 151-178.
Nilakant, V & Ramnarayan, S 2006, *Change management: Altering mindset in a global context,* Sage Publications, New Delhi.
Northouse, PG 2010, *Leadership: Therory and practice,* SAGE Publications, California.
Notter, J & Blair, M 2004, 'Conflict and trust: Expressions of culture and keys to organisational success ', *Journal of Association Leadership,* vol. 2, no. 2, pp. 1-10.
Novella, EJ 2008, 'Theoretical accounts on deinstitutionalization and the reform of mental health services: a critical review', *Medicine, Health Care, and Philosophy,* vol. 11, no. 3, pp. 303-314.
Ofori-Atta, A, Read, UM, Lund, C & Consortium, MHRP 2010, 'A situation analysis of mental health services and legislation in Ghana: challenges for transformation', *African Journal of Psychiatry,* vol. 13, no. 2, pp. 99-108.
Online dictionary 2013, 'Merriam-Webster', viewed 4 July 2013, http://www.merriam-webster.com/.
Patel, M, Doku, V & Tennakoon, L 2003, 'Challenges in recruitment of research participants', *Advances in Psychiatric Treatment,* vol. 9, no. 1, pp. 229-238.
Patel, V 2007, 'Mental health in low- and middle-income countries', *British Medical Bulletin,* vol. 81-82, no. 1, pp. 81-96.
Patel, V & Kleinman, A 2003, 'Poverty and common mental disorders in developing countries', *Bulletin of the World Health Organization* vol. 81, no. 8, pp. 609-616.
Patrick, WC, Amy, K & Lissa, K 2005, 'The stigma of mental illness: Explanatory models and methods for change', *Applied and Preventive Psychology,* vol. 11, no. 53894404-b954-eb2c-6a79-4e2fab981353, pp.
Patton, MQ 1990, *Qualitative Evaluation and Research Methods,* Sage Publications, Inc., Newbury Park, California.
Patton, MQ 2002, *Qualitative research and evaluation methods,* Sage Publications, Inc, California, USA.
Piccinelli, M & Homan, F 1997, *Gender differences in the epidemiology of affective disorders and schizophrenia,* WHO Press, Geneva.
Pols, H 2006, 'The development of psychiatry in Indonesia: From colonial to modern times', *International Review of Psychiatry,* vol. 18, no. 4, pp. 363-370.
Popay, J 2003, 'Qualitative research and the epidemiological imagination: a vital relationship', *Gac Sanit,* vol. 17, no. 3, pp. 58-63.

Popay, J, Rogers, A & Williams, G 1998, 'Rationale and standards for the systematic review of qualitative literature in health services research', *Qual Health Res,* vol. 8, no. 3 pp. 341-351.

Porath, N 2008, 'The naturalization of psychiatry in Indonesia and its interaction with indigenous therapeutics', *Bijdragen tot de Taal-, Land-en Volkenkunde,* vol. 164, no. 4, pp. 500-528.

Powell, WR 2002, 'Organizational change models', *Futurics,* vol. 26, no. 3/4, pp. 20-46.

Prasetiyawan, Viora, E, Maramis, A & Keliat, BA 2006, 'Mental health model of care programmes after the tsunami in Aceh, Indonesia', *International Review of Psychiatry,* vol. 18, no. 6, pp. 559-562.

Prasojo, E, Kurniawan, T & Holidin, D 2007, *State reform in Indonesia* Administrative Sciences Department, University of Indonesia Jakarta.

Preston, J, Kisely, S & Xiao, J 2002, 'Assessing the outcome of compulsory psychiatric treatment in the community: epidemiological study in Western Australia', *BMJ,* vol. 324, no. pp. 1-5.

Primm, SA & Clark, TW 1996, 'The Greater Yellowstone policy debate: What is the policy problem?', *Policy Sciences,* vol. 29, no. 1, pp. 137-166.

Puckett, A 1993, *Community Mental Health,* W. B. Saunders, Marrickville, NSW.

Pülzl, H & Treib, O 2007, 'Implementing public policy', *in* Fischer, F, Miller, G & Sidney, M (eds.) *Handbook of public policy analysis: theory, politics, and methods.* CRC Press, Boca Raton, FL.

Puteh, I, Marthoenis, M & Minas, H 2011, 'Aceh Free Pasung: Releasing the mentally ill from physical restraint', *International Journal of Mental Health Systems,* vol. 5, no. 1, pp. 1-5.

Rainey, HG 2003, *Understanding and managing public organizations,* John Wiley & Sons, Inc, San Fransisco.

Raphael, D 2009, *Social determinants of health: Canadian perspectives,* Canadian Scholar's Press Inc., Ontario.

Redmond, A, Keenan, A & Landorf, K 2000, ''Horses for courses': the differences between quantitative and qualitative approaches to research', *Australasian Journal of Podiatric Medicine,* vol. 34, no. 1, pp. 5-14.

Robert, G, Hardacre, J, Locock, L, Bate, P & Glasby, J 2003, 'Redesigning mental health services: Lessons on user involvement from the Mental Health Collaborative', *Health Expectations,* vol. 6, no. 1, pp. 60-71.

Roberts, MJ, Hsiao, W, Berman, P & Reich, MR 2008, *Getting health reform right: A guide to improving performance and equity,* Oxford University Press, New York.

Robichau, RW & Lynn, LE 2009, 'The implementation of public policy: Still the missing link', *Policy Studies Journal,* vol. 37, no. 1, pp. 21-36.

Rokx, C, Giles, J, Satriawan, E, Marzoeki, P, Harimurti, P & Yavuz, E 2010, *New insight into the provision of health services in Indonesia,* The World Bank, Washington.

Rose, K & Webb, C 1998, 'Analysing data: Maintaining rigor in a Qualitative Study', *Qualitative Health Research,* vol. 8, no. 4, pp. 556-562.

Rose, N 2006, 'Disorders without borders? The expanding scope of psychiatric practice', *BioSocieties,* vol. 1, no. 1, pp. 465-484.

Rosenau, JN 1992, 'Governance, order, and change in world politics', *in* Rosenau, JN & Czempiel, E (eds.) *Governance without government: Order and change in world politics.* Cambridge University Press, Cambridge.

Rosenberg, S 2011, 'True North? Twenty years of Australian mental health reform', *International Journal of Mental Health,* vol. 40, no. 2, pp. 8-24.

Rosier, C, Williams, H & Ryrie, L 1998, 'Anxiety management groups in a community mental health team', *The British Journal of Occupational Therapy,* vol. 61, no. 5, pp. 203-206.

Rothbard, A, Kuno, E, Schinnar, A, Hadley, T & Turk, R 1999, 'Service utilization and cost of community care for discharged state hospital patients: a 3-year follow-up study', *American Journal of Psychiatry,* vol. 156, no. 6, pp. 920-927.

Rottig, D 2013, 'A marriage metaphor model for sociocultural integration in international mergers and acquisitions', *Thunderbird International Business Review,* vol. 55, no. 4, pp. 439-451.

Rowe, M, Lawless, M, Thompson, K & Davidson, L 2011, 'Classics of community psychiatry' in Oxford University Press, New York.

Ruggeri, M, Salvi, G, Perwanger, V, Phelan, M, Pellegrini, N & Parabiaghi, A 2006, 'Satisfaction with community and hospital-based emergency services amongst severely mentally ill service users: A comparison study in South-Verona and South-London', *Soc Psychiatry Psychiatr Epidemiol* vol. 41, no. pp. 302-309.

Rutter, D, Manley, C, Weaver, T, Crawford, MJ & Fulop, N 2004, 'Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London', *Social Science and Medicine,* vol. 58, no. 10, pp. 1973-1984.

Ryu, Y, Mizuno, M, Sakuma, K, Munakata, S, Takebayashi, T, Murakami, M, Falloon, I & Kashima, H 2006 'Deinstitutionalization of long-stay patients with schizophrenia: the 2-year social and clinical outcome of a comprehensive intervention program in Japan', *Australian & New Zealand Journal of Psychiatry,* vol. 40, no. 5, pp. 462-470.

Sadovnik, AR 2007, 'Qualitative research and public policy', *in* Fischer, F, Miller, G & Sidney, M (eds.) *Handbook of public policy analysis: theory, politics, and methods.* CRC Press, Boca Raton, FL.

Salhani, D & Coulter, I 2009, 'The politics of interprofessional working and the struggle for professional autonomy in nursing.', *Soc Sci Med,* vol. 68, no. 7, pp. 1221-8.

Saltman, RB, Bankauskaite, V & Vrangbaek, K 2007, *Decentralization in health care,* Open University Press, New York.

Saraceno, B, Van, M, Batniji, R & Cohen, A 2007, 'Barriers to improvement of mental health services in low-income and middle-income countries', *The Lancet,* vol. 370, no. -, pp. 1164-1174.

Sartorius, N 2007, 'Stigma and mental health', *The Lancet,* vol. 370, no. 1, pp. 810-812.

Saxena, S, Thornicroft, G, Knapp, M & Whiteford, H 2007, 'Resources for mental health: scarcity, inequity, and inefficiency', *Lancet,* vol. 370, no. -, pp. 878-89.

Scott, CD & Baehler, K 2010, *Adding value to policy analysis and advice* University of New South Wales Press Ltd, Sydney.

Sham, P, MacLean, C & Kendler, K 1994, 'A typological model of schizophrenia based on age at onset, sex and familial morbidity', *Acta Psychiatr Scand,* vol. 89, no. 2, pp. 135-41.

Shield, R, Thorpe, R & Nelson, A 2002, 'Hospital mergers and psychological contracts', *Strategic Change,* vol. 11, no. 7, pp. 357-367.

Simanjuntak, H 2010, *A life in chains* [Online]. viewed 8 July 2013 http://www.thejakartapost.com/news/2010/05/04/a-life-chains.html.

Stake, RE 2008, 'Qualitative case study', *in* Norman, K & Lincoln, YS (eds.) *Strategy of qualitative inquiry.* Sage Publications, Inc., California.

Starks, H & Brown, TS 2007, 'Choose your method: A comparison of Phenomenology, Discourse Analysis, and Grounded Theory', *Qualitative Health Research,* vol. 17, no. 10, pp. 1372-1380.

Statistics Indonesia 2011, *Statistical Yearbook of Indonesia 2011* [Online]. viewed 20 May 2012, http://www.bps.go.id/flip/flip11/index3.php.

Statistics Indonesia 2012, *Trends of selected socio-economic inddicators of Indonesia February 2012,* BPS – Statistics Indonesia, Jakarta.

Stone, D 1999, 'Learning Lessons and Transferring Policy across Time, Space and Disciplines', *Politics,* vol. 19, no. 1, pp. 51-59.

Sturdy, S, Freeman, R & Smith-Merry, J 2013, 'Making knowledge for international policy: WHO Europe and mental health policy, 1970–2008', *Social History of Medicine,* vol. 26, no. 3, pp. 532-554.

Sun, PYT & Anderson, MH 2012, 'Civic capacity: Building on transformational leadership to explain successful integrative public leadership', *The Leadership Quarterly,* vol. 23, no. 3, pp. 309-323.

Suryani, LK, Lesmana, CBJ & Tiliopoulos, N 2011, 'Treating the untreated: applying a community-based, culturally sensitive psychiatric intervention to confined and physically restrained mentally ill individuals in Bali, Indonesia', *European Archives of Psychiatry and Clinical Neuroscience,* vol. 261, no. 2, pp. 140-144.

Suryani, LK, Page, A, Lesmana, CBJ, Jennaway, M, Basudewa, IDG & Taylor, R 2009, 'Suicide in paradise: aftermath of the Bali bombings ', *Psychological Medicine,* vol. 39, no. 8, pp. 1317-1323.

Terris, M 1984, 'Newer perspectives on the health of Canadians: Beyond the Lalonde Report', *Journal of Public Health Policy,* vol. 5, no. 3, pp. 327-337.

Thakker, J, Ward, T & Strongman, K 1999, 'Mental disorder and cross-cultural psychology: A constructivist perspective ', *Clinical Psychology Review,* vol. 19, no. 7, pp. 843-874.

Thomas, JW & Grindle, MS 1990, 'After the decision: Implementing policy reforms in developing countries', *World Development,* vol. 18, no. 8, pp. 1163-1181.

Thornicroft, G & Tansella, M 2004, 'Components of a modern mental health service: a pragmatic balance of community and hospital care. ', *The British Journal of Psychiatry,* vol. 185, no. 1, pp. 283-290.

Tjiptoherijanto, P 2008, 'Civil service reform in Indonesia', *International Public Management Review* vol. 8, no. 2, pp. 39-53.

Tobin, M, Leathley, C & Chen, L 2002, 'Consumer participation in mental health services: who wants it and why?', *Australian Health Review,* vol. 25, no. 3, pp. 91-100.

Trottier, T, Van Wart, M & Wang, X 2008a, 'Examining the nature and significance of leadership in government organizations', *Public Administration Review,* vol. 68, no. 2, pp. 319-333.
Trottier, T, Wart, MV & Wang, X 2008b, 'Examining the nature and significance of leadership in government organizations', *Public Administration Review,* vol. 68, no. 2, pp. 319-333.
Turbin, J 2001, 'Policy borrowing: lessons from European attempts to transfer training practices', *International Journal of Training and Development,* vol. 5, no. 2, pp. 96-111.
Turner, T 2004, 'The history of deinstitutionalization and reinstitutionalization', *Psychiatry,* vol. 3, no. 9, pp. 1-4.
Van Wart, M 2003, 'Public-sector leadership theory: An assessment', *Public Administration Review,* vol. 63, no. 2, pp. 214-229.
Vauth, R, Kleim, B, Wirtz, M & Corrigan, P 2007, 'Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia', *Psychiatry Research,* vol. 1, no. 7, pp. 71-81.
Wæraas, A & Byrkjeflot, H 2012, 'Public sector organizations and reputation management: Five problems ', *International Public Management Journal,* vol. 15, no. 2, pp. 186-206.
Wahl, OF 1999, 'Mental health consumers' experience of stigma', *Schizophrenia Bulletin,* vol. 25, no. 3, pp. 467-78.
Walt, G & Gilson, L 1994, 'Reforming the health sector in developing countries: the central role of policy analysis', *Health Policy and Planning* vol. 9, no. 4, pp. 353-370.
Weaver, K & Olson, JK 2006, 'Understanding paradigms used for nursing research', *Journal of Advanced Nursing,* vol. 53, no. 4, pp. 459-469.
Webber, M & Huxley, P 2004, 'Social exclusion and risk of emergency compulsory admission. A case-control study', *Social Psychiatry and Psychiatric Epidemiology,* vol. 39, no. 1, pp. 1000 -1009.
Weidner, JR 2009, 'Governmentality, Capitalism, and Subjectivity', *Global Society,* vol. 23, no. 4, pp. 387-411.
Weiner, BJ 2009, 'A theory of organizational readiness for change', *Implementation Science,* vol. 4, no. 1, pp. 67-76.
Westhoff, WW, Cohen, CF, Cooper, EE, Corvin, J & McDermott, RJ 2012, 'Cooperation or competition: Does game theory have relevance for public health?', *American Journal of Health Education,* vol. 43, no. 3, pp. 175-183.
Westwood, RI 1992, *Organisational behaviour : Southeast Asian perspectives* Longman Group, Hongkong.
WHO 2005, *Improving access and use of psychotropic medicines,* World Health Organisation, Geneva.
WHO 2008a, *Integrating mental health into primary care: A global perspective,* WHO Press, Geneva.
WHO 2008b, *Mental health gap action programme : scaling up care for mental, neurological and substance use disorders,* World Health Organization, Geneva.
WHO 2009a, *Improving health systems and services for mental health,* WHO Press, Geneva.

WHO 2009b. Improving health systems and services for mental health. Geneva, Switzerland: World Health Organization.
WHO 2009c, *Mental health systems in selected low- and middle-income countries: a WHO-AIMS crossnational analysis,* World Health Organization, Geneva.
WHO 2010, *Best practices: Mental health service development,* World Health Organization, Geneva.
WHO 2011a, *Mental health atlas 2011,* World Health Organization, Geneva.
WHO 2011b, *Mental health policy, planning & service development,* World Health Organization, Geneva.
WHO 2012. The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Geneva: World Health Organization.
Wilson, KM, Brady, TJ & Lesesne, C 2011, 'An organizing framework for translation in public health: The knowledge to action framework', *Public Health Research, Practice, and Policy,* vol. 8, no. 2, pp. 1-7.
WJMH 2012, *Profil Rumah Sakit Jiwa Provinsi Jawa Barat,* WJMH, Bandung.
Wolman, H & Page, E 2002, 'Policy Transfer among Local Governments: An Information–Theory Approach', *Governance,* vol. 15, no. 4, pp. 577-501.
Yanow, D 1993, 'The communication of policy meanings: Implementation of interpretation and text', *Policy Sciences,* vol. 26, no. 1, pp. 41-61.
Yanow, D 2000, *Conducting interpretive policy analysis,* Sage Publications, Inc, Thousand Oak, California.
Yanow, D 2007, 'Qualitative-interpretive methods in policy research', *in* Fischer, F, Miller, G & Sidney, M (eds.) *Handbook of public policy analysis: theory, politics, and methods.* CRC Press, Boca Raton, FL.
Yanow, D & Schwartz-Shea, PME 2006, *Interpretation and method: Empirical research methods and the interpretive turn,* M.E. Sharpe, Inc., New York.
Yin, RK 1994, *Case study research: Design and methods,* Sage Publication, Inc, Thousand Oaks, California.
Yin, RK 2009, *Case study research design and methods,* Sage Publications, Thousand Oaks, California.
Younes, N, Hardy-Bayle, M, Falissard, B, Kovess, V & Gasquet, I 2008, 'Impact of shared mental health care in the general population on subjects’ perceptions of mental health care and on mental health status', *Soc Psychiatry Psychiatr Epidemiol,* vol. 43, no. pp. 113-120.
Zand, DE 2007, *The leadership triad: Knowledge, trust, and power,* Oxford University Press, New York.

Appendix

Ethics approval

FINAL APPROVAL NOTICE

Project No.:	**5881**
Project Title:	Indonesia mental health reform: A discourse analysis
Principal Researcher:	Ms Emi Patmisari
Email:	patm0005@flinders.edu.au
Address:	School of Public Health

Approval Date:	31 October 2012	Ethics Approval Expiry Date:	**31 December 2013**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation
   Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

   - all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
   - the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
   - the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

   This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports
   In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on the 31 October (approval anniversary date) for the duration of the ethics approval using the annual progress / final report pro forma. *Please retain this notice for reference when completing annual progress or final reports.*

   If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

   Your first report is due on 31 October 2013 or on completion of the project, whichever is the earliest.

3. Modifications to Project
   Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such matters include:

- proposed changes to the research protocol;
- proposed changes to participant recruitment methods;
- amendments to participant documentation and/or research tools;
- extension of ethics approval expiry date; and
- changes to the research team (addition, removals, supervisor changes).

To notify the Committee of any proposed modifications to the project please submit a Modification Request Form to the Executive Officer. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints
   Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

   - any complaints regarding the research are received;
   - a serious or unexpected adverse event occurs that effects participants;
   - an unforseen event occurs that may affect the ethical acceptability of the project.

MODIFICATION (No.1) APPROVAL NOTICE

Project No.:	**5881**
Project Title:	Understanding Indonesian mental health reform: A case study of West Java
Principal Researcher:	Ms Emi Patmisari
Email:	patm0005@flinders.edu.au
Address:	School of Public Health

Modification Approval Date:	2 May 2013	Ethics Approval Expiry Date:	**31 December 2013**

I refer to your modification request for the project above that has been approved previously. I am pleased to inform you that the Chairperson has approved your request to modify the project as outlined below:

	Approved Modification(s)	**Details of approved modification(s)**	
	Change of Project Title	From:	Indonesia mental health reform: A discourse analysis
		To:	Understanding Indonesian mental health reform: A case study of West Java
	Modified research protocol:	Approval to use a translator to translate 50% of one interview transcript back into the original language. Please ensure that the translator is asked to sign a confidentiality agreement.	

Discipline of Public Health
Faculty of Health Sciences
Flinders University

GPO Box 2100
Adelaide SA 5001
Tel: +61 8 7221 8426
Fax: +61 8 7221 8426

http://www.flinders.edu.au/courses/postgrad/dr-publichealth/
CRICOS Provider No. 039963E

INFORMATION SHEET

Title: 'Indonesia mental health reform: A discourse analysis'

Investigator:
Ms Emi Patmisari
Discipline of Public Health
Faculty of Health Sciences
Flinders University

Description of the study:
This study is part of the project entitled '*Indonesia mental health reform: A discourse analysis'*. This project will investigate how mental health reform policy implementation works in West Java by interviewing stakeholders. This project is supported by Flinders University Discipline of Public Health.

Purpose of the study:
This present study is intended to understand the notion of mental health reform policy implementation which is embedded in a web of social meanings shaped and reshaped through discursive practices by the officials in West Java Province.

What will I be asked to do?
You are invited to attend a one-on-one interview with a Doctorate student who will ask you a few questions about your views about mental health reform policy implementation in West Java. The interview will take up to 90 minutes. The interview will be recorded using a digital voice recorder to help with looking at the results. Once recorded, the interview will be transcribed (typed-up) and stored as a computer file and then destroyed once the results have been finalised. This is voluntary.

What benefit will I gain from being involved in this study?
The sharing of your experiences will improve the planning and delivery of future programs. We are very keen to deliver a service and resources which are as useful as possible to people.

Will I be identifiable by being involved in this study?
We do not need your name and you will be anonymous. Once the interview has been typed-up and saved as a file, the voice file will then be destroyed. Any identifying information will be removed and

the typed-up file stored on a password protected computer that only the coordinator (Ms Emi Patmisari) will have access to. Your comments will not be linked directly to you.

Are there any risks or discomforts if I am involved?
Other group members may be able to identify your contributions even though they will not be directly attributed to you. The investigator anticipates few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigator.

How do I agree to participate?
Participation is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project number INSERT PROJECT No. here following approval). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

LEMBAR INFORMASI

Judul: 'Reformasi Kesehatan Jiwa Indonesia: Sebuah analisa diskursus'

Peneliti:
Emi Patmisari
Jurusan Kesehatan Masyarakat
Fakultas Ilmu Kesehatan
Universitas Flinders

Penjelasan tentang penelitian

Penelitian ini adalah bagian dari proyek berjudul 'Reformasi Kesehatan Jiwa Indonesia: Sebuah analisa diskursus'. Penelitian ini bermaksud menggali bagaimana kebijakan reformasi kesehatan jiwa dilaksanakan di Jawa Barat dengan mewawancara pemangku kebijakan. Proyek penelitian ini didukung oleh Jurusan Kesehatan Masyarakat, Universitas Flinders.

Apakah tujuan dari penelitian ini?

Penelitian ini bertujuan untuk menyelediki lebih dalam penerapan kebijakan reformasi kesehatan jiwa yang berakar dari pemaknaan yang dibentuk melalui tindakan atau praktek diskursif oleh para pemangku kebijakan di provinsi Jawa Barat.

Apa yang harus saya lakukan jika saya berpartisipasi?

Anda diundang untuk menghadiri wawancara tatap muka dengan seorang mahasiswa doktor yang akan mengajukan beberapa pertanyaan tentang pandangan Anda tentang pelaksanaan kebijakan reformasi kesehatan jiwa di Jawa Barat. Wawancara akan berlangsung hingga 90 menit. Wawancara akan direkam, menggunakan perekam suara digital untuk membantu melihat hasilnya. Setelah direkam, wawancara akan ditranskripsi (diketik) dan disimpan sebagai dokumen komputer dan kemudian akan dihapus setelah hasil telah selesai. Partisipasi bersifat sukarela.

Apa manfaat yang akan saya peroleh dari yang terlibat dalam studi ini?
Dengan membagi pengalaman Anda dalam penelitian ini, akan meningkatkan perbaikan perencanaan dan pelaksanaan program di masa mendatang. Kami sangat peduli untuk meningkatkan pelayanan yang berguna untuk masyarakat.

Apakah saya akan diidentifikasi dengan keterlibatan dalam penelitian ini?
Kita tidak perlu nama Anda dan Anda akan diganti dengan nama samaran. Setelah wawancara diketik dan disimpan sebagai dokumen, kaset kemudian akan dihancurkan. Setiap informasi mengidentifikasi identitas akan dihapus dan dokumen yang telah diketik akan disimpan pada komputer dan dilindungi kata sandi dan hanya peneliti (Emi Patmisari) akan memiliki akses. Pendapat Anda tidak akan dihubungkan langsung kepada identitas Anda.

Apakah ada risiko atau ketidaknyamanan jika saya terlibat?
Anggota kelompok lainnya mungkin dapat mengidentifikasi kontribusi Anda meskipun mereka tidak akan langsung dihubungkan dengan identitas Anda. Peneliti sudah mengantisipasi beberapa risiko dari keterlibatan Anda dalam penelitian ini. Jika Anda memiliki kekhawatiran mengenai risiko atau ketidaknyamanan, silahkan menghubungi dan berdiskusi dengan peneliti.

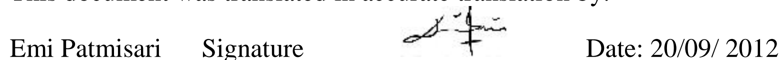
Bagaimana saya setuju untuk berpartisipasi?
Partisipasi bersifat sukarela. Anda mungkin menjawab 'tidak ada komentar' atau menolak untuk menjawab setiap pertanyaan dan Anda bebas untuk menarik diri dari wawancara setiap saat tanpa efek atau konsekuensi. Sebuah formulir kesediaan berpartisipasi disediakan menyertai lembar informasi. Jika Anda setuju untuk berpartisipasi silahkan membaca dan menandatangani formulir tersebut.

Bagaimana saya menerima umpan balik?
Hasil dari proyek tersebut akan diringkas dan diberikan kepada Anda oleh penyidik jika Anda ingin mengetahui hasilnya.

Terima kasih telah meluangkan waktu untuk membaca lembar informasi ini dan kami berharap Anda akan menerima undangan kami ini untuk berpartisipasi.

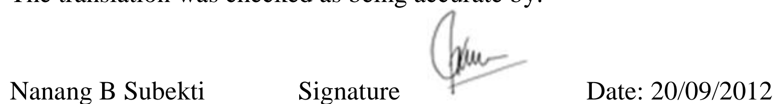
Penelitian ini telah disetujui oleh komisi etik tentang penelitian ilmu-ilmu sosial Universitas Flinders (Nomor Penelitian:…..). Untuk informasi lebih lanjut mengenai persetujuan penelitian ini, silakan menghubungi dewan komisi etik melalui nomor telepon +61 8 8201 3116, fax +61 8 8201 2035 atau email human.researchethics@flinders.edu.au

This document was translated in accurate translation by:



Emi Patmisari Signature Date: 20/09/ 2012

The translation was checked as being accurate by:



Nanang B Subekti Signature Date: 20/09/2012

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(Interview)

I …... being over the age of 18 years hereby consent to participate as requested in the Letter of Introduction and Information Sheet for the research project on "**Indonesia mental health reform: A discourse analysis**"

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
4. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
5. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed. ** delete as appropriate*

Participant's signature……………………………………Date…………………..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name……………………………….…………………….................

Researcher's signature…………………………………..Date…………………….

NB: Two signed copies should be obtained. The copy retained by the researcher may then be used for authorisation of Items 8 and 9, as appropriate.

8. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature……………………………………Date…………………..

9. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature……………………………………Date…………………..

FORMULIR PERNYATAAN KESEDIAAN BERPARTISIPASI DALAM PENELITIAN
(Wawancara)

Saya.. berusia di atas 18 tahun dengan ini menyatakan kesediaan untuk berpartisipasi dalam penelitian tentang **"Reformasi kesehatan jiwa Indonesia: Sebuah analisa diskursus"**

1. Saya telah membaca semua informasi yang diberikan terkait dengan penelitian tersebut.

2. Prosedur dan resiko yang mungkin timbul dari penelitian tersebut telah dijelaskan kepada saya dan saya memahaminya.

3. Saya mengerti bahwa saya harus menyimpan formulir ini jika diperlukan suatu saat nanti.

4. Saya mengerti bahwa:

   - Secara langsung saya tidak akan mendapatkan keuntungan apapun dari penelitian ini.

   - Saya bebas untuk mundur dari penelitian ini kapanpun dan berhak untuk tidak menjawab pertanyaan yang tidak saya inginkan.

   - Informasi dan peranserta saya dalam penelitian ini akan dijaga kerahasiaannya.

   - Saya berhak untuk meminta rekaman wawancara dihentikan kapanpun dan mengundurkan diri kapanpun tanpa ada konsekuensi apapun.

5. Saya setuju/tidak setuju* hasil rekaman wawancara saya diserahkan kepada peneliti/orang lain yang bukan anggota dari penelitian ini yang melakukan penelitian yang berkenaan dengan penelitian ini dengan syarat bahwa identitas saya akan dijaga kerahasiaannya. * Coret yang tidak perlu

Tanda tangan peserta: .... **Tanggal**: ....

Saya menyatakan bahwa saya telah menjelaskan tentang penelitian ini kepada calon peserta dan meyakini bahwa yang bersangkutan memahami dan dengan suka rela menyatakan kesediaanya untuk berpartisipasi.

Nama peneliti: .... **Tanggal**: ....

Tanda tangan peneliti: .... **Tanggal:** ....

Catatan: Dua lembar formulir ini yang telah ditanda tangani harus diterima. Lembaran yang diterima oleh peneliti digunakan untuk pengesahan poin nomor 8 dan 9.

8. Saya, peserta penelitian, yang bertanda tangan di bawah ini telah membaca hasil wawancara saya dan setuju untuk penggunaan hasil wawancara tersebut seperti yang dijelaskan oleh peneliti.

Tanda tangan peserta: .... **Tanggal:** ....

9. Saya, peserta penelitian, yang bertanda tangan di bawah ini telah membaca laporan penelitian ini dan menyetujui informasi yang ada dalam laporan ini untuk dipublikasi.

Tanda tangan peserta: .... **Tanggal**…………………………………………