The Indonesian Mental Health Act

The Indonesian Mental Health Act: Psychiatrists' views on the Act and its implementation

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Key messages

- We conducted in-depth interviews with 27 psychiatrists in Bali, Indonesia, to obtain insight into their views on the Mental Health Act (2014) and its implementation into practice
- The MHA is seen as a welcome step to improve mental health services, create awareness, and provide clarity on some specific topics.
- Lack of practical guidance, and the discrepancy in interpretations of mental health between the psychiatrists and the MHA contributed to disengagement and questioning the priority of the MHA
- The Ministry of Health and other key stakeholders should consider mental healthcare providers' perspectives to facilitate the MHA's implementation process

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Ethics approval

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Abstract

In 2014 the Indonesian government passed the Mental Health Act (MHA) to address the country's complex mental health situation. The implementation of the MHA has been slow, and little is known about how the MHA is perceived by mental healthcare providers within local settings. This study aimed to obtain insight into psychiatrists' views on the MHA, including on how it affected their clinical practice and on challenges of translating the MHA into practice. The study was conducted in Bali, and 27 psychiatrists (15 men and 12 women) participated in a semi-structured interview. Thematic analysis indicated four overarching themes: raising the profile of mental health, developing a shared understanding of mental illness, integrating psychiatric practice with other services, and views on implementation of the MHA into practice. Overall, the psychiatrists viewed the MHA as a step in the right direction to improve mental health services and to create awareness at local and national levels. However, there was consensus that the meaning of the MHA's concepts of mental problems and disorders were not compatible with psychiatric everyday practice or their patients' understandings. As a result, many assumed that the MHA was targeted at government and policy officials. Furthermore, there was a perceived lack of clarity on issues relating to collaborating with other services and unequal access to resources among regencies, that impacted on their clinical practice in a negative way. Moreover, a few psychiatrists raised concerns that local beliefs and practices were not acknowledged in the MHA. According to the participants, mental health remained a highly political issue and without national support, mental health would remain a low priority. In conclusion, insights

into providers' perspectives contributes to developing an evidence-base that can inform the implementation process of the MHA in Indonesia, and possibly elsewhere, into local level guidelines and regulations.

Introduction

Mental health is widely acknowledged to be an important part of health, however, health services tend to be geared towards physical and infectious diseases (Patel et al., 2018; WHO 2013). Mental illness deserves further attention, given its global widespread prevalence and its significant impact on morbidity and mortality. According to the Global Burden of Disease Study around 10% of the global burden was related to mental health in 2016; the trend is rising (Patel et al., 2018) while mental health disorders remain widely under-reported (Vigo, Thornicroft, and Atun, 2016). Due to the growing number of people with mental disorders, and the considerably lower priority given to mental health policy and government budget expenditure on mental health services, a large number of the globally affected populous remains untreated, misdiagnosed, or experiences low quality healthcare (Patel et al., 2018). Additionally, relative absence of relevant education and fear of cultural stigma tends to lead to treatment avoidance, subsequently leaving sufferers vulnerable to further mental health deterioration. Indeed, in many cases, patients do not seek professional help until their mental condition has severely deteriorated (Patel et al., 2018; Thornicroft, 2008). Finally, intense stigmatisation, discrimination and human rights violations experienced by people affected by mental disorders have been widely reported, thereby linking mental disorders inextricably with human rights issues (Asher et al., 2017; Minas, 2009).

The urgency to address poor mental health outcomes and to scale up services to tackle the growing gap between the need for treatment and the provision of appropriate mental

healthcare have become global priorities on the international health agenda highlighted in the United Nations *Sustainable Development Goals* (SDG) (UN, 2015) and World Health Assembly's *Comprehensive Mental Health Action Plan* 2013-2020 (WHO, 2013). As a result, there is increased pressure on countries to develop or improve legislation and policies to deal with their state of mental health services and to respect the human rights of people suffering from mental illness. A target of the WHO's Mental Health Action Plan (WHO, 2013) is for 50% of the countries to have a mental health law in line with international human rights conventions such as the Convention on the Rights of Persons with Disabilities (UN, 2006) and national human rights agreements.

The Indonesian government passed the Indonesian Mental Health Act (MHA) in 2014 to address the country's complex mental health situation that is hindered by a lack of available or allocated resources (Diatri and Maramis, 2015; Pols et al, 2019). Six percent of the Indonesian national health budget is spent on mental health, while the ratios of mental health staff per 100,000 population is well below the global mean of 9:100,000 population (varying between <2: 100,000 population in Low Income Countries and 70:100,000 population in High Income Countries) (WHO, 2017a). In Indonesia, which is classified as a Middle Income Country, the ratio for psychiatrists is 0.31:100,000 population, for mental health nurses 2.52:100,000 population, and for psychologists 0.17:100,000 population (WHO, 2017b).

The Indonesian National Health Survey estimates that an average of 9.8% of the population (15+ years) suffers from mental and emotional problems (Balitbangkes, 2018), although due to the sensitivity surrounding mental health, this is likely an underestimation. Additionally, a relative shortage of accessible and adequate mental healthcare has led to ongoing practises of restraining and confinement of individuals (*pasung*) with mental health problems (Human

Rights Watch, 2016; Irmansyah et al. 2009; Minas and Diatri, 2008; Suryani et al., 2011). According to the National Health Survey (Balitbangkes, 2018), 14.0% of Indonesian households have practised pasung.

Indonesia has ratified most of the human rights conventions (WHO, 2017), as reflected in its MHA, by acknowledging patients' rights, and improving the quality of and accessibility to services, through the integration of mental health services within the general health services at community and hospital levels (President of the Republic of Indonesia, 2014). The MHA integrates with several national level health reforms toward decreasing the treatment gap (i.e. the percentage of people needing treatment but not receiving it) and developing comprehensive, integrated and sustainable care. In early 2014, the government implemented the Jaminan Kesehatan Nasional, a scheme to provide *Universal Health Coverage* (UHC) for a range of treatments from public providers and from private organisations that opted in the scheme (Agustina et al., 2019). UHC is a key objective for health reform by the WHO (WHO, 2017) and is part of the United Nation's SDGs (target 3.8) (UN, 2015) as it aims to increase access to healthcare, and thereby offers support for people with mental disorders who are often marginalised.

To facilitate the UHC, the government launched a referral system with entitlements to specialist care in hospitals, depending on referrals from primary care centres (Agustina et al., 2019; Kutzin et al., 2017). As a result, primary care staff are more heavily involved in screening for mental disorders and treating basic mental disorders, while referring the more severe cases to district hospitals or mental health hospitals where patients are treated within a set timeframe (Diatri and Maramis, 2015; Praharso et al., 2020).

Despite major reforms in the healthcare system, the implementation of the MHA into practice is still in its early stages, and it has been hampered by the lack of detailed regulation and adequate funding (Pols et al., 2019). A systematic review highlighted that slow and inconsistent implementation and under-implementation of national mental health plans are common. Furthermore, the severity of challenges facing implementation are greater in low and middle income countries (LMICs) than in HICs due to underfunding, lack of human resources and administration (Zhou et al., 2018). Implementation science literature gives deeper insights into issues that influence the process. A recent systematic review by Means et al. (2020) assessing the applicability of the Consolidated Framework for Implementation Research (CFIR) in LMICs identified several features specifically relevant to LMICs at the system level, such as the administrative design of the health system and the nature of interactions across specific administrative levels, and the degree to which the perceived priorities and needs of relevant stakeholders are aligned with system policies. In line with implementation research (Esponda et al., 2020; Means et al., 2020), the WHO (2013) suggests facilitating the implementation process by considering the expertise of mental health professionals on mental healthcare delivery and interaction with the patients, as they are at the heart of the MHA. To date there is a lack of research looking at the impact of changes in the healthcare system from the providers' perspectives in Indonesia. The aim of this study was to obtain an insight into how the national level legislation of the MHA was perceived by psychiatrists in Bali, within their local context, and whether the MHA affected challenges encountered in their clinical practice.

METHODS

Study setting

The study was conducted in Bali, which is one of the 34 Indonesian provinces. Administratively Bali is divided in nine districts or regencies. Bali has a population of 4.2 million (BPS, 2015) and an approximate 8.5% mental illness prevalence (Indonesian Ministry of Health, 2018). Bali has two in-patient psychiatric units, which are in the main mental hospital (in Bangli regency), with 400 beds, and in Sanglah General Hospital, in the regency of the capital city Denpasar, with 16 beds. Nine further public hospitals, with outpatient psychiatric units are located on the island. At the time of the study one regency (Jembrana) did not have a psychiatrist and was served by visiting psychiatrists from Sanglah General Hospital, while the single psychiatrist working in another regency was hospitalised. The number of psychiatrists increased from 8 psychiatrists in 2004 to 52 psychiatrists in 2018, of which 19 (36.5%) were female. These psychiatrists practise in the general, private, and military hospitals, private practices, and NGOs, with most of them based in Denpasar.

Research design and reflexivity

To obtain insight into the psychiatrists' experiences of the MHA, we conducted qualitative face-to-face interviews in line with the interpretivist paradigm. This approach does not attempt to reveal one ultimate "truth" but adopts the position that reality is both changing and subjective, and that the data are co-created between the interviewer, interpreter, and participants (Bunnis and Kelly, 2010; Hennick, 2008). Throughout the study, the team discussed their own perceptions on the topic and kept memos to track biases and the development of ideas. The research team had successfully collaborated before and consisted of a psychiatrist from Bali (CBJL) specialising in community care, a psychologist based in

Australia (NT) and trained in mental disorders, and a social scientist based in the UK (AB) teaching public health.

Recruitment and sample

The study population consisted of the 52 psychiatrists practising in Bali. To allow for a wide range of relevant in-depth accounts to address the research question, the psychiatrists were purposively sampled. This was done to ensure that the sample included participants with the following characteristics: 1) male and female psychiatrists, 2) working in public hospitals from all regencies (two regencies were without a psychiatrist), and 3) graduated before and after the MHA was enacted. Potential participants were selected from the Psychiatry register and approached by email. To increase the likelihood of data saturation, the target was to interview at least half (26) of the psychiatrists. To reach our target we invited 32 psychiatrists of whom 27 agreed to participate in an interview. Saturation was reached just before this point after which no new relevant information was obtained from the interviews. Five psychiatrists declined due to personal commitments during the data collection period, including attending a religious ceremony or hospitalisation.

Participants received the study Participant Information Sheet and were given the opportunity to ask questions prior to being interviewed. It was emphasised that participation was voluntary and that they could stop the interview and/or withdraw from the study at any time. Informed consent was obtained prior to the interview. Participants were reimbursed $50 AUD for the time they spent on the study. Data collection took place during February 2018.

Interview guide and data collection

The literature review and team discussions formed the bases of the initial interview topic guide that focused on awareness and understanding of the MHA, its applicability, the implementation process, and views on the mental healthcare system. The interview schedule was piloted during the first two interviews, which were longer in length as a result of feedback sought during the interaction. As this was an explorative study, we used the guide flexibly to allow for further exploration of new topics, while making sure that the interviews also covered similar topics to allow for comparisons between transcripts. The interviews were conducted in the privacy of the participant's office or in a separate room in their workplace, except for two that were done in a quiet public place. Interviews lasted between 45 and 90 minutes. We conducted the interviews in a mixture of English and Bahasa Indonesian, with one of the study authors (CBJL), who is a native Indonesian/Balinese speaker, acting as an interpreter when required. CBJL is also an acting psychiatrist in Bali and is familiar with all the psychiatrists on the island. Interviews were audio recorded, anonymised, and transcribed by an Indonesian professor of English and checked by the research team for accuracy. Transcripts were not returned to the participants for comments.

Data analysis

Data were analysed through Thematic Analysis (Braun and Clarke, 2006). The field notes and transcripts were read and re-read carefully by AB and a selection by NT and CBJL. After careful reading of eight transcripts, we began to discuss potential codes and develop the coding framework. This involved merging overlapping codes and discussing differences in coding. The agreed coding frame was applied across the data, which was led by AB, while deviations were explored and discussed by the team. In seeking to fulfil the research aim we

arrived at four themes. Three relate to challenges affecting everyday clinical practice in relation the MHA: raising the profile of mental health; developing a shared understanding of mental illness; and integrating psychiatric practice with other services. The last theme addresses perceived challenges of the implementation of the Act into practice.

RESULTS

Overall 15 male and 12 female psychiatrists took part. Twenty-three participants worked for public general hospitals and often in combination with a psychiatric position in another setting (such as private hospitals or practices, NGOs or universities). Four participants worked in psychiatric positions with the public health service. In total 6 psychiatrists had graduated before 2015, and the rest in 2015 or afterwards. All participants had heard about the MHA, though some participants reported they had not read the Act until the invitation to the study.

Raising the profile of mental health (across all levels)

It was clear from the participants' accounts that they welcomed having an MHA as they claimed that mental health was not considered a priority in society, and was still a highly stigmatised area. As such, having an Act was seen by default to raise awareness and underline the importance of mental health across different levels of society, including by some of their patients and other clinicians not working in mental healthcare.

Perceived level of awareness among patients

According to the participants, most people are aware only of severe mental illness. A common remark by the participants was that in the community "being mentally ill equals having schizophrenia or being psychotic" (e.g. participant 23). However, the psychiatrists had

noticed changes in the types of conditions that they saw. They attributed this change to an increased awareness and to a lower threshold to seek help due to the UHC.

Yes there is a change, before people think psychiatrist is doctor gila, crazy doctor [laughs]. Doctor only for crazy people, before, but right now like patient here [in this hospital] or in my private practice there are psychotic patients, but more neurotic patients, like their problem with their sleep, emotions something like that. Not only for psychotic patient. [participant 14]

While it was acknowledged that there was some progress in people's thinking that mental illness comes in different forms and presents in different ways, all highlighted the ongoing stigma surrounding mental health.

Yes, they are afraid to go to psychiatrist here. My room is beside the internal medicine room. Even though I have a lot of patients by that time, all of my patients will wait in front of the internal medicine room. There is still a stigma, because they don't know if there is, because this is general hospital they don't know if family come and see you by psychiatrist they don't know what to say. So yeah it is still a problem…Because they still think that mental problem is just like schizophrenic yeah it is just like that, mental illness is just like a very bad illness. Still the stigma. [participant 22]

Perceived level of awareness among non-mental health clinicians

Many reported that over the years they had also noticed more awareness of mental health among other clinicians who consulted with them more frequently in the hospital albeit often as a last resort. While all participants perceived mental health as part of a person's overall health status and closely linked to physical health, they noted some colleagues began to share this view:

For the young specialists, they already understand that there is a link but for the older specialists, they are still differentiate between the physical and mental health. [participant 19]

As a result, there was more collaboration with other specialities and several said, jokingly, that they were no longer referred to as "*the crazy doctor"* [participant 3].

Developing a shared understanding of mental illness

Another perceived benefit of the MHA was that it could facilitate a shared vision of the direction to improve the mental health services, which could also aid the successful implementation of the MHA.

With this Act they will regulate all the stakeholders, all the people who work in mental health can work in the same direction with the mental health regulation. [participant 21]

Having a shared understanding was perceived to be fundamental in providing information to patients and family members with lay knowledge and to the community, especially with mental illness having a high stigma. However, throughout the interviews it became evident that the way the psychiatrists viewed mental illness differed from the way it was conceptualised in the MHA.

The MHA distinction between mental problems and mental disorders

In the MHA the approach to mental illness is based on a distinction between mental problems (ODMK) and mental disorders (ODGJ). A mental problem refers to: "*a physical, mental, social, and development disorder, and/or living quality problems, and carries the risk of suffering from a mental disorder"* (Art 1.2). Within the MHA, there is an indication that people with mental problems do not receive medicines to alleviate the condition and are capable to self-manage their condition (Art. 68/69). In the MHA a mental disorder is defined

as: *"suffering from a psychological, behavioural, and emotional disorder which is manifested through a series of symptoms and/or significant behaviour changes, which can potentially cause suffering and detriments of such person's performance of his/her function as a human being"* (Art 1.3).

The psychiatrists' perception of mental problems and mental disorders

The psychiatrists viewed mental health from a medical angle and, in line with their psychiatric training, within the context of the diagnostic framework of the Indonesian edition of the ICD-10 framework (the 10th revision of the International Classification of Disease by the WHO) (Depkes RI, 1993) and the drug treatment options available within their setting. The importance of a diagnosis leading to an ICD code was emphasised throughout the participants' accounts, the reason being that since the introduction of the UHC the insurance regulations require an ICD code for a patient in order for the hospital to be reimbursed for the treatment.

Yes because the insurance, when the insurance coding for the payment, they should use the code for ICD10. So if we give a diagnosis then the insurance has to make a coding of the diagnosis with ICD 10 code. [participant 7]

When asked about the two concepts of mental problem and disorder many participants explained the distinction in similar ways as in the MHA, i.e. by using an observable level of severity with some cut-off point that made a person move from having a mental problem to a disorder, and a variety of examples were given, such as becoming a burden to others through violent behaviour, no longer being able to take care of oneself, the type of conditions, or receiving a medical diagnosis as is illustrated by this quote:

People with a mental disorder are people diagnosed with a mental disorder. People with mental problems are everybody, everybody has mental health problems. [participant 18]

Several participants commented that the MHA's distinction influenced people's attitudes to mental health, though they explained it in different ways. Some claimed that the distinction made mental problems more acceptable. Others said that it created more awareness for mental disorders, and therefore, reduced people's negative attitudes towards disorders, but increased stigma for mental problems as is illustrated in the following quote:

People are more aware for the severe case. For the mild and moderate there is still stigma. They don't accept them having mental problems. But for the severe one they accept that they have already mental issues. But when they have anxiety or depression then they still think this is not mental health. [participant 5]

One participant explained the distinction by categorising Lesbian, Gay, Bi-sexual, and Transgender in accordance with the MHA distinction, a disputed area heightened by statements from the Indonesian Psychiatric Association (PDSKJI) and Ministry of Health. They categorised people who are homosexual and bisexual as people with mental problems (ODMK) and are at risk of developing a mental disorder (ODGJ), and people who are transsexual as having a mental disorder (PDSKJI, 2016).

ODMK is people who just have a mental health problem but ODGJ is people with positively suffering mental health disorder. For example LGBT, the gay people, if they still enjoy being gay, is no problem then I will consider that as people with mental problems, but if this person himself feel that there is something wrong with himself and ask for a help then for him that is considered ODGJ (people with mental disorder). [participant 5]

Relevance of distinction between mental problem and disorder to everyday practice

While there was variety in the ways the participants interpreted the MHA's definitions, overall there was consensus that the meaning of the MHA's concepts was broad and not relevant to psychiatric everyday practice.

The universal health coverage is based on ICD. So our diagnoses are covered by insurance. But in the universal health coverage, they do not talk about people with mental disorder or people with mental problems. The pay based on the ICD code, the ICD10. [Participant 2]

I don't know why they do it like that. Maybe for the government or for the health services it would make it easier to see the difference, people with mental disorder and people with mental problems. But in the implementation it creates more stigma because you start to differentiate these two areas. Rather than saying mental health should be included in every person, physical and mental health… The wholeness of human, must see the wholeness, physical and mental. [participant 27]

With the MHA emphasising the categories of mental problem and mental disorder, and the psychiatrists not applying this terminology in their diagnosis or using it in their interactions with patients, many reported that they assumed that the MHA was targeted at government and policy officials and not the psychiatrists:

I think it's not uh related, related but only a little. It is the area of the department of health to understand the law. Not the area for the psychiatrists. [participant 14]

No, it's just for ministry of health and for the members parliament member. It was not from all psychiatrists like psychiatric organization not from every region come and then meeting and then socialisation, during the draft. [participant 23]

Integrating psychiatric practice with other services

Collaborating with health services and social sectors

The MHA includes several articles (Art. 20, 33-35, 56) on improving integration between psychiatric services and other services. Nearly all psychiatrists highlighted the lack of collaboration between the primary healthcare services, the general hospitals and the main mental health hospital as on ongoing challenge in terms of keeping track of patients. Due to this lack of integration, they said that patients were generally not followed up if they did not attend an appointment or after they were referred to another service:

In hospital they will ask the patient to come back, maybe in 2 weeks, and then after that they always ask the patient come. But if the patient not come, they forgot it. So they don't know, the patient recover completely or not. [participant 1]

Lack of follow up or aftercare led to problems in the patients' treatment, often leading to relapse. Indeed, some psychiatrists did not refer patients back to the health centres due to the lack of medicine and absence of trained mental healthcare staff:

We ask the patients to come back to the hospital and not go to the puskesmas [health centre] *because I know that in the primary care centre they don't have the medicine and also not the human resource for mental illness* [participant 21]

A lack of collaboration with other sectors, such as the social housing sector or social care was another challenge they hoped would be addressed once the MHA was implemented:

Since that regulation more cover, more broad area, more people what we call inclusive, rather than exclusive. That means that mental health not only responsibility of hospital but also other institution must work together with the hospital. Like social, also social department, minister of social department, minister of what we call like internal affair. Like inclusion so, we agree with department work with police, justice, something like that. So every institution, each institution who [pauses a lot thinks about English] involved with

people cover by this regulation… in supporting our mental health like what we call home care. Home care, supposed to be developed in each district area but there is no regulation to make this happen home care. The transition home care to hospital, transition hospital to home supposed to be developed. [participant 6]

The importance of having support from other sectors, when patients were discharged from hospital, was explained by participant 8, who highlighted some of the difficulties people faced when returning home:

It's a difficult thing. It is not always easy thing because when they go back to their house often some of them told me they don't find right schedule as in the hospital. The breakfast, the what, when they get cookies or refresh, singing dancing and when they go back to the family the family keep busy working, so late to give the breakfast and that makes emotions so often relapse and back again. [participant 8]

Collaborating with traditional healers

Interestingly, neither the MHA nor the psychiatrists mentioned working with traditional healers as a suitable option within the current system. Yet all psychiatrists reported that many of their patients associated mental health related issues with the supernatural. The majority of the Balinese population practices Balinese Hinduism to which *Balians* (traditional healers) are an intrinsic part. They reported that, as a result, many patients would consult a traditional healer prior to a doctor, which would lead to delay in treatment:

Because our culture when the patient gets schizophrenia, they always link this with the culture. So they think the patient don't need to go to the hospital, they only need uh uh alternative medicine maybe, a ritual maybe, yeah. So that's why a little bit difficult. [participant 7]

For some participants the lack of acknowledgement in the medical discourse of the role of Balians or the link between mental health and the supernatural led to question the psychiatric approach taken as is illustrated by this participant.

It is make it easy to follow the system [ICD10], but to understand the people there is something missing. Their belief system, you cannot force them to understand that it is hallucination, it is part of daily life and their culture. The element of culture is missing. [participant 2]

Views on implementation of the MHA into practice

All participants highlighted that progress of the implementation of the MHA was slow. Especially the participants with longer psychiatric experience viewed the MHA within the wider legal and policy context and concluded that delays with or abandonment of regulations were not uncommon in Indonesia.

Barriers to implementation

A perceived lack of priority of mental health at the structural level, combined with negative attitudes to mental illness, were given as the most frequent reasons by the participants as a barrier to progress on the implementation of the MHA:

The [hospital] management know already about the MHA, but they still have argumentation "We already have a mental hospital" According to the management it is not profitable, even more beds needed for mental illness. [participant 19]

Still, still stigma, but hard to change the stigmatization. It has changed, but minimal change. First we got uh the mental health system from the generally, not as a priority… The budgeting is not a priority and uh from the central to the local and the province district and

uh puskesmas the budgeting is not a priority. So uh that is uh providing resourcing budgeting and so forth for mental health not. [participant 27]

Those experienced with working in the more deprived regencies or in remote areas commented on the need for a more equal spread of resources across Bali to facilitate successful implementation:

We need more psychiatrists spread around I not just concentrate on big cities such as Denpasar or on Java island. Probably in Irian Jaya or other remote area. I hope more psychiatrists spread. More access to the mental health as mentioned in the Act, to prevent mental illness. Because if you have more access to the mental health then it also becomes less of a burden for us. In that Act you have to prevent, right, but how can you prevent if there is no psychiatrist in a very basic system? [participant 22]

The role of the Psychiatric Association

Finally, and quite interestingly, participants had different views on the role the Indonesian Psychiatric Association could play in adding pressure or facilitating the implementation by the federal or local governments. Some claimed that the Association should be more involved, while others saw no connection between the implementation of the MHA and their Association or themselves. As such, they questioned the potential influence of the Association:

It needs infrastructure, they must prepare from the top to down because if, maybe from the bottom to the top maybe that needs a long long long time to prepare the infrastructure. [participant 23]

DISCUSSION

Our study explored the views and experiences of the MHA by psychiatrists working in Bali and attempted to identify whether the MHA affected challenges encountered in their clinical practice. The study provided insight into how the MHA related to the Balinese psychiatrists' conceptualisation of mental health and illness and to their everyday practice. We found that overall the psychiatrists viewed mental health by looking at a person in a holistic manner, and by emphasising the integrated link between mental and physical health. While this overall state of health is widely acknowledged in the literature (WHO, 2005) this is less the case in the MHA, which does not explicitly address its link to physical health.

Within the participants' psychiatric practice, the ICD-10 framework informed the diagnosis of a disorder – ICD-11 had not yet been published when this study was conducted. While there are ongoing debates on whether this diagnostic model leads to adequate representations of reality (Mellsop et al., 2007; Byng et al., 2019) and on challenges from exporting mental health expertise from Western to non-Western settings (Cooper, 2016; Cox and Webb, 2015), only a few participants showed similar concerns and questioned the lack of cultural context and determinants of health. The study showed that the psychiatrists found it difficult to identify with the MHA's approach due to its distinction between people suffering from mental problems and mental disorders. The MHA has a continuum approach to mental health with mental disorders (ODGJ) on the one side of the spectrum and mental problems (ODMK) in between those and healthy states. Through the MHA the Indonesian government highlights the view that anyone can suffer from a mental problem but that not all people will develop a mental disorder. With high levels of stigma and little, yet increasing, information on mental health for the lay public, this broad approach to mental health in the MHA could positively affect the acknowledgement and acceptance of mental health and in turn identify earlier those who are at risk of becoming mentally ill (Art 7). However, the implementation science literature (Means et al 2020) has shown that a discrepancy in the psychiatrists understanding

of the content of an intervention can hinder the subsequent implementation process. Moreover, some participants pointed out that the distinction could increase stigma due to an ongoing lack of understanding of mental problems.

The lack of consensus among the psychiatrists on where the cut-offs are in terms of moving from suffering from a mental problem to a more specific episode of a mental disorder reflects a wider problem in the mental health literature on what underlies mental disorders and how to define boundaries (Brugha, 2015). Since many participants said that they did not feel involved with the MHA or that it was not the role of the Psychiatry Association to facilitate the implementation or promote their views on legislation, it could explain why quite a few psychiatrists did not engage with the MHA. Moreover, within the broader bureaucratic organisational healthcare structure, psychiatrists may not see the relevance or opportunities to be involved in shaping its implementation, which in turn can affect the implementation success at a later stage as highlighted by the implementation literature (Esponda et al., 2020; Means et al., 2020). Interestingly a recent study in Indonesia by Sustani et al. (2020) reported on growing willingness by patients and family members to be more involved in shaping mental health services for their care. Yet engagement happened mainly in the third sector as community organisations were perceived to be more open to patient and public involvement (PPI) and with less power imbalances than the formal mental health system (Sustani et al., 2020). Future research may focus on third sector organisations and patients' and their carers' to explore their perceptions of their needs and legal rights contained in the MHA.

Moreover, all participants reported that many patients believed in the association between the supernatural and mental health, leading patients seeking help from traditional healers. This is in line with other studies conducted in Bali (Muryani et al., 2018; ; Suryani et al., 2011) and

other parts of the world (Nortje et al., 2016), showing that traditional or spiritual healers play a large role in mental health care. The WHO (2013b) endorses engagement of traditional health practices to improve the healthcare system. However, the participating psychiatrists in the current study saw it as part of their role to educate people and primary care staff on mental health in line with the medicalised discourse of healing, but not to work with traditional healers. The ongoing debate in the literature on whether the diagnostics of Western psychiatry are applicable within the local setting (Ecks, 2016; Suryani et al., 2011) was hardly raised by the participants in this study nor were local belief systems or practices raised in the MHA.

According to the participants, mental health remained a highly political issue due to stigmatisation. This was heighted by the Health Ministry and Indonesian Psychiatric Association (PDSKJI) announcing the classification of LGBT+ as people with a mental problem (homosexual and bi-sexual) or a mental disorder (transgender), as alluded to by one participant. This categorisation led to national and international responses (APA, 2016; HRW, 2016). Without national support, mental health would most likely remain a low priority. Unsurprisingly, the low priority of mental health was regarded the main barrier to the implementation of the MHA at the local level. This was further exacerbated by previous experiences of other Health Acts that had been passed but had still not been implemented. Despite this, the psychiatrists reported the potential of the MHA and observed positive changes, however small, that had already occurred. The participants welcomed the MHA because it contributed to the importance of mental health, which in turn raised awareness and could address the stigma surrounding mental illness. In line with other studies in Indonesia (Irmansyah et al., 2020), the participating psychiatrists often attributed stigma to patients experiencing discrimination or treatment delay. The wider literature shows that mental health

related stigma prevents family members and patients from seeking help (Irmansyah et al. (2020). The underlying factors contributing to and the devastating effects of stigma are increasingly researched and reported in the literature (Agustina et al., 2019; Henderson and Thornicroft, 2009; Thornicroft, 2008). According to Mascayano et al. (2015), the lack of investment in the mental health infrastructure and the absence of interest at national and institutional decision-making levels influence stigma. As such, it could be argued that the slow implementation of the MHA could indicate a lack of interest in people with mental health conditions and could potentially increase negative attitudes towards mental illness.

One of the biggest challenges the participants faced that could be resolved by further implementation was the integration with the other health services and social sectors. The referral system had led to a push of dealing with mental health at the primary care level, a development that is strongly promoted by the WHO. Task-shifting helps to address the mental health needs at community level and in remote areas, though recent studies raise questions about training and overburdening of primary care workers (Hoeft et al., 2018; Praharso et al., 2020). With most participants being hospital-based they reported having little contact with primary care staff and most were not engaged with mental healthcare at the community level. As a result, the extent the psychiatrists can be aware of the scale of mental health issues beyond their practice can be questioned.

This study found that treatment focuses mainly on medicalising patients with little help from sectors outside the health service. Research shows the need for inter-sectoral collaboration for mental health patients to deal with their lives (Patel et al., 2018). Without the implementation of the MHA the participants noted a lack of accountability by other sectors and felt that without this inter-sectoral approach their treatment would be less sustainable, thus increasing the chance of patients' relapse. The need for partners across other sectors to address the treatment gap and the social and economic burden has been widely supported in the literature

(Patel, et al., 2018; Pathare et al, 2018) and highlighted by the Mental Health Plan 2013–2020 (WHO, 2013).

Another perceived barrier to achieve the quality care promoted in the MHA was the insufficient resources. Some participants reported that the availability of resources and staff varied across the regencies with wealthier regencies having better access for patients. This overlaps with the finding by Tristiana et al. (2018) who found that patients on the island of Java experienced ongoing barriers due to a lack of equal spread of resources and psychiatrists. Future research is needed to look at the mental health care provided at the primary care centres in the community.

Strengths and weaknesses

A strength of the study was that this is the first study that looks into the MHA from the viewpoint of mental healthcare staff. According to the WHO (2013) this perspective is important to facilitate the implementation of mental health laws and policies. Another strength is the variability and regional coverage of the study sample, which included just over half of the psychiatrists, who are the main professional group working with an expertise in mental health in Bali. Finally, the international collaboration and expertise in the research team allowed us to explore the broader mental health agenda in a cultural context.
Furthermore, several methodological considerations need to be taken into account. Firstly, the participants were voluntary, and their responses could have been subject to social desirability bias. While most participants spoke English, cross-cultural and linguistic elements, especially when the interpreter translated concepts and meanings into the shared language of the team, may have resulted in degrees of loss of meaning (e.g. Hennick, 2008). We counteracted this possibility by cross-checking topics across interviews and through ongoing team discussions, but we acknowledge that some meaning and context have been lost in translation.

CONCLUSION

With the above considerations in mind, the study demonstrated that psychiatrists in Bali viewed the MHA as a welcome step in the right direction for Indonesian mental health services. The study identified challenges regarding the implementation that can assist in developing an evidence-base that can in turn inform the implementation process of the MHA in Indonesia, and possibly elsewhere, into local level guidelines and regulations. Ultimately, this would improve the quality of life of the people suffering from a mental health condition and those who care for them.

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