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Development of Mental Health and Social Rehabilitation Service Models for Psychosocial Disabilities

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This study aims to determine the extent to which policies related to persons with disabilities and mental health can accommodate the rights of people with psychosocial disabilities, then the extent to which the model of mental health services and social rehabilitation for psychosocial disabilities contributes to mental health treatment in DIY. YAKKUM Rehabilitation Center through capital development of mental health services and post-recovery social rehabilitation that is accessible and community-resourced. This model is oriented towards improving the quality of life of people with psychosocial disabilities and the existence of communities that contribute proactively to community-based mental health efforts in DIY. The data mining method in this study uses a mixed method, namely discriptive studies, descriptive qualitative, participant as observer and participant non observer. Subjects in this study included people with psychosocial disabilities, caregivers, mental health cadres, village governments, puskesmas and related local organizations. The results of this study show that the service model developed by the YAKKUM rehabilitation center is able to encourage social recovery in people with psychosocial disabilities, strengthen their role in the community in community-based mental health, local mental health policies that accommodate the rights of people with psychosocial disabilities, the existence of a mental health service system that focuses on fulfilling the rights of psychosocial disabilities and social rehabilitation.

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1. Introduction

Mental health disorders, including depression, bipolar disorder, schizophrenia, psychosis, dementia, and developmental disorders, are significant global health issues. The World Health Organization (WHO) reported that in 2016, there were 35 million people affected by depression, 60 million by bipolar disorder, 21 million by schizophrenia, and 47.5 million by dementia worldwide. In Indonesia, the 2018 Basic Health Research (Riskesdas) revealed that the Special Region of Yogyakarta ranks second nationally, after Bali, for the highest prevalence of mental health disorders, with a rate of 10.93 per mille compared to the national average of 7 per mille.

The high prevalence of mental disorders in Yogyakarta can be attributed to various factors, including the migration of individuals with psychosocial disabilities from neighboring areas, high poverty rates, limited job opportunities, and cultural factors. Additionally, the lack of public understanding, stigma associated with mental health, and uneven distribution of mental health services further exacerbate the problem.

Given these challenges, the YAKKUM Rehabilitation Center has developed a community-based Mental Health and Psychosocial Rehabilitation Program aimed at improving the quality of life for people with psychosocial disabilities in Yogyakarta. This program, initiated in 2017, operates in Sleman Regency, Kulon Progo Regency, and Gunungkidul Regency, focusing on community assistance, capacity building, and policy advocacy. As of July 2023, the program has assisted 362 individuals with psychosocial disabilities and provided support to their caregivers and mental health cadres.

This study aims to explore the strategies employed by the YAKKUM Rehabilitation Center in addressing mental health issues using community resources, assess the effectiveness of related policies, and evaluate the impact of the community-based mental health and social rehabilitation model on mental health treatment in the Special Region of Yogyakarta. The findings highlight the importance of a comprehensive, community-based approach to mental health care, beyond traditional medical and institutional interventions, to create an inclusive ecosystem for people with psychosocial disabilities.

2. Method

The research methodology in this study uses mixed methods and is designed cross-sectionally. The data collection strategy consisted of surveys, in-depth interviews, literature reviews and case studies in community-based mental health programs. The survey was conducted to people with psychosocial disabilities, their families, while in-depth interviews were conducted to stakeholders at the village level and mental health cadres. Focus Discussion Group is carried out at the

stakeholder level at the District and District Provincial levels. The questionnaire and question guide were adapted from the assessment form used by the community-based mental health program, YAKKUM Rehabilitation Center.

3. Result and Discussion

In discussing the results of this study, researchers collected various sources of data obtained from experience and development during the project. The following are various efforts of the YAKKUM Rehabilitation Center in developing Mental Health and Social Rehabilitation Programs, starting from empowering People with Psychosocial Disabilities and families, mobilizing multistakeholder support in community-based mental health treatment**.**

High cases of DIY Mental disorders and Development of Community-Based Mental Health Models

At the regional level, DIY is the second region with the highest number of mental health problems in Indonesia. The prevalence of households that have household members with schizophrenia or psychosis mental disorders in DIY based on the results of a basic health research survey in 2018 was reported to be 11 per 1000 population. Another finding was that 31.5 percent of households reported shackling in the past three months to family members who had severe mental health problems. This mental health burden has the potential to increase if you look at the prevalence rate of depression in the population aged more than and equal to 15 years, which is 6.1 percent, and only 9 percent of them seek treatment or access medical care**.**

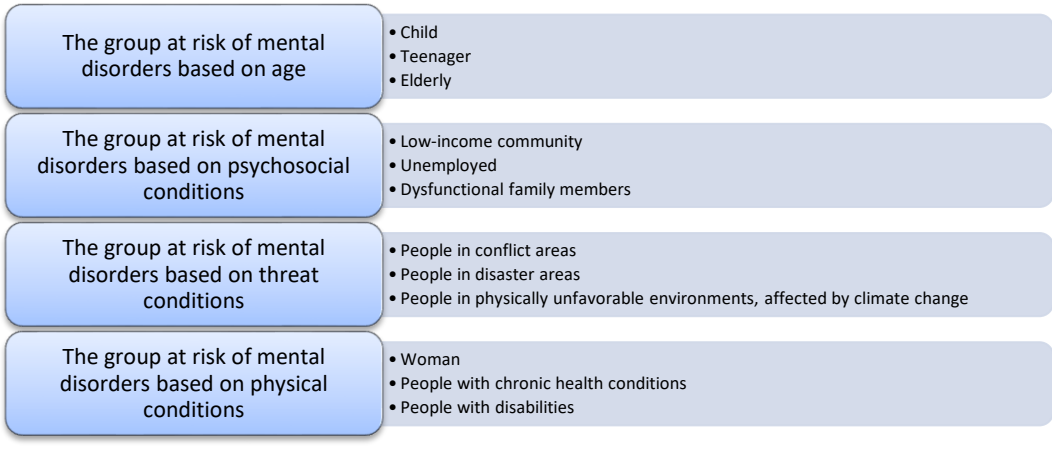
This data increased significantly compared to the data from the risk of 2013 which was only 2.3 per 1000 households. What is surprising is that the number of mental health cases in DIY is quite far above the national figure of 7 out of 1000 households. This fact is certainly not something that can be ignored by the DIY Government considering that mental health is a serious health problem and requires long treatment. Especially during the COVID-19 pandemic which has lasted for almost two years, it has had a tremendous impact and life pressure in various sectors of life. This condition will potentially increase the number of mental health disorders of the DIY community.

The above is in line with the publication from the DIY Health Office which states that the skyrocketing of mental health cases in DIY is suspected by several triggering factors including heavy life pressure, children's education, social media to various games that can be played easily through various types of devices [1]. The condition of the COVID-19 pandemic has also had an impact on increasing poverty,

including in DIY. Based on BPS data, the percentage of poverty in DIY in 2021 reached 12.80%, an increase of around 0.52% from 2020 of 12.28%. Again, this figure is far above the national poverty percentage of only 10.14%. When viewed from the trend in the number of poor people in DIY in the last 5 (five) years based on data from Bappeda DIY shows that in 5 (five) districts/cities there has been an increase from 2019 – 2020 as follows[2]:

Region	2016	2017	2018	2019	2020
Yogyakarta City	32,06	32,2	29,75	39,45	31,62
Sleman Regency	96,63	96,75	92,04	90,17	99,78
Bantul Regency	142,76	139,67	134,84	131,15	138,66
Kulon Progo Regency	84,34	84,17	77,72	74,62	78,06
Gunungkidul Regency	139,15	135,74	125,76	123,08	127,61
Total	**494,94**	**488,53**	**460,11**	**448,47**	**475,73**
Unit (Thousand Inhabitants)					

Referring to some previous research, people who come from bad economic conditions will feel less happy and even experience serious mental disorders such as depression, schizophrenia, and personality disorders. Unfortunately, in Indonesia, the mental health condition of the poor has not been given much attention[1]. The poor will have a stressful life and the absence of social rewards which greatly affects psychosocial conditions so that they are included in the community group at risk of mental disorders. The group at risk of mental disordersconsists of several classifications, including: groups of people at risk of mental disorders based on age, based on psychosocial conditions, based on threat conditions and based on physical conditions [2].



Referring to the potential prevalence of mental health problems, it is necessary to identify groups that have a high risk of experiencing mental problems. These groups are people who have chronic diseases, disharmonious families, parents of ODDP or twin siblings of ODDP, victims of violence, jobs that have high levels of stress, people with disabilities and poor families. While special situations that can cause mental disorders are natural disasters, social conflicts and the impact of climate change. Thus, it is necessary to

take several approaches in handling mental health to be able to reach these high-risk groups, namely with a gender mainstreaming approach. In addition, with a special condition map that can bring up mental health problems, it is also necessary to carry out mental health treatment with an adaptive approach to mainstream disaster risk reduction.

In an effort to overcome mental health problems, the Indonesian government has actually rolled out Law No. 18 of 2014 concerning mental health. However, its implementation still faces a number of challenges, one of which is that there is still a gap in treatment for ODDP. Based on the results of Riskesdas (2018), only about 10 percent of ODDP have undergone medical treatment. This can have an impact on decreasing the quality of life of ODDP, as well as the quality of human life in general related to health status, productivity and others.

Efforts to handle mental health comprehensively from the center to the regions are a must. In handling this, cross-sectoral cooperation and participatory stakeholder involvement in policy formulation are needed to become a common reference. There are several challenges in the process of handling mental health, ranging from overlapping regulations, differences in understanding of the basic concepts of mental health services to discrepancies in the translation of treatment concepts that have been formulated. Therefore, alignment of rules is needed so that mental health services can achieve optimal benefits.
So far, ODDP as a party experiencing mental health problems is often ignored in the policy formulation process. This causes policy interventions and programs that are formulated not in accordance with the problems and needs of ODDP. In addition, mental health services that have been run so far are more centralistic. Therefore, through Law on Local Government Number 23 of 2014, the central government gives authority to local governments to carry out mental health handling efforts (promotive, preventive, curative and rehabilitative) in accordance with regional conditions. Mental health services should not only be accessible through specialist care facilities but should also be available in general health care facilities, primary health care facilities and community-based mental health services.

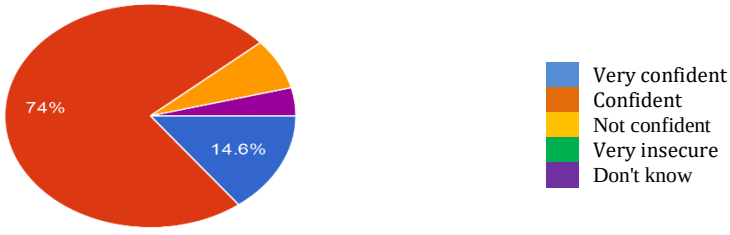
If viewed at the DIY level, there is already a Governor Regulation Number 81 of 2014 concerning Guidelines for Pasung Management, one of whose mandates is to order the district / city government to form a community mental health implementation team. In addition, the district/city government is also tasked with providing access to sustainable services including treatment, psychosocial recovery, rehabilitation, assistance and/or other adequate support for ODDP. Unfortunately, the implementation of existing policies and regulations from the central to the regional is not in accordance with what is aspired so that mental health problems have not been resolved. In line with this, some approaches chosen by the government often ignore the rights of ODDP and do not lead to efforts to eliminate negative stigma in society. This causes many ODDPs who have recovered to relapse or relapse because their families and communities do not accept them. Therefore, a policy advocacy process is needed to ensure that good policies can be implemented and policies that have not accommodated the needs of people with psychosocial disabilities can be changed to include the needs of people with psychosocial disabilities.
For approximately 6 years, YAKKUM Rehabilitation Center has been running the CEPLERY program to contribute to accelerating mental health treatment in DIY. In the program, a community-based social rehabilitation approach has been developed as a more comprehensive rehabilitation effort and proven to be able to minimize relapse. Community-based social rehabilitation emphasizes the process of environmental acceptance, both family and community, to post-curative ODDP and panti rehabilitation. This approach certainly requires participation from all communities to be able to create an inclusive environment for ODDP. This Community-Based Social Rehabilitation approach is important to be encouraged into a mental health treatment policy by the government referring to the effectiveness of the results undertaken so far. In addition, reflecting on the case of the Covid-19 pandemic, it is important to ensure that mental health services also begin to include mainstreaming disaster risk reduction and gender responsive issues so that they can reach vulnerable and marginalized groups who are the groups most at risk of experiencing mental health problems.
The mental health and social rehabilitation program aims to establish a model of post-recovery services that are accessible and community-resourced. The general objective is to improve the quality of life of

people with psychosocial disabilities in the work area of the program. While the specific goal is a community that contributes proactively to integrated community-based mental health efforts in selected work areas in Yogyakarta, precisely in Temon and Pengasih Districts , in Kulon Progo Regency, Godean and Seyegan Districts in Sleman Regency and Wonosari and Playen Districtsin Gunung Kidul Regency. This goal can be achieved through four outcomes which include knowledge, motivation, expertise and opportunities for people with psychosocial disabilities and/or caregivers, relevant stakeholders, cadres, community organizers and the Yakkum Rehabilitation Center (hereinafter abbreviated as PRY) as the organization implementing this project. The project is planned to provide direct benefits to up to 752 people with psychosocial disabilities in the Sleman, Gunung Kidul and Kulon Progo regions, and indirect benefits to approximately 5,000 people with psychosocial disabilities in the three regions. This program is also expected to contribute and benefit stakeholders on related issues in three districts, up to the DIY provincial level.

The call and commitment that mental health issues should soon become a Joint Movement because their relevance and urgency are very clear and have begun with a more concrete initial form in Project Ceplery is the main conclusion of the evaluation process. This hope is not only called for by civil society organizations but also by provincial and district governments even though at the national level the Mental Health Program is currently not included in the national program priorities at the Ministry of Health. This proves that the issue of community-based mental health is very relevant.
The mental health program developed by the YAKKUM Rehabilitation Center shows a significant level of achievement because in the selected work areas there have been forms of proactive community contribution to community-based mental health efforts, both at the family level, at the village level with the formation of 21 psychosocial disability self-help groups with budget support from villages in 21 villages with different amounts and allocations and networks wider stakeholders such as TPKJM (Community Mental Health Implementation Team) at the sub-district level and from puskesmas, TPKJM at the district level and and TPKJM at the DIY provincial level.

The approach taken by the YAKKUM Rehabilitation Center through the Community-based Mental Health Program organizes ODDP, families and cadres in SHG with main activities such as group activity therapy (TAK) and start-up kits support being the initial platform to encourage social recovery of People with Psychosocial Disabilities and strengthen their further role in society.
From a survey on companion perceptions, 74% of companions said that family members who are ODDP feel more confident to participate in the community than they did 3 years ago, even 14.6% said they were very confident. As shown in Graph 1.

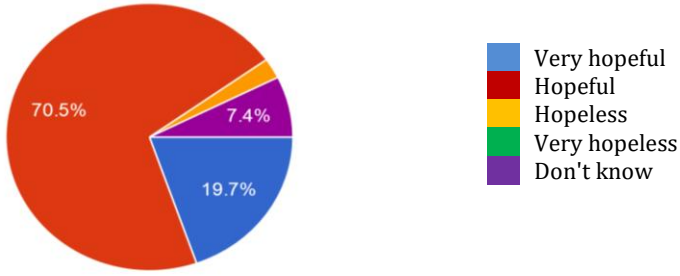
Graph 1. Companion perceptions of ODDP social participation in the community



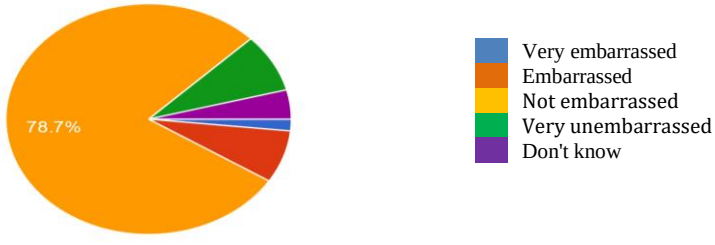
In fact, not infrequently from ODDP encountered in interviews and focused discussions said that they were invited by neighbors and relatives to join in various community activities. This also confirms a more positive change in acceptance at the community level. The visit conducted by the field facilitator of the YAKKUM Rehabilitation Center, as well as trained cadres in the village where ODDP lives is a window for ODDP and companions to simply convey complaints, as well as provide motivation and information needed related to psychiatric disorders, knowledge about mentoring, maintaining enthusiasm to regularly take medicine, and other things that are needed by ODDP and their companions.

The survey also showed that family acceptance of ODDP itself showed a positive trend as 70.5% of ODDP companions expressed more optimism about their family life, and 78% said they were no longer ashamed of having an ODDP family. Of the total survey respondents, 68% of ODDP family members were present when answering the survey When compared to the baseline report at the beginning of the project, this is a good development because the baseline report concludes that "the quality of life of ODDP is at a low level. This can be seen from three aspects, namely the health aspect (health and symptoms), the social participation aspect and the activityof the family bag.

Graph 2.Companion's perception of the future of the accompanied ODDP

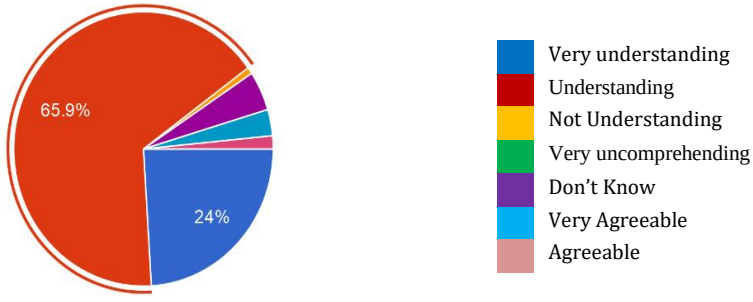


Graph 3. Companion's perception of the accompanied ODDP (embarrassed/not)



From the aspect of health services, the companion perception survey shows that 65.9% of companions feel that health workers in puskesmas or hospitals understand mental health better (plus 24% who say they understand very well, so a total of almost 90% understand) compared to 3 years ago as shown in the graph below.

Graph 4. Perceptions of companions regarding health workers' understanding of mental health



From the explanation given by the companion, this understanding is not only assessed from knowledge about mental health but more from attitudes and acceptance when interacting with ODDP and their families.

Apart from clinical aspects, psychosocial assistance, the YAKKUM Rehabilitation Center encourages relevant stakeholders to support non-clinical aspects of mental health in the form of:

a. Home visits for people with psychosocial disabilities and their families/companions

b. More meaningful mobilization and involvement of the community and people with psychosocial disabilities in mental health services in the region, collaborating with sub-districts and community health centers to provide education about mental health and ODDP, especially to reduce stigma and discrimination against ODDP. For example, through the formation of psychosocial disability self-help groups or self-help groups facilitated by the village government together with mental health cadres.

c. Strengthening the governance of mental health services at community health centers by developing mental health program planning in the community health center planning mechanism. This allows the integration of mental health service activities and budgets into the main community health center programs ranging from promotion, prevention to social rehabilitation.

d. Support community health centers as the leading sector in the community mental health management team (TPKJM) to activate and optimize their role and function in handling ODDP in each Kapanewon, including the management of patients who do not have population documents.

e. Development of regional policies that support the implementation of inclusive mental health services.

f. Advocating to the DIY and district governments to formulate regulations related to the role of Kapanewon and sub-districts in handling disability problems, including ODDP. This regulation is a reference for developing policies at the Kapanewon and sub-district levels.

g. Carry out sensitization and education to sub-district, sub-district/village, hamlet, RW/RT officials about mental health and ODDP.

h. Conduct training on planning and budgeting specifically for handling mental health problems based on the applicable village fund planning mechanism or APBD (village

Musrenbang or Subdistrict Musrenbang to be able to prepare regulations for programs and budgets for; Data collection and regular updating of ODDP data in sub-district areas local, Handling cases starting from referral to community health centers to follow-up after treatment. Providing social and economic assistance as well as productive activities to underprivileged ODDP families, Implementing mental health alert villages (DSSJ) or community movements caring for People with Psychological Disabilities,

i. Support for mental health cadre activities in sub-districts, more meaningful mobilization and involvement of the community and ODDP in mental health services in the region,

j. Collaborate with sub-districts and community health centers to provide education about mental health and ODDP, especially to reduce stigma and discrimination against ODDP.

k. Encourage collaboration between community health centers and sub-district officials to recruit and conduct training for cadres on mental health.

l. Develop technical guidelines for the implementation of DSSJ or the ODDP caring community movement in collaboration with community health offices and sub-district officials as a reference for the community to participate in handling mental health problems.

m. Develop IEC media in various forms (digital or print) to support reducing stigma and discrimination among ODDP.

n. Develop case management guidelines for cadres to assist ODDP who need assistance services for treatment, care, social rehabilitation, social assistance or economic assistance for ODDP in need.

o. Initiate the formation of organizations for people with psychosocial disabilities at sub-district level as a forum for peer support and aspirations for the needs of ODDP in the area. This initiation is also accompanied by the management of the organization to ensure its sustainability.

p. Strengthening networks in the region to realize ODDP treatment that is in line with the need for comprehensive mental health services.

Policies that are relevant and support the implementation of social rehabilitation for people with psychosocial disabilities

Health issues are a matter of mandatory basic services, including mental health treatment,

which must be carried out in an integrated manner and involve the active role of all parties from the village to the center. This is confirmed in Law no. 23 of 2014 concerning Regional Government, the division of health matters starting from health efforts, health human resources, pharmaceutical preparations, medical equipment and food and drink as well as community empowerment is the authority of all levels of government from central to regional. Meanwhile, villages also have the authority to create health care villages in accordance with PermendesaPDTT No. 21 of 2020 concerning General Guidelines for Village Development and Village Community Empowerment which mandates the achievement of sustainable development goals/Village SDGs. Of the 18 Village SDGs goals, goal 3 is a healthy and prosperous village which includes realizing quality mental health for village communities. Apart from that, there is also a program to establish Mental Health Alert Villages (DSSJ), which is one of the CMHN (Community Mental Health Nursing) programs to provide mental health education for the community. This program has been encouraged by the central government to be implemented in villages as an effort to accelerate the handling of mental health problems. The development of treatment interventions in accordance with the authority at each level of government starting from the province, district/city to village/sub-district can accelerate the target for handling mental health cases in DIY. This division of authority will also be closely related to the budgeting process for mental health program interventions. Therefore, it is necessary to clearly regulate the division of authority for mental health issues in DIY so that it can become a guide for all stakeholders in distributing their resources.

Mapping mental health problems in DIY is carried out by looking at 3 aspects of public service sustainability which include:

a. Policy/regulation

This aspect tries to find out mental health problems related to the policies implemented by the DIY government and its staff. Apart from that, to ensure the continuity of good practices in treating mental health.

b. Institutional and HR,

This aspect tries to look at problems related to human resource capacity, quantity of mental health human resources. Apart from that, it also tries to map how mental health management institutions run optimally.

c. Infrastructure consisting of Data, Infrastructure, Services, Budget.

This aspect tries to map the infrastructure that can support the mental health treatment process so far. This infrastructure includes ODDP data, facilities and infrastructure for mental health services, mental health services that have been implemented so far and a budget to finance mental health treatment programs and activities.

These three aspects were then brought into the problem mapping FGD with all stakeholders related to mental health in the three program area districts, namely Gunungkidul, Sleman and Kulon Progo as well as the DIY government. From the mapping results, it was found that some of the problems faced in the three assisted location districts are almost the same, so they can be generally classified as follows:

` Picture1. Map of Mental Health Problems in DIY

POLICY/REGULATION	INSTITUTIONAL AND HUMAN RESOURCES	INFRASTRUCTURE
•Mental health issues have not yet become a priority for local governments. •There are no regional regulations on mental health management that can serve as a reference for all parties in the Yogyakarta Special Region (DIY). Up until now, the reference has been the Governor's Regulation No. 81 of 2014, but it specifically addresses guidelines for dealing with shackling. •There is no Memorandum of Understanding (MoU) between the local government and universities that have psychology departments. •There is no legal basis for budgeting related to mental health at the village (Kalurahan) level. •Informed consent is needed for psychologists. •There is no standard operating procedure (SOP) for mental health care yet. •There is no specific policy at the provincial level regarding suicide prevention yet. •There needs to be a review of the policy on handling cases of restraint to make it more operational. •The existing referral system is not very effective for promptly addressing relapses, primarily due to the limited duration of inpatient coverage under BPJS and the fact that not all healthcare services offer mental health care. • Mental health policies remain gender-biased, as the regional regulation No. 14 of 2021 on Gender Mainstreaming (PUG) has not yet been used as a reference in mental health care. •Policies on SDGs for Villages have not yet been used by local governments (Kalurahan) as a reference for allocating budgets for mental health care.	•The mental health management institution (TPKJM) is not yet functioning optimally. •Job rotation poses a challenge in the management of the TPKJM institution. •Knowledge transfer has not been implemented during job rotations, resulting in new personnel in TPKJM often being unaware of their roles and responsibilities. •There is no specific guideline related to the TPKJM organization (handbook). •Mental health management is still confined to health and social affairs, and has not yet become cross-sectoral. •There is still a lack of competency related to mental health. •There is a stigma associated with Guidance and Counseling teachers. •There is a shortage of clinical psychologists in healthcare centers. •Stigma surrounding ODDP (Outpatient Drug Detoxification Program) still exists in the community. •Lack of education related to mental health. •Many people are unaware that JKN (National Health Insurance) covers mental health care.	•There is no budget allocated for mental health from the village (kalurahan) level. •Healthcare services are not yet accessible to people with severe mental disorders (ODDP). •Data on people with severe mental disorders (ODDP) is not yet synergized, integrated from the village level to the national level, and up-to-date. •The currently available data is not yet disaggregated (by age, types of disabilities, required therapies, gender, needs, etc.). •Involvement in mental health handling is still dominated by female volunteers, with participation from both women and men not yet balanced. •Transportation for mental health care is still problematic. •The reach for people with disabilities is still limited. •Stigma from family and society still exists. •The reach of health services for ODDP using health insurance is still limited. •Rehabilitation services provided are still dominated by medical rehabilitation compared to social rehabilitation. •The National Health Insurance (JKN) has not yet optimally covered mental health services. •The early detection system is not yet optimal, leading to mental health disorders being identified only when someone exhibits severe symptoms. •Not all healthcare services have mental health services.

In addition to the summary of the problem map above, community-based mental health and social rehabilitation problems from the three districts and DIY regional government can be categorized into 6 levels which include community, sub-district, Kapanewon, health center, district and province. Using the problem map database that has been mapped will make it easier for the team

to prepare an advocacy plan that will be carried out to realize comprehensive, gender responsive, adaptive and rights-based mental health treatment for ODDP.

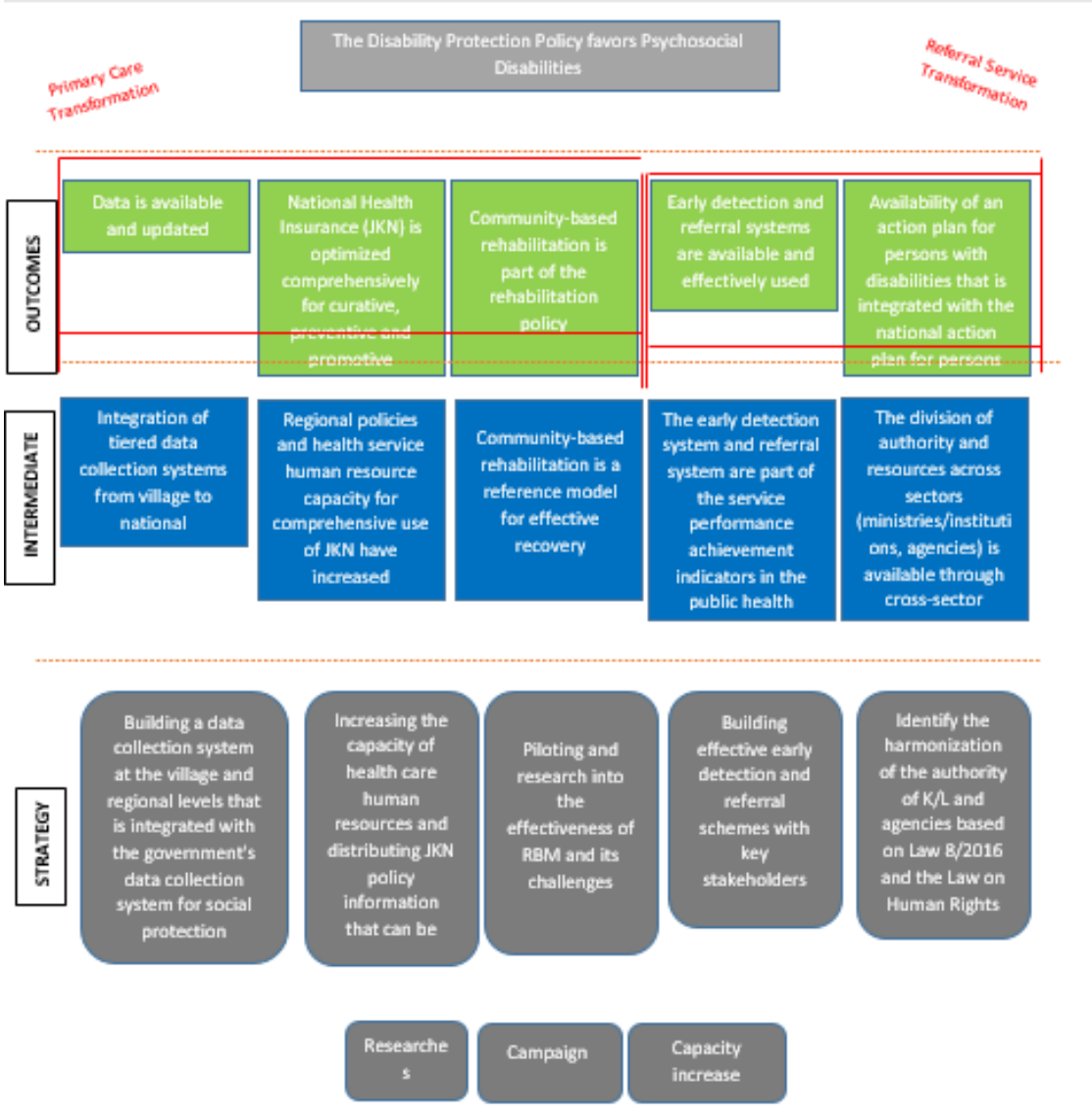
Mental health data management must be carried out comprehensively and continuously. Data is key in the development planning process for fulfilling public services to fulfill basic rights for people with mental problems (ODMK) and ODDP or ODGJ. Mental health observers believe that data on mental health sufferers in Yogyakarta is currently largely unknown and therefore not yet included in the government database. empowerment. enter the data collected in an integrated system and update the data continuously.

Collaboration in handling mental health problems must be carried out by all stakeholders from the central, regional and village levels. Apart from that, relations between Regional Apparatus Organizations (OPD) are key in ensuring that the implementation of the planned treatment can run optimally. So far, handling mental health is still synonymous with the duties and responsibilities of the Health Service alone. However, to optimize and accelerate the handling of mental health problems, it must be carried out in an integrated manner. Therefore, the sectoral ego that still occurs in the context of mental health issues must be pushed aside and collective steps must be taken. That the Health Service is the leading sector for mental health issues is true, but other services also have roles in accordance with their respective main tasks and functions. The development of roles between departments or OPD can refer to four approaches to mental health management, namely promotive, preventive, curative and rehabilitative. In accordance with the mandate of Minister of Health Regulation no. 4 of 2019 concerning Technical Standards for Fulfilling Basic Service Quality in Minimum Service Standards in the Health Sector, Article 2 paragraph 3 states that health care for people with serious mental disorders is not only emergency care but also includes preventive and promotive measures.

Preventive, promotive and rehabilitative efforts in the future need to be further intensified in collaboration with Regional Apparatus Organizations (OPD) according to their duties and under the coordination of the health service. For example, preventive and promotive efforts can be carried out through outreach, campaigns to increase public awareness about mental health and carried out by the health service in collaboration with the communications and information services, education services and other OPDs. This effort is made so that people are aware of maintaining their mental health, their souls, knowing what the signs are, how to prevent it, where to report it, etc. so that there will be no increase in mental health cases. Apart from preventive and promotive efforts, other efforts that have so far received little attention and implementation are rehabilitative efforts. In fact, this rehabilitative effort is an important key to the sustainability of the recovery conditions for ODDP. When they have completed curative efforts and are declared recovered, they will return to

their families and communities through rehabilitative efforts. This rehabilitative effort needs to be carried out not only by the health service but also by the social service, village government, village cadres, community assistants and other stakeholders in the community.

The following is a mapping chart of efforts to encourage mental health policies that accommodate psychosocial disability rights;



Development of community-based mental health and social rehabilitation model programs for psychosocial disabilities for health care

The community-based mental health and social rehabilitation approach model here is a

foundational activity that ensures the existence of a sustainable system centered on the rights of people with psychosocial disabilities, the authority/responsibility and capacity of the parties in fulfilling these rights, especially in the context of social rehabilitation provided. This also includes livelihood programs where identification or assessment of ODDP needs and subsequent facilitation need to be carried out in an integrated manner involving various parties so that it is sustainable. This model can be started from the assessment stage where there is a need for some kind of guide or standard case management flow for support for ODDP up to the mentoring phase; Apart from that, this program also identifies sustainable institutions or mechanisms that can provide similar start-up kit support for scale-up purposes to other ODDP.

Planning in the second phase needs to be more measurable in determining results and indicators in order to strengthen the self-sufficiency model. For example, for the Psychosocial Disability Self-Help Group (SHG), its development projections need to be targeted as a support group as well as a community group that has legal recognition at the village level. Village support needs to be raised to a stronger level of commitment in terms of legal policies and budget proportions. The stages of developing a psychosocial self-help group are not linear or gradual from therapy group, supportive group to community group but rather a "natural logical" form that is contextual according to needs (can even be all three) and based on the decision of the self-help group.

The stages in developing a more systematic community-based mental health and social rehabilitation program model need to include the following approaches:

a. Individual case management: Effective assessment of individual needs, the role of people with psychosocial disabilities and families when preparing individual plans, start up kit stages which are based on a more comprehensive assessment, capacity building materials in the form of TAK or materials related to start up kits

b. Initiating, maintaining, facilitating self-help groups with psychosocial disabilities/Self Help Groups, group capacity building materials including leadership enhancement and group networking.

c. Cadres: cadre roles, cadre capacity building materials (including relevant regulations) etc

d. Local resource management, role of TPKJM, data management, community-based mental health coordination mechanisms

e. Strengthening the leadership of people with psychosocial disabilities and families

who are members of self-help groups through self-advocacy assistance.

f. Including the role of young people and information technology in this flow, because young people show their potential so they are not only limited to being targets for self-sufficiency education but also become potential for mental health movements, campaigns and advocacy.

Thenthe importance of a support system to ensure the sustainability of the community-based mental health treatment system at the local level from the movement aspect which essentially relies on self-help groups which have the capacity and act as channels for ODDP aspirations; and needs to have legal force for its sustainability. Psychosocial disability self-help groups are facilitated to have networking capabilities and have the need to network, also connect to other relevant parties including the mental health community, professional community, hobby community and ultimately the self-help group can decide on its role or work more independently.

From the results of the program study, it is known that one of the promotion and prevention activities for community mental health that has been carried out by cadres and regional apparatus organizations (OPD) is education/information. This activity is aimed specifically at local officials regarding the flow of handling emergency mental health cases and providing assistance to families of people with psychosocial disabilities. This is done because not all local officials understand the procedures for dealing with mental health cases that occur in their area. Education and mentoring activities are also carried out for ODDP families so that they can provide adequate care, supervision and treatment for ODDP. Another role of cadres and OPD in collaboration with stakeholders is to carry out monitoring for ODDP who do not have families. This is to ensure that ODDP can receive proper treatment.

Another role carried out by cadres in the three study areas is data collection and finding mental health cases. Cadres are more likely to find cases to be reported to the Community Health Center. According to several cadres, the discovery of the case began when they were visited by the ODDP family because a family member was experiencing mental problems. Cadres then follow up with monitoring, data collection and reporting to the Community Health Center. The community mental health reflection workshop for psychosocial health, livelihood and emergency resilience in the province of Yogyakarta (CEPLERY) which was held on 2 February 2023 at the YAKKUM Rehabilitation Center office carried out a more specific strategy.

1. ODDP and companions strengthen knowledge, productivity and strategies in the community and are involved in mental health promotion.

a. Percentage of ODDP and caregivers who have basic knowledge of social care rehabilitation (which is detailed in MELF) and are actively involved in community activities. Results: 83 ODDP and 71 Caregivers (19% of target 75%).

b. Percentage of ODDP and caregivers who are able to carry out productive activities continuously and proven through updated IAP. Results: 90 ODDP and 105 caregivers (30% of 80%)

c. Percentage of ODDP and caregivers who actively participate in promoting RBM for Keswa. Results: 51 ODDP and 60 caregivers (15.6% of 50%)

2. Strengthening the knowledge and commitment of village and sub-district governments, community leaders and related stakeholders to promote and implement gender-based self-sufficiency principles in order to ensure the fulfillment of the basic rights of ODDP and caregivers. Key points of achievement:

a. Percentage of mental health volunteers, cadres and community leaders who have knowledge and awareness of the rights of ODDP and gender equality in the self-sufficiency model in their respective villages. Results ; 76 cadres already have knowledge of ODDP rights and gender equality (Target 70%; Results 98%).

b. Percentage of government at the village, sub-district and district levels that have increased knowledge and awareness of the rights of ODDP and gender equality in the self-sufficiency model in their respective regions. Results: 68 government staff have increased knowledge about gender and social and social rehabilitation models (at village, sub-district and district levels) 61.34 of the target of 70%

c. Percentage of SHGs that have gender-sensitive action plans within their group. Results: 8 SHGs have gender action plans, or 38 % of the target of 80 %

d. Number of villages that have developed gender-sensitive public health action plans and are committed to implementing them. Results ; 12 villages have made gender and mental health action plans out of a target of 18 villages

e. Percentage of DPOs who are actively involved in promoting gender-sensitive public health issues at the sub-district, district and provincial levels. Results: 17 DPOs have been trained to promote gender and mental health.

3. Increased access for ODDP and caregivers to social rehabilitation services in disaster and non-

disaster situations. Key points of achievement:

a. Number of service providers (at the village and community health center level) who have been trained in disaster preparedness principles and continue to provide services to both disability groups and other communities. Results: 21 village governments, 7 health centers and 6 project-assisted sub-districts have been trained in preparing disaster contingency plans that are inclusive of psychosocial disabilities. The existence of a disaster contingency plan is used for village governments and community health centers to facilitate community-based mental health and psychosocial disability services during disasters and non-disasters. The target of 30 was achieved by 34 service providers.

b. Number of service providers (at the village and community health center level) who have a service continuity plan/contingency plan. Results: 3 Community Health Centers have a mental health services sub-cluster disaster preparedness plan from target 5 documents (target year 1)

c. Number of TPKJM carrying out further policy coordination and advocacy roles to ensure ODDP access in disaster and non-disaster contexts. Results: 7 TPKJM at the sub-district level have been trained in preparing disaster contingency plans to adapt mental health services and social rehabilitation during disasters and non-disasters. The status of this indicator is still in progress because the contingency plan document is in draft form. The project facilitates the strengthening of TPKJM in 3 districts and provinces.

4. Availability of relevant policy development and stakeholders that will strengthen the implementation of social and social rehabilitation services at the district level. Key points of achievement:

5. YAKKUM Rehabilitation Center receives support that enables its internal system to carry out quality projects related to self-sufficiency and become a resource organization in the field of self-sufficiency. Key points of achievement:

a. Percentage of project indicators achieved. Results ; 6 indicators achieved from 18 indicators at result level (35% of target 80%) and 1 indicator achieved at SO level from 4 indicators at SO level

b. The percentage of staff whose capacity has increased in implementing gender-sensitive public health programs (Achieved). Results: Program and supporting staff were trained on gender in December 2022. 30 program and supporting staff

were trained, 11 men and 19 women.

c. There is an organizational gap assessment report in the area of welfare, gender balance and broader social inclusion for people with disabilities, including people with psychosocial disabilities. Results: Gender gap assessment for the Yakkum Rehabilitation Center has not been facilitated by the project. In quaryal 4, project and supporting staff are trained first. The gender gap assessment will be carried out in Q1 2023.

d. There is an institutional operational plan to move towards an inclusive, gender-sensitive institution for people with disabilities, including people with psychosocial disabilities (Achieved). Results ; PRY has prepared a gender-sensitive Mental Health and Disability Center Recourse Roadmap along with its logframe.

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4. Conclusion

The call and commitment that mental health issues should immediately become a Joint Movement because the relevance and urgency is very clear and has started with an initial form that is visually more concrete in the Community-Free Mental Health Program is the conclusion. This hope is not only expressed by civil society organizations but also by the provincial government, even though at the national level the Mental Health Program is currently not yet a priority national program at the Ministry of Health.

This proves that the issue of community-based mental health is very relevant. This program shows a significant level of achievement because in the selected work areas there have been forms of proactive community contribution to community-based mental health efforts, both at the family level, at the village level and in wider stakeholder networks such as sub-district TPKJM and Public health center. The approach taken by the Mental Health and Community-Based Program is by organizing people with psychosocial disabilities, families and cadres in self-help groups with main activities such as group activity therapy (TAK) and providing start-up kits as the initial platform for encouraging social recovery for ODDP and strengthening the role they are next in society. Although this model needs to be better documented to make it easier to replicate and scale up in other regions.

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