



Initiating Mental Health Services for Youth Involved in the Juvenile Justice System in Indonesia: Lessons from the US Systems of Care

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Abstract

The children's mental health service has become an inseparable part of the juvenile justice system in developed countries. The United States has successfully reformed the children's mental health system by utilizing the systems of care framework, embracing its principles and values in the juvenile's mental health treatments. In contrary, Indonesia as a developing country is still struggling with finding the directions and determining the mental health services framework to design mental health programs, policies, treatments, and services. The juvenile justice system in this country even has no concept of the importance of providing the mental health services for the juveniles. Therefore, this paper aims to examine and to explain the possible efforts that can be implemented in Indonesia by learning from the systems of care practice in the US related to the juvenile mental health services.

Keywords: *Juvenile, Mental Health, Systems of Care, Indonesia*

Abstrak

Pelayanan kesehatan mental anak menjadi bagian yang tidak terpisahkan dalam sistem peradilan bagi remaja di negara maju. Amerika Serikat telah berhasil mereformasi sistem kesehatan mental anak dengan memanfaatkan kerangka berpikir sistem perawatan (systems of care), menganut prinsip-prinsip dan nilai-nilai yang terkandung di dalamnya dalam perawatan kesehatan mental remaja. Sebaliknya, Indonesia sebagai negara berkembang masih berjuang untuk menemukan arah serta menentukan kerangka berpikir pelayanan kesehatan mental untuk digunakan dalam menyusun program, kebijakan, perawatan, dan pelayanan kesehatan mental. Sistem peradilan bagi remaja di negara ini bahkan tidak menyebutkan konsep tentang pentingnya menyediakan pelayanan kesehatan mental bagi remaja. Oleh karena itu, makalah ini bertujuan untuk membahas dan menjelaskan upaya yang memungkinkan untuk diterapkan di Indonesia dengan belajar dari praktek sistem perawatan di Amerika Serikat terkait dengan layanan kesehatan mental remaja.

Kata kunci: *Remaja, Kesehatan Mental, Sistem Perawatan, Indonesia*



Introduction

Indonesia with more than 250 million population ranked as the fourth most populous country in the world follows the US in the third rank. However, the vast number of the population is not parallel with the mental health care services. There are several barriers to provide the mental health care services in Indonesia. The first barrier is related to the stigma of mental health that comes from the government and the society. The government does not prioritize the mental health as the vital program in the national government work plan. Although the Mental Health Act had been issued in 2014 and conceived as a comprehensive law to promote mental health services, the mental health condition of Indonesian people is untraceable. People with mental illness in Indonesia prefer to keep the problems as their family's secret and are reluctant to seek help for the mental health treatment. The cultural and socioeconomic factor seems to influence the mindset and stigma of the mental illness. Pasung- the physical restraint and confinement of the mentally ill person practice can still be found in modern Indonesian society. In 2013, there are 15.6% people with mental illness were restrained (Balitbangkes, 2013). This phenomenon shows that mental illness is still perceived as a disgrace condition and an embarrassing thing in the society.

Furthermore, the inadequate attention from the government affects the mental health facilities and human resources availability in Indonesia. The allotment budget for the mental health services is only 2.89% of all the total health budget allocated by the government. There are only 53 mental health hospitals, and centers in Indonesia-which 32 of them are public hospitals, 15 private hospitals and two specialized-mental health centers where the services are delivered by 6500 nurses. Furthermore, the number of beds allocated to mental illness inpatient is only 7500 beds across this 16,000 islands country (ASEAN Mental Health Systems, 2016). Indonesia is also one of the lowest ranked countries regarding providing mental health services in Asia, with 700 psychiatrists, one for every 350,000 people and over half of them provide treatments on the main island of Java, in Jakarta, the capital city of Indonesia (Emont, 2016).

Even though the statistical data about the Indonesian people's mental health condition is scarcely available, there are some mental health prevalence rates have been collected for this paper. Based on WHO data, the mortality rate due to suicide in Indonesia in 2012 is 10,000. The number trends increased compared to the data in 2010 which was 5,000 deaths. The Ministry of Health research in 2013 found that the prevalence of severe mental disorders, such as schizophrenia reached about 400,000 people or as many as 1.7 per 1,000 population. Whereas, the prevalence of emotional, mental disorder shown with symptoms of depression and anxiety for people age 15 years and above reached about 6% of the total population of Indonesia. There were 42.2 % children suffered from emotional problems, and 54.81% of them have peer problems in the same year (Wiguna, Manengkei, Pamela, Rheza, Pamela & Hapsari, 2010). By 2016, the WHO data shows that there were about 35 million people affected by depression, 60 million people with bipolar, 21 million with schizophrenia, and 47.5 million with dementia. In addition to the low ratio of the number of psychiatrists and mental health workers, as well as inadequate mental health service facilities compared to the population, the limited budget for mental health is also a problem for the provision of adequate mental health services in Indonesia (WHO, 2016).

The prevalence rate of the juvenile with mental health needs in Indonesia is not procurable because the Department of Corrections has never been concerned about this issue. The poor policing, the scarcity of research and the human resource competencies are some of the reasons why this institution has not taken any actions. Therefore, this paper aims to encourage the juvenile justice system policymakers to establish the adequate mental health services for the juveniles. The systems of care principles and values that are adopted in the juvenile's mental health services in the US might

be possible to be implemented in Indonesia.

Juveniles with Mental Health Illness in the US Criminal Justice System Among the population of the juvenile with mental health illness in the US, most of them need mental health treatment (Vermeiren, Jaspers & Moffitt 2006). The National Center for Mental Health and Juvenile Justice (NCMHJJ) conducted mental health prevalence study in 2006 and found that more than 70% juvenile population has at least one mental health problem (Shufelt & Cocozza, 2006). Other findings that discussed explicitly on gender and race differences in the population with mental health symptoms revealed that more whites (72.4%) than blacks (65.6%) or Hispanics (67.2%) were above caution on at least one MAYSI-2 scale and girls have higher mental health symptoms rate than boys. Furthermore, black or Hispanic juveniles were less likely to report suicide ideation and somatic complaints than white juveniles. For the substance use disorder, it was reported that white and Hispanic juveniles were more likely have the symptoms (Vincent, Grisso, Terry & Banks 2008).

Given the high prevalence rates of the juvenile with mental health needs, the US government took actions in addressing the juvenile's mental health needs. The President's New Freedom Commission Report on Mental Health in 2003 began the "fundamental transformation" of the nation's mental health system into a strength-based system to provide access and services to the children and adolescent with mental health problems, including youths in the juvenile justice system. The Comprehensive Community Mental Health Services Program for Children and Their Families is the 'systems of care' initiative that promotes the cross-agency networks in implementing a wraparound strengths-based approach in mental health care services. The systems of care funding assists in developing community- and evidence-based treatments for the juvenile. The collaborative actions performed in establishing a multisystem planning committee to create strategies in involving the family, schools and police in the prevention program, defending the juvenile's best interest and dissociate the juvenile with mental health problems from the criminal justice system, and creating aftercare services in the reentry programs so that, the juveniles can reintegrate to the community successfully and have access to mental health care services (Cocozza, Skowyra, and Shufelt, 2010).

One of the strategies to divert the juveniles was undertaken by establishing the Juvenile Mental Health Courts (JMHCs) in 2001. The foundational principles of JMHCs represent the systems of care values as well as the principles and court operational is based on the therapeutic jurisprudence. In this court, the juvenile justice and mental health professionals work in harmony to identify the psychological, educational, and social needs that contribute to criminal behavior. By using a strengths-based approach, they work to provide intensive case and management services to assure the juveniles get the best treatment and to prevent recidivism (Gardner, 2011).

The treatment models mostly used in the US Juvenile's Mental Health Care Services are cognitive behavior and evidence-based treatment. Both of these treatment types are energized by the wraparound approach that has functioned since decades ago to power the mental health treatments operationalization for the juveniles. This approach is also perceived as a vigorous process because it proves the efficacy and effectiveness in generating many potentials in providing the best mental health treatment for the juvenile and the families, without need much support from the research teams (Suter and Bruns, 2009).

Methods

Research method used in this article is literature review, by reviewing articles and data related to mental health care system issue in the US and Indonesia, to identify the gap of the juvenile mental health services in the Mental Health System in both of the countries. Moreover, the literature review also helped in determining the research question, that is what can be done in initiating the juvenile mental health in Indonesia by mirroring in the US Systems of Care.

Findings and Discussion

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Discussion

The mental health screening and assessment is carried out to get the mental health information from the juvenile that might affect the further criminal process. Moreover, the assessment result can be developed as a database for mental health documentation in the juvenile justice system. The mental health screening and assessment should be conducted in three phases of the criminal justice process, which are the pre-adjudication phase, adjudication phase, and post-adjudication phase.

However, the implementation ways in each stage are similar, so that the initial stage procedure can be replicated in the next two levels.

The first level of screening and assessment will be conducted in the pre-adjudication phase. In this phase, the police officer typically contacts the probation officer related to the diversion program. The probation officer will be writing a social inquiry report to explain the demographic conditions and criminal activity of the juvenile. Because the criminal process begins on the investigation stage, the pre-adjudication phase can function as the starting point to provide the mental health screening and assessment in the juvenile justice system. The mental health screening and assessment report should be included in the social inquiry report to provide juvenile comprehensive information. In this phase, the process will begin by conducting the mental health screening carried out by the intake officer.

This process will involve the juvenile and the families to see whether any emotional or mental problems on the juveniles. The intake officer should ask the permission from the juvenile's parents or caregivers before doing the assessment. Because in their age juveniles spend more time at schools, it is also recommended to invite the juvenile's school teacher or counselor in the assessment process to generate better assessment. But, all the participants in the assessment process should be voluntary. After conducting the mental health screening, the intake officer will review the screening result. If the juveniles need further intervention program, they will have to undergo the mental health assessment to determine the right treatment. To ensure the quality of the mental health assessment result, the mental health professional will solely conduct the clinical assessment.

The social inquiry report together with the mental health assessment is supposed to provide the information of the mental illness diagnoses. The mental health assessor will share the result with the juvenile, family and law enforcement officers involved in the pre-adjudication process. Therefore, they will understand the diagnoses and the police officer together with the probation officer can decide whether the juvenile will be eligible for the diversion. However, to protect the juvenile's right and to prevent the stigma related to mental health illness, the law enforcement officers must keep the assessment confidentiality and only use it for legal concerns (the policy-makers should state in the regulation about the confidentiality of the assessment report and the use of the information only restricted to legal concerns). Because the result of the assessment will need to be followed up by the juvenile, the families, and the probation officer as the juvenile mentor, there should be the list of possible treatments and mental health providers information to refer the juvenile.

In this pre-adjudication phase, the policymakers should consider about the possibility to incorporate the provision of the screening and assessment and juvenile's mental health condition into the diversion government regulation. The US juvenile justice system has developed the Sequential Intercept Model as an alternative to diverting the juvenile with mental health disorder from entering the criminal justice system (SAMHSA, 2017). This model aims to keep the juveniles with serious mental health problems from the criminal justice system. Therefore, the juveniles can stay in the less restrictive environment close to their family and get the mental health services in more comfortable ways. Because the juvenile justice system in Indonesia already has the similar diversion program, there is no encumber thing to promulgate the notion of mental health assessment as an important consideration in diversion decision.

As the preparation for the mental health screening and assessment services in the juvenile justice system, the policymakers are likely required to recruit the intake officers and to provide the assessment training. In addition, the designing of regulations and standards to conduct the mental health assessment for the juvenile are required. The assessment tools are compulsorily provided to facilitate this mental health assessment. In the US children's mental health services, there are several mental health assessment tools that are used commonly. The Child and Adolescent Needs and Strengths As-

essment-Mental Health (CANS- MH) is a functional assessment that supports to design effective treatment care and level of care decision making because it involves the juvenile and family needs and strengths. This assessment tool also upholds the systems of care principle related to cultural and linguistic competence as it focuses on the family and juvenile domain cultures, such as the preferences, norms, and beliefs. And the most important thing is this tool has a specific assessment of the juvenile justice-involved youth (Praed Foundation 1999, 2017). The other mental health assessment tools that potential to be used are Achenbach System of Empirically Based Assessment, Adolescent Psychopathology Scale, Adolescent Psychopathology Scale-Short Form, and Reynolds Adolescent Adjustment Screening Inventory, The Behavior Assessment System for Children, Second Edition and Behavioral and Emotional Screening System, Connor's Parent Teacher Rating Scale, Diagnostic Interview Schedule for Children Version Four and Diagnostic Interview Schedule for Children Predictive Scales.

Besides the mental health assessment, the policymakers also must include the juvenile's criminogenic assessment on the policy framework. The criminogenic assessment by employing the risk and needs assessment instruments is significant in predicting the reoffending likelihood on juveniles. According to Andrews and Bonta (2000) (as cited in Prins, Skeem, Mauro, & Link, 2015), there are four risk factors that predict criminal conduct, namely history of antisocial behavior, antisocial personality pattern, antisocial cognition, and antisocial associates. The risk and needs assessment based on the risk-needs-responsivity model will measure the juvenile's needs, risks and protective factors (Listenbee, 2014). This is an initial step for the police, probation officer, judge and correction officer in determining the intervention program for the juvenile.

Some of the risk and assessment tools that best used in the US are, Correctional Offender Management Profile for Alternative Sanctions (COMPAS), Level of Service Inventory-Revised (LSI-R) and Level of Service/Case Management Inventory (LS/CMI), Offender Screening Tool (OST), Ohio Risk Assessment System (ORAS), Static Risk and Offender Needs Guide (STRONG), and Correctional Assessment and Intervention System (CAIS) which was based on the earlier Wisconsin Risk and Needs (WRN) instruments and the Client Management Classification (CMC) planning guide (Casey, P.M., Elek.J.K., Warren.R.K., Cheesman.F, Kleiman.M., & Ostrom.B (2014).

Moreover, the criminogenic assessment will address the essential factors to crime by incorporating the clinical and non-clinical factors in a balanced way. Emphasizing the clinical factors solely as the factor of delinquency will abandon the non-clinical criminogenic factors such as family background, education level, and recreation. In addition, thinking about the non-clinical factors as the other source of criminal behavior is prominent to prevent the bias of criminalization hypothesis that assumes the overexert of individuals with mental illness (clinical factors) in the criminal justice system (Ringhof, 2012). By directing the intervention treatment to the clinical and non-clinical factors, it is potential to maximize the outcome of juvenile's mental health and to prevent the reoffending.

Conclusion

The mental health care services in Indonesia still have many flaws in general conditions. The main problem that causes this circumstance is because the government and the society view the mental illness as a negative stigma. In contrary, the US mental health system has developed in an advance way as it has established the collaboration with various organization to provide especially the mental health services for children. Since the US government found that the prevalence rate of juvenile with mental health illness was high, they took some actions and utilized the systems of care to fulfill the juvenile's mental health needs. Learning from the US experience, the juvenile justice system in Indonesia can take lessons from the practice of systems of care in designing the policy for the initial juvenile's mental health services program. Although there might be difficulties to start this

new thing, this groundbreaking effort can be seen as another reform in Indonesia juvenile justice and mental health system.

Implication

Kilmer and Cook (2012) discussed about the issues, needs and directions in implementing the Systems of Care philosophy to yield better outcomes by improving the systems, policies and practices outcomes. Because the SoC as the system and the children's mental health are dynamic while the resources in the SoC are limited, the policymakers have to comprehend the characteristics of SoC and how to direct and to target changes in obtaining better services for the children and their families. They recommend several issues to comprehend the needs of SoC alteration in the level of policymakers, administrators, agency directors, and professionals. The first, wraparound as the primary practice approach that represents the SoC philosophies is vulnerable to adherence issues. Therefore, the effort to ensure and to evaluate the fidelity of the wraparound is crucial in determining the prominent features of wraparound to maximize the service advantages. The Wraparound Fidelity Assessment System (WFAS) that was created by National Wraparound Initiative (NWI) is the sole assessment used to measuring the wraparound fidelity (FidelityEHR, n.d.).

Secondly, because SoC is a segmental system that consists of cross-agencies collaboration and coordination that provide service in different contexts, sectors and populations, the identifying of the nature of each context is required to understand what changes are needed. Moreover, it is also important to examine the impact of the intervention program based on the wraparound approach, such as the family support model that is exceptionally represent the SoC philosophies and the school-based interventions. Furthermore, the critical points to system change in SOCs is bringing up the collaboration of the family, service providers, and community empowerments. Overall, the tangible efforts that cover all the changes are the strategies to improve the policies, programs, services and mental health care resources quality in satisfying the needs of children and the families.

Besides the importance of the cross-agencies collaboration, engaging families and juveniles in the mental health treatment planning is also crucial. In systems of care, family are seen as the system partners that not only take the role as the service consumer but also as to utilize their participation in sustaining the systems of care itself. By including the cultural and linguistic competence in the family participation, the outcomes of the treatment service can be maximized (Miller, Blau, Christopher, and Jordan, 2012). Moreover, the development of community-based treatments also will provide the natural support the juvenile needs after being released from the prison as they will reintegrate to community life. Reflecting the cultural and linguistic competence in the US systems of care, this family-driven, community-based treatment and cultural approach can be implemented optimally and optimistic in Indonesia.

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