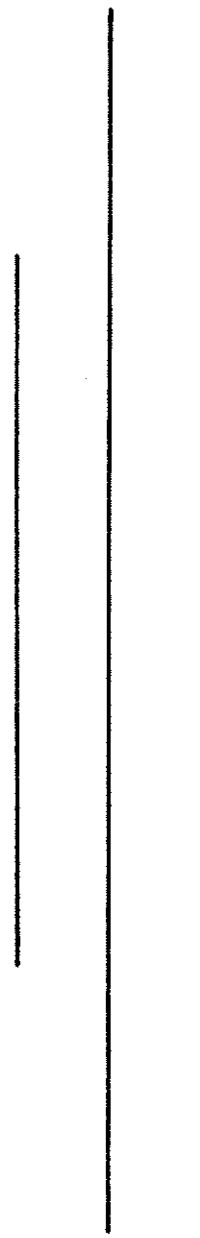
MENTAL RETARDATION IN INDONESIA

(COUNTRY REPORT FROM INDONESIA)



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1981.

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INTRODUCTION

Geographical situation

The Republic of Indonesia, the larges archipelago in the world, straddles the Equator between 6 degrees North and 11 degrees South, between 95 degrees and 141 degrees East. The greatest distance from West to East is 5,110 Km and from North to South 1,888 Km. Total land area is about 2,000,000 Km2.

Indonesia consists of 13,667 islands, of which approximately 931 (7%) are inhabited. The islands range in size from a few acres to the largest island Kalimantan with a land area of 539,460 Km2, followed in size by Sumatera, Irian Jaya (West New Guinea), Sulawesi (Celebes) and Java. Jakarta is the capital city, located on the island of Java.

Population

Indonesia ranks fifth among the world's most highly populated nations, following China, India, U.S.S.R. and U.S.A., the sixth and seventh are Japan and Pakistan. At the time of the last population census in 1980, the population was estimated at 147,49 million with an annual growth rate of 2.32%.

Population distribution is very uneven : approximately 80% live in the rural areas and 20% in urban areas. Sixty-two percent of the total population live on the island of Java which covers only 6.89% of the total land area. As a result, population density varies extremely from island to island. (Java 690 per square kilometre, Maluku and Irian Jaya only 5, and the average population density is 77).

Forty-two percent of the population are children aged 0 - 14 years, estimated crude birth rate is 37.3 permille and crude death rate is 17.3 permille life expectancy at birth is 52 years. The Indonesian people consists of about 300 ethnic groups (suku bangsa), each with its own dialects, customs, beliefs, social structure and basic characteristic traits. The major group is the Javanese (45%), followed by Sundanese (13%), Madurese (6.6%), Riau (5.2%), Minangkabau (3.8%), Bugis (2.8%), Chinese (2.3%), Balinese (1.9%), Acehnese (1.5%), and the rest (14.6%) are minor groups. Though, there is an official language the Bahasa Indonesia (Indonesian), more than 250 dialects are spoken locally.

The majority of Indonesians are Moslems (89%), and the rest are Protestants (5%), Roman Catholics (2%), Hindus (1%) and others (3%).

Under the "umbrella" of Pancasila* as the basic philosophy of life, Indonesians are united as one nation and living together in a spirit of mutual cooperation (gotong-royong).

THE STATE OF MENTAL RETARDATION IN INDONESIA.

Mental Retardation is not an isolated disease entity. It is a lifelong condition that affects the individual, ~~modofoes~~ modifies his progress throughout life, and causes concern to those with whom he lives and those who must deal with him.

Some people regard it as a medical, some as a social, and others as an educational problem. A great number of parents blame school teachers for labelling their child as "mentally retarded", since scholastic performance is usually regarded as a reflection of the individual's intelligence level. Most children who fail in school are diagnosed as mentally retarded with little regard to polygenetic and socio-cultural factors.

During the first Indonesian Five Year Development Plan (1969-1974) reports claim that relatively large numbers of students left school before completing elementary education. The large number of drop outs, more than 50% reflected by differences of school attendance of first and six grade students. Evidently not all drop outs are mentally retarded. There are many other factors involved, such as, quality of teachers, curriculum not designed to meet the need of society, not appropriate teaching methods, competition of school to attract the best students, ~~cultural bound factors~~, etc. (6)

Statistics of the Jakarta General Hospital, Child Psychiatric Out-Patient clinic during 1970 showed that 12.8% of the children (4-18 years) referred are diagnosed as mentally retarded : 86% mild, 5% moderate and 9% severe. Fifty nine percent are referrals from elementary schools. In 76% apparent cause could be detected. (6)

In other cities like Bandung, those children between 2-15 years who are hospitalized in Mental Hospitals mostly suffered from both Mental Retardation and psychiatric disorders. (6)

During the special Workshop on Registration and Data Development of 1974 Physically Handicapped in Yogyakarta it was estimated that 2.46% of the Indonesian population was ~~effective~~ affected among 0.40% are mentally retarded. (4)

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* Pancasila consists of Five Principles incorporated in one unity :

(1) Belief in the One Supreme God.
(2) Just and civilized Humanity
(3) The Unity of Indonesia
(4) Democracy wisely led by the wisdom of deliberations among representatives and
(5) Social justice for the whole of the People of Indonesia.

The last Population Census in 1980 gave the number of 1.683. 182 handicapped in Indonesia of which 169.349 were mentally retarded (29.9% were children and 70.1% were adults).

Those diagnosed as mildly retarded are usually accepted in the community. Most moderately and severely retarded stay at home with their families. Due to a lack of educational institutions remaining with their families may also be seen as an acceptable solution for the mentally retarded, at least temporarily. There is also widespread belief that having a mentally retarded child may either be a blessing or a curse from God.

Health Organization

1. Central level

The organizational structure of the Ministry of Health can be described as follows :

The highest official is the Minister of Health. For managerial functions he is assisted by :

- A Secretary General with six Bureaus
- An Inspector General with three Inspectorates
- A National Institute of Health Research and Development with six Centres for Research and Development
- A Centre for Education and Training

For executive functions the Minister is assisted by :

- Four Directors General, each responsible for Community Health, Medical Care, Communicable Disease Control, Food and Drug Control, respectively, with 18 Directorates, covering all components of the community health services.
- Various Institutions directly administered by the Central Government, such as Central General Hospitals, Special Hospitals and other institutions.
- Other Institutions and Hospitals are administered by the local government.

2. Provincial level

As an extention of the Ministry of Health at provincial level, a branch office of the Ministry of Health is established in each province. This office constitutes a part of the central administration assisted by a secretariate which carries out the managerial functions of the office, and two divisions, the planning division and the division for services and monitoring. Beside the branch office of the Ministry of Health, Provincial Health Services responsible to the Provincial Government, carry out the operational duties at provincial level.

To maintain linkage between Ministry of Health administration and Provincial Health Services the chief of the Ministry of Health branch office is at the sometime nominated as chief of the autonomous provincial health office. This unique arrangement provides a channel for coordination and cooperation bet - ween the two agencies which facilitate planning and management of the health sector at provincial level.

Mental Health Policy and delivery of services is organized by the Directorate of Mental Health, Directorate General of Medical Care. This Directorate has 4 subdirectorate which deals respectively with (1) Prevention and Promotion, (2) Curative Services, (3) Rehabilitation, and (4) Data Collection and Programme Development.

At present 22 State Mental Hospitals are directly under its authority and 5 Provincial Governmental Hospitals maintain active working relationship with the Directorate of Mental Health. Total bed capacity is 7.000. Out patient departments are attached to all mental hospitals. In some mental hospitals a day-care pro - gram has been initiated. Most of the State Mental Hospitals have a comprehensive mental health care service, i.e. preventive and promotive service (such as mental health education and crisis interventions), curative and rehabilitative services.

The mental health program is aimed at developing a community approach. The first step was stimulating inter-disciplinary approach and inter-sectoral collaboration towards integration of mental health concepts and programs into existing health and human services. In First and Second Five Year Development Plan (Pelita I, 1969-1974 and II, 1974-1979) the integration of mental health in general health service such as the Health Centres was instituted , Every Five Year Development Plan 100 Health Centres will provide service integrated with mental health. The Third Five Year Development Plan (Pelita III 1979-1984) will see to integration of mental health service in the general hospitals.

DEFINITION, CLASSIFICATION AND CAUSAL FACTORS IN MENTAL RETARDATION

The definition by American Association of Mental Deficiency and the World Health Organization is now generally accepted. Differentation is made between the following categories :

a. Subaverage intellectual functioning.
b. Origin of syndrome development period.
c. Impaired adaptive behaviour.

With further classification of IQ (Intelligence Quotient test adapted to Indonesia).

Borderline mental retardation	68 - 85
Mild mental retardation	52 - 67
Moderate mental retardation	36 - 51
Severe mental retardation	20 - 35
Profound mental retardation	below 20

Some causative factors are : genetics and hereditary factors, prenatal, perinatal and natal conditions, and environmental situation.

1. Genetics and hereditary factors

   a. In born errors of metabolism

      In 1970 laboratory test for phenylketonuria were done at the General Hospital Department of Psychiatry , out-patient clinic and newborn baby clinic of the Department of Paediatrics in Jakarta, but these preliminary efforts were suspended due to lack of funds. (6)

   b. Chromosomal anomalies.

      Anomaly caused by chromosomal aberration must be differentiated from hereditary diseases caused by mutation of genes.
      This chromosomal disturbance appears with inadequate materials of autosome or sex-chromosome as a failure of chromosomal duplication. Aberration could be linked to autosome or sex-chromosome, Mental Retardation generally is caused by more severe autosomal aberration. Most of them are Down syndrome, but it is very interesting to make further studies and research in this field to recognize other genetic diseases and in born error of metabolism.

2. Prenatal conditions.

   Prenatal care at rural village level is practically unknown so that no preventive measures exist for "high risk" (mental retardation) pregnancies. In some urbanized areas where Family Planning programs are active, some prevention is being done in the areas of infectious diseases, general nutrition during pregnancy and lactation, etc. It is generally accepted that mothers younger than 19 and older than 35 years are more likely to give birth to mentally retarded children. Closely spaced births also have been found to be correlated with reduced mental ability. Babies with intersibs-interval of less than 12 months score significantly on lower mental achievement tests when compared with children with longer sibling intervals (24 - 60 month).

It is suggested that excessive work during the last month of pregnancy can produce difficulties during the natal period. In the lower socio-economic group it is still a custom for girls to marry at a very young age, usually after their first menstruation. It also is still common to have many children with short intersibs.

It is also still rather common have many children with short intersibs. - intervals. Pregnant mothers also usually have to work hard until their last month of pregnancy. With the increasing activity of Family Planning programs, some relaxation in these problems can be expected.

3. Prenatal/natal conditions

Mental subnormality is significantly associated with complications of pregnancy and the perinatal period. However, although modern obstetrical techniques have contributed to a lower perinatal mortality rate, there is some evidence for a higher rate of subnormal children. (6)

4. Postnatal conditions

Brain injury, brain infection, febrile convulsions and malnutrition during infancy can be important causes of mental retardation. An investigation was carried out to determine the correlation between nutritive condition and I.Q. in school children. This investigation showed that children of the low socio-economic group relatively have lower I.Q. (6)

To promote their general health condition Kindergarten and elementary schools give weekly additional food and vitamins. Regular immunization (BCG, Chotypa, and formerly variola) is also given.

5. Environmental conditions

The difficult socio-economic situation is another contributing factor. The cost of basic living in Jakarta is about U.S.$50.00. Young graduates (medicine, education etc.) earn US$50.00. Obviously there is a great lack of good teachers, resulting on overcrowded classrooms, decreased individual attention for pupils, decline of teacher's authority, etc.

Other social factors which may have relevance to the problem are general poverty of the population, big families and lack of understanding of developmental stages. It is interesting to observe that 12.2% of young narcotic drug addicts admitted to the Dependence Unit, Fatmawati Hospital (now Drug Dependence Hospital) in Jakarta, were classified as mildly retarded (90% borderline and 10% mildly retarded).

It is also interesting to observe that failure of scholastic performance usually is used by the general public as an indication of mild mental retardation. For this segment of children another program is needed, different from the one for the severely retarded. A research project for mild mentally retarded children was done by the subdivision of Child Psychiatry, Department of Psychiatry, Faculty of Medicine, University of Indonesia. Its aims are :

1. to select familial mental retardation from the total number of school fai - lures.
2. to reduce the flow to the mentally retarded schools.
3. to design a program for intervention of predicted school failures.

MENTAL RETARDATION SERVICES IN INDONESIA

The goals of community care for the mentally retarded as determined by W.H.O. are :

1. to ensure early detection of affected child;
2. to provide effective treatment for associated medical conditions;
3. to provide clear, consistent and continuous advice and support for the families of such children;
4. to coordinate efforts with local education and social welfare services;
5. to ensure appropriated vocational training and provision of work for men - tally retarded individuals;
6. to protect and enhance the rights of mentally retarded individuals.

A W.H.O. Expert committee on Child Mental Health and Psychosocial Deve - lopment, which met in Geneva in November 1976, laid down three general principles for the provision of services :

1. make use of existing services that readily accessible to the community;
2. enhance cooperation between different workers responsible for services to the child;
3. involve families in treatment and seek to increase parental skills and confidence.

Mental retardation services in Indonesia covering activities of social work, education and medical care.

a. Services organized by Ministry of Social Affair Activities in the mental retardation services in Indonesia started in 1904 with the establishment of "Zwakzinnigenzorg Stichting" at Temanggung. This establishment has become the pilot project of rehabilitation of the mentally retarded (children until 16 years) of the Ministry of Social Affair. Another rehabilitation institution for the mentally retarded (age 16-45 years) is located in Sragen.

It is also organized by the Ministry of Social Affair. These two institutions provide training in farming, carpentry, sewing, wearing etc. They provide residential care facilities where the trainees can stay there until they have the skill and obtain the job.

The Ministry of Social Affair has a Sub Directorate for the Care of the Handicapped, which is responsible for the rehabilitation of the mentally retarded.

b. Education

On 30 May 1927, the first special school for the Mentally Retarded was established in Bandung. The school is managed by Vereniging voor Bintengewoon Lager Onderwijs. After the War of the Independence, this institution changed name to Perkumpulan Pengajaran Luar Biasa (PPLB, Federation of Special Education) At present, there are 81 Special Schools for the Mentally Retarded Children, of which two are run by the Government (Ministry of Education and Culture) and the others by private organizations, and which have a capacity of 3801 children. These private organizations were started by individuals who recognize the educational and training needs for the mentally retarded.

A number of medical and paramedical disciplines (paediatricians, psychiatrists, psychologists, dentists, social workers) are attached as consultants to such institutions mostly as volunteers. Educational service for the mentally retarded as a subsystem of national education services is under the authority of Ministry of Education and Culture, which has a Sub-Directorate for the Education of the Handicapped. This Sub-Directorate is responsible for :

- supervising the special schools for the mentally retarded (governmental as well as private schools),
- teachers training,
- upgrading of teachers, school principals, school administrators (governmental and private school personnel),
- curricula development,
- textbooks writing,
- cooperation with other department, e.g. the Ministry of Health, the Ministry of Social Affair, private organizations working in the same field.

It is the governments responsibility :

1. to make sure that the rules and the regulations of the government is followed,
2. to provide facilities, teachers and other needed facilities,
3. to conduct seminars and surveys,
4. to establish relation with other countries,
5. to train and develop the family and the community in general.

c. Medical care

Health and medical care services in Indonesia are available through :

- Mother and child Health facility
- School Health facility
- Health Centres
- General Hospitals
- Mental Hospitals and other mental health facilities.

provided by the Ministry of Health. There are also military health facilities and private medical care facilities. The medical aspect of mental retardation is the responsibility of the Ministry of Health.

After the diagnosis has been made, it is suggested that mentally retarded children or adults should go to a special school or shelthered workshop. Theoretically Indonesia has adopted a policy for compulsary education although in practise many youngsters do not go to school due to socio-economical reasons. Opportunity to obtain elementary education are not alway available. To obtain special education, mostly in big cities, many children have to remain on the waiting lists for long periods of time. Since most schools are private, it is obvious that the high private school fee-again an extra financial burden-proses a problem for many of these children and their families.

For mental retardation with behavioured or psychiatric disorders medication is given, while for mildly retardated with slow psychomotor behaviour, brain stimulant drugs are also given.

Psychosocial factors determine to a considerable extent the degree of disability that results from mental retardation. With a supportive family environmental and appropriate education many mentally retarded individuals are able to have productive and enjoyable lives.

PREVENTION

The prevention of mental retardation consists of :

a. Improve antenatal and natal care, early infant care which decrease the risks of brain damage associated with hypoxia and birth injury.
b. The control of infectious diseases,
c. Adequate nutrition in early childhood, which is the period of rapid brain development;

combined with Health Education of parents are seen as the most effective preventive measures. All efforts concerning these must be carried out.

LEGISLATION

In Indonesia although no specification is given concerning the mentally retarded, they are considered as mental disordered patient. The commitment into a Mental Hospital of the mentally retarded should be accompanied by an introductory letter from a psychiatrist as stipulated in the Law on Mental Health, 1966.

The legal proxy for the mentally retarded in the Indonesian Civil Law is only mentioned in a general way, without clear specification. Criminal code is more specific but also more complicated ~~became~~ because this touches on the rights of the patient and ~~community~~ peace of the community.

Another important issue is their mental competence in case of a criminal offense. Psychiatric medical certification is often sought for in these proceedings.

FUTURE PLAN

Future plans are associated with activities of education, social work, medical and international cooperation.

1. Education

Interest in the problem of mental retardation should be developed (lectures, seminars, leaflets, booklets, publications etc.). In general training curricula for medical and paramedical personnel as well as educators should include mental retardation as a specific subject. ~~Closes~~ Classes with special educational programs for the mildly retarded children should be provided in normal elementary schools.

For improving the special schools for mentally retarded, the Ministry of Education and Culture in the Third Five Year Plan Development (Pelita III) has the following activities :

a. to establish ~~one Founder~~ Special Schools with promotive function (Sekolah Luar Biasa Pembina) for the mentally retarded at the National level and provincial level, which serve :
   - as model of special school arrangement
   - as training centre for teachers and promoters
   - as national and international informative and cooperative centre
   - as community services centre in special education.

b. to provide more fund in financing the following activities :
   - curricula development
   - providing the Guide Books for the teachers and pupils
   - providing equipments and other educational facilities
   - standardization of the quality of founders and principals through training courses
   - providing literatures
   - establishing or rehabilitating governmental and private special schools.

c. the policy.

2. Social Work

More facilities for rehabilitation institutions, sheltered workshop should be provided with the aid of the government and foreign agencies.

Shortage in vocational centers, sheltered workshop, placement agencies may cause stagnations of mentally retarded children in institutions and special schools. The Ministry of Health, the Ministry of Education and Culture, and Ministry of Social Affair should play a more active role. Nutritive condition of pregnant mothers and infants of the low socio-economic class should be improved. Family Planning programs should take a more active part in preventing rapid succession of pregnancies and young marriages.

3. Medical

In order not to confuse mental retardation with psychosis, deafness, aphasia and other neurological conditions, the procedures of clinical diagnosis should be improved. Specific learning disability must be separated from mental retardation. Emotional problems that usually accompany mental retardation should not be overlooked. Improvement of collaboration with public health agencies in case finding, patient management and parents counseling. In treatment the concept of team approach should be actively employed.

S U M M A R Y

The situation of mental retardation in Indonesia was described. Also mentioned are someresearch projects, approaches and treatment which were done, and at the present time carried out. Future plans was described. The main problem in Indonesia in helping the mentally retarded ~~his~~ lies in the lack of manpower facilities on the other The situation is serious, but with the assistance and advices of others working in the same field, there is still some hope that the situation will gradually improved.

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ACKNOWLEDGEMENT

I would like to express my deep gratitude to Prof.Dr.R. Kusumanto Setyonegoro, Director of Mental Health, Ministry of Health and Dr.S.O.Gardjito, Head, Sub-Directorate of Rehabilitation, Directorate of Mental Health, who have provided me with valuable informative material for the preparation of this report.

I also wish to thank Dr.W.M.Roan, Head, Sub-Directorate of Prevention and Promotion, Dr. Han Kandouw, Head, Sub-Directorate for Curative Services, the Staff members of The Directorate of Mental Health and others, who assisted me in writing this report.

The same goes to Dr.Rudy Salan, Head, Sub-Directorate of Programme Development, Directorate of Mental Health, who spent innumerable hours to proofread this report.
