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Original Article

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Arrangements of Involuntary Treatment for People with Mental Disorders in Indonesia

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Abstract
Mental disorders are health conditions where individuals experience changes in thinking patterns, emotions, or behavior, or a combination of these changes. During relapses, it is not uncommon for individuals with mental disorders to refuse treatment or therapy prescribed by doctors. Involuntary treatment for individuals with mental disorders (ODGJ) sometimes becomes an unavoidable option if there is a risk of harm to themselves or others. This research is a normative legal study aimed at examining the implementation of involuntary treatment for ODGJ in Indonesia and several other countries, using a legislative and comparative approach. The Indonesian Health Law (2023) does not specifically regulate involuntary treatment but implicitly addresses it in Article 80, paragraphs (1) to (5). There are vague norms regarding the criteria for involuntary treatment, its duration, and the patient's right to review the treatment they receive. In some countries, there are clear criteria regarding the conditions for involuntary treatment, family obligations, and its duration. In the derivative regulations, it is recommended to include the necessary additional criteria to create legal certainty and protection for medical personnel, as well as for patients and their families.

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Introduction

Mental health as a human right is crucial for an individual's well-being and ability to function and develop. It is influenced by factors at the individual, family, community, and government levels. Adverse conditions like poverty, violence, and inequality increase the risk of mental health disorders, often leading to chronic stress and trauma. Conversely, protective factors such as strong social skills, access to education, stable employment, and community support can enhance resilience against mental health issues. Multisectoral interventions are essential, as those with mental health problems often need support beyond clinical care (Osborn et al., 2022). Thus, a holistic and collaborative approach is essential in efforts to improve mental health and protect the human right to mental health.

In recent years, the importance of mental health in achieving global development goals has been recognized, as reflected in the UN's Sustainable Development Goals, specifically goal 3.4. Depression, a leading cause of disability, significantly affects individual productivity and societal well-being. The high suicide rate, the fourth leading cause of death among 15 to 29-year-olds, underscores the urgency of addressing mental health in youth. WHO data indicates that people with serious mental health conditions

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often die two decades earlier due to preventable physical conditions (WHO, n.d.). This demonstrates a shortage of attention to the physical health of people with mental disorders, who are often overlooked in the health care system. Furthermore, the COVID-19 pandemic has caused a worldwide mental health crisis, leading to both immediate and long-term stress and adversely affecting the mental well-being of millions of individuals. (Osborn et al., 2022). Collaborative efforts from multiple sectors are needed to guarantee that people with mental disorders get the care they need, not only for their mental health but also for their physical health.

Mental disorders are complex health conditions in which individuals experience changes in thought patterns, emotions, or behaviour, or a combination of the three. This condition is often related to distress or difficulty in social functioning, work, or family relationships. As stated by the WHO, mental disorders are typically identified by a combination of unusual thought patterns, emotions, behaviors, and disruptions in relationships with others. (WHO, 2022). Understanding mental disorders as a spectrum with diverse manifestations is crucial for effective care and treatment. While some individuals may experience mild and temporary conditions, others may face severe and chronic disorders. These conditions impact not only the individuals but also their families and communities. Support from family, friends, and the community plays a vital role in the recovery process.

In 2019, 1 in 8 people globally, or 970 million individuals, had a mental disorder, with anxiety and depression being the most common. The COVID-19 pandemic in 2020 caused a significant rise in these conditions, with major anxiety disorders increasing by 26% and major depressive disorder by 28%. Despite effective prevention and treatment options, most people with mental disorders lack proper care, and stigma, discrimination, and human rights violations are widespread (WHO, 2022). The 2018 Basic Health Research (Riskesdas) showed a significant increase in the prevalence of schizophrenia in Indonesia, rising from 0.3 - 1 per 1,000 people in 2013 to 6.2 - 7.1 per 1,000 in 2018. In Bali, the prevalence surged from 2.3 per 1,000 in 2013 to 11.1 per 1,000 in 2018, the highest in the country. Although 84.9% of individuals with schizophrenia or psychosis receive treatment, 51.1% do not take their medication regularly. Some reasons for not taking medication regularly include feeling healthy (36.1%), not having regular medication (33.7%), not being able to afford medication regularly (23.6%), not being able to tolerate the side effects of medication (7%), often forget to take medication (6.1%), feel the dose is not appropriate (6.1%) and medication is not available (2.4%) (Kemenkes RI, 2018). This situation highlights the need for a more comprehensive approach to treating schizophrenia, which focuses not only on initial diagnosis and treatment but also on continuity of treatment and patient support.

Most studies state that non-compliance with taking medication for schizophrenia causes a fairly high recurrence of the disorder. Treatment nonadherence was assessed as a major predictor of recurrence. Various studies state that the causes of relapse/exacerbation in schizophrenia sufferers are many factors, including: substance abuse, treatment non-compliance, treatment adverse effects, living alone, lack of social support, low religiosity, age at illness onset, living circumstances, family history, socioeconomic class, work status, educational background, and length of illness. Relapses that occur more frequently can hinder the recovery of people with mental disorders (Pasaribu, 2019). Each episode of relapse not only worsens symptoms but also reduces the individual's ability to function normally in daily life. In addition, repeated recurrences can result in decreased quality of life and prolong the duration of recovery.

Involuntary medication is administered in 8.2% of psychiatric inpatient admissions, primarily for patients with schizophrenia, those under involuntary legal status, and those with a history of prior commitments. (Kaltiala-Heino et al., 2003). Involuntary treatment for psychiatric patients with medical illnesses can be ethically challenging, as patients may refuse life-saving treatment but the treatment itself carries significant risk (Irvin, 2003). People with mental disorders with poor insight into their condition create challenges and the burden on caregivers becomes increasingly higher. Often caregivers look for various methods, including mixing medication in food and drink so that treatment can proceed according to doctor's recommendations. People with serious mental disorders are also often neglected and disrupt general stability. Bali as a tourism area also experiences these problems. In fact, not only Indonesian Citizens, Foreign Citizens also often disrupt public stability. People with mental disorders who are dumped on the streets may have received insufficient care or perhaps no care at all.

Based on Article 80 of Law Number 17 of 2023 about Health (hereinafter referred to as the Indonesian Health Law 2023) regulates the treatment of people with mental disorders. The people with mental disorders in question must give their written consent before they can be admitted to a hospital. An exception to this rule applies in cases where the person with mental illness is judged incapable of giving consent. In these cases, consent for inpatient treatment may be granted by a spouse or partner, parent, child or sibling who is at least 18 years old, guardian or caregiver, or authorized official in line with the relevant laws. Medical therapy can be administered without authorization to individuals with mental disorders who are in an emergency situation but do not belong to the aforementioned group. People with mental disorders in an emergency situation that indicates thoughts and/or behaviour that endangers himself, other people or his surroundings, authorized health workers can carry out medical action or administer psychopharmaceutical drugs according to Mental Health service standards aimed at controlling dangerous behaviour.

Involuntary treatment for people with mental disorders intersects with human rights, which emphasize autonomy and equality. Individuals have the right to consent to or refuse medical treatment, including for mental disorders. Having a mental disorder does not automatically make a person incompetent to make treatment decisions. Assuming incompetence without strong evidence is discriminatory. While many states view harm as evidence for intervention, danger alone does not prove incompetence (Pasaribu, 2019). This approach can lead to violations of individual rights if not carried out carefully and based on accurate assessments.

In cases of relapse, it is common for patients with mental disorders to refuse treatment or take medication given by a doctor. Involuntary treatment for people with mental disorders is sometimes an option that cannot be avoided. This can happen when you are initially admitted to hospital in a condition where you are unable to take responsibility for yourself. Involuntary admission will be followed by involuntary medication and medical procedures. Involuntary treatment warranted in most cases can be exemplified by the cases of suicidal and psychotic patients who were unaware that they needed treatment. There are those who argue that involuntary treatment curbs individual freedom or limits individuals from determining their own rights. Based on the above, the author is very interested in knowing the involuntary treatment for people with mental disorders in Indonesia and other countries as well as the model of involuntary treatment arrangements that can be implemented well in Indonesia.

Method

The type of research method used is the normative legal research method. Normative legal research is legal research that places law as a building with a system of norms. Researchers collect and analyze legal norms related to the research topic. The statute approach, which examines statutory regulations pertaining to the research topic, was employed in this study. This study also employs a comparative approach by examining various laws pertaining to involuntary treatment in other nations. This is helpful in determining the history of the emergence of specific legal provisions for the same issue in two or more nations. This information may be applied as a guide when creating or amending laws. (Tan, 2021).

Before carrying out processing and analysis, the author collected legal materials, which were then used using a qualitative descriptive method. The results of literature reviews and analyses of the laws governing involuntary treatment were summarized and described in order to analyze the legal materials. These results are then discussed and presented qualitatively in an in-depth and systematic description of legal arguments as a scientific paper.

Discussion

International Legal Instruments on Mental Health

Mental health is an international issue faced by the international community for a long time and is part of human rights. The Universal Declaration of Human Rights (UDHR), Article 25, paragraph (1), contains the following information: "Everyone has the right to a standard of living adequate for the health and welfare of himself and his family, including food, clothing, housing and medical care and

social services. which is important, and the right to security when unemployed, sick, disabled, widowed, elderly and other disadvantages..." The Universal Declaration of Human Rights (UDHR) serves as the foundation for numerous international legal agreements pertaining to human rights and has been acknowledged as customary international law.

The obligation of the state to ensure that its citizens have access to appropriate health services is articulated in Article 12 of the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR). This article affirms the right of everyone to enjoy the highest attainable standard of physical and mental health. To achieve the full realization of this right, states are required to take steps including the reduction of stillbirth rates and infant mortality, the promotion of healthy child development, and the improvement of all aspects of environmental and industrial hygiene. Additionally, states must focus on the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases. Furthermore, the creation of conditions that ensure access to medical services and attention in the event of sickness is essential. These measures collectively underscore the comprehensive responsibility of states to promote and protect the health of their populations. The country must ensure that the available health system is able to reach all levels of society, especially vulnerable and marginalized groups.

The state's obligation to ensure the right to health for its citizens is elaborated in General Comment No. 14 (2000) on the right to the highest attainable standard of health, as detailed in Article 12 of the International Covenant on Economic, Social and Cultural Rights by the Committee on Economic, Social and Cultural Rights. Paragraph 33 of General Comment No. 14 identifies three types of state obligations: to respect, protect, and fulfill the right to health. Respecting this right means that states must not interfere with individuals' health rights. Protecting this right requires states to prevent third parties from infringing upon the protections established in Article 12. Fulfilling this right involves the duty to enable, provide, and promote conditions for health. This includes adopting suitable legislative, administrative, budgetary, judicial, and other measures to fully realize the right to health.

The United Nations (UN) published the Agenda for Sustainable Development (SDGs), an international development concept that is valid from 2015 to 2030 and aims to promote changes in sustainable development based on human rights. One of the agendas for sustainable development is mental and physical health. The promotion of equality and human rights (HAM) can foster social, economic, and environmental progress. No one will be left behind, or "no one left behind," thanks to the universal, integrated, and inclusive principles that guide the implementation of the SDGs. Target 3.4, which focuses on both promoting mental health and well-being and reducing the number of early deaths from non-communicable diseases by one-third via prevention and treatment, is one of the two (two) SDGs targets pertaining to mental health. Target 3.5 aims to enhance the prevention and treatment of substance abuse, encompassing narcotics abuse and the harmful consumption of alcohol (Kementerian PPN/Bappenas, 2020).

Mental Health Regulations in Indonesia

The development of mental health law in Indonesia began during the Dutch East Indies era. On December 30, 1865, Koninlijk Besluit (Royal Decree) was issued and on May 14, 1867, the Governor General's Decree was issued for the construction of mental hospitals in Indonesia. In 1966 Indonesia became one of the few countries in the world that had a law regarding mental health, namely: Law No. 3 of 1966 concerning Mental Health which was later changed to Law no. 23 of 1992 concerning Health (hereinafter referred to as the 1992 Health Law). In the 1992 Health Law there are 4 articles that regulate mental health. The 1992 Health Law was amended by Law No. 26 of 2009 concerning Health which contains 8 articles concerning mental health (Setiawan, 2009).

In further developments, the Indonesian Government issued Law no. 18 of 2014 about Mental Health (hereinafter referred to as the 2014 Mental Health Law) which specifically regulates mental health, so the regulations are separate from the Health Law. This law outlines important matters in the mental health sector, especially regarding the rights of ODGJ, obligations of the government and society, mental health service facilities and the mental health budget (Idaiani & Riyadi, 2018). Currently the 2014 Mental Health Law is no longer valid with the issuance of Law No. 17 of 2023 about Health (2023 Health Law). Apart from that, in Indonesia there are several laws that are related to mental health, such as Law no. 11 of 2009 about Social Welfare, Law no. 8 of 2016 concerning Persons with Disabilities,

Law no. 8 of 1999 concerning Consumer Protection, Law no. 39 of 1999 concerning Human Rights (Setiawan, 2009).

According to Article 80 of the Health Law (2023), the people with mental disorders in question must give written consent for their inpatient treatment. Nonetheless, consent may be granted by the spouse, parents, children or siblings who are at least 17 (seventeen) years old, a guardian or guardians; or an authorized official in compliance with the requirements of statutory regulations in the event that the person with mental disorders is judged incapable of making decisions. A specialized psychiatrist or other physician providing medical services at that time makes the decision on whether or not a person with a mental illness is capable of making decisions, including approving medical treatment. Mental disorders are a unique condition because they are often not realized and the person experiencing them feels fine. Forced treatment often gives rise to the patient's desire to sue their family or health workers. This is why forced treatment also has legal risks for health workers. Forced treatment actually has good intentions, especially for the patient himself. If you suspect you have a mental disorder, the important thing to do is provide therapy.

Involuntary Treatment Regulations in Several Countries

This section will discuss the criteria for forced treatment and procedures in several countries. Involuntary treatment can disrupt the therapeutic relationship and alter the quality of doctor patient communication. On one hand, involuntary treatment can be viewed as abusive in the context of medical care. On the other hand, it can be seen as a safeguard for the patient's rights, including their freedom and their right to be heard in the review and appeal process of involuntary treatment decisions.

In Singapore, government general hospitals, the Institute of Mental Health (IMH), state psychiatric hospitals, outpatient polyclinics and private psychiatric services all provide mental health care. IMH is the only psychiatric hospital that offers involuntary hospitalization as there are no beds for mental patients in public hospitals (Ho et al., 2015). Section 10 of Singapore's Mental Health (Care and Treatment) Act 2008 outlines three stages of involuntary treatment for individuals with mental disorders. The first stage permits up to 72 hours of involuntary treatment if the patient poses a risk to themselves or others. The second stage allows for an extension of up to one month, following an examination by designated medical personnel. The third stage permits up to six months of involuntary treatment if two medical personnel determine that the patient continues to pose a risk. Doctors in Singapore assess a person's capacity by evaluating two factors: the presence of an impairment and whether it hinders decision-making ability. The assessment follows guiding principles similar to those in the UK. (Ho et al., 2015). Article 2 of the UK Mental Capacity Act 2005 defines a person as lacking mental capacity if there is a permanent or temporary impairment of mind or brain functions, not based on age, appearance, or behaviour. Capacity questions are decided on the balance of probabilities in legal proceedings.

In China, inpatient treatment for mental disorders is typically voluntary. However, Article 30 of the Mental Health Law of the People's Republic of China (2012) specifies that while inpatient treatment should generally be voluntary, there is an exception for individuals with severe mental disorders. (Chen et al., 2012). This exception allows for inpatient treatment if an individual poses a risk to themselves or others due to an unstable mental state, but only with the guardian's consent. Without consent, the guardian must ensure home care. Disagreements on the diagnosis or need for treatment can lead to a reassessment by two independent psychiatrists within three days, and if needed, a legally binding independent medical examination by a qualified evaluator (Zhang et al., 2015). The Mental Health Law of the People's Republic of China (2012) emphasizes voluntary inpatient treatment for mental disorders but permits involuntary treatment in cases where there is a risk of self-harm or harm to others. This approach balances patient autonomy with the need to protect both the individual and public safety in situations involving severe mental disorders.

Japan has implemented two approaches to manage offenders with mental disorders. The first approach is an administrative involuntary hospitalization scheme, initially established in 1950 and subsequently integrated into the Mental Health and Welfare Act (latest version 2013). Under this scheme, cases of mental disorders are reported to the prefectural governor, who can mandate hospitalization based on a psychiatrist's evaluation. The second approach is the Medical Treatment and Supervision Act (2003), which involves a court panel determining whether an individual is in a state of

insanity or diminished responsibility. This scheme includes confronting the offense and preventing recidivism, with many patients discharged without reoffending (Shiina et al., 2019). In Japan, involuntary hospitalization includes two types: compulsory admittance by two doctors for patients with a mental illness posing a risk, and compulsory admission with consent from a responsible person after a physician's examination. The initial treatment term is four weeks, with no set limit for continuation. A psychiatric review committee monitors these decisions and reviews discharge petitions (Saya et al., 2019).

In South Korea, The Mental Health and Wellness Promotion Act, implemented on May 30, 2017, introduced several revisions to address involuntary hospitalization issues, aiming to reduce unnecessary admissions and safeguard patients' rights to self-determination and well-being during treatment. The Act categorizes psychiatric hospitalization into five types: voluntary hospitalization, hospitalization with consent, forced hospitalization by legal guardians, forced hospitalization by administrative officials (Mayor, Governor, or Head of District), and emergency hospitalization. The patient and one legal guardian may consent to hospitalization under a new category called approved inpatient care. The statute also increased the length of time that might be spent in an involuntary hospitalization. Previously, a hospitalization could last up to six months, but now, two psychiatrists from separate institutions would need to diagnose a patient for a three-month stay (Go et al., 2020). This approach aims to better balance patient autonomy with necessary medical intervention.

In Taiwan, the Mental Health Act of 2007 legally defines the criteria for involuntary treatment as being applicable to patients in a psychotic state who are unable to adhere to treatment and pose a danger to themselves or others. Psychiatrists in Taiwan are responsible for initiating emergency placements and implementing involuntary hospitalization within two days, while regional commitment committees, composed of multidisciplinary professionals, must approve these hospitalizations within three days. Family members play a significant role in the decision to admit psychiatric patients, and Taiwanese psychiatrists expect their involvement in inpatient care decisions. The rate of involuntary hospitalizations in Taiwan is low (7.3 per 100,000) because patients, despite initially refusing hospitalization, are often persuaded by their families to consent (Wang et al., 2015). This approach underscores the importance of family support in mental health treatment in Taiwan, balancing the need for medical intervention with respect for patient autonomy and familial influence.

In Malaysia, the Ministry of Health introduced the Mental Health Act 2001, along with the Mental Health Regulations 2010, marking a significant turning point in mental health care by providing comprehensive policy guidelines for service delivery. This legislation consolidates laws related to mental disorders and establishes regulations for the admission, detention, accommodation, care, treatment, rehabilitation, control, and protection of individuals with mental disorders. (Ikkos, 2016). A relative can file a form with the Medical Director to admit someone suspected of having a mental illness to a mental institution, with a medical recommendation based on a recent examination. This recommendation must state the need for treatment or detention for safety reasons. The Medical Director must then conduct an examination within 24 hours to decide on continued detention. If needed, an initial detention order of up to one month can be issued, with a further examination by two medical officers required before extending detention for up to three months.

Long-term mental health problems often require repeated hospital admissions and discharges. Countries such as the UK, Australia, Canada, Israel and New Zealand are reforming their services to ensure people can manage their health close to home. Involuntary community treatment (CCT) for people with severe mental health problems is an alternative to involuntary hospitalization, aiming to keep patients at home but requiring adherence to a treatment schedule. If they fail, patients can be returned to involuntary hospitalization (Kennedy, 2019). CCT offers a more humane alternative, but can be counterproductive by keeping patients away from professional medical services.

Vague Norms of Involuntary Treatment in the 2023 Health Law

Involuntary treatment is one of the most controversial topics in modern psychiatry and is a legacy of institutional history, but but it remains difficult to assess its benefits. Even though the majority of persons with mental illnesses are not coerced into receiving treatment, involuntary treatment is a widespread occurrence in mental health care and merits consideration in health ethics (Sugiura et al., 2020). The idea that health care is voluntary and dependent on agreement is almost exclusively violated

by the widespread practice of involuntary treatment. The moral complexity of using coercive measures lies in balancing patient autonomy with the need to provide effective healthcare. Coercive measures are only morally acceptable if their benefits outweigh their negative impact on patient autonomy and integrity (Laureano et al., 2024). Generally intended to assist the patient, can also serve to protect others or, in some instances, be excessively applied by health professionals, making them morally complex. According to the 2015 "Resource Book on Mental Health, Human Rights, and Legislation," principle 16 states that coercive treatment may be warranted for individuals with serious mental disorders and impaired judgment, as failing to intervene could lead to significant deterioration of their condition or hinder the provision of necessary treatment only available through admission to a mental health facility (WHO, 2005). This shows the moral complexity in the implementation of forced treatment.

However, currently there is a shift in perspective regarding involuntary treatment, in the book "*Mental health, human rights and legislation: guidance and practice*" in 2023 where in Box 2 it is stated that coercion is opposed legally, ethically and from a clinical point of view. Coercive methods in mental health care are contravene international human rights law, particularly the 2006 Convention on the Rights of Persons with Disabilities (CRPD), according to human rights experts. Such practices undermine the right to equal recognition before the law and legal protection by denying individuals their legal capacity. Coercion infringes upon a person's fundamental rights to freedom and security. It also violates the right to informed consent and, more broadly, the right to health. Coercion can result in serious consequences to an individual, including extreme pain and suffering, long-term effects on their physically and emotional well-being that can impede healing, serious trauma, and even death (WHO, 2023). We can work to create a more humane, ethical, and effective mental health care environment that respects and protects the human rights of all individuals.

Complex and challenging cases, often referred to as "hard cases", cannot be used as a basis for general rules in psychiatry. Extreme situations like aggressive behaviour, psychosis, or suicide attempts are the main focus of discussions on coercion in mental health care. This framing often fails to acknowledge that these cases are the result of a failed mental health system that is unable to adequately respond to trauma and crisis (WHO, 2023). In medical emergencies, like suicide attempts, immediate life -saving actions are taken without considering the patient's wishes if they cannot communicate. Individuals with mental disorders who pose a risk to others may receive involuntary treatment in mental health facilities, with law enforcement involvement and possible forced medication. For those with psychosis, whose decision-making capacity is often questioned, a judge, physician, or family member may act as a surrogate decision-maker. If the patient disagrees, physical or chemical restraints may be used. People with unusual beliefs are often stigmatized and seen as a risk, leading to the need for mental health treatment.

The criteria for implementing involuntary treatment in each country are different, but most require the existence of a severe mental disorders and the requirement that treatment be limited to safeguarding the patient's welfare or safety or the protection of others. The basic requirement in all countries is that the patient has a mental disorder, although the type and severity of mental disorder that qualifies a person for involuntary treatment varies in each country. There are countries that allow involuntary treatment only for "serious mental disorders"; others define specific mental disorders, such as "psychotic disorders" and other countries use broader definitions of mental disorders. In Indonesia, based on the Health Law (2023), it does not clearly discuss involuntary treatment, but implicitly states that there is a mental disorder accompanied by incompetence or an emergency situation. There is no mention of a diagnosis of a specific mental disorder or mention of the severity of the mental disorder. This needs to be clarified in the implementing regulations regarding the type of mental disorder that is considered a crisis that requires involuntary treatment. The next condition is that there is an imminent risk of danger. One of the main requirements of mental health regulations is the prevention of injury to oneself or others. The most prevalent extra criterion is the "dangerousness criterion," which refers to a genuine threat or risk to oneself or others. In many legislations, this criterion is the only one that permits involuntary treatment. According to the Elucidation to Article 80 paragraph (3) of the Health Law (2023), in an emergency situation, people with mental disorder can be given medical treatment without approval. Medical action aimed at dealing with emergencies, among other things, is carried out on people with mental disorders who show thoughts and/or behaviour that can endanger themselves, other people, and/or their surroundings. These criteria are clear enough, but it could also be added that there is a poor

view of the disorder they are experiencing.

Article 80 paragraph (4) of the Health Law (2023) explains that determining the abilities of people with mental disorders is carried out by a specialist in mental medicine or a doctor providing medical services at that time. The medical personnel who determine whether or not involuntary treatment is necessary varies in each country. In some countries, it is recommended that the individual be evaluated by two independent psychiatrists. However, this would be less than ideal and would take a lot of time if done in a country that has few psychiatrists. On the other hand, there are countries that form crisis teams consisting of various trained professionals such as psychologists and social workers who can recommend involuntary treatment. The book "The Resource Book on Mental Health, Human Rights and Legislation (2015)" recommends that 2 (two) independent medical practitioners who examine patients carry out separate and independent assessments (WHO, 2005). This idea is really significant. That being said, this is frequently not feasible or deemed impracticable in low-income nations with a shortage of psychiatrists and other medical specialists, and in certain developed nations as well. In these cases, reasonably organized alternatives may be available. Article 80 paragraph (5) of the Health Law (2023) states that people with mental disorders who have been cured have the right to determine the medical treatment they will take. This article does not specify the duration of treatment or the time intervals for re-assessment. It only addresses the right to determine medical actions after being assessed as cured. These regulatory gaps can lead to varying interpretations and inconsistent practices, which can ultimately affect the quality and continuity of care.

Conclusion

Involuntary treatment is a complex issue that balances the individual's right to autonomy and the right to consent to treatment with the obligation to protect individuals who experience serious mental disorders who are at risk of causing harm to themselves or others. WHO advises against compulsion, emphasizing ethical, legal, and clinical objections. However, there are some exceptions to this rule, such as in situations where there is a crisis associated with an attempted suicide, aggressive or violent behavior, or psychosis. The Indonesian Health Law (2023) does not specifically regulate involuntary treatment but is implicitly stated in Article 80 paragraphs (1) to (5). There is a vague norms regarding the criteria for involuntary treatment, the time period and legal protection for people with mental disorders and health workers, so it is hoped that in the derivative legislation, the additional criteria that are needed will be clarified in order to create legal certainty and protection for medical and health workers as well as for patients and the patient's family.

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