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Role of Family and Community Support in the Eliminating Restraint of Persons with Mental Illness

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Abstract

This study aims to identify and analyze the potential and challenges in dealing with cases of shackles for persons with mental disabilities through family support for PDM who has been deprived of shackles, or restraint, or who have been released from shackles, and the community support for families and PDMs who experience shackles, re-sharing, or those who have been released from shackles. This study used the descriptive qualitative research method. Data collection techniques are interviewing focus group discussions and observation. The result of this study found that the average support for families with mental disabilities in *pasung* is still low but in general, it is in the moderate category. To improve and restore PDM recovery, it is necessary to have the attitude and support of families who are directly involved in handling it, avoiding hostile actions, providing support, warmth, and giving a little criticism. The family has a strategic function in reducing the recurrence rate, increasing independence, living standards, and adaptability to return to society and social life. Family support is an important factor in preventing shackles and re-incarceration.

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1 Introduction

The progress of human civilization that brings with it social changes has an impact on the condition of human health. At the same time, the dynamics of socio-economic changes can have an impact on increasing trends in health disorders, especially depression and anxiety (WHO Atlas, 2005). Mental health is still a significant health problem in the world, including in Indonesia. According to WHO data (2016), there are about 35 million people affected by depression, 60 million affected by bipolar disorder, 21 million affected by schizophrenia, and 47.5 million affected by dementia (Hwang et al., 2010; Walker et al., 2010). In Indonesia, with various biological, psychological, and social factors with population diversity, the number of mental disorders continues to increase which has an impact on increasing the burden on the state and decreasing human productivity in the long term. Moreover, considering the total population of Indonesia according to BPS (2015), there are as many as 257.6 million people, with a productive population of 180.3 million (70%). Previous data from Riskesdas in 2013 stated that the prevalence of the Indonesian population with mental disorders was 400,000 people or 1.7 per 1000 population.

The shackles of people with mental disorders are public actions against people with mental disorders by being locked up, chained, put in wooden blocks, imprisoned in a room for an indefinite period, and so on so that their freedom is lost. *Pasung* is a form of treatment that robs them of their freedom and opportunity to receive adequate care and respect as human beings. In line with what was stated by Broch (2001) in Minas & Diatri (2008), the word *pasung* refers to the restraint or confinement of criminals, people with mental disorders, and people who commit violent acts that are considered dangerous. Physical restraint on individuals with mental disorders has a long and heartbreaking history. Sanctuary is a gross violation of human rights (Psacharopoulos, 1994; Wu et al., 2013). The assessment is heavy because it is carried out on people who have severe mental disabilities so that they are powerless to help themselves and unable to access existing services (Cooper & Vetere, 2008). The term shackling is a form of restraint on freedom carried out by PDM in the community which results in deprivation of freedom to access services that can help restore the PDM's function. Detention is mostly done to PDM with violent behavior in society which in the end robs PDM of human rights as human beings (Minas & Diatri, 2008).

People with mental disorders (ODGJ) were later replaced with the term Persons with Mental Disabilities (PDM) because according to the Law on Persons with Disabilities number 8 of 2016 is the official term for people with mental disorders. PDM is a person who experiences disorders of thought, emotion, and behavior which include: 1) psychosocial including schizophrenia, bipolar, depression, anxiety, and personality disorders; and 2) developmental disabilities that affect social interaction skills such as autism and hyperactivity (Kemensos, 2016). In Indonesia, PDM, especially people with severe mental disorders, schizophrenia, have not fully received good treatment and fulfilled human rights (Irmansyah et al., 2009). The act of depriving PDM is an act that is prohibited and is punishable by a criminal offense. Law No. 18 of 2014 concerning mental health, article 86 states "Everyone who intentionally carries out shackles, neglect, violence and or orders others to carry out shackles, neglect and or violence against PDM or other actions that violate the PDM law will be punished according to the laws and regulations. Responding to the phenomenon of shackling in society which is increasing in cases, the Minister of Social Affairs at the January 2016 National Coordination Meeting decided to launch the 2017 Stop Deprivation Movement (GSP) which was later revised to become the 2019 GSP one of the implementations of Presidential Regulation Number 75 of 2015 concerning the National Action Plan for Human Rights and Presidential Instruction Number 10 of 2015 concerning Human Rights 2015. The Stop Deprivation Movement is an effort to respond to the high number of shackles for people with mental disabilities (Campbell, 2020; Chan et al., 2020). People with mental disabilities, especially those who experience shackles, can still be rehabilitated or restored—recovering in the sense of being independent, accepting self-identity, being able to control oneself, lowering the potential for

relapse, and being happier (Yildiz, 2015). Often PDM is described as an individual who is stupid, strange, and dangerous (Irmansyah, 2006). Generally, they are not taken to a doctor (psychiatrist), they are hidden. If they are going to be taken for treatment, they are not taken to a doctor but are taken to alternative medicine or "smart people" (Hawari, 2007). To eliminate the stigma in families and society toward this mental disorder, various efforts need to be made considering that this disease is still not popular among the general public and until now the appropriate therapy has not been found to cure it (Irmansyah, 2006; Hawari, 2007).

Barrowclough & Tarrier (1990) found that people with mental disabilities after treatment in mental hospitals who lived with unsupportive families showed low recovery rates. To improve and restore PDM recovery, it is necessary to have the attitude and support of families who are directly involved in handling it, avoiding hostile actions, providing support, warmth, and giving a little criticism (Hearn, 2010). The results of the above study indicate that one of the factors that can improve the functioning of PDM is family support. According to Satiadarma & Francis (2004), family support is assistance/support received by one family member from other family members to carry out life functions. The success of hospital care will be in vain if it is not supported by the participation and support of the family. Research conducted by Jenkins & Deuze (2008), shows that family caregivers are a very potential source to support PDM recovery. Nurdiana et al. (2007), in their research stated that the family plays an important role in the recovery of PDM. The results of this study are confirmed by another study conducted by Dinosetro (2008), which states that the family has a strategic function in reducing recurrence rates, increasing independence, living standards, and adaptability back to society and social life.

Based on data from the BPS in 2016, cases of shackles reached 58,000 people and only 7900 cases could be handled. The rest is still homework for the government and the community. It is recognized that *pasung* is a complex health issue, so it is not easy to determine concrete steps to establish policies and achieve policy objectives. In addition, *pasung* seems to affect those who suffer from severe mental disorders (psychotic), this disorder is found in sufficient quantity because it is easy to identify, although it is believed that there are still many cases of pasung that have not been recorded because of the attitude of the people who prefer to hide their children or take their children for treatment to “smart people” (Hawari, 2007). In addition, pasung is the last alternative because the family has tried various ways to heal their child, but to no avail. As a result, pasung is chosen so that the person concerned does not become a threat to both himself and his environment. *Pasung* can be seen as a community response to mental health conditions that drastically reduce the quality of life for sufferers and their families (Tyas, 2008). The practice of shackles contains various dimensions, including health, social, economic, and cultural dimensions. Therefore, the active role of various parties is very important (Hook, 2008). Based on the description above, the formulation of the problem is as follows; how is family support for Mental Disability Patients, and how does the community support Mental Disability Patients and their family (Oono et al., 2013). This study aims to identify and analyze the potential and challenges in dealing with cases of shackles for persons with mental disabilities through:

- Family support for PDM who has been deprived of shackles, *re-pasung*, or who has been released from shackles.
- Community support for families and PDMs who experience shackles, re-sharing, or those who have been released from shackles.

The benefits of the results of this study are expected to be used as a basis or reference in the preparation of programs related to the prevention and handling of cases of deprivation.

2 Materials and Methods

The method used in this research is descriptive qualitative research. With data collection techniques are as follows: a. Interviews were conducted using FGD interview guidelines, b. Focus group discussions were carried out using FGD guidelines to obtain data according to the research objectives, and c. Observations to get an overview of data about the condition of people with mental disabilities who are in shackles, their families, and their social environment.

Research locations and samples
The research locations were determined purposively as many as 3 (three) locations based on:
- The location has data on cases of PDM in pasung which is quite high,
- The research locations also represent rural and urban areas.

Informants
Families with family members who experience shackles Informants were selected using the Snowbowl method so it is hoped that those who provide information understand the problem well.

Data analysis processing techniques
The data collected were analyzed using descriptive statistics, namely the frequency distribution. Data analysis was carried out by editing, coding, tabulating, and analyzing steps.

Research Locus
The research was conducted in Lima Puluh Kota District, West Sumatra Province with a focus on locations that have a high number of cases of shackles, such as Gunung Omeh, Suliki, and Bukit Barisan sub-districts.

3 Results and Discussions

The condition of the PDM in pasung according to gender, age, location of residence, and deprivation will be described in the following table 1-4.

Table 1
Number of Pasung PDM by District and Gender

No.	Sub District	Male	Female	Total
1.	Bukit Barisan	4	-	4
2.	Gunung Omeh	9	2	11
3.	Suliki	6	-	6
4.	Guguak	1	1	2
5.	Mungka	-	1	1
6.	Kapur IX	2	-	2
7	Pangkalan	1	-	1
8.	Akabiluru	3	1	4
9.	Luak	2	-	2
10.	Harau	-	1	1
	Jumlah	28	6	34

Source: Dinas Sosial Kabupaten 50 Kota, 2017

Of the 10 sub-districts, it is known that the most PDM pasung sub-districts are Gunung Omeh, Suliki, and Bukit Barisan sub-districts (table 1). Accordingly, the sampling of the research was focused on these 3 sub-districts. The three sub-districts before the regional division came from one sub-district, namely Suliki District. The FGD was conducted in Suliki District where the participants came from the three sub-districts. The data above also illustrates that most of the PDM in pasung in District 50 Cities are male, and only 6 are female.

Table 2
Data on deprivation of people with mental disorders

PDM Pasung by Age Group		
Age Group	Total	Percentage
< 18 Year	1	2,94
19-54 Year	32	94,12
> 54 Year	1	2,94
Number of PDM Pasung and Current Condition		
Current Condition	Total	Description
Released	25	4 currently in PSBL Bengkulu, all referred to Mental Health Hospital Saanin
Released by the Family	2	
In the Process of release	3	
Still not release	4	Locked 3, and Restraint 1

Source: Dinas Sosial Kabupaten Lima Puluh Kota, 2017

Based on the table, the age of PDM *pasung* can be grouped into three, namely the age of children, productive age, and elderly age. The results of the study show that most of the PDM in *pasung* in 50 Cities are of productive age, only 1 person is a child and 1 person is elderly. Their current condition is that some have been released at the initiative of the government through sub-district social welfare workers (TKSK), some have been initiated by their families and are in the process of being released (Davidson & Guy, 2012; Scott & Resnick, 2006). Most of the PDM *pasung* have been released at the initiative of the government through TKSK. For PDMs who have been released from their *pasung*, they are taken directly to Mental Health Hospital HB. Saanin will be escorted by TKSK. Four people have been released and have gone through the recovery process at RSJ HB. Saanin has been referred to PSBL Bengkulu to undergo social rehabilitation. For those who were released, their families were taken care of by their families. At this time there are still 4 people in *pasung*, most of them are carried out by confining the PDM (Table 2).

Informant's profile

Informants in this study were PDM pasung families selected from 10 families from 19 PDM located in 3 sub-districts, namely Suliki, Gunung Omeh, and the Bukit Barisan. Of the 10 families of PDM *Pasung*, 7 of them have been released from *pasung* and 3 are still in *pasung* or one PDM has experienced *re-pasung.* To find out more in-depth about the factors that influence the success, and failure of PDM released from shackles, and those who have not been released from their shackles, 3 family cases were selected with the criteria of 1 family who succeeded in recovering and caring for their PDM family member after being released, 1 family who did not succeed and 1 family after being released successfully, and 1 family that has not been released. The socio-economic condition of the PDM family is seen in an age, education, occupation, and income (Li & Fawcett, 2014; Wardle et al., 2000). Besides that, PDM's age and education are also presented. The age of the head of the family is grouped into two groups, namely less than 60 years and 60 or more, with the assumption that elderly families are less able to provide support for PDM.

Table 3
Informant Socio-demographic Data

Number and Percentage of PDM Families by Age category		
Age Group	Total	Percentage
< 60 Year	7	70
> 60 Year	3	30
Number and Percentage of PDM Families by Education Level		
Level of Education	Total	Percentage
Not Finish Primary Education	1	10
Elementary Education	1	10
Junior High School	3	30
Senior High School	5	50
Number and Percentage of PDM Families by Employment		
Type of Employment	Total	Percentage
Farmer	4	40
Selling	1	10
Breeding	1	10
Number and Percentage of PDM Families by Income		
Earning Income	Total	Percentage
< 1 Million IDR	6	60
1 – 2 Million IDR	3	30
> 2 Million IDR	1	10
Number and Percentage of PDM Families by Family Dependant		
Tanggungan	Total	Percentage
1 – 3	5	50
4 – 5	4	40
> 5	1	10
Number and Percentage of Reasons for Families to do Confinement		
Reason	Total	Percentage
Annoying	8	70
Killing	1	10
Destructive	1	10

Source: Research Results

The results showed that there were 30% of PDM families over the age of 60 years. The physical condition of this elderly family is quite apprehensive, besides their education is low (table 3), they are also less able to work and do not even have a job, and their income is also low, generally at two million or less 50% of PDM families have education at the high school level, 30% at the junior high school level and the rest only finish elementary school and don't finish elementary school. When compared with the average length of schooling for the population of Lima Puluh Kota District, which is 7.91, the average length of schooling or the education level of PDM families is better. The work of the PDM family is mostly farming, raising livestock, and selling, even 40% of them do not work due to age factors or because the family's physical condition is no longer possible to work. Table 3 shows that the income of PDM families is mostly under one million. This is by the type of work. For those who do not work, the cost of daily living is borne by the children and the pity of the people around them. Only 10% of PDM families earn more than 2 million. With a low income, the number of

dependents of the family is also quite large, namely 50% of the number of dependents of the PDM family of more than 3 people. The condition of the family as described in Table 3 can be said that the socioeconomic status of the PDM family is low or is part of 7.65% of the poor population in Lima Puluh Kota District.

The reason why families hold PDM in prison, most of them say that PDM often goes on a rampage so it disturbs the surrounding community. The disturbances included slapping, hitting, and destroying houses by breaking windows, some even killed their uncle. Most of the PDM education is low, that is, they did not finish and finished elementary school. However, there are also 10% of those with D3 or tertiary education. The condition can be said that PDM education is low. 70% of PDM only have elementary school education or less with less than 6 years of schooling. Table 3 illustrates that PDM has suffered from schizophrenia for a long time, namely in general (80%) over 5 years, only 20% are under 6 years. But they are not in *pasung* since they have a mental disability. This can be seen from the length of time they have been in shackles (Table 3).

The duration of PDM experiencing implantation varies between 1-4 years (Table 3), mostly 2 to 3 years. According to the family, the shackles are sometimes cut off, meaning that they are not always in *passing*. If his emotional condition improves or he doesn't tantrum, he is released. For example, Ali case (Initial Name). Ali education is quite high, Diploma III, and has worked in a company. It was during this work that he first became ill. According to his family (brother), he didn't have the heart to put Ali in shackles, but because it disturbed the peace of the surrounding community, his brother was forced to chain Ali's hands and feet until there were scars on his hands and feet (Sembiring et al., 2022). When Ali is not angry, he is released and he can even be productive in gardening and making compost. Why is Ali's condition unstable? Sometimes calm and sometimes furious. When we interviewed Ali, according to Ali he was not sick, only his brother said he was sick. Therefore, he does not want to take medication regularly. According to Ali, "if I take medicine, I get sleepy and can't work." His obsession is to work and work, he doesn't want to be like the current condition, "I want to be an office worker too," he said, full of hope.

Family support

To improve and restore the social functioning of post-treatment PDM, it is necessary to have a family attitude that is directly involved in handling it, avoiding hostile actions, warmth, and giving a little criticism. One of the factors that can improve the social functioning of PDM after hospitalization is family support. Family support according to Satiadarma & Francis (2004), is assistance/support received by one family member from other family members to carry out the functions contained in a family. The success of treatment at the hospital, namely the administration of drugs, will be in vain if it is not supported by the role of family support. Research conducted by Jenkins & Deuze (2008), shows that family caregivers are a very potential source to support PDM recovery. Nurdiana et al. (2007), in their research stated that the family plays an important role in determining the method or nursing care needed by PDM at home so that it will reduce the recurrence rate. The results of this study are confirmed by another study conducted by Dinosetro (2008), which states that the family has a strategic function in reducing recurrence rates, increasing independence and standard of living and patients can adapt back to society and their social life. The support that a person has can prevent problems from developing due to the pressure they are facing. A person with high support will be more successful in dealing with and overcoming his problems than those without support (Taylor, 1995).

According to Friedman & McCown (1998), family support is the attitude, action, and acceptance of the family towards its members. Family members are seen as an inseparable part of the family environment. Family members view that supportive people are always ready to provide help and assistance if needed. Family support includes emotional, informational, instrumental, and reward support. The results showed that the support for PDM families who had a history of *pasung* or who were still in *pasung* overall was not maximal or still classified as a moderate category or with a score of 2.23 (Figure 1). When viewed each type of support is as follows:

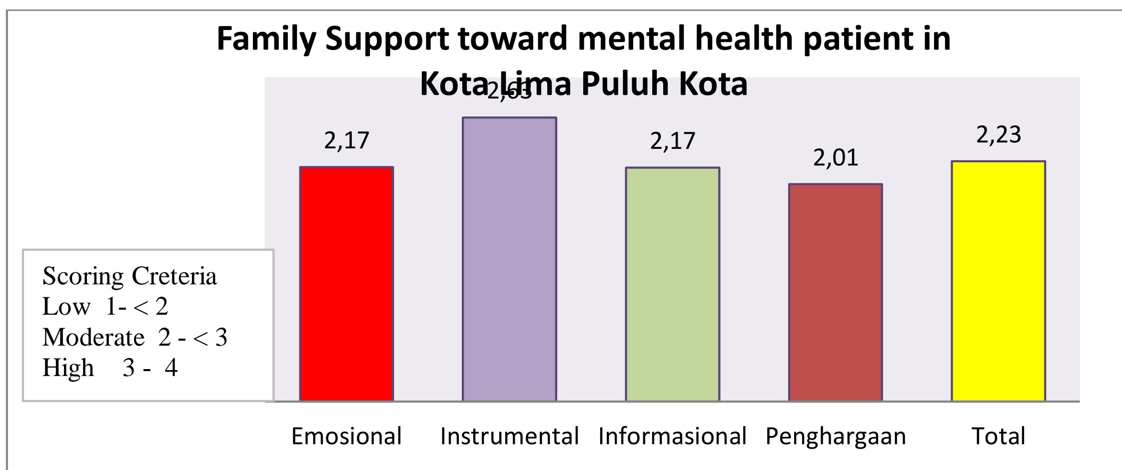

Figure 1. Family support toward mental health patients
Source: Research result

Emotional support

During the depression, individuals often suffer emotionally, sad, anxious, and lose self-esteem. If depression reduces a person's feelings of belonging and being loved. Emotional support gives individuals a feeling of comfort, feeling loved when experiencing depression, and assistance in the form of enthusiasm, empathy, trust, and attention so that individuals who receive it feel valuable. In this emotional support, the family provides a place of rest and encouragement. In the case of a family (released from pasung) who manages to provide good emotional support, family members, whether it's their parent's siblings or even their children, always make time for PDM, such as accompanying them when they go for treatment or take medicine, and take medication regularly, and are not shy introduce to others. At work always encourage. PDM is not isolated and is always invited to communicate. On the other hand, in the case of families (free of shackles) whose emotional support is still low, parents, both mothers, and fathers, are busy working in the fields, the family pays less attention or takes less time to pay attention to PDM, does not give busyness, finally, PDM goes berserk again, which is angry with each other parents and finally put in shackles again. For PDM recovery, families need to give more attention than other family members, especially emotional support such as giving special attention or feeling safe and comfortable when PDM is under stress.

Information support

This type of support includes communication networks and shared responsibilities, including providing solutions to problems, providing advice, direction, suggestions, or feedback about what someone is doing. Families can provide information by suggesting doctors, therapies that are good for themselves, and specific actions for individuals to deal with stressors. Individuals who are depressed can come out of their problems and solve their problems with support from their families by providing feedback. This information supports the family as information collectors and information providers. The results showed that the information support of family members for PDM is the same as emotional support, the average value is 2.17 which is in the moderate category. The support provided is still limited to PDM's health, such as reminding to take medication regularly, when to take medication, and not yet providing information about the disease that PDM suffers from and ways to treat and treat it. This is because most PDMs come from poor families and have low education. Some even live not with their immediate family or extended family (aunts or cousins from the grandmother). Many families do not know information about treatment, social rehabilitation, and mental illness in general. They only know that the cause of their illness is due to the influence of spirits, witchcraft, and so on.

Instrumental support

This support includes the provision of physical support such as services, financial and material assistance in the form of tangible assistance (instrumental support or material support), a condition where objects or services will help solve practical problems, including direct assistance, such as when someone gives or lends money, helps daily work, conveying messages, providing transportation, caring for and caring for when sick or experiencing depression can help solve problems. Real support is most effective when valued by the individual and reduces the individual's depression. On the real support of the family as a source to achieve practical goals and real goals. The results of the study (Figure 1) show that instrumental support is the highest support given by families to PDM compared to other supports. However, this support is still limited to meeting basic physical needs such as food, clothing, and bedding. In general, PDM has not been accompanied and facilitated to carry out routine productive activities. This often causes recurrence.

Award support (assessment)

This support includes helping the individual to better understand the occurrence of depression as well as the sources of depression and coping strategies that can be used in dealing with stressors. This support is also the support that occurs when there is an expression of a positive assessment of the individual. Individuals have someone to talk to about their problems, this occurs through the expression of positive individual expectations for other individuals, encouragement, approval of one's ideas or feelings, and positive comparisons of a person with other people, for example, underprivileged people. Family support can help improve individual coping strategies with alternative strategies based on experience that focuses on positive aspects. The results of the field research show that family appreciation support is generally still in the moderate category with a lower value close to low (Figure 1). This shows that the family has not maximally provided support to PDM in terms of giving appreciation for the ideas and efforts made by PDM. This is due to a lack of family knowledge about support and PDM's need for such support.

Case 1: Successful PDM after releasing *pasung*

Budi (Initial Name)
47 years old, suffering from mental disorders since 1989, has been shackled since 2000 because of his tantrums. Pasung has been released since 2013 by the TKSK in Suliki District and taken to the Saanin Hospital for treatment twice. After that, he was referred to PSBL Bengkulu to participate in social rehabilitation for 2 years. At PSBL Budi attended sewing skills training. In 2014 Budi returned to his family and was treated as an outpatient by his family, especially his younger brother who gave his full attention, was accompanied by every time he took his medicine, and always,s supervised him when took medicine. Providing productive activities, namely the family providing business capital for raising quail.

Budi's family
His father works as a tailor, who takes care of and takes care of Budi day-to-day as his younger brother. According to his younger brother, Budi, the trigger factor for his sister to become a PDM was a household divorce, so that her s was stressed and then isolated and over time she became angry. After about 2 years at PSBL Bengkulu, his sister has started to stabilize. To remain stable, Budi has to take medication regularly, always under assistance. The medicine is taken every month by his sister and the most important thing is given the activity of raising quail. Until now, Budi remains stable because he is always accompanied by his family (his younger brother). Besides raising quail, Budi helps his father in sewing when his father has a lot of stitches.

Case 2: Unsuccessful PDM after releasing *pasung*

Miko (Initial Name)
Miko, born in 1984 (33 years old), started suffering from mental disorders in 2000 (16 years old). His education did not finish junior high, only up to grade 2. Miko has been in pasung since 2012 because he was angry with his grandfather, his father was slapped until his teeth fell out. Since the incident, Miko has been confined by confining her in a room with iron bars. In 2013 the TKSK was released and brought for treatment to RSJ HB Saanin. After leaving RSJ Miko, he was referred to the Bina Laras Social Institution (PSBL) in Bengkulu to take part in Social Rehabilitation. After 3 years (2013-2015) at PSBL Bengkulu Miko was sent home. At home, Miko likes to relapse and be locked up again. After that, he went to the HB Saanin Hospital for treatment again. At the time of the study, Miko was in a state of confinement after 2 times to RSJ HB Saanin and 3 years at PSBL Bengkulu. The reason for the confinement is that he still likes to be angry.
Miko's Family
Husband and wife work in the fields, physically they do not have time to take care of Miko. There are only three of them, namely mother, father, and Miko. So when her parents went to the fields (paddy, chocolate, areca nut) Miko was watched by her mother's sister from a different house. For physical needs such as eating, drinking, and clothing, the adequate room where Miko is in brackets has a bathroom in the room. However, their psychological and social needs are neglected. According to Miko's family, she took her own medicine without being supervised. The problem is that Miko is in shackles because the community and family are afraid that Miko will go berserk.

Case 3: Hadi (*Initial Name*) who has not released his passing
Hadi, whose birth date is unknown, because he is not taken care of by his immediate family, but is taken care of by a distant family. The place to live is far from habitable, which is small, without doors and windows (like a chicken coop). Location near a public garbage dump. The bed is made of bamboo and the legs are tied with chains under the bales. The need for food, clothing, and bathing is served by a family whose residence is some distance from the PDM prison. Only wearing sarongs and T-shirts, bathing and eating in the same place, accompanied by bathing water by the family who cares for him. No emotional support, information, or appreciation at all. Because the one who takes care of it is a distant family who is also busy working in his shop. Hadi has been in pasung since he suffered from a mental disorder in 2005 until now. The reason for being in pasung is because they often disturb the community in their environment.

Hadi's family
His immediate family did not want to take care of him. According to the family who takes care of it (distant family) the cause of mental disorders is the marijuana addiction factor. The obstacle experienced by the family who cared for him was that PDM was not allowed by his close family to be taken for treatment. In connection with that, he hopes that the relevant government parties can handle the PDM recovery so that it can recover as before.

From the results of the study of case 1, namely family support is maximal or already high where the family pays more attention to PDM such as always accompanying him both in taking medicine and taking medicine, giving the enthusiasm to work, providing employment, providing working capital and giving appreciation for work results. PDM. On the other hand, in case 2, those who failed to recover after being treated medically and following social rehabilitation. In case 2, family support is lacking or low, the family does not provide emotional support, appreciation, or information. The family only provides the fulfillment of physical needs such as food, clothing, and rooms with iron bars (still in pasung). Both parents are busy making a living in the fields, and PDM lives alone at home, paying little attention to the recovery of their children such as taking medicine and fulfilling their psychological and social needs. This is because families do not understand the needs of their children who suffer from mental disorders and ways to restore PDM so that they remain in a

stable condition. Another case is case 3 which has not been released from shackles, the problem is that PDM is not noticed by the nuclear family, the nuclear family does not care for and cares about PDM, even PDM is not allowed to be taken for treatment to the RSJ. Families who take care of PDM (distant families) only meet their needs for food, clothing, and bathing. The place to live is also very inadequate. From the three cases mentioned above, it can be seen that family support greatly influences the success of PDM recovery.

4 Conclusion

The average support for families with mental disabilities in pasung is still low but in general, it is in the moderate category. To improve and restore PDM recovery, it is necessary to have the attitude and support of families who are directly involved in handling it, avoiding hostile actions, providing support, warmth, and giving a little criticism. The family has a strategic function in reducing the recurrence rate, increasing independence, living standards, and adaptability to return to society and social life. Family support is an important factor in preventing shackles and re-incarceration. Providing support for PDM in its handling and prevention efforts is still not fully understood by the community. This condition causes the community to have not been able to support the Stop Imprisonment Movement. In addition, from the results of research in the field, it was found that community support was influenced by the level of knowledge and understanding of people with mental disorders. Most people still agree with the use of shackles for reasons of the safety of PDM, their families, and others. The low level of community support is because they do not understand how to approach, prevent and treat people with mental disorders.

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