Bridging Formal Law and Local Wisdom: A Systematic Literature Review on Legal Empowerment for Persons with Mental Disorders Through Community Mental Health Cadres

Erih Williasari[1]
[1] *University Swadaya Gunung Jati, Indonesia*

Corresponding Author: Erih Williasari, **E-mail**: williasari@ymail.com

| ABSTRACT
Despite increasingly rights-based mental health and disability laws, people with mental disorders (PWMDs) in Indonesia and other low- and middle-income settings continue to experience exclusion, coercion, and practices such as pasung (restraint and confinement). This paper reviews how community mental health cadres can bridge formal legal mandates and local wisdom to advance legal empowerment and rights protection. A systematic literature review was conducted following PRISMA 2020. Searches were performed in Google Scholar, PubMed, ScienceDirect, and DOAJ for peer-reviewed articles published in 2020–2025 using keywords combining mental disorders, cadres/community health workers, legal empowerment/rights, and local wisdom/culture. After screening 72 records, 9 studies met the inclusion criteria and were synthesized thematically. The review identified three main findings: (1) a persistent implementation gap between national prohibitions of coercion and local practices, shaped by stigma, family burden, limited services, and culturally embedded explanatory models of illness; (2) cadres act as cultural brokers who translate biomedical services and legal norms into locally acceptable support, facilitate referrals, and mediate with families and community leaders; and (3) legal empowerment is strengthened when cadre activities are coupled with rights literacy, multi-sector referral pathways (health–social–legal aid), and community accountability mechanisms. This study proposes an integrative conceptual model positioning cadres at the interface of primary health care and village governance to operationalize SDG 3 (health) and SDG 16 (justice and strong institutions) through culturally grounded, rights-based mental health care.

| KEYWORDS
(Legal Empowerment, Mental Health Law, Local Wisdom, Community Mental Health Cadres, Persons with Mental Disorders)

I. INTRODUCTION

Pasung—community-based restraint and confinement of people with mental disorders—remains reported in Indonesia despite decades of policy efforts to eliminate coercion and expand access to care. Evidence syntheses and empirical studies describe how pasung is maintained by stigma, limited service availability, and family burden, and how it constitutes a serious human rights concern because it restricts liberty, dignity, and access to health services [2][9].

At the normative level, Indonesia has adopted a rights-oriented legal framework, including the Mental Health Act (Law No. 18/2014) and the Persons with Disabilities Act (Law No. 8/2016), complemented by broader health sector reforms (Law No. 17/2023) and international commitments such as the Convention on the Rights of Persons with Disabilities (CRPD) [14][15][16][17]. Global guidance also emphasizes aligning mental health services with human rights standards and using the least-restrictive alternatives [12]. However, policy analyses highlight persistent implementation gaps caused by decentralized governance, unclear institutional mandates, and insufficient community-based services and accountability mechanisms [4][5].

Community mental health cadres—trained volunteers embedded in villages—have been positioned as a pragmatic response to workforce shortages and as trusted intermediaries in collectivist communities. Qualitative evidence shows cadres provide emotional support, facilitate referrals, conduct home visits, and mediate between families, primary health care, and local leaders [9][10]. In this context, local wisdom (e.g., gotong royong, community deliberation, and the influence of religious/traditional leaders) can either reinforce exclusion or become a resource for culturally legitimate care and dispute resolution, particularly when paired with legal empowerment strategies that strengthen rights literacy and access to remedies [11][12].

This paper aims to synthesize recent (2020–2025) literature on how legal empowerment for persons with mental disorders can be operationalized through community mental health cadres, and how such efforts can bridge formal law and local wisdom. The review addresses two questions: (1) What roles do cadres play in reducing rights violations and improving access to care? and (2) What mechanisms enable cadres to translate legal mandates into locally accepted practices that protect autonomy and dignity.

This review contributes to the literature in three ways. First, it consolidates recent (2020–2025) evidence on how community mental health cadres function as cultural brokers who translate legal norms and biomedical services into locally legitimate practices. Second, it synthesizes actionable legal empowerment pathways, rights literacy, multi sector referral linkages (health–social–legal aid), and community accountability mechanisms—that can reduce coercion and expand access to care. Third, it proposes an integrative conceptual model positioning cadres at the interface of primary health care and village governance to operationalize SDG 3 and SDG 16 through culturally grounded, rights-based mental health support.

The COVID-19 era accelerated attention to rights-based health and disability governance, yet community-level realities continue to reflect a gap between formal protections and lived experience. In Indonesia, the persistence of pasung and other coercive practices illustrates how stigma, limited service coverage, and family burden can override legal mandates—especially in decentralized settings where institutional roles and accountability mechanisms are uneven across districts.

II. METHODOLOGY

This systematic literature review followed the PRISMA 2020 reporting guideline [1]. The protocol was not registered. The review focused on literature published between January 2020 and May 2025 to capture recent post-reform developments in mental health systems, disability rights, and community-based care in Indonesia.

A. Information sources and search strategy: Searches were conducted in Google Scholar, PubMed, ScienceDirect, and the Directory of Open Access Journals (DOAJ). The main Boolean string was adapted per database and combined terms for (i) mental disorders ("mental disorder" OR "severe mental illness" OR schizophrenia OR ODGJ), (ii) community cadres (cadre OR "community mental health" OR "community health worker" OR "lay health worker" OR "kader kesehatan jiwa"), and (iii) rights/legal empowerment ("legal empowerment" OR rights OR "human rights" OR pasung OR restraint OR confinement OR "access to justice"), with Indonesia/local wisdom terms added when necessary.

B. Eligibility criteria: Studies were included if they (1) were peer-reviewed journal articles or conference papers; (2) were published in 2020–2025; (3) discussed persons with mental disorders/psychosocial disabilities and community-level responses (including cadres/CHWs, families, and local leaders); and (4) contained rights- or empowerment-relevant outcomes (e.g., reduction of coercion/pasung, access to care, advocacy, autonomy, stigma reduction, or linkage to remedies). Studies were excluded if they were purely biomedical/clinical without community or empowerment content, outside the time window, not available in full text, or not relevant to the cadre/community mechanism.

C. Study selection: Records were screened in two stages (title/abstract, then full text). Of 72 records identified, 39 were excluded during title/abstract screening. Thirty-three full-text articles were assessed, and 24 were excluded (most commonly because they did not address legal/rights dimensions or lacked a community-based cadre/CHW component). Nine studies were included in the final synthesis; the screening process is summarized in Table I.

D. Data extraction and quality appraisal: For each included study, we extracted author/year, location, design, participants, intervention or context (cadre activities and/or pasung response), and findings relevant to legal empowerment. Methodological quality was appraised using the Joanna Briggs Institute (JBI) checklists appropriate to each study design, and quality concerns were considered during interpretation.

E. Data synthesis: A narrative thematic synthesis was undertaken. Findings were coded iteratively and grouped into higher-order themes describing (1) drivers of rights violations and the law–practice gap; (2) local wisdom and community authority structures; (3) the cadre's role as a cultural broker; and (4) legal empowerment mechanisms and system linkages.

Note: Because this review integrates legal and socio-cultural dimensions, both empirical studies and policy-oriented analyses were considered eligible when they provided evidence on implementation or community practice.

III. RESULTS AND DISCUSSION

A. Study selection and overview: The final synthesis comprised nine studies published between 2020 and 2024. The literature was heterogeneous, including one systematic review [2], one policy analysis [4], one longitudinal program evaluation [8], and multiple qualitative studies exploring experiences of families, caregivers, local actors, and cadres [3][5][6][7][9][10]. Most studies were situated in Indonesia and focused on pasung, community-based mental health services, and the social conditions shaping access to care.

Table I summarizes the PRISMA 2020 screening process. The included studies primarily comprised qualitative research on pasung and caregiver/community experiences [3][5][6][7], policy-oriented analyses [4], program evaluations [5][8], and cadre-focused qualitative studies [9][10].

B. Theme 1 The law–practice gap and the persistence of coercion: National-level reforms and the Indonesia Free Pasung agenda have increased awareness, yet implementation remains uneven across provinces and districts. Policy analysis points to fragmented mandates, ambiguous messaging among policy actors, and incomplete decentralization of primary care as barriers to eliminating pasung [4]. Empirical evaluations similarly report that access barriers (costs, distance, service availability) interact with stigma and fear to sustain coercive practices even after programmatic interventions [5][8].

C. Theme 2 Local wisdom, explanatory models, and community authority: Families often navigate mental distress through culturally embedded explanatory models (e.g., spiritual/supernatural interpretations), and may seek help first from traditional or religious leaders before formal services [3][6][7]. These local authority structures can reinforce exclusion (e.g., normalizing confinement) but also provide culturally legitimate entry points for non-coercive support when engaged respectfully and aligned with rights-based messages [5][6][7].

D. Theme 3 Cadres as cultural brokers and cross-system connectors: Studies on mental health cadres describe them as trusted local volunteers who provide emotional support, facilitate treatment access, conduct home visits, and mediate between families and primary health services [9], [10]. Because cadres share community language and norms, they can translate formal health guidance and rights principles into locally acceptable practices, reducing stigma and enabling earlier help-seeking.

E. Theme 4 Legal empowerment pathways through cadres: Legal empowerment approaches strengthen community legal capability (rights literacy, navigation skills, and collective voice) and create practical pathways to remedies and accountable services [11]. Applied to community mental health, cadres can operationalize legal empowerment by (i) disseminating rights-based information consistent with national law and the CRPD [14][15][16][17], (ii) supporting supported decision-making and family negotiation processes [13], and (iii) linking communities to health, social protection, and legal aid actors for escalation when rights violations occur [11][12].

Synthesizing these themes, we propose a bridging model in which cadres sit at the interface of primary care and village governance: they translate legal mandates into culturally grounded practices, mobilize community resources to reduce coercion, and activate referral and accountability pathways. Practical components of the model are summarized in Table II.

- Family members and caregivers of PWMDs (first responders and key decision-makers) [3][7][8].
- Religious/traditional leaders and respected community figures (gatekeepers for local legitimacy) [5][6][7].
- Village government and neighborhood structures (RT/RW) to enable community agreements and resource allocation [4][11].
- Primary health care (puskesmas) and district health offices for clinical pathways and supervision of cadres [9][10].
- Social services, human rights institutions, and legal aid organizations to address welfare needs and rights

violations [11][12].

Operationally, this model requires cadre training packages that integrate mental health literacy with legal and human rights content (e.g., non-discrimination, least-restrictive alternatives, consent and confidentiality) and skills for culturally sensitive communication with families and local leaders [9][10][11][12].

At the local governance level, village deliberation forums (musyawarah) and community mutual-help norms (gotong royong) can be leveraged to create supportive environments—for example, by establishing community agreements against pasung, allocating local resources for transport and follow-up, and clarifying referral roles between cadres, primary health centers (puskesmas), social services, and legal aid organizations [4][11][12].

Safeguards are essential: cadre programs should avoid informal coercion, protect privacy, and include supervision and grievance mechanisms so that community members can report abuse safely. Rights-based guidance stresses that restraint should be a last resort and that systems should build alternatives through community-based supports and accountable services [12].

Research gaps remain. Few studies evaluate legal empowerment outcomes directly (e.g., changes in legal capability, complaint resolution, or access to justice). Future work should test integrated interventions that combine cadre support with legal aid pathways, measure rights-based outcomes, and examine how local wisdom can be engaged without reproducing stigma or discrimination.

TABLE I. PRISMA 2020 SCREENING SUMMARY

PRISMA stage	n
Records identified through database searching	72
Records screened (title/abstract)	72
Records excluded (title/abstract)	39
Full-text reports assessed for eligibility	33
Full-text reports excluded (with reasons)	24
Studies included in qualitative synthesis	9

TABLE II. SYNTHESIZED THEMES AND PRACTICAL IMPLICATIONS

Theme	Evidence from included studies	Implications for bridging law and local wisdom
1. Law–practice gap	Mandate/role ambiguity, decentralization, and limited services sustain coercion [4], [5], [8].	Clarify roles across village–puskesmas–district; define accountability and escalation pathways.
2. Local wisdom & authority	Explanatory models, religious/traditional authority, and community norms shape care decisions [5]–[7].	Engage local leaders as allies; frame anti-pasung commitments in culturally legitimate terms.
3. Cadres as cultural brokers	Cadres provide trusted support, home visits, and referrals; translate services into local language [9], [10].	Train cadres in culturally sensitive communication + rights literacy; provide supervision and incentives.
4. Legal empowerment mechanisms	Legal capability and access-to-remedy pathways strengthen service responsiveness [11], [12].	Integrate cadres with legal aid/social protection; enable supported decision-making and complaint mechanisms [12], [13].

IV. CONCLUSION

This review highlights that the effectiveness of community mental health responses in Indonesia depends on the interaction between legal mandates, service capacity, and socio-cultural dynamics. While pasung has been framed

as a human rights and public health problem, the evidence shows that coercive practices can persist when families lack support and services are difficult to access [2][3][4][5][6][7][8].

Community mental health cadres emerge as key bridging actors. They are trusted local volunteers who can translate formal policies and rights principles into everyday community practice through home visits, psychoeducation, referral facilitation, and mediation with families and local leaders [9][10].

For cadres to contribute to legal empowerment, their activities should be strengthened with rights literacy, supported decision-making, and clear pathways to accountable services and remedies—connecting primary care, social protection, and legal aid actors [11][12][13].

This review is limited by the small number of eligible studies (n=9) and the heterogeneity of designs and outcomes, which constrained cross-study comparability and precluded meta-analysis. The search strategy prioritized peer-reviewed literature (2020–2025) and may have undercaptured relevant gray literature, program reports, and unpublished evaluations where community cadre and legal empowerment practices are often documented. In addition, most included studies were situated in Indonesia; therefore, transferability to other low- and middle-income contexts should be interpreted cautiously.

Future research should move beyond describing pasung and cadre roles to testing integrated interventions that measure rights-based outcomes (e.g., reduced coercion, improved autonomy, complaint resolution, and equitable access to care) and that examine how local wisdom can be engaged without reproducing stigma or discrimination.

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