Limits of Family Authority in Giving Consent to Medical Treatment for Patients with Mental Disorders

Manahap Cerarius Fransiskus Pardosi, Irsyam Risdawati, T. Riza Zarzani

Abstract

Law No. 17 of 2023 on Health allows family members to give consent to treatment for persons with mental disorders who are considered incapable, but the limits of that authority are not set out in a single provision. This study analyses how the family's authority to consent to medical treatment for patients with mental disorders is regulated and which limits must be kept so that the authority does not replace the patient's rights and autonomy. It uses normative legal research that is descriptive and analytical, with statutory, conceptual and case approaches, the latter limited to a Constitutional Court decision and other researchers' findings. The results show that the family's authority is subsidiary: it arises only when a doctor judges the patient incapable of the decision at hand, must be in writing, is confined to the medical action explained, and ends when the patient is again able to decide. The articles read do not answer what criteria and evidence govern the capacity assessment, what order applies and what happens when family members disagree, what follows when a patient judged incapable refuses, what standard the family's decision must meet, and how the family's consent is reviewed. The study concludes that the family's authority is valid only when it respects five limits, namely trigger, holder, scope, standard, and safeguards and review, and that implementing regulations need to close these gaps.

***Keywords**: consent to medical treatment; mental disorder; family authority; capacity; substitute decision-making*

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Introduction

Article 28H(1) of the 1945 Constitution of the Republic of Indonesia guarantees everyone the right to health services, and Article 28I(4) makes the protection and fulfilment of human rights a responsibility of the state, above all the government [1]. Law No. 17 of 2023 on Health (the Health Law) gives patients the right to consent to or refuse medical action (Article 276(d)) and requires consent to every individual health service after an adequate explanation (Article 293) [2], [3]. For patients with mental disorders, that right meets a problem other patients do not face: the ability to decide may be impaired, while in practice the decision is often taken together with, or replaced by, the family.

The Health Law addresses this in Article 80. The management of a person with a mental disorder as an inpatient must have the written consent of that person (paragraph (1)). If the person is considered incapable of making decisions, consent may be given by the spouse, parents, a child or sibling aged at least 18, a guardian or curator, or an authorised official (paragraph (2)) [4]. Government Regulation No. 28 of 2024 (GR 28/2024) repeats that list for every medical action in the management of persons with mental disorders (Article 158) [5]. The list answers who may give consent, but it does not by itself answer how far that authority extends.

The limit matters because family consent replaces the patient's decision and because its performance can become a formality. In a socio-legal study at a regional psychiatric hospital before the Health Law took effect, family members signed consent for electroconvulsive therapy with premedication without understanding the side effects, and consent was taken once for several procedures [6]. That is another researcher's finding from one hospital and from before the Health Law, so it cannot be generalised, but it shows what is at stake when family authority is not bounded by a norm that can be tested.

Earlier legal studies approach the problem from other sides. Raqib and Indrawan assess the legal protection of the right to consent of patients with mental disorders and propose a hybrid model, but their study rests on Law No. 18 of 2014 on Mental Health and Government Regulation No. 2 of 2022, and does not mention Article 80 of the Health Law or GR 28/2024 [7]. The first of those laws was revoked by the Health Law [3]. Agusmidah et al. show that criteria of incapacity are not uniform across statutes but, according to their abstract, do not specifically address mental disorders [8], and Kusumaningrum et al. discuss the therapeutic transaction of patients with mental disorders [9]. Studies by lecturers of Universitas Pembangunan Panca Budi address the fulfilment of the right of patients with mental disorders to access services [10], [11] and the implementation of consent to treatment in general [12], [13], but according to their summaries do not test the limits of family authority. This article fills that gap by reading Article 80(1) to (5) of the Health Law, Articles 148 and 158 of GR 28/2024, and the neighbouring provisions together. The novelty claim is limited to the sources reviewed.

This article asks two questions. First, how does Indonesian law regulate the family's authority to give consent to medical treatment for patients with mental disorders? Second, how far may that authority extend so that it does not replace the patient's rights and autonomy? The aim is to explain that regulation, to distinguish what is permitted from what is not permitted and what is unclear, and to formulate limits on family authority that can be tested.

Literature Review

1. *Consent, capacity, and substitute decision-making*

Appelbaum describes a patient's capacity to consent to treatment as four abilities, namely to express a choice, to understand the relevant information, to appreciate the consequences of treatment and non-treatment for oneself, and to reason about treatment options [14]. The systematic review by Marcó-García et al. of psychiatric inpatients found that most patients can make treatment decisions, and that capacity varies with the stage of care, the legal status of the admission, the type of decision, and the information given [15]. That finding is clinical and is

not an Indonesian norm. The authors use it as a reminder that a diagnosis of mental disorder is not the same as incapacity; this is the authors' choice in reading that study.

Buchanan and Brock build a theoretical framework for decisions by substitutes and apply it, among others, to psychiatric patients [16]. In the health ethics literature, a substitute is generally asked to follow the patient's wishes as far as they can be known and, where they cannot be known, the patient's best interests; this formulation is the authors' summary of that general idea and not a quotation from a particular part of the book. The guidance of the World Health Organization and the Office of the United Nations High Commissioner for Human Rights recommends a rights-based approach and measures to eliminate coercion in mental health systems [17].

2. *Legal protection and legal certainty*

Hadjon distinguishes preventive legal protection, which gives an opportunity to object before a decision becomes final, from repressive legal protection, which resolves disputes that have already arisen [18]. In this article the authors adapt that distinction to family consent: the preventive element is the norm that sets when, by whom, and by what measure substitute consent is given, and the repressive element is review and dispute resolution afterwards. This adaptation is the authors' choice.

Legal certainty is understood operationally through five test questions used in the discussion. First, the trigger: when family authority arises and who assesses it. Second, the holder: who has the authority and what happens when they disagree. Third, the scope: which actions and matters are covered and when the authority ends. Fourth, the standard: what measure binds the family. Fifth, safeguards and review: which rights remain with the patient and how the family's decision is reviewed. These five questions are the authors' own formulation from reading the norms and literature above, not a framework taken from one source.

3. *Earlier studies*

Table 1 summarises the studies the authors read and the gap this article addresses. Rahmiyati et al. give an empirical picture of family consent before the Health Law, and according to them the basis for family consent at that time was Minister of Health Regulation No. 290/Menkes/Per/III/2008 [6]. Raqib and Indrawan note the absence of a standard instrument for assessing capacity and advocate supported decision-making, with the family shifting from decision-maker to supporter [7].

Table 1. Earlier studies read and the gap this article addresses

Study	Focus and findings	Basis or approach	Gap for this article
Rahmiyati et al., 2020	Socio-legal study at a regional psychiatric hospital; families signed consent without understanding the side effects; consent taken once for several procedures; difficulty reaching families [6]	MoH Reg. 290/2008; interviews and documents	Before the Health Law; one hospital; limits not tested
Raqib and Indrawan, 2026	Protection of the right to consent of patients with mental disorders; no standard instrument for assessing capacity; supported decision-making; hybrid model [7]	Law 18/2014, GR 2/2022, Law 8/2016, Civil Code, CRPD	Article 80 of the Health Law and GR 28/2024 not mentioned
Agusmidah et al., 2026	Criteria of incapacity not uniform across statutes; criteria of emergency not objective [8]	Health Law; statutory and conceptual	Not specific to mental disorders according to the abstract
Kusumaningrum et al., 2026	Therapeutic transaction for patients with mental disorders; consent weakly implemented; adapted consent procedures [9]	Health Law; normative	Limits of family authority not the focus according to the abstract

Study	Focus and findings	Basis or approach	Gap for this article
Farhan et al., 2025 and 2026	Right of patients with mental disorders to access services in hospitals; obstacles of facilities, staff and stigma [10], [11]	Health Law; interviews	Consent not addressed according to the abstract
Marcó-García et al., 2024	Clinical systematic review; most psychiatric inpatients can decide; capacity varies [15]	International clinical study	Not Indonesian law; used as a concept
Azzahra, Firdaus and Achmad, 2025	Analysis of Constitutional Court Decision 93/PUU-XX/2022; guardianship remains so protection is not yet optimal [19]	Normative; case	Consent to medical treatment not addressed according to the abstract

Note: the fourth column is the authors' reading of the abstract or article page; the full text was mostly not read.

Studies by lecturers of Universitas Pembangunan Panca Budi provide comparative material. Chairul, Risdawati and Aspan found that consent to treatment is now mandatory and legally well founded, but that its implementation is hampered by administrative formalism, patients' limited understanding, and weak supervision [12], [13]. Azzahra, Risdawati and Simarmata found similar obstacles, namely limited understanding of procedure and inadequate supervision of policy, and recommended training and stricter supervision [20]. Carlos, Risdawati and Simarmata found that the Health Law gives a basis for acting without prior consent in an emergency, with obstacles of documentation and procedure [21]. Farhan, Sahlepi and Risdawati, in two publications that appear to report the same study, found that fulfilment of the right of patients with mental disorders to access services is hampered by limited facilities and staff, hospitals' low awareness of non-discriminatory care, and cultural factors and stigma [10], [11].

Mushari, Sidi and Risdawati assess the effectiveness of mediation in patient–hospital disputes and propose a combined model [22]. Sinaga, Zarzani and Sahlepi found that the shift of medical dispute resolution from litigation to non-litigation has not been accompanied by norms on institutional roles and technical procedure [23]. Adrianto, Sumarno and Zarzani found a large gap between regulation and practice in protecting health workers in remote areas, with weak coordination among institutions [24], and Pasaribu, Zarzani and Sahlepi concluded that existing regulation does not regulate the status of co-assistants in teaching hospitals in enough detail and requires coordination among the parties [25]. These studies do not address family authority; they are used as comparative material for a recurring pattern, namely a basic norm that exists while procedural detail, supervision and coordination remain unfilled.

4. *Legal politics, criminal policy, and supervision*

The analytical framework draws on Tanjung's studies with co-authors. Tanjung and Arminsyah argue that a non-transparent omnibus process with minimal public participation weakens legitimacy, and that the breadth of the government's power to change regulations is a risk [26]. Tanjung, Syahnan and Syahputra assess that Government Regulation in Lieu of Law No. 2 of 2022 met the requirement of compelling urgency under Article 22(1) of the 1945 Constitution, but note concerns about subjectivity and the potential abuse of power [27]. Tanjung examines the Judicial Commission's supervision of judges and notes that other institutions also hold supervisory powers [28]. In his study of narcotics trafficking he proposes an integrated approach of prevention, enforcement, therapy and rehabilitation [29], and a recent study with Arminsyah and Syam proposes a model in which an arbitration body resolves disputes and the court supervises, ratifies and executes its awards, together with synchronisation of regulations [30].

Suwarto, Sutiarnoto and Magda assess that criminal law policy on digital crime remains reactive and fragmented, and recommend harmonisation of norms [31]. Mahruzar, Simarmata and Sahlepi found a conflict of norms between general criminal law and newer, more specific statutes in the legal protection of doctors, and regard criminal law as a last resort [32].

Research Method

This is normative juridical research that is descriptive and analytical, with statutory, conceptual and case approaches, the last limited to one Constitutional Court decision and other researchers' findings. The primary legal materials are Articles 28H(1) and 28I(4) of the 1945 Constitution [1]; Article 80 of the Health Law [4]; Articles 81, 276, 293, 453 and 454 of the Health Law [3]; Articles 148 and 158 of GR 28/2024 [5]; Minister of Health Regulation No. 290/Menkes/Per/III/2008 on Consent to Medical Treatment (MoH Reg. 290/2008) [33]; Articles 4, 12 and 32 to 34 of Law No. 8 of 2016 on Persons with Disabilities (Law 8/2016) [34]; and Constitutional Court Decision No. 93/PUU-XX/2022 [35]–[37]. The secondary materials are journal and proceedings articles, including the studies by Universitas Pembangunan Panca Budi lecturers cited above. The materials were collected through library and document study and analysed qualitatively, using grammatical interpretation of the wording of articles, systematic interpretation across statutes, government regulations and ministerial regulations, and an assessment of each element against the five test questions.

The study has six limitations. First, Article 80 of the Health Law was read from the official file on the website of the Ministry of Health's legal documentation network through a page-reading tool that returns paraphrase and short quotations rather than a verbatim copy, so the wording needs to be checked against the official text [4]. Second, Articles 81, 276, 293, 453 and 454 of the Health Law and Articles 148 and 158 of GR 28/2024 were read from the Pasal.id database, which contains character errors, so paragraph and letter numbers in those articles also need checking [3], [5]. Third, MoH Reg. 290/2008 was read from a file downloaded from the Ministry of Health website in January 2024, the authors found no regulation revoking or replacing it, and its status after the Health Law is inferred only from Article 453 [3], [33]. Fourth, the Constitutional Court decision was read from a summary and a database page, not the full decision [35], [36]. Fifth, the authors found no court decision on family consent for patients with mental disorders; the case approach therefore uses the Constitutional Court decision and other researchers' findings, which are not data tested by the authors. Sixth, the study conducted no interviews, observation or surveys, and does not address criminal or civil liability, compulsory treatment, or capacity to undergo criminal proceedings, which Article 81 of the Health Law regulates [3].

Results and Discussion

1. A map of the norms on family authority

Table 2 maps the norms on consent to medical treatment for patients with mental disorders. The regulation is layered: the Health Law sets the right and the list of persons, GR 28/2024 extends the written-consent requirement to every medical action, Law 8/2016 and the Constitutional Court decision govern the route of legal capacity, and MoH Reg. 290/2008 remains the only ministerial regulation specific to consent to treatment that the authors found.

Table 2. Map of the norms on consent to medical treatment for patients with mental disorders

Instrument and article	Content of the provision	Meaning for family authority
1945 Constitution Articles 28H(1) and 28I(4)	Right to health services; protection and fulfilment of human rights is a responsibility of the state, above all the government [1]	Constitutional basis
Health Law Article 276(b), (d) and (f)	Right to an adequate explanation; right to refuse or consent to medical action, except for preventing communicable disease and handling outbreaks or epidemics; right to seek another worker's opinion [3]	Rights exercised personally or replaced

Instrument and article	Content of the provision	Meaning for family authority
Health Law Article 293	Consent after explanation; written for invasive or high-risk action; given by the patient, or by a representative if incapable; signed and witnessed; emergency action without consent in the patient's best interests; procedure in a ministerial regulation [3]	General framework and the only best-interests measure
Health Law Article 80(1) and (2)	Inpatient care needs the patient's written consent; if considered incapable, consent may be given by five categories of party [4]	Basis of family authority
Health Law Article 80(3) to (5)	Emergency without consent where no party to consent exists; capacity determined by a specialist in psychiatry or the doctor serving at the time; right to determine action after cure [4]	Trigger, emergency, and end of authority
GR 28/2024 Article 148(c), (d) and (g)	Right to consent, with an exception for a severe mental disorder judged incapable, without a companion, and in an emergency; honest and complete information; managing own property, annulable only by court order [5]	Rights remaining with the patient; separation from property
GR 28/2024 Article 158	Written consent to medical action in the management of patients with mental disorders and narcotics abuse; list of five categories of party [5]	Extension from inpatient care to medical action
Law 8/2016 Article 12(d) and Articles 32 to 34	Right to determine one's own health services; a person with a disability may be declared incapable by district court order, with evidence from a doctor, psychologist and/or psychiatrist; the order may be annulled [34]	Route of legal capacity
Constitutional Court Decision 93/PUU-XX/2022	Article 433 of the Civil Code: "must" construed as "may"; "intellectually impaired, mentally ill or in a blind rage" construed as part of mental and/or intellectual disability [35], [36]	Guardianship is not automatic
MoH Reg. 290/2008 Article 1(2) and (7), Article 13	A competent patient, among other things, has no mental illness; the closest family comprises the spouse, biological parents, biological children, biological siblings, or a curator; consent by a competent patient or the closest family [33]	Still in force insofar as not conflicting (Article 453); a part presuming incapacity from diagnosis cannot be used (authors' reading)

Note: the third column is the authors' reading. Article 80 was read from the official file through a page-reading tool; other Health Law articles and GR 28/2024 from Pasal.id; MoH Reg. 290/2008 from a file downloaded in January 2024.

Three notes can be added. First, the scope of Article 80 and Article 158 differs. Article 80(1) speaks of management as an inpatient, whereas Article 158(1) of GR 28/2024 refers to medical action in the management of persons with mental disorders, addicts, abusers and victims of abuse of narcotics, psychotropic substances and other addictive substances [4], [5]. In the authors' reading, the list of persons in Article 158(2) fills a gap for medical action outside inpatient care, and it also covers addicts and abusers, whom Article 80 does not mention. Second, Article 293(12) leaves the procedure for consent to a ministerial regulation [3], and the authors found no ministerial regulation replacing MoH Reg. 290/2008. Third, under Article 453, implementing regulations of revoked statutes remain in force insofar as they do not conflict with the Health Law [3]; MoH Reg. 290/2008 therefore does not lapse automatically, but a part that conflicts cannot be used. The authors return to this point in the subsection on protection of rights.

2. Three situations and the trigger of authority

Articles 80 and 293 can be read as three different situations, and the distinction determines whether the family has any authority at all. Figure 1 summarises them, and Table 3 sets out who

decides, the basis, and what is not regulated in the articles read. This distinction into three situations is the authors' formulation from reading those articles.

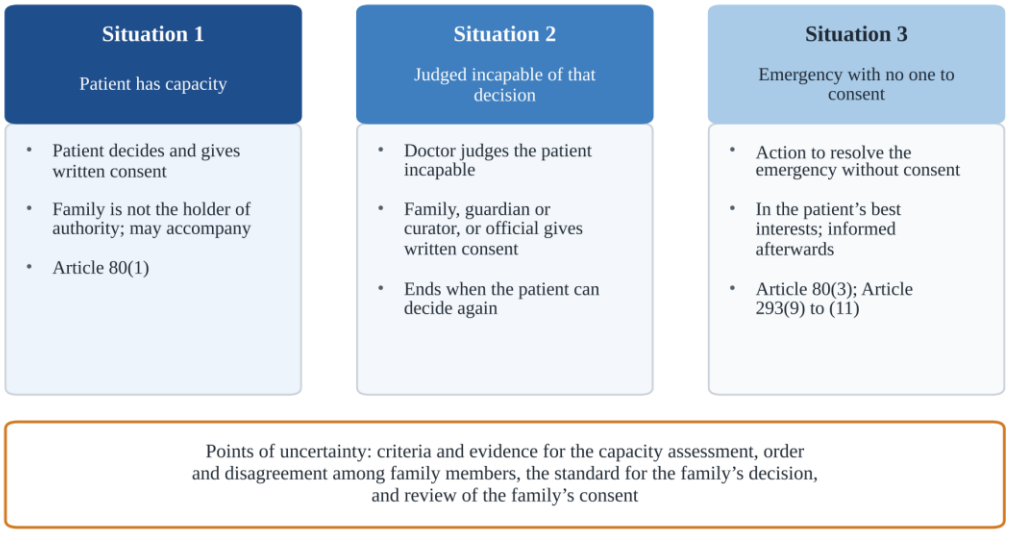

Figure 1. Three decision situations for medical treatment of a patient with a mental disorder and the points of uncertainty. Prepared by the authors from [3]–[5]; the marking of the points of uncertainty is the authors' reading.

Table 3. Three decision situations and what is not regulated

Situation	Who decides	Basis	Not regulated in the articles read
1. Patient has capacity	The patient; written consent for inpatient care and for medical action [4], [5]	Article 80(1); GR 28/2024 Articles 148(c) and 158(1)	Role of a companion; position if the family disagrees with a patient who has capacity
2. Judged incapable of that decision	One of the five parties in paragraph (2), after a doctor assesses [4], [5]	Article 80(2) and (4); GR 28/2024 Article 158(2)	Criteria and evidence for the assessment; order and disagreement; standard for the decision; the patient's refusal; review
3. Emergency with no one to consent	The medical or health worker in the patient's best interests, without consent [3], [4]	Article 80(3); Health Law Article 293(9) to (11)	A family that is present but refuses; meaning of companion in GR 28/2024 Article 148(c)

Note: the distinction into three situations and the fourth column are the authors' reading.

The first situation is a patient who has a mental disorder but has capacity. Article 80(1) places consent with the person with a mental disorder, Article 293(6) states that consent is given by the patient, and Article 148(c) of GR 28/2024 gives them the right to consent to medical action [3]–[5]. In the authors' reading, the family has no authority to give consent in this situation, because the opening clause of paragraph (2) applies only "where" the patient is considered incapable. The family may accompany the patient, but accompanying is not consenting, and the text read does not detail the role of a companion.

The second situation is a patient considered incapable of the decision at hand. The opening clause of paragraph (2) uses the wording "considered incapable of making decisions", not "has a mental disorder", and paragraph (4) leaves the determination of capacity to a specialist in psychiatry or the doctor providing medical care at the time [4]. Two points can be noted. First, that wording is consistent with the finding of Marcó-García et al. that capacity varies with the decision and the stage of care [15], whereas MoH Reg. 290/2008 defines a competent patient, among other things, as one with no developmental disorder or mental illness [33], which can be read as a presumption of incapacity based on diagnosis. Second, the words "at the time" in paragraph (4) imply an assessment when the decision is taken, which fits the

changeable nature of capacity; but the text read states no assessment criteria, instrument, or duty to record the basis. Raqib and Indrawan note that no standard instrument for assessing capacity exists [7], and Agusmidah et al. note that criteria of incapacity are not uniform across statutes [8].

Because the assessor may be the doctor providing care at the time, the quality of the assessment is at stake: not every doctor who assesses is a specialist in psychiatry. The four abilities described by Appelbaum can serve as a conceptual yardstick for the content of the assessment [14], but it is not an Indonesian norm and Article 80 does not require it. This reading is the authors' choice, and a proposal for the minimum content of an assessment is among the recommendations. Difficulty reaching family members, distance of residence, and patients without a home, which Rahmiyati et al. report as obstacles to obtaining consent [6], indicate that capacity assessments will often be made under time pressure.

The third situation is an emergency. Article 80(3) provides that where the patient is considered incapable and the party who may give consent under paragraph (2) does not exist, medical action to resolve the emergency may be given without consent. Article 293(9) to (11) adds that such emergency action is taken in the patient's best interests as decided by the medical or health worker, and must be communicated to the patient once capable or to the representative once present [3], [4]. Carlos, Risdawati and Simarmata found that this basis for acting without prior consent exists, with obstacles of documentation and procedure [21].

Article 148(c) of GR 28/2024 gives the right to consent, "except for those with a severe mental disorder who are considered incapable of making decisions and have no companion and are in an emergency" [5]. This wording can be read in two ways. The first reading treats the three conditions as cumulative, so that the exception applies only to a patient with a severe mental disorder who is considered incapable, has no companion, and is in an emergency. The second reading separates the conditions, so that the exception also applies to a patient who is merely considered incapable. The authors choose the first reading, because it narrows an exception to a right, and because the second would deprive Article 80(2) of meaning. This choice is the authors' interpretation. The difference from the wording of Article 80(3) should also be noted: GR 28/2024 refers to a "companion" and to a "severe mental disorder", whereas Article 80(3) refers to the absence of a party who may consent under paragraph (2) without limiting it to severe disorders.

One situation is not answered in the articles read, namely a family that is present but refuses action that is needed in an emergency. Article 80(3) and Article 293(9) apply when there is no party from whom consent can be sought, not when that party exists and refuses. The text read does not say who decides in that situation, and the authors found no decision that answers it.

3. The holders of authority: who, in what order, and in disagreement

Article 80(2) names five categories of party: the spouse; the parents; a child or sibling aged at least 18; a guardian or curator; and an official authorised under the laws and regulations [4]. Article 158(2) of GR 28/2024 contains the same list [5]. MoH Reg. 290/2008 defines the closest family as the spouse, biological parents, biological children, biological siblings, or a curator [33]. Both regulations use the wording "may give" and state no order, and the authors found no provision on order in the articles read.

The absence of an order raises three problems that the text does not answer. First, when family members in the same category disagree, for example two children one of whom consents and the other refuses, there is no rule on who decides. Second, when different categories disagree, for example a spouse and a parent, there is no rule of priority. Third, without an order, a facility could choose whichever party is willing to sign, which risks choosing the party easiest to reach rather than the one who best represents the patient's interests. These three points are the authors' reading of the structure of the articles, not findings about practice. Rahmiyati et al. report that reaching family members was a real difficulty in the hospital studied [6], so the question of order will often arise precisely when time is short.

Two other categories are also unclear. The age limit of 18 for a child or sibling shows that the lawmaker deliberately screened out minors, but it does not say whether that age suffices when the family member is under distress or has a conflicting interest. The category of authorised official under the laws and regulations carries no reference to a particular regulation, and the authors found no regulation designating that official in the articles read. Where the patient has no family, this party is the textual way out, but who the official is cannot be read. Article 148(c) of GR 28/2024 uses the term companion, which is not the same as the list in Article 80(2) and is not defined in the articles read [5].

4. Scope and standard of the family's decision

Family authority is limited to consent to medical action. Article 293(3) requires an explanation covering the diagnosis, indication, the action and its purpose, the risk of complications, alternatives, the risk if the action is not taken, and the prognosis [3]. In the authors' reading, an explanation of that content can be given only for a particular action, so consent taken once for several procedures, as reported by Rahmiyati et al. [6], does not meet the content of that explanation for procedures not yet explained. Article 158(1) of GR 28/2024 even requires written consent for medical action in the management of patients with mental disorders without screening for invasive or high-risk action as Article 293(5) does [3], [5]; this is the authors' reading of the two articles.

Family authority also does not extend to property or other legal acts. Article 148(g) of GR 28/2024 gives the patient the right to manage their own property, which can be annulled only by court order [5]. Family consent to medical action is therefore not a declaration of legal incapacity and gives no power to perform other legal acts on the patient's behalf.

Family authority ends when the patient is again able to decide. Article 80(5) states that a person with a mental disorder who has been cured has the right to determine the medical action to be taken [4]. Read literally, that wording ties the right to cure. In the authors' reading, a literal reading would leave a patient who is again able to decide, but not yet declared cured, under the family's decision, although capacity varies with the stage of care and the decision according to Marcó-García et al. [15]. A reading more consistent with paragraph (2) is functional: family authority ends for each decision the patient is again able to take. This reading is the authors' interpretation and has not been tested.

As to the standard for decisions, the text read contains only one measure, namely the patient's best interests for emergency action under Article 293(10), decided by the medical or health worker [3]. There is no measure for a family giving consent in the second situation. In the authors' reading, such a measure should exist and be tiered: the family follows the patient's wishes as far as they can be known, for example from earlier statements, and best interests only where wishes cannot be known. This tiered formulation follows the general idea in the literature on substitute decision-making [16], not an existing norm. The guidance of the World Health Organization and the Office of the High Commissioner for Human Rights points towards reducing coercion [17], and Raqib and Indrawan urge that the family shift from decision-maker to supporter, while noting that supported decision-making has not been formally adopted in Indonesia [7].

The right to information does not disappear when the family gives consent. Article 276(b) of the Health Law gives the patient the right to an adequate explanation, and Article 148(d) of GR 28/2024 gives the right to honest and complete information about their mental health data, including treatment received and to be received [3], [5]. In the authors' reading, the explanation to the patient must still be given to the extent the patient can understand it, and an explanation to the family does not replace it. The text read states no such duty for the second situation, apart from the duty to inform after capacity returns for emergency action under Article 293(11).

5. Capacity for consent and legal capacity

Table 4 distinguishes two routes of capacity that are often conflated. The first is the doctor's assessment of capacity for consent to treatment under Article 80(4). The second is the

district court order declaring a person with a disability incapable under Articles 32 to 34 of Law 8/2016, whose application must be accompanied by evidence from a doctor, psychologist and/or psychiatrist, and which can be annulled by the person or the family with evidence that the person is capable [34].

Table 4. Capacity for consent to treatment and legal capacity

Aspect	Capacity for consent to treatment	Legal capacity
Assessor	A specialist in psychiatry or the doctor providing medical care at the time [4]	District court on application, with evidence from a doctor, psychologist and/or psychiatrist [34]
Object of assessment	Ability to decide on the action at hand (the authors' reading of the wording of paragraph (2))	Legal status of a person with a disability; for guardianship, Article 433 of the Civil Code [34], [36]
Nature	May change with the decision and the stage of care (the authors' reading; see Marcó-García et al.) [15]	Persists until annulled; guardianship is "may", not "must" [36]
Review	Not regulated in the articles read; right to decide after cure (paragraph (5)) [4]	Annulment by the person with a disability or the family with evidence of capability (Article 34) [34]
Substitute	The five parties in paragraph (2)(a) to (e) [4]	Guardian or curator (paragraph (2)(d)) [4]

Note: the table was prepared by the authors from the articles read; the assessment of the relation between the two routes is in the text.

Constitutional Court Decision No. 93/PUU-XX/2022, pronounced on 31 July 2023, partly granted the petition on Article 433 of the Civil Code on guardianship. The phrase "dungu, sakit otak atau mata gelap" (roughly, intellectually impaired, mentally ill or in a blind rage) was construed as part of persons with mental and/or intellectual disability, and the word "harus" (must) was construed as "dapat" (may), so that guardianship becomes an option decided by a judge case by case, not an obligation [35], [36]. According to the summary read, the Court held that guardianship is still needed to protect persons with severe disabilities and those who deal with them, and viewed mandatory guardianship as conflicting with Article 32 of Law 8/2016 [36]. The petitioners in that case highlighted that Article 433 already recognises the state of being capable at times but treats episodic and permanent conditions alike [37]. Azzahra, Firdaus and Achmad assess that because the guardianship system remains, not all the rights of persons with mental disabilities can be fulfilled, so protection is not yet optimal [19].

The relation between the two routes can be read as follows. Family members under paragraph (2)(a) to (c) act on the doctor's functional assessment without a court order, whereas a guardian or curator under (d) acts on a court order. However, the opening clause of paragraph (2) applies to all letters, so textually the condition "considered incapable of making decisions" also applies to consent by a guardian or curator, and paragraph (4) places that determination with the doctor [4]. In the authors' reading, a guardianship order does not by itself remove the need to assess the patient's capacity for the medical decision at hand, and the curator's authority should be read as limited to what the order covers and to real incapacity for that decision. The text read does not say so, and it is the authors' interpretation that implementing regulations need to make explicit.

The difference has practical meaning. Article 12(d) of Law 8/2016 gives persons with disabilities the right to determine their own health services independently and responsibly [34]. The doctor's route is quick but has no review in the articles read, whereas the court route has review (Article 34) but is slow and unsuited to urgent medical decisions. The gap between the two, namely a doctor's assessment that cannot be reviewed, is where the greatest risk lies for a patient wrongly judged incapable.

6. Protection of patients' rights and prevention of abuse

The articles read keep several rights with the patient even when the family consents: the right to an adequate explanation (Article 276(b)), the right to seek the opinion of another health worker ((f)), the right to information about their mental health (Article 148(d) of GR 28/2024), the right to manage their property ((g)), and the right to determine action after cure (Article 80(5)) [3]–[5]. These rights, however, are not accompanied by a mechanism that makes them enforceable at the moment the family decides.

Documentation is the safeguard available. Article 80(1) requires written consent for inpatient care, Article 158(1) of GR 28/2024 for every medical action, and Article 293(8) requires written consent to be signed by the patient or representative and witnessed by a medical or health worker [3]–[5]. But a signature does not guarantee understanding: families in the hospital studied by Rahmiyati et al. had signed without understanding the side effects [6], and Chairul et al. and Azzahra et al. found formalism and weak supervision in consent to treatment generally [12], [13], [20]. In addition, the articles read do not require the capacity assessment and its basis to be recorded. Without that record, the condition that creates family authority cannot be checked later, and the family's signature becomes the only evidence. This is the authors' reading of a gap, not a finding about practice.

The articles read contain no prevention of conflicts of interest. A family may have interests different from the patient's, such as the burden of care, a relationship to property, or stigma, and Farhan et al. record stigma and cultural factors as obstacles to fulfilling the rights of patients with mental disorders [10], [11]. The authors found no evidence that such interests influence family consent and state this as a normative risk, not a finding. Article 80(2)(e) does provide for an authorised official, but does not say when that official replaces an interested family.

The articles read provide no route to review family consent. Kusumaningrum et al. found that consent is weakly implemented for patients with mental disorders and recommend adapted consent procedures and stricter sanctions and supervision [9]. Sinaga et al. found that the institutional role and technical procedure of non-litigation dispute resolution have not been regulated [23], and Mushari et al. propose a combined mediation model [22]. These findings are relevant as directions, not as findings about family consent.

The relation to MoH Reg. 290/2008 needs to be noted. Article 1(7) of that regulation, as the authors read it, classes a patient with mental illness as generally not competent, and Article 13(1) leaves consent to the closest family for an incompetent patient [33]. In the authors' reading, insofar as that wording treats a person as incapable on the basis of diagnosis, it conflicts with Article 80(2) and (4) and Article 148(c) of GR 28/2024, which require an assessment of capacity, so under Article 453 that part cannot be used [3]–[5]. This reading rests on a text downloaded in January 2024 and does not account for later changes, and for facilities still using the old forms the difference is practical.

7. The five-limits test

Table 5 tests the regulation of family authority against the five questions formulated in the literature review. The assessment is the authors' reading of the text read.

Table 5. The five-limits test of family authority

Limit	Finding in the text read	Authors' assessment
(1) Trigger	Authority arises when the patient is considered incapable; a doctor assesses (Article 80(2) and (4)); criteria, instrument, evidence and recording not regulated [4]	Partly
(2) Holder	Five categories of party; no order, resolution of disagreement, or meaning of companion and authorised official [4], [5]	Not yet
(3) Scope	Written and for medical action; does not extend to property; ends on cure, functional reading not made explicit [4], [5]	Partly
(4) Standard	Best interests only for emergency action (Article 293(10)); no standard for the family in the second situation [3]	Not yet

Limit	Finding in the text read	Authors' assessment
(5) Safeguards and review	Information, property and decision after cure remain with the patient; written consent witnessed; no recording of the assessment, prevention of conflicts of interest, or route of review [3], [5]	Partly

Note: the assessment is the authors' reading of the text read and is not based on data on practice.

On the first limit, the trigger, the norm already provides that family authority arises when the patient is considered incapable and that a doctor assesses (Article 80(2) and (4)) [4]. What is unclear is the criteria, instrument and evidence for the assessment, and whether a doctor other than a specialist in psychiatry may assess without consultation. Assessment: partly met.

On the second limit, the holder, the list of five categories exists, but an order, resolution of disagreements, and the meaning of companion and authorised official do not. Assessment: not met.

On the third limit, the scope, consent must be written and for medical action (Article 80(1), Article 158(1)), authority does not extend to property (Article 148(g) of GR 28/2024), and it ends on cure (Article 80(5)) [4], [5]. What is unclear is the reading of cure as regained ability to decide, and the relation of the doctor's assessment to a guardianship order. Assessment: partly met.

On the fourth limit, the standard, there is only best interests for emergency action (Article 293(10)) [3]. There is no standard for the family in the second situation. Assessment: not met.

On the fifth limit, safeguards and review, the rights to information, property and decision after cure remain with the patient, and written consent witnessed by a health worker is required [3], [5]. What is absent is a duty to record the capacity assessment, prevention of conflicts of interest, and a route of review. Assessment: partly met.

Grouped by status, what is permitted under the articles read is that the family or another party in paragraph (2) gives written consent when a doctor judges the patient incapable, and that medical workers act without consent in an emergency when no party can give consent (Article 80(2) to (4)). What is not permitted by the wording is the family replacing the decision of a patient with capacity (Article 80(1)), medical action without written consent (Article 158(1) of GR 28/2024), and annulling the right to manage property without a court order (Article 148(g)) [4], [5]. What is unclear is a family that refuses emergency action, a patient judged incapable who refuses, disagreement among family members, and review of the doctor's assessment. This grouping is the authors' reading of the text read.

8. Legal politics, supervision, and dispute resolution

Tanjung's studies with co-authors provide lenses for reading the findings above. All three are the authors' reading of the relevance of those studies, not findings about family consent. The first lens is the legitimacy of the form of regulation. Tanjung and Arminsyah argue that a non-transparent process with minimal public participation weakens legitimacy, and that the breadth of the government's power to change regulations is a risk [26]. Here, what determines the validity of family consent, namely the procedure for consent (Article 293(12)) and the designation of the authorised official (Article 80(2)(e)), is left to lower instruments that the authors did not find [3], [4], while MoH Reg. 290/2008 from the era of the revoked statute remains the only specific ministerial regulation [33]. If those instruments are not issued or change without participation, patients, families and facilities cannot know the limit.

The second lens is discretion. Tanjung, Syahnan and Syahputra assess that the requirement of compelling urgency was met but note concerns about subjectivity and the potential abuse of power [27]. The wording "considered incapable" and "emergency" has a similar quality on a much smaller scale: the power to assess exists, but objective measures cannot be read in the articles read [4], [5]. The third lens is supervision. Tanjung notes that supervision of judges is not held only by the Judicial Commission [28]. Supervision of family consent is also divided: hospitals, professional organisations, the government, and the courts through annulment of an order under Article 34 of Law 8/2016 [34], without a single route

linking the doctor's assessment to review. Adrianto, Sumarno and Zarzani found that weak coordination among institutions widens the gap between regulation and practice [24], and Pasaribu, Zarzani and Sahlepi concluded that coordination among the parties is needed to close gaps in detail [25].

The integrated approach in Tanjung's study of narcotics, which includes prevention, therapy and rehabilitation alongside enforcement [29], is relevant because Article 158 of GR 28/2024 also covers addicts and abusers of narcotics [5]. The view of Mahruzar et al. that criminal law is a last resort [32] is relevant to choosing instruments: abuse of family consent should first be handled through administrative, ethical and civil routes. This article does not examine that criminal liability. Suwarto, Sutiarnoto and Magda recommend harmonisation of norms for policy that is reactive and fragmented [31]; the relation among Article 80, Article 158, MoH Reg. 290/2008 and Law 8/2016 requires similar harmonisation. This is the authors' reading of that study.

On dispute resolution, Tanjung, Arminsyah and Syam propose a division of roles between a dispute-resolution body and a court that supervises, ratifies and executes its awards, together with synchronisation of regulations [30]. That model comes from Islamic economic disputes and has not been tested on consent to medical treatment. In the authors' reading, its pattern can be borrowed as a design: tiered review of family consent, starting at the hospital, with the court as the tester of capacity through the route that already exists in Article 34 of Law 8/2016, provided that the role and deadline of each institution are set in a norm that can be read.

9. Recommendations

The following recommendations are the authors' proposals and need to be tested by the regulator. First, the ministerial regulation implementing Article 293(12) should set the minimum content of a capacity assessment, namely the four abilities described by Appelbaum or a similar measure [14], that the assessment is made for each decision, that a non-specialist doctor consults a specialist in psychiatry where possible, and that the basis of the assessment is recorded in the medical record. Second, an order among the holders of authority, resolution of disagreement among family members, and the meaning of companion and authorised official need to be set, including who decides when a family that is present refuses emergency action.

Third, it should be made clear that family authority is subsidiary and ends for each decision the patient is again able to take, without waiting for cure, and that family consent does not extend to property or other legal acts. Fourth, a tiered standard for the family's decision should be set, namely the patient's knowable wishes and, where they cannot be known, best interests, together with a duty to explain to the patient to the extent they can understand and to respond to the refusal of a patient judged incapable. Fifth, prevention of conflicts of interest, a tiered route of review from the hospital to the court, and alignment of MoH Reg. 290/2008 with Article 80 and GR 28/2024 need to be designed. Sixth, further research should use interviews and medical-record data, which this article did not, to learn how family authority is exercised after the Health Law took effect.

Conclusion

Indonesian law regulates the family's authority to give consent to medical treatment for patients with mental disorders as a subsidiary authority. It arises when a doctor judges the patient incapable, is held by five categories of party, must be written, is confined to the medical action explained, does not extend to property, and ends when the patient is again able to decide (Article 80 of the Health Law and Articles 148 and 158 of GR 28/2024) [4], [5]. The authority does not apply to a patient with capacity, and in an emergency action may be given without consent when no party gives consent.

Legal certainty for the limits of that authority is only partly achieved. The trigger, the scope, and safeguards and review are partly answered, whereas the holder and the standard are not. The criteria and evidence for the capacity assessment, the order and disagreement among family members, the response to the refusal of a patient judged incapable and to a family that

refuses emergency action, the standard for the family's decision, and review of the family's consent are not answered in the articles read. This conclusion is limited to the text read, part of it from secondary sources, and is not supported by data on practice after the Health Law took effect.

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