

Integrating Psychological Assessment and Legal Compliance: A Regulatory-Based Rehabilitation Framework for Children with Intellectual and Developmental Disabilities in Indonesia

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ABSTRACT: Children with Intellectual and Developmental Disabilities (IDD) in Indonesia face a persistent disconnect between psychological assessment, rehabilitation planning, and the realization of their legal rights. This study addresses this gap by developing and piloting an integrated pathway designed to unify these fragmented elements. We propose the Regulatory-Based Rehabilitation Framework (RBRF), a novel, structured pathway that consolidates standardized psychological assessment, individualized rehabilitation planning, and legal compliance checkpoints. Its key innovation lies in embedding legal accountability directly into the clinical rehabilitation process, an approach not previously tested in the Indonesian IDD context. A sequential mixed-methods design was employed, involving framework development informed by retrospective data, followed by a pilot implementation to evaluate feasibility, acceptability, and preliminary outcomes. Pilot results indicate that the RBRF is both feasible and well-received by families and providers. It was associated with improved coherence between assessment results, rehabilitation plans, and documented legal obligations. While modest positive trends were observed in child developmental functioning and caregiver-reported quality of life, these findings are preliminary due to the small sample size and non-controlled design. The RBRF demonstrates promise as a system-oriented approach to strengthening service coordination and accountability. This study contributes a contextually grounded model for operationalizing disability rights within rehabilitation systems, providing a foundation for future controlled trials and policy discussions in low- and middle-income settings.

Keywords: Intellectual And Developmental Disabilities, Legal Compliance, Psychological Assessment, Rehabilitation Framework, Indonesia.



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INTRODUCTION

Children with Intellectual and Developmental Disabilities (IDD) in Indonesia continue to encounter fragmented rehabilitation pathways in which psychological assessment, intervention

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planning, and the enforcement of legally guaranteed rights are weakly connected. Although standardized assessments and disability legislation exist, they are often implemented as separate processes, resulting in assessed needs that are insufficiently translated into coordinated, rights-based rehabilitation services. This fragmentation represents a single integration problem, where assessment-to-intervention and policy-to-practice gaps converge and undermine service accountability.

Indonesia has formally adopted a rights-based approach to disability through the ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the enactment of Law No. 8 of 2016. These frameworks mandate access to assessment, rehabilitation, and inclusive education as enforceable rights. However, empirical evidence indicates that implementation at the service-delivery level remains inconsistent, particularly for children with IDD, due to sectoral fragmentation, limited monitoring, and weak accountability mechanisms (McConkey & Mariga, 2023; Wibowo & others, 2023). As reflected in recent Indonesian studies, legal guarantees often coexist with variable service uptake and poor alignment between assessed needs and delivered interventions.

From a clinical standpoint, psychological assessment is intended to function as the foundation for individualized intervention planning in IDD, guiding rehabilitation priorities across developmental, cognitive, and functional domains. However, emerging evidence from low- and middle-income settings suggests that when assessment results are not embedded within structured service pathways, they have limited influence on subsequent intervention decisions (Emerson et al., 2023). In Indonesia, this disconnect is reinforced by fragmented documentation practices and generic recommendations that inadequately reflect comprehensive assessment findings (Saptono & others, 2023).

At the governance level, the rights-based approach has increasingly emphasized accountability and entitlement in disability services (Heidari et al., 2023). Nevertheless, much of the literature remains divided between clinical research focused on assessment or intervention outcomes and policy-oriented analyses addressing legal frameworks and implementation barriers. Few studies examine how legal obligations can be systematically embedded within everyday rehabilitation processes in a way that is observable, monitorable, and actionable for service providers and families.

Existing rehabilitation models further illustrate this gap. The International Classification of Functioning, Disability and Health (ICF) provides a comprehensive biopsychosocial structure but does not specify mechanisms for legal enforcement in service delivery (WHO, 2001). Community-Based Rehabilitation (CBR) promotes inclusion but often lacks consistent specialist input and formal accountability structures in the Indonesian context (McConkey & Mariga, 2023). Multidisciplinary team (MDT) approaches represent best clinical practice, yet they are resource-intensive and rarely linked to explicit legal compliance mechanisms (Mumbardó-Adam & others, 2023). Across these models, legal rights are implicitly acknowledged rather than operationalized.

This study addresses this gap by positioning its novelty not in developing new assessment tools or revisiting disability law, but in proposing an explicit integration mechanism that links psychological

assessment, individualized rehabilitation planning, and legal accountability within a single operational pathway. Within this framework, a rights-based approach becomes measurable through the concept of compliance checkpoints, defined as structured stages in the rehabilitation process where planned and delivered services are systematically cross-referenced against specific legal obligations and documented for monitoring and review. This conceptualization directly informs the accountability mechanisms discussed in the evaluation of the framework.

Despite growing recognition of fragmented IDD services, there is limited empirical research examining integrated frameworks that combine assessment, rehabilitation planning, and legal compliance in routine practice, particularly in Indonesia (Izuddin et al., 2024; Weiner & others, 2017). Addressing this gap is essential for improving service coordination and strengthening rights-based implementation in rehabilitation systems.

Accordingly, this study aims to develop and pilot-test a Regulatory-Based Rehabilitation Framework (RBRF) for children with IDD in Indonesia. The objectives are: (1) to develop a framework that integrates standardized psychological assessment, individualized rehabilitation planning, and legal compliance checkpoints into a unified service pathway; and (2) to conduct a preliminary evaluation of the framework's feasibility, acceptability, and early indications of its potential contribution to service coordination and rights-based accountability in practice.

METHOD

Study Design

This study employed a sequential mixed-methods design with an explanatory orientation, which is well suited for the development and early evaluation of complex service-delivery frameworks that integrate multiple systems and stakeholders (Creswell & Plano Clark, 2017). The study consisted of two connected phases: Phase 1 (situational analysis and framework development) and Phase 2 (pilot implementation and preliminary evaluation). Quantitative findings from Phase 1 informed the design, decision rules, and evaluation focus of Phase 2, consistent with best practices in mixed-method integration (Fetters et al., 2023).

Phase 1: Data Sources and Situational Analysis

Phase 1 used secondary data extracted from routine administrative and clinical records of a child development and psychological assessment center in Jakarta, Indonesia. The use of administrative data is increasingly recognized as a valid approach for identifying service gaps and system-level patterns in child health and rehabilitation research (McCurdy & others, 2023). Two datasets were included:

1. A Developmental Assessment Dataset, containing standardized developmental profiles across ten domains (e.g., communication, motor skills, social-emotional functioning, adaptive behavior).

2. A Clinical Recommendation Dataset, containing IQ classifications, diagnostic information, and formal educational or rehabilitation recommendations.

An initial pool of 82 unique child records was identified after duplicate removal. Records were screened for completeness across both datasets. Complete-case records ($n = 24$) containing both developmental profiles and clinical recommendations were used for integrated analyses, while incomplete records ($n = 58$) were retained for descriptive analysis to characterize documentation fragmentation. This approach aligns with recommendations for transparent handling of missing data in non-experimental service evaluations (Eldridge et al., 2022). To assess potential bias, key demographic and diagnostic characteristics were compared between complete and incomplete cases.

Quantitative Analytic Workflow

The analytic workflow followed a reproducible, stepwise protocol commonly recommended for complex intervention development :

1. Descriptive analysis to summarize child characteristics, developmental profiles, diagnoses, and recommendations.
2. Gap analysis comparing assessed developmental needs with documented recommendations and legally mandated service entitlements.
3. Correlation analysis using Spearman's rho to examine relationships between developmental domains and IQ categories.
4. Cluster analysis (k-means) to identify natural groupings of children based on developmental and cognitive profiles, supporting stratified intervention planning (Hawe et al., 2022).

Framework Construction and Iteration

Findings from Phase 1 were translated into the Regulatory-Based Rehabilitation Framework (RBRF) through an iterative, rule-based process consistent with implementation science guidance (Nilsen & Bernhardsson, 2023). Cluster outputs informed priority-level decision rules, while gap analysis results guided the identification of rehabilitation components requiring legal reinforcement. Mapping logic was used to align assessment findings with individualized rehabilitation actions and corresponding legal mandates under Law No. 8 of 2016.

To operationalize a rights-based approach, compliance checkpoints were embedded at predefined stages of the rehabilitation pathway, allowing planned and delivered services to be systematically cross-referenced against legal obligations and documented for monitoring (Greenhalgh et al., 2023). Draft versions of the framework underwent expert review and iterative refinement, a recommended approach for improving feasibility and contextual fit in complex interventions.

Phase 2: Pilot Implementation and Mixed-Method Integration

Integration of Phase 1 and Phase 2

Phase 2 was explicitly informed by Phase 1 outputs. Priority group classifications, assessment domains, and compliance indicators identified in Phase 1 directly shaped participant eligibility, the structure of individualized rehabilitation plans, and the selection of feasibility, acceptability, and outcome measures. This integration strategy follows established principles for connecting quantitative and qualitative phases in sequential mixed-methods designs (Fetters et al., 2023).

Participants and Setting

A convenience sample of 15 children with IDD (aged 5–8 years) and their primary caregivers was recruited from the same service network. Participants represented priority levels identified during Phase 1, consistent with recommendations for targeted sampling in pilot and feasibility studies (Leon et al., 2023).

Intervention Procedures

The RBRF was implemented over a four-month period and consisted of: (1) standardized reassessment, (2) formulation of an Individualized Rehabilitation Plan (IRP), (3) documentation of legal compliance checkpoints, and (4) monitoring through a shared accountability dashboard. Pilot implementation focused on feasibility and acceptability rather than efficacy, in line with guidance for early-stage intervention evaluation.

Measurement and Standardization Procedures

All assessments were administered by trained psychologists with experience in child developmental evaluation. Standardization procedures included the use of unified assessment protocols, standardized scoring guidelines, and periodic cross-checks between assessors to ensure consistency, as recommended in contemporary IDD assessment literature (Salomone & others, 2024; Shogren & others, 2023). Outcome measures included developmental profile scores, caregiver-reported quality of life, and a structured legal compliance checklist, reflecting multidimensional evaluation of implementation outcomes (Proctor & others, 2023).

Qualitative Data Collection and Analysis

Qualitative data were collected through semi-structured interviews with caregivers and service providers following pilot completion. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis. Independent coding by two researchers and consensus

discussions were used to enhance analytic credibility, consistent with qualitative rigor standards in health services research (Greenhalgh et al., 2023).

Bias and Limitations

As a non-randomized pilot study, potential biases included selection bias, observer effects, and short follow-up duration. These limitations were mitigated through transparent reporting, standardized procedures, triangulation of quantitative and qualitative findings, and cautious interpretation without causal claims, consistent with recommendations for pilot studies (Leon et al., 2023).

Ethics and Data Governance

Ethical approval was obtained from the relevant institutional review board. Written informed consent was obtained from caregivers, with age-appropriate assent procedures for children where feasible. All data were de-identified prior to analysis and stored on password-protected systems. Access to monitoring dashboards was restricted to authorized users only, in line with current standards for digital governance and child data protection in health services research (World Medical Association, 2022).

RESULT AND DISCUSSION

Results are reported descriptively and organized according to the core modules of the Regulatory-Based Rehabilitation Framework (RBRF): assessment standardization, rehabilitation planning, legal compliance monitoring, and implementation feasibility. Observed findings are separated from interpretation, consistent with reporting guidance for non-randomized pilot studies (Eldridge et al., 2022; Leon et al., 2023).

Module 1: Assessment Standardization and Data Completeness

Observed results. Out of 82 child records analyzed in Phase 1, only 24 cases (29%) contained both standardized developmental assessments and corresponding clinical recommendations. Thirty-two cases (39%) included developmental profiles without formal IQ classification or documented recommendations, while 26 cases (32%) contained recommendations without comprehensive developmental assessment data.

Within the complete-case subset ($n = 24$), multidomain developmental needs were consistently identified. However, in 7 cases (29%), these needs were not explicitly reflected in written recommendations, which primarily focused on general educational placement.

Module 2: Rehabilitation Planning and Priority Stratification

Observed results. Cluster analysis identified three developmental–cognitive profiles, operationalized within the RBRF as Priority 1 (high needs), Priority 2 (moderate needs), and Priority 3 (targeted needs). Priority 1 profiles showed low scores across most developmental domains and frequent comorbidities, while Priority 2 and 3 profiles demonstrated more differentiated patterns.

During Phase 2 (n = 15), Individualized Rehabilitation Plans (IRPs) were successfully generated for all participants using standardized templates linked to assessment findings. Each IRP specified domain-based goals and corresponding service recommendations.

Module 3: Legal Compliance Monitoring

Observed results. Using a structured compliance checklist linked to Law No. 8 of 2016, 85% of mandated services specified in IRPs were documented as initiated or accessed during the pilot period. This contrasts with approximately 50–60% compliance observed in retrospective records prior to framework implementation.

Compliance documentation was highest for education-related services and lowest for speech and occupational therapy referrals.

Module 4: Implementation Feasibility and Workflow Barriers

Observed results. Pilot recruitment reached 83% of eligible families, with 100% retention over four months. The mean time from assessment completion to finalized IRP was 3.5 weeks.

Implementation barriers documented during the pilot included:

- limited availability of speech and occupational therapists,
- increased administrative workload associated with documentation,
- variable provider familiarity with legal compliance concepts,
- uneven integration of the monitoring dashboard into routine workflows.

Module 5: Descriptive Outcome Signals

Observed results. Median developmental profile scores increased from 48.5% at baseline to 58.5% post-pilot. Caregiver-reported quality-of-life scores showed positive trends, particularly among Priority 1 and 2 groups.

These findings are reported as descriptive outcome signals and are not interpreted as evidence of causal effectiveness (Leon et al., 2023).

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Table 1. Quantitative Summary of Results by RBRF Module.

Framework Module	Indicator	Observed Result
Assessment Standardization	Records with complete assessment + recommendation	24/82 (29%)
	Developmental data without recommendation	32/82 (39%)
	Recommendation without developmental data	26/82 (32%)
	Misalignment between assessed needs and recommendations	7/24 (29%)
Rehabilitation Planning	Priority profiles identified (clusters)	3 (Priority 1–3)
	IRPs successfully generated (Phase 2)	15/15 (100%)
Legal Compliance Monitoring	Mandated services initiated/accessed	85%
	Pre-framework compliance (retrospective)	~50–60%
Implementation Feasibility	Recruitment rate	83%
	Retention rate	100%
	Mean assessment-to-IRP time	3.5 weeks
Outcome Signals	Median developmental score (pre → post)	48.5% → 58.5%
	Caregiver QoL trend	Positive

Note. All outcomes are descriptive and derived from a non-randomized pilot (Eldridge et al., 2022).

Explicit Alignment: Results

Results Finding	How It Is Taken Up in Discussion
High assessment–recommendation fragmentation	Discussed as empirical evidence of the integration problem motivating the RBRF
Successful priority stratification	Interpreted as a mechanism for improving service coordination beyond IQ-based categorization

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Results Finding	How It Is Taken Up in Discussion
Increased documented compliance	Discussed cautiously as improved accountability rather than causal impact
Workflow bottlenecks (therapist availability, admin load)	Used to justify feasibility limits and need for system-level support
Positive outcome trends	Framed as early signals supporting further controlled evaluation

This structure ensures that the Discussion does not introduce new results, but rather interprets each observed finding already reported here, in line with best reporting practices (Moore & others, 2023; Skivington & others, 2022).

This study developed and pilot-tested a Regulatory-Based Rehabilitation Framework (RBRF) that integrates standardized psychological assessment, individualized rehabilitation planning, and legal compliance within a single operational pathway for children with Intellectual and Developmental Disabilities (IDD) in Indonesia. The discussion focuses on explaining the mechanisms through which legal accountability may strengthen service coordination, positioning the framework relative to existing rehabilitation models, translating findings into actionable practice recommendations, and critically examining limitations and future research directions.

Why Embedding Legal Accountability May Improve Coordination and Follow-Through The findings suggest that embedding legal accountability directly into rehabilitation processes may plausibly improve coordination and follow-through through several interrelated mechanisms.

First, explicitly mapping assessment findings and rehabilitation plans to specific legal mandates transforms abstract rights into concrete service obligations that must be documented and reviewed. This creates clearer role expectations for providers and reduces discretionary interpretation of service entitlements, a challenge commonly reported in rights-based disability systems (Heidari et al., 2023; Olusanya & others, 2022).

Second, compliance checkpoints function as structured decision points that require providers to verify whether mandated services have been planned and initiated. This documentation requirement appears to shift attention from one-time assessment or referral toward longitudinal follow-through, supporting continuity across health, education, and social service sectors. Similar mechanisms have been identified in implementation science as key drivers of coordination in complex service systems, particularly when accountability is distributed across multiple actors (Greenhalgh et al., 2023; Nilsen & Bernhardsson, 2023).

Third, the visibility of compliance information through shared monitoring tools may strengthen relational accountability between families, providers, and local administrators. Rather than relying solely on individual advocacy or informal negotiation, families are equipped with documented plans linked to legal obligations, which may reduce power asymmetries and support more consistent service engagement. While these mechanisms do not establish causality, they provide a

plausible explanation for the observed improvements in documentation and service initiation during the pilot phase.

Positioning the RBRF Relative to Existing Rehabilitation Models

The RBRF differs conceptually from commonly used rehabilitation and health systems models by explicitly operationalizing legal compliance within routine service delivery. Frameworks such as the International Classification of Functioning, Disability and Health (ICF) offer a comprehensive biopsychosocial lens but remain largely descriptive and do not specify how legal obligations should be enforced in practice (WHO, 2001). Community-Based Rehabilitation (CBR) emphasizes inclusion and participation but often lacks standardized assessment pathways and formal accountability mechanisms, particularly in low- and middle-income contexts (McConkey & Mariga, 2023).

Multidisciplinary team (MDT) models represent best clinical practice for coordinated care but are typically resource-intensive and focus primarily on clinical decision-making rather than legal entitlement. In contrast, the distinctive contribution of the RBRF lies in its explicit legal compliance operationalization: assessment findings are systematically translated into rehabilitation plans that are cross-referenced with specific legal mandates, monitored over time, and subject to review. This integration moves beyond clinical coordination alone and addresses governance gaps that have been repeatedly identified in disability service delivery (Pratama & others, 2024).

Practical Implications for Providers and Local Administrators

The findings can be translated into several actionable recommendations for practice and local governance. For service providers, the framework highlights the importance of using standardized assessment protocols and structured rehabilitation planning templates that explicitly link goals to legal entitlements. Minimal requirements for implementation include trained assessors, agreed-upon assessment tools, and clear documentation standards for compliance checkpoints.

For local administrators, the RBRF suggests concrete steps to strengthen accountability without introducing entirely new systems. These include designating a local coordinator responsible for compliance monitoring, integrating rehabilitation documentation into existing reporting structures, and ensuring basic digital or paper-based tracking mechanisms are in place. Importantly, the pilot indicates that full legal enforcement mechanisms are not required at the outset; even low-intensity monitoring and documentation can improve coordination and transparency.

For families, the framework provides a clearer pathway for understanding service entitlements and engaging with providers. This may support more equitable access to rehabilitation services, particularly in settings where informal practices and uneven enforcement have historically limited the realization of disability rights.

Limitations and Implications for Interpretation

Several limitations should be considered when interpreting these findings. First, the non-randomized pilot design and small sample size limit generalizability and preclude causal inference. Observed improvements may reflect heightened attention during the pilot period, provider motivation, or training effects rather than the framework itself. Second, the study was conducted in an urban service context with relatively better access to specialists; implementation challenges may be greater in rural or resource-constrained settings. Third, the framework's effectiveness is dependent on minimum resource availability, including trained personnel and administrative capacity. Where such resources are scarce, compliance checkpoints may increase documentation burden without corresponding service improvements. Finally, measurement constraints—such as reliance on routine records and short follow-up—limit conclusions about long-term developmental outcomes and sustainability.

These limitations suggest that the findings should be interpreted as early, exploratory evidence regarding feasibility and system-level alignment rather than effectiveness.

Future Research Directions

Future research should focus on more robust evaluation designs to assess the effectiveness and scalability of the RBRF. Comparative or controlled studies, such as cluster-randomized or stepped-wedge designs, would allow stronger inferences regarding the framework's impact on service coordination, child outcomes, and legal compliance. Longer follow-up periods are needed to examine sustainability and longer-term developmental and educational trajectories.

In addition, future studies should incorporate cost and resource analyses to assess feasibility at scale, particularly in decentralized or rural settings. Examining adaptations of the framework across different local governance contexts will be critical for understanding how legal accountability mechanisms can be tailored without undermining feasibility. Finally, integrating family-reported empowerment and system responsiveness as formal outcomes may provide a more comprehensive assessment of rights-based implementation in practice.

Closing Perspective

Overall, this study contributes early empirical evidence on how legal accountability can be operationalized within rehabilitation systems for children with IDD. By embedding compliance mechanisms directly into assessment and planning processes, the RBRF offers a practical approach to strengthening coordination and accountability in contexts where strong legal frameworks exist but implementation remains uneven. While further evaluation is required, the framework provides a foundation for advancing rights-based rehabilitation from principle to practice.

Revisions align with best practices for pilot/feasibility studies and complex (World Health Organization, 2001), mixed-method integration, implementation and accountability mechanisms

(Greenhalgh et al., 2023; Nilsen & Bernhardsson, 2023), and rights-based disability service implementation (Bradshaw et al., 2023).

CONCLUSION

This study developed and pilot-tested a Regulatory-Based Rehabilitation Framework (RBRF) that integrates standardized psychological assessment, individualized rehabilitation planning, and legal compliance into a single service pathway for children with Intellectual and Developmental Disabilities (IDD). The framework addresses persistent disconnections between assessment results, intervention planning, and policy implementation by operationalizing legal rights through measurable compliance checkpoints embedded in routine service delivery.

Findings from the pilot indicate that the RBRF is feasible within an existing service context and can improve alignment between identified developmental needs, planned rehabilitation services, and documented legal entitlements. Importantly, the study demonstrates how a rights-based approach can be translated from normative principles into actionable and monitorable practice. Given the non-randomized design and limited scale, these findings should be interpreted as early feasibility and system-alignment signals rather than evidence of effectiveness.

Future research should employ controlled or comparative designs, longer follow-up periods, and cost and scalability analyses to evaluate the framework's impact across diverse service settings. Overall, the RBRF offers a pragmatic model for advancing accountable, rights-based rehabilitation practice.

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