WILEY | Hindawi

Research Article

Perspectives of Indonesian Caregivers and Health Practitioners on Community-Based Mental Health Services

Ira Kusumawaty [ID],[1] Yunike [ID],[1] and Arif Setyo Upoyo [ID][2]

[1]Department of Nursing, Politeknik Kesehatan Kemenkes Palembang, Palembang, South of Sumatera, Indonesia
[2]Department of Nursing, Faculty of Health Sciences, Universitas Jenderal Soedirman, Purwokerto, Indonesia

Correspondence should be addressed to Arif Setyo Upoyo; afkarfadholi@gmail.com

The establishment of integrated mental health services (IMHS) can downgrade a substantial gap in mental health psychotherapy. Although the hurdles of IMHS implementation are well-known, barely any research has been conducted on the viewpoint of satisfaction and expectations of caregivers for people with mental diseases (CPWMDs) towards IMHS. Identifying and analyzing the perspective of CPWMD as an IMHS service user is crucial for closing the gap and achieving community mental health optimization. *Purpose.* This study intends to investigate the perspective of Indonesian caregivers and health practitioners on community-based mental health services. *Method.* The study was conducted in four IMHS with twenty-three CPWMD, and families who have a relative with a mental disorder assisted them in using IMHS. Through in-depth interviews with caregivers, this study collected qualitative data. Triangulation of sources and techniques is to ensure reliability by undertaking focus group discussions (FGDs) with eight health workers and eight health cadres. The results of data collection were transcribed and then analyzed thematically. During the analysis procedure, repeating the data recording process aims to obtain complete information. *Results.* The CPWMDs were satisfied since their assistance supported them in overcoming mental health issues in the family. Even though pharmaceuticals and psychotherapy are available at no cost, they consider that psychological procedures are necessary but receive less attention. Significant challenges that impede access to IMHS include the restricted availability of health workers for patient follow-up, the frequent depletion of medication supplies, the absence of a private space for consultations, and stigma. *Conclusion.* The IMHS are accessible to the community and positively affects the patient's mental health. A psychotherapy supply management system, a confidential consultation space, and an online self-help group be developed. Additional training among health workers and health cadres in psychoeducation is significantly critical to diminish the stigma.

1. Introduction

Severe mental problems can result in patient productivity deterioration and a considerable cost burden for families, communities, and governments. In terms of incidence and severity, mental illness also significantly correlates with community-level issues [1–3], meaning that mental illness conditions have a serious impact on community problems. Mental health issues are accountable for 10.4 percent of the worldwide illness burden of disability-adjusted life years (DALYs) [4]. There is a considerable difference between the number of individuals who require mental health care and those who already receive such care. Previous studies showed above 75% of those with anxiety, psychological disorders, or substance disorders [5] and 87.7% of those with alcoholism and addiction [6, 7] did not experience psychotherapy throughout the preceding year. One in twenty-seven individuals with depression and one in ten individuals with an anxiety illness who provide care for a patient receive the least suitable psychotherapy [1, 7].

People with serious mental illnesses can be chained, kept in forced seclusion, and experience sexual violence and other abuses on community platforms, comprising family, traditional medicine, and other religious institutions in some African countries [8–10]. Outreach to the community is vigorous for the protection of human rights. Poverty, racial

intolerance, trauma experiences, and human rights violations [8, 11] are the main problems. In addition, escalated stigma in the population and broader healthcare providers against individuals with mental illness can hinder patients from accessing professional mental health services. The limited assessment and recognition of their need for care, the scarcity of the transportation system to the public health center (PHC) and the availability of health workers and health cadres trained in psychiatric care, and the lack of the best psychosocial intervention in health facilities all perform to be additional obstacles [12–14].

In Indonesia, the proportion of mental disorders was quite significant based on the 2018 Basic Health Research results compared to the 2013 Basic Health Research results, up from 1.7% to 7%. In the South Sumatra, the number of people with schizophrenia reached 6.7 per mile, with adherence to taking the medication regularly at only 48.9% [3]. According to the South Sumatra Provincial Health Office it was known from 2017 to 2018, there was the enhancing number of PWMD by 31.73%, and in Palembang there is a declining amount of mental health service visits by 9.93%, and a reduction in the utilization of mental health services by 63.02%. Although shackles are considered a severe human rights violation [3, 15, 16], the cases of restraints in Palembang still exist.

The family as a system has attachments between family members. The condition of mental disorders of family members affects individual family members and the family as a system. Satisfaction and fulfillment of family expectations for health services can contribute to caring for family members with mental disorders in undergoing long periods of care. Satisfaction and fulfillment of family expectations for health services is very crucial in determining the continuity of family caring for the relative in long treatment period due to suffering from mental disorders [17]. One research illustrated family satisfaction improving care for psychiatric patients and is particularly important for assessing psychiatric care [18]. This study uses the Brazilian Mental Health Service Satisfaction with a qualitative approach to identify family satisfaction includes various components of health services, including psychotherapy outcomes, family acceptance, practitioner competence, and confidentiality protection [18]. The SERVQUAL model directs almost the same approach in evaluating service quality, namely, the tangible, reliability, responsiveness, assurance, and empathy aspects [19].

Considering the accessibility of mental health services across the population by increasing the affordability of services, acceptance, expenditure, and sustainability in particular conditions. Medication adherence also has favorable clinical outcomes [20–22]. Furthermore, community services may portray an essential responsibility in raising awareness of mental health issues, eliminating prejudice and discrimination, encouraging recovery and adjustment, and avoiding mental illness [23–25]. Consequently, the latest initiatives and recommendations worldwide are placing a convincing emphasis on psychiatric services in the community that can minimize inequality in access to mental health services. The World Health Organization's (WHO) Mental Health Action Plan for 2013–2020 calls for the delivery of essential, strategic, and long-term healthcare delivery, including community promotion and prevention programs that incorporate the perspective and engagement of healthcare providers and families [3].

Progressively studies have demonstrated the efficiency of mental health services by qualified healthcare professionals [26–28], and this method has also been widely supported as a technique for completing psychotherapy. In inequality, especially in low- and middle-income countries, mental health professionals are scarce and mental health spending is unbalanced, even though mental health is very much influential in the emotional, physical, and social well-being of life. Some investigations [2, 29, 30] have reported challenges to the introduction and scalability of mental health care within the healthcare system at PHC; however, this study mainly focuses on the perspective of CPWMD, who are always caring the patient at home and together visit IMHS. We investigated the experiences and perspectives of CPWMD, eight health practitioners (four nurses and four doctors), and eight health cadres who work at four community health centers in Palembang, Indonesia. Investigative efforts through a qualitative approach were conducted to gain a deep understanding of the family's satisfaction and expectations for the services provided, in addition to being able to provide suggestions for optimizing quality of services. This study aims to explore the satisfaction and expectations of CPWMD to recommend constructive efforts in managing IMHS according to its potential and following the development of science and technology material and methods.

2. Method

The study was conducted at four public health centers (PHC) in Palembang, South Sumatra Province, Indonesia. The four health centers integrate mental health services through the establishment of IMHS. This study involved the caregiver as a relative of a person with a mental disorder (depression, alcoholism, and psychosis) and had participated in IMHS activities. The Baron et al. cohort study [28] explained that service users were chosen intentionally according to predetermined criteria, namely, being at least 16 years old, enrolled in a cohort study, and has a relative with mental disorder who is receiving health services at IMHS. The study was conducted on [23] PWMD caregivers, [6] with depression, [12] with psychosis, and [5] with alcohol addiction. As a triangulation effort, this study recruited eight health workers (four doctors and four nurses) and eight health cadres from four health centers. Nurses and doctors are the holders of mental health programs in community health centers, and the health cadres recruited are mental health cadres. Ethical approval has been obtained from the Health Research Ethics Committee at the Palembang Health Polytechnic with the number 1271/KEPK/Adm2/IX/2021, and stated that this study was in accordance with the Declaration of Helsinki. The participants involved signed the informed consent form before participating in the study.

2.1. Data Collection and Analysis. Before the data collection, the researcher enlightened the informed consent of the participants and signed it after they comprehended the study's objectives. Data collection through in-depth interviews with patient caregivers was accomplished using a semistructured interview protocol. Before initiating data collection, the researcher created a reliable interview guidance, and the questions were suitable and well-defined by conducting trials on other laypeople. According to a mutual agreement, in-depth interviews for 60–90 minutes were carried out at the caregiver's house. To ensure the trustworthiness of the research, after completing the in-depth interviews, the researchers triangulated methods and sources by conducting separate FGD with groups of health workers (doctors and nurses) and groups of health cadres. The FGD location was determined based on the researcher and participants' agreement with a duration of 120 minutes. Voice recorders and cameras facilitated the entire data collection process, and information conveyed could be appropriately documented. Key themes related to services for both consumers and mental health providers are the availability of care received and the time spent by health workers and cadres. Another component concerns the confidentiality of information conveyed by caregivers, attitudes, skills, and competencies of health workers, satisfaction, and obstacles to running mental health services. The data gathering is conducted between October 2021 and February 2022. The experienced research team worked and recorded all interviews in Indonesia.

The questions asked refer to in-depth interview guidelines based on the concept of family system, Brazilian Mental Health Service Satisfaction, and SERVQUAL. For the purposes of data triangulation, the research team conducted FGDs with practitioners to clarify information that had been conveyed by caregivers in previous in-depth interviews. The researcher guarantees data credibility by translating back and forth from English to Indonesian.

This study uses thematic analysis when analyzing the data [32, 33]. Initially, the audio-recorded interview was changed into the original language (Indonesian), and it immediately followed the conversation. Data analysis was carried out comprehensively and repeatedly. First, two researchers read the transcripts to familiarize themselves with the material and find new themes and appropriate codes for each topic. Next, they categorized the interviews independently and created a coding framework for content analysis based on the interview schedule and new topics discovered during data acquisition. Third, the coding framework was evaluated and discussed with other team members who participated in topic development and field data collection and linked the information obtained based on the results of the focus group discussions. Research reporting follows the consolidated criteria for reporting qualitative research (COREQ) guidelines.

3. Results

Tables 1 and 2 describe the characteristics of the participants.

This study resulted in the following six themes: affordability to reach health services, the complexity of interaction during services, various customer satisfaction with services, the appearance of services provided, barriers to access health services, and health services impact (Table 3).

3.1. Affordability to Reach Health Services. Although every health worker in the four PHCs had been trained, offerings (such as psychological and pharmacological therapy) were provided free of charge, and community members, namely caregivers, had mixed feelings about the accessibility of services. Caregivers who live close to health facilities explain that the system is widely available when needed. Another respondent who lives far from healthcare facilities stated that they have difficulty in accessing therapy because of the distance. Some service users are reluctant to visit health facilities because they must pay for transportation. In many circumstances, healthcare professionals regularly contact caregivers for follow-up and to verify that clients receive medications on time. "Health workers used to visit our home and advise and reassure my father," said a caregiver of one participant with depression about how primary health workers encouraged her father during home visits. They gave me medicine and then called once a month to check on my dad's health at IMHS." (caregivers for a patient with depression).

Based on the results of the FGD, it seems that "Most of the caregivers who are diligent in remonitoring patients at IMHS are patients whose houses are close to IMHS, usually those reached on foot. But some caregivers bring sufferers here even though their homes are distant. We go to the patient's house, especially if the patient has never been monitored directly at the PHC; we bring medicine and examination curves to his house. In some cases, the caregiver only asks for medicine because the patient refuses to be brought to IMHS." (groups of doctors and nurses). The cadre group added, "it's a bit difficult to motivate the family to come to IMHS to inspect if the house is a bit faraway" (health-cadre group).

3.2. The Complexity of Interaction during Services. Caregivers of patients expressed positive interactions with healthcare professionals. The behavior of health workers is multibeneficial, compassionate, respectful, and empathetic, as it encourages them to use solutions and provides valuable advice (psychoeducation and counseling). The following statement was given by patient's caregiver: "I am pleased with their service. They gave me more detailed information about my son's problem. They managed to convince me on the importance of therapy for my son's situation. Then, I realized that treatment was for my children, not for them. After talking to them, I feel much more comfortable and pleasant. They are very good to me. My son also got medicine. I'm back from getting a prescription for my son." (an alcohol-addict caregiver).

Caregivers raise concerns with health workers if they cannot provide time to deliver input or direction when the caregivers consult regularly or get additional treatment. Another problematic issue expressed by participants was

TABLE 1: Participant's characteristics.

No	Participant's code	Age (yrs)	Gender	Race/ethnicity	Religious background
1	P1	60	Female	Javanese	Moslem
2	P2	58	Female	Sumatran	Moslem
3	P3	59	Female	Sumatran	Moslem
4	P4	55	Female	Sumatran	Moslem
5	P5	55	Female	Javanese	Moslem
6	P6	59	Female	Sumatran	Moslem
7	P7	59	Male	Sumatran	Moslem
8	P8	54	Male	Sumatran	Moslem
9	P9	53	Female	Sumatran	Moslem
10	P10	58	Female	Sumatran	Moslem
11	P11	58	Female	Sumatran	Moslem
12	P12	57	Female	Sumatran	Moslem
13	P13	56	Female	Sumatran	Moslem
14	P14	56	Female	Sumatran	Moslem
15	P15	58	Female	Sumatran	Moslem
16	P16	55	Female	Sumatran	Moslem
17	P17	60	Male	Javanese	Moslem
18	P18	53	Female	Sumatran	Moslem
19	P19	57	Female	Sumatran	Moslem
20	P20	56	Female	Sumatran	Moslem
21	P21	58	Female	Sumatran	Moslem
22	P22	59	Female	Javanese	Moslem
23	P23	61	Female	Sumatran	Moslem

TABLE 2: Mental disorder history of participants' relative.

No	Patients code	First diagnosed mental disorder	The main problems
1	C1	2018	Psychosis
2	C2	2018	Psychosis
3	C3	2017	Depression
4	C4	2017	Alcohol addiction
5	C5	2018	Psychosis
6	C6	2016	Psychosis
7	C7	2014	Psychosis
8	C8	2014	Alcohol addiction
9	C9	2015	Depression
10	C10	2014	Alcohol addiction
11	C11	2013	Depression
12	C12	2018	Alcohol addiction
13	C13	2017	Psychosis
14	C14	2018	Psychosis
15	C15	2017	Psychosis
16	C16	2016	Psychosis
17	C17	2015	Depression
18	C18	2015	Depression
19	C19	2017	Alcohol addiction
20	C20	2018	Psychosis
21	C21	2019	Psychosis
22	C22	2013	Depression
23	C23	2016	Psychosis

that some health workers did not arrive at the health facility on time. They believe that convinced health workers are not serious about fulfilling their responsibilities and only care about getting the job done. Some caregivers stated that an adequate explanation does not always follow drug treatment. They did not allow me to think critically or seek further advice from them.

FGD participants clarified the information provided by the patient's caregiver, "at certain times when there are many patient visits, it is difficult to take the time to provide advice for sufferers and their caregivers. However, we always try to maintain our professional appearance" (FGD of doctors and nurses). The healthcare group added, "we are cadres together with doctors and nurses trying to provide the best service for

TABLE 3: Theme formulation processes.

Excerpts of in-depth interviews and FGDs	Coding	Category	Theme
Psychotherapy was provided free of charge … the system is widely available when needed … health workers used to visit our home and advise and reassure my father … medicine once a month	Treatment	The driving force to reach public health centers	Affordability to reach health services
Healthcare professionals regularly contact caregivers for follow-up and to verify the timely reception of medications	Advocation		
… We have difficulties accessing psychotherapy because of the distance … it is far…	Remoteness	The obstacle to reaching public health centers	
Some service users are reluctant to visit health facilities because they must pay for transportation … we are poor people ….	Shell out		
They are multibeneficial, compassionate, respectful, and empathetic, as it promotes them to use solutions and provides valuable advice	Gracious	Professional service as expected	The complexity of interaction during services
They gave me more detailed information about my son's problem, convince me the psychotherapy importance for my son's situation	Preserving		
… I feel much more comfortable . very good … we always try to maintain our professional appearance	Hearten		
We often run out of time for consultation services when caregivers come to us … we will not be able to spend much time providing feedback or guidance	Lack of time	Serve in a limited time	
Some health workers did not reach the health facility on time. …we do not always obtain adequate explanations	Delayed		
I appreciated the whole psychotherapy process, from taking my medication to receiving ongoing psychosocial counseling for my family…good advice and guidance…the patient's condition improved after receiving IMHS services … I feel happy because I received much help from IMHS for my child	Proficient	Practitioners fulfill customer expectation	Various customers' satisfaction with services
A nurse once came to my house and promoted me not to be afraid of my partner and to care for him as best i could… they encourage the family to check the patient	Motivate		
… Advised to love and speak to patients them with kindness…my son has improved … They examine, monitor symptoms, administer medication, and provide psychoeducation, counseling…	Knowledgeable		

TABLE 3: Continued.

Excerpts of in-depth interviews and FGDs	Coding	Category	Theme
Sometimes we cannot receive psychotherapy due to the lack of availability of medication we are forced to buy medication ... only a few psychotherapies are provided	Scarcity	Worries about inadequate medicines availability	Barriers to accessing health services
...Need the transportation costs plus buy medicine...which are quite expensive and we do not think we can afford it...	Costly		
...The unavailability of a private room for consultation ... the health workers did not provide a separate room for consultations ... actually I wanted to talk about my sadness	Lack of privacy	There is no private consultation space	
We were embarrassed when we had to consult because other people could listen during the consultation ... unpleasant for us...	Uncomfortable		
Only one doctor or nurse often serves us ... the health workers who did not even come to the health facilities on schedule...	Inadequacy	Limited health expert personnel	
Caregivers often claim unpleasant comments from the local community ...afraid of being attacked suddenly ... saw them as embarrassing	Distinction	Prejudice and stigma	
We feel humiliated, ostracized, annoyed, and considered as suffering from a cursed disease because someone is mentally ill at home	Discrimination		
Some caregivers also experienced human rights violations, including being detained or locked in rooms by their relatives because they were afraid the patients would attack others	Assault		
Caring for a relative with mental illness causes stress and also strains household finances	Money limitation	The poverty of the patient's family	
...Poor economic conditions and poverty were the cause of mental disorders...the stress experienced due to poverty is the leading cause of this disease	Scarcity		
My son showed improvements in his condition... signs such as talking and smiling alone, wandering, and disorientation, had begun to decrease...their behavior had improved dramatically... his son did not scream, make repetitions, hurt himself anymore...	Decrease symptoms	Decrease in severity	The increased positive impact of health services
Before the psychotherapy started, my sister always talked to herself. Now my sister can do normal activities like everyone else...after receiving counseling, his son's suicidal ideation was significantly reduced	Normal interest		
Now, he can perform daily tasks, including self-care, cleaning, bathing, washing clothes, making meals, and completing homework after receiving psychotherapy from a primary healthcare facility	Increased capabilities	Ability to participate in daily life	
Previously, the child did not want to be involved in simple activities at home, such as sweeping the floor, but now he offers to help his mother After psychotherapy, the patients had a better social life and	Being involved		
connections...initially, I used to sit alone, put my palm on his forehead, and held my head with his hands, repeating questions to myself, but now I am happy to see his changes	Communication	Interaction with the social environment	
The community's attitudes toward them have changed due to psychotherapy ... patients are willing to make friends and do not close themselves off	Behavior		

them. We often run out of time for consultations when sufferers and their caregivers come to doctors and nurses" (group of health cadres).

3.3. *Various Customers' Satisfaction with Service.* Several patient caregivers reveal the identical perspective on the competency of trained health workers. Caregivers trust that healthcare professionals are self-assured to contribute, including significant advice to ascertain the patient's condition. They believe that if health practitioners are incompetent, the patient's condition will not improve. "They are adept and intelligent. The first and most important change is that my son has improved. It's not like my son's previous bad situation; Gradually, he's getting better." Other caregivers of depressed patients pointed out that "the healthcare workers who provided the service gave them good advice and guidance" (caregiver for a depressed patient).

On the other hand, caregivers still report that health care employees lack the knowledge and expertise. Several other caregivers expressed dissatisfaction with healthcare providers. They believe health workers seem incapable of treating them because they have difficulty or are not interested in their treatment(caregiver for psychosis). "Medicine for my daughter may be available at this PHC, but the staff there have not shown enough enthusiasm in helping cure my child. Therefore, I am not excited to use the health services here for my son's recovery." (caregiver of a depressed patient).

Most patients' caregivers are happy with the services provided by the healthcare staff. One caregiver for a psychotic patient reported that her husband appreciated the entire treatment process, from taking medication to receiving ongoing psychosocial counseling. Now and then, health workers came to see them and chat with patients, and the patient's condition improved significantly. As the caregiver (wife) of a depressed patient relates: ". . .a nurse once came to my house and encouraged me not to be afraid about my partner and to care for him as best I could." He further informed us that people with difficulties like us could use IMHS facilities to get essential health services for treatment. He also advised us not to talk about hurtful things to patients but rather to love them and speak to them with kindness (caregiver of a depressed patient).

The results of the FGD with the group of doctors and nurses stated that "sometimes we are too tired so maybe the sufferer's family can't accept our attitude, we realize that this is a shortcoming that should not be done." The cadre group added that health workers must serve many things, and we cannot help. We can only motivate the family to bring the patient and carry out an examination. We also feel inadequate to provide advice or input to the sufferer's family."

3.4. *The Appearance of Services Provided.* Many different influences principles to the fulfillment of requirements during episodes of depression, alcoholism, and psychotic symptoms. Patients' conditions have improved after IMHS services, and sufferers increasingly realized the significance of adhering to medication. A caregiver for a depressed patient stated that the patient's condition improved after receiving assistance from the health service. "I have the impression of being pleased. I am relieved that I received a lot of help from IMHS for him. We have now received the treatment we expected from them. I am happy with the service."

When dealing with patient problems, several patient caregivers reported that health workers' delivery is based on their seniors' recommendations. An exciting experience was shared by a patient's caregiver, who stated that "their service was quite good because they already provided me with information during the counseling. Moreover, they instructed me to take medicine for a certain period. They explained reducing drug dose after considering changes in the patient's condition. I'm sure the service here is of high quality."

A patient caregiver noted that, in addition to medication, the consultation process was fundamental, especially when medicine failed to recover the patient's illness, "I think medication was imperative, but I also had to acquire how to speak properly. It would also be wonderful if they paid courtesy to my difficulty and allowed me to ask questions. The patient started communicating with me, and I monitored his activities while at home. The consultation results were beneficial for me in my brother's recovery. The discussion section at IMHS has helped me understand how to treat patients, and my brother was finally able to break his isolated tendencies. Hopefully, the knowledge of how to treat quickly makes patients recover quickly can be applied" (caregiver of patient with psychosis).

Other caregivers of patients said that having the opportunity of consulting made them feel more comfortable and safer because they could share their concerns and challenges with the counselor. According to some of the patient's caregivers, counseling has improved the patient's symptoms, including empty thoughts and thoughts of self-harm. One of the patient's caregivers stated that she was allowed to talk to health staff about her concerns and express her grief. She stated that "they also let me call them directly by phone if I have an urgent issue that needs to be addressed immediately" (caregiver of patient with depression).

The group of doctors and nurses reported that when providing services, they carried out examinations, monitored symptoms, gave drugs, and provided psychoeducation. Health cadres also suggest matching information about the form of health services offered at IMHS.

3.5. *Barriers to Access Health Services.* Although caregivers of mentally ill patients provided favorable comments, many cited the complexity of many circumstances or features that made it difficult to initiate or continue therapy. The following section will discuss the most frequently encountered obstacles.

3.5.1. *Worries about Inadequate Medicines Availability.* Patient caregivers have many healthcare benefits, such as getting free medicines, but they have not always had this convenience. Some caregivers of patients reported that

sometimes they could not get the treatment they needed due to lack of availability of medicine or not being provided by health services according to applicable policies. This situation increased family spending on transportation and drug purchases.

Caregivers of other patients who have received treatment services from different locations and are trying to undergo further therapy complained that the administration of drugs in health care facilities was not the same as previously accepted. One of them stated that "if my father can get treatment according to the previous treatment, I will try to take advantage of the health service. I will go there if they give medicine for my father to take regularly."

The limited supply of drugs in health facilities was also complained of by caregivers of patients with psychosis and alcoholism. One of them stated that "patients need a lot of drugs, but very few drugs are available there. So, if you calculate the transportation costs plus additional costs to buy medicine, it will be almost the same as the costs incurred are pretty significant. Only a few treatments are provided, and not all of the medication supplies are available at the PHC. It would be nice if I could obtain all medicines there; I will come to the health service post."

The group of doctors and nurses during the FGD informed that in some conditions, patients do not always get their psychotropic medication needs. Drug supplies must be sufficient in terms of type and quantity. A health cadre also conveys a complaint from the patient's family that sometimes patients run out of medicine at the PHC, and to get the medication, one needs a lot of money.

3.5.2. Lack of Private Consultation Space. Many caregivers of patients said that the unavailability of a private room for consultation was a barrier to access support. One of the variables that contributed to their displeasure with offerings was that some felt very uncomfortable expressing their difficulties in front of others. For instance, a caregiver for a depressed patient revealed that "when I was at IMHS, the health workers did not request me to communicate in a separate room to keep my conversations with them would remain confidential. I don't want others to hear my consultation with them, but PHC provides an open space for consultation; therefore, other people recognize our problems. Sometimes there is no consultation, and after the patient's caregivers get the medicine, they go home immediately. Caregivers of people with depression support this comment. She reported, "I wanted to talk about my sadness when there were not many people around me. But since many people seem to want to hear my story, I canceled it."

The unavailability of a consultation space makes it possible to maintain the confidentiality of patient information, recognized by the group of doctors and nurses as an obstacle that must be overcome immediately. They understand the importance of maintaining the confidentiality of the information and the heavy burden of the family in providing care for sufferers. The health-cadre group confirmed the same information about the unavailability of a consultation room. Families often complain of being embarrassed when they must consult, while many others can hear their complaints. The patient's family wants a particular room for a consultation to feel comfortable.

3.5.3. Limited Health Expert Personnels. The limited availability of the same health personnel for follow-up consultations was another issue raised. Some patients' caregivers expressed dissatisfaction with the health workers who did not even come to the health facilities on schedule. "Only one doctor or nurse often serves," said the psychotic caregiver.

The doctors and nurses are aware that sometimes they cannot be on duty, so they have replaced the shift with others due to sudden tasks immediately. Occasionally, other activities must be delegated to other health workers who did not monitor the patient's previous condition. Health workers admit that changes in health personnel can happen, but they are scarce. The family members have conveyed their discomfort regarding the shift of health workers who take care of their family members. Hopefully, the health workers who provide care do not change to thoroughly understand the patient's condition.

3.5.4. Prejudice and Stigma. Patients, including all illnesses, recognized stigmatizing behavior from relatives and community members as barriers to access mental health services. Caregivers often claim to encounter discrimination and unpleasant comments from the local community because of sufferers' mental health problems. Caregivers of sufferers also describe the social stigma associated with mental illness in the general population, stating that some suggest placing people with psychoses in chains or chaining them. Due to societal stigma, caregivers are forced to disclose their relatives' mental health disorders. Some will travel to health services in secret to administer medication to their families to prevent people from saying bad things about them. One caregiver for people with psychosis said "they felt humiliated, ostracized, and thought to be suffering from a cursed disease. Many people avoid seeing the sufferer and are afraid if the sufferer suddenly attacks them" (caregivers of psychosis people).

Discrimination, social exclusion, and ill-treatment are the only standard types of stigma faced by sufferers and their families. Most caregivers stated that they felt ostracized or belittled by their family members. They felt bad when their relatives commented severely on them in public and saw them as embarrassing. Some caregivers of sufferers also experienced human rights violations, including being detained or locked in rooms by their relatives because they were afraid, they would attack others.

The results of the FGD showed that the community's stigma towards people with mental disorders was still very high, resulting in the reluctance of families to bring sufferers to access health services. The pacing treatment is a way so that the sufferer does not interfere with the comfort of the community and family, is not disturbed, and avoids embarrassment. Health cadres expressed shame, sadness, irritation, and torment with the presence of sufferers whose recovery takes a long time. Even the feeling of despair

occasionally enveloped the family so that the thought crossed the sufferer even though he did not have the heart to do it (group of health cadres).

3.5.5. Poverty of the Patient's Family.

Most study participants came from poor socioeconomic backgrounds, such as labor, those on daily incomes, or those who work for low wages and had difficulty controlling basic expenses such as food. Caregivers, in particular, talked about how they reduced their food consumption to once a day to save money because sufferers were no longer working. Caregivers believe wholeheartedly that their lives have been affected by the mental health problems of family members. Her husband lost his occupation because of his drinking habit, and the caregiver for an alcoholic admits that he must work to support his family.

"I am responsible for feeding and educating my children." Consider a woman at home whose husband is in that situation; he struggles to feed his household and is responsible for his grown daughter. Consider the magnitude of the problem." Caring for a relative with mental illness is seen as a problem by some caregivers because it causes stress and strains household finances.

The health-cadre group conveyed the heavy burden of the family having to care for family members with mental disorders. One of the heads of the family even told us that poor economic conditions and poverty were the cause of mental disorders. The stress experienced by poverty is the leading cause of this disease. The doctors and nurses also emphasized that people with mental illnesses come from low-income families, although not all of them are like that. Poverty causes stress in the family, and the inability to meet the needs of life, adds to the burden of suffering (doctors and nurses group).

3.6. Health Service Impact.

Individual health effects, ability to participate in daily activities, and improvement in household financial status were the most commonly reported effects of mental health therapy offered by qualified primary care practitioners.

3.6.1. Increased Positive Impact on Health Status.

Caregivers of patients with depression, psychosis, and alcoholism almost reported improvements in the severity of their symptoms. After receiving treatment, caregivers of psychosis patients stated that signs such as talking and smiling alone, wandering, and disorientation had begun to decrease. One caregiver of a depressed patient noted that the sufferer started to reduce his loneliness in his room since starting treatment.

She explained, "before the treatment started, my sister talked to herself a lot. Now my sister can do normal activities like everyone else" (caregiver of psychosis patient). "My sister has started doing light activities, not heavy daily tasks, and I am delighted to see the progress of my sister's condition" (caregiver of a depression patient).

Caregivers of psychotic patients explained that their behavior had improved dramatically. Their relatives with mental disorders have reduced complaints of difficulty sleeping, reduced pain, reduced suicidal ideation, and increased appetite and self-esteem. After receiving counseling from health workers and therapists, one of the caregivers of a depressed patient stated that his son's suicidal ideation had significantly reduced. "I'm not sure what will happen to my child if the health workers don't care for him. He used to scream and cry, carry a rope, walk into our backyard, and shout things, hurting himself. After being persuaded by the health workers, he doesn't say anything like that anymore."

Caregivers of alcohol dependents observed no noticeable improvement in the intensity of their problems, unlike other illnesses, but they reported feeling fitter and happier than before. Among the critical benefits reported by alcoholic patients, after quitting drinking, appetite and weight gain were increased.

Based on the results of the FGD showed a significant improvement in the patient's condition, there was a decrease in symptoms in the patient, and the family also expressed gratitude for the improvement in the patient's condition (doctors and nurses group). My neighbor is very grateful that his son is no longer screaming and hurting himself and not threatening to commit suicide (group of health cadres).

3.6.2. Able to Participate in Daily Life.

Most caregivers said they had to spend too much time caring for their relatives who had mental health problems. They become able to perform daily tasks, including taking care of themselves (e.g., cleaning, bathing, and washing clothes), making meals, and completing homework after receiving treatment from a primary healthcare facility, allowing caregivers to focus on other tasks. Caregivers of psychotic patients stated the following phrase: "He doesn't get up to clean his forehead when he's not taking his medication. He'd been up on time lately, showered, and done his homework. If there is work to be done, he goes his own way. He works as a construction worker."

The patient's caregiver supports this to be able to complete personal tasks independently or help relatives with household tasks. After therapy, a depressed person shared how he went about his daily routine. "He can fall whether he's preparing, doing farm work, or doing household chores. His dilemma had lessened once he acknowledged it. He completed so much work that he could on his own. He then used workers for every job, and now, he does everything himself."

The FGD states that there was a report from the patient's family who said that after several times undergoing treatment at IMHS, the patient had started to be able to help with household chores such as sweeping or cleaning his room. They are thrilled with the positive changes experienced by sufferers. (group of doctors and nurses). FGD cadres reported information from families who welcomed the changes in their children. Previously, the child did not want to be involved in simple activities at home, such as sweeping

the floor, for example, but now it is the sufferer who offers to help his mother (a group of health cadres).

3.6.3. Interact with the Social Environment Gradually.
After treatment, the patient's caregivers reported that the sufferer had a better social life and connections. At first, the patient's presence was often rejected, especially for people with alcohol addiction, which made the family embarrassed and frustrated. On the other hand, many caregivers claim that their community's attitudes toward them have changed due to therapy. According to reports, their favorable experiences with family and relatives have also increased, and they have received great feedback about their transformation. "Yes, there have been many changes in his household activities, including his increasing love for his wife, children, and relatives."

Caregivers of psychotic patients described a similar experience in that psychotic family members became more involved after treatment. Some caregivers say they can tolerate gatherings and want to participate in fun events. "Initially, I used to sit alone, put my palm on his forehead, held my head with his hands, repeating questions to myself, but now I'm happy to see his changes," said the caregiver for this psychotic patient.

The results of the FGD said that, in general, many positive changes occurred in patients, and there was a desire to communicate; although, of course, it had to be gradual. This impact occurs if the sufferer and his family comply with the recommendations given and do not take actions that make the sufferer feel threatened until he feels comfortable. Health cadres provide the same information support. Families of sufferers' report that the condition of sufferers has improved. They are willing to make friends and do not close themselves off (group of health cadres).

4. Discussion

Very few studies in Indonesia explore the perspectives and expectations of CPWMD and compare them with the perceptions of healthcare providers at IMHS. The implications for improving access and quality mental healthcare in PHC and communities in Indonesia. This study involved caregivers with depression, alcoholism, and psychosis. Caregivers of patients are generally pleased with the services provided by health workers and health cadres. In addition, many caregivers may receive assistance from mental health specialists while under supervision, leading to an overall level of comfort between caregivers and patients. At this time, IMHS has provided free pharmacological psychotherapy, although, in some conditions, the need for medication supply has not been fully met. The sufferer's family highly appreciates the availability of free psychotherapy because it can reduce travel time and costs and medical costs. Psychotherapy has been given by doctors and nurses, not by psychologists, because, at PHC, no health workers work as psychologists. Health cadres have also received psychoeducational training that can be practiced when assisting the families of sufferers.

Previous studies [34–36] have illustrated that primary care-based psychotherapy is critical in improving individual-level functionality and clinical outcomes. According to recent research, health professionals at PHC provide effective psychoeducation, including counseling services in care [37–39]. Despite their favorable attitude towards mental health services, caregivers of sufferers reported various barriers and problems in obtaining mental health support in primary care. Caregivers of patients also frequently mention the lack of psychotropic medications in health facilities, which can be attributed to the prolonged bureaucratic system for procurement and distribution of medications, which results in frequent stockouts. Many studies have observed problems with the regular administration of psychotropic medications. It is one of the most significant barriers to integrate mental health services into community health [13, 40, 41].

One of the reasons for the dissatisfaction of caregivers with sufferers is the lack of confidentiality in healthcare facilities and the limited time for consultation with health workers. In some low- and middle-income countries [28, 29, 42], lack of human resources and facilities is a significant barrier to receiving mental health services at PHC. Satisfaction and fulfillment of family expectations for health services is very crucial in determining the continuity of family caring for relative in long treatment period due to suffering from mental disorders [17]. One research illustrated family satisfaction improving care for psychiatric patients and is particularly important for assessing psychiatric care [18]. This study uses the Brazilian Mental Health Service Satisfaction with a qualitative approach to identify family satisfaction includes various components of health services, including psychotherapy outcomes, family acceptance, practitioner competence, and confidentiality protection [18]. The SERVQUAL model directs almost the same approach in evaluating service quality, namely, the tangible, reliability, responsiveness, assurance, and empathy aspects [19].

The stigma attached to PWMD is challenging to remove. A study in India of medical practitioners identified that most of them had unpleasant emotions about patients with mental disorders [13, 30]. The sufferers from Indonesia face the same fact [43–45]. The results of this study have many implications for improving access and quality of mental health care in PHC and communities in Indonesia.

First, caregivers say psychological measures are in direct need of psychosocial consultation. Psychologists are needed to manage consultation services at PHC, and recruited health cadres must be better equipped for psychoeducation. Previous randomized controlled trials have found that patients who received facility-based and community-based counseling had better health outcomes than patients who received only facility-based care [46]. Doctors and nurses and psychologists should provide psychotherapy in PHC and IMHS.

Second, in some trials, health workers who had not been trained in mental health, including nurses, rural physicians, and general practitioners, were always the primary caregivers for psychiatric patients [27, 47–49]. The same thing
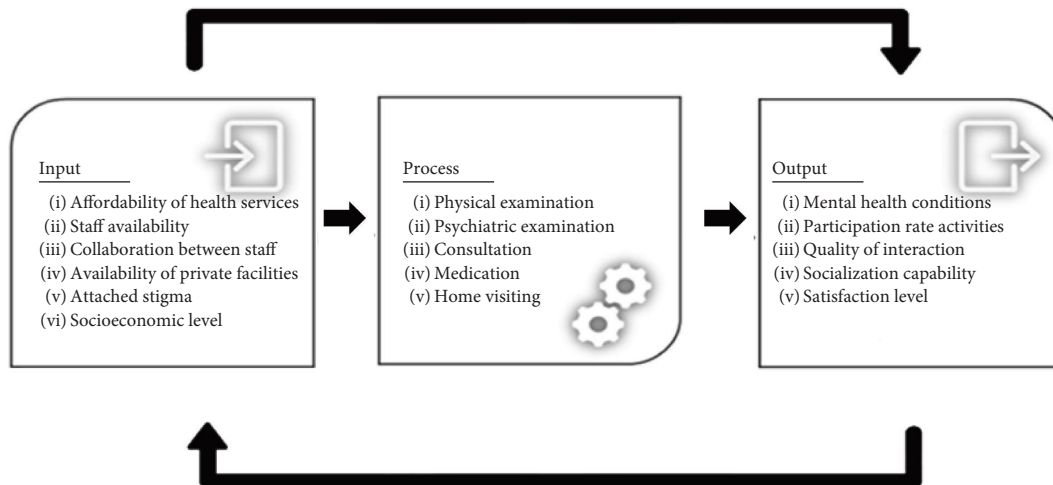
FIGURE 1: Model of satisfaction and expectations of integrated mental health services.

happened in Indonesia. In all PHCs, doctors and general nurses provide all mental health services who have further education and training. Meanwhile, health cadres involved in the management of IMHS have received training and attended seminars [31, 50] related to detection and psychoeducation efforts to be implemented to help ease the burden on the families of sufferers. The establishment of self-help group software is beneficial in further social services. It is easy to transfer to the public by conveying healthcare information on a large scale and initiating this implementation by the PHC or health cadres who are part of the community, so they know best to how to influence it.

Third, many sufferers' caregivers report being hesitant to communicate their difficulties with health professionals in public because of the lack of private consultation rooms. The lack of consultation facilities can create feelings of shame and reluctance to tell the patient's condition because if many people know the information, it can lead to stigma. As in Chitwan, perceptions of stigma and prejudice were reported as one of the main reasons people do not seek psychotherapy for depression. Similarly, skilled health workers have identified the lack of intimate areas as one of the most significant barriers to mental health care integrated into IMHS [50].

Fourth, caregivers have admitted to opt out of psychotherapy because of the lack of needed medications in health facilities, including frequently running out of supplies of medicines. If psychotropic medications are not available for a long time, they can hurt the patient's psychotherapy and rehabilitation. Very crucial to change medication procurement procedures must ensure medication availability in primary care.

Most caregivers stated that they were worried and uncomfortable due to their significant focus on caring for and supporting a mentally ill close relative. Extreme parenting stress can negatively affect the caregiver's overall health, leading to burnout and emotional exhaustion. As a result, community-based psychological strategies to empower relatives of people with mental illness must be designed and implemented.

According to the result, Figure 1 shows the model of satisfaction and expectations of caregivers and health practitioners as a system consisting of input, process, and output components on community-based mental health services.

Each theme is grouped into a foundation that forms a framework for thinking about integrated mental health services. There is continuity and interplay between components. The sustainability of one component is largely determined by the other components.

5. Conclusion

Health services must be evaluated periodically as the foundation of studies in accelerating their quality. The level of satisfaction of IMHS users as the closest service to the community that was explored qualitatively was able to reveal the actual service conditions. The complexity of the condition of mental disorders provides a heavy burden for the family to be able to cause boredom for the family in accompanying the patient. It takes creativity of practitioners in seeking quality services to fulfill family expectations and satisfaction. Caregiver's family satisfaction for a relative with mental disorders determines their continuity in assisting during the treatment period. The length of the treatment period is a challenge for practitioners to be able to meet family expectations for mental health services. Improvement of staff and system components in IMHS services supported by policies will determine the quality of services, encouraging the sustainable use of IMHS. Increasing the practitioners capacity along with complete facilities is a consideration for policy makers to improve the quality of IMHS as the closest service to the community.

Abbreviations

DALY: Disability-adjusted life years
IMHS: Integrated mental health services
CPWMD: Caregivers for people with mental diseases

FGD: Focus group discussions
PHC: Public health center
WHO: World Health Organization
PWMD: People with mental disorders

Data Availability

All the data used to support the findings of this study are provided within the article.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

References

[1] G. Thornicroft, S. Chatterji, S. Evans-Lacko et al., "Under-treatment of people with major depressive disorder in 21 countries," *British Journal of Psychiatry*, vol. 210, no. 2, pp. 119–124, 2017.

[2] F. J. Charlson, A. J. Baxter, T. Dua, L. Degenhardt, H. A. Whiteford, and T. Vos, "Excess mortality from mental, neurological and substance use disorders in the Global Burden of Disease Study 2010," *Epidemiology and Psychiatric Sciences*, vol. 24, no. 2, pp. 121–140, 2015.

[3] R. Keynejad, J. Spagnolo, and G. Thornicroft, "WHO mental health gap action programme (mhGAP) intervention guide: updated systematic review on evidence and impact," *Evidence-Based Mental Health*, vol. 24, no. 3, pp. 124–130, 2021.

[4] H. A. Whiteford, A. J. Ferrari, L. Degenhardt, V. Feigin, and T. Vos, "The global burden of mental, neurological and substance use disorders: an analysis from the global burden of disease study 2010," *PLoS One*, vol. 10, no. 2, Article ID e0116820, 14 pages, 2015

[5] S. Evans-Lacko, S. Aguilar-Gaxiola, A. Al-Hamzawi et al., "Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) Surveys," *Psychological Medicine*, vol. 48, no. 9, pp. 1560–1571, 2018.

[6] R. Kohn, S. Saxena, I. Levav, and B. Saraceno, "The treatment gap in mental health care," *Bulletin of the World Health Organization*, vol. 82, no. 11, pp. 858–866, 2004.

[7] J. Alonso, Z. Liu, S. Evans-Lacko et al., "Treatment gap for anxiety disorders is global: results of the World Mental Health Surveys in 21 countries," *Depression and Anxiety*, vol. 35, no. 3, pp. 195–208, 2018.

[8] N. Drew, M. Funk, S. Tang et al., "Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis," *The Lancet*, vol. 378, no. 9803, pp. 1664–1675, 2011.

[9] A. Ofori-Atta, J. Attafuah, H. Jack, F. Baning, and R. Rosenheck, "Joining psychiatric care and faith healing in a prayer camp in Ghana: randomised trial," *British Journal of Psychiatry*, vol. 212, no. 1, pp. 34–41, 2018.

[10] L. Asher, A. Fekadu, S. Teferra, M. De Silva, S. Pathare, and C. Hanlon, "I cry every day and night, I have my son tied in chains": physical restraint of people with schizophrenia in community settings in Ethiopia," *Globalization and Health*, vol. 13, no. 1, pp. 47–14, 2017.

[11] V. Patel, H. A. Weiss, N. Chowdhary et al., "Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial," *The Lancet*, vol. 376, no. 9758, pp. 2086–2095, 2010.

[12] G. Thornicroft and M. Tansella, "The balanced care model for global mental health," *Psychological Medicine*, vol. 43, no. 4, pp. 849–863, 2013.

[13] W. S. Gwaikolo, B. A. Kohrt, and J. L. Cooper, "Health system preparedness for integration of mental health services in rural Liberia," *BMC Health Services Research*, vol. 17, no. 1, pp. 508–510, 2017.

[14] M. Angdembe, B. A. Kohrt, M. Jordans, D. Rimal, and N. P. Luitel, "Situational analysis to inform development of primary care and community-based mental health services for severe mental disorders in Nepal," *International Journal of Mental Health Systems*, vol. 11, no. 1, pp. 69–16, 2017.

[15] K. Kementerian, "PMK No 54 tahun 2017 penanggulangan pemasungan pada ODGJ," *Penanggulangan Pemasungan pada Orang Dengan Gangguan Jiwa*, vol. 110265, 2017.

[16] S. P. Mann, V. J. Bradley, and B. J. Sahakian, "Human rights-based approaches to mental health: a review of programs," *Health Hum Rights*, vol. 18, no. 1, pp. 163–276, 2016.

[17] B. G. Druss, S. A. Von Esenwein, M. T. Compton, K. J. Rask, L. Zhao, and R. M. Parker, "A randomized trial of medical care management for community mental health settings: the primary care access, referral, and evaluation (PCARE) study," *American Journal of Psychiatry*, vol. 167, no. 2, pp. 151–159, 2010.

[18] M. Marmot, S. Friel, R. Bell, T. A. Houweling, and S. Taylor, "Closing the gap in a generation: health equity through action on the social determinants of health," *The Lancet*, vol. 372, no. 9650, pp. 1661–1669, 2008.

[19] P. Huxley, "Mental illness in the community: the Goldberg-Huxley model of the pathway to psychiatric care," *Nordic Journal of Psychiatry*, vol. 50, no. 37, pp. 47–53, 1996.

[20] S. Evans-Lacko, C. Henderson, and G. Thornicroft, "Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012," *British Journal of Psychiatry*, vol. 202, no. 55, pp. 51–s57, 2013.

[21] A. F. Jorm, "Mental health literacy; empowering the community to take action for better mental health," *American Psychologist*, vol. 67, no. 3, pp. 231–243, 2012.

[22] J. Brekke, D. D. Kay, K. S. Lee, and M. F. Green, "Biosocial pathways to functional outcome in schizophrenia," *Schizophrenia Research*, vol. 80, no. 2-3, pp. 213–225, 2005.

[23] V. Patel, J. K. Burns, M. Dhingra, L. Tarver, B. A. Kohrt, and C. Lund, "Income inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms," *World Psychiatry*, vol. 17, no. 1, pp. 76–89, 2018.

[24] V. Sharifi, M. Tehranidoost, M. Yunesian, H. Amini, M. Mohammadi, and M. Jalali Roudsari, "Effectiveness of a low-intensity home-based aftercare for patients with severe mental disorders: a 12-month randomized controlled study," *Community Mental Health Journal*, vol. 48, no. 6, pp. 766–770, 2012.

[25] I. Petersen, D. Marais, J. Abdulmalik et al., "Strengthening mental health system governance in six low- and middle-

income countries in Africa and South Asia: challenges, needs and potential strategies," *Health Policy and Planning*, vol. 32, no. 5, pp. 699–709, 2017.

[26] G. M. Esponda, S. Hartman, O. Qureshi, E. Sadler, A. Cohen, and R. Kakuma, "Barriers and facilitators of mental health programmes in primary care in low-income and middle-income countries," *The Lancet Psychiatry*, vol. 7, no. 1, pp. 78–92, 2020.

[27] S. Sathyanath, R. D. Mendonsa, A. M. Thattil, V. M. Chandran, and R. S. Karkal, "Socially restrictive attitudes towards people with mental illness among the non-psychiatry medical professionals in a university teaching hospital in South India," *International Journal of Social Psychiatry*, vol. 62, no. 3, pp. 221–226, 2016.

[28] E. C. Baron, S. D. Rathod, C. Hanlon et al., "Impact of district mental health care plans on symptom severity and functioning of patients with priority mental health conditions: the Programme for Improving Mental Health Care (PRIME) cohort protocol," *BMC Psychiatry*, vol. 18, no. 1, pp. 61–14, 2018.

[29] V. Braun and V. Clarke, "Using thematic analysis in psychology," *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77–101, 2006.

[30] L. S. Nowell, J. M. Norris, D. E. White, and N. J. Moules, "Thematic analysis: striving to meet the trustworthiness criteria," *International Journal of Qualitative Methods*, vol. 16, no. 1, Article ID 160940691773384, 13 pages, 2017

[31] M. J. D. Jordans, N. P. Luitel, P. Pokhrel, and V. Patel, "Development and pilot testing of a mental healthcare plan in Nepal," *British Journal of Psychiatry*, vol. 208, no. 56, pp. s21–s28, 2016.

[32] M. J. D. Jordans, L. Aldridge, N. P. Luitel, F. Baingana, and B. A. Kohrt, "Evaluation of outcomes for psychosis and epilepsy treatment delivered by primary health care workers in Nepal: a cohort study," *International Journal of Mental Health Systems*, vol. 11, no. 1, pp. 70–78, 2017.

[33] National Institute of Health and Fwm, "Manual of mental health for," 2016, https://dghs.gov.in/WriteReadData/userfiles/file/Training%20Manual%20SW%20.pdf.

[34] N. Faizi and S. Kazmi, "Universal health coverage - there is more to it than meets the eye," *Journal of Family Medicine and Primary Care*, vol. 6, no. 1, pp. 169-170, 2017.

[35] N. Thomas, M. Hayward, E. Peters et al., "Psychological therapies for auditory hallucinations (voices): current status and key directions for future research," *Schizophrenia Bulletin*, vol. 40, no. 4, pp. S202–S212, 2014.

[36] Who, *Hospital-Based Mental Health Services: Promoting Person-Centred and Rights-Based Approaches*, World Health Organization, Geneva, Switzerland, 2021.

[37] E. K. Wakida, Z. M. Talib, D. Akena et al., "Barriers and facilitators to the integration of mental health services into primary health care: a systematic review," *Systematic Reviews*, vol. 7, no. 1, pp. 211–213, 2018.

[38] G. B. Mihretie, G. M. Legas, T. B. Azale, H. Sciences, and M. W. Abera, "Magnitude and associated factors of disability in patients with schizophrenia attending Gondar, Felegehiwot and Debretabor hospitals Amhara North West Ethiopia 2019: institutional based cross-sectional," *Search life-sciences literature*, vol. 2020, pp. 1–16, 2020.

[39] B. Saraceno, M. van Ommeren, R. Batniji et al., "Barriers to improvement of mental health services in low-income and middle-income countries," *The Lancet*, vol. 370, no. 9593, pp. 1164–1174, 2007.

[40] I. Kusumawaty, R. Surahmat, S. Martini, and Muliyadi, "Family support for members in taking care of mental disordered patients," in *Proceedings of the First International Conference on Health, Social Sciences and Technology (ICoHSST 2020)*, pp. 115–120, Palembang, Indonesia, October 2021.

[41] I. Kusumawaty, Y. Yunike, and I. Erman, "The complexity of family stigma living with mental illness patients," *Global Journal of Medicine and Public Health*, vol. 8, no. 2, pp. 13–21, 2019.

[42] L. Sheehan, P. W. Corrigan, M. A. Al-Khouja et al., "Behind closed doors: the stigma of suicide loss survivors," *Omega*, vol. 77, no. 4, pp. 330–349, 2018.

[43] M. J. D. Jordans, N. P. Luitel, E. Garman et al., "Effectiveness of psychological treatments for depression and alcohol use disorder delivered by community-based counsellors: two pragmatic randomised controlled trials within primary healthcare in Nepal," *British Journal of Psychiatry*, vol. 215, no. 2, pp. 485–493, 2019.

[44] U. A. Botha, L. Koen, J. A. Joska, L. M. Hering, and P. P. Oosthuizen, "Assessing the efficacy of a modified assertive community-based treatment programme in a developing country," *BMC Psychiatry*, vol. 10, no. 1, 73 pages, 2010.

[45] Z. Li and D. Arthur, "Family education for people with schizophrenia in Beijing, China: randomised controlled trial," *British Journal of Psychiatry*, vol. 187, no. 4, pp. 339–345, 2005.

[46] M. S. Ran, M. Z. Xiang, C. L. W. Chan et al., "Effectiveness of psychoeducational intervention for rural Chinese families experiencing schizophrenia," *Social Psychiatry and Psychiatric Epidemiology*, vol. 38, no. 2, pp. 69–75, 2003.

[47] S. Rai, D. Gurung, B. N. Kaiser et al., "A service user co-facilitated intervention to reduce mental illness stigma among primary healthcare workers: utilizing perspectives of family members and caregivers," *Families, Systems & Health*, vol. 36, no. 2, pp. 198–209, 2018.

[48] N. P. Luitel, E. C. Garman, M. J. D. Jordans, and C. Lund, "Change in treatment coverage and barriers to mental health care among adults with depression and alcohol use disorder: a repeat cross sectional community survey in Nepal," *BMC Public Health*, vol. 19, no. 1, pp. 1350–1410, 2019.

[49] N. Upadhaya, U. Regmi, D. Gurung et al., "Mental health and psychosocial support services in primary health care in Nepal: perceived facilitating factors, barriers and strategies for improvement," *BMC Psychiatry*, vol. 20, no. 1, pp. 64–13, 2020.

[50] B. A. Kohrt, M. J. D. Jordans, E. L. Turner et al., "Reducing stigma among healthcare providers to improve mental health services (RESHAPE): protocol for a pilot cluster randomized controlled trial of a stigma reduction intervention for training primary healthcare workers in Nepal," *Pilot Feasibility Study*, vol. 4, no. 1, pp. 1–18, 2018.