Public Health Perspectives Journal 9 (2) 2025

Public Health Perspectives Journal

http://journal.unnes.ac.id/sju/index.php/phpj

Evaluation of Mental Health Services: Family Experiences, Stigmatization, Health Cadres Schizophrenia in Semarang City

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Article Info

Article History:
Submitted
07 August 2025
Revised
28 October 2025
Accepted
21 November 2025

Keywords:
Schizophrenia, Mental Health Services, Caregiver, Stigma

DOI:
https://doi.org/10.15294/phpj.v9i3.30487

Abstract

Schizophrenia is the most common mental illness, with prevalence of 1.7 million in Indonesia. In 2020, 58.9% of patients with schizophrenia in Indonesia received services. This means that 41.1% of patients with schizophrenia, haven't received comprehensive services. Central Java has a 9.8% prevalence of mental disorders and ranks fifth in terms of the highest number of schizophrenia patients. This will undoubtedly impact the quality of life for schizophrenia patients. The aim of this study is to evaluate mental health services, focusing on family experiences, stigmatization, and role of community health workers in schizophrenia cases in Semarang City. The research design used a qualitative descriptive phenomenological, employing in-depth interviews and purposive sampling, along with triangulation from several informants, including the experiences of families of people with mental disorders, cadres staff, and collaboration with the Social Affairs Department. Data analysis techniques used thematic analysis based on the CIPP model, using NVivo 15 software. The results showed that mental health services in Semarang had a positive impact on schizophrenia. However, there is still need to strengthen aspects of resources, cross-sector involvement, and anti-stigma strategies. Sustained collaborative interventions are needed to ensure the holistic quality of life for patients and their families.

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p-ISSN 2528-5998
e-ISSN 2540-7945

INTRODUCTION

Schizophrenia is a severe mental disorder characterized by psychotic symptoms such as delusions, hallucinations, and disorganized thoughts that interfere with daily functioning (Ebrahim et al., 2020; WHO, 2017). Schizophrenia, as defined in the DSM-V, is a chronic psychotic disorder characterized by acute episodes that cause individuals to become dissociated from reality (Alfimaghfirah et al., 2022). This disorder is chronic and has a significant impact on the quality of life of sufferers and their families. Globally, approximately 24 million people live with schizophrenia, yet access to mental health services remains limited (WHO, 2022). Despite advances in medical interventions, relapse rates remain high, hampering psychosocial recovery (Takeuchi et al., 2019).

Globally, the WHO (2022) reports that the target prevalence of schizophrenia worldwide is estimated at around 24 million, or 1 in 300 people (0.32%). Furthermore, through the publication of the Comprehensive Mental Health Action Plan 2013–2030, the WHO promotes universal access to mental health care as a long-term global goal. Approximately 20 million people worldwide suffer from a spectrum of schizophrenia illnesses, which typically appear by the age of 20 (Solmi et al., 2022). Within the first year of treatment, up to 70% of patients experiencing a first episode of psychosis experience symptomatic remission of acute symptoms (Phahladira et al., 2020).

In Indonesia, the 2018 Basic Health Research (Riskesdas) showed a prevalence of 1.7 people per 1,000 population with severe mental disorders, equivalent to approximately 1.7 million people. However, according to the 2020 Basic Health Research (Riskesdas), only 58.9% of people with severe mental disorders had received treatment, meaning that 41.1% of patients, including those with schizophrenia, still had not received adequate treatment. This gap indicates that mental health services in Indonesia still face obstacles.

A similar situation is seen in Central Java, particularly in Semarang City. Data from the Semarang City Health Office (2023) recorded thousands of active cases of severe mental illness (ODGJ) treated in health facilities. In 2023, the majority of cases were found in the productive age group 15-59 years (92.3%), while cases in children (0-14 years) and the elderly (≥60 years) were relatively few (Gondohutomo, 2023; Ministry of Health of the Republic of Indonesia, 2022; Semarang City Health Office, 2023). In 2024, community health center services in Semarang City recorded 3,872 cases in children aged 15-59 years, 348 cases in those aged ≥60 years, and 13 cases in children (Semarang City Health Office, 2024). The high number of cases in the productive age group underscores the significant burden of mental health at the city level, which requires a comprehensive, community-based service strategy.

Family is crucial for the recovery of people with severe schizophrenia, commonly referred to as ODGJ. Lack of social support from family members is associated with poor medication adherence in schizophrenia sufferers, according to research (American Psychiatric Association, 2013). Furthermore, according to (Durand, V. Mark, and Barlow, 2014), the way families interact, communicate, and play roles with schizophrenia patients has the potential to encourage the development of brain disorders. According to Brown, people with schizophrenia are more likely to relapse if their families display high levels of hostility, disapproval (criticism), and excessive emotional involvement (Chen et al., 2019).

Schizophrenia patients also benefit from the support of family caregivers. Support can take the form of assistance with paying for care and treatment, accessing resources, and avoiding stigma. Adherence to treatment and ultimately patient recovery can be predicted by the level of family participation and caregiving. Involvement includes monitoring and providing therapy, as well as the family's supportive attitude toward the patient's treatment (Fauziah et al., 2024). For example, in India, individuals who tend to avoid clinical pharmaceutical therapy also tend to have poor levels of social support. According to Kumar et al (2016), a study conducted in Ethiopia found a strong correlation between the risk of relapse in schizophrenia patients and their level of social support (Samuel et al., 2022).

Physical illnesses such as diabetes, heart disease, and hypertension, which have become

significant global health issues, often receive more attention and focus. While prevention and treatment efforts have improved significantly, mental health is often neglected and underserved. Just as important as the impact of physical illness, which is usually easier to observe and measure medically, the impact of mental health is equally crucial to our quality of life (Iriyanti & Widiana, 2024). When it comes to treating mental illness, medical facilities play a crucial role. Modern cities often have more stressors, which can lead to a number of mental health problems. Consequently, the accessibility and availability of appropriate medical facilities are crucial in addressing these issues (Manesh et al., 2023).

In the context of primary mental health services, there remains a gap in understanding the subjective experiences of stakeholders, particularly families caring for patients with severe schizophrenia. Despite the critical importance of mental health services, the role of families as caregivers is crucial for the continuity of treatment and patient recovery. Unfortunately, the psychosocial, economic, and emotional burdens are often not a primary focus in program evaluations.

Physical illnesses such as diabetes, heart disease, and hypertension, which have become significant global health issues, often receive more attention and focus. Although prevention and treatment efforts have increased rapidly, mental health is often neglected and not in the best condition. Just as important as the impact of physical illnesses, which are typically easier to observe and measure medically, the impact of mental health is equally important to the quality of our lives (Iriyanti & Widiana, 2024). When it comes to treating mental illnesses, medical facilities play a crucial role. Modern cities often have more stress triggers, which can lead to various mental health issues. As a result, the accessibility and availability of appropriate medical facilities are crucial in addressing these issues (Manesh et al., 2023).

This qualitative study seeks to in-depth evaluate the quality and challenges of mental health services through a phenomenological approach, focusing on the burden on families of people with severe mental disorders (ODGJ) (family caregivers), societal stigmatization, and mental health cadres. The primary informants for this qualitative study were the Mental Health Coordinator (Keswa) of the Semarang City Health Office and the program manager for people with severe mental disorders (ODGJ) at the Community Health Center (Puskesmas). Triangulation informants included the Coordinator of the Semarang City Social Service, families caring for patients with ODGJ (family caregivers), and mental health cadres from various sub-districts serving in various community health centers (Puskesmas) in Semarang. Using a triangulation approach, this study not only examines mental health programs normatively but also explores the multidimensional dynamics in the field.

In the context of community services, families and mental health workers play a crucial role in ensuring medication adherence, accompanying patients, and preventing relapse. However, they often face emotional, economic, and social stigma burdens that complicate treatment (Chen et al., 2019; Fauziah et al., 2024). Stigma is not only experienced by patients but also by families, worsening quality of life and limiting access to services. Although numerous studies have examined the effectiveness of medical therapy and clinical services for mental health, studies specifically exploring the subjective experiences of families, the stigma they face, and the role of health workers at the city level are still limited. Therefore, this study offers a novel approach by highlighting the experiences of family caregivers and workers in implementing mental health services in Semarang City. This focus is important because it can provide a new perspective for evaluating community-based mental health programs, which have been dominated by clinical approaches.

METHOD

This study was conducted in the working areas of Community Health Centers X, Y, and Z from May 2025 to June 2025. The type of research used was qualitative research with an evaluative design using a phenomenological approach to explore in depth the subjective experiences of informants, particularly families of people with severe mental disorders

(schizophrenia) and mental health cadres. The subjects in this study were selected using purposive sampling and consisted of 6 main informants and 6 triangulation informants. The main informants included the Mental Health Coordinator from the Health Department, the Mental Health Coordinator from the Community Health Center, and mental health workers at the village level. The triangulation informants included family members caring for ODGJ (family caregivers), neighbors of ODGJ, and program officers responsible for ODGJ from the Social Affairs Department.

The principal investigator is a postgraduate student in public health with prior research experience in mental health analysis and qualitative research, including training in in-depth interviews and thematic analysis. The researcher also served as a key instrument in the data collection and interpretation process. Data collection techniques included in-depth interviews using a semi-structured interview guide, field observation, and documentation. The interview procedure involved first explaining the details to the informant, then providing the informant with a consent form, and then obtaining permission to record the interview using a mobile phone recorder. The researcher carefully observed the informant's intonation and facial expressions to enrich the interpretation. The researcher also maintained control of the interview to ensure in-depth yet flexible exploration of the themes.

To ensure the credibility and dependability of the data, this study applies the technique of extending observations, increasing persistence, and overcoming potential bias by conducting member checking to ensure the accuracy of the researcher's understanding of the information provided by the informant.

Informants and Sampling Technique

Informants were selected using purposive sampling according to the following inclusion criteria: (1) Families caring for a person with severe mental illness (schizophrenia) for at least the past 6 months; (2) mental health cadres actively involved with the patient; (3) community health center health workers who provide mental health services; and (4) relevant parties such as the Social Services Department. Exclusion criteria included informants who refused to participate or experienced significant communication barriers. The number of informants was determined based on the principle of data saturation. When additional interviews no longer yield new relevant information, saturation was reached after 12 in-depth interviews were conducted at three community health centers (X, Y, and Z) and related agencies.

Data Collection Procedure

Data were collected through in-depth interviews, with an average duration of 45-60 minutes per informant. Interviews were conducted in locations deemed convenient by the informants: homes (for families and cadres), community health centers (for health workers), and the Social Services office. The interview guide was developed based on the CIPP evaluation model, with example key questions such as:

- *"How has your experience been supporting a family member with schizophrenia?"*
- *"What are the main obstacles you face in accessing mental health services at the Community Health Center?"*
- *"How was the communication and support from health workers or cadres during the treatment process?"*

All interviews were conducted after obtaining ethical clearance from the Health Research Ethics Committee and written informed consent from the informants. Informants were provided with an explanation of the purpose of the study, data confidentiality, and the right to discontinue participation at any time.

Data Analysis

Data analysis integrated the Miles & Huberman model with thematic analysis. The data reduction, data presentation, and conclusion drawing stages were carried out in line with the thematization process, namely identifying initial codes, grouping them into categories, and forming main coding themes. The analysis process was assisted by NVivo 15 software for qualitative data management. To ensure credibility, analysis was conducted by two researchers independently on a portion of the transcripts, then the results were compared. Discussions were held to reach consensus on coding differences. Reliability was strengthened

through a documented audit trail and verification of themes by the research supervisor.

RESULTS AND DISCUSSIONS

Table 1. Characteristics of Key Informants

	Question	Interview Result					
		KI 1	KI 2	KI 3	KI 4	KI 5	KI 6
1	Name (*code*)	SE	DA	MA	SA	PJ	SR
2	Age	30 y.o	39 y.o	40 y.o	40 y.o	42 y.o	43 y.o
3	Gender	W	M	W	W	W	W
4	Highest level of education	Master's degree	Bachelor's degree	Bachelor's degree	Associate degree	Senior high school	Senior high school
5	Occupation	Health Department	Cadre	Cadre	Cadre	house wife	house wife
6	Length of employment	6 years	6 years	4 years	5 years	7 years	5 years

Table I shows that the main sources of information for this study were those actively involved in home visits and ODGJ care, including mental health coordinators from the Health Office, mental health coordinators from community health centers, and health cadres/PSM in the sub-district.

Table 2. Characteristics of Triangulation Informants

	Question	Interview Result					
		TI 1	TI 2	TI 3	TI 4	TI 5	TI 6
1	Name (*code*)	TU	MA	AA	MO	AN	TR
2	Age	45 y.o	39 y.o	56 y.o	48 y.o	45 y.o	53 y.o
3	Gender	P	L	P	P	P	P
4	Highest level of education	Bachelor's degree	Junior high school	Bachelor's degree	Associate degree	Senior high school	Senior high school
5	Occupation	Teacher	Farmer	Housewife	Housewife	Entrepreneur	Civil servant
6	Length of employment	9 years	-	-	-	-	8 years

Table 2 shows that the sources of triangulation informants in this study included family caregivers of people with mental disorders, neighbors of people with mental disorders, and administrators of the Social Services Agency's program for people with mental disorders.

Input Evaluation:

a. Availability of Mental Health Services at Community Health Centers

Mental health services at community health centers in Semarang City have included health screening, home visits, and treatment for severe mental disorders. However, due to limited coverage areas, irregular implementation, and the fact that not all families of ODGJ members are willing to report their family members, some ODGJ patients do not receive optimal services. Additionally, due to time constraints, not all home visits can be carried out within the target time frame.

"Sometimes there are families who are reluctant to report their family members as ODGJ to the health center cause they feel it is shameful and are afraid of becoming the talk of the neighborhood" (TI_1)

"*We sometimes have limited time to visit all the homes with ODGJ, but when we do visit, they are very happy to see us."* (KI_2)

b. Facilities and Infrastructure

The facilities and infrastructure for mental health services at community health centers are still quite limited. Most community health centers do not have special counseling rooms or equipment to support mental health services. Medication for schizophrenia patients is not provided, as community health centers only provide vitamins and general medication. This is in line with the statements of informants

"So, we usually recap each other's work, and for mental health, we don't have a special room; we go to the general clinic." (KI_4)

"Yes, that's right. At this health center, we don't have inpatient care, only outpatient care. And for medication, we usually only give vitamins." (KI_3)

The majority of community health center staff (3 out of 4 health worker informants) stated that there was no dedicated space for mental health counseling or inpatient facilities. Furthermore, specific medications for schizophrenia were not provided, leaving patients with only vitamins or general medications. This statement is confirmed in the informant's quote above.

c. Health Workers

Health workers who treat severe ODGJ at Puskesmas are generally not specialized mental health workers such as psychologists or psychiatrists. Services are mostly provided by nurses or general practitioners with limited training. In addition, some mental health cadres have not received specialized training. Informants stated that the workload of health workers is quite high because they also have to handle many other programs.

Most Puskesmas do not have adequate specialized mental health personnel. Puskesmas

rely on general nurses or general practitioners to handle mental health cases due to limited human resources.

"I'm not a mental health nurse, but since there aren't any, I also take care of patients with mental disorders. So, most of us handle and help each other from other programs, but we still have responsibilities in our own departments." (KI_5)

d. Resources and Social Aspects

1) Schizophrenia Family (*Family Caregiver*)

For people with schizophrenia, the family is the primary caregiver and also the closest to the person with schizophrenia (Rosdiana, 2018). The type of care or treatment needed at home for people with schizophrenia is determined by the family. The low role of the family is also triggered by the low motivation of the family as the driving force. To provide the best care for family members suffering from severe schizophrenia, the family must pay close attention to them (Surya, 2013).

In addition to the family's crucial role as the primary companion of schizophrenia patients in their daily lives, they also play a role in monitoring medication consumption, behavior, and accompanying them during visits to health facilities (Adianta & Putra, 2021).

This finding is in line with research by (Iriyanti & Widiana, 2024), which states that caregivers of people with mental disorders need emotional support and ongoing education from health workers in order to be able to care for patients optimally (Eni & Herdiyanto, 2018).

The numerous and varied treatments or actions that families must take to care for people with mental disorders will become a separate problem that they must face. It is likely that families will not be able to provide good care to people with mental disorders if they feel burdened. The low economic status of families and the condition of patients who are unable to work also add to the burden of caring for patients.

This is also supported by Setiawan's (2018) statement that objective burdens are problems related to the implementation of patient care, including accommodation, food, transportation, treatment, and finances. Families face economic burdens when providing care, with factors such as low socioeconomic status and high medical costs acting as barriers.

In this study, the family care approach must be gradual and not harsh, meaning that gentle care is needed for people with schizophrenia. According to previous research findings by (Fadli & Mitra, 2013), the family care approach is recommended not to treat patients harshly because it can worsen their condition.

Based on the results of observations conducted in this study, informants said that they always prepare and supervise patients when they take their medicine so that they do not forget and take it on time.

"I am the one who usually reminds my child to take their medication. If I don't, they won't take it. Sometimes they even refuse, so I have to force them, but gently, you know... I have to be very patient, otherwise I'm afraid they will get angry again." (TI_3)

2) Mental Health Cadres

In the recovery process for people with mental disorders (ODGJ), cooperation with the community, such as cadres and community leaders, is needed. Cadres play a key role in community development and empowerment programs (Yusuf, Fitryasari & Nihayati, 2015).

"When I visit their homes to check on the patients, I communicate with their families. I am close to the ODGJ, so they already know me well. I remind them to always take their medication regularly" (KI_2).

The presence of mental health cadres, commonly referred to as PSM (Community Social Workers), will enable the community to become more familiar with mental health issues, which will in turn facilitate the process of identifying new cases of ODGJ in the community. Mental health cadres also serve as a support system within the community. These workers are capable of performing simple tasks such as early detection of mental health disorders, encouraging families to live healthily, preventing health risks, and encouraging participation in mental health education sessions. They also motivate ODGJ to undergo examinations at health centers and conduct home visits to patients (Noviana Ayu, 2024).

"I am just an ordinary citizen, but I have been

entrusted with monitoring residents of this village who have mental disorders. I follow the instructions from the community health center and the local government, ma'am. Sometimes I feel confused, but I still take the initiative myself." (KI_6)

Therefore, training is needed for health cadres to improve their abilities to manage and carry out health services, especially in conveying health information and education directly to the surrounding community (Rosyikin, 2020).

3) Stigmatization

Social stigma remains a significant barrier in the treatment of people with mental disorders. Many families hesitate or delay treatment because they are afraid of being ostracized or looked down upon by their neighbors (Davy et al., 2024).

"Sometimes neighbors who don't know about it are still afraid, so they tend to avoid us, but our family also hides when my child has an episode, afraid that people will think he is possessed or crazy." (TI_4)

"I've taken my child to a spiritual healer several times to have them prayed for, but even now, they still sometimes have outbursts when they're having an episode." (TI_5)

In fact, the government has provided many health facilities in every region, especially in the city of Semarang, starting from community health centers and hospitals in Semarang that should be used for medical treatment by utilizing existing health facilities. However, there are still many ordinary people who do not utilize these health facilities. Instead, they take their sick family members to traditional healers or village doctors for treatment. Therefore, it is important to raise awareness among the general public, especially among families with mental health issues, about the importance of utilizing the existing healthcare facilities (Manesh et al., 2023).

One of the environments that has a significant impact on the recovery of schizophrenia patients is social stigma (Ebrahim et al., 2020). It is feared that family members who act as caregivers for schizophrenia patients (family caregivers) may feel stressed and overwhelmed due to social stigma, which not only affects the schizophrenia patient but also other family members. The presence of social stigma can cause families to feel ashamed of having a family member with schizophrenia. Schizophrenic patients may receive less care due to the shame felt by family caregivers.

Caregivers experience spiritual changes while caring for their family members. In other words, every caregiver faces physical and emotional stress, but they are able to navigate each stage of life while caring for a schizophrenic patient because they possess self-acceptance and family belief in recovery.

"Yes, usually I can only pray continuously, if I am tired, I complain to Allah, what else can I do, it is destiny, I just accept it" (TI_2)

4) Social Support

Social support is assistance received by a person to make them feel calmer, cared for, and confident. They will feel loved, valued, and a sense of belonging when receiving social support (Herlyansyah, 2019). Social support for ODGJ is the presence of others who care for them, value them, and love them by doing something for them (Kumalasari et al., 2020). Kuntjoro's view on social support in (Kumalasari et al., 2020) is that it is input, assistance, or concrete actions provided by people who are close to ODGJ sufferers. One way to understand social support for ODGJ is when the patient's closest relatives regularly take them to medical facilities for treatment to prevent relapse (Adianta & Putra, 2021).

Social support encompasses all forms of family support that can facilitate the recovery process for schizophrenia patients. There are five types of social support according to (Eni & Herdiyanto, 2018), namely:

(1) Supportive assistance is social support from the family that includes care, availability of time and energy in terms of treatment and daily life of people with schizophrenia. (2) Emotional support can take the form of closeness or openness between the person with schizophrenia and family members. Because the person with schizophrenia feels able to be honest and open with their family, sharing all their experiences and concerns, and the family is already aware of the person's condition. (3) Instrumental support includes financial assistance during the healing

process, whether it be therapy or medication, care for the schizophrenia patient, and meeting the patient's needs such as bathing supplies, clothing, and food. (4) Group support involves the availability of others to spend time with the patient, creating an atmosphere of mutual support, sharing stories, experiences, and advice, and engaging in activities together. The group support referred to in this study is support from outside the family that is accessed by the family or the schizophrenia patient as part of the patient's recovery process. (5) Information support is one form of support provided by the family through advice, responses, or suggestions to assist the schizophrenia patient in their recovery process.

This is in line with research (Maghfiroh & Khamida, 2018), which suggests that it would be beneficial for people with schizophrenia and others if they could interact well. Therefore, to build social support and foster a positive stigma for those affected, it is essential to involve social engagement, the role of family, and the role of society in helping those affected to build better social connections in their surroundings and treat one another with humanity without regard to differences, striving to treat them well.

"Mr. X, you know, when he's in his normal phase, he can actually be joked with, and he understands what's being said. But it's different when he's in his manic phase—he gets violent, sometimes hitting people. Sometimes he goes out without clothes" (TI_4)

"I'm the one who usually goes directly to the field, ma'am. I visit the ODGJ's homes, so I understand their personalities. So far, I've come to understand that we must treat all creatures equally. I can't bear to see the ODGJ suffer; they're pitiful. They actually need help" (KI_5)

Process Evaluation:

a. Service Mechanism:

The types of mental health services provided at Community Health Centers X, Y, and Z include mental health education, counseling, basic mental health services integrated into general clinics, home visits, family empowerment, and referral services. The process of providing services for schizophrenia patients and conducting home visits in managing cases begins with data collection. In the initial stages of mental health services at Health Centers X, Y, and Z, an initial assessment is conducted by healthcare workers or general practitioners on duty.

Based on applicable standard guidelines, each Puskesmas conducts an initial assessment as an effort for early detection of mental health issues to identify mental health problems earlier, enabling the preparation of treatment and preventive steps as well as referral actions for patients. The initial assessment is conducted using a Mental Status Exam (MSE) and screening with a Self-Reporting Questionnaire (SQR). In the interview results, informants revealed that mental health enumerators will conduct home visits for patients with severe schizophrenia, but before that, they will first inform mental health programmers to formulate further interventions and management for patients with severe schizophrenia (Rahmakusuma & Budi, 2024).

Home visits are conducted by monitoring the condition of ODGJ patients and providing education to patients or families regarding patient care and treatment. Home visits enable healthcare workers to obtain the latest information on patients with mental disorders. These visits also enable healthcare workers to coordinate with the families of ODGJ patients in handling ODGJ cases. Referring to the Minimum Service Standards (SPM), the implementation of home visits is an activity that must be carried out in healthcare services for ODGJ cases. In these activities, self-care, household activities, and simple work activities are also conducted (Agustin, Nur Laili, Sriatmi, Ayun dan Budiyanti, 2020).

b. Communication Aspects

In implementing human resource strategies, the main factors are the need for policies, finances, and adequate facilities and infrastructure, as theorized by Van Meter and Van Horn (van Manen & van Manen, 2021), One aspect that must be considered is the availability of internal resources and internal communication to implement a program and policy. Internal communication in this case involves communication with the mental health coordinator, the head of the community health center, and the ODGJ program manager.

The internal communication forum aspect in the implementation of the mental health program has been present in mini-workshops (lokmin), previously referred to as "*programmer meetings*." These meetings can be attended by the head of the health center, the program coordinator, the health center's UKM coordinator, and all health workers at the health center. These activities are conducted by the health center once a month. The PIS-PK team can hold monthly internal coordination meetings during the data collection phase to monitor implementation, provide guidance before going into the field, and conduct monitoring and issue instructions (Rahmakusuma & Budi, 2024). Additionally, during the local meeting, PIS-PK results such as IKS results, involvement indicators, and challenges encountered in the field can be discussed, and a joint evaluation can be conducted (Agustin, Nur Laili, Sriatmi, Ayun dan Budiyanti, 2020).

In the context of external communication forums, one of the topics discussed there is cross-sector communication outside of community health centers during the implementation of the PIS-PK ODGJ program. In this case, the external communication component shows that there is communication between parties outside of the health facilities referred to as community health centers. Health cadres, village heads, community leaders, sub-district heads, school representatives, and the Social Affairs Office attended the monthly follow-up meeting of the local government, which is a cross-sectoral meeting held every three months. This includes future improvements and the achievement of objectives from the previous local government meeting that have not yet been achieved. The health center organizes these cross-sectoral meetings with the aim of enhancing stakeholder collaboration in efforts to improve community health comprehensively. The hope is that with these efforts, health programs such as mental health programs can be implemented more effectively and sustainably by integrating various relevant parties (Rahmakusuma & Budi, 2024).

c. Cross-sectoral involvement and programs

People with mental disorders who are neglected, homeless, pose a threat to themselves and/or others, or disturb public order and/or security must receive the necessary care and treatment. One of the obligations that must be carried out by the government is to rehabilitate all of them (Affrian, 2019). The local government is responsible for fulfilling the rights of people with mental disorders, which include the right to receive treatment, care, and rehabilitation aimed at recovery and returning to being normal, productive human beings (Setianingrum & Maulani, 2025).

Local governments have professional social workers in the Social Services Agency who are responsible for providing services to people with mental disorders. The Social Services Agency is also tasked with assisting local governments in carrying out social duties in their areas. Their responsibilities include providing social security for individuals with conditions such as mental disabilities, the elderly, the abandoned, the vulnerable, and the underprivileged. These responsibilities involve collaboration between the government, families, the community, and the disabled individuals themselves (Marbun et al., 2023).

"Actually, ma'am, visits are the domain of the community health center, not us. ODGJ are mentally ill. The Health Department and community health centers should be the ones taking action. Because the mindset of the community is still to rely on the Social Services Agency for everything, we have no choice but to help. But so far, after admitting them to the mental hospital and rehab, that's all we can do." (TI_6)

This statement reflects the situation in many regions in Indonesia, where the role of the Social Services Department is often understood to be limited to "abandoned ODGJ," meaning patients without family or adequate economic means who cannot access healthcare services. Routine medical visits and monitoring of psychopharmacological therapy are not considered their responsibility but rather the domain of the Health Department and community health centers.

In practical terms, this situation indicates a shift in roles because the community still believes that no matter how serious the mental health issue is, it should be handled by the Social Services Agency. This is consistent with the

analysis of mental health services in Indonesia, where stigma and low mental health literacy cause "delayed treatment and dependence on social channels" rather than medical ones (Belarminus et al., 2025).

"*Sometimes it's not sustainable. The relationship between PM (those with issues) and the Social Services Department is unbalanced*." (TI_6)

This indicates an imbalance in terms of function and capacity. The Social Services Department feels overwhelmed because they lack authority, resources, and specialized expertise compared to the Health Department. However, they continue to provide post-hospitalization care or rehabilitation services because the community demands continuity of care.

According to a study by Basrowi (2024), the gap between institutional capacity and community expectations often forces social functions to become a "long-term support" for mental health services. However, the primary task is to provide space for more appropriate clinical and medical services (Basrowi et al., 2024).

Output Evaluationt:

Evaluation of the output aspects of mental health services shows that the availability of services at the community health center (Puskesmas) level has a real impact on the condition of schizophrenia patients. Most family informants stated that patients experienced behavioral improvement and a decrease in recurrence after taking medication regularly. However, this stabilizing effect is highly dependent on medication adherence and the continuity of services. When patients stop treatment or families experience physical or psychological exhaustion, relapses often occur again.

Mental health services at the Puskesmas level are insufficient if they rely solely on interactions between families, community health workers, and healthcare providers. The successful management of severe mental disorders, particularly schizophrenia, requires structured and sustained collaboration among all parties. In the city of Semarang, collaboration between Puskesmas, the Social Services Agency, sub-districts, and referrals to mental hospitals is already underway, but it is not yet fully facilitated by formal mechanisms.

In addition to the impact on the patient's condition, changes in family attitudes toward ODGJ are also an important outcome of mental health services. Education and guidance provided by health workers and cadres have improved families' understanding and acceptance of schizophrenia as a controllable illness, rather than a stigma or curse. This process is not instantaneous; some families still experience denial and hide the patient's condition from society. However, most are beginning to recognize the importance of long-term treatment and care. This is supported by the findings of Puspitasari et al. (2024), who state that increasing family knowledge through structured education can reduce psychological resistance in caring for family members with mental disorders.

The role of mental health cadres has proven to be one of the pillars of successful mental health services at the primary level. In this study, cadres not only served as information liaisons between families and community health centers, but also as emotional companions for families who felt isolated and unable to cope with the situation on their own. Cadres actively conducted home visits, provided information about treatment, and assisted families in the referral process. Some families acknowledged that the presence of cadres made them feel "not alone" in dealing with the patient's condition. This role is consistent with the findings of Patel et al. (2020) in a study in India, which showed that the involvement of health cadres can improve treatment outcomes and reduce the burden on caregivers in the context of mental disorders.

The role of mental health cadres has been proven to be a pillar of successful primary mental health services. In this study, cadres not only served as information liaisons between families and the Community Health Center (Puskesmas), but also as emotional companions for families who felt isolated and unable to cope alone. Cadres actively conducted home visits, provided information about treatment, and assisted families with the referral process. Several families acknowledged that the presence of cadres made them feel less alone in dealing with the patient's

condition. This role is consistent with the findings of Patel et al. (2020) in a study in India, which found that the involvement of health cadres can improve treatment outcomes and reduce caregiver burden in the context of mental disorders. However, unlike in India, where cadres primarily support medication adherence, in Semarang, mental health cadres play a broader role, not only monitoring treatment but also bridging communication between families and the Puskesmas, conducting home visits, and helping reduce stigma in the community. This suggests that the contribution of cadres in Semarang is more oriented towards social support and the integration of community-based services, a practice not widely recognized in studies in other countries..

However, one of the main obstacles to improving service outcomes is the persistent social stigma against people with mental disorders (ODGJ). Although families have begun to accept the patient's condition, the surrounding community still displays discriminatory attitudes, such as avoiding interaction, spreading negative rumors, and even suggesting non-medical alternatives like spiritual healing or ostracization. This stigma causes some families to be reluctant to bring patients to care facilities, preferring to hide their family member's condition.

"The advice from those in authority at the shelter is that we need a shelter. Those who have been living there for decades, even though shelters should be classified separately. In the shelter, everyone is mixed together, including people with HIV, the elderly, bedridden elderly, people with high and low levels of mental disorders, people with disabilities, and people without ID cards. It's a pity for them." (TI_6)

Additionally, the lack of supporting infrastructure remains a major challenge. The absence of specialized shelters for abandoned ODGJ at the district/city level has led to shelters becoming mixed facilities that do not meet care needs. ODGJ patients are mixed with ODMK, bedridden elderly, and even PGOT, which indirectly hinders the recovery process and increases the risk of relapse.

"After rehabilitation, they are given entrepreneurship training by the Ministry of Social Affairs. We only provide accompaniment and monitoring, as we have a responsibility to the ministry. After rehabilitation at the shelter, they are given entrepreneurship training, and the progress of their entrepreneurship is monitored every three months." (TI_6)

Furthermore, post-rehabilitation monitoring efforts carried out by the Ministry of Social Affairs in the form of entrepreneurship training and monitoring for three months show a progressive policy direction. However, as stated by Purgato et al (2021), post-rehabilitation interventions for people with mental disorders will only be effective if they are followed by long-term assistance and sustainable cross-sectoral support, including in legal, social, and economic aspects.

Overall, the evaluation of the output aspect shows that although there are positive impacts of medical and social interventions on patients and families, challenges such as social stigma and dependence on services provided by specific individuals (such as cadres or a single officer) remain obstacles to achieving optimal outcomes. Therefore, a more comprehensive service system, ongoing anti-stigma education, and tiered training for cadres are needed to ensure the continuity of support for schizophrenia patients and their families.

The findings of this study can be understood through the framework of Social Support Theory, which explains that social support consists of emotional, instrumental, informational, and appraisal dimensions. In this context, families and mental health cadres in Semarang City play a role in providing emotional support (providing encouragement and empathy), instrumental support (assisting with treatment and monitoring), and informational support (providing mental health education). However, strong social stigma often hinders the function of this support, thereby reducing the effectiveness of community-based interventions.

Figure 1 & 2. Thematic map of the evaluation of community mental health services in Semarang, derived from NVivo 15 analysis. The figure illustrates three main domains (*Input*, *Process*, and *Output*) and their subthemes based on 12 interviews with family caregivers, mental health cadres, and health workers.

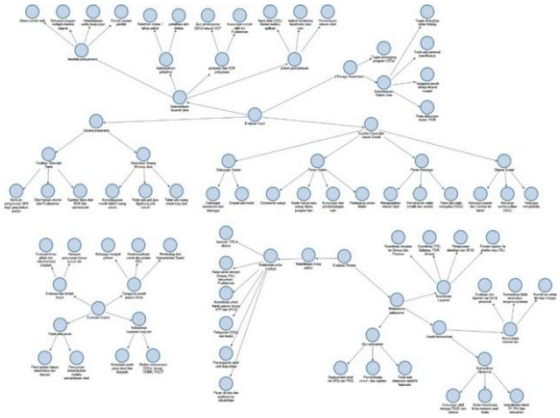

Figure 1. Schematic representation of interview results using NVivo 15 software

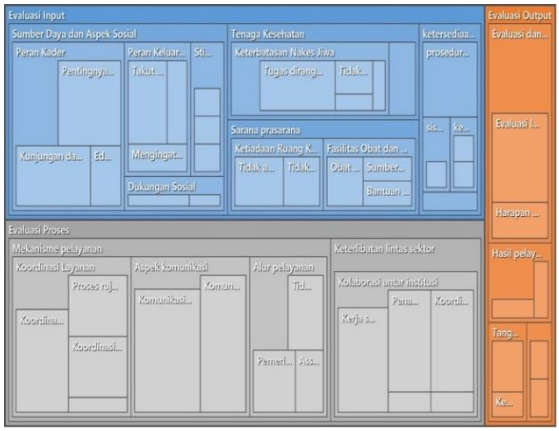

Figure 2. Theme findings from interview results using NVivo 15 software

CONCLUSION

This study shows that mental health services at the Semarang City Community Health Center have had a positive impact on the condition of schizophrenia patients, particularly through routine treatment and support from family members and mental health cadres. Patients have experienced stabilization of symptoms, and some families have begun to show a more accepting attitude toward the condition of their family members. In addition, cadres have proven to be key actors in bridging communication and services between the Community Health Center and the community.

However, the success of services is still overshadowed by several challenges, such as irregular service delivery, limited mental health personnel, inadequate training of cadres, and the persistent social stigma against people with mental disorders (ODGJ). Stigma not only impacts patients but also influences family attitudes, perceived burden, access to services, and the overall recovery process. Therefore, evaluation of service outputs indicates that service success is not sufficient through medical intervention alone but must also address the social and cultural aspects of the community more deeply. Thus, the findings of this study reinforce the concept of Social Support Theory, which states that the success of social support depends on social acceptance and a lack of stigma within the community.

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