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Forgotten Patients: Family Caregivers in Psychiatric Care Transitions and Readmission Prevention

Saverinus Suhardin[1], Yohana Teodosia Setu[2], Imakulata Bete[3], Camelia Bakker[4], Joli Riyana Nubatonis[5], Kurnia B. Yunita Pellondou[6]
[1, 2, 4, 5, 6] Nursing Study Program, Maranatha College of Health Sciences, [3]Naimata Regional Psychiatric Hospital
e-mail: [1] saverinussuhardin@gmail.com, [2]yohanasetu11@gmail.com, [3]imakulatabete@gmail.com, [4]graciatimothy@gmail.com, [5]jolinubatonis@gmail.com, [6]yunitapellondou57@gmail.com

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Abstract. *Introduction* Psychiatric readmission remains a major challenge in mental health care, particularly in resource-limited settings where continuity of care following hospital discharge is often fragmented.
Aim This study explored the role of discharge planning in preventing psychiatric readmission from the perspectives of patients, family caregivers, psychiatric hospital staff, and primary healthcare nurses in East Nusa Tenggara, Indonesia.
Result The findings showed that fragmented discharge planning limited continuity of care after psychiatric discharge and increased the responsibilities of family caregivers in coordinating post-discharge care. Four interrelated themes emerged: (1) family burden extending beyond hospital discharge; (2) emotional exhaustion and psychological distress among family caregivers; (3) fragmented discharge planning and weak continuity of care following psychiatric discharge; and (4) living with limited resources.
Conclusion These findings suggest that psychiatric readmission is influenced not only by patient-related factors but also by fragmented transitions of care that unintentionally transfer greater responsibility for continuity of care to family caregivers.

Introduction

Severe mental illness (SMI), particularly schizophrenia, continues to be one of the leading causes of long-term disability and psychosocial burden worldwide (Ono & Okamura, 2026). Although considerable progress has been made in psychiatric treatment, relapse and repeated hospitalizations remain common, especially in low- and middle-income countries (LMICs). Recovery from severe

mental illness extends beyond symptom stabilization during hospitalization. It also depends on how well patients are supported after returning home through consistent medication use, meaningful family involvement, and accessible community-based mental health services (Chadda et al., 2021).

Discharge planning has become an essential component of psychiatric care because it bridges the transition from hospital treatment to community living (Petkari et al., 2021). When implemented effectively, discharge planning promotes continuity of care, improves treatment adherence, and lowers the risk of relapse and psychiatric readmission. Nevertheless, in many clinical settings, the process remains largely focused on preparing patients for discharge, while the needs and readiness of family caregivers receive considerably less attention (Asgharzadeh et al., 2025).

This imbalance becomes particularly important in LMICs, where families often assume responsibility for caring for relatives with severe mental illness once they leave the hospital. Beyond supervising medication, family caregivers provide emotional support, arrange transportation to health facilities, manage financial needs, and respond to psychiatric crises that may arise at home (Chadda et al., 2021; Verity et al., 2021). Yet many caregivers begin this responsibility with limited information, inadequate psychoeducation, and little involvement in discharge planning (Asgharzadeh et al., 2025). As a result, caregiving frequently evolves into a demanding responsibility that affects not only caregivers' emotional, social, and financial well-being but also the continuity of treatment and efforts to prevent relapse (Mbadugha et al., 2023).

Evidence consistently shows that involving families in mental health care contributes to better treatment outcomes and lower readmission rates (Petkari et al., 2021). However, much of the existing literature has examined discharge planning from the perspectives of patients or healthcare professionals, while the experiences of family caregivers remain less visible. This gap is even more apparent in resource-limited settings, where shortages of mental health professionals, limited service availability, transportation barriers, medication access difficulties, and persistent

stigma increase caregivers' responsibilities while simultaneously restricting the support available to them (Verity et al., 2021; Hovland et al., 2025).

Previous studies have described caregiver burden and emphasized the importance of involving families in psychiatric care (Hegde et al., 2019; Shiraishi & Reilly, 2019). Nevertheless, relatively little is known about how family caregivers actually experience the transition from hospital to home in settings where health systems remain fragmented, and community mental health resources are limited (Iversen et al., 2026). This issue is particularly relevant in Indonesia, especially in East Nusa Tenggara, where specialized mental health services are concentrated in only a few facilities. Consequently, families and primary healthcare services become the main pillars supporting patients after hospital discharge.

A previous study conducted in the same setting identified a major breakdown in the transition process, described as "Silent Discharge." The study revealed that primary healthcare centers often remain unaware that patients have been discharged because no formal communication exists between psychiatric hospitals and community health services (Setu et al., 2026). Although these findings highlighted important structural weaknesses and proposed a collaborative cross-sectoral discharge model, they mainly addressed the problem from a health system perspective. They offered limited understanding of how families experience and respond to these fragmented transitions in their everyday lives, despite being the individuals who ultimately compensate for the absence of coordinated services.

Against this background, the present study explored the role of discharge planning in preventing psychiatric readmission among people with severe mental illness from the perspectives of patients, family caregivers, psychiatric hospital staff, and primary healthcare nurses in East Nusa Tenggara, Indonesia. Rather than examining discharge planning solely as a clinical procedure, this study seeks to understand how it is experienced across the continuum of care. In doing so, it brings attention to family caregivers as the often overlooked partners in recovery who

carry substantial responsibility after discharge while receiving only limited support from the mental health system.

Method

Research Design

This study employed an exploratory qualitative case study design to explore experiences of psychiatric discharge, continuity of care, relapse prevention, and readmission among people with severe mental illness (SMI) in East Nusa Tenggara, Indonesia. The study was conducted at Naimata Psychiatric Hospital, the only government psychiatric referral hospital in the province, which serves a population living in a resource-limited setting characterized by geographic challenges, limited mental health resources, and persistent stigma surrounding mental illness. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guideline.

Participants and Setting

Data were collected between August and October 2025 at Naimata Psychiatric Hospital and selected primary healthcare centers providing post-discharge mental health services. Participants were recruited purposively based on their direct involvement in discharge planning, post-discharge care, or experiences of psychiatric readmission.

Participants included hospital-based mental health professionals (psychiatrists, psychiatric nurses, and social workers), primary healthcare nurses responsible for mental health programs, patients with severe mental illness who had recently experienced psychiatric hospitalization, and their primary family caregivers. Particular attention was given to family caregivers because they assumed primary responsibility for medication supervision, symptom monitoring, crisis management, and day-to-day care following discharge. Recruitment continued until thematic saturation was achieved and no substantial new information emerged from subsequent interviews.

Data Collection

Data were generated through semi-structured interviews, non-participant observations, and document review to facilitate methodological triangulation. Semi-structured interviews explored experiences related to discharge planning, continuity of care, medication management, caregiver preparedness, relapse prevention, and perceived causes of readmission. Interviews were conducted in private locations convenient for participants, lasted approximately 45–90 minutes, were audio-recorded with consent, and transcribed verbatim.

Non-participant observations were conducted to understand discharge preparation processes, interactions between healthcare providers and families, and caregiving practices within community settings. Field notes were recorded throughout the study. Relevant documents, including discharge summaries, referral forms, discharge planning records, and institutional policies related to mental health services, were reviewed to support triangulation and contextual interpretation.

Researcher Role and Reflexivity

The principal investigator conducted all interviews and observations. Reflexive journaling was maintained throughout the study to document assumptions, methodological decisions, and emerging interpretations, thereby enhancing analytical transparency.

Data Analysis

Data were analyzed using inductive thematic analysis following Braun & Clarke (2021). Analysis involved familiarization with the data, initial coding, category development, theme generation, theme review, and interpretation. Themes were developed across interviews, observations, and documents to identify recurring patterns related to discharge planning, continuity of care, caregiver experiences, and psychiatric readmission.

Particular attention was given to narratives describing caregiver burden, emotional exhaustion, fragmented service coordination, and post-discharge support

needs. The final themes were interpreted in relation to continuity-of-care theory and mental health service delivery in resource-limited settings.

Trustworthiness

Trustworthiness was established through triangulation of interviews, observations, and documentary evidence; member checking with selected participants; maintenance of an audit trail; reflexive journaling; and regular discussions among members of the research team. Detailed descriptions of the study setting, participants, and healthcare context were provided to support transferability.

Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee of STIKES Guna Bangsa Yogyakarta (Approval No. 059/KEPK/VI/2025). All participants received verbal and written explanations regarding the study objectives, procedures, potential risks, and confidentiality protections before providing informed consent.

Participation was voluntary, and participants were informed of their right to withdraw at any stage without consequence. To protect privacy, all identifying information was removed from transcripts and replaced with pseudonyms. For participants with severe mental illness, participation was permitted only after clinical stability had been confirmed by the treating psychiatrist.

Result

Participant Characteristics

This study involved 14 participants (10 females, 4 males) aged 30 to 68 years. The sample comprised five mental health professionals from Naimata Psychiatric Hospital (a psychiatrist, a case manager, an emergency unit head, an outpatient unit head, and an inpatient head nurse), three community nurses from Oepoi, Bakunase, and Penfui Health Centers, three stable outpatients with illness durations of 9 to 20 years and multiple readmissions, and three primary family caregivers. Despite

national health insurance coverage, participants consistently reported systemic challenges regarding transportation costs, medication access, and service continuity.

Themes Identified

Analysis of interview transcripts, observations, and document review generated four interrelated themes describing experiences following psychiatric discharge.

Table 1.
Themes and Subthemes

Theme	Subthemes
Family Burden Extends Beyond Hospital Discharge	Caregiving responsibilities; Limited caregiver preparation; Financial and social burden
Emotional Exhaustion and Psychological Distress Among Family Caregivers	Chronic stress and fatigue; Hopelessness and emotional burden
Fragmented Discharge Planning and Weak Continuity of Care Following Psychiatric Discharge	Limited inter-service communication; Lack of structured follow-up; Family-led care coordination
Living with Limited Resources: Medication Adherence, Stigma, and Access Barriers as Drivers of Readmission	Medication non-adherence; Stigma; Transportation and service access barriers

Family Burden Extends Beyond Hospital Discharge

Family caregivers consistently described that their responsibilities increased considerably once patients returned home from the psychiatric hospital. After discharge, they became the primary individuals responsible for supervising medication, observing behavioral changes, assisting with daily activities, and responding to early signs of relapse. For many participants, these responsibilities emerged immediately after discharge, often without adequate preparation.

Several caregivers expressed that although they had received brief instructions before leaving the hospital, they still felt uncertain about how to manage patients in everyday situations. One caregiver explained:

"The doctor told us not to get angry and just let her express her emotions, but after returning home we still had to figure out many things ourselves." (Family Caregiver 1)

This experience was also acknowledged by hospital staff, who explained that discharge preparation had not yet been supported by a standardized discharge planning system. Instead, education was generally provided through routine nursing practice rather than a structured discharge planning process.

"There is no specific discharge planning form. However, nurses have been providing discharge education in practice." (Hospital Staff 1)

Beyond the practical aspects of caregiving, participants also described the emotional, social, and financial consequences of caring for a family member with severe mental illness. These findings suggest that the challenges faced by families do not end when patients leave the hospital. Instead, the transition home often marks the beginning of a prolonged period of responsibility in which families become the main providers of care while receiving only limited support from the formal mental health system.

Emotional Exhaustion and Psychological Distress Among Family Caregivers

Beyond the practical demands of caregiving, participants described a considerable emotional burden associated with caring for family members with severe mental illness. Feelings of fatigue, frustration, anxiety, and emotional exhaustion were commonly expressed, particularly among caregivers who had experienced repeated episodes of relapse over many years. One caregiver reflected on this prolonged struggle by saying:

"I am tired. I have been struggling alone for years." (Family Caregiver 2)

The emotional burden experienced by caregivers was also recognized by healthcare professionals. Hospital staff observed that prolonged caregiving responsibilities often left families feeling overwhelmed and emotionally drained, especially when recurrent relapses occurred without sufficient support from the health system.

"Many families become exhausted. Some even say they would rather die together because they no longer know what to do." (Hospital Staff 2)

Participants further described that emotional strain frequently affected relationships within the family. In several interviews, patients themselves acknowledged that tension, misunderstanding, or conflict within the household sometimes intensified their own emotional distress and made recovery more difficult. Taken together, these findings indicate that the impact of severe mental illness extends beyond the patient, creating a shared psychological burden that influences the well-being of caregivers, family relationships, and the continuity of care after discharge.

Fragmented Discharge Planning and Weak Continuity of Care Following Psychiatric Discharge

Participants consistently described a fragmented transition from psychiatric hospital care to community-based services. Rather than being supported through a coordinated discharge process, patients often returned home without formal communication between the psychiatric hospital and primary healthcare facilities. Consequently, community health workers frequently became aware of a patient's discharge only after the patient or family independently visited the local health center. As one community nurse explained:

> *"There has never been any formal communication from the hospital. We receive information only when patients come back to us." (Community Nurse 1)*

Other participants described this absence of communication as a major barrier to ensuring continuity of care. They emphasized the need for a formal referral pathway that could connect psychiatric hospitals with primary healthcare services and enable timely follow-up after discharge.

> *"Official communication has not yet been established. We need a bridge connecting the hospital and primary healthcare services." (Community Nurse 2)*

Hospital staff also acknowledged that coordination across levels of care remained inadequate and recognized that this weakness affected efforts to prevent relapse and psychiatric readmission.

"Coordination with primary healthcare facilities has not functioned optimally, and this contributes to repeated admissions." (Hospital Staff 4)

In the absence of an integrated discharge system, families often assumed responsibilities that would normally be supported by the healthcare system. They became the informal coordinators of care, arranging follow-up visits, transferring information between healthcare providers, and ensuring that treatment continued after discharge. These findings illustrate that continuity of care frequently depended on the capacity of families to bridge the gap between hospital-based and community-based mental health services.

Living with Limited Resources: Medication Adherence, Stigma, and Access Barriers as Drivers of Readmission

Participants described that maintaining treatment after discharge was often complicated by limited resources and restricted access to mental health services. Medication adherence was influenced not only by patients' willingness to continue treatment but also by practical challenges such as transportation difficulties, financial constraints, medication side effects, and the long distance to psychiatric care. These barriers frequently disrupted follow-up treatment and increased the risk of relapse.

One family caregiver described how transportation costs became a major obstacle to accessing psychiatric services:

"Transportation to the psychiatric hospital is expensive. We hope public transportation can reach the hospital area." (Family Caregiver 3)

Community nurses shared similar experiences, explaining that economic and geographical barriers often delayed follow-up visits or medication refills after patients returned home.

"When medications run out, families often struggle because of distance and transportation costs." (Community Nurse 1)

In addition to these practical challenges, participants also described the persistent stigma surrounding mental illness within their communities. Negative

attitudes and discrimination sometimes discouraged patients and their families from seeking treatment or participating in social activities, further weakening the continuity of care. Taken together, these findings suggest that psychiatric readmission cannot be understood solely as a consequence of individual treatment adherence. Rather, it reflects the combined influence of structural barriers, social stigma, and limited access to mental health services that continue to shape recovery after discharge.

Discussion

This study provides a deeper understanding of how psychiatric readmission is shaped by the interaction between family caregiving experiences and the organization of mental health services in a resource-limited setting. The findings indicate that readmission cannot be understood solely as a consequence of illness severity or medication non-adherence. Instead, it emerges within a broader context in which families are required to sustain recovery after discharge despite limited continuity of care and restricted access to community-based mental health services. In this situation, family caregivers assume responsibilities that extend far beyond traditional caregiving roles, including coordinating treatment, monitoring symptoms, arranging follow-up care, and responding to crises when relapse occurs.

One important finding of this study is that the transition from hospital to home often occurred without structured communication between psychiatric hospitals and primary healthcare services. Consistent with our previous analysis describing the phenomenon of *Silent Discharge* (Setu et al., 2026), community nurses frequently became aware of a patient's discharge only when patients or their families independently sought care. As a result, continuity of care depended largely on the ability of families to bridge the gap between different levels of service. While discharge planning is intended to support a safe and coordinated transition following hospitalization (Petkari et al., 2021), participants in this study described a process that was largely informal and focused primarily on medication-related

instructions. This finding suggests that discharge often represented the end of hospital-based care rather than the beginning of a coordinated recovery process involving families, primary healthcare services, and community resources.

The findings also highlight how the absence of coordinated post-discharge support contributes to caregiver burden. According to the Stress-Appraisal-Coping Model, caregiver burden develops when caregiving demands exceed available coping resources (Hegde et al., 2019). Although previous studies have consistently reported emotional distress, anxiety, and social burden among caregivers of individuals with schizophrenia (Shiraishi & Reilly, 2019; Batool et al., 2021), the present study suggests that these experiences are further intensified when families are required to assume responsibilities that would otherwise be supported by the health system. Participants described prolonged uncertainty regarding medication management, relapse prevention, and access to services, while many caregivers reported feeling insufficiently prepared for these responsibilities. Consequently, caregiving became not only a source of emotional strain but also a long-term responsibility that affected family well-being, social participation, and economic stability.

Another important contribution of this study is the recognition that family caregivers frequently function as informal coordinators of care following psychiatric discharge. In the absence of formal communication pathways, families often became the primary link connecting psychiatric hospitals, primary healthcare facilities, and community services. This role was rarely acknowledged within existing service arrangements, yet it was essential for maintaining treatment continuity. The findings therefore extend previous discussions on family involvement in mental healthcare by demonstrating that, in resource-limited settings, families are not only providers of emotional and practical support but also key actors in coordinating care across fragmented service systems.

Several structural barriers further complicated recovery following discharge. Participants described transportation difficulties, financial constraints, medication

access challenges, and persistent stigma surrounding mental illness. Similar findings have been reported in other low- and middle-income countries, where treatment interruption is often influenced by limited service accessibility and socioeconomic barriers rather than unwillingness to adhere to treatment recommendations (Abed et al., 2025; Ono & Okamura, 2026). Stigma also continued to affect both patients and caregivers by discouraging help-seeking and reducing opportunities for social participation (Kaur et al., 2021). Together, these barriers created conditions in which maintaining treatment continuity became increasingly difficult, thereby increasing the likelihood of relapse and subsequent readmission.

Taken together, the findings suggest that psychiatric readmission should be viewed not only as a clinical issue but also as a reflection of how effectively health systems support care transitions after discharge. The study contributes to the growing evidence that families play a central role in sustaining recovery among individuals with severe mental illness. More importantly, it highlights how the absence of structured coordination mechanisms may unintentionally transfer substantial responsibility for continuity of care to family caregivers. Strengthening communication between psychiatric hospitals and primary healthcare services, expanding caregiver-focused psychoeducation, and developing community-based follow-up systems may therefore represent important strategies for reducing preventable readmissions while supporting the well-being of families who remain at the center of long-term mental health care.

Conclusion

This study demonstrates that psychiatric readmission in resource-limited settings is influenced not only by patient-related clinical factors but also by how continuity of care is organized following hospital discharge. The findings suggest that fragmented discharge planning and limited communication between psychiatric hospitals and primary healthcare services unintentionally transfer responsibility for coordinating post-discharge care to family caregivers. As a result,

families assume multiple roles that extend beyond providing emotional support, including coordinating treatment, monitoring recovery, facilitating access to services, and responding to relapse, often with limited preparation and formal support.

An important contribution of this study is the identification of family caregivers as informal care coordinators within a fragmented mental health system. This finding extends the concept of *Silent Discharge* by showing how the absence of structured care transitions places families at the center of post-discharge care while simultaneously exposing them to substantial emotional, social, and practical burdens. These findings highlight the need to strengthen continuity of care through family-centered discharge planning, structured communication between psychiatric hospitals and primary healthcare services, and caregiver-focused support to reduce preventable psychiatric readmissions.

This study was conducted in a single psychiatric hospital with a limited number of participants, which may affect the transferability of the findings. Future research should evaluate the effectiveness of integrated family-centered transitional care models and structured communication systems in improving continuity of care, supporting family caregivers, and reducing psychiatric readmission in resource-limited settings.

Suggestions

Mental health services should strengthen discharge planning by adopting a family-centered transitional care approach that actively involves caregivers throughout the discharge process. This approach should include caregiver education, assessment of caregiver preparedness, formal communication pathways between psychiatric hospitals and primary healthcare services, and community-based follow-up support. Strengthening these components may improve continuity of care, reduce avoidable treatment interruptions, and lessen the burden experienced by family caregivers while contributing to lower psychiatric readmission rates.

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Author contribution

SS, YTS, and IB conceptualized and designed the study. CB, JRN, and KBYP contributed to data collection and transcription. All authors contributed to data interpretation, manuscript revision, and approval of the final manuscript.

Competing interest

The authors declare that there are no competing interests.

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