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## Mental Health Support for Hemodialysis Patients and Families: Needs, Programs, and Barriers

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### Abstract

Patients undergoing long-term hemodialysis frequently experience significant psychological distress and psychosocial challenges. At the same time, mental health services within dialysis settings remain insufficiently integrated and often overlook the needs of family caregivers. This study aimed to explore the needs, existing programs, and barriers to mental health service implementation for hemodialysis patients and their families at St. Vincentius General Hospital, Singkawang. Using a qualitative approach, 26 participants were recruited through purposive sampling, comprising 10 hemodialysis patients, 10 family caregivers, and 6 nurses. Data were collected through semi-structured interviews, participatory observation, and document review, and were analyzed using thematic analysis. The analysis revealed three major themes. First, patients and families reported significant psychosocial needs stemming from emotional distress, challenges in treatment adaptation, and caregiver burden. Second, existing mental health services were limited, informal, and primarily delivered through therapeutic communication and spiritual support without structured screening, counseling, or referral mechanisms. Third, critical implementation barriers were identified, including limited clinical time, high nursing workloads, insufficient mental health training, low awareness among stakeholders, and a lack of standardized referral pathways. These findings underscore the urgent need for integrated, structured mental health services to enhance continuity of care and improve the well-being of hemodialysis patients and their families.

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## 1. INTRODUCTION

Chronic Kidney Disease (CKD), particularly in its advanced stage requiring hemodialysis (HD), remains a major global and national health challenge and has been recognized as a key priority within the global public health agenda due to its rising prevalence, high morbidity, and substantial mortality burden (Francis et al., 2024). Beyond its physical burden, CKD is increasingly recognized as a condition with substantial psychological and social consequences, as patients frequently experience depression, anxiety, impaired social functioning, and reduced quality of life, particularly during long-term hemodialysis treatment (Mawaddah, Mujiadi, & Utomo, 2023; Moreira et al., 2023; Adejumo et al., 2024). Recent evidence indicates that more than one-third of hemodialysis patients exhibit depressive symptoms, many of which remain under-recognized in routine practice (Chilcot, 2025). Because psychological distress has been associated with poor treatment adherence, increased hospitalization, and higher mortality, mental health should be regarded as an essential component of comprehensive hemodialysis care (Adejumo et al., 2024; Kubanek et al., 2024).

The complexity of care becomes even more pronounced because the burden of hemodialysis is not limited to patients alone, but also extends substantially to family caregivers, who often experience significant physical, emotional, social, and financial strain related to long-term caregiving responsibilities (Driehuis et al., 2024; Zhang et al., 2024). Long-term care-giving responsibilities, frequent accompaniment to hospital visits, home-based support, financial adjustments, and uncertainty regarding disease progression often place family members at high risk of stress, burnout, depression, and caregiver fatigue (Nimah et al, 2024). Recent studies have shown that family caregivers of patients undergoing hemodialysis commonly experience moderate to high levels of psychological distress and burden, which significantly affect the continuity and quality of home care (Zhang et al, 2024). Moreover, caregiver distress has been associated with reduced care-giving capacity, poorer patient support at home, and diminished quality of life among caregivers themselves, while mental health support services for families remain limited in most healthcare settings (Nimah et al., 2024; Zhang et al., 2024). Therefore, the mental health needs in hemodialysis services must be understood as a dual burden involving both patients and their families (Nimah et al, 2024).

Despite growing international evidence regarding psychological distress among patients undergoing hemodialysis and their family caregivers, important gaps remain within the Indonesian context. Several studies in Indonesia have reported a substantial psychological burden among patients with chronic kidney disease and those receiving hemodialysis. Perdhana et al. (2021) identified depression as a significant predictor of mortality among Indonesian patients with CKD, while Wakhid et al. (2019) reported a considerable proportion of hemodialysis patients experiencing depressive symptoms in a hospital setting in Semarang. Similarly, Marthoenis et al. (2020) found that 46.0% of patients undergoing hemodialysis experienced depression and 30.5% experienced anxiety, both of which were associated with poorer quality of life. Beyond patients, family caregivers also face substantial challenges related to long-term caregiving responsibilities. Caregiver burden may involve physical, emotional, financial, and social strain that negatively affects psychological well-being and caregiving capacity (Pio et al., 2022). In Indonesia, family caregivers frequently experience stress, anxiety, depression, and burnout, highlighting the dual psychological burden faced by both patients and their families.

However, existing Indonesian studies have primarily focused on the prevalence and impact of depression, anxiety, quality of life, and caregiver burden. Limited attention has been given to how mental health services are organized, delivered, and integrated into routine hemodialysis care. Furthermore, evidence regarding collaborative mental health

care between hospital-based hemodialysis services and primary healthcare centers (Puskesmas) remains scarce. Although patients routinely receive dialysis treatment in hospitals, continuity of psychosocial support after discharge is often fragmented due to the absence of structured referral pathways, follow-up mechanisms, and interfacility collaboration (Hustrini, 2022; Kana et al., 2025; Rondhianto et al., 2024).

To date, no study has comprehensively explored the mental health service needs of patients and families, existing mental health programs, and barriers to implementation within Indonesian hemodialysis settings. Furthermore, evidence regarding collaboration between hospital-based hemodialysis services and primary healthcare centers (Puskesmas) remains limited. To our knowledge, this is the first qualitative study in Indonesia to simultaneously examine mental health service needs, existing service practices, and implementation barriers from the perspectives of patients, family caregivers, and nurses while considering the integration of hospital-based and primary healthcare services. By adopting a health-service perspective rather than focusing solely on the prevalence of psychological problems, this study provides context-specific evidence to inform the development of an integrated hospital–Puskesmas collaborative mental health care model that emphasizes early psychological screening, family involvement, multidisciplinary collaboration, and continuity of care after hospital discharge.

Despite increasing evidence on psychological distress among patients undergoing hemodialysis and their family caregivers, Indonesian studies have primarily focused on the prevalence and consequences of depression, anxiety, and caregiver burden. Little is known about how mental health services are currently organized and delivered within routine hemodialysis care, particularly regarding service needs, existing support mechanisms, implementation barriers, and continuity of care between hospitals and primary healthcare centers (Puskesmas). This study addresses these gaps by providing a comprehensive exploration of mental health service needs, existing service practices, and implementation barriers from the perspectives of patients, family caregivers, and nurses. To our knowledge, this is the first qualitative study in Indonesia to examine these issues while generating context-specific evidence to inform the development of an integrated hospital–Puskesmas collaborative mental health care model that emphasizes early psychological screening, family involvement, multidisciplinary collaboration, and continuity of care after hospital discharge. Therefore, this study aims to explore the needs, existing programs, and barriers to implementing mental health services for hemodialysis patients and their families in the Hemodialysis Unit of St. Vincentius General Hospital, Singkawang. In addition, this study seeks to generate evidence that can support the development of integrated and sustainable mental health services for patients undergoing hemodialysis and their families in Indonesia.

## **2. METHOD**

This study employed a descriptive exploratory qualitative design to obtain an in-depth understanding of the needs, existing programs, and barriers related to mental health service implementation for patients undergoing hemodialysis and their families. This design was considered appropriate because mental health service delivery in hemodialysis care remains insufficiently explored within the local context and requires an understanding of participants' experiences and perspectives.

The research was conducted in St. Vincentius Hospital Singkawang, West Kalimantan, Indonesia. The setting was purposively selected due to its role in managing a substantial number of chronic kidney disease patients receiving maintenance hemodialysis, many of whom experience psycho-social and emotional challenges during treatment. The

study was carried out from December 15, 2025 to April 15, 2026, encompassing the phases of preparation, fieldwork, data analysis, and manuscript preparation.

Patients were required to have received maintenance hemodialysis for at least three months and be able to communicate their experiences. Family caregivers were defined as family members who had been directly involved in providing physical or emotional support to the patient for at least three months. Nurses were eligible if they had at least two years of experience working in the hemodialysis unit.

An initial recruitment target of 24–30 participants was established to ensure adequate representation of patients, family caregivers, and nurses. Data saturation was assessed iteratively through concurrent data collection and preliminary analysis. Saturation was considered achieved when no new codes, categories, or themes emerged from successive interviews. Two additional interviews were subsequently conducted to confirm thematic consistency and ensure completeness of the findings. Demographic information, including age, sex, educational background, duration of hemodialysis treatment, caregiver relationship, and years of nursing experience, was collected to describe participant characteristics and provide contextual understanding of the findings. Participant characteristics are presented in Table 1.

**Table 1.** Participant Characteristics

<b>Participant Group</b>	<b>(n)</b>	<b>Age Range (years)</b>	<b>Sex (Female/male)</b>	<b>Additional Characteristics</b>
Hemodialysis patients	10	35–68	6/4	Receiving maintenance HD for >3 months
Family caregivers	10	28–65	7/3	Spouses, children, or parents providing direct care
Nurses	6	28–45	4/2	Nurses were required to have a minimum of two years of clinical experience in hemodialysis nursing to ensure adequate familiarity with the hemodialysis procedure and patient care process.

Data were collected through semi-structured in-depth interviews, participatory observation, and document review. In-depth interviews were conducted face-to-face using an interview guide that explored participants’ perceptions of mental health needs, existing support programs, and barriers to service delivery. The interview guide was developed through a review of relevant literature on psychological distress, caregiver burden, and mental health service delivery in hemodialysis settings. The guide comprised open-ended questions exploring participants’ experiences, perceived mental health needs, existing support mechanisms, and barriers to service implementation. The guide was subsequently reviewed by two qualitative research experts and pilot-tested with one hemodialysis patient and one nurse to ensure clarity, relevance, and comprehensibility. Minor modifications in wording and question sequencing were subsequently made. Before data collection, the interview guide was reviewed by two experts in qualitative research and mental health nursing to assess its clarity, relevance, and comprehensiveness. A pilot interview with one hemodialysis patient and one nurse was subsequently conducted to evaluate the wording,

sequence, and comprehensibility of the questions, resulting in minor revisions to improve the interview flow.

Each interview lasted approximately 30 to 60 minutes and was audio-recorded with informed consent. To enrich and validate the findings, participatory observation was undertaken to capture interactions among patients, family members, and healthcare providers during the dialysis process, thereby providing a deeper understanding of the clinical and psycho-social environment. In addition, relevant institutional documents, including service guidelines, mental health-related policies, educational records, and hospital program documents, were reviewed as supplementary data sources. All interviews were conducted by the principal researcher, who had prior training and experience in qualitative interviewing and was not directly involved in the participants' clinical care. The researcher had no supervisory or therapeutic relationship with the participants and was independent from clinical decision-making processes in the hemodialysis unit.

In line with qualitative methodology, the researcher functioned as the primary instrument, playing an active role in developing interview guides, conducting interviews, observing the field setting, interpreting data, and maintaining reflexivity throughout the research process. The principal researcher has a professional background in nursing and previous experience in qualitative research and mental health studies. The researcher was not involved in the participants' direct clinical management, thereby minimizing potential role conflict and coercion. Throughout the study, reflexive field notes and analytic memos were maintained to document personal assumptions, methodological decisions, and emerging interpretations, enabling continuous reflection on how the researcher's perspectives might influence data collection and analysis.

Data analysis was performed simultaneously with data collection using the interactive model of Miles and Huberman (1994), which comprises data reduction, data display, and conclusion drawing with verification. Relevant data from interviews and observations were first selected and condensed, then systematically organized into thematic narratives and analytic matrices to facilitate interpretation. Emerging themes were subsequently refined and verified through triangulation and member checking. Preliminary findings and emerging themes were returned to several participants for member checking to ensure that the interpretations accurately reflected their experiences and perspectives.

To enhance the rigor and trustworthiness of the study findings, this research adopted the criteria for qualitative rigor proposed by Lincoln and Guba (1985), encompassing credibility, transferability, dependability, and confirmability. Credibility was established through member checking with participants, triangulation across multiple data sources, and peer debriefing, allowing the researcher to verify the consistency and accuracy of the emerging themes. Transferability was enhanced rich descriptions of the study setting, participant characteristics, and data collection procedures, enabling readers to assess the applicability of the findings to similar contexts.

Furthermore, dependability and confirmability were maintained through the use of an audit trail, systematic documentation of the research process, and continuous verification to ensure that the interpretations and conclusions were grounded in the participants' narratives rather than the researcher's personal assumptions or biases. All quotations presented in this study were originally collected in Bahasa Indonesia and subsequently translated into English by the researcher for reporting purposes, with careful attention to preserving the participants' intended meanings and contextual nuances.

Ethical approval was obtained from the Health Research Ethics Committee of Poltekkes Kemenkes Pontianak, Indonesia (Approval No. 028/KEPK-PK.PKP/XII/D/2025; December 11, 2025). Written informed consent was obtained from all participants prior to data collection. Participation was voluntary, and participants were informed of their right to

withdraw from the study at any time without consequences. Confidentiality and anonymity were ensured by using participant codes and securely storing all research data.

### 3. RESULTS AND DISCUSSION

The study was conducted in the Hemodialysis Unit of St. Vincentius Hospital, Singkawang, West Kalimantan, Indonesia, a referral service for patients with chronic kidney disease requiring routine hemodialysis two to three times per week. In addition to physical treatment, patients and their families experienced substantial psychological challenges, including stress, anxiety, and emotional exhaustion associated with long-term treatment dependency. Although the unit was supported by a multidisciplinary clinical team consisting of physicians, nurses, and other healthcare personnel, an integrated mental health service program had not been optimally implemented at the time of the study. Psychosocial support was still delivered individually and remained largely unstructured.

The participants consisted of three major groups: 10 hemodialysis patients, 10 primary family caregivers, and 6 nurses working in the hemodialysis service. Patients had been receiving routine hemodialysis for at least three months, while family participants were the main caregivers accompanying the patients during treatment. The distribution of informants can be seen in Table 1.

**Table 1.** Distribution of characteristics of Informants.

<b>Informants Groups</b>	<b>Description</b>	<b>n</b>
Hemodialysis Patient	Undergoing HD >3 months	10
Families Caregivers	Primary caregivers of HD patients	10
Nurses	Responsible for HD service delivery	6

The qualitative data analysis identified three major themes and several sub-themes related to the needs, existing programs, and barriers in mental health service implementation. The themes and sub-themes can be seen in Table 2.

**Table 2.** Distribution of themes and sub-themes.

<b>Main Theme</b>	<b>Sub themes</b>
Mental and emotional support needs	Anxiety, spiritual support, emotional exhaustion, need to be heard
Existing mental health programs	Informal education, spiritual activities, limited referral, no schedule counselling
Barrier to service implementation	Limited time, lack of training, low awareness, no SOP

#### **Theme 1: Mental and Emotional Support Needs Among Hemodialysis Patients**

The first major theme identified was the need for emotional and psychosocial support among patients undergoing long-term hemodialysis. Participants frequently described feelings of fear, anxiety, uncertainty, and emotional exhaustion related to their dependence on lifelong dialysis treatment. Concerns about physical deterioration, fear of death, and reliance on dialysis machines were commonly expressed.

*“Sometimes I feel scared that if this machine stops, it means my life stops too.” (P1)*

*“Every time, if I come for dialysis, I always feel afraid. My feeling that something might happen, afraid that my body may no longer be strong enough”. (P3)*

Family caregivers also observed persistent anxiety among patients and reported that emotional distress often intensified before dialysis sessions.

*“Before coming for dialysis, my husband often becomes quiet and anxious because he worries about his condition”*(F2)

*“He often cannot sleep before dialysis sessions because he worries something bad might happen during treatment”* (F3)

Similarly, nurses recognized anxiety and emotional instability as common experiences among patients receiving long-term hemodialysis.

*“Many patients appear anxious before dialysis. Some repeatedly ask whether they will be okay during the procedure”* (N3)

In addition, participants emphasized the importance of spiritual and motivational support as a source of emotional stability and acceptance.

*“When the spiritual counselor comes and prays with me, I feel much better emotionally”* (P3)

*“After praying every day, I feel calmer inside, and it becomes easier for me to accept my condition”*(P4)

*When we pray together, my mother becomes calmer and more accepting of her illness. She says that praying gives her strength to continue dialysis”* (F3)

Another prominent finding was emotional exhaustion and feelings of hopelessness caused by the repetitive treatment routine.

*“Sometimes the tiredness is not just in my body, but also in my mind. It feels like my life is only about going back and forth to the hospital for dialysis.”* (P2)

*Sometimes she cries at home and says that she is tired of living with dialysis”* (F5)

*After years of dialysis, some patients appear mentally exhausted and lose motivation”* (N1)

Patients also highlighted their need to be listened to and emotionally understood, particularly by nurses and family members.

*“When the nurse listens to what I’m going through during hemodialysis, it makes me feel lighter”*. (P5)

*“Without encouragement from my family, it feels really difficult for me to keep coming here for dialysis.”*(P2)

## **Theme 2: Existing Mental Health Service Programs**

The second theme described the existing forms of mental health and psychosocial support available within the hemodialysis service. Across all participant groups, emotional support was perceived as being largely informal and dependent on individual initiatives rather than structured mental health programs. Participants reported that nurses frequently provided encouragement and therapeutic communication during routine dialysis sessions, which was considered helpful in alleviating emotional distress. Patients acknowledged that emotional support from nurses helped them feel calmer and less isolated during treatment.

*“Usually, we just try to encourage patients when they seem withdrawn, but there is no specific mental health or other structured program”*. (N1)

*“When the nurses ask about my condition and encourage me, I feel more comfortable and not alone in facing this illness.”* (P4)

Hospital-based spiritual care activities were also perceived as beneficial in helping patients cope with emotional distress, although these activities were not specifically organized for hemodialysis patients and were implemented irregularly.

*“It really helps when there is a mass or group prayer, but it is not done regularly in the dialysis room.” (P5)*

*“We usually pray together before dialysis because it makes my mother feel calmer and more accepting of her condition.” (F6)*

Collaboration with mental health professionals such as psychologists or psychiatrists was described as limited and mainly reserved for severe psychological cases.

*“If the patient shows severe depression, only then do we refer them to psychiatric services”.* (N5)

Importantly, participants consistently reported the absence of structured psychological counseling services.

*“There is no fixed counseling schedule for dialysis patients. If a problem arises, we usually do our best to manage it.”(N2)*

*“No one has ever asked us regularly about our emotional condition or whether we need counseling services.” (P2)*

Family caregivers also appreciated the emotional support provided by healthcare providers, although they perceived that such support was delivered inconsistently and depended largely on individual staff members.

*“The nurses sometimes talk with my husband and encourage him when he looks sad, but there is no specific program or regular activity for psychological support”.*(F3)

Family caregivers similarly reported that they had never received information regarding psychological consultation services unless patients demonstrated severe emotional problems.

*“We have never been offered counseling or psychological consultation. Usually, we only seek additional help if the patient becomes very distressed”.*(F7)

### **Theme 3: Barriers to Mental Health Service Implementation**

The third theme explored barriers to the implementation of structured mental health services within the hemodialysis unit. Participants identified several interrelated challenges at the organizational, professional, and patient levels. Organizational barriers included limited staffing, heavy workloads, and time constraints, which required nurses to prioritize physical and procedural aspects of care over psychosocial support.

#### **Organizational barriers**

Participants consistently described limited staffing, high patient volumes, and time constraints that required nurses to prioritize technical dialysis procedures over psychosocial care.

*“There are so many patients that our focus has to be on the procedures first. It leaves us with almost no time for in-depth conversations about their mental or emotional needs.” (N5)*

Patients also perceived that healthcare professionals were often too busy to discuss emotional concerns.

*“The nurses are always busy with the machines and procedures. Sometimes I want to talk about how I feel, but I do not want to disturb them”.(P7)*

Family caregivers similarly reported that interactions with healthcare providers were predominantly focused on physical treatment.

*“Usually we only receive information about the dialysis process and medicines. Nobody really asks how the patient or family is coping emotionally.” (F4)*

### **Professional barriers**

Another barrier was the lack of specific training in psycho social, therapeutic communication skills, and mental health intervention for nurses working in dialysis services.

*“We have never received any specific training regarding mental health care for chronic patients”. (N1)*

Participants also described low awareness among patients and families regarding the importance of mental health, with emotional distress often being normalized.

*“I know my husband feels sad sometimes, but I do not know what to say or how to help him emotionally.” (F6)*

### **Patient and family barriers**

Participants frequently perceived emotional distress as a normal consequence of chronic illness and therefore not requiring professional attention.

*“Having a chronic illness always brings stress and depression, and to me, that feels normal.”(P6)*

Family caregivers expressed similar views.

*“We thought feeling sad and anxious was something that every dialysis patient has to go through”.(F2)*

### **Institutional barriers**

Participants also highlighted the absence of formal policies and procedures for mental health care.

*“Currently, there is no specific SOP in place for providing mental health care to dialysis patients”.(N6)*

### **Theme 1: Mental and Emotional Support Needs Among Hemodialysis Patients**

The findings of this study demonstrate that the burden experienced by patients undergoing long-term hemodialysis extends far beyond the physical consequences of chronic kidney disease. Anxiety, emotional distress, uncertainty about the future, and feelings of hopelessness emerged as common experiences among participants, reflecting the continuous psychological challenges associated with lifelong dependence on dialysis treatment. Rather than representing isolated emotional reactions, these experiences appear to constitute an ongoing adaptation process in which patients must repeatedly confront physical limitations, treatment dependency, and uncertainty regarding disease progression and survival.

These findings are consistent with previous studies indicating that psychological distress is highly prevalent among patients receiving maintenance hemodialysis and is associated with poor treatment adherence, diminished quality of life, and adverse clinical outcomes (Barello et al., 2023; Wang et al., 2025). The present findings further suggest that mental health problems among patients undergoing hemodialysis should not be regarded merely as secondary consequences of chronic illness but rather as integral components of comprehensive chronic kidney disease management.

An important finding of this study is the central role of family members and nurses in providing emotional support. Family involvement appeared to enhance patients' motivation, acceptance, and coping capacity, while nurses were often the first healthcare professionals to recognize emotional distress through their continuous interactions during dialysis sessions. The findings indicate that emotional support in hemodialysis care is strongly dependent on interpersonal relationships and the availability of supportive communication. Effective therapeutic communication may facilitate emotional expression, reduce feelings of isolation, and strengthen patients' psychological adaptation to long-term treatment.

However, psychosocial support remained largely informal and depended heavily on individual initiative rather than structured service delivery. Consequently, the quality and consistency of emotional support may vary according to staff availability, workload, and individual competencies. Previous evidence has demonstrated that structured psychosocial interventions, including psychoeducation, counseling, and coping-skills training, significantly reduce anxiety and depressive symptoms among patients undergoing hemodialysis (Barello et al., 2023; Riyadi, Siagian, & Saragih, 2023; Zahra et al., 2023; Ariyanto et al., 2024). Therefore, strengthening nurses' competencies in mental health assessment, therapeutic communication, and psychosocial intervention should be considered an important component of comprehensive dialysis care.

### **Theme 2: Existing Mental Health Service Programs**

Another important finding of this study concerns the limited availability of structured mental health services within the hemodialysis unit. Although emotional support was occasionally provided through therapeutic communication and spiritual activities, participants consistently reported the absence of routine psychological screening, formal counseling services, standardized referral pathways, and systematic follow-up for patients and families. These findings indicate that mental health support remains supplementary rather than being fully integrated into routine dialysis care.

The predominance of informal psychosocial support observed in this study is consistent with previous evidence indicating that mental health care in dialysis settings often remains fragmented and reactive rather than systematically integrated into routine services. Kubanek et al. (2024) reported that psychological problems among patients undergoing hemodialysis frequently remain under-recognized because mental health

assessment is not routinely incorporated into standard dialysis care pathways. Similarly, Smylie and Prasad (2024) emphasized that regular mental health screening and early psychosocial intervention should be considered essential components of comprehensive dialysis management. The present findings suggest that emotional support in the hemodialysis unit is still largely dependent on individual initiative and available resources rather than institutionalized programs. Consequently, patients experiencing mild or moderate psychological distress may remain unidentified and receive delayed intervention.

The absence of structured mental health programs is particularly concerning given the substantial psychological burden reported by participants. Routine mental health screening using validated instruments, scheduled counseling services, psychoeducational interventions, and clearly defined referral mechanisms may facilitate earlier identification of psychological problems and promote timely intervention. Previous studies have demonstrated the feasibility and clinical utility of integrating brief psychological screening tools such as the PHQ-9 and BDI-II into dialysis services. Watnick et al. (2005) first validated these instruments among patients receiving dialysis, and more recent evidence by Vázquez, Figueiras, & Salgado-Barreira (2025) further supports their use as practical approaches for early identification of depression in routine dialysis settings. Incorporating routine screening into standard dialysis assessments may facilitate earlier recognition of psychological distress and provide opportunities for timely intervention before symptoms progress to more severe conditions.

These findings suggest that integrating mental health services into standard hemodialysis care pathways may represent an important strategy to address patients' psychosocial needs more comprehensively. This study contributes to the limited evidence available from Indonesian hemodialysis settings by moving beyond the documentation of depression, anxiety, and caregiver burden. While previous studies have primarily focused on the prevalence and impact of psychological problems, the present study provides contextual evidence regarding existing mental health service practices and service gaps from the perspectives of patients, family caregivers, and nurses.

### **Theme 3: Barriers to Mental Health Service Implementation**

The barriers identified in this study suggest that the implementation of mental health services in hemodialysis settings is influenced by both organizational and sociocultural factors. At the organizational level, limited staffing, high patient volumes, and substantial procedural demands encourage a task-oriented model of care in which physical treatment is prioritized over psychosocial support. Similar barriers have been reported in previous studies, where workforce shortages, high patient volumes, and competing clinical priorities limited the provision of psychosocial care in chronic disease settings (Barello et al., 2023; Kubanek et al., 2024). These constraints often encourage healthcare professionals to prioritize technical and procedural aspects of care while emotional concerns receive less systematic attention. The findings of the present study indicate that mental health care cannot rely solely on individual commitment but requires organizational arrangements that allocate sufficient time and resources for psychosocial assessment and intervention.

Although healthcare professionals recognized the importance of emotional well-being, the existing service structure provided limited opportunities for systematic psychological assessment and intervention. At the professional level, insufficient training in psychosocial assessment and therapeutic communication reduced healthcare providers' confidence in identifying and managing psychological distress. Previous studies have demonstrated that healthcare professionals frequently report inadequate preparation and low confidence in conducting mental health assessment and psychosocial interventions among patients with chronic illness (Wang et al., 2025; Zhang et al.,

2025). Therefore, workforce development initiatives that include training in therapeutic communication, psychological screening, and basic counseling skills may strengthen nurses' capacity to identify and respond to emotional distress in dialysis settings.

This finding indicates that improving mental health services requires not only additional human resources but also workforce development and institutional support to enhance professional competencies in psychosocial care. Sociocultural factors also appeared to influence mental health service implementation. Many patients and family caregivers perceived anxiety, sadness, and emotional exhaustion as inevitable consequences of chronic illness and long-term dialysis treatment. Similar findings have been reported in Asian healthcare contexts, where psychological distress is frequently perceived as an expected consequence of chronic illness and therefore receives limited professional attention (Winarti, Trigantara, & Fatmawati, 2024; Zhang et al., 2024; Wang et al., 2025). Cultural reliance on family support and spiritual coping mechanisms may provide emotional resilience; however, these perspectives may also contribute to delayed help-seeking behavior and under-recognition of mental health problems.

The normalization of psychological distress may discourage help-seeking behaviors and contribute to the under-recognition of mental health problems in routine clinical practice. Within the Indonesian cultural context, emotional difficulties are often managed through family support and spiritual coping strategies rather than professional mental health services. Although these approaches may provide important sources of comfort and resilience, they may simultaneously delay early identification and intervention when psychological symptoms become persistent or severe.

Taken together, these findings suggest that improving mental health care for patients undergoing hemodialysis requires interventions at multiple levels, including organizational restructuring, workforce capacity building, patient and family education, and institutional policy development. Rather than demonstrating the effectiveness of an integrated care model, the present findings highlight the need for structured mechanisms that facilitate continuity of psychosocial care across healthcare settings.

Importantly, the findings provide practical implications for the development of a hospital-Puskesmas collaborative mental health care pathway. Hospital-based hemodialysis services may serve as the primary setting for routine psychological screening using validated instruments such as the PHQ-9, initial psychoeducation, counseling, and referral during dialysis treatment. Following discharge or between dialysis sessions, Puskesmas could continue psychosocial monitoring, family education, and community-based follow-up while providing early identification of emerging psychological problems. Standardized referral pathways, regular communication, and feedback mechanisms between hospitals and Puskesmas may strengthen continuity of care and facilitate earlier intervention for patients and families requiring additional support. The proposed collaborative pathway is consistent with contemporary chronic care models emphasizing integrated and community-based management of long-term conditions. Recent evidence suggests that continuity of psychosocial care across healthcare settings facilitates earlier identification of mental health problems, strengthens family engagement, and improves long-term adaptation among individuals living with chronic diseases (Wang et al., 2025; Zhang et al., 2025).

In the present study, the findings suggest that hospitals may serve as the primary setting for psychological screening and initial intervention, while Puskesmas could facilitate community-based follow-up and family support after patients return home. Overall, the findings support a shift from a predominantly biomedical approach toward a more integrated and patient-centered model of hemodialysis care that incorporates mental health assessment, family engagement, multidisciplinary collaboration, and community-

based follow-up as essential components of comprehensive chronic kidney disease management.

#### 4. CONCLUSION

This study demonstrates that patients undergoing long-term hemodialysis and their family caregivers experience substantial psychological and psychosocial burdens, while mental health support within hemodialysis services remains largely informal and insufficiently integrated into routine care. Major barriers include limited human resources, high workloads, inadequate mental health training, low awareness of psychological needs, and the absence of structured service protocols.

A key contribution of this study is the identification of the need for an integrated hospital-Puskesmas collaborative mental health care model that extends support beyond hospital-based dialysis services. Such a model may facilitate routine psychological screening, timely referral, family-centered psychoeducation, and community-based follow-up, thereby improving continuity of care and promoting better psychosocial outcomes and quality of life for patients undergoing long-term hemodialysis and their families.

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