Open Access

CEOS CENTER OF EXCELLENCE FOR OPEN SCIENCE

Email: csm@ceospublishers.com

CEOS Psychiatry and Mental Health

Research Article

Understanding the Challenges of Engaging Patients in Mental Health Services After Psychiatric Hospitalization: A Qualitative Study of Peer Staff Perspectives

Regina Misch, Logan Johnson, Jessica Dodge, Andrew Sarkin*

Health Services Research Center, Herbert Wertheim School of Public Health and Human Longevity Science
University of California, San Diego, 6363 Greenwich Drive, San Diego, CA 92122

Received Date: December31,2022
Accepted Date: January 31, 2023
Published Date: February 03,2023

*Corresponding Author

Andrew Sarkin, Health Services Research Center, Herbert Wertheim School of Public Health and Human Longevity Science, University of California, San Diego, 6363 Greenwich Drive, San Diego, CA 92122 Tel: 858.622.1771, Email: asarkin@ucsd.edu.

Citation

Andrew Sarkin, Regina Misch, Logan Johnson, Jessica Dodge (2023) Understanding the Challenges of Engaging Patients in Mental Health Services After Psychiatric Hospitalization: A Qualitative Study of Peer Staff Perspectives. CEOS Psychiatry Mental Health 2: 1-9

Abstract

Introduction: Prior research shows a high re-hospitalization rate for patients with mental health disorders, due in part to the challenges of engaging the clients in treatment services after psychiatric hospitalization. This study was carried out to investigate the reasons for the difficulty of engaging clients in services after a psychiatric hospitalization, based on the perspectives of peer staff with lived experience of mental illness.

Methods: This qualitative study was conducted with 33 staff from San Diego's Next Steps program. The interview protocol included 12 questions on demographics, program success and challenges, and barriers to client engagement after hospitalization. Using a qualitative descriptive approach, analysis focused on developing themes regarding staff's perceptions of reasons clients may not engage in services after psychiatric hospitalization. The transcribed interviews were analyzed using in Vivo coding to identify themes. Qualitative analysis was completed using Dedoose software.

Results: The most frequently reported themes included challenges arranging services, homelessness, and lack of funding for programs or resources. Other noteworthy themes that presented challenges were clients still in their symptoms, denial, prioritizing basic needs, lack of family support, and transportation.

Conclusion: The findings provide a better understanding of client lack of engagement with services after hospitalization from the perspective of peer staff. Additionally, the findings are connected to social work practice by providing some ways the Next Steps program is overcoming these challenges through peer-based programming.

Keywords: peers; lived experience; mental health; mental illness; qualitative methods; qualitative research; service engagement; engagement challenges; psychiatric hospitalization

Introduction

According to the National Agency for Healthcare Research and Quality, in 2012, 15 % of patients admitted to the hospital due to mood disorders are readmitted within 30 days of discharge. Patients with schizophrenia or some other form of mental health or substance use disorder have a 22 % and 15.4 % readmission rate, respectively [1]. The most significant factor in readmission is the lack of connection to community resources after discharge from the hospital. Without a connection to appropriate services, former mental health patients may experience poor health outcomes [2]. Outside of readmission, these other poor outcomes include homelessness, suicide, and medication noncompliance.

Research supports that linkage to outpatient services following hospital discharge is a crucial indicator of quality of care and predicts future mental health care use [3]. In response to this need, it is recommended that community based mental health programs streamline outpatient mental health care so that clients can be effectively connected to services to reduce the chance for readmission or poor health outcomes in treatment [4].

Connecting mental health hospital patients to continuing outpatient services is not simple. Difficulty engaging in services may be due to a client's perception that treatment is not working, lack of trust with clinicians and therapists, or structural barriers to making appointments and getting to treatment [5]. However, it appears that attitudinal barriers are far more common than structural barriers. Two studies on client engagement in St. Louis, MO and Christchurch, New Zealand, found that reasons for not engaging in treatment of mental health or substance abuse disorders were mainly attitudinal, such as the feeling of wanting to take care of the health concern on their own [6]. Low perceived need is often the most common reported reason for not engaging in mental health treatment, regardless of the level of symptoms [7]. This research further showed that among those who recognized a need for treatment, the desire to address the issue on one's own was the most common reason for not seeking treatment.

In consideration of these barriers to treatment, mental health program should prioritize being a resource for those who recognize they need help, as well as address the barrier for clients who display low perceived need. This article explores peer staff perceptions why clients may not engage in services after hospitalization and how peer programs can address these challenges.

Peer-Based Programs

Peer-based programs and interventions provide a unique approach to assisting those with mental health issues. The peer specialist profession comprises one of the fastest-growing occupations in the mental health labor force in the U.S.

[8] In this role, staff use their own lived experience in mental health and substance use recovery to assist their clients in navigating the mental health system and keeping them encouraged along the way. Such support may include peer-led self-help groups, consumer-operated services and supports, and mutual understanding on behalf of the peer [9]. Peer specialists can also offer support and hope in the form of mentorship to help the client overcome their mental health challenges [10]. One study found that clients supported by staff with lived experience reported higher ratings of quality of life, social support, stable program engagement, and a lower number of major life problems than case managers without lived experience [11]. Other evidence shows that peer programs are equally as effective as other traditional mental health programs [12, 13].

Peer-based programs show promising effects in terms of building relationships with clients. It has been demonstrated that participants rated higher levels of positive regard, empathy, and unconditional care with peer providers when compared to interactions with a non-peer case manager. Likewise, this same study demonstrated an increase in client engagement in the first 12 months of treatment for those supported by peer staff compared to traditional staff. It appears peer support specialists are able to produce an environment for greater participation in recovery in the early stages of treatment [14].

However, even peer-based programs experience challenges with engaging clients. This qualitative study uncovers themes from interview with Next Steps staff that highlight the most common challenges with engaging clients after psychiatric hospitalization. After better understanding these challenges, this article looks to an example of a peer program, Next Steps that has integrated some solutions to mitigate the challenges of engaging psychiatric hospital patients in services after hospitalization.

Next Steps Program Description

Next Steps is a joint collaborative effort from the National Alliance on Mental Illness (NAMI), Family Health Centers of San Diego, Mental Health Systems Inc., and the Union of Pan Asian Communities of San Diego. By being recovery-oriented, Next Steps strives to provide outreach and engagement support for those with mental health, physical health, or substance use issues and is partnered with a local County Psychiatric Hospital and County Behavioral Health Services. Most clients connect with the program during psychiatric hospitalization.

They are assigned to a peer specialist who helps the client navigate the recovery journey, which includes obtaining resources for basic needs and transportation, developing client goals, and coordinating referrals to community mental health services and resources. One of this program's significant goals is to successfully link patients who have recently been discharged from the County Psychiatric Hospital to community-based mental health services.

Methods

Qualitative methods were used in the present study to examine the opinions of the peer support staff who work directly with mental health clients. This type of research can reveal underlying themes and draw on personal experiences that may not be possible in traditional experimental designs. This method is useful in evaluation research as it reveals a program's story according to the staff member being interviewed [15]. Face-to-face structured interviews permit a live interaction between the interviewer and respondent, and the interviewer can formulate follow-up questions to encourage interactive discussion. Respondents provided verbal consent before completing the interview. All interviews were audio-recorded in order to use verbatim transcripts for analysis.

This study was based on staff interviews from the Next Steps program. The qualitative research design included 33 semi-structured interviews that were conducted from July to August 2016. All members of the staff at the Next Steps program were included in the interview. All but one interviewee gave verbal consent to participate in the interview and be recorded. For the one interviewee that was not recorded, consent was obtained to conduct the interview and hand-written notes were taken and used for analysis.

The interview questions were developed by the University of California, San Diego Health Services Research Center (HSRC hereafter) staff, including input and approval from clinical supervisory staff at Next Steps. The interview consisted of 12 questions about program success and challenges, barriers to clients engaging in services and resources, and program improvement ideas. Additionally, two demographic questions were asked: current role at the program and length of employment at Next Steps. The length of time it took to administer the interviews ranged between 15 and 50 minutes. The focus of the analysis for this study was on the question regarding possible reasons for clients not engaging with services after hospitalization. Specifically, the question asked, "What are some reasons why you think some clients do not engage in regular services after leaving the hospital?" After an initial response, the interviewer asked probing questions such as, "Are there things about the system that could make getting services difficult and what individual characteristics could make getting services difficult?"

The analysis method used for this study was a qualitative descriptive approach. In a comprehensive article about qualitative methods titled, "Whatever Happened to Qualitative Description," it is noted that the strength of the qualitative descriptive approach is that it allows the researchers to "stay closer to their data and to the surface of words and events than researchers conducting grounded theory, phenomenological, ethnographic, or narrative studies". Thus, allowing the data in the interviews to speak for itself. Specifically, In Vivo coding, was used to identify themes and apply codes to excerpts of interviews. The in Vivo technique utilized data integrity by labeling the themes with exact words in the interviews. This approach is able to capture key elements of the interviews in the words of the participants, in a way that other techniques may not be able to [17]. This process included content analysis of the interviews in which the interviews were read several times, and apparent themes and patterns were identified and named in a process of in Vivo coding. Once themes were independently identified and agreed upon by two research staff, a codebook was created. The interviews were analyzed using qualitative software, [18].

Participants

All Next Steps staff voluntarily participated in the interviews (N=33) for this study. Staff roles consisted of peer support specialists, AOD counselors, behavioral health clinicians, family support specialists, nurses, administrative staff, the director,

benefits specialist, health navigators, and multi-role direct services staff. The majority (91%) of the staff were in direct service roles (Table 1). Most of the staff had been at Next Steps for less than two years. Additionally, 33% had been employed at Next Steps for over two years, and only 9% were there for 6 months or less.

Table 1: Detailed Interview Participant Job Function.

Job Function	%
Administrative/Management	9%
Direct Services Staff	91%
Peer Support Specialist	24%
AOD Counselor	18%
Multiple direct service roles	12%
Family Support Specialist	12%
Behavioral Health Clinician	9%
Nurse	9%
Benefits Specialist	3%
Health Navigator	3%

Analysis

The qualitative descriptive approach used through Dedoose allowed themes to emerge directly from the interviews, using the respondent's exact words. These themes (parent codes) were the conceptual framework of analysis developed to organize these qualitative data. Additionally, subthemes (child codes) were used when more specific themes could be logically grouped into a general theme.

Inter-rater reliability was completed through the Dedoose training center, allowing the researcher to obtain inter-rater reliability statistics by testing the code agreement with specific excerpts and producing a Cohen's Kappa statistic. The Cohen's Kappa was .71. According to Jacob Cohen, a statistic of .61 to .80 signifies substantial inter-rater reliability [19]. This technique does not simply take the average of each chance code application agreement among raters, but rather it summarizes agreement across many codes to illustrate the inter-rater agreement [20].

Results

Common Challenges to Engagement after Psychiatric Hospitalization

There were 14 common themes that emerged when analyzing the question regarding client engagement in services after hospitalization. The top three most frequently reported themes were challenges arranging services, homelessness, and lack of funding for programs or resources. Other prominent themes

Table 2: Most Common Themes for Clients Not Engaging in Services after Psychiatric Hospitalization(N=33)

Theme	Definition	Count of Staff Who Mention Theme	Count of Mentions of Theme
1. Challenges arranging services	The intake requirements preventing or delaying clients form getting into clinics or other services.	20	41
2. Homelessness	Client is homeless or in an unstable living situation.	13	19
3. Lack of funding for programs or resources	Lack of adequate public resources to provide care and services to clients.	13	18
4. Still in their mental health symptoms	Mental health symptoms are prohibiting a client from being able to seek treatment.	12	18
5. Denial/Anosognosia	The belief (either psychological or neurologically caused) that nothing is wrong and that treatment for mental health symptoms is not needed.	11	16
6. Not taking medication appropriately	Lack of treatment maintenance or client doesn't want to take pills.	10	13
7. Inadequate knowledge of services	Clients not knowing what services are available to them.	9	14
8. Prioritizing basic needs	Clients have trouble seeking mental health or recovery services because their priority is meeting basic needs such as shelter, food, and clothing.	8	9
9. Transportation	The client does not have the ability or means to get to services.	7	9
10. Lack of family support	Not having family member(s) actively involved in the client's treatment.	7	8
11. Capacity of the clinic	The number of staff and workload can inhibit ability to provide care.	4	4

were clients still in their symptoms, denial, and inadequate knowledge of resources. Table 2 illustrates the most common themes. These themes identify a wide variety of reasons for lack of service engagement.

The most common theme was challenges arranging services. This theme was reported by 20 staff (61%) and was defined as the requirements to receive additional care prevented clients from getting into clinics or other services. One Next Steps staff member remarked, "Many clinics you can't get processed in one day. You go in and start step one, and you start step two another day, and step three another day, so that's another issue."

Next Steps staff shared during interviews that the challenges in arranging services often entails additional requirements in the referral and intake process of other mental health programs that prevent or delay clients from getting services. For instance, sometimes clients need to obtain identification or health benefits before being able to access mental health services, and these processes can be difficult to navigate alone, especially when health concerns complicate one's ability to navigate the mental health system. Peer staff can broker negotiations with professionals, clinicians, and agencies that might otherwise be extremely challenging for the client [21].

Homelessness was noted by 13 staff (39%) and was the second most commonly reported challenge. The Treatment Advocacy Center estimates that one-third of individuals who are chronically homeless have a severe mental illness and this percentage may increase to 50% in some areas [22].

The third most common theme, also reported by 13 staff (39%), was lack of funding for programs or resources. This was defined as the lack of adequate public resources to provide care and services to clients. An example of lack of funding for resources seen in an interview was "They don't have the shelter or somewhere to go to… we don't have enough resources in the County to house, to treat, to create a sense of community…."

There were also 12 staff members (36%) who shared their perception that a major barrier was with clients still in their mental health symptoms. This theme was defined as symptoms are prohibiting a client from being able to seek treatment. For example, one staff member commented, "…when they're in their symptoms and you're giving them our brochure, they're not really focused on reading that…."

Other Helpful Insights to Client Challenges with Engaging in Services after Psychiatric Hospitalization

The interviews provided insight into other reasons clients do not engage or re-engage in services. While these were less frequently reported, they may prove useful in strategies to consider as the first steps towards client engagement. These themes included denial, lack of knowledge of resources by the client, lack of family support, prioritizing basic needs, and transportation challenges. The staff shared that it was difficult to engage participants in services due to denial or Anosognosia, which was defined as the belief (either psychological or neurologically caused) that nothing is wrong and that treatment for mental health symptoms is not needed. One person summarized this challenge as "I think the biggest thing is the denial part, that they think there isn't anything wrong; they think that everybody else is wrong."

Some staff shared their concern that clients may have inadequate knowledge of resources available to them or the client may not understand what was available and how to access the resources. One staff member noted, "… they just don't know it [program] is available. They thought they needed to pay for it. They don't know that the specialty mental health clinics are available…."

Prioritizing basic needs was another concern reported by the peer staff. Prioritizing basic needs was defined as clients not seeking mental health or recovery services because it is not a top priority compared to other needs. One Next Steps staff member explained it, "I would say, their priorities, a lot of people need housing, a lot of people need food sources, so their main concern is not of getting better but where is the next meal going to come from or where am I going to sleep or be safe, not exactly their care."

Staff noted that a lack of family support was a major challenge to client engagement. One interviewee explained the issue further by saying, "So many of our patients' families are tired of dealing with them and they just want everyone else to take care of them. And leave them out of the picture. No support system at all – not even families." Research has proven that family involvement in adult mental health treatment has preventative outcomes towards relapse and reduces hospital readmissions, while encouraging compliance with medication [23, 24].

Lastly, staff described transportation challenges as a barrier to receiving services. Staff at Next Steps reported, "It's like for me

that I have a car, I have a home, and everything, to me it's tedious; now imagine somebody doesn't have transportation, they have to call every day, no phone, and all that stuff, and that's where it comes down to be a problem. Accessibility to the services, it's challenging." This quote nicely summarizes the issue regarding access to services. While not all clients may have their own vehicle, this challenge is further exasperated by services and resources not easily accessible by public transportation or too far from their home. Researchers found that when transportation is provided, clients use these services to get to their appointments. This finding suggests that providing transportation to clients may reduce the barrier of distance to obtain care for those with both co-occurring substances use and mental health disorders [25].

Discussion

The interviews of 33 staff from a peer-based program provided insight into several common barriers to client engagement in services after psychiatric hospitalization. Over 60 % of the respondents noted in their interview that challenges arranging services was a significant barrier to client engagement. The second most common reported themes were homelessness (39%) and lack of funding for program or resources (39%). Other important opinions expressed included the themes of still in their mental health symptoms, denial, lack of knowledge of resources by the client, lack of family support, prioritizing basic needs, and transportation challenges.

While it can be challenging getting clients who were hospitalized for mental health concerns to engage in services once discharged, the Next Steps has implemented a system of care that fosters an environment of empathy, encouragement, and honesty that supports the client where they are and provides the structure and attitudes needed to keep them engaged in the recovery process. The Next Step program, with its peer-based design, helps to address the common barriers reported in this study. A benefit of the Next Steps program is that the peer staff understand the mental health journey, can meet the client where they are at, and as such, understand that some people will take longer to engage. Next Steps mitigates the challenge of arranging services for the client after hospitalization in two key ways. First, while the client is at the psychiatric hospital, a staff member from Next Steps meets with the client and establishes a connection. The staff focus on encouraging the client to start engaging in services at the hospital, such as peer groups. After hospital discharge, clients are connected with a peer specialist that will continue to engage them in services. As a peer specialist, the staff can support the client's journey throughout the program. Next Steps also includes other professionals, such as alcohol and drug specialists, that provide services in the interim while arranging referrals to other programs.

To address the challenges of transportation, basic needs, and inadequate knowledge of resources, Next Steps provides resources such as bus passes and clothing, as well as information on local resources and referrals to other services. The staff understand the need to address these basics to make the path to wellness successful. This gives the individual the assurance that other needs will also be addressed and becomes the basis for trust to work with staff. In FY 2018-19, Next Steps was able to successfully connect 91 % of the 571 transportation referrals (Rule et al, 2019). Being able to build rapport with potential clients and trust with individuals in the community encourages individuals with significant mental health concerns to engage in services. This allows Next Steps to build a reputation in the community to be available to help clients in recovery.

The qualitative analysis of the interviews also showed that a challenge to engaging in services after hospitalization is that sometimes programs are not available; this includes programs with long wait lists. The Next Steps program provides peer specialists who engage the client during these wait times and provides useful services including peer counseling, mental health assessment, peer navigation, substance use counseling, group education, benefits and housing assistance and other direct services. Specifically, in FY2018-19, Next Steps provided 58,341 services and connected 4,471 clients and family members to other programs and resources [26].

As already noted, family involvement in adult mental health treatment effectively mediate the difficulties of mental health treatment after hospitalization [27]. The lack of family involvement was a frequently reported challenge noted by Next Steps peer staff and is documented as a challenge in the literature on family involvement in treatment of patients with psychosis. Where family involvement is not an option, peer staff support can provide the practical, social, and emotional support clients see as beneficial. A qualitative study of the views of clients in a peer-based program showed "participants viewed peer support as especially valuable because of the opportunity for

non-treatment-based, normalizing relationship". At Next Steps, family members and friends are encouraged to participate and are eligible to receive services and referrals themselves if needed. The results of the interviews show that clients may face both external and internal challenges in engaging in services after hospitalization. Utilizing staff with lived experience to support clients throughout recovery could be a viable option in improving engagement, especially when coupled with addressing basic needs and the clients' priorities.

Limitations

Some limitations of the study are important to consider. First, mental illness and low service engagement are complex issues with many root causes. In addition, there is no one size fits all solution because of the variety of contextual factors involved with the issues.

Limitations of the method included minimal demographic data for the respondents. Only job function and length of employment at Next Steps were obtained. Additional demographic data including race, gender, and age could be used in a mixed-methods analysis to determine if there were any biases based on these demographics.

The structure of the interview allowed for limited follow-up questions and probing for additional information. In reflection, the information in the interviews could have provided richer context to how this peer program addressed engagement challenges by adding follow-up questions or allowing for a more open dialogue.

This study focused on one specific type of program. Because of this, our findings may not be generalizable to all other mental health programs. And finally, this study was subject to both self-report and social desirability bias, which could result in people providing assumed desired responses that are favorable to the program rather than their own experiences in service provision.

Conclusion and Implicatins

The study's goal was to use staff perspectives from a peer-based mental health program to better understand the barriers to client engagement in regular ongoing mental health services after a psychiatric hospitalization by determining what barriers are reported most frequently. The most commonly reported barriers in this study included challenges arranging services, homelessness, lack of funding for programs or resources, clients still in their symptoms, denial, unwilling to medicate, inadequate knowledge of services, lack of transportation and basic needs, limited family support, and clinic capacity. Our findings suggest that while there are many barriers to engaging clients, some of the less frequently reported barriers, such as transportation, basic needs, and inadequate knowledge of services, may be the first steps programs take to improve client engagement. We provided a few examples from the Next Steps program that other programs can implement in order to successfully engage with clients and connect them to services.

Declaration of Conflict of Interest

The authors declare that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.

Funding Acknowledgments

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Authors' contributions

Logan Johnson and Andrew Sarkin designed the study. Logan Johnson carried out the interviews and Logan Johnson, Jessie Rampton, and Regina Misch performed the analysis. All authors aided in interpreting the results and worked on the manuscript.

Acknowledgments

We are especially grateful to the HSRC staff that reviewed this manuscript to ensure the common themes found were accurately represented and those responsible for transcription of the interviews including Subashini Sudarsan and Felix Tran.

References

1.Heslin KC and Weiss AJ (2015) Hospital Readmissions Involving Psychiatric Disorders.

2. Nelson EA, Maruish ME and Axler JL (2000) Effects of Discharge Planning and Compliance with Outpatient Appointments on Readmission Rates. Psychiatric Services 51: 885-9.

3. Tulloch AD, David AS and Thornicroft G (2016) Exploring the predictors of early readmission to psychiatric hospital. Epidemiology and Psychiatric Sciences 25: 181-93.

4. Steffen S, Kösters M, Becker T, et al. (2009) Discharge Planning in Mental Health Care: A Systematic Review of the Recent Literature. Acta Psychiatrica Scandinavica 120: 1-9.

5. Dixon LB, Holoshitz Y and Nossel I (2016) Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry 15: 13-20.

6. Wells JE, Robins LN, Bushnell JA, et al. (1994) Perceived Barriers to Care in St. Louis (USA) and Christchurch (NZ): Reasons for Not Seeking Professional Help for Psychological Distress. Social Psychiatry and Psychiatric Epidemiology 29: 155-64

7. Mojtabai R, Olfson M, Sampson NA, et al. (2011) Barriers to mental health treatment: results from the National Comorbidity Survey Replication. Psychological Medicine 41: 1751–1761.

8. Druss BG, Zhao L, von Esenwein SA, et al. (2010) The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research 118: 264–70.

9. Ahmed AO, Doane NJ, Mabe PA, et al. (2012) Peers and Peer-Led Interventions for People with Schizophrenia. Psychiatric Clinics of North America 35: 699-715.

10. Davidson L, Chinman M, Sells D, et al. (2006) Peer Support Among Adults with Serious Mental Illness: A Report from the Field. Schizophrenia Bulletin 32: 443-50.

11. Felton CJ, Stastny P, Shern DL, et al. (1995) Consumers as peer specialists on intensive case management teams: impact on client outcomes. Psychiatric Services 46: 1037-44.

12. Davidson L, Shahar G, Stayner DA, et al. (2004) Supported socialization for people with psychiatric disabilities: Lessons from a randomized controlled trial. Journal of Community Psychology 32: 453-77.

13. O'Donnell M, Parker G, Proberts M, et al. (1999) A Study of Client-Focused Case Management and Consumer Advocacy: The Community and Consumer Service Project. Australian & New Zealand Journal of Psychiatry 33: 684-93.

14. Sells D, Davidson L, Jewll C, et al. (2006) The Treatment Relationship in Peer-Based and Regular Case Management for Clients with Severe Mental Illness. Psychiatric Services 57: 1179-84.

15. Goering P, Boydell KM and Pignatiello A (2008) The Relevance of Qualitative Research for Clinical Programs in Psychiatry. The Canadian Journal of Psychiatry 53: 145-51.

16. Openakker R (2006) Advantages and Disadvantages of Four Interview Techniques in Qualitative Research. Forum Qualitative Sozialforschung / Forum: Qualitative Research.

17. Saldaña J (2015) The Coding Manual for Qualitative Researchers. 3rd edition. SAGE Publications Ltd.

18. Dedoose Version 8.0.35 (2018) SocioCultural Research Consultants, LLC.

19. McHugh ML (2012) Interrater reliability: the kappa statistic. Biochemia Medica 22: 276-82.

20. De Vries H, Elliott MN, Kanouse DE, et al. (2008) Using Pooled Kappa to Summarize Interrater Agreement across Many Items. Field Methods 20: 272-82.

21. Austin E, Ramakrishnan A and Hopper K (2014) Embodying Recovery: A Qualitative Study of Peer Work in a Consumer-Run Service Setting. Community Mental Health Journal 50: 879-85.

22. Treatment Advocacy Center (2016) Serious Mental Illness and Homelessness.

23. Pilling S, Bebbington P, Kuipers E, et al. (2002) Psychological

treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behavior therapy. Psychological Medicine 32: 763-82.

24. Pharoah F, Mari JJ, Rathbone J, et al. (2010) Family intervention for schizophrenia. Cochrane Database System of Systematic Reviews.

25. Whetten R, Whetten K, Pence BW, et al. (2006) Does distance affect utilization of substance abuse and mental health services in the presence of transportation services? AIDS Care 18: 27-34.

26. Rule K, Misch RA and Sarkin A (2019) Next Steps Annual Report. University of California, San Diego. Health Services Research Center.

27. Mottaghipour Y and Bickerton A (2005) The Pyramid of Family Care: A framework for family involvement with adult mental health services. Australian e-Journal for the Advancement of Mental Health 4: 210-7.

28. Olfson M, Marcus SC and Doshi JA (2010) Continuity of Care After Inpatient Discharge of Patients with Schizophrenia in the Medicaid Program: A Retrospective Longitudinal Cohort Analysis. Journal of Clinical Psychiatry 71: 831-8.

29. Olfson M, Mechanic D, Hansell S, et al. (1999) Prediction of Homelessness Within Three Months of Discharge Among Inpatients with Schizophrenia. Psychiatric Services 50: 667-73.

30. Olfson M, Wall M, Wang S, et al. (2016) Short-term Suicide Risk After Psychiatric Hospital Discharge. JAMA Psychiatry 73: 1119-26.

31. Sandelowski M (2000) Whatever happened to qualitative description? Research in Nursing & Health. Health 23: 334-40.

32. Corbin J and Strauss A (2014) Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory. 4th ed. Sage Publications.

33. Eassom E, Giacco D, Dirik A, et al. (2014) Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors. BMJ Open 4: e006108.

34. Gidugu V, Rogers ES, Harrington S, et al. (2015) Individual Peer Support: A Qualitative Study of Mechanisms of Its Effectiveness. Community of Mental Health Journal 51: 445-52.

35. Solomon P and Draine J (1995) The Efficacy of a Consumer Case Management Team: 2-year Outcomes of a Randomized Trial. The Journal of Mental Health Administration 22: 135-46.

CEOS CENTER OF EXCELLENCE FOR OPEN SCIENCE

CEOS is an growing Open Access Publisher with diverse peer reviewed journals supported by Aca demic Editors, Scholars, Physicians, Instructors,

CEOS Publishers follow strict ethical standards for publication to ensure high quality scientific studies, credit for the research participants. Any ethical issues will be scrutinized carefully to maintain the integrity of literature.

CEOS Publishers believes scientific integrity and intellectual honesty are essential in all scholarly work. As an upcoming publisher, our commitment is to protect the integrity of the scholarly publications, for which we take the necessary steps in all aspects of publishing ethics.

All the articles published in CEOS Publisher journals are licensed under Creative Commons CC BY 4.0 license, means anyone can use, read and download the article for free. However, the authors reserve the copyright for the published manuscript.