Barriers to Engagement:

Client Perspectives from a Community Based Organization

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Abstract

This study examines what barriers stand in the way of individuals having consistent and meaningful engagement with their mental health service provider. Through qualitative research with mental health consumers and service providers at a partnered community based organization in West Los Angeles, we found that there are several significant barriers to engagement, including, but not limited to, poor therapeutic alliance, lack of adequate resources, and differing understandings of what it means to engage in services. Our research provided a wealth of insightful findings, which allowed us to offer numerous suggestions on how to strategize for improved engagement, both at the partnered agency and beyond. As our findings demonstrated, many of these barriers can be overcome by improvements made to the agency's strategies for service provision. Conversely, some of the barriers that we found are out of the control of the agency or consumer.

Barriers to Engagement: Client Perspectives from a Community Based Organization

Client disengagement presents numerous problems for mental health agencies and represents a significant barrier to effective mental health treatment. Failed appointments due to client disengagement result in inefficient use of staff time and a decrease in staff morale. Frequent client withdrawal increases the cost of treatment, decreases revenue for therapists and agencies, and denies access to limited mental health resources for others in need (Barrett et al., 2008; Chen et al., 2017; Harris, 1998; Orgrodniczuk, Joyce, & Piper, 2005; Sparks, Johnson, & Daniels, 2003; Swift et al., 2012). Client disengagement is an issue well known to service providers and social researchers alike. Whereas numerous studies have attempted to gain insight into the problem and offer practical solutions for both clients and clinicians, client attrition still needs greater understanding and better solutions. Therefore, our goal is to understand, from the perspective of clients and case managers, the barriers that prevent consumers from accessing mental health care and engaging in the treatment process. Findings can suggest practical and efficient solutions to address these barriers, resulting in increased client engagement within outpatient mental health settings.

Pursuing mental health treatment can pose numerous challenges for people, and the path to service utilization is often obstructed by a myriad obstacles that leave people at risk. Social circumstances, including homelessness and housing instability, limited transportation options, unaffordable childcare, and proximity to a service organization are among many environmental components that can leave individuals incredibly vulnerable, and will thus impede engagement

with services (Gilmer et al., 2010). Personal attitudes toward seeking treatment, stigma surrounding mental illness, and cultural views of mental health also pose significant barriers to treatment utilization, which vary in their degree of impact across individuals (Corrigan et al., 2014). Furthermore, mental health issues make it increasingly difficult for individuals to pursue treatment, and most people with mental disorders do not receive sufficient treatment despite the availability of effective interventions (Sareen et al., 2007). The presence of any disorder, especially chronic, comorbid conditions, poses a significant obstacle to accessing treatment (Priester et al., 2016).

People also experience barriers to service engagement on an organizational and systemic level. Organizations face issues including long wait times before appointments and extensive waitlists to receive treatment, as well as uninviting clinic settings and lack of therapeutic alliance between clients and providers (Barrett et al., 2008). The quality of care provided by any given agency will have a direct impact on the number of people seeking services with that organization. Furthermore, systemic barriers to accessing care are pervasive in our culture. Structural barriers such as the cost of services and lack of insurance eligibility make it nearly impossible for many Americans, often struggling in poverty, to receive care (Jones et al., 2014). A general lack of available services, especially lack of culturally competent care, significantly impedes access on a larger scale.

This study explores the barriers that inhibit client engagement with mental health care at St. Joseph Center, a community-based service agency located in West Los Angeles, California. Little information currently exists regarding the uniquely personal, self-reported barriers to mental health service utilization in general, and particularly among homeless and housing-insecure populations. To address this existing gap in the available literature, the research team interviewed clients identified as difficult to engage in mental health treatment by St. Joseph Center, as well as their case managers, asking for their perspectives, experiences, and the various factors that lead to disengagement from services. We hope that our findings will lead to actionable conclusions that can be implemented not only by St. Joseph Center, but also by other community-based agencies facing similar issues.

Personal/Cultural Barriers

Accessing treatment for mental illness is difficult for many Americans, yet more than half of the population will experience a mental illness in their lifetime (Kalibatseva & Leong, 2011). Existing research has demonstrated that many personal and cultural barriers can impact access to mental health care.

Personal Characteristics

At the individual level, characteristics including gender, age, and education can influence attitudes, values, and beliefs, all of which can prevent an individual from seeking treatment.

Some people feel that they would rather take mental health care into their own hands, whereas others avoid seeking treatment altogether due to negative past experiences with healthcare providers and institutions (Barret et al., 2008). A study by Fleury and colleagues (2014) discussed individual predisposing factors that influence service utilization, including gender, age, life satisfaction, marital status, and self-rated health. Their research found that high levels of education, being a woman, and being young were all correlated with a greater likelihood of seeking help for mental disorders (Fleury et al., 2014). For others, the main determinants of mental health care utilization are perceived social support, positive attitude toward providers, or high income. The absence of even one of these factors often predicts a person's lack of desire or ability to seek treatment (Barret et al., 2008).

Stigma

Stigma also impedes mental health care-seeking. Stigma is a complicated social construct that casts people with mental illness in a negative light, framing them as disadvantaged and often leading to discrimination. Stigma is informed by public perception of mental illness and leads to negative stereotypes about mentally ill individuals (Crisp et al., 2000). These stereotypes create a cultural bias based on years of publicly upheld opinions and is then internalized by individuals (Conner et al., 2010). The disconnect between effective treatments available and care-seeking behaviors can be attributed, in large part, to prejudice and discrimination surrounding mental

illness (Corrigan et al., 2014), and can lead individuals with mental health issues to hold negative feelings about themselves. At the personal level, negative attitudes and stigma towards mental illness affect health decisions, leading to avoiding treatment or dropping out of treatment prematurely (Barret et al., 2008). Corrigan and colleagues (2014) explain that poor mental health literacy, beliefs of treatment ineffectiveness, or lack of a support network that would promote care-seeking can all inhibit access to care.

Culture (Cognitive, Affective, and Value-Oriented Barriers)

The cultural relevance of mental health care also plays an important role in access and retention. For members of racial and ethnic minority groups, the path to treatment is often blocked by cultural views of mental illness and therapy, and several studies indicate that minority groups, particularly those from Asian backgrounds, experience a disproportionately higher burden from unmet mental health needs (Kalibatseva & Leong, 2011). Acculturation is related to cultural barriers that inhibit mental health service utilization among various racial and ethnic minority groups (Rodenhauser, 1994). Acculturation is a process that many immigrants and second-generation Americans undergo in which they adopt the customs of the majority group by changing their behaviors and attitudes. Research shows that individuals who have low levels of acculturation may perceive more barriers to seeking help (Leong & Lao, 2001), as mental health treatment is still more broadly utilized by White and European Americans.

One's conceptualization of causes and cures for illness is also culturally influenced. Kalibatseva and Leong (2011) explain that Asian, Hispanic, and African American individuals often hold beliefs that a mental illness can be overcome through "willpower, heroic stoicism, and avoidance of morbid thoughts" (Kalibatseva & Leong, 2011, p. 5) rather than seeking professional psychological help. For example, a study by Sue et al. (1976) suggested that Asian Americans were more likely than Caucasian Americans to believe that mental health was enhanced by "exercising self-control and avoiding morbid thoughts" (p. 707), whereas a traditional psychoanalyst would consider avoidance of morbid thoughts to be a harmful, repressive mechanism (Kalibatseva & Leong, 2011 citing Sue et al., 1976). An additional affective barrier for cultural groups is the mistrust that some minority groups hold with regard to the mental health system. This mistrust stems from a history in which the field of psychology has misdiagnosed racial/ethnic minorities due to cultural insensitivity and invalid diagnostic instruments, developed with primarily White samples (Neighbors et al., 1989).

Finally, cultural values shape one's expression, communication, and behavior. Racial and ethnic minority groups such as Hispanics and Asians tend to be oriented toward more collectivist values (Kalibatseva & Leong, 2011). As a result, the process of psychotherapy, which is primarily focused on an individual's internal thoughts and feelings, may seem foreign. For members of these groups, communicating about intimate issues with a professional who is not

family or a trusted member of an in-group may be a barrier. Collectivist cultures, unlike Western cultures, are encouraged to prioritize community goals, thus focusing on individual needs could be construed as selfish. Therefore, our traditional Western model of psychotherapy and mental health services may not hold relevance for individuals or families within a collectivist value orientation (Leong & Lao, 2001), and helps to explain barriers to access and attrition among these groups. This study poses an opportunity to explore the extent to which personal attitudes, stigma and culture influence barriers for the population served by St. Joseph Center.

Environmental Barriers

Studies have shown that many external factors increase the difficulty for an individual or a family to engage in mental health services, such as access to transportation and childcare, housing conditions, and proximity to service providers (Mojtabai et al., 2011; Priester et al., 2016; Slaunwhite, 2015; Stergiopoulos et al., 2010). When an individual or a family experiences one or more of these factors, the likelihood of obtaining mental health services may decrease. Adults living in poverty face unique stressors such as poor housing and limited resources, which can increase risk for developing mental health problems and it is unlikely for those living in poverty to be connected to quality mental health care (Hodgkinson, Godoy, Beers, & Lewin 2016).

Homelessness

Understanding the interplay between homelessness and mental health is a critical element of this research, as St. Joseph Center serves a significant portion of homeless individuals.

Previous studies have documented the unmet needs among the homeless population and have found an association between homelessness and mental illness (Stergiopoulos et al., 2010). Homeless populations face challenges including cognitive, interpersonal, and increased severity of mental health conditions when they do not receive the mental health treatment they need (Stergiopoulos et al., 2010). Homeless individuals are likely to have co-occurring conditions, such as substance use, which contributes to the difficulty of receiving treatment, as some mental health service providers do not treat substance use disorders (Kiser & Hulton, 2018).

Homeless individuals with mental health needs often utilize emergency departments and hospitalizations for treatment (Stergiopoulos et al., 2010). This is problematic, as these individuals are not getting consistent mental health services and are only receiving treatment during times of crisis. Overcrowding in emergency room departments can have negative effects on quality of care, as the demands on the hospital staff are extremely high (Rocovich & Patel, 2012). Poor treatment by providers will likely drive away homeless individuals in need of care. Therefore, mental health service systems must address the needs of the homeless in order to make care more accessible for this vulnerable population.

Homeless individuals fail to receive quality mental health services even when they are successfully engaged in treatment. Stergiopoulos and colleagues (2010) found that providers treat homeless individuals with mental health conditions poorly due to their housing status and that homeless individuals were receiving infrequent service delivery. Furthermore, the research found that case managers at many community-based mental health agencies were undertrained in providing mental health services and using ineffective interventions (Stergiopoulos et al., 2010).

An additional barrier for this population is that homeless individuals often struggle to have their basic needs met (i.e., shelter, food, clothing), which pushes mental health treatment to the back burner (Kiser & Hulton, 2018). Sleeping on the streets or in shelters can be stressful and exhausting for individuals. Gilmer and colleagues (2010) found that implementing a housing-first model increased the utilization of outpatient mental health services, decreased the number of inpatient and emergency services rendered, and increased the quality of life reported by clients. Integrated systems and wrap-around care may increase client engagement by allowing homeless individuals to meet their basic needs and receive resources from their mental health providers.

Transportation

Lack of car access, unreliable public transit, and far travel distances can make pursuing mental health services very difficult. Problematic transportation may cause individuals and families to be late or miss their appointments, which can negatively affect the services they receive. Specifically, Los Angeles covers many service areas due to the large size of the county, which can be difficult to navigate using public transportation. Mojtabai et al. (2011) found that past clients have reported problems with transportation and scheduling that would have made it difficult to stay in mental health treatment. Approximately, 17% of individuals with mental health diagnoses reported transportation as their reason for dropping out of treatment (Mojtabai et al., 2011). Syed, Gerber, and Sharp (2013) found that transportation barriers impact patients' access to pharmacies and subsequently affects patients' ability to get their medications. This research study focused on transportation barriers regarding health care treatment; however,

individuals receiving mental health treatment also have medication needs that may be unmet due to transportation issues.

Transportation barriers affect individuals of all age groups, demographics, and socio-economic statuses (Mojtabai et al., 2011). Veterans, homeless individuals, and those involved in the criminal justice system experience transportation barriers to accessing mental health treatment (Priester et al., 2016). Existing research has documented that transportation challenges pose a particular barrier to older adults in accessing mental health services (Solway, Etes, Goldberg, & Berry, 2010). Lack of transportation may be specifically relevant to St. Joseph clients as these individuals may have a limited support system that they can rely on for transportation. Gould et al. (2012) claim that 46% of government insured clients in their study identified lack of transportation as a barrier for children receiving mental health services, as families were not able to accommodate schedules for their children's care. Both older adults and families experience multiple barriers to accessing public transportation.

Childcare

Families are paying significantly more for childcare in recent years due to increasing fees and rates in this industry, which especially affects low-income individuals who may have difficulty subsidizing their childcare needs (Gorry & Thomas, 2017). Tasks such as attending mental health appointments may be compromised in the absence of affordable, quality childcare. Lack of transportation and childcare are commonly grouped together as reasons that individuals and families disengage from mental health treatment (Slaunwhite, 2015). Additional studies also show that a lack of transportation and childcare deters individuals from seeking mental health

services when in need (Mojtabai et al., 2011). A possible explanation of the overlap between transportation and childcare may be because both of these issues are experienced by people living in poverty. Additionally, if individuals are unable to afford the costs of transportation, they may not be able to afford childcare expenses.

Slaunwhite (2015) reported that women are 51% more likely than men to report lack of transportation or childcare as their barrier to receiving mental health services; he discusses how women experience high levels of caregiver burden and face challenges in managing their own needs along with others. This study also found that men are more likely than women to report stigma, which acts as another explanation of the variability among genders (Slaunwhite, 2015). A more recent study found that women specifically identified a lack of mental health treatment centers that offer onsite childcare (Priester et al., 2016). Additionally, female caregivers and mothers experience high levels of stress and burnout, which can negatively affect their mental health (Slaunwhite, 2015). Increasing the availability of integrated services, such as onsite childcare, may lead to increasing levels of client engagement in mental health services (Priester et al., 2016).

Geographic Proximity

Individuals seeking services will have an easier time accessing care when a service provider is located nearby. Research indicates that geographic proximity affects access to mental health treatment (Priester et al., 2016). Slaunwhite (2015) found that approximately 8% of surveyed individuals (n = 4134) reported that their ability to access mental health services was negatively impacted by the lack of available providers in their area. St. Joseph Center provides

services specifically across the West Los Angeles region; therefore, geographic proximity may be a relevant factor to the clients that the agency serves.

Severe Mental Health and Health Barriers

Studies have shown that the presence of a severe mental health diagnosis, or undiagnosed symptoms that cause significant functional impairment, can deter access to care and engagement in mental health services. In addition to groups facing poverty, lower educational attainment, lack of health insurance, and racial minority status, those with severe mental health issues and medical comorbidities face an unmet need for mental health care (Jones et al., 2014). Jones and colleagues used a 2009 Health Care patient survey in their 2014 cross-sectional study to collect sociodemographic information on health symptoms and behaviors; by analyzing factors associated with unmet mental healthcare needs, researchers found that whereas affordability was the primary explanation for lack of engagement, serious mental illness was also a factor. Even though these individuals may be more in need of services than someone with a moderate condition, severity of their symptoms could prevent them from understanding how treatment could be beneficial or from showing up to appointments. Systemic barriers such as delays or capacity issues are associated with affordable wrap-around care for severely mentally ill clients. For example, Barrett and colleagues (2008) suggest that the connection between Axis II comorbidity and higher rates of attrition could be explained by symptoms such as isolation, aggression and paranoia that can inhibit rapport and engagement with providers. Other studies have made the connection that psychiatric symptoms, such as psychosis, mania, and depression, can cause poor insight and poor psychological mindedness (Barrett, et al., 2008). Similarly, a

study in 2001 showed that as many as half of people with schizophrenia and bipolar disorder diagnoses were unaware of their illness (Corrigan et al., 2014).

Severe mental illness, such as schizophrenia or major depressive disorder, can introduce additional barriers to engagement resulting from an increase in functional impairment. When asked about the reasons for disengagement, respondents with severe disorders reported more reasons for disengagement than those with more moderate disorders (Mojtabai et al., 2011). One reason for this early disengagement may have to do with behavioral problems or motivational challenges; for example, clients with severe depression may have difficulty getting themselves out of bed and to services from one day to the next (Corrigan et al., 2014). A 2016 study reported that 80% of young adults who have experienced their first psychotic break drop out of treatment within their first year (Dixon et al., 2016). An explanation for this could be poor rapport or insight, mistrust of the system, functional disabilities and/or need for hospitalization (Dixon et al., 2016). The consequences of not reaching this population are paramount, including the potential for hospitalization, re-hospitalization, escalating symptoms and impaired functioning, and incarceration (Dixon et al., 2016).

An individual-level barrier for this population is a disconnected care system with separate referrals for substance use disorders and psychiatric disorders, despite these two conditions being frequently comorbid, which makes it extremely challenging for clients to navigate treatment efficiently and effectively. Many clients reported that they received opposing information and criteria from separate providers (Dixon et al., 2016). Co-morbidity can often worsen health conditions such as cardiovascular disease, diabetes, obesity, asthma and cancer, which have a

higher prevalence in more impoverished communities who already experience disproportionate barriers to care (Kiser & Hulton, 2018). Our study may help understand how the presence of severe mental health and health issues may pose a barrier to service utilization for St. Joseph Center's clients.

Internal Organizational Barriers

An analysis of barriers influencing client engagement would not be exhaustive without examining the role of organizations. Existing research has highlighted the ways in which service agencies play a role in client disengagement, ranging from therapists' abilities to form a positive alliance with their clients to the welcoming nature of the clinical environment. Understanding the barriers that organizations inadvertently place on their clients' abilities to access these services could both improve the means of service provision and the efficacy of service delivery outcomes.

Therapeutic Alliance

A wealth of existing research points toward service providers' ability to form a positive relationship with their clients as a protective factor against disengagement from treatment (Barrett et al., 2008; Chen et al., 2017; Dixon et al., 2016; Jung et al., 2013; Roos, 2011; Swift et al., 2012). Available data demonstrate that poor therapeutic alliances are predictive of early termination from therapy (Barrett et al., 2008). While there is not a universally agreed-upon definition of the term "therapeutic alliance," it is most often understood as the process by which clinicians and their clients build rapport and work collaboratively in the interest of problem solving and goal attainment (Swift et al., 2012). Baldwin and colleagues (2007), and later Gearing and colleagues (2014), found that characteristics of therapists, such as their flexibility,

clinical experience, prior education, and warmth, were more likely to predict client outcomes – including client disengagement – than the characteristics of patients. Clarkin and Levy (2003), citing Beckham (1989), argued that clients' poor initial impressions of their therapists helped predict cases of early withdrawal from treatment. Simply put, if clients are unable to feel a connection with their service provider, they are more likely to prematurely terminate treatment or disengage from treatment, as opposed to clients who form a strong bond with their service provider.

While research has demonstrated the importance of the therapists' characteristics in predicting treatment outcomes, the onus is not entirely placed on the clinician as the deciding influencer of client withdrawal from treatment. Client dropout and dissatisfaction are not synonymous terms. Not all dissatisfied clients will disengage from services prematurely – dissatisfied patients may stay in treatment and satisfied patients may disengage – and the decision to prematurely terminate treatment is motivated by variables that vary from person to person (Roos, 2011). However, dissatisfied clients are more likely to disengage from treatment than satisfied clients (Barrett et al., 2008), and existing data has shown that sources of client satisfaction or dissatisfaction vary in their origins – including distrust of the clinician or a perceived lack of personal growth (Swift et al., 2012).

Policies and Practices

Scholars have long studied the impact that agencies' internal policies and practices have had on clients' treatment success. While the results of these studies vary (Barrett et al., 2008; Chua & Barrett, 2007; Gearing et al., 2014; Festinger, Lamb, Marlowe, & Kirby, 2002;

Hampton-Robb, Qualls, & Compton, 2003; Manthei, 1996; Sirles, 1990), one consistent finding is that agency policies and practices, such as placing clients on waitlists and cultivating a welcoming office environment, do indeed impact rates of client attrition.

Some studies have demonstrated that factors related to treatment environments, including treatment settings and clinic facilities, are important predictors of client disengagement (Barrett et al., 2012; Chua & Barrett, 2007). For example, Chua and Barrett (2007) found that among urban clinics facing issues related to client attrition, a 10% increase in client attendance to the first session was related to refurbishing waiting areas and treatment room settings to be more inviting to clientele. While this research is compelling, further research is warranted to draw a greater connection between clinical milieus and rates of client attrition.

Findings on the effect of wait times on rates of client attrition have long divided the research community. While some researchers contend that there is a lack of relationship between waitlist times and client dropout (Hampton-Robb, Qualls, & Compton, 2003), the bulk of existing data demonstrate that placement on a waiting list and long waiting times between the initial contact and the first treatment session strongly predict client disengagement or withdrawal from treatment (Barrett et al., 2008; Gearing et al., 2014; Manthei, 1996; Sirles, 1990). Barrett and colleagues (2008) found this was particularly true for wait times exceeding one week.

Clients are most likely to attend their intake session when the period between initial contact and intake is within 24 hours of first contact (Festinger, Lamb, Marlowe, & Kirby, 2002). Although this is not always realistic, especially in clinics experiencing high volumes of referrals, findings have indicated that practices can be implemented to negate the harmful effects of

waitlists and the influence that waitlists have on a client's decision to withdraw from treatment. Prescreening appointments and telephone follow-ups have both been associated with increased rates of first appointment attendance, and combining both strategies has been associated with higher instances of consistent appointment attendance (Gearing et al., 2014). Manthei (1996) suggests that follow-up conversations with waitlisted clients aimed at assessing how the potential client is coping with having to wait, as well as their presenting problem(s), coupled with updating the potential client on his or her waitlisted status, should moderate client concerns and reduce rates of attrition. Ultimately, an agency's ability to perform intakes and decrease appointment-waiting times is reliant on the agency's staff availability, and for many agencies, this issue is both unavoidable and not easily resolved.

Systemic Barriers

Under-resourced communities and individuals living in poverty are disproportionately affected by unmet mental health needs (Jones, Leburn-Harris, Sripipatana, & Ngo- Metzger, 2014). Cost of services and insurance issues are reported as major barriers to seeking mental health services (Jones et al., 2014). Jones and colleagues (2014) found that 39% of individuals reported cost as the main reason for their unmet mental health needs. More recent literature also points to insurance status as an indicator for receiving mental health treatment (Walker, Cummings, Hockenberry, & Druss, 2015). Adults with mental health conditions who hold any type of insurance are significantly more likely to receive care than those without insurance coverage (Walker et al., 2015). Walker and colleagues (2015) found that 75% of uninsured adults with mental health conditions did not receive care. Additionally, lack of funding was

identified as a barrier to accessing children's mental health care reported at 52% in state mental health care plans (Gould, Beals-Erickson, & Roberts, 2012). Systemic barriers such as the inability to afford the cost of treatment, lack of insurance, and lack of funding are commonly reported among those who are seeking mental health treatment. Each individual should have access to the mental health treatment that they need regardless of their insurance coverage or their ability to afford services.

The Current Study

In summary, much of the available research on client disengagement applied quantitative research methods to understand rates of client attrition, potentially missing crucial information that could be obtained using a qualitative approach. As Manthei (1996) aptly recognized, hearing directly from clients might offer valuable information toward better understanding the root causes of client attrition.

Thus, this research study attempts to fill gaps in the existing literature on the topic of client engagement by utilizing a qualitative approach. Partnering with St. Joseph Center, a community-based mental health clinic located in West Los Angeles, California, provides a unique opportunity to gain an intimate look at the problem of client disengagement by utilizing a prominent community-based agency and their existing client-base. Our research question asks, what impediments stand in the way of St. Joseph Center's clients engaging with mental health services? Through this research, we aim to offer practical solutions that may directly benefit St. Joseph Center and similar agencies facing comparable difficulties, while providing compelling research that will enhance the available collection of literature on this topic.

Methods

Research Design

In the Summer of 2019, St. Joseph Center approached UCLA's Luskin School of Public Affairs seeking Social Work student researchers to conduct a study on the agency's behalf, for the purpose of understanding client disengagement from the agency's services. This research team was chosen from among several applicants, following an interview with the agency. St. Joseph Center then deferred to the research team to create a research design and later gathered the study sample on the team's behalf. Once the study sample was selected by St. Joseph Center, researchers evaluated reasons for disengagement using a qualitative approach, gathering data, comparing it with previous research findings and conducting one-on-one interviews with a total of five St. Joseph Center's clients and three case managers who work for the agency.

Study Sample

Initially, we planned to conduct approximately 20 interviews with clients and case managers. However, due to recruitment barriers including client availability, interest in participating, and staff ability to locate clients, the agency was able to connect our team with five adult clients. These individuals were identified and selected by St. Joseph Center as being difficult to engage, or as having previously disengaged from services, for a variety of reasons. St. Joseph Center independently determined the inclusion and exclusion criteria for selecting individuals that they considered "difficult to engage" in services, as the agency generated this topic of study and is most familiar with their client population. The sample also included three case managers from St. Joseph Center who offered their perspectives on client disengagement.

This led to a total sample size of eight adult participants ranging in age and ethnic background, all living within the greater Los Angeles area. Specific demographic data has been intentionally omitted from this paper in order to protect participant confidentiality. While this sample size is not generalizable to the entire population, it was a feasible size given St. Joseph Center's reach within the West Los Angeles Area and yielded results that could be applied widely to various agencies facing similar challenges.

Study Procedures

This study began with St. Joseph Center's case managers contacting their clients to introduce the study and ask for their consent to be contacted by our research team. Following consent gathering, each case manager shared the contact information of potential study participants with the research team. The researchers then contacted these clients in one of two ways. Four out of five clients consented to in-person interviews, in which researchers accompanied a designated case manager to the client's location. The case manager then facilitated a warm handoff to the researchers, where a subsequent face-to-face interview took place in a semi-private space. Three out of the four in-person client interviews took place without the presence of the case manager. One in-person client interview took place with a case manager present, with the consent of the client.

Of the five clients identified, one agreed to a phone interview, as he was unwilling to be interviewed in person and was more comfortable speaking on the phone. Researchers called the client and identified themselves before proceeding with the interview. The other four client interviews took place in a range of locations, including client homes, St. Joseph Center and

public spaces. Finally, two out of three case managers were available for, and consented to, in-person interviews. One out of the three case managers was available for, and consented to, a phone interview.

All eight interviews, including six face-to-face interviews and two phone interviews, began with researchers asking the participant for verbal consent to be interviewed, as well as verbal consent for the interview to be audio-recorded. The research team conducted this necessary step to both comply with ethical research guidelines and counter any risk of coercion due to the chosen recruitment method. Researchers then provided details about the study procedure and confidentiality, and answered any questions about the study (see Appendix A). All eight participants provided their verbal consent.

This script allowed our team to establish each participant's willingness to participate in the brief interview and allowed researchers to obtain each participant's verbal consent for the interview to be audio recorded. The researchers then began the short interview, ranging from 15-30 minutes in duration, asking each client three questions and each case manager six questions, all regarding their experience with personal or client engagement (see Appendix B). By limiting the interview to three to six brief questions, the research team was able to keep the attention and engagement of each participant, without overwhelming or burdening them, as well as ensuring greater reliability between team members. Given the small sample size and St. Joseph Center's familiarity with the clients and case managers, it is possible that the agency would be able to identify the interviewee based on their interview responses. For this reason, all

identifying information for both clients and case managers, including demographics, remained confidential in order to mitigate this risk.

Concepts and Instrument

This study drew upon qualitative methodology to highlight the experiences of the selected study participants in relation to their utilization of services with St. Joseph Center. The researchers utilized open-ended, semi-structured interviews to understand the extent to which, and why, participants struggled with service engagement and how they felt about their experience at St. Joseph Center. Researchers also interviewed the clients' case managers in order to understand if their perspective of engagement differed from their clients' and to capture a deeper understanding of the barriers both groups faced. This methodology was aimed at helping St. Joseph Center decrease future rates of attrition through an in-depth understanding of influential factors from clients' own voices.

Through these interviews, the study collected information about the client and case manager-identified factors related to disengagement. Open-ended interviews also allowed for the application of an ecological framework for understanding disengagement. This framework, which helped to inform our interview questions, looked at client-level, provider-level, organizational-level, and environmental-level factors, along with intervention- level and service delivery characteristics when considering clients' responses to interview questions.

Depending on the nature of the conversations, and how open participants were with being interviewed, follow-up questions were asked in order to clarify information and further

understand barriers as well as potential solutions to accessing services. Examples of potential follow up questions can also be found in Appendix B.

Analysis Plan

The process of raw data analysis utilized in this study aided in the research team's ability to uncover explanatory patterns within the data (Rubin & Babbie, 2017). The previous literature on this topic helped us to deduce the significant themes and theories that emerged from our data collection; additionally we took an inductive approach in that we identified new ideas and perspectives that were gleaned from the use of open-ended interview questions. Given the qualitative research design that the research team elected to implement in this study, appropriate analytical tools included open, axial, and selective coding.

Members of the research team transcribed recorded interviews verbatim. Interview transcripts were then de-identified and pseudonyms were assigned to each interviewee by the research team to preserve the confidentiality of each participant. Due to the research team's inability to strip confidential information from audio transcripts, interview recordings were only accessible to the research team.

Interview transcripts were then coded by the research team using a three-step process to identify data trends. The research team developed appropriate codes through a combination of inductive and deductive methods: first, the research team deductively identified dominant themes apparent in existing literature and developed codes that reflected these themes; later, the research team inductively identified themes that became apparent during the data analysis process and developed additional codes that represented these novel themes. All members of the research

team participated in the coding process; to ensure that each member of the research team agreed upon codes, the research team conducted in-person and virtual meetings to discuss and clarify developed codes.

The research team first utilized line-by-line open coding methods to organize and label interview data by segmenting interview sections into brief meaningful summaries based upon the segments' meanings. Next, interview data was re-coded utilizing axial coding methods to regroup initially coded data into appropriate categories, which helped identify core concepts and patterns across interview transcripts. Lastly, the research team utilized selective coding to link acquired data with data outlined in our review of existing literature. A codebook, developed using Microsoft Excel, can be found within Appendix C. Coding served to provide structure and organization to participant interviews and also aided in determining any explanatory patterns within the gathered data.

All interview transcripts, notes, and coded interview data were housed within a secure shared document located on an encrypted server, and were accessible only to members of the research team. This practice secured participant data and preserved the integrity of the research design. The chosen data analysis method employed within this study enabled the research team to easily identify central themes within acquired data and organize the results section accordingly.

Positionality

As researcher bias can taint the gathering and interpreting of data, the researchers took multiple steps to mitigate these risks (Cheraghi et al., 2014). The researchers have professional

experience working with the adult mental health population in multiple arenas such as Full Service Partnerships (FSP) and Intensive Mental Health Treatment Programs (IMHTP), from which the clients and case managers are being recruited. This past experience prepared the researchers to approach clients with respect and dignity and conduct interviews with an understanding of mental health symptoms and possible impairments. Additionally, the research team has prior experience with clients who have disengaged in mental health treatment or faced barriers to accessing care. Lastly, the researchers used an inductive interview approach, by asking open ended questions guided from previous research findings, in an attempt to combat any existing biases while collecting or analyzing data.

Results

The results of our study highlight a combination of factors that hinder a client's ability to engage in St. Joseph Center's services, and the following major themes stood out most. Clients identified difficulties accessing services due to lack of reliable transportation, long traveling distances between their home or resting area and the clinic, and inconsistent case manager contact. In addition, some clients mentioned that their homeless and/or low-income status impacted their ability to have consistent and meaningful engagement with their case managers. Case manager responses appeared to align with these client reports; however, the case manager group also identified frequent staff turnover and high caseloads as having a negative impact on client engagement.

Defining Client Engagement

Direct interviews with clients and clinicians offered valuable data that painted a broad picture of what barriers clients and clinicians experience while attempting to engage with each other. Of the clients we interviewed, all shared favorable views of St. Joseph Center's services and staff; interestingly, none of the clients believed they were difficult to engage with or had disengaged from services, though all clients detailed instances where it had been difficult to engage with staff in the past – an important distinction that each client made during their respective interview.

Clients' disbelief in the notion that they were difficult to engage in services, despite the agency identifying them as such, prompted us to clarify amongst the case managers what "client engagement" meant to them. This proved to be significant, as case managers varied in their definitions of client engagement, ranging from a specific to a broad-based definition. Case manager C had the most specific definition for engagement as requiring a willingness to meet and talk, stating:

> Just meeting with us, being willing to meet with us is what engagement is to me. Whether or not they receive medical or psychiatric [care]… housing…whatever else they need…is just a bonus. But if they are willing to meet with me and talk with me about anything that's going on in their life to me that would mean they're engaging.

Case manager B held a broader definition, focusing on lowering the threshold for engagement accessibility:

> So client engagement to me means meeting them where they're at. Understanding that absolutely there's going to be challenges faced with, you know, providing support, but, you know, it's doing what we can to the best of our ability to meet them and help them and support them.

Case manager A held the broadest definition of client engagement, commenting that client engagement takes place through forming *any* connection between case manager and client, stating: "Client engagement to me means trying to establish a connection with clients in order to provide adequate services without having them come to you."

Across each case manager's definition of engagement is a common theme of connection, however, the case managers appeared to have varied ideas of how that connection should transpire. For case managers A and B, forming a connection appeared to be a two-way street, however, for case manager C, the onus to form a connection appeared to fall upon the client. These varying definitions of client engagement held by each case manager shed important light on the framework that the clinical staff utilized for approaching this topic. These differences not only explain why there appeared to be some disconnect between staff and client views on level of engagement, but also demonstrated the varied understanding of the topic amongst clients and case managers.

It is also important to note that case managers did not appear to view an absence of or deficiencies in client engagement as a lack of interest in services. Rather, they all appeared to view lack of client engagement as indicative of a greater systemic issue, such as homelessness, mental health complications, transportation, or internal agency policies and practices. As case manager C aptly stated, "I think it's really important to know that even when a client is disengaged, that doesn't mean that they might not want help. They just need it in a different way."

Homelessness

Case managers and clients both identified homelessness as a barrier to accessing mental health services, which previous literature noted. Two out of three case managers reported that homelessness was a barrier their clients faced in receiving care at St. Joseph Center. The case managers identified transience as a challenge that they faced with their homeless clients. Case manager A described how homeless clients move frequently in order to adapt to their environments, resulting in an inability to access services as needed, stating:

> I think the biggest barrier is kind of understanding that clients are going to have inconsistency in their life that they kind of have to adapt to. And because not everyone wants a homeless individual in their area. So they constantly have to adapt to their environment. And that limits their ability to access services and that limits their access to us so I think that serves as a barrier. Not every community's receptive to having those individuals or that population working with or, like, receiving services in their area.

Of the clients interviewed, three out of five reported that homelessness was a barrier to receiving services, either in the past or currently, and all of the clients mentioned that they had experienced homelessness at some point during their time with St. Joseph Center. The agency's efforts to secure client housing was recognized by three clients, yet two clients still viewed homelessness as one of their ongoing difficulties to engagement. Client A stated:

> Well, just what they're doing now...is taking me off the streets at least for six days and...Um...hopefully the agencies that they deal with that find apartments for people in my position...that's the biggest…. I'm on some kind of list...like a waiting list…and in the meantime, I'm just out there, you know. So, that's pretty much my situation.

Homelessness also seemed to cause, and negatively influence, other barriers identified by clients and case managers, further challenging engagement. Client E affirmed that being homeless created challenges to engagement, stating: "Well I didn't have a cell phone then [at

time of homelessness] and yeah. So…but…St. Joseph's usually ran into me and knew where I was at the time." Despite St Joseph Center's efforts to assist clients with housing, homelessness is a barrier to engagement recognized by both clients and case managers. Similar to housing, transportation is not accessible to all and can be costly to those facing economic hardships.

Transportation

Based on the data gathered, case managers did not identify transportation as a barrier to client engagement; however, three out of five clients expressed that transportation was a barrier to regularly accessing services. Client A and client C expressed that lack of funds for transportation was an issue that they faced, which increased their inability to access St. Joseph Center's services; however, client B and client C acknowledged that the agency provided them with a bus pass when possible. Three clients reported that having access to transportation would make it easier for them to access services at St. Joseph Center. Client B described personal challenges with transportation, sharing:

> There was one time that I was stuck in, uh, I was stuck in Downey, I went to Kaiser Permanente…and I got off, I was on a train, where they didn't have a map, so I got stuck in Downey and I didn't know what bus to take, or anything, and I tried to call them to get [a] ride back here, and they were unable to provide a ride. So, I was able to get back by hopping on the bus, and not, not having any money, and getting back on good will …but, uh, other than that, I, it would be difficult to get back…

Client A stated:

> So the transportation and the fact that I was homeless were the biggest problems for me...and they've given me bus passes and that helps...Because you know, I'm moving around…

Additionally, client C stated:

> But, um, a lot of it has to do with like transportation and stuff. But, um, cause I don't have a car...but, um, and uh, my, I don't have any money or anything like that, so…like, you know, like, I'm flat broke so it's, it's hard to do anything…when you have no money.

Transportation also depended on the client's geographic proximity, which was another barrier identified by clients.

Geographic Proximity

While homelessness and transportation were more commonly reported barriers, geographic proximity was identified by one client and one case manager as a barrier for client engagement in mental health services. Accessing St. Joseph Center services was reported to be "easy" for one client who is in walking distance of the clinic. Case manager A described how location can limit a client's access to services:

> …And sometimes the services that in a given area aren't as you know, adequate compared to others. Like for example, Venice has a number of services. If you go to like Malibu area, there's practically nothing there… So I don't think clients should be restricted access to services just because of their inability to kind of go out of the way to look for those services.

Similarly, client A described their own experience living far from St. Joseph Center below:

> Well for one, I can say I like [Location Retracted] area. And I guess it's a long distance to St. Joseph's...their facility in Santa Monica, but we [case manager and client] were meeting...we [case manager and client] met about a half a dozen times or more at the [Location Retracted]...It's been my biggest difficulty. But that's why they come and meet us in my area…"

While geographic proximity was identified as a barrier, overall, clients expressed that St. Joseph Center's staff went out of the agency building to meet them for sessions in the clients' desired location.

Systemic Barriers

While clients did not reference systemic issues as barriers to engagement, all three case managers identified systemic barriers as having an impact on client disengagement. In particular, all three case managers described the challenge of trying to locate their clients within the medical or criminal justice systems as major systemic barriers to continued engagement in services. Case manager C reported:

> I had a client that we couldn't find for six months. We called hospitals, we called jail. Like I looked at the jail website, I even looked at the mortuary website, trying to find an unclaimed body, which is really morbid If you think about it, but it's part of the job, trying to find our clients. And when he got out he called us. And we're like, "Where were you?!" And he just told us, he was like, "I went to the hospital. And then I was in a drug treatment program for six months, I bounced back and forth between different programs. They sent me to different programs", and now we're helping him and he is in.

Similarly, case manager B commented on the process of locating a client, stating:

> Well, let me just clarify by dropping out of services. We've never had anyone completely like… that I've experienced, like completely say "we're done" and then be discharged. We have our protocol, but it's never been that they've stopped talking to us and then they're gone. It's been like maybe they'll go missing for a couple of weeks so that's where we're calling places, we're looking in areas they visited.

Another systemic barrier identified by case managers was lack of funding for mental health resources. All three of the case managers identified lack of funding, and therefore lack of resources, as an impediment to the agency in providing varied resources. Engagement with

clients was also impaired when managing frequent and unexpected changes in funding sources. When asked if there were any other barriers not yet mentioned that get in the way of client engagement, case manager A explained:

> Lack of resources or funding. So I would say the most recent one is like I'm hearing like that they're working on trying to reduce the amount of social services to people who are struggling, like the vulnerable populations. And then also they, the funding rapidly changes from like month to month, and it's difficult because then clients have to keep this, it's like an additional stress for clients kind of having to do, redo, things over and over and still try to survive in their situation.

The unpredictability of funding and resources influences the client/provider relationship, as consistency in services is essential for clients who are coping with multiple environmental stressors in their day-to-day.

Policies and Practices

The data gathered from both clients and case managers suggest that specific agency policies and practices that are within the agency's control - such as agency hiring practices, wage policies, and caseload expectations - influence the barriers that clients face in accessing and utilizing mental health services. This is an important finding, as agencies have the direct ability to adjust the ways in which they offer their services to improve overall service utilization. Moreover, practical solutions can most easily be devised through the consideration of these findings, which will be addressed further in our discussion.

Clients and case managers both identified staff shortages and high caseloads as a substantial barrier to client engagement. Case managers reported that staff shortages resulted in large gaps in service delivery and growth of clients' distrust in their case manager's ability to

meet their needs. Case managers also noted that large caseloads meant less time to meet with each individual client, resulting in decreased client engagement. All three case managers also agreed that low wages and a lack of prospective applicant interest in the position compounded the issue of staff shortages. Case manager C specifically noted that their low wages meant that they had to take on a second job to meet their financial needs, a reality that is far too common both amongst case managers at St. Joseph Center and elsewhere. Case manager C argued that this meant less time to spend with their clients, and less energy to meet their clients' needs, stating:

> And as social workers, we don't get the funding that we need to be able to maybe even just have this job, right? Like most of the people I work with have a second job. I had a second job for the first year I worked here…for the first 8 months I worked here…

Additionally, both case managers and clients identified that a high rate of staff turnover was a problematic influence on client engagement. Both clients E and D remarked that they experienced disengagement due to staff turnover, though interestingly, they appeared to differ in how they understood these experiences. Client E appeared to be more understanding of the issue, stating that "sometimes [switching case managers] happens", while client D had a less understanding view, stating:

> Well one thing they could do is not take services away… There's such a thing called overtime and when somebody doesn't have services, they should be getting services. I'm sorry, but when you sign on to a…uh…full service partnership team … and they tell you that you'll be getting a therapist, you'll be getting a case manager…they should not be taking services away and then say "oh sorry, we don't have anyone to fill these services."

Staff turnover is often an unavoidable byproduct of staff shortages amongst agencies with finite personnel resources, limited funding, high demand for productivity, and service

populations composed of vulnerable persons; however, the negative impact that this has on those in need is still clearly felt amongst the client and case manager populations.

High caseloads coupled with demand for productivity and completion of lengthy county-mandated paperwork also seems to influence service providers' ability to meet the demands of their clientele - a finding that appears to impact the clients' ability to have meaningful engagement with their case managers. Case managers B and C made note of this during their interviews, stating:

> I think that policies and organizations kinda need to change that with...If I had a smaller caseload I could make a difference, like a bigger difference, like I wanted to, as opposed to being overloaded with client work and documentation and housing applications and case management appointments for clients who need medical care...[case manager C]

> We need to hire more people and their caseloads need to be smaller, and there will be less turnover…there will be less…there'll be more room for growth and for client care, and less room for turnover when if our caseloads were smaller, and we felt less frantic all the time. [case manager B]

Similar to the impact that high staff turnover has on client engagement, the demand for productivity and lack of staff availability results in less time for case managers to fit clients into their schedule, and less time to focus directly on meeting the needs of their clientele, both resulting in client disengagement.

Interestingly, previous studies' (Chua & Barrett, 2007) findings that wait times and unfriendly clinical environments negatively impacted client engagement did not appear to be an issue that impacted the clients and clinicians interviewed for this study. Clients in this study appeared to receive services when they initially needed them, though some participants expressed that they experienced gaps in service provision which led to their disengagement.

Similarly, no client in this study made mention of an unfriendly clinical environment as a reason for their disengagement, unlike in Chua & Barrett's (2007) study.

Therapeutic Alliance

Therapeutic alliance was a recurring theme in the interviews with case managers. Of the three case managers interviewed, all three discussed therapeutic alliance as a barrier to engagement. This barrier to engagement is evidenced by the descriptions of distrust of former providers described by the case managers and client B and client D, who identified elements of the therapeutic alliance as a factor in engagement.

It is clear from the interviews that a distrust of current providers resulted from past negative experiences with providers. These negative experiences reportedly affected the therapeutic relationship, thus impacting client engagement. Case manager C described how clients have frequently expressed the idea that their distrust of St. Joseph Center's providers stemmed from discouraging relationships with previous service providers, stating:

> Like, I've gone through this before. I didn't get the help I needed. And now I'm still here. So why would I trust you? Why would I engage with you? It's just going to waste my time. And you're not going to do for me what I need.

Case manager B also reported that clients feel discouraged by distrust of their clinicians, noting: "They're like 'oh, this is another service provider that says she just wants to help me, but she's not doing anything."

These past negative experiences that influence the client provider relationship were also evident during the interview with case manager A, who discussed the importance of improving the client/provider relationship by correcting clients' assumptions based on past negative

experiences, that a provider won't be able to help them. Case manager A also spoke about the importance of transparency when it came to what the agency can and cannot provide given capacity, reporting:

> There are some clients who are hesitant because of their past experiences. Usually those are negative experiences with service agency staff, where they feel that they've been wronged in some way or their services weren't adequate... I think that's where there's a lot of apprehension there. So what we try to do is kind of model the corrective emotional experience to the best of our abilities and try to provide them with transparency

Two of the providers emphasized that in order to avoid disengagement, case managers need to prioritize support in their relationships with clients, but due to high caseloads and high agency turnover rates, this task is not always easy. Case manager B acknowledged this need for smaller caseloads to improve client care.

Case manager A also described how some of his clients have had experiences with other providers where they did not feel respected, reporting:

> I would just recommend just being your authentic self because clients are very easily able to catch on, they actually know by now, the specific jargon that students or service agency staff use. So they'll pick it up. And more often than not, they'll be receptive to it. But there will be times where they'll feel like you're being condescending in a way. Because at the end of day, they just, they just want to be treated like everyone else, right?

He explained how in order to have a supportive relationship with a client, providers need to be genuine with clients and treat them as equal human beings. Similarly, client D described how he had been able to engage with St. Joseph Center initially despite his adverse life experiences due to the staff's support and validation, reporting:

> …it was difficult for me at first because of everything I've been through but my staff originally started off being excellent for me. They were able to deal with everything I had

> to say without discounting it and I think that they were quite supportive and for the first several months everything was beautiful.

Client D then went on to describe how his St. Joseph Center case manager was promoted and he was not assigned a new case manager for six weeks, which prevented engagement for him during this time.

Client B, who reported a positive experience with St. Joseph Center and limited disengagement, described the client/provider relationship in terms of help, support and security, reporting:

> They've helped me with numerous things, I've actually volunteered too, but uh, they just, overall, it's been, it's been a really good experience. They've uh, I feel really good being here, I feel comfortable and safe here, and uh, it's just, it's a good place.

Case manager A also seemed to encourage client self-determination as a way of improving the client-provider relationship, and thus improving client engagement. Case manager A expressed that the more involved a client is in their progress and future, the more engaged they are with providers, reporting: "Yeah, so [being] supportive is like your main goal, you're basically just a passenger," meaning that the client should be the one to decide what their needs are and drive the direction of their treatment; the provider should support their client's decisions rather than decide where they should go.

Therapeutic alliance seemed to be a priority for the case managers when it came to engagement with clients. While all clients discussed engagement with St. Joseph Center in terms of their relationship with the agency and their experiences with staff, they did not specifically identify or address their relationship with case managers or providers when discussing engagement. The significance of this will be further explored later in our discussion.

Health and Mental Health

Health and mental health, specifically the presence of severe and chronic mental health symptoms or comorbid substance use, was also a recurring theme in our data, arising mainly from our interviews with case managers. All three case managers discussed health and mental health in some form as a barrier to engagement. Of the five clients interviewed, only client A described mental health and health issues that influenced their level of engagement.

While client A disclosed that problems with substance use landed them in the hospital, they reported that this had actually not impaired engagement with services, saying, "I had a problem with alcohol and I was in the hospital for withdrawal and then that is what led me to St. Joseph's. They actually came to the hospital and then they just have been...we've been meeting." Later in the interview, they went on to describe how St. Joseph Center had also assisted with medication support, which had significantly helped their functioning. Despite this report from the client, all three case managers described how it is very difficult to consistently engage clients when compounding health and mental health issues force them into different treatment or residential settings. The case managers further touched on how many of their clients struggle with a combination of health, mental health, and environmental barriers that sometimes make it difficult to locate or contact them. Case manager A reported that "health issues, incarceration, and mental health issues" can cause "client fall out," further stating: "sometimes clients just fall out because of any given circumstances, health issues, incarceration, mental health issues, and it's just kind of letting go of the idea of control and not personalizing it." Case

manager B reported similar compounding barriers during their interview, specifically related to client mental health, health and substance use, saying:

> A lot of barriers are, you know, with our clients with the mental, you know, because our clients, they have a tri-morbid of mental health, medical and substance abuse on top of being chronically homeless.

Case manager A and C also discussed how many of their clients have severe and chronic mental illnesses with symptoms that could prevent them from trusting staff, or cause them to avoid places or interactions that may be triggering to them. For example, case manager A reported:

> And sometimes their mental health just gets triggered by seeing someone with like a badge reaching out to them. So it's something that they're not used to sometimes, so kind of throws them off and just it becomes difficult to engage.

Case manager C identified similar experiences with clients with severe mental illness and engagement, reporting:

> It can be as simple as substance use, and as serious as mental health, right? Like, if you have pretty severe schizophrenia and the voices in your head are telling you "don't trust this person" they're not going to trust you because the voices have been with you longer than I have.

It is important to also think about this in the context of certain policy and practice barriers, such as high turnover rates and large caseloads. In order for clients with psychotic symptoms to really trust and engage with service individuals, they need strong rapport, frequent and consistent communication, and providers who really know and understand them and their conditions. If new staff members are constantly working with them, they are less inclined to trust and connect with their service provider, according to the reports from these case managers.

Discussion

Client disengagement presents a significant issue for community mental health agencies that serve some of the most vulnerable populations. By improving modes of engagement and addressing barriers to treatment utilization, agencies could increase revenue and morale, as well as reach a larger population of individuals struggling with their mental health and activities of daily living. Prior research on barriers to service engagement does not leverage both clients' and providers' perspectives on this issue in an open, informal, neutral format. Therefore, the experiences of the actual individuals utilizing and providing services should be used to inform service models and agency interventions. By targeting one agency, our research team was able to identify the individual, community and society level barriers and challenges for this specific staff and clientele. The results of this study revealed several findings that were consistent with existing literature, as well as two new findings that we did not anticipate. We envision that these findings will reveal new opportunities for St. Joseph Center, and similar agencies, to improve the efficacy of their service provision.

Therapeutic Alliance

One salient theme that stood out within our findings was the importance of therapeutic alliance and trust between client and case manager. As prior research indicated, positive therapeutic alliance between case manager and client, as well as the level of satisfaction a client has with their service provider, has the power to act as a preventative measure against client disengagement (Barrett et al., 2008; Swift et al., 2012). As some participants indicated, positive relationship building with their case manager was indeed an important influencer regarding level of engagement with St. Joseph Center's services. Similarly, all three case managers commented

on having difficulty engaging with clients who have had a negative experience with mental health providers in the past. St. Joseph Center's case managers might benefit from prioritizing relationship building with their clients, as it may positively impact their ability to provide consistent and meaningful services. One example of how this idea might be operationalized is by offering training and workshops to case managers that focus on rapport building techniques and establishing trust, specifically with the mentally ill client population.

Homelessness and Co-Occurring Disorders

As our review of literature suggested, homeless individuals tend to receive infrequent or inadequate services, often because case managers do not receive extensive training regarding how to best serve this population (Stergiopoulos et al., 2010). However, we found that the issue appears to result from a lack of resources required to address the needs of this population, rather than a lack of proper training about those needs. In the present study, two case managers described this exact issue, explaining that when a client is homeless, or holds no consistent residence, it becomes increasingly difficult and time consuming to locate and engage with them. Locating a client can ultimately lead to a depletion of valuable resources, such as time and funds, before ever having the opportunity to provide that individual with needed services; this not only takes away from the ability to have meaningful and consistent engagement with that particular client, but also with other clients on the case manager's caseload. St. Joseph Center's clients who face homelessness reported experiencing major financial challenges as well, such as being unable to afford transportation or cell phones, which would allow them to more easily communicate with their case managers.

Additionally, case managers in this study spoke to the difficulty of working with individuals who are experiencing other issues that often compound homelessness, such as substance use and mental illness. One case manager explained the importance of meeting a client's basic needs first, such as addressing medical issues or connecting them with substance abuse treatment or temporary housing. This task can require much time and effort and becomes the focus of the case manager's work, long before they can begin mental health service delivery. The solution to this problem likely involves increasing funding to the agency so that resources can be directed toward facilitating engagement more easily with homeless and hard to locate clients, though we recognize that acquiring funding is no easy task. A realistic and cost effective way to address this issue could involve St. Joseph Center compiling an updated list of resources and referrals to target specific problems that are commonly faced by their homeless clients, such as programs for financial assistance, temporary housing, and substance abuse treatment. Having a readily available and up to date list of resources for the agency's homeless or chronically mentally ill clients will allow case managers to quickly address these issues, leaving more time for them to focus on the client's more complex needs and problems.

Geographic Proximity

Another important theme that was consistent across both previously composed literature and our own findings was the importance of service accessibility and service center location. The issue of service inaccessibility was reported by both clients and clinicians at St. Joseph Center. This barrier is consistent with findings in previous literature, which noted that individuals reported a lack of providers in their area as a barrier to engaging in services (Slaunwhite, 2015).

We offer some specific suggestions to counter the negative impact of these barriers in the Implications for Policy and Practice section to follow.

Defining Engagement

The final, and perhaps most significant theme that emerged from our findings, is the inconsistency amongst client and case manager definitions of "client engagement." The purpose of this study was to investigate barriers to client engagement, yet we found a discrepancy in the way each participant understood the concept of client engagement. This theme of defining 'engagement' did not exist in the literature reviewed prior to the start of our own research. This disconnect between clients and case managers, as well as among St. Joseph staff, appears to hinder staff ability to uniformly address the issue at hand. Our team was surprised to find that several clients did, in fact, consider themselves to be well-engaged in services, while their case managers did not. This finding highlights the importance of forming a standardized definition of what it means to engage in services, so that case managers may enact a uniform approach to addressing disengagement and improving service utilization. Actionable solutions for client disengagement can be created by developing a mutual understanding of what client engagement means among staff members. The agency could host workshops to create a dialogue among its staff and generate a shared, clearly defined, understanding of client engagement from an organizational perspective, which could be used to inform agency practices with clients. Furthermore, St. Joseph Center could encourage, if not require, its staff to clearly communicate expectations with clients during the initial stages of treatment, explicitly defining specific goals and the general meaning of what it is to be engaged in services at this agency.

Limitations

While the design of this study offered numerous benefits, such as a richness in collected data due to the qualitative approach, it is important that we also address the study's limitations for best transparency. This research study interviewed clients and case managers from St. Joseph Center in the Greater Los Angeles region; although findings may have implications for lack of engagement among the adult mental health population, there are limitations to generalizing these findings to target populations in different regions. As the participants of this study were young to middle aged single adults, findings cannot be generalized to other populations such as children, families, or older adults as these populations may face different barriers to engaging in services that were not uncovered within this study. Other limitations of the research study included the short time frame of the project deadlines and the research team's restricted access to the study sample.

As the purpose of this research study sought to understand reasons for disengagement, the study sample inherently involved clients that were difficult to engage, for a variety of reasons. With this knowledge, the research team made repeated efforts to contact various identified clients but were unable to reach them. Furthermore, St. Joseph staff was responsible for gathering client consents before releasing their protected health information to the researchers. The researchers used strategic planning to contact clients and case managers to set up interviews in a timely manner. As the research team suspected, obtaining consents and beginning interviews with disengaged clients was a lengthy process. Additionally, as St. Joseph Center's staff gathered

the informed consents, some clients may have been initially reluctant to engage with the researchers.

This might explain, for example, the case of one client who was identified by the agency but declined to be interviewed once the researchers had arrived with the case manager at the client's chosen location to meet with researchers.

Finally, our data collection was cut short due to California's stay-at-home regulation during the COVID-19 pandemic. St. Joseph Center's staff members were required to temporarily stop client interaction due to the virus and therefore the researchers were unable to conduct further client interviews.

Direction for Future Research

The current research study uncovered various reasons for lack of engagement in mental health services from a client perspective; however, there is much more research to be done on this topic in order to truly understand the complexities of the barriers that clients face. Future research can contribute to the understanding of barriers that other populations face by focusing on populations such as children, families, and older adults. Further research that focuses on these populations might result in rich data regarding the impact that consistent childcare has on parental engagement in mental health treatment. Additionally, studies that focus on racial and ethnic minority populations could potentially uncover important pathways to more inclusive service delivery and improvements to service efficacy overall. Another important related topic to be explored that might result in fascinating data is how reported barriers may differ among mental health diagnoses (e.g. schizophrenia, bipolar disorder, depression, etc.). Furthermore,

future research can conduct qualitative interviews over a longer time frame to deepen an understanding for how client barriers may change over time. Lastly, future research can explore staff training and implementation of client engagement strategies as the current study found variation in definitions of client engagement and reported client barriers by case managers.

Implications for Policy and Practice

The research team was specifically recruited to investigate reasons for inconsistent client engagement amongst St. Joseph Center's client population, ultimately for the purpose of improving client engagement. The results of this study have many important implications for potential adjustments to the agency's policies and practices in several key areas: service center accessibility, case manager caseload, and staffing turnover.

Our findings suggest that better client engagement might result from improving accessibility of services. For many clients interviewed for this study, the physical location of the service facility, and the distance needed to travel to the site from client housing or resting areas, appeared to be a significant barrier to accessing offered services. This barrier to client engagement might best be resolved through the opening of additional service sites or satellite offices. While this solution may not be feasible given the financial burden of procuring and developing additional office space, increasing the ability for case managers to meet with clients remotely might result in similar outcomes while being mindful of the costs incurred. This might also be accomplished by allocating funds for providing clients with transportation to sessions, such as offering monthly bus passes for clients most in need of transportation-related assistance.

Better client engagement might also be addressed by decreasing individual case manager responsibility. As each case manager interviewed for the study detailed, the heavy caseload assigned to each case manager impedes their ability to make time for meaningful and consistent client engagement. Decreasing caseloads would serve to improve case managers' ability to meet the expectations of their clients, as well as improve overall service utilization. This could most easily be addressed through hiring additional case managers to share in the burden of managing open cases, thereby decreasing the number of active cases on each case manager's caseload and increasing the amount of available time for each case manager to meet with their clients. Again, we are aware of the financial implications of this suggestion.

Results of our study suggest that staff turnover also appears to negatively impact the ability for both clients and case managers to develop positive rapport and practice consistent engagement. Case managers identified the high demand for productivity and large caseloads as directly influencing the high turnover rate for St. Joseph staff. It goes without saying that an overloaded case manager cannot have sufficient time with each client to make expected progress and impact. Lack of job satisfaction created by a perceived inability to function at a high level and achieve success are likely factors that contribute to problems with staff retention (Green et al., 2014). Increasing staff numbers and decreasing caseloads might serve to improve staff retention in addition to increasing face-to-face client time as previously mentioned, both potentially improving rates of consistent client engagement. Prioritizing staff morale and strategizing for ways to provide additional support to staff members is another option targeted at improving staff retention if increasing staffing is not feasible. Moreover, increasing the amount

of client face-to-face time might also increase client willingness to engage with case managers through improved therapeutic alliance – an important influencer of client engagement detailed within our study.

Our findings underscore the significant impact that policy and practice models have on utilization management within community-based organizations. As our findings, and those of studies before us, have indicated, client engagement does not exist within a silo. Agency policies directly impact the ease with which case managers and clients practice meaningful and consistent engagement. Therefore, it is imperative that St. Joseph Center, and other similar community-based organizations, consider the impact that their policies and practice models have on their client outcomes.

Conclusion

The present study's research findings highlight important themes that can be applied to future research and clinical practice with community mental health populations in West Los Angeles. Prioritizing therapeutic alliance, accessibility, the identification of measurable goals that focus on clients' basic needs, and policies that allow for more manageable staff caseloads, are all areas in which St. Joseph Center can improve their services to address the problem of client disengagement. Client engagement is essential for the effective utilization of mental health services and understanding barriers to this utilization is a necessary step in reaching the individuals most in need of services. By not reaching these individuals in an effective way, agencies are limited in their ability to make an impact in their communities. We thank St. Joseph

Center for this unique opportunity to research the problem of client disengagement through in-person interviews, and we hope that our findings offer potential solutions to this issue.

Authorship Statement

This paper was made possible by the collaborative efforts of the research team. The introduction, personal and cultural barriers, and population sample were written by Chloe Horowitz; the environmental and systemic barriers, ethical concerns, and limitations sections were contributed by Nicole White; the severe mental health barriers and concepts and measures sections were authored by Sarah Katz; the internal organization barriers and included subsections, as well as the analysis plan and rationale were provided by Zachary Cecil. All members contributed equally to the research and written results, discussion, editing, and formatting of the final document.

Appendix A.

The following script was used to introduce participants to the research team and the study:

> "Hello, We are __ and ___ from the UCLA research team. We are partnered with St Joseph's Center to conduct a research study about client engagement with staff members and services. You were identified as someone who would potentially be interested in speaking with us. Your participation is voluntary and you may stop the interview at any time. You do not have to answer any questions in which you don't feel comfortable. Your name and info will not be included in our project and this interview will be confidential. Do you have about 10 minutes to speak with us and answer some questions related to your experience at St Josephs?"

All eight participants answered "yes." Researchers then asked each participant:

"Do you consent to us audio recording the interview so we can accurately reflect your experiences in our research project?"

> All eight participants answered "yes."

Appendix B.

The questions that were asked during the client interview included:

1. Tell me about your experience engaging with St Josephs.
2. What has prevented you from engaging with St Josephs?
3. What could St. Joseph's do to make it easier to engage in their services?

The questions that were asked during the case manager interview included:

1. What does client engagement mean to you?
2. Tell me about your experience engaging clients in services at St. Joseph's and any difficulties you may have faced.
3. About how many clients have you had challenges engaging in services?
4. What do you think is the biggest barrier to clients engaging in services?
5. What do you think would help improve client engagement?

Examples of potential follow up questions included:

- Do you feel comfortable providing more information about that?
- Where were you at that time?
- Was it difficult to connect with St. Joseph's at that time? Why or why not?
- What made it difficult for you to engage in services with St. Joseph's?

- Did you find that St. Joseph's was helpful?

Appendix C.

Table 1

(Categories of) codes representing treatment barriers

Code	Definition	Frequency
Geographic Proximity	**Access to services as it relates to distance required to travel to service center from housing or resting area**	**6**
Health & Mental Health	**Health and mental health complications or comorbidities**	**9**
Homelessness	**Currently or previously unhoused**	**10**

Policies & Practices	**Related to staff and client policies, including staff census, wages, provider fatigue, high caseloads, and lack of funding**	**24**
Systemic Barriers	**Barriers outside of the control of the agency or individual**	**8**
Therapeutic Alliance	**Forming a positive bond between case manager and client; establishing trust between case manager and client; ability to reach case manager when needed**	**12**
Transportation	**Ability to access services as it relates to ability to acquire means of transportation to service center**	**5**

Engagement	**Related to definition of engagement**	**5**

References

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842–852. https://doi.org/10.1037/0022-006X.75.6.842

Barrett, M. S., Chua, W.-J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, *45*(2), 247–267. https://doi.org/10.1037/0033-3204.45.2.247

Chen, R., Piercy, F. P., Huang, W.-J., Jaramillo-Sierra, A. L., Karimi, H., Chang, W.-N., … Antonio, A. (2017). A Cross-National Study of Therapists' Perceptions and Experiences Of Premature Dropout From Therapy. *Journal of Family Psychotherapy*, *28*(3), 269–284. doi: 10.1080/08975353.2017.1343067

Cheraghi, M. A., Sanjari, M., Bahramnezhad, F., Fomani, F. K., & Shoghi, M. (2014). Ethical challenges of researchers in qualitative studies: the necessity to develop a specific guideline. *Journal of Medical Ethics and History of Medicine* , *7*(14). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/pdf/jmehm-7-14.pdf

Chua W.-J., Barrett M. S. (2007).The influence of physical environment on engagement in psychotherapy; Paper presented at the annual meeting of the North American Society for Psychotherapy Research; New York. 2007.

Clarkin, J. F., Levy, K. N. (2003). The influence of client variables on psychotherapy. In: Bergin and Garfield (5th ed). *Handbook of psychotherapy and behavior change*. (pp. 194-226). New York: Wiley

Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., & Brown, C. (2010). Mental Health Treatment Seeking Among Older Adults With Depression: The Impact of Stigma and Race. *The American Journal of Geriatric Psychiatry*, *18*(6), 531–543. doi: 10.1097/jgp.0b013e3181cc0366

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, *177*(1), 4–7. doi: 10.1192/bjp.177.1.4

Dixon, L. B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*, *15*(1), 13–20. https://doi.org/10.1002/wps.20306

Festinger, D. S., Lamb, R. J., Marlowe, D. B., & Kirby, K. C. (2002). From telephone to office: Intake attendance as a function of appointment delay. *Addictive Behaviors*, *27*(1), 131–137. https://doi.org/10.1016/S0306-4603(01)00172-1

Fleury, M.-J., Ngamini Ngui, A., Bamvita, J.-M., Grenier, G., & Caron, J. (2014). Predictors of Healthcare Service Utilization for Mental Health Reasons. *International Journal of Environmental Research and Public Health*, *11*(10), 10559–10586. https://doi.org/10.3390/ijerph111010559

Gearing, R. E., Townsend, L., Elkins, J., El-Bassel, N., & Osterberg, L. (2014). Strategies to Predict, Measure, and Improve Psychosocial Treatment Adherence: *Harvard Review of Psychiatry*, *22*(1), 31–45. https://doi.org/10.1097/HRP.10.1097/HRP.0000000000000005

Gilmer, T. P., Stefancic, A., Ettner, S. L., Manning, W. G., & Tsemberis, S. (2010). Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness. *Archives of General Psychiatry*, *67*(6), 645–652. https://doi.org/10.1001/archgenpsychiatry.2010.56

Gorry, D., & Thomas, D. W. (2017). Regulation and the cost of childcare. *Applied Economics*, *49*(41), 4138–4147. doi: 10.1080/00036846.2016.1276275

Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012). Gaps and Barriers in Services for Children in State Mental Health Plans. *Journal of Child and Family Studies*, *21*(5), 767–774. doi: 10.1007/s10826-011-9529-1

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The Roles of Individual and Organizational Factors in Burnout among Community-Based Mental Health Service Providers. *Psychological Services*, *11*(1), 41–49. https://doi.org/10.1037/a0035299

Hampton-Robb, S., Qualls, R. C., & Compton, W. C. (2003). PREDICTING FIRST-SESSION ATTENDANCE: THE INFLUENCE OF REFERRAL SOURCE AND CLIENT INCOME, 12.

Harris, P. M. (1998). Attrition Revisited. *AMERICANJOURNAL OF EVALUATION*, 13.

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2016). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*, *139*(1). doi: 10.1542/peds.2015-1175

Jones, E., Lebrun-Harris, L. A., Sripipatana, A., & Ngo-Metzger, Q. (2014). Access to Mental Health Services Among Patients at Health Centers and Factors Associated with Unmet Needs. *Journal of Health Care for the Poor and Underserved*, *25*(1), 425–436. https://doi.org/10.1353/hpu.2014.0056

Jung, S. I., Serralta, F. B., Nunes, M. L. T., & Eizirik, C. L. (2013). Beginning and end of treatment of patients who dropped out of psychoanalytic psychotherapy, 11.

Kalibatseva, Z. and Leong, F. T. L. (2011). "Depression among Asian Americans: Review and Recommendations," Depression Research and Treatment, vol. 2011, Article ID 320902, 9 pages,. https://doi.org/10.1155/2011/320902.

Kiser, T., & Hulton, L. (2018). Addressing Health Care Needs in the Homeless Population: A New Approach Using Participatory Action Research. *SAGE Open*, *8*(3), 215824401878975. https://doi.org/10.1177/2158244018789750

Leong, F. T. L., & Lau, A. S. L. (2001). Barriers to Providing Effective Mental Health Services to Asian Americans. *Mental Health Services Research*, 2.

Manthei, R. J. (1996). A follow-up study of clients who fail to begin counselling or terminate after one session, 14.

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., … Kessler, R. C. (2011). Barriers to mental health treatment: results from the National Comorbidity Survey Replication. *Psychological Medicine*, *41*(8), 1751–1761. doi: 10.1017/s0033291710002291

Neighbors, H. W., Jackson, J. S., Campbell, L., & Williams, D. (1989). The influence of racial factors on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal*, *25*(4), 301–311. https://doi.org/10.1007/BF00755677

Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2005). Strategies for Reducing Patient-Initiated Premature Termination of Psychotherapy: Harvard Review of Psychiatry, 13(2), 57–70. https://doi.org/10.1080/10673220590956429

Priester, M. A., Browne, T., Iachini, A., Clone, S., Dehart, D., & Seay, K. D. (2016). Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review. *Journal of Substance Abuse Treatment*, *61*, 47–59. doi: 10.1016/j.jsat.2015.09.006

Rocovich, C., & Patel, T. (2012). Emergency department visits: Why adults choose the emergency room over a primary care physician visit during regular office hours? *World Journal of Emergency Medicine*, *3*(2), 91–97. doi: 10.5847/wjem.j.issn.1920-8642.2012.02.002

Rodenhauser, P. (1994). Cultural barriers to mental health care delivery in Alaska. *The Journal of Mental Health Administration* 21, 60–70 https://doi.org/10.1007/BF02521346

Roos, J. (2011). Left behind : A review of therapist and process variables influencing dropout from individual psychotherapy. https://doi.org/10.1037/e530142013-001

Rubin, A. & Babbie, E.R. (2017). *Research Methods for Social Work, 9th edition*. Cengage Learning.

Sareen, J., Jagdeo, A., Cox, B. J., & Clara, I. (2007). Perceived Barriers to Mental Health Service Utilization in the United States, Ontario, and the Netherlands. *PSYCHIATRIC SERVICES*, *58*(3), 8.

Sirles, E. A. (1990). Dropout from intake, diagnostics, and treatment. *Community Mental Health Journal*, *26*(4), 345–360. doi: 10.1007/bf00752725

Slaunwhite, A. K. (2015). The Role of Gender and Income in Predicting Barriers to Mental Health Care in Canada. *Community Mental Health Journal*, *51*(5), 621–627. doi: 10.1007/s10597-014-9814-8

Solway, E., Estes, C. L., Goldberg, S., & Berry, J. (2010). Access Barriers to Mental Health Services for Older Adults from Diverse Populations: Perspectives of Leaders in Mental

Health and Aging. Journal of Aging & Social Policy, 22(4), 360–378. doi: 10.1080/08959420.2010.507650

Sparks, W. A., Daniels, J. A., & Johnson, E. (2003). Relationship of referral source, race, and wait time on preintake attrition. *Professional Psychology: Research and Practice*, *34*(5), 514–518. https://doi.org/10.1037/0735-7028.34.5.514

Stergiopoulos, V., Dewa, C., Durbin, J., Chau, N., & Svoboda, T. (2010). Assessing the Mental Health Service Needs of the Homeless: A Level-of-Care Approach. *Journal of Health Care for the Poor and Underserved*, *21*(3), 1031–1045. doi: 10.1353/hpu.0.0334

Sue S., Wagner N., Ja D., Margullis C., Lew L. (1976). Conceptions of mental illness among Asian and Caucasian-American students. *Psychological Reports.* 38(3), 703–708.

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice*, *43*(4), 379–387. https://doi.org/10.1037/a0028291

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling Towards Disease: Transportation Barriers to Health Care Access. *Journal of Community Health*, *38*(5), 976–993. doi: 10.1007/s10900-013-9681-1

Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance Status, Use of Mental Health Services, and Unmet Need for Mental Health Care in the United States. *Psychiatric Services*, *66*(6), 578–584. doi: 10.1176/appi.ps.201400248