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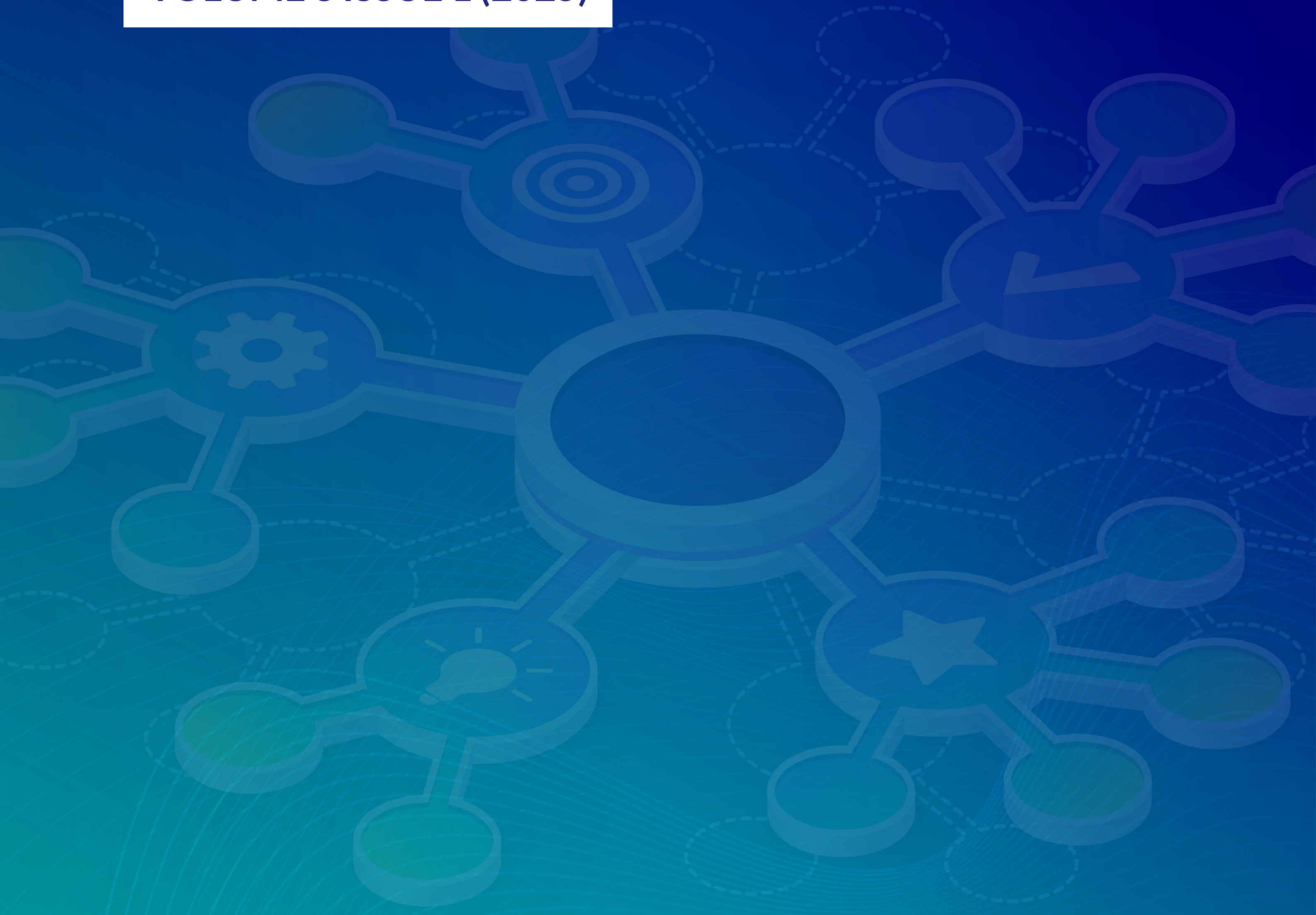

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Barriers to Accessing Mental Health Services among Schizophrenia Patients: A Qualitative Study on Patient Experiences and Systemic Challenges

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ABSTRACT

Schizophrenia is a serious mental illness that causes considerable social and personal dysfunction. The study aims to identify and analyze the barriers that schizophrenia patients face in accessing mental health services. A qualitative cross-sectional study design and semi-structured interviews were conducted with the consent of twenty schizophrenia patients who recently sought the services of a mental health facility. Recruitment was carried out through clinics, and support groups for hemochromatosis individuals. Transcripts of the interviews were analyzed using thematic analysis to establish common themes and care-related barriers. The analysis revealed five main barriers: organizational restraint, providers and systems, social and psychological, resource limitation, and improvement recommendations. The study supports patient-information-level and policy-level interventions on care integration, stigma, and mental health services. These barriers potentially construct mental health service usage and quality for consumers with schizophrenia, enhancing both health status and quality of life.

INTRODUCTION

Schizophrenia is a severe and long-term illness that impacts the thinking, mood, feelings, and behaviors of an individual. It can be diagnosed with a variety of signs and symptoms, such as delusions, hallucinations, disorganized speech, and affective flattening, which necessarily interfere with major life activities and social functioning (Harm *et al.,* 2013). The disorder typically begins in early adulthood, especially in the late teenage years, and the global prevalence estimations are about 20 million, with an incidence ratio of 1% (WHO, 2022). This condition requires ongoing intervention, which involves addressing social and work issues, disrupted interactions, and, in its worst case, turning off social marginalization forms (Van Os *et al.,* 2010). Some patients may have episodic flares of symptoms if the course of Schizophrenia is not clear. In contrast, others have a chronic deteriorative process; a consistent treatment of the illness is essential to monitor and treat.

As a mental disorder, Schizophrenia has a tremendous effect on the life of the patient and families in society. People with Schizophrenia lose their ability to care for themselves, work, and establish relationships and well-being; thus, they experience a profound social and economic impact (Galletly *et al.,* 2016). Cognitive dysfunctions remain clinically significant when other positive symptoms are effectively treated, which prevents recovery and limits functional improvements (Harvey *et al.,* 2012). Considering such factors, people with Schizophrenia need comprehensive mental health care that includes pharmacological treatment, psychotherapy, psychosocial rehabilitation, and support to increase functional capacities and recovery (Kane *et al.,* 2016). Schizophrenia requires services in the management of emotional disorders. The first-line treatment for Schizophrenia is an antipsychotic drug that helps to reduce symptoms and prevent their recurrence (Leucht *et al.,* 2013). On the other hand, medications require complementary therapeutic approaches such as cognitive behavioral therapy, social skills training, and supported employment programs to help improve clients' overall quality of life (Wykes *et al.,* 2008). Patients with Schizophrenia need to be encouraged to deal with the disease, including family interventions, peer support, and psychological interventions as mood corrective mechanisms (Pitschel-Walz *et al.,* 2001). Moreover, early intervention programs that use medication, therapy, and follow-up have efficacy for preventing further episodes of non-affective psychosis and comprehensive treatment for people who have their first episode of psychosis, showing the significance of early detection and treatment of mental disorders (McGorry *et al.,* 2008).

Neurocognitive deficits create significant obstacles that could make utilization of mental health services extremely challenging or unfeasible. Neuropsychological impairments regarding memory, attention, and calculation abilities limit patients' abilities to understand recommended treatments, take medications, and follow through with therapeutic regimens independently (Green, 1996). These cognitive challenges can be problematic for patients, who often lack a robust support system to manage their medication and reminders, remember appointments, and prevent hospital readmissions (Jääskeläinen *et al.,* 2013).

There are specific obstacles within the healthcare systems

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at the institutional level that hinder the access of SCH patrons to mental health services. These gaps inform the current study, which focuses on documenting and describing the main challenges faced by persons with Schizophrenia in accessing mental health services. This work analyzes the obstacles to access presented in the literature by examining individual and contextual factors. It will also explore details about how patients with schizophrenia experience such barriers in their daily processes as a way of revealing how to improve mental health service delivery for this population. These are significant barriers to identify to lessen the personal and societal cost burden of Schizophrenia and for increasing mental health disparity and quality of life among those diagnosed with Schizophrenia, a severe and persisting mental illness. Therefore, this study aims to identify and analyze the barriers that schizophrenia patients face in accessing mental health services.

LITERATURE REVIEW

Schizophrenia is well known to require attentive psychiatric care that includes access to mental health services. Many scholars find that there are numerous factors that either hinder or prevent proper care for clients diagnosed with severe mental illnesses. Schizophrenia patients especially experience certain obstacles in receiving mental health care primarily because of the very nature of this disease: it has cognitive and social aspects. It requires long-term, highly qualified treatment (Green, 1996). Besides, all these may worsen the impact of Schizophrenia on individuals, families, and healthcare facilities, pointing to the importance of studying and overcoming barriers to accessing care (Rossler *et al.,* 2005).

Thornicroft *et al.* (2017) argued that mental health organizations in low and middle-income countries are currently in big cities, and patients in rural areas cannot access care (Thornicroft *et al.,* 2016). Unlike this concentration, patients have limited access, delayed diagnoses and treatment interruptions, and higher stigma due to the limited community support. Services are even scarcer within high-income countries. The rural population has fewer specialized practitioners and fewer services or items related to Schizophrenia and other comparable severe mental illnesses (Saxena *et al.,* 2006).

Insufficient financial resources also emerge as a substantial concern, as the provision of mental health care for individuals with Schizophrenia generally entails considerable costs that may surpass the means available through insurance coverage or government health programs. Harvey *et al.* (2012) also argue that people with Schizophrenia are predisposed to socioeconomic disadvantages like lack of job, poor income, and dependence and disability benefits that make them ineligible to pay for care (Harvey *et al.,* 2012). Several research shows that high consumer charges, co-payments, and restricted insurance coverage for mental health services can be sources of considerable expenses, which render continual treatment unmanageable for lots of patients (Stuart, 2006). This results in discontinuity in care, non-adherence to treatment plans due to no attendant financial support, substance abuse, high incidences of relapse, and hospitalization (Corrigan *et al.,* 2014).

Some of the community barriers include stigma, which is another critical factor that affects the utilization of mental health services. Charles, a patient diagnosed with Schizophrenia, complained of discrimination, prejudice, and lack of understanding from society. According to Corrigan and Watson (2002), it was identified that the degree of Stigma of Schizophrenia is higher compared to that of other disorders, and patients are often seen as violent or uncontrollable and get excluded from their social or health care system (Corrigan *et al.,* 2002). It also leads to self-stigma that hinders them from seeking assistance and also impacts the perception of doctors towards Schizophrenia, which makes them offer substandard treatment because of the negative prejudice they have against such persons (Pescosolido *et al.,* 2013). Thornicroft *et al.* (2009) reveal that out of anonymous stigma, people with Schizophrenia can receive inadequate or discriminatory services in health facilities (Thornicroft *et al.,* 2009).

Furthermore, numerous papers described barriers on the individual and community levels, and Scarce studies addressed the system and organizational level in healthcare organizations. There is a lack of healthcare reimbursement policies, availability of resources, and issues arising from administration and polity significantly influence the availability of mental health care, especially for clients who have continued needs and disorders such as Schizophrenia (Saxena *et al.,* 2007). Stuart (2006) also stresses the fact that the significant challenge to be met is the policy level as other usual mental health programs remain an underfinanced and low priority on the health care system hierarchy, meaning that people with severe mental illness may find themselves with limited available resources, whether it is possible to identify the structural changes that would improve the availability of schizophrenic patients caring for psychiatrists that a more detailed look on the systemic concerns in the mental health systems is needed (Stuart, 2006).

MATERIALS AND METHODS

Study Design

The study adopted an explorative, descriptive, and phenomenological research approach focusing on the experiences of participants diagnosed with Schizophrenia in accessing mental health services. Based on the literature, one might suggest using qualitative methods is appropriate for studying personal and social aspects of health-related topics as it enables researchers to provide a richness and depth of participants' stories (Creswell & Poth, 2016; Patton, 2014). Indeed, the phenomenological paradigm was adopted to focus on participants' experiences and explore homeowners' perceived barriers and the systemic, social, and psychological factors affecting access to mental health facilities.

Participants and Sampling

A purposive sampling approach was used to identify individuals, diagnosed with Schizophrenia at least 6 months before the study, and who were enrolled in service in the previous year. Using purposive selection is appropriate in qualitative research since the participants selected should experience events that can be useful in addressing the research question (Palinkas *et al.,* 2015). Participants were recruited via mental health clinics, schizophrenia support groups, and discussion forums based on the topic of Schizophrenia. This approach was meant to use various techniques to get different ideas and compare differences in access barriers across contexts (Marshall & Rossman, 2014).

Total of 20 participants were involved, which aligns with the recommendation of the qualitative method literature, where the aim is the saturation point, a juncture where the data analysis does not bring any new ideas or themes into focus anymore (Guest *et al.,* 2006).

Data Collection

Information was gathered by conducting semi-structured interviews since they impose a modest structure to the study and offer maximum variability between interviews (Kvale, 2009). The interview guide was created using existing literature on factors that can hinder the utilization of mental health services among persons with Schizophrenia. It comprised questions likely to garner participants' accounts, the type of providers they had encountered, and any social or structural barriers.

All interviews were conducted separately and face-to-face or using secure online video communication to consider participants' preferences and practical circumstances. The interviews were recorded and conducted after obtaining participants' consent and lasted between 45 and 60 minutes each (Saldana, 2021).

Ethical Considerations

In adherence to our steadfast commitment to ethical principles, we ensured that every participant provided informed consent and implemented stringent measures to safeguard their identity and confidentiality.

Data Analysis

The study applied thematic analysis, a qualitative method used to identify, analyze, and report data patterns, using Braun and Clarke's (2006) six-phase approach (Braun & Clarke, 2006). This method is particularly appropriate for exploratory research due to its possibility of systematic coding without being rigid, which supports effective theme development (Braun & Clarke, 2012). The two independent researchers created other codes through ongoing code booking (Jackson & Bazeley, 2019). Researchers refined the index codes to be more interpretive when coding was underway, and themes started appearing. Subsequently, codes were categorized in superordinate categories to consider patterns observed and perceived as possible impediments to mental health service use.

A pilot interview with the whole research team to keep checking the themes with the data (Nowell *et al.,* 2017). After developing themes, the authors compared them with the coded data to determine the degree of their correspondence to participants' accounts. Nine subthemes were developed and elaborated through several analysis cycles in light of emergent concerns (Lincoln, 1985). For credibility, another researcher validated the themes by tallying a portion of the actual transcripts independently (Abuse & Administration, 2014).

RESULTS AND DISCUSSION

The analysis of the interviews produced the following themes and subthemes, which describe the problems of patients with Schizophrenia regarding mental health services usage. They are Structural Barriers, Provider and Systemic Constraints, Social and Psychological Constraints, Resource Constraints, and Possibilities for Enhancement. Both themes provide a distinctive view of participants' concerns.

Forced Exclusion: Structural Barriers to Service Utilization

Logistical barriers are cognate with the organizational and procedural factors that prevented mental healthcare service accessibility among the participant population regarding waiting time, geographical location, and costs. Child-focused structural discrepancies have also been reported in earlier studies exploring Mental Health Service utilization threats to the vulnerable population (Abuse & Administration, 2014).

Long Waiting Hours And Limited Service

Prolonged duration of access to care was an area of concern regarding overall therapeutic intervention, with participants experiencing long time gaps of several months to years. Prolonged time to get specialized health care is detrimental; according to Reavley and Jorm (2011), it increases stress and contributes to treatment interference (Reavley & Jorm, 2011).

"Getting an appointment can take me hours; sometimes, I've been on waitlists for months. By the time I see someone, it seems like I am back to square one of having to recount my symptoms to a doctor."

Another issue was the lack of specialists in schizophrenia treatment, which is a particularly acute problem in rural areas. This lack of specialists corresponds to boost supremacy mental form services, particularly for patients with cluttered afflictions harmonizing to, for example, Schizophrenia (Thornicroft *et al.,* 2009).

"There are still long waiting lists at most locations, so I've had to wait a long time between my sessions."

Geographic And Transportation Features

Rural or remote area users reported difficulty with travel, stating that because of distance and lack of transportation options, they rarely attend appointments. Studies show that geographical factors were frequently found to reduce the possibility of access to more regular mental health consultations, especially among those from rural areas (Breslau *et al.,* 2014).

"Getting to the clinic may take me several hours since I live in a rural area, and this will cause me to lose one day's salary every time."

Considering the patients who had to use public transport solutions, the lack of schedule coherence and high transport prices discouraged those persons from appointments, which, in turn, worsened their mental health condition. This can be attributed to transportation as a significant rural mental health care issue (Corrigan *et al.,* 2014).

"I always fail to honor appointments because I don't own a car, and few buses are available."

Taxation/Financial and Insurance Constraints

A significant factor was, for instance, finances, revealing that high out-of-pocket charges interfered with the regularity of therapy. Stuart (2006) has pointed out the role of financial pressure in accessing healthcare services for chronic diseases when treatment is required repeatedly and consistently (Stuart, 2006).

"Insurance doesn't cover some services, so I must find the balance by paying out-of-pocket many times."

Smaller networks of available providers also limited participants' choices as they had to go further and choose providers who were not as knowledgeable about Schizophrenia. Cost is the significant factors that limit access to mental health care, particularly for patients with multiple problems (Alegria *et al.,* 2008).

"I never went for therapy again since it was too costly for me."

Provider and System Factors' Constraints

It deals with participants' experiences with the providers and barriers encountered in the healthcare system. The participants mentioned the provider attitudes, personal characteristics, and organizational policies about continuity of care and paperwork as perceived barriers (Mead & Bower, 2000).

Lack of Empathy

High-risk clients were found to communicate often with providers about how they felt unlistened and unappreciated due to care providers' perceived hurried or unsympathetic demeanour. Provider empathy is crucial in gaining patients' trust and confidence, particularly in a mental health context (Prins *et al.,* 2008).

"Some service providers are polite while others don't appear to care or just give the impression that they are hearing."

Some participants complained that some of the providers were unaware of the specific needs of people with Schizophrenia, and this was leading to the provision of wrong treatment approaches. These results are similar to the conclusions made by Smith *et al.* (2013), who underlined the importance of providers' training and specialization in treating intricate mental disorders (Smith *et al.,* 2013).

"I get the impression they practice a lack of empathy. "

Co-ordinated and Sequential Care

Participants also described care as being fragmented because they were moved from one provider to another and from one department to another. Fragmentation is one of the significant challenges in the mental health domain that jeopardizes the continuity and outcomes of interventions (Thornicroft *et al.,* 2009).

"I was passed from one department to another, and it appeared that nobody was talking to each other, and I felt abandoned."

Administrative and Bureaucratic Burdens

Numerous patient participants stressed out administrative details, paperwork, pre-authorization, and referrals. This result supports past research that found that administrative healthcare structures hinder timely mental health care (SAMHSA, 2020).

"They owe me well-managed intake, but it wasn't efficient; I wasn't given proper instructions."

Psychological and Social Factors

Self-reported barriers were social: mental health-related stigma, low family involvement, and the use of self-management tactics due to a lack of formal care services. These barriers are often documented in research on mental health and stigma (Corrigan & Watson, 2002).

Stigma and Fear of Judgment

Schizophrenia-related stigma meant most participants felt ashamed to seek support, which deterred them. The stigma from family, friends, and even healthcare providers kept this individual isolated (Pescosolido *et al.,* 2013).

"I receive criticism from others; therefore, people see me as shy to explain my condition."

Limited Support of Family and Friends

Several participants received a lack of support or even stigmatization from their families regarding seeking mental health services for Schizophrenia. Lack of such family support dramatically affects mental health treatment compliance (Link *et al.,* 1997).

"I'm so frustrated about my family. They don't know much about my condition, and they sometimes tell me not to go for therapy."

Coping Alone

Since participants had limited access to formal support, sometimes the only coping strategies would be writing in a journal or listening to music. Although these tactics offered some assistance, they began to be realized as inadequate substitutes for expert care. These findings are similar to the study by Rosenfield (1997), which describes the failure of the independent relief model in coping with mental disorders without an organized structure (Rosenfield, 1997).

'To overcome such moments, I use music.'

Resource Limitations

As such, resource constraints mainly related to a shortage of qualified services and funding for mental health were the significant and recurring barriers in the users' report.

Absence of Specific Endowment and Support Groups

There was a limited availability of literature on such issues and the absence of schizophrenia support groups. The lack of such resources made them feel neglected and alone by other service users because mental health needs require specific attention (Thornicroft *et al.,* 2009).

"It is true that for people with schizophrenia, it is difficult to get support groups."

Lack of Appropriate Sources of Financial Support

Limited access to affordable treatment and a lack of viable financing schemes forced many of the participants to discontinue care. The financial constraints influence the rejection of subsequent mental health care (Stuart, 2006).

"Availability of funds to help the patient pay for his treatment is almost out of the question."

Ideas For Increasing the Chances

Participants made various suggestions to increase access related to the role model, including increasing empathy among providers, broadening the services offered, and increasing visibility.

Need for Provider Empathy and Understanding

The providers should listen more attentively to their clients. Empathy and the ability to comprehend clients are significant factors in trust-building within therapeutic relationships (Prins *et al.,* 2008).

"Patients should be heard without criticism, and people should not get tired of us."

Flexibility and Accessibility of Services

Proposals concerning advancements were made in the telemedicine segment, hours of operations, and neighborhood bolster centers regarding logistic challenges. These suggestions are consistent with the body of work suggesting enhanced fluidity of mental health care delivery to enhance usage (Breslau *et al.,* 2014).

"Online consult that I can have when I can't come to the office would go a long way."

Public Awareness and Anti-Stigma Initiatives

The participants discussed raising awareness campaigns that would dissuade people from avoiding help due to their fear of being stigmatized. Educating the community to reverse this effect and promote mental health Pescosolido *et al.,* 2013).

"Awareness of schizophrenia could minimize judgment and increase the likelihood of taking an individual to seek help."

Discussion

The study highlights the main facets of minority stress and service implementation of mental health among Schizophrenia, with an emphasis on structural, social, and cognitive factors that influence access and quality of care. Physical factors, including distance, cost, and lack of accessibility to cheaper services, were cited as significant challenges regarding structural factors, which aligns with other research on mental health care access (Breslau *et al.,* 2014). The patients in the rural areas suffer from a lack of psychiatric services and a scarcity of specialists. While travelling to these facilities, they are exposed to pressure, which results in high levels of relapse and re-hospitalization (Thornicroft *et al.,* 2016). Another critical challenge is financial constraints; the therapy costs are exceptionally high (Harvey *et al.,* 2012). Hypothesized Stake: Patients with low insurance and high out-of-pocket expenses have higher risks of treatment abandonment, impeding their health (Stuart, 2006).

Evolving prejudice and cultural attitudes about Schizophrenia delay recovery and deter patients from seeking care because they fear being stereotyped or discriminated against with stereotypes of patient violence or irrationality (Corrigan & Watson, 2002). This social stigma can be internalized, resulting in patients having fewer visits to healthcare centres (Pescosolido *et al.,* 2013). The healthcare personnel take these stigmatizing attitudes and offer substandard care to these patients (Thornicroft *et al.,* 2009). Thus, It is crucial to fight stigmatizing attitudes through continuing healthcare worker education through mandatory training programmes.

It also highlights the shortage of mental health interventions. In LMICs, scarcity of resources, stigma, and a lack of infrastructure compound the access challenges in the majority of patients with Schizophrenia worldwide (Thornicroft *et al.,* 2016; Saxena *et al.,* 2007).

Recommendations: Clinical and Public Health Policy Implications

In the study, the scholars suggest medical, psychological, and social interventions where one healthcare provider is responsible for the total caring of people with Schizophrenia. Improving organization and communication, i.e., limiting the number of forms to fill and simplifying the appointment schedule, can significantly improve access, including for patients with dementia. The successful implementation of mHealth applications can help maintain continuity of care for those unable to attend appointments. Patients with symptoms suggestive of COVID-19 and needing to avoid contact with healthcare workers will also benefit, as will the healthcare staff who no longer need to chase overdue appointments or remind their patients to schedule their medications. Schizophrenia-related educational intervention for healthcare providers that includes information on cognitive impairment and communication, respect, and empathy is essential in decreasing the stigma and improving the atmosphere around the patients. From a policy perspective, increased use of financial incentives to provide incentives to deliver services to underserved areas, telepsychiatry to extend services into rural areas, and service subsidies for people experiencing poverty can enhance access. Further, schizophrenic awareness campaigns to inform communities and increase understanding of Schizophrenia will make it easier to dismantle traditional stigma issues as a hindrance to treatment. The measures mentioned in clinical and policy measures will serve to improve the well-being of people diagnosed with Schizophrenia and to progress mental health in a more fundamental way.

REFERENCES

Alegría, M., Chatterji, P., Wells, K., Cao, Z., Chen, C.-n., & Takeuchi, D. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11), 1264–1272. https://doi.org/10.1176/ps.2008.59.11.1264

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). *Thematic analysis.* American Psychological Association.

Breslau, J., Marshall, G. N., Pincus, H. A., & Brown, R. A. (2014). Are mental disorders more common in urban than rural areas of the United States? *Journal of Psychiatric Research, 56*, 50–55. https://doi.org/10.1016/j.jpsychires.2014.05.004

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16–20.

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

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.

Galletly, C., Castle, D., Dark, F., Humberstone, V., Jablensky, A., & Killackey, E. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. *Australian & New Zealand Journal of Psychiatry, 50*(5), 410–472. https://doi.org/10.1177/0004867416641195

Green, M. F. (1996). What are the functional consequences of neurocognitive deficits in schizophrenia? *The American Journal of Psychiatry, 153*(3), 321–330. https://doi.org/10.1176/ajp.153.3.321

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Harvey, P. D., Heaton, R. K., Carpenter, W. T., Jr., Green, M. F., Gold, J. M., & Schoenbaum, M. (2012). Functional impairment in people with schizophrenia: Focus on employability and eligibility for disability compensation. *Schizophrenia Research, 140*(1–3), 1–8. https://doi.org/10.1016/j.schres.2012.03.025

Jääskeläinen, E., Juola, P., Hirvonen, N., McGrath, J. J., Saha, S., & Isohanni, M. (2013). A systematic review and meta-analysis of recovery in schizophrenia. *Schizophrenia Bulletin, 39*(6), 1296–1306. https://doi.org/10.1093/schbul/sbs130

Jackson, K., & Bazeley, P. (2019). *Qualitative data analysis with NVivo* (3rd ed.). SAGE Publications.

Kane, J. M., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., & Rosenheck, R. A. (2016). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, 173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

Kvale, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). SAGE Publications.

Leucht, S., Cipriani, A., Spineli, L., Mavridis, D., Örey, D., & Richter, F. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: A multiple-treatments meta-analysis. *The Lancet, 382*(9896), 951–962. https://doi.org/10.1016/S0140-6736(13)60733-3

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* SAGE Publications.

Link, B. G., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38*(2), 177–190. https://doi.org/10.2307/2955424

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research* (5th ed.). SAGE Publications.

McGorry, P. D., Killackey, E., & Yung, A. (2008). Early intervention in psychosis: Concepts, evidence and future directions. *World Psychiatry, 7*(3), 148–156.

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1–13. https://doi.org/10.1177/1609406917733847

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and Policy in Mental Health and *Mental Health Services Research, 42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications.

Pescosolido, B. A., Medina, T. R., Martin, J. K., & Long, J. S. (2013). The "backbone" of stigma: Identifying the global core of public prejudice associated with mental illness. *American Journal of Public Health, 103*(5), 853–860. https://doi.org/10.2105/AJPH.2012.301147

Pitschel-Walz, G., Leucht, S., Bäuml, J., Kissling, W., & Engel, R. R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia—A meta-analysis. *Schizophrenia Bulletin, 27*(1), 73–92.

Prins, M. A., Verhaak, P. F. M., Bensing, J. M., & van der Meer, K. (2008). Health beliefs and perceived need for mental health care of anxiety and depression—The patients' perspective explored. *Clinical Psychology Review, 28*(6), 1038–1058. https://doi.org/10.1016/j.cpr.2008.02.009

Reavley, N. J., & Jorm, A. F. (2011). Young people's stigmatizing attitudes towards people with mental disorders: Findings from an Australian national survey. *Australian & New Zealand Journal of Psychiatry, 45*(12), 1033–1039. https://doi.org/10.3109/00048674.2011.621060

Rosenfield, S. (1997). Labeling mental illness: The effects of received services and perceived stigma on life satisfaction. *American Sociological Review, 62*(4), 660–672. https://doi.org/10.2307/2657432

Rössler, W., Salize, H. J., Van Os, J., & Riecher-Rössler, A. (2005). Size of burden of schizophrenia and psychotic disorders. *European Neuropsychopharmacology, 15*(4), 399–409. https://doi.org/10.1016/j.euroneuro.2005.04.009

Saldaña, J. (2021). *The coding manual for qualitative researchers* (4th ed.). SAGE Publications.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: Scarcity, inequity, and inefficiency. *The Lancet, 370*(9590), 878–889. https://doi.org/10.1016/S0140-6736(07)61239-2

Smith, T. E., Easter, A., Pollock, M., Pope, L. G., & Wisdom, J. P. (2013). Disengagement from care: Perspectives of individuals with serious mental illness and of service providers. *Psychiatric Services, 64*(8), 770–775. https://doi.org/10.1176/appi.ps.201200463

Stuart, H. (2006). Mental illness and employment discrimination. *Current Opinion in Psychiatry, 19*(5), 522–526. https://doi.org/10.1097/01.yco.0000238482.27264.0d

Substance Abuse and Mental Health Services Administration. (2014). *National survey on drug use and health.* U.S. Department of Health and Human Services.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *The Lancet, 373*(9661), 408–415. https://doi.org/10.1016/S0140-6736(08)61817-6

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry, 15*(3), 276–286. https://doi.org/10.1002/wps.20349

Van Os, J., Kenis, G., & Rutten, B. P. (2010). The environment and schizophrenia. *Nature, 468*(7321), 203–212. https://doi.org/10.1038/nature09563

World Health Organization. (2022). *Schizophrenia.* https://www.who.int/news-room/fact-sheets/detail/schizophrenia

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin, 34*(3), 523–537. https://doi.org/10.1093/schbul/sbm114