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A community-based rehabilitation program for youth with mental health conditions: a qualitative study protocol

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Manuscripts

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6 A community-based rehabilitation program for youth with mental health
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8 conditions: a qualitative study protocol
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14 Hila Tuaf¹ and Hod Orkibi¹
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19 ¹ School of Creative Arts Therapies, Faculty of Social Welfare and Health
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21 Sciences, University of Haifa, Israel
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30 Corresponding author: H. Orkibi, University of Haifa,
31
32 199 Aba Khoushy Av., Mount Carmel, Haifa 3498838, Israel
33
34

35 horkibi@univ.haifa.ac.il
36
37

38 Cell: +972544393621
39

40 ORCID ID: <https://orcid.org/0000-0003-1498-7953>
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Abstract

Introduction: In Israel, 12% of all adolescents cope with mental health conditions. Approximately 600 adolescents with mental health conditions are hospitalized each year and about 40% of them return to the hospital and are thus cut off from their daily lives and peers in the community. In contrast to adults, youth with mental health conditions in Israel are not eligible by law for rehabilitation services. Thus, the overarching goal of this qualitative study is to generate a best practice model for the implementation of community-based psychosocial rehabilitation program for this population by examining *Amitim for Youth*, the first program in Israel established in 2018 by the Israel Association of Community Centers in cooperation with the Ministry of Health, the Ministry of Education, and the Special Projects Fund of the National Insurance Institute.

Methods and analysis: Qualitative data will be collected through in-depth semi-structured interviews and focus groups. To identify themes and patterns in the data, the 6-stage thematic analysis approach will be used. A triangulation procedure will be conducted to strengthen the credibility of the findings collected by different methods and from different types of stakeholders in the program: the program's decision makers, team, intended beneficiaries and referring mental health professionals. To insure the trustworthiness of the findings, three strategies will be employed: memos writing, reflexive journaling, and member checking.

Ethics and dissemination: This study was approved by the Ethics Committee for Human Research in the Faculty of Social Welfare and Health Sciences at the University of Haifa (#455-18) and by the Chief Scientist in the Ministry of Education (#10566). All participants will sign an informed consent form and will be guaranteed confidentiality and anonymity. Data collection will be conducted in the next two years

(2019-2020). After data analysis, reports will be written, and articles will be submitted for publication.

Strengths and limitations of this study

- This is a pioneering study that will examine a community-based psychosocial rehabilitation program for youth with mental health conditions in Israel.
- The findings will offer a best practice model to meet the needs and goals of all stakeholders by addressing potential barriers and facilitators for program implementation.
- The findings can contribute to policy recommendations and legislation in the field of adolescent psychiatric rehabilitation.
- Recruiting adolescents with mental health conditions can be challenging due to their condition and motivation.
- Recruiting referring mental health professionals can be challenging due to a poor continuity of care between services.

Keywords: adolescents, youth, psychiatric rehabilitation, mental illness, mental health, recovery, community.

Introduction

Youth with Mental Health Conditions (MHC)

Adolescence is characterized by physiological, psychological and social changes that are known to be associated with many challenges.^{1,2} According to Erikson's psychosocial developmental theory,³ adolescents are in the "identity versus role confusion" stage, where they search for personal identity and strive for independence through the exploration of social roles, personal values, beliefs and goals while distancing themselves from their parents. For adolescents with MHC (i.e., who cope with a psychiatric diagnosis) this developmental task is even more complex and may lead to a lack of identity formation or a negative identity.² Adolescents with MHC may also have to deal with maladaptive thoughts, dysregulated emotions and behaviors which may impact their interaction with peers and family members, academic performance, and in severe cases may involve loss of contact with reality.⁴ Therefore, it is important to differentiate between adolescents who are coping with age-appropriate challenges and adolescents who are coping with MHC.

Another challenge that adolescents with MHC may face is coping with stigma. The mental health literature distinguishes between public stigma and self-stigma. Public stigma refers to negative labeling (stereotype, prejudice and discrimination) of a group of people in order to distance them from society, whereas self-stigma (also termed "internalized stigma") refers to the internalization of those negative labels in a way that changes people's self-perception.⁵ While there is ample evidence that youth with MHC experience public stigma,^{6,7} self-stigma is under-investigated and insufficiently understood in adolescents with MHC.⁸⁻¹⁰ In some studies adolescents' self-stigma has been associated with reduced self-esteem,¹¹ limited social interactions, secrecy, shame,¹² and less adaptive coping strategies.¹³ Recent qualitative findings

1
2
3 suggest that adolescents' decisions to disclose their MHC is highly influenced by fear
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5 of stigma.^{15 14}
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8 A worldwide meta-analysis study showed that 13% of all adolescents cope with
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10 MHC.¹⁶ In Israel, from 1993 to 2016 there was an increase of 130% in the number of
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12 children and adolescents who were admitted to psychiatric hospitals. In 2016, 767
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14 adolescents aged 12 to 17 were admitted to these hospitals.¹⁷
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16
17 A bill entitled "Rights and Services for Children and Adolescents with Mental
18
19 Difficulties" was submitted to the Israeli Knesset for the first time in 2014.¹⁸ The
20
21 purpose of the bill was to:
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24 ensure the rights of children and adolescents with mental disabilities
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26 to rehabilitation and care in the community, in such way as to provide an
27
28 appropriate response to their special needs and enable them to integrate
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30 into the community as their peers do, while utilizing their abilities to the
31
32 fullest.
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35 The bill stressed that children and adolescents must be provided with services in the
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37 community, including leisure activities, care and guidance by counselors from the
38
39 field of mental health, and include the provision of information, practical and
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41 emotional support, and assistance in imparting life and social skills.¹⁸ However, to
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43 date this bill has not passed and youth with MHC in Israel thus remain without
44
45 legislated state supported rehabilitative psychosocial services in the community.
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49 **Services for Youth with MHC in Israel**

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51 Adolescents with MHC are provided with different services than those for
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53 adults given their different needs and because the "Rehabilitation in the Community
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55 of Persons with Mental Disabilities Law of 2000" applies only to adults aged 18 and
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57 over.¹⁹ In Israel, there are three main ministries that provide services to children and
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2
3 adolescents with MHC. The Ministry of Health is responsible for the medical
4 treatment provided by mental health clinics and in psychiatric hospitals. The Ministry
5 of Labor, Social Affairs and Social Services is responsible for out-of-home care (post-
6 hospitalization boarding schools). The Ministry of Education is responsible for
7 educational services within the school system (providing personalized educational and
8 psychological services), home-schooling and in out-of-home settings. However, the
9 division of responsibility across the ministries is unclear and coordination is poor.
10 Particularly problematic is the fact that there is no centralized system for creating a
11 shared database for use by all three ministries.
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24 The proposed study will investigate *Amitim for Youth*, the first community-
25 based psychosocial rehabilitation program for youth with MHC in Israel. *Amitim for*
26 *Youth* was established in 2018 by the Israel Association of Community Centers in
27 cooperation with the Ministry of Health, the Ministry of Education, and the Special
28 Projects Fund of the National Insurance Institute. The overarching goal of this study is
29 to generate a best practice model for the implementation of community-based
30 psychosocial rehabilitation program for youth with MHC. More specifically, the study
31 will: (1) identify barriers and facilitators for implementation of youth psychosocial
32 rehabilitation in the community, (2) characterize the continuity of care, or lack
33 thereof, between the referring mental health professionals (MHP) and the program;
34 (3) identify the needs of youth participants and their parents, program team, and
35 referring MHP; (4) assess the satisfaction of youth participants and their parents with
36 the overall program and its components; (5) characterize the services in the program
37 and their value according to youth participants.
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The Recovery Approach

For many years, the medical approach in the Western mental health system has been dominant. It views people with MHC as “patients” who should be hospitalized for prolonged periods to reduce their symptoms.²⁰ In recent decades, the rehabilitation policy of the mental health systems has been influenced by the Personal Recovery Approach which is based on the “person-centered” principle.²¹ This approach focuses on integration into the community, improving quality of life, restoring a sense of control, autonomy, choice, meaning, independence as well as responsibility and hope despite the person's symptoms.^{20 21} Accordingly, personal recovery is not measured in terms of a reduction in symptoms or by a return to the state prior to the mental crisis, but rather by the ability to rebuild a personal identity and live a meaningful life, with satisfying social roles and a sense of inclusion in the community.^{22 23}

In Israel, the transition from the medical approach to the recovery approach has been reflected in several significant changes in the attitude of the state and society towards people with MHC. One of the main changes involved the enactment of the "Rehabilitation in the Community of Persons with Mental Disabilities Law of 2000" that provides a package of rehabilitation services to adults with MHC coping with a significant dysfunction in their life and who are eligible for these services according to criteria determined by law.²⁴ This law has contributed to increased integration of these individuals in the community which also reduced prolonged hospitalization and residence in institutions.²⁴ Changes in the attitude of the state and society to people with MHC has led to initiatives to establish a variety of programs for community-based rehabilitation. One of these programs is the *Amitim* program for adults.

Amitim for Youth

In 2001, the *Amitim* program for adults was established out of commitment to the abovementioned law for the inclusion of adults (aged 18+) with at least a 40% mental disability as determined by the National Insurance Institute.¹ The *Amitim* program is the outcome of cooperation between the Ministry of Health and the Israel Association of Community Centers and operates currently in 77 community centers across the country with about 3000 participants with MHC.

In January 2018, a pioneering *Amitim for Youth* program was launched by the Israel Association of Community Centers in cooperation with the Ministry of Health, the Ministry of Education, and the Special Projects Fund of the National Insurance Institute. An inter-ministerial steering committee that consists of representatives from each of these stakeholders was involved in the founding of the program and its initial implementation. The program provides a response to the absence of community-based psychosocial rehabilitation services in adolescents' after-school leisure time. The program consumers are adolescents (aged 12-18) who have a psychiatric diagnosis and are identified in the education system as those with "code 57". The programs' pilot began gradually in six geographical districts near psychiatric hospitals which have a youth department (Haifa and Beer-Sheva), and near special education schools for children with MHC (Rehovot, Netanya, Petah-Tikva and Carmiel). In each district, there is a coordinator who provides services to about 20 adolescents in the local community centers. Each adolescent in the program is provided with a stipend (1,200 Israeli shekels per year) for participation in leisure activities in the community. The

¹ The National Insurance Institute in Israel (NII) determines the disability level (from 0–100%) under the provisions of clauses 33 or 34 of the appendix to the NII Regulations for Determining the Level of Disability. For instance, a 40% mental health disability refers to a person in a post-psychotic condition with significant signs of impairment, limitation of work capacity, and significant disruption of behavioral, mental, and social functioning. See: https://www.health.gov.il/English/Topics/Mental_Health/rehabilitation/Pages/sal.aspx

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3 goals of *Amitim for Youth* relate to three dimensions: youth, their family, and the
4
5 wider community. For youth, the goals are to foster socialization and a sense of
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7 belonging to the community, the ability to cope with self-stigma, prevention of
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9 repeated hospitalizations and shorter hospitalization duration, return to age-
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11 appropriate functioning according to personal goals and finding a meaningful activity
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13 that will lead to satisfaction and self-actualization. For the family, the goal of the
14
15 program is to provide support by the program's coordinator. Finally, the goal for
16
17 members of the community at large is to change attitudes towards youth with MHC
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19 by raising awareness.
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23 24 **Research Questions**

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26 The following research questions will be explored. They relate to:
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28 infrastructure, implementation, and continuity of care.
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31 **Program infrastructure:** (1) What characterizes the referral procedure
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33 to the *Amitim for Youth* program, and what are its barriers and facilitators factors? (2)
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35 What characterizes youth who participate in the program? (3) What is the demand for
36
37 the various components offered by the program? What services are offered to the
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39 participants and how do they perceive them? What services are missing from the
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41 participants' point of view?
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45 **Program implementation:** (4) how is the program implementation experienced by
46
47 the stakeholders? (5) What are the barriers and facilitators factors for program
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49 implementation according to the adolescents themselves (participants and dropouts),
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51 parents, team members and referring MHP? (6) What best-practice guidelines emerge
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53 from the perspective of all actors involved?
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56 **Continuity of care:** (7) What characterizes the relationship between the referring
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58 MHP and the program team in the community? (8) What best practice guidelines
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3 emerge from the interface between referring MHP and community-based services
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5 according to the actors involved?
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8 **Methods and Analysis**

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10 The proposed qualitative study is situated between the pragmatic and
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12 constructivist paradigms.²⁵ The pragmatic paradigm “focuses primarily on data that
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14 are found to be useful for stakeholders”.²⁵ It has been defined as a real-world practice-
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16 oriented framework that focuses on useful applications (“what works”) and practical
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18 solutions to problems, to gather information and insights on what is relevant to the
19
20 stakeholders.^{26 27} The constructivist paradigm “focuses primarily on identifying
21
22 multiple values and perspectives”.²⁵ Accordingly, a close interaction with the
23
24 stakeholders will be established to better understand their experiences, by taking the
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26 multiple perceptions of the different stakeholders of the program into consideration.²⁵
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26 The two paradigms complement one another, given the fact that their boundaries
are permeable.²⁵

35 **Participants**

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38 As can be seen in Figure 1, the participants in this study will be composed of
39
40 the following six groups of stakeholders: (1) the program decision makers, who
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42 include the program commissioners and funders from different ministries, who are
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44 members of the program's inter-ministerial steering committee; (2) the program team,
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46 which includes coordinators and volunteers; (3) the intended beneficiaries of the
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48 program; namely, adolescents enrolled in the *Amitim for Youth* program for at least
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50 three months; (4) parents of these adolescents; (5) adolescents who dropped out of the
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52 program, and (6) referring MHP from clinics, hospitals, and schools. Each of the six
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54 groups will have about 6-12 participants which is an acceptable number in qualitative
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56 research.
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-Insert Figure 1 about here-

Figure 1. The six groups of participants.

Procedure

The study will follow a *maximum variation sampling* approach of purposefully selecting a wide range of cases to document diversity and common patterns on dimensions of interest,²⁶ and achieve data saturation until no new relevant knowledge can be obtained from new participants. The research team will reach out by phone to the abovementioned program stakeholders (i.e., decision makers, team members, referring MHP) to invite them to participate in the study. Those who provide their written informed consent will be interviewed at their workplace or on the phone, at their convenience. Parents and adolescents will be approached by the program coordinators who will give the parents a formal letter explaining the study and an informed consent form for the parents' and/or the teens' participation. Only those parents who provide their consent will be contacted by the research team to schedule interviews at their community center or homes, at their convenience. The researchers will also attend the meetings of the program's inter-ministerial steering committee (participants in group 1 above) to document their perspectives and interactions.

Data Collection

Semi-structured in-depth interviews. Adolescents (participants and dropouts) and their parents will be invited to participate in individual interviews, to better understand their subjective experiences.²⁸ Examples of questions for the adolescents in the program and their parents include: What is important to you to get from the program? What do you suggest maintaining or strengthening in the program? And what do you think should change? Has the program contributed to you and how? Examples of questions for the adolescents who dropped out: How did you experience

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3 the program? What relationship would you have liked to have with the coordinator of
4 the program (frequency, satisfaction)? What made you leave the program, what could
5 have helped you stay?
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10 The referring MHP will be interviewed to characterize and evaluate
11 recruitment processes and contacts with the program team. For example: What
12 characterizes the adolescents you refer to the program? Describe the process of
13 referring adolescents to the program: How is it conducted, what factors help you
14 decide, what can be improved? Are you updated by the program team about the
15 adolescents you referred to the program? And if so, how does this take place and for
16 what length of time?
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26 Members of the steering committee will be interviewed to assess the formation
27 and implementation of the program, for example: What difficulties, challenges and
28 dilemmas did you encounter during the setting up and implementation of the
29 program? What can be improved and how? What is missing from the program? The
30 interviews will be conducted by the first author (HT) and will last roughly 60-90
31 minutes.
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40 **Focus groups.** Each of the program teams (i.e., coordinators and volunteers)
41 will be invited to attend focus groups, to express their impressions of the training, the
42 program implementation, as well as their relationship with the participants
43 (adolescents and their parents) and with the referring MHP. The advantages of focus
44 groups are that each participant can express his/her opinion, in a collaborative forum
45 that enables an exchange of different points of view, diverse interpretations, personal
46 and collective experiences, in an honest and open discussion, without fear of criticism
47 or censorship.²⁹ Examples of questions for the coordinators and volunteers: What
48 preparation and training did you get to work/volunteer in the program? What
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3 difficulties, challenges and dilemmas have you encountered in the program? What is
4 your role definition? Is it clear to you? Describe the relationship with adolescents and
5 their parents (nature, frequency, content). Note that to minimize social desirability,
6 individual interviews will also be conducted that may provide a deeper understanding
7 of each coordinator's personal experience. Focus groups will be conducted by the first
8 author (HT) and will last 90 minutes.
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17 **Sociodemographic questionnaire.** Adolescents will complete a
18 sociodemographic questionnaire on their age, gender, country of birth, religion, length
19 of time participating in the program, and number of days a week participating in the
20 program. The sociodemographic questionnaire for parents will include questions about
21 socioeconomic status, marital status, their child's medical history and whether their
22 child takes psychiatric medication.
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30 **Data Analysis**

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33 The qualitative data collected from the interviews and focus groups will be
34 recorded and transcribed. To identify themes and patterns in the data, the 6-stage
35 thematic analysis approach will be used, which is comprised of familiarization with
36 and immersion in the data, coding of the data, constructing initial themes, reviewing
37 themes, defining and naming themes, and writing up the report with illustrative data
38 extracts.³⁰ This thematic analysis procedure will be used within the pragmatic and
39 constructive frameworks. The analysis will include looking for best practice
40 guidelines from the perspectives of the different stakeholders in the program.^{26 27}
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Meaning and experience will be examined at both semantic and latent levels. The
checklist for good thematic analysis will be used as a guide to ensure an analysis that
is rigorous and robust.³¹ The data analysis procedure will be conducted by the first
author (HT) and assessed by second author (HO); disagreements will be resolved by

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3 discussion. A qualitative data analysis software (ATLAS.ti v8) will be used for data
4 management and analysis.
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8 To strengthen the credibility of the findings, a triangulation procedure will be
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10 conducted with the qualitative data that will be collected by different methods
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12 (individual interviews and focus groups) and from different types of stakeholders in
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14 the program: the program's decision makers, team, intended beneficiaries, and
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16 referring MHP.^{27 32}

17 18 19 **Study Trustworthiness**

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21 To strengthen the trustworthiness of the findings in addition to the
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23 triangulation, three strategies will be employed, as suggested in the qualitative
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25 research literature.³² Memo writing will be used to record decision-making, the
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27 process of meaning extraction from the data and subsequent conceptual development,
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29 as well as to facilitate continuous communication within the research team.³³ A
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31 reflexivity journal will be used to gain and maintain self-awareness of the researcher's
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33 perspective and its potential impact on the research process and interpretation of the
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35 findings.³² To increase the credibility of the research, member checking will be held
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37 (also known as participation validation). In this procedure, the findings will be
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39 presented to the participants who will be asked to respond whether they reflect their
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41 experience, meanings, and perspectives.^{32 34} Finally, to enhance the rigor of the study
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43 we will use the 32-item checklist for interviews and focus groups of the Consolidated
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45 Criteria for Reporting Qualitative research (COREQ; see online supplementary file).³⁵
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50 51 **Discussion**

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53 To date, youth with MHC in Israel are not eligible for community-based
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55 psychosocial rehabilitation services by law, despite the rising need. No study has
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57 examined a similar community-based psychosocial rehabilitation program for youth
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3 with MHC in Israel. The implementation of this type of program can be challenging
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5 because of the pioneering nature of the program and the specific nature of its target
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7 population: adolescents who do not only face age-related challenges but are also
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9 coping with MHC. Thus, recruiting adolescents with MHC to participate in this
10
11 research might be challenging given their condition and motivation. Recruiting
12
13 referring MHP to participate in the study might be complex possibly due to
14
15 inconsistent continuity of care, which refers to the way mental health consumers
16
17 perceive and experience their care services as connected and coherent, for example
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19 between hospital and community services.³⁶ In children and adolescents, coordination
20
21 between different services is crucial because they are going through multiple service
22
23 transitions and are therefore more vulnerable to the risks of discontinuity.
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29 The findings will provide a best practice model to optimize the operation and
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31 implementation by service providers, enhance the service contribution to the
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33 consumers (adolescents and their parents) while meeting their needs and goals, and
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35 inform policy makers. Specific attention will be paid to addressing the potential
36
37 barriers and facilitators for effective program implementation. The findings may
38
39 ultimately serve as a basis for currently under-developed policy recommendations and
40
41 legislation in the field of adolescent psychiatric rehabilitation.
42
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44 **Ethics and dissemination**

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47 The study in its current design was approved by the Ethics Committee for
48
49 Human Research in the Faculty of Social Welfare and Health Sciences at the
50
51 University of Haifa (#455-18), and by the Chief Scientist in the Ministry of Education
52
53 (#10566). All participants will sign an informed consent form and will be guaranteed
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55 confidentiality and anonymity. Adolescents' participation will be obtained by their
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57 parents or guardians, which will also be signed by the child. Data collection will be
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3 conducted in the next two years (2019-2020). A report in Hebrew will be submitted to
4
5 the National Insurance Institute. The results will be disseminated in articles that will
6
7 be written in English as part of a doctoral dissertation.
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10 **Authors' contributions:** Both authors contributed equally to the conceptualization
11
12 and design of the study. HT contacted the literature review that was examined and
13
14 approved by HO. Both authors read and approved the final manuscript.
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16

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18
19 16343).
20
21

22 **Competing interests:** The authors declare that they have no competing interests. The
23
24 funding body will have no role in data collection, analysis, interpretation, or
25
26 publications.
27
28

29 **Patient and Public Involvement:** We did not involve patients or the public in our
30
31 work.
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34 **Consent for publication:** Not applicable
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37 **Word count:** 3475.
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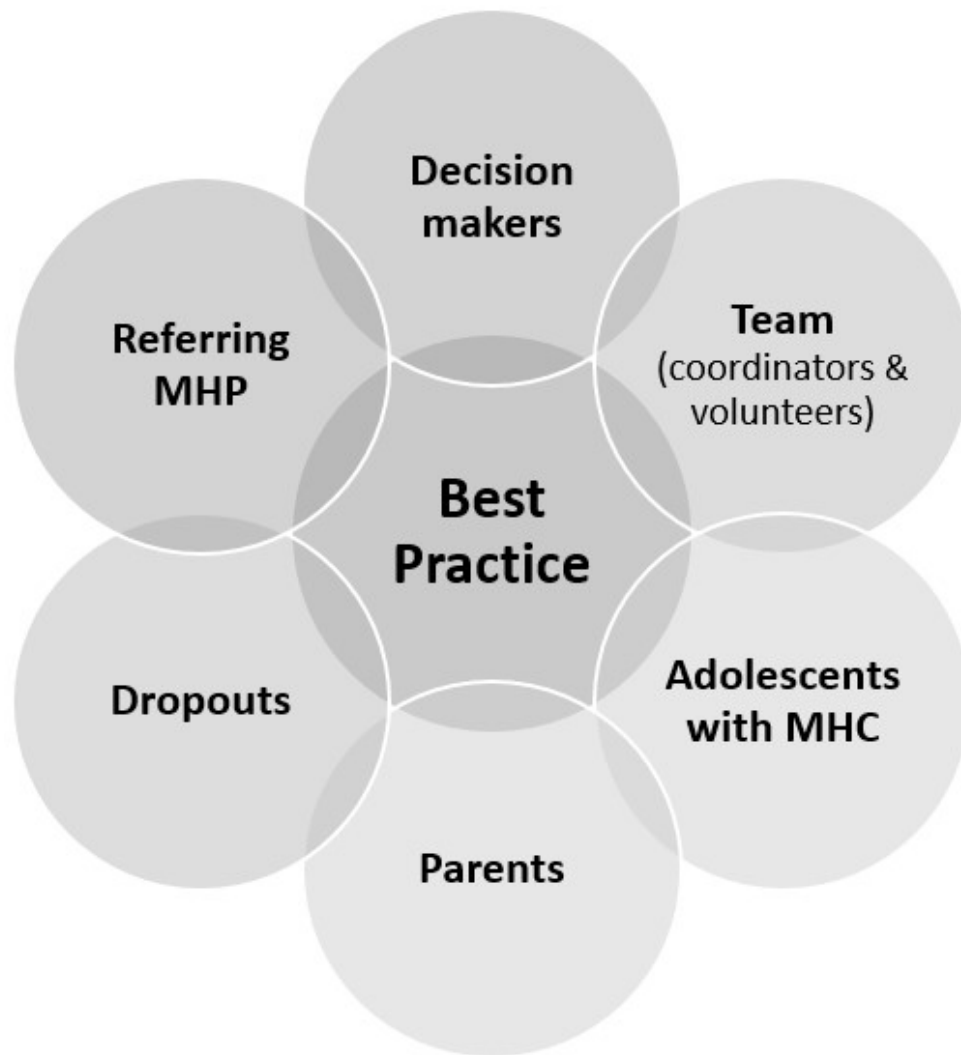


Figure 1. Six groups of participants in the study

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

Tuaf, H. & Orkibi, H. (2019). A community-based rehabilitation program for youth with mental health conditions: A qualitative implementation study protocol.

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|--|--------------------|
| Domain 1: Research team and reflexivity | | | |
| Personal characteristics | | | |
| Interviewer/facilitator | 1 | Which author/s conducted the interview or focus group? | 12 |
| Credentials | 2 | What were the researcher's credentials? E.g. PhD, MD | 16 |
| Occupation | 3 | What was their occupation at the time of the study? | 16 |
| Gender | 4 | Was the researcher male or female? | 16 |
| Experience and training | 5 | What experience or training did the researcher have? | 16 |
| Relationship with participants | | | |
| Relationship established | 6 | Was a relationship established prior to study commencement? | 10-11 |
| Participant knowledge of the interviewer | 7 | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | 16 |
| Interviewer characteristics | 8 | What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | 16 |
| Domain 2: Study design | | | |
| Theoretical framework | | | |
| Methodological orientation and Theory | 9 | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | 9,10 |
| Participant selection | | | |
| Sampling | 10 | How were participants selected? e.g. purposive, convenience, consecutive, snowball | 10 |
| Method of approach | 11 | How were participants approached? e.g. face-to-face, telephone, mail, email | 10,11 |
| Sample size | 12 | How many participants were in the study? | N/A |
| Non-participation | 13 | How many people refused to participate or dropped out? Reasons? | N/A |
| Setting of data collection | 14 | Where was the data collected? e.g. home, clinic, workplace | 10,11 |
| Presence of non-participants | 15 | Was anyone else present besides the participants and researchers? | 12,13 |
| Description of sample | 16 | What are the important characteristics of the sample? e.g. demographic data, date | 12,13 |
| Data collection | | | |
| Interview guide | 17 | Were questions, prompts, guides provided by the authors? Was it pilot tested? | 11, 12 |
| Repeat interviews | 18 | Were repeat interviews carried out? If yes, how many? | N/A |
| Audio/visual recording | 19 | Did the research use audio or visual recording to collect the data? | 13 |
| Field notes | 20 | Were field notes made during and/or after the interview or focus group? | 13 |
| Duration | 21 | What was the duration of the interviews or focus group? | 12 |
| Data saturation | 22 | Was data saturation discussed? | 10 |

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|---|--------------------|
| Transcripts returned | 23 | Were transcripts returned to participants for comment and/or correction? | N/A |
| Domain 3: Analysis and findings | | | |
| Data analysis | | | |
| Number of data coders | 24 | How many data coders coded the data? | 13 |
| Description of the coding tree | 25 | Did authors provide a description of the coding tree? | N/A |
| Derivation of themes | 26 | Were themes identified in advance or derived from the data? | 13 |
| Software | 27 | What software, if applicable, was used to manage the data? | 13 |
| Participant checking | 28 | Did participants provide feedback on the findings? | 14 |
| Reporting | | | |
| Quotations presented | 29 | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number | N/A |
| Data and findings consistent | 30 | Was there consistency between the data presented and the findings? | N/A |
| Clarity of major themes | 31 | Were major themes clearly presented in the findings? | N/A |
| Clarity of minor themes | 32 | Is there a description of diverse cases or discussion of minor themes? | N/A |

Note: The checklist consists of items that should be included in reports on a qualitative study that has been completed. N/A = item not applicable to the current protocol of a study in the participant recruitment phase.

Checklist reference:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007; 19(6): 349-357.

BMJ Open

A community-based rehabilitation program for youth with mental health conditions in Israel: a qualitative study protocol

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14 5 Hila Tuaf¹ and Hod Orkibi¹
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19 7 ¹ School of Creative Arts Therapies, Faculty of Social Welfare and Health
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22 8 Sciences, University of Haifa, Israel
2324
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30 11 Corresponding author: H. Orkibi, University of Haifa,
3132
33 12 199 Aba Khoushy Av., Mount Carmel, Haifa 3498838, Israel
3435
36 13 horkibi@univ.haifa.ac.il
3738
39 14 Cell: +972544393621
4041
42 15 ORCID ID: <https://orcid.org/0000-0003-1498-7953>
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1 **Abstract**

2 **Introduction:** In Israel, 12% of all adolescents have mental health conditions.

3 Approximately 600 adolescents with mental health conditions are hospitalized each
4 year and about 40% of them return to the hospital and are thus cut off from their daily
5 lives and peers in the community. In contrast to adults, adolescents with mental health
6 conditions in Israel are not eligible by law for rehabilitation services. Thus, the
7 overarching goal of this qualitative study is to generate a best practice model for the
8 implementation of community-based psychosocial rehabilitation program for this
9 population by examining *Amitim for Youth*, the first program in Israel established in
10 2018 by the Israel Association of Community Centers in cooperation with the
11 Ministry of Health, the Ministry of Education, and the Special Projects Fund of the
12 National Insurance Institute.

13 **Methods and analysis:** Qualitative data will be collected through in-depth semi-
14 structured interviews and focus groups. To identify themes and patterns in the data,
15 the 6-stage reflexive thematic analysis approach will be used. A triangulation
16 procedure will be conducted to strengthen the validity of the findings collected by
17 different methods and from different types of stakeholders in the program: the
18 program's decision makers, program team members, intended beneficiaries and
19 referring mental health professionals. To insure the trustworthiness of the findings,
20 three strategies will be employed: memos writing, reflexive journaling, and member
21 checking.

22 **Ethics and dissemination:** This study was approved by the Ethics Committee for
23 Human Research in the Faculty of Social Welfare and Health Sciences at the
24 University of Haifa (#455-18) and by the Chief Scientist in the Ministry of Education
25 (#10566). All participants will sign an informed consent form and will be guaranteed

1 confidentiality and anonymity. Data collection will be conducted in the next two years
2 (2019-2020). After data analysis, the findings will be disseminated via publications.

3 **Strengths and limitations of this study**

- 4 • This is a pioneering study that will examine a community-based psychosocial
5 rehabilitation program for adolescents with mental health conditions in Israel.
- 6 • The findings will inform the development of a best practice model to meet the
7 needs and goals of all stakeholders by addressing potential barriers and facilitators
8 for program implementation.
- 9 • The findings may contribute to policy recommendations and legislation relating to
10 adolescent psychiatric rehabilitation.
- 11 • Recruiting adolescents with mental health conditions may be challenging due to
12 their psychiatric condition.

13
14 **Keywords:** adolescents, youth, psychiatric rehabilitation, mental illness, mental
15 health, recovery, community.

1 Introduction

2 Adolescents with Mental Health Conditions (MHC)

3 Adolescence is characterized by physiological, psychological and social
4 changes that are known to be associated with many challenges.^{1,2} According to
5 Erikson's psychosocial developmental theory,³ adolescents are in the “identity versus
6 role confusion” stage, where they search for personal identity and strive for
7 independence through the exploration of social roles, personal values, beliefs and
8 goals while distancing themselves from their parents. For adolescents with MHC (i.e.,
9 who have a psychiatric diagnosis) this developmental task is even more complex and
10 may lead to a lack of identity formation or a negative identity.² Adolescents with
11 MHC may also have to deal with maladaptive thoughts, dysregulated emotions and
12 behaviors which may impact their interaction with peers and family members,
13 academic performance, and in severe cases may involve loss of contact with reality.⁴
14 Therefore, it is important to differentiate between the needs of adolescents who face
15 age-appropriate challenges and adolescents who have MHC.

16 Another challenge that adolescents with MHC may face is coping with stigma.
17 The mental health literature distinguishes between public stigma and self-stigma.⁵
18 Public stigma refers to negative labeling (stereotype, prejudice and discrimination) of
19 a group of people to distance them from society, whereas self-stigma (also termed
20 internalized stigma”) refers to the internalization of those negative labels in a way that
21 changes people’s self-perception.⁵ While there is ample evidence that adolescents
22 with MHC experience public stigma,^{6,7} self-stigma is under-investigated and
23 insufficiently understood for adolescents with MHC.⁸⁻¹⁰ In some studies adolescents'
24 self-stigma has been associated with reduced self-esteem,¹¹ limited social interactions,
25 secrecy, shame,¹² and less adaptive coping strategies.¹³ Recent qualitative findings

1 suggest that adolescents' decisions to disclose their MHC is highly influenced by fear
2 of stigma.^{14 15} A worldwide meta-analysis study reported that 13% of all adolescents
3 have MHC.¹⁶ In Israel, from 1993 to 2016 there was an increase of 130% in the
4 number of children and adolescents who were admitted to psychiatric hospitals. In
5 2016, 767 adolescents aged 12 to 17 were admitted to Israeli hospitals.¹⁷

6 A legislative bill entitled "Rights and Services for Children and Adolescents
7 with Mental Difficulties" was submitted to the Israeli Knesset for the first time in
8 2014.¹⁸ The purpose of the bill was to:

9 ensure the rights of children and adolescents with mental disabilities
10 to rehabilitation and care in the community, in such way as to provide an
11 appropriate response to their special needs and enable them to integrate
12 into the community as their peers do, while utilizing their abilities to the
13 fullest.

14 The bill stressed that children and adolescents must be provided with services in the
15 community, including leisure activities, care and guidance by counselors from the
16 field of mental health, and include the provision of information, practical and
17 emotional support, and assistance in imparting life and social skills.¹⁸ However, this
18 bill has not been passed and adolescents with MHC in Israel thus remain without
19 legislated, state supported rehabilitative psychosocial services in the community.

20 Note that in line with the recovery approach described below, we adopt the
21 widely used umbrella term "mental health conditions" (rather than mental illness or
22 psychiatric disorders or disability), which is consistent with the United Nations
23 General Assembly 2017 report on Mental Health and Human Rights.¹⁹

1 **Services for Adolescents with MHC in Israel**

2 Adolescents with MHC are provided with different services than those for
3 adults given their different needs and because the “Rehabilitation in the Community
4 of Persons with Mental Disabilities Law of 2000” applies only to adults aged 18 and
5 over.²⁰ In Israel, there are three main ministries that provide services to children and
6 adolescents with MHC. The Ministry of Health is responsible for the medical
7 treatment provided by mental health clinics and in psychiatric hospitals. The Ministry
8 of Labor, Social Affairs and Social Services is responsible for out-of-home care (post-
9 hospitalization boarding schools). The Ministry of Education is responsible for
10 educational services within the school system (providing personalized educational and
11 psychological services), home-schooling and in out-of-home settings. However, the
12 division of responsibility across the ministries is unclear and coordination is poor.
13 Particularly problematic is that there is no centralized database with data on service
14 consumers across the three ministries in Israel that provide services for adolescents
15 with MHC. This may lead to inconsistent continuity of care, which refers to the way
16 mental health consumers perceive and experience their care services as connected and
17 coherent, for example between hospital and community services.²¹

18 **The Recovery Approach**

19 For many years, the medical approach in the Westernized mental health
20 system has been dominant. It views people with MHC as “patients” who should be
21 hospitalized for prolonged periods to reduce their symptoms.²² In recent decades, the
22 rehabilitation policy of the mental health systems has been influenced by the Personal
23 Recovery Approach which is based on the “person-centered” principle.²³ This
24 approach focuses on integration into the community, improving quality of life,
25 restoring a sense of control, autonomy, choice, meaning, independence as well as

1 responsibility and hope despite the person's symptoms.^{22 23} Accordingly, personal
2 recovery is not measured in terms of a reduction in symptoms or by a return to the
3 state prior to the mental crisis, but rather by the ability to rebuild a personal identity
4 and live a meaningful life, with satisfying social roles and a sense of inclusion in the
5 community.^{24 25}

6 In Israel, the transition from the medical approach to the recovery approach
7 has been reflected in several significant changes in the attitude of the state and society
8 towards people with MHC. One of the main changes involved the enactment of the
9 “Rehabilitation in the Community of Persons with Mental Disabilities Law of 2000”
10 that provides a package of rehabilitation services to adults with MHC with a
11 significant dysfunction in their life and who are eligible for these services according
12 to criteria determined by law.²⁶ This law has contributed to increased integration of
13 these individuals in the community which also reduced prolonged hospitalization and
14 residence in institutions.²⁶ Changes in the attitude of the state and society to people
15 with MHC has led to initiatives to establish a variety of programs for community-
16 based rehabilitation. One of these programs is the *Amitim* program for adults. The
17 program was established at 2001, to comply with the abovementioned law for the
18 inclusion of adults (aged 18+) with at least a 40% mental disability as determined by
19 the National Insurance Institute.¹ The *Amitim* program is the outcome of cooperation
20 between the Ministry of Health and the Israel Association of Community Centers and
21 operates currently in 77 community centers across the country. It currently serves
22 about 3000 adults with MHC.

¹ The National Insurance Institute in Israel (NII) determines the disability level (from 0–100%) under the provisions of clauses 33 or 34 of the appendix to the NII Regulations for Determining the Level of Disability. For instance, a 40% mental health disability refers to a person in a post-psychotic condition with significant signs of impairment, limitation of work capacity, and significant disruption of behavioral, mental, and social functioning. See: https://www.health.gov.il/English/Topics/Mental_Health/rehabilitation/Pages/sal.aspx

1 The literature on the recovery approach highlights the importance for services
2 to consider adolescents' developmental needs for independence, self-determination,
3 and self-efficacy when implementing a recovery-oriented adolescent-centered
4 approach.²⁷⁻²⁹ This approach, which encourages them to express their needs and
5 opinions about the services and engage actively in their rehabilitation process,^{27 28 30-33}
6 was adopted by the *Amitim for Youth* program.

7 **Amitim for Youth**

8 In January 2018, a pioneering *Amitim for Youth* program was launched by the
9 Israel Association of Community Centers in cooperation with the Ministry of Health,
10 the Ministry of Education, and the Special Projects Fund of the National Insurance
11 Institute. An inter-ministerial steering committee that consisted of representatives
12 from each of these stakeholders was involved in the founding of the program and its
13 initial implementation. The program provides a response to the absence of
14 community-based psychosocial rehabilitation services for adolescents' after-school
15 leisure time. The program consumers are adolescents (aged 12-18) who have a
16 psychiatric diagnosis and are identified in the education system as those with "code
17 57". The programs' pilot was gradually implemented in six geographical districts near
18 psychiatric hospitals which have a youth department (Haifa and Beer-Sheva), and
19 near special education schools for children with MHC (Rehovot, Netanya, Petah-
20 Tikva and Carmiel). In each district, there is a coordinator who provides services to
21 approximately 20 adolescents in the local community centers. Each adolescent in the
22 program is provided with a stipend (1,200 Israeli shekels per year) for participation in
23 leisure and arts activities in the community. The goals of *Amitim for Youth* relate to
24 three dimensions: adolescents, their family, and the wider community. For
25 adolescents, the goals are to foster socialization and a sense of belonging to the

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3 1 community, the ability to cope with self-stigma, prevention of repeated
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5 2 hospitalizations and shorter hospitalization duration, return to age-appropriate
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7 3 functioning according to personal goals and finding a meaningful activity that will
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9 4 lead to satisfaction and self-actualization. Another goal of the program is to provide
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11 5 support to the adolescents' family members (particularly parents), which is facilitated
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13 6 by the program's coordinator in each district. Finally, the goal for members of the
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15 7 community at large is to change attitudes towards adolescents with MHC by raising
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17 8 awareness.

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21 9 The overarching goal of this study is to generate a best practice model for the
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23 10 implementation of community-based psychosocial rehabilitation program for
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25 11 adolescents with MHC. More specifically, the study will: (1) identify barriers and
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27 12 facilitators for implementation of adolescents psychosocial rehabilitation in the
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29 13 community, (2) characterize the continuity of care, or lack thereof, between the
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31 14 referring mental health professionals (MHP) and the program; (3) identify the needs
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33 15 of adolescents and their parents, program team, and referring MHP; (4) assess the
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35 16 satisfaction of adolescents and their parents with the overall program and its
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37 17 components; (5) characterize the services in the program and their value according to
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39 18 adolescents.

19 **Research Questions**

20 The following research questions will be explored. They relate to:
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22 infrastructure, implementation, and continuity of care.

23 **Program infrastructure:** (1) What characterizes the referral procedure
24 for the *Amitim for Youth* program, and what are the barriers and facilitators factors?
25 (2) What characterizes adolescents who participate in the program? (3) What is the
demand for the various components offered by the program (including the arts)?

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2
3 1 What services are offered to the participants and how do they perceive them? What
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5 2 services are missing from the participants' perspective?
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8 3 **Program implementation:** (4) How is the program implementation experienced by
9
10 4 the stakeholders? (5) What are the barriers and facilitators factors for program
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12 5 implementation according to the adolescents themselves (participants and those who
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14 6 withdrew), parents, program team members, and referring MHP? (6) What best-
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16 7 practice guidelines emerge from the perspective of all involved?
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19 8 **Continuity of care:** (7) What characterizes the relationship between the referring
20
21 9 MHP and the program team in the community? (8) What best practice guidelines
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23 10 emerge from the interface between referring MHP and community-based services
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25 11 according to the actors involved?
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28 12 **Methods and Analysis**

29
30 13 The proposed qualitative study is situated between the pragmatic and
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32 14 constructivist paradigms.³⁴ The pragmatic paradigm “focuses primarily on data that
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34 15 are found to be useful for stakeholders”.³⁴ It has been defined as a real-world practice-
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36 16 oriented framework that focuses on useful applications (“what works”) and practical
37
38 17 solutions to problems, to gather information and insights on what is relevant to the
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40 18 stakeholders.^{35 36} The constructivist paradigm “focuses primarily on identifying
41
42 19 multiple values and perspectives”.³⁴ Accordingly, a close interaction with the
43
44 20 stakeholders will be established to better understand their experiences, by taking the
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46 21 multiple perceptions of the different stakeholders of the program into consideration.³⁴
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51 22 ³⁵ The two paradigms complement one another, given that their boundaries are
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53 23 permeable.³⁴
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1 **Participants**

2 As can be seen in Figure 1, the participants in this study will be composed of
3 the following six groups of stakeholders: (1) the program decision makers, who
4 include the program commissioners and funders from different ministries, who are
5 members of the program's inter-ministerial steering committee; (2) the program team
6 members, which includes coordinators and volunteers; (3) the intended beneficiaries
7 of the program; namely, adolescents enrolled in the *Amitim for Youth* program for at
8 least three months; (4) parents of these adolescents; (5) adolescents who withdrew
9 from the program, and (6) referring MHP from clinics, hospitals, and schools. Each of
10 the six groups will have approximately 6-12 participants which is an acceptable
11 number in qualitative research.

12 -Insert Figure 1 about here-

13 Figure 1. The six groups of participants.

14 **Procedure**

15 The study will use a *maximum variation sampling* approach of purposefully
16 selecting a wide range of cases to document diversity and common patterns on
17 dimensions of interest.³⁵ The research team will contact the program decision makers
18 and program team members by phone to invite them to participate in the study. The
19 program coordinators will contact the parents and referring MHP via a formal letter
20 explaining the study and including an informed consent form. Only those who provide
21 their written informed consent will be contacted by the research team to schedule an
22 interview. The MHP will be interviewed at their workplace or via the phone, at a
23 convenient time for them. The parents and adolescents will be interviewed at their
24 community center or homes, at a time of their convenience. The researchers will also

1 attend the meetings of the program's inter-ministerial steering committee (participants
2 in group 1 above) to document their perspectives and interactions.

3 **Data Collection**

4 **Semi-structured in-depth interviews.** Adolescents and their parents will be
5 invited to participate in individual interviews, to better understand their subjective
6 experiences.³⁷ Examples of questions for the adolescents in the program and their
7 parents include: What do you want to get from the program? What should be
8 maintained or strengthened in the program? What do you think should change in the
9 program? What benefits have you received from the program? Examples of questions
10 for the adolescents who withdrew from the program: How did you experience the
11 program? What relationship would you have liked to have with the coordinator of the
12 program (frequency, satisfaction)? What made you leave the program, what could
13 have helped you stay?

14 The referring MHP will be interviewed to describe and evaluate recruitment
15 processes and contacts with the program team in terms of continuity of care. For
16 example: What characterizes the adolescents you refer to the program? Describe the
17 process of referring adolescents to the program: How is it conducted, what factors
18 help you decide, what can be improved? Are you updated by the program team about
19 the adolescents you referred to the program? And if so, how does this take place and
20 for what length of time?

21 Members of the steering committee will be interviewed to assess the
22 development and implementation of the program, for example: What difficulties,
23 challenges and dilemmas did you encounter during the setting up and implementation
24 of the program? What can be improved and how? What is missing from the program?

1
2
3 1 The interviews will be conducted by the first author (HT) and will last approximately
4
5 2 60-90 minutes.

6
7
8 3 **Focus groups.** Each of the program teams (i.e., coordinators and volunteers)
9
10 4 will be invited to attend focus groups, to discuss their impressions of the training, the
11
12 5 program implementation, as well as their relationship with the participants
13
14 6 (adolescents and their parents) and with the referring MHP. The advantages of focus
15
16 7 groups are that each participant can express his/her opinion, in a collaborative forum
17
18 8 that enables an exchange of different points of view, diverse interpretations, personal
19
20 9 and collective experiences, in an honest and open discussion, without fear of criticism
21
22 10 or censorship.³⁸ Examples of questions for the coordinators and volunteers: What
23
24 11 preparation and training did you receive to work/volunteer in the program? What
25
26 12 difficulties, challenges and dilemmas have you encountered in the program? Describe
27
28 13 your role. Is your role clear to you? How would you describe your relationship with
29
30 14 the adolescents and their parents (nature, frequency, content)? Note that to minimize
31
32 15 social desirability, individual interviews will also be conducted that may provide a
33
34 16 deeper understanding of each coordinator's personal experience. Focus groups will be
35
36 17 conducted by the first author (HT) and will last 90 minutes.

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42 18 **Sociodemographic questionnaire.** Adolescents will complete a
43
44 19 sociodemographic questionnaire on their age, gender, country of birth, religion, length
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46 20 of time participating in the program, and number of days a week participating in the
47
48 21 program. The sociodemographic questionnaire for parents will include questions about
49
50 22 socioeconomic status, marital status, their child's medical history and whether their
51
52 23 child takes psychiatric medication.
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1 **Data Analysis**

2 The qualitative data collected from the interviews and focus groups will be
3 recorded and transcribed. The primary emphasis of this study is on identifying
4 themes, commonalities, differences, and patterns across the dataset. Meaning and
5 experience will be examined at both the semantic and latent levels and best practice
6 guidelines will be identified from the perspectives of the different stakeholders in the
7 program.^{35 36} To this end, the 6-stage reflexive thematic analysis approach will be
8 used, which is comprised of familiarization with and immersion in the data, coding of
9 the data, constructing initial themes, reviewing themes, defining and naming themes,
10 and writing up the report with illustrative data extracts.³⁹ This reflexive thematic
11 analysis procedure will be used within the pragmatic and constructive frameworks.
12 The checklist for good reflexive thematic analysis will be used as a guide to ensure an
13 analysis that is rigorous and robust.⁴⁰ The data analysis procedure will be conducted
14 by the first author (HT) and assessed by second author (HO); disagreements will be
15 resolved by discussion. A qualitative data analysis software (ATLAS.ti v8) will be
16 used for data management and analysis.

17 To strengthen the validity of the findings, a triangulation procedure will be
18 conducted with the qualitative data that will be collected by different methods
19 (individual interviews and focus groups) and from different types of stakeholders in
20 the program: the program's decision makers, team, intended beneficiaries, and
21 referring MHP.^{36 41}

22 **Study Trustworthiness**

23 To strengthen the trustworthiness of the findings in addition to the
24 triangulation, three strategies will be employed, as suggested in the qualitative
25 research literature.⁴¹ Memo writing will be used to record decision-making, the

1 process of meaning extraction from the data and subsequent conceptual development,
2 as well as to facilitate continuous communication within the research team.⁴² A
3 reflexivity journal will be used to gain and maintain self-awareness of the researcher's
4 perspective and its potential impact on the research process and interpretation of the
5 findings.⁴¹ To increase the credibility of the research, member checking will be held
6 (also known as participation validation). In this procedure, the findings will be
7 presented to the participants who will be asked to respond whether they reflect their
8 experience, meanings, and perspectives.^{41 43} Finally, to enhance the rigor of the study
9 we will use the 32-item checklist for interviews and focus groups of the Consolidated
10 Criteria for Reporting Qualitative research (COREQ; see online supplementary file).⁴⁴

11 **Patient and Public Involvement**

12 We did not involve patients or the public in our work.

13 **Discussion**

14 Recovery-oriented adolescent-centered services in the community are crucial
15 in the critical developmental period of adolescence, which might be even more
16 complex for adolescents with MHC and might lead to difficulties in identity
17 formation.² To date, adolescents with MHC in Israel are not eligible for community-
18 based psychosocial rehabilitation services by law, despite the rising need. Moreover,
19 there is no centralized database with data on service consumers that is accessible by
20 the three ministries that provide services for adolescents with MHC in Israel, which
21 may result in inconsistent continuity of care. Coordination between different services
22 is crucial for adolescents with MHC who go through multiple service transitions and
23 are therefore more vulnerable to the risks of discontinuity.^{16 30 32 33 45 46}

24 No study has examined a similar community-based psychosocial rehabilitation
25 program for adolescents with MHC in Israel. The *Amitim for Youth* program will

1
2
3 1 serve for a better understanding of the barriers and facilitators related to the
4
5 2 infrastructure, implementation, and continuity of care of these services in Israel. The
6
7 3 implementation of this type of program can be challenging because of its pioneering
8
9 4 nature and its target population: adolescents who do not only face age-related
10
11 5 challenges but also have MHC. Thus, recruiting adolescents with MHC to participate
12
13 6 in this research might be challenging given their psychiatric condition. Some
14
15 7 adolescents might be reluctant to participate out of self-stigma or low motivation
16
17 8 whereas others might be eager to participate to share their experiences and express
18
19 9 their voice. The findings will provide a best practice model to optimize the operation
20
21 10 and implementation by service providers, enhance the service contribution to the
22
23 11 consumers (adolescents and their parents) while meeting their needs and goals, and
24
25 12 inform policy makers. Specific attention will be paid to addressing the potential
26
27 13 barriers and facilitators for effective program implementation. The findings may
28
29 14 ultimately serve as a basis for currently under-developed policy recommendations and
30
31 15 legislation in the field of adolescent psychiatric rehabilitation.
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37 **Ethics and dissemination**

38
39
40 17 The study in its current design was approved by the Ethics Committee for
41
42 18 Human Research in the Faculty of Social Welfare and Health Sciences at the
43
44 19 University of Haifa (#455-18), and by the Chief Scientist in the Ministry of Education
45
46 20 (#10566). All participants will sign an informed consent form and will be guaranteed
47
48 21 confidentiality and anonymity. Adolescents' participation will be obtained by their
49
50 22 parents or guardians, which will also be signed by the child. Data collection will be
51
52 23 conducted in the next two years (2019-2020). A report in Hebrew will be submitted to
53
54 24 the National Insurance Institute. The results will be disseminated in articles that will
55
56 25 be written in English as part of a doctoral dissertation.
57
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1 **Authors' contributions:** Both authors contributed equally to the conceptualization
2 and design of the study. HT (MA, PhD candidate, drama therapist, female) conducted
3 the literature review that was examined and approved by HO (PhD, researcher, male).

4 Both authors read and approved the final manuscript.

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7 **Competing interests:** The authors declare that they have no competing interests. The
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9 publications.

10 **Consent for publication:** Not applicable.

11 **Word count:** 3641

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Figure 1. Six groups of participants in the study

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

Tuaf, H. & Orkibi, H. (2019). A community-based rehabilitation program for youth with mental health conditions in Israel: A qualitative study protocol.

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|--|--------------------|
| Domain 1: Research team and reflexivity | | | |
| Personal characteristics | | | |
| Interviewer/facilitator | 1 | Which author/s conducted the interview or focus group? | 13 |
| Credentials | 2 | What were the researcher's credentials? E.g. PhD, MD | 17 |
| Occupation | 3 | What was their occupation at the time of the study? | 17 |
| Gender | 4 | Was the researcher male or female? | 17 |
| Experience and training | 5 | What experience or training did the researcher have? | 17 |
| Relationship with participants | | | |
| Relationship established | 6 | Was a relationship established prior to study commencement? | 11 |
| Participant knowledge of the interviewer | 7 | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | 17 |
| Interviewer characteristics | 8 | What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | 17 |
| Domain 2: Study design | | | |
| Theoretical framework | | | |
| Methodological orientation and Theory | 9 | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | 10,14-15 |
| Participant selection | | | |
| Sampling | 10 | How were participants selected? e.g. purposive, convenience, consecutive, snowball | 11 |
| Method of approach | 11 | How were participants approached? e.g. face-to-face, telephone, mail, email | 11 |
| Sample size | 12 | How many participants were in the study? | N/A |
| Non-participation | 13 | How many people refused to participate or dropped out? Reasons? | N/A |
| Setting of data collection | 14 | Where was the data collected? e.g. home, clinic, workplace | 11 |
| Presence of non-participants | 15 | Was anyone else present besides the participants and researchers? | 11-13,17 |
| Description of sample | 16 | What are the important characteristics of the sample? e.g. demographic data, date | 13,16 |
| Data collection | | | |
| Interview guide | 17 | Were questions, prompts, guides provided by the authors? Was it pilot tested? | 12-13 |
| Repeat interviews | 18 | Were repeat interviews carried out? If yes, how many? | N/A |
| Audio/visual recording | 19 | Did the research use audio or visual recording to collect the data? | 14 |
| Field notes | 20 | Were field notes made during and/or after the interview or focus group? | 14-15 |
| Duration | 21 | What was the duration of the interviews or focus group? | 13 |
| Data saturation | 22 | Was data saturation discussed? | 11 |

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|---|--------------------|
| Transcripts returned | 23 | Were transcripts returned to participants for comment and/or correction? | 15 |
| Domain 3: Analysis and findings | | | |
| Data analysis | | | |
| Number of data coders | 24 | How many data coders coded the data? | 15 |
| Description of the coding tree | 25 | Did authors provide a description of the coding tree? | N/A |
| Derivation of themes | 26 | Were themes identified in advance or derived from the data? | 10, 14-15 |
| Software | 27 | What software, if applicable, was used to manage the data? | 14 |
| Participant checking | 28 | Did participants provide feedback on the findings? | 15 |
| Reporting | | | |
| Quotations presented | 29 | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number | N/A |
| Data and findings consistent | 30 | Was there consistency between the data presented and the findings? | N/A |
| Clarity of major themes | 31 | Were major themes clearly presented in the findings? | N/A |
| Clarity of minor themes | 32 | Is there a description of diverse cases or discussion of minor themes? | N/A |

Note: The checklist consists of items that should be included in reports on a qualitative study that has been completed. N/A = item not applicable to the current protocol of a study in the participant recruitment phase. Page numbers refer to those in the Word document submitted to the journal for peer review.

Checklist reference:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007; 19(6): 349-357.

BMJ Open

A community-based rehabilitation program for adolescents with mental health conditions in Israel: a qualitative study protocol

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| Secondary Subject Heading: | Qualitative research |
| Keywords: | MENTAL HEALTH, QUALITATIVE RESEARCH, Child & adolescent psychiatry < PSYCHIATRY |
| | |

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7 3 conditions in Israel: a qualitative study protocol
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11 5 Hila Tuaf¹ and Hod Orkibi¹
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16
17 7 ¹ School of Creative Arts Therapies, Faculty of Social Welfare and Health Sciences,
18
19 8 University of Haifa, Israel
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21

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24
25
26 11 Corresponding author: H. Orkibi, University of Haifa,
27
28 12 199 Aba Khoushy Av., Mount Carmel, Haifa 3498838, Israel
29

30 13 horkibi@univ.haifa.ac.il
3132 14 Cell: +972544393621
33
3435 15 ORCID ID: <https://orcid.org/0000-0003-1498-7953>
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40 18 Word count: 3646
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1
2
3 **1 Abstract**
4

5 **2 Introduction:** In Israel, 12% of adolescents have mental health conditions.
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8 3 Approximately 600 adolescents with mental health conditions are hospitalized each
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10 4 year and about 40% of them return to the hospital and are thus cut off from their daily
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12 5 lives and peers in the community. In contrast to adults, adolescents with mental health
13
14 6 conditions in Israel are not eligible by law for rehabilitation services. Thus, the
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16 7 overarching goal of this qualitative study is to identify best practices for the
17
18 8 implementation of community-based psychosocial rehabilitation programs for this
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20 9 population, by examining the first such program in Israel. *Amitim for Youth*, which
21
22 10 was established in 2018 by the Israel Association of Community Centers in
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24 11 cooperation with the Ministry of Health, the Ministry of Education, and the Special
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26 12 Projects Fund of the National Insurance Institute.
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30 **13 Methods and analysis:** Qualitative data will be collected through in-depth semi-
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32 14 structured interviews and focus groups. To identify themes and patterns in the data, a
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34 15 6-stage reflexive thematic analysis approach will be used. A triangulation procedure
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36 16 will be conducted to strengthen the validity of the findings collected by different
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38 17 methods and from various stakeholders in the program: the program's decision
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40 18 makers, program team members, the intended beneficiaries and referring mental
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42 19 health professionals. To insure the trustworthiness of the findings, three strategies will
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44 20 be employed: memo writing, reflexive journaling, and member checking.
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49 **21 Ethics and dissemination:** This study was approved by the Ethics Committee for
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51 22 Human Research in the Faculty of Social Welfare and Health Sciences at the
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53 23 University of Haifa (#455-18) and by the Chief Scientist in the Ministry of Education
54
55 24 (#10566). All participants will sign an informed consent form and will be guaranteed
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1 confidentiality and anonymity. Data collection will be conducted in the next two years
2 (2019-2020). After data analysis, the findings will be disseminated via publications.

3 **Strengths and limitations of this study**

- 4 • This is a pioneering study that will examine a community-based psychosocial
5 rehabilitation program for adolescents with mental health conditions in Israel.
- 6 • The findings will inform best practices to meet the needs of all stakeholders by
7 addressing potential barriers and facilitators for program implementation.
- 8 • The findings may contribute to policy recommendations and legislation relating to
9 adolescent psychiatric rehabilitation.
- 10 • Recruiting adolescents with mental health conditions may be challenging due to
11 their psychiatric condition.

12
13 **Keywords:** adolescents, youth, psychiatric rehabilitation, mental illness, mental
14 health, recovery, community.

15 16 17 18 19 20 21 22 23 24 25 **Introduction**

1 **Adolescents with Mental Health Conditions (MHC)**

2 Adolescence is characterized by physiological, psychological and social
3 changes that are known to be associated with many challenges.^{1,2} According to
4 Erikson's psychosocial developmental theory,³ adolescents are in the “identity versus
5 role confusion” stage, where they search for personal identity and strive for
6 independence through the exploration of social roles, personal values, beliefs and
7 goals while distancing themselves from their parents. For adolescents with MHC (i.e.,
8 who have a psychiatric diagnosis), this developmental task is even more complex and
9 may lead to a lack of identity formation or a negative identity.² Adolescents with
10 MHC may also have to deal with maladaptive thoughts, dysregulated emotions and
11 behaviors which may impact their interaction with peers and family members,
12 academic performance, and in severe cases may involve loss of contact with reality.⁴
13 Therefore, it is important to differentiate between the needs of adolescents who face
14 age-appropriate challenges and adolescents who have MHC.

15 Another challenge that adolescents with MHC may face is coping with stigma.
16 The mental health literature distinguishes between public stigma and self-stigma.⁵
17 Public stigma refers to negative labeling (stereotype, prejudice and discrimination) of
18 a group of people to distance them from society, whereas self-stigma (also termed
19 internalized stigma) refers to the internalization of those negative labels in a way that
20 changes people's self-perception.⁵ While there is ample evidence that adolescents
21 with MHC experience public stigma,^{6,7} self-stigma is under-investigated and
22 insufficiently understood for adolescents with MHC.⁸⁻¹⁰ In some studies adolescents'
23 self-stigma has been associated with reduced self-esteem,¹¹ limited social interactions,
24 secrecy, shame,¹² and less adaptive coping strategies.¹³ Recent qualitative findings
25 suggest that adolescents' decisions to disclose their MHC is highly influenced by fear

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3 1 of stigma.^{14 15} A worldwide meta-analysis study reported that 13% of all adolescents
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5 2 have MHC.¹⁶ In Israel, from 1993 to 2016, there was an increase of 130% in the
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7 3 number of children and adolescents who were admitted to psychiatric hospitals. In
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9 4 2016, 767 adolescents aged 12 to 17 were admitted to Israeli hospitals.¹⁷

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12 5 A legislative bill entitled “Rights and Services for Children and Adolescents
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14 6 with Mental Difficulties” was submitted to the Israeli Knesset for the first time in
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16 7 2014.¹⁸ The purpose of the bill was to:

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19 8 ensure the rights of children and adolescents with mental disabilities
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21 9 to rehabilitation and care in the community, in such a way as to provide
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23 10 an appropriate response to their special needs and enable them to
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25 11 integrate into the community as their peers do, while utilizing their
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27 12 abilities to the fullest.

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31 13 The bill stressed that children and adolescents must be provided with services in the
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33 14 community, including leisure activities, care and guidance by counselors from the
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35 15 field of mental health, and include the provision of information, practical and
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37 16 emotional support, and assistance in imparting life and social skills.¹⁸ However, this
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39 17 bill has not been passed and adolescents with MHC in Israel thus remain without
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41 18 legislated, State supported rehabilitative psychosocial services in the community.

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44 19 Aligned with the recovery approach described below, the widely used
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46 20 umbrella term “mental health conditions” (rather than mental illness or psychiatric
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48 21 disorders or disability) was adopted, which is consistent with the United Nations
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50 22 General Assembly 2017 report on Mental Health and Human Rights.¹⁹

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58 25 **Services for Adolescents with MHC in Israel**

1 Services for adolescents with MHC are different than those for adults, given
2 their needs and because the “Rehabilitation in the Community of Persons with Mental
3 Disabilities Law of 2000” applies only to adults aged 18 and over.²⁰ In Israel, there
4 are three main ministries that provide services to children and adolescents with MHC.
5 The Ministry of Health is responsible for the medical treatment provided by mental
6 health clinics and in psychiatric hospitals. The Ministry of Labor, Social Affairs and
7 Social Services is responsible for out-of-home care (post-hospitalization boarding
8 schools). The Ministry of Education is responsible for educational services within the
9 school system (providing personalized educational and psychological services), home-
10 schooling and in out-of-home settings. However, the division of responsibility across
11 the ministries is unclear and coordination is poor. Particularly problematic is that there
12 is no centralized database with data on service consumers across the three ministries
13 in Israel that provide services for adolescents with MHC. This may lead to
14 inconsistent continuity of care, in terms of how mental health consumers perceive and
15 experience their care services as connected and coherent, for example between
16 hospital and community services.²¹

17 **The Recovery Approach**

18 For many years, the medical approach in the Westernized mental health
19 system has been dominant. It views people with MHC as “patients” who should be
20 hospitalized for prolonged periods to reduce their symptoms.²² By contrast, in recent
21 decades, the rehabilitation policy of mental health systems has been influenced by the
22 Personal Recovery Approach which is based on the “person-centered” principle.²³
23 This approach focuses on integration into the community, improving quality of life,
24 restoring a sense of control, autonomy, choice, meaning, independence as well as
25 responsibility and hope despite the person's symptoms.^{22 23} Accordingly, personal

1 recovery is not measured in terms of a reduction in symptoms or by a return to the
2 state prior to the mental crisis, but rather by the ability to rebuild a personal identity
3 and live a meaningful life with satisfying social roles and a sense of inclusion in the
4 community.^{24 25}

5 In Israel, the transition from the medical approach to the recovery approach
6 has been reflected in several significant changes in the attitude of the State and society
7 towards people with MHC. One of the main changes involved the enactment of the
8 “Rehabilitation in the Community of Persons with Mental Disabilities Law of 2000”
9 that provides a package of rehabilitation services to adults with MHC with a
10 significant dysfunction in their life and who are eligible for these services according
11 to criteria determined by law.²⁶ This law has contributed to increased integration of
12 these individuals in the community which also has reduced prolonged hospitalization
13 and residence in institutions.²⁶ Changes in the attitude of the State and society to
14 people with MHC has led to initiatives to establish a variety of programs for
15 community-based rehabilitation. One of these programs is the *Amitim* program for
16 adults. The program was established at 2001, to comply with the abovementioned law
17 for the inclusion of adults (aged 18+) with at least a 40% mental health disability as
18 determined by the National Insurance Institute.¹ The *Amitim* program is the outcome
19 of cooperation between the Ministry of Health and the Israel Association of
20 Community Centers and operates currently in 77 community centers across the
21 country. It currently serves approximately 3000 adults with MHC.

¹ The National Insurance Institute in Israel (NII) determines the disability level (from 0–100%) under the provisions of clauses 33 or 34 of the appendix to the NII Regulations for Determining the Level of Disability. For instance, a 40% mental health disability refers to a person in a post-psychotic condition with significant signs of impairment, limitation of work capacity, and significant disruption of behavioral, mental, and social functioning. See:
https://www.health.gov.il/English/Topics/Mental_Health/rehabilitation/Pages/sal.aspx

1 The literature on the recovery approach highlights the importance for services
2 to consider adolescents' developmental needs for independence, self-determination,
3 and self-efficacy when implementing a recovery-oriented adolescent-centered
4 approach.²⁷⁻²⁹ This approach, which encourages them to express their needs and
5 opinions about the services and engage actively in their rehabilitation process,^{27 28 30-33}
6 was adopted by the *Amitim for Youth* program.

7 **Amitim for Youth**

8 In January 2018, a pioneering *Amitim for Youth* program was launched by the
9 Israel Association of Community Centers in cooperation with the Ministry of Health,
10 the Ministry of Education, and the Special Projects Fund of the National Insurance
11 Institute. An inter-ministerial steering committee that consisted of representatives
12 from each of these stakeholders was involved in the founding of the program and its
13 initial implementation. The program provides a response to the absence of
14 community-based psychosocial rehabilitation services for adolescents' after-school
15 leisure time. The program consumers are adolescents (aged 12-18) who have a
16 psychiatric diagnosis and are identified in the education system as those with "code
17 57". The program pilot was gradually implemented in six geographic districts near
18 psychiatric hospitals which have a child and adolescent department (Haifa and Beer-
19 Sheva), and near special education schools for children with MHC (Rehovot,
20 Netanya, Petah-Tikva and Carmiel). In each district, there is a coordinator who
21 provides services to approximately 20 adolescents in the local community centers.
22 Each adolescent in the program is provided with a stipend (1,200 Israeli shekels per
23 year) for participation in leisure and arts activities in the community. The goals of
24 *Amitim for Youth* relate to three dimensions: adolescents, their family, and the wider
25 community. For adolescents, the goals are to foster socialization and a sense of

1 belonging to the community, the ability to cope with self-stigma, prevention of
2 repeated hospitalizations and shorter hospitalization duration, return to age-
3 appropriate functioning according to personal goals, and finding a meaningful activity
4 that will lead to satisfaction and self-actualization. Another goal of the program is to
5 provide support to the adolescents' family members (particularly parents), which is
6 facilitated by the program's coordinator in each district. Finally, the goal for members
7 of the community at large is to change attitudes towards adolescents with MHC by
8 raising awareness.

9 The overarching goal of this study is to identify best practices for the
10 implementation of a community-based psychosocial rehabilitation program for
11 adolescents with MHC. More specifically, the study will: (1) identify barriers and
12 facilitators for the implementation of adolescents psychosocial rehabilitation in the
13 community, (2) characterize the continuity of care, or lack thereof, between the
14 referring mental health professionals (MHP) and the program; (3) identify the needs
15 of adolescents and their parents, program team, and referring MHP; (4) assess the
16 satisfaction of adolescents and their parents with the overall program and its
17 components; (5) characterize the services in the program and their value according to
18 adolescents.

19 **Research Questions**

20 The following research questions will be explored. They relate to
21 infrastructure, implementation, and continuity of care.

22 **Program infrastructure:** (1) What characterizes the referral procedure for the
23 *Amitim for Youth* program, and what are the barriers and facilitators factors? (2) What
24 are the characteristics of the adolescents who participate in the program? (3) What is
25 the demand for the various components offered by the program (including the arts)?

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3 1 What services are offered to the participants and how do they perceive them? What
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5 2 services are missing from the participants' perspective?
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8 3 **Program implementation:** (4) How is the program implementation experienced by
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10 4 the stakeholders? (5) What are the barriers and facilitators factors for program
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12 5 implementation according to the adolescents themselves (participants and those who
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14 6 withdrew), parents, program team members, and referring MHP? (6) What best
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16 7 practices emerge from the perspectives of all involved?
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19 8 **Continuity of care:** (7) What characterizes the relationship between the referring
20
21 9 MHP and the program team in the community? (8) What best practices can be
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23 10 identified from the interface between referring MHP and community-based services
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25 11 according to the actors involved?
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28 12 **Methods and Analysis**

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31 13 This qualitative study is situated between the pragmatic and constructivist
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33 14 paradigms.³⁴ The pragmatic paradigm “focuses primarily on data that are found to be
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35 15 useful for stakeholders”.³⁴ It has been defined as a real-world practice-oriented
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37 16 framework that focuses on useful applications (“what works”) and practical solutions
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39 17 to problems, to gather information and insights on what is relevant to the
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41 18 stakeholders.^{35 36} The constructivist paradigm “focuses primarily on identifying
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43 19 multiple values and perspectives”.³⁴ Accordingly, a close interaction with the
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45 20 stakeholders will be established to better understand their experiences, by taking the
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47 21 multiple perceptions of the different stakeholders of the program into consideration.³⁴
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51 22 ³⁵ The two paradigms complement one another, given that their boundaries are
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53 23 permeable.³⁴
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1 **Participants**

2 As can be seen in Figure 1, the participants in this study will be composed of
3 the following six groups of stakeholders: (1) the program decision makers, who
4 include the program commissioners and funders from different ministries, who are
5 members of the program's inter-ministerial steering committee; (2) the program team
6 members, which includes coordinators and volunteers; (3) the intended beneficiaries
7 of the program; namely, adolescents enrolled in the *Amitim for Youth* program for at
8 least three months; (4) parents of these adolescents; (5) adolescents who withdrew
9 from the program, and (6) referring MHP from clinics, hospitals, and schools. Each of
10 the six groups will have approximately 6-12 participants which is an acceptable
11 number in qualitative research.

12 -Insert Figure 1 about here-

13 Figure 1. The six groups of participants.

14 **Procedure**

15 The study will use a *maximum variation sampling* approach of purposefully
16 selecting a wide range of cases to document diversity and common patterns on
17 dimensions of interest.³⁵ The research team will contact the program decision makers
18 and program team members by phone to invite them to participate in the study. The
19 program coordinators will contact the parents and referring MHP via a formal letter
20 explaining the study and including an informed consent form. Only those who provide
21 their written informed consent will be contacted by the research team to schedule an
22 interview. The MHP will be interviewed at their workplace or via the phone, at a
23 convenient time for them. The parents and adolescents will be interviewed at their
24 community center or homes, at a time of their convenience. The researchers will also

1 attend the meetings of the program's inter-ministerial steering committee (participants
2 in group 1 above) to document their perspectives and interactions.

3 **Data Collection**

4 **Semi-structured in-depth interviews.** Adolescents and their parents will be
5 invited to participate in individual interviews, to better understand their subjective
6 experiences.³⁷ Examples of questions for the adolescents in the program and their
7 parents include: What do you want to get from the program? What should be
8 maintained or strengthened in the program? What do you think should change in the
9 program? What benefits have you received from the program? Examples of questions
10 for the adolescents who withdrew from the program are: How did you experience the
11 program? What relationship would you have liked to have with the coordinator of the
12 program? What made you leave the program, what could have helped you stay?

13 The referring MHP will be interviewed to describe and evaluate recruitment
14 processes and contacts with the program team in terms of continuity of care. For
15 example: What are the characteristics of the adolescents you refer to the program?
16 Describe the process of referring adolescents to the program: How is it conducted,
17 what factors help you decide, what can be improved? Are you updated by the program
18 team about the adolescents you referred to the program? And if so, how does this take
19 place and for what length of time?

20 Members of the steering committee will be interviewed to assess the
21 development and implementation of the program, for example: What difficulties,
22 challenges and dilemmas did you encounter during the setting up and implementation
23 of the program? What can be improved and how? What is missing from the program?
24 The interviews will be conducted by the first author (HT) and will last approximately
25 60-90 minutes.

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4 1 **Focus groups.** Each of the program teams (i.e., coordinators and volunteers)
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6 2 will be invited to attend focus groups, to discuss their impressions of the training, the
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8 3 program implementation, as well as their relationship with the participants
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10 4 (adolescents and their parents) and with the referring MHP. The advantages of focus
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12 5 groups are that each participant can express his/her opinion in a collaborative forum
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14 6 that enables an exchange of different points of view, diverse interpretations, personal
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16 7 and collective experiences, in an honest and open discussion, without fear of criticism
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18 8 or censorship.³⁸ Examples of questions for the coordinators and volunteers are: What
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20 9 preparation and training did you receive to work/volunteer in the program? What
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22 10 difficulties, challenges and dilemmas have you encountered in the program? Describe
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24 11 your role. Is your role clear to you? How would you describe your relationship with
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26 12 the adolescents and their parents (nature, frequency, content)? To minimize social
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28 13 desirability, individual interviews will also be conducted that may provide a deeper
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30 14 understanding of each coordinator's personal experience. Focus groups will be
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32 15 conducted by the first author (HT) and will last 90 minutes.
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37 16 **Sociodemographic questionnaire.** Adolescents will answer sociodemographic
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39 17 questions on their age, gender, country of birth, religion, length of time participating in
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41 18 the program, and number of days a week participating in the program. The
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43 19 sociodemographic questionnaire for parents will include questions about socioeconomic
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45 20 status, marital status, their child's medical history and whether their child takes
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47 21 psychiatric medication.
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51 22 **Data Analysis**

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54 23 The qualitative data collected from the interviews and focus groups will be
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56 24 recorded and transcribed. The primary emphasis of this study is on identifying
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58 25 themes, commonalities, differences, and patterns across the participants. Meaning and
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1 experience will be examined at both the semantic and latent levels, and best practices
2 will be identified from the perspectives of the different stakeholders in the program.³⁵
3 ³⁶ To this end, a 6-stage reflexive thematic analysis approach will be used, which is
4 comprised of familiarization with and immersion in the data, coding of the data,
5 constructing initial themes, reviewing themes, defining and naming themes, and
6 writing up the report with illustrative data extracts.³⁹ This reflexive thematic analysis
7 procedure will be used within the pragmatic and constructive frameworks. The
8 checklist for good reflexive thematic analysis will be used as a guide to ensure an
9 analysis that is rigorous and robust.⁴⁰ The data analysis procedure will be conducted
10 by the first author (HT) and assessed by second author (HO); disagreements will be
11 resolved by discussion. A qualitative data analysis software (ATLAS) will be used for
12 data management and to assist data analysis.

13 To strengthen the validity of the findings, a triangulation procedure will be
14 conducted with the qualitative data that will be collected by different methods
15 (individual interviews and focus groups) and from different types of stakeholders in
16 the program: the program's decision makers, team, intended beneficiaries, and
17 referring MHP.^{36 41}

18 **Study Trustworthiness**

19 To strengthen the trustworthiness of the findings in addition to the
20 triangulation, three strategies will be employed, as suggested in the qualitative
21 research literature.⁴¹ Memo writing will be used to record decision-making, the
22 process of meaning extraction from the data and subsequent conceptual development,
23 as well as to facilitate continuous communication within the research team.⁴² A
24 reflexivity journal will be used to gain and maintain self-awareness of the researcher's
25 perspective and its potential impact on the research process and interpretation of the

1 findings.⁴¹ To increase the credibility of the research, member checking will be held
2 (also known as participation validation). In this procedure, the findings will be
3 presented to the participants who will be asked to respond whether they reflect their
4 experience, meanings, and perspectives.^{41 43} Finally, to enhance the rigor of the study
5 the 32-item checklist for interviews and focus groups of the Consolidated Criteria for
6 Reporting Qualitative research (COREQ; see online supplementary file) will be
7 used.⁴⁴

8 **Patient and Public Involvement**

9 Patients or the public are not involved in the project.

10 **Discussion**

11 Recovery-oriented adolescent-centered services in the community are crucial
12 in the critical developmental period of adolescence, which might be even more
13 complex for adolescents with MHC and might lead to difficulties in identity
14 formation.² To date, adolescents with MHC in Israel are not eligible for community-
15 based psychosocial rehabilitation services by law, despite the rising need. There is no
16 centralized database with data on service consumers that is accessible by the three
17 ministries that provide services for adolescents with MHC in Israel, which may result
18 in inconsistent continuity of care. Coordination between different services is crucial
19 for adolescents with MHC who go through multiple service transitions and are
20 therefore more vulnerable to the risks of discontinuity.^{16 30 32 33 45 46}

21 No study has examined a similar community-based psychosocial rehabilitation
22 program for adolescents with MHC in Israel. This study of the *Amitim for Youth*
23 program will enable a better understanding of the barriers and facilitators related to
24 the infrastructure, implementation, and continuity of care of these services in Israel.
25 The implementation of this type of program can be challenging because of its

1 pioneering nature and its target population: adolescents who do not only face age-
2 related challenges but also have MHC. Thus, recruiting adolescents with MHC to
3 participate in this research might be challenging given their psychiatric condition.
4 Some adolescents might be reluctant to participate out of self-stigma or low
5 motivation whereas others might be eager to participate to share their experiences and
6 express their voice. The findings will provide best practices recommendations to
7 optimize the operation and implementation by service providers, enhance the service
8 contribution to the consumers (adolescents and their parents) while meeting their
9 needs and goals, and inform policy makers. Specific attention will be paid to
10 addressing the potential barriers and facilitators for effective program implementation.
11 The findings may ultimately serve as a basis for currently under-developed policy
12 recommendations and legislation in the field of adolescent psychiatric rehabilitation.

13 **Ethics and dissemination**

14 The study in its current design was approved by the Ethics Committee for
15 Human Research in the Faculty of Social Welfare and Health Sciences at the
16 University of Haifa (#455-18), and by the Chief Scientist in the Ministry of Education
17 (#10566). Informed consent will be obtained from all participants and they will be
18 guaranteed confidentiality and anonymity. Consent for the adolescents' participation
19 will be also obtained from their parents or guardians via written consent. Data
20 collection will be conducted in the next two years (2019-2020). A report in Hebrew
21 will be submitted to the National Insurance Institute. The results will be disseminated
22 in articles that will be written in English as part of a doctoral dissertation.

23 **Authors' contributions:** Both authors contributed equally to the conceptualization
24 and design of the study. HT (MA, PhD candidate, cognitive behavioral drama

1 therapist, female) conducted the literature review that was examined and approved by
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1 therapist, female) conducted the literature review that was examined and approved by
2 HO (PhD, researcher, male). Both authors read and approved the final manuscript.

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4 16343).

5 **Competing interests:** The authors declare that they have no competing interests. The
6 funding body will have no role in data collection, analysis, interpretation, or
7 publications.

8 **Consent for publication:** Not applicable.

9 **Word count:** 3646

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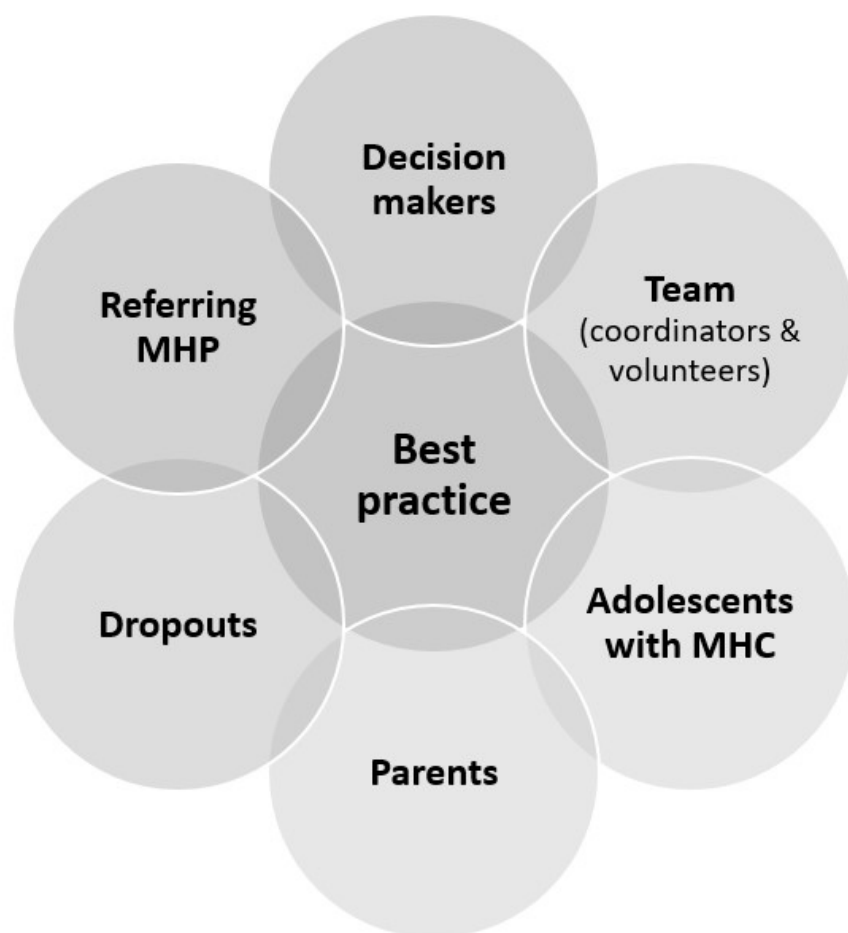


Figure 1. Six groups of participants in the study.

166x163mm (96 x 96 DPI)

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

Tuaf, H. & Orkibi, H. (2019). A community-based rehabilitation program for adolescents with mental health conditions: A qualitative study protocol.

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|--|--------------------|
| Domain 1: Research team and reflexivity | | | |
| Personal characteristics | | | |
| Interviewer/facilitator | 1 | Which author/s conducted the interview or focus group? | 12,13 |
| Credentials | 2 | What were the researcher's credentials? E.g. PhD, MD | 17 |
| Occupation | 3 | What was their occupation at the time of the study? | 17 |
| Gender | 4 | Was the researcher male or female? | 17 |
| Experience and training | 5 | What experience or training did the researcher have? | 17 |
| Relationship with participants | | | |
| Relationship established | 6 | Was a relationship established prior to study commencement? | 11-12 |
| Participant knowledge of the interviewer | 7 | What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | 17 |
| Interviewer characteristics | 8 | What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | 17 |
| Domain 2: Study design | | | |
| Theoretical framework | | | |
| Methodological orientation and Theory | 9 | What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | 10 |
| Participant selection | | | |
| Sampling | 10 | How were participants selected? e.g. purposive, convenience, consecutive, snowball | 11 |
| Method of approach | 11 | How were participants approached? e.g. face-to-face, telephone, mail, email | 11-12 |
| Sample size | 12 | How many participants were in the study? | N/A |
| Non-participation | 13 | How many people refused to participate or dropped out? Reasons? | N/A |
| Setting of data collection | 14 | Where was the data collected? e.g. home, clinic, workplace | 11-12 |
| Presence of non-participants | 15 | Was anyone else present besides the participants and researchers? | 13 |
| Description of sample | 16 | What are the important characteristics of the sample? e.g. demographic data, date | 13 |
| Data collection | | | |
| Interview guide | 17 | Were questions, prompts, guides provided by the authors? Was it pilot tested? | 12-13 |
| Repeat interviews | 18 | Were repeat interviews carried out? If yes, how many? | N/A |
| Audio/visual recording | 19 | Did the research use audio or visual recording to collect the data? | 13 |
| Field notes | 20 | Were field notes made during and/or after the interview or focus group? | 14 |
| Duration | 21 | What was the duration of the interviews or focus group? | 12-13 |
| Data saturation | 22 | Was data saturation discussed? | 11 |

COREQ- Consolidated criteria for reporting qualitative research: a 32-item checklist for interviews and focus groups

| Section/Topic | Item # | Checklist item | Reported on page # |
|--|--------|---|--------------------|
| Transcripts returned | 23 | Were transcripts returned to participants for comment and/or correction? | N/A |
| Domain 3: Analysis and findings | | | |
| Data analysis | | | |
| Number of data coders | 24 | How many data coders coded the data? | 14 |
| Description of the coding tree | 25 | Did authors provide a description of the coding tree? | N/A |
| Derivation of themes | 26 | Were themes identified in advance or derived from the data? | 14 |
| Software | 27 | What software, if applicable, was used to manage the data? | 14 |
| Participant checking | 28 | Did participants provide feedback on the findings? | 14-15 |
| Reporting | | | |
| Quotations presented | 29 | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number | N/A |
| Data and findings consistent | 30 | Was there consistency between the data presented and the findings? | N/A |
| Clarity of major themes | 31 | Were major themes clearly presented in the findings? | N/A |
| Clarity of minor themes | 32 | Is there a description of diverse cases or discussion of minor themes? | N/A |

Note: The checklist consists of items that should be included in reports on a qualitative study that has been completed. N/A = item not applicable to the current protocol of a study in the participant recruitment phase. Page numbers are for the document submitted for review.

Checklist reference:

Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007; 19(6): 349-357.