PERSON-CENTRED CARE APPROACH BY PROFESSIONAL CAREGIVERS IN POPULATION WITH MENTAL ILLNESS: SYSTEMATIC REVIEW

ENFOQUE DE ATENCIÓN CENTRADA EN LA PERSONA POR CUIDADORES PROFESIONALES EN POBLACIÓN CON ENFERMEDAD MENTAL: REVISIÓN SISTEMÁTICA

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Abstract

The model of Person-Centred Care (PCC) has as fundamental principles the emphasis on the person within its context, individualized attention and empowerment. However, studies about this approach on mental illness (MI) are scarce. The aim of this work is to carry out a systematic review of articles studying the approach of PCC provided by professional caregivers in people with MI. After analysis of the 19 articles, the results show that PCA leads to positive outcomes for patients, such as increased patient engagement, adherence and quality of treatment, and the opportunity to better manage their disease, as well as for professionals, such as better conditions to support them and an "optimistic attitude". However, more information for users, more emphasis on the relationship between users and services, and more training of professionals are needed.

Keywords: person-centred care; formal caregiver; mental health; systematic review.

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Resumen

El modelo de Atención Centrada en la Persona (ACP) tiene como principios fundamentales el énfasis en la persona dentro de su contexto, la atención individualizada y el empoderamiento. Sin embargo, los estudios de este enfoque en enfermedades mentales (EM) son escasos. El objetivo de este trabajo es realizar una revisión sistemática de los artículos que estudian el abordaje de la ACP que brindan los cuidadores profesionales en personas con EM. Tras el análisis de los 19 artículos, los resultados muestran que la ACP conlleva resultados positivos para los pacientes, como una mayor participación, adherencia y calidad del tratamiento, y la oportunidad de gestionar mejor su enfermedad, así como para los profesionales, como mejores condiciones para apoyarlos y una "actitud optimista". Sin embargo, son necesarios más información para los usuarios, más énfasis en las relaciones entre éstos y los servicios y una mayor formación de los profesionales.

Palabras clave: atención centrada en la persona; cuidador formal; salud mental; revisión sistemática.

Introduction

The American Psychiatric Association (APA, 2020) defines mental illness (MI) as a significant alteration of emotional, cognitive and/or behavioral type, where basic psychological processes such as emotion, motivation, cognition, awareness, behavior, perception, learning, or language are often affected. In addition, MI are associated with subjective distress and problems in social, professional, or cultural functioning. Treatment of MI requires long-term interventions that may include periods of hospitalization. Currently, is being developed a model that focuses on the provision of services in which the subject has a passive role as a receiver of services. Patients often feel that they have very few opportunities to work alongside their professional caregivers and that, in these few interactions, their attempts to participate are ignored.

The fundamental principles from the so-called Person-Centred Care (PCC) model are the change in the focus of attention of the disease to the person within their social context, taking into account their experiences, values and preferences, the individualized attention determined by the needs and preferences of each person rather than by the organization standards and the promotion of empowerment respecting the values of freedom and choice (Smith & Williams, 2016). PCC also provides a greater sense of choice and control of care and support, higher quality of life, increased degree of subjective well-being mood, autonomy, dependency, and satisfaction with the care received, reduction of the use of emergency and hospitalization services and greater profitability (Smith, & Williams, 2016). Despite the significant extension of this approach, the absence of clear consensus and definition regarding its meaning can become a barrier for both its implementation and its evaluation (Sharma et al., 2016).

Furthermore, PCC ensures that professionals are trained in the relevant skills and methodology, as caregivers are one of the agents that have the greatest impact on the quality of life of the cared-for person (Abraha et al., 2017). Furthermore, due to the high burden of caregiving on caregivers, their own well-being should certainly be taken into account and intervention goals should aim to provide them with different types of support to improve their quality of life. Current studies on formal caregivers working with populations such as people with dementia or functional diversity are beginning to suggest that the provision of PCC can produce multiple benefits not only among the care recipient, but also for the workers themselves (Smythe et al., 2020).

The PCC model addresses such important and overlooked aspects as the quality of care provided, respect for the rights of these people and their full participation in everything that concerns them, and it has multiple benefits for both them and the caregivers who apply it. However, there is still a lot of research to be done on the use of this approach in MI. For this reason, the aim of this paper is to carry out a systematic review of the literature that addresses the study of PCC, through empirical research or interventions, provided by professional caregivers in people with MI. The specific objectives are to find out the main characteristics of PCC and what outcomes it offers for professional caregivers and for people with MI.

Methodology

For the correct elaboration of this study, guidelines for carrying out systematic reviews proposed in the PRISMA statement (Page et al., 2021) have been followed (Appendix A).

Information sources and search strategy

The systematic search was performed between the months of May and June 2020 in the Web of Science (WoS), PubMed, ScienceDirect and Dialnet databases, including all articles published from 1900 to 2019 (inclusive). The combination of terms used are the following: "person-centred" care AND mental health and "person-centred" care AND mental illness. These were searched for in the topic field for WoS, title and abstract for PubMed, title, abstract and keywords for ScienceDirect; and the equivalent terms in Spanish for Dialnet. A total of 798 articles were recovered: 409 articles in WoS, 264 in PubMed, 58 in ScienceDirect and 67 in Dialnet.

Eligibility criteria

Although no protocol was recorded, before reading the abstracts and selecting the final sample of articles, the inclusion and exclusion criteria were defined.

The inclusion criteria were: (a) articles that included empirical research or interventions, (b) that investigated the application of PCC by formal caregivers in people with MI, (c) in any language, and (d) to which full-text access was possible.

The exclusion criteria were: (a) articles that included synthesis studies (i.e., systematic reviews or meta-analyses), (b) that include people with other types of illnesses or dementias, (c) that included informal caregivers as participants, and (d) that include other care approaches (e.g., traditional community care model).

Selection process

Since the definition and interpretation of PCC varies extensively (Gondek et al., 2016; Sharma et al., 2016), articles containing elements common to this approach were accepted. The summaries of all the articles were read, and only 46 were considered adequate after passing an initial screening process. After the screening, an analysis of the full text of these 46 articles was carried out. With that, 27 were eliminated, as they did not include empirical research or interventions (n = 6) or did not include persons with MI (n = 4) or did not include PCC (n = 14) or for problems with accessing the entire document (n = 3). The remaining 19 articles that met all the inclusion criteria were selected for analysis in the systematic review. This process was carried out by one of the authors and corroborated by another using the Covidence tool (Veritas Health Innovation, 2014).

Data collection process

From each of the articles included in the systematic review, the following data were extracted: authors, year and country of study, aim, methodology, participants, outcomes, and limitations.

Results

The search process and the number of selected and excluded results can be seen in Figure 1.

Most of the articles are empirical research (n = 13), followed by articles dedicated to interventions (n = 6). In terms of the aims of the work, these include implementation and evaluation of intervention programs (n = 6), study of shared decision-making (n = 4), recovery-oriented care (n = 4), skills used by professionals in the context of PCC (n = 2), experiences in sensory rooms (n = 2) and disconnection from hospital services (n = 1). All of them are divided into quantitative (n = 2), qualitative (n = 13) and mixed methods (n = 4) studies, and cross-sectional (n = 13) and longitudinal (n = 6) studies. Some of these studies have not exposed the limitations of their studies

Figure 1.

PRISMA flowchart.
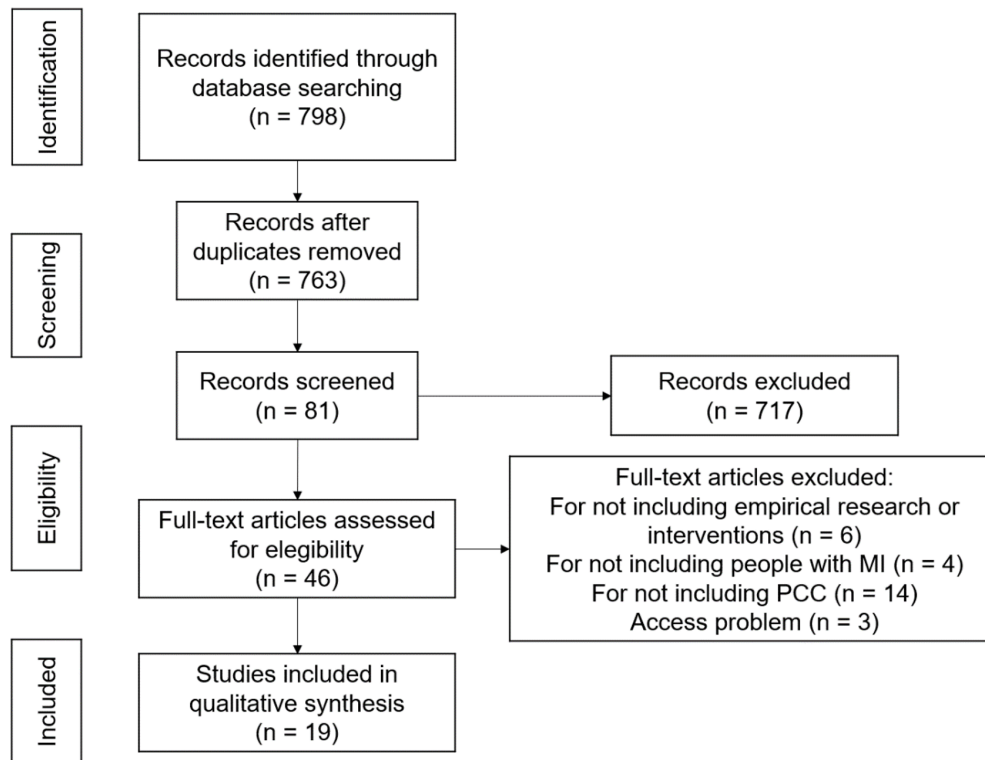
(n = 5). Through the analysis carried out, several different but interrelated topics have been developed below.

Shared decision-making between professional and patient plays a fundamental role in providing PCC. Developing the care plan with the nurse is seen by the person with MI as just helpful in their recovery as the goals and strategies themselves. In addition, it allows staff to better understand the objectives of the participants and to be better able to support them (Reid et al., 2018). This approach can also be used for collaborative prescription of medication, although its implementation depends on a variety of barriers and facilitators at micro (the most powerful and dependent on the appropriate relationships between users, caregivers and mental health professionals), meso (through a holistic approach to treatment and recovery-based activities to engage users) and macro levels (top-down protocols; Brooks et al., 2017). This joint decision-making is essential to promote a healthy lifestyle and it must be present at all levels of the organization (Lundström et al., 2019). In developing countries, the use of this approach can be limited due to the inaccessibility of the chosen treatment, and because it is only used when people are considered as clinically "recovered". Furthermore, caregivers argue that the use of coercion is justified to guarantee the intake of medication (Souraya et al., 2018). It has been found two intervention programs which contain this decision-making approach and, in addition, person-centred relationships and self-directed service (SDS) components (Buchanan et al., 2014; Peterson et al., 2014). In both studies, the results show that the application of these elements allows a greater sense of empowerment and an expansion of connections with the community, as

well as an enriched sense of oneself and a better quality of life.

Recovery-oriented care is another key element in PCC. The use of this approach can lead the person with MI to an increase in resilience, to stronger connections with therapeutic services and to a better understanding of mental health and of the importance of seeking help (Green et al., 2019). Moreover, it can produce to the professionals who use it an "optimistic attitude" that comprises a more positive vision of the future of MI patients, a "new approach to dialogue with clients" in which they focus more on the individual's goal for recovery than in disease-induced goals and, finally, a "person-centred role" through which they value the patient's own ideas, as well as professional standards (Dalum et al., 2015). A study carried out by the team of Hornik-Lurie et al. (2018) with a sample of professionals trained in recovery-oriented care and another one untrained, reveals more significantly positive attitudes in the experimental group than in the control one. Furthermore, the use of this approach is seen by people with MI as necessary to avoid readmission and to improve their quality of life (Cleary et al., 2012). Regarding the disconnection of hospital services, users manifest that the greatest sources of dissatisfaction are related to not feeling involved in the care plan, as well as not knowing the availability of treatments (Nolan et al., 2011). Their main concerns are related to the health and community services and installations available at medical discharge, and to seeking help to overcome loneliness, to structure the day and to find accommodation (Nolan et al., 2011).

Two of the studies implement a community PCC program (Banfield, & Forbes, 2018; Paziuc, 2018). The first one, which contains a sample that includes people with MI, caregivers and service providers, reveals that all participants feel satisfaction with the service in most dimensions (communication, continuity, coordination, teamwork and sustainability). The second one, whose key element is case management, has been associated with an improvement in symptoms and in the level of social and global functioning, with fewer days of hospitalization, with a greater number of contacts between clients and professionals, with a decrease in dropout rates of mental health services and with a lower total cost of care. On the other hand, the team of Stiles et al. (2008) has made a comparison of treatment approaches that include cognitive behavioral therapy (CBT), person-centred therapy (PCT) and psychodynamic therapy (PDT). Comparing the groups treated with each approach, or with one of them plus an additional one (integrative, art or supportive), the results show that the six groups started the treatment with equivalent scores, and that all averaged a marked improvement. However, neither the treatment approach (CBT, PCT or PDT) nor the degree of purity ("alone" or "+1") had statistically significant differences and, furthermore, the distributions of the change scores were all similar.

The possibility of offering home PCC programs is another factor that has been studied. In the study by Giménez-Díez et al. (2019), all respondents report high levels of satisfaction with this type of service, although patients to a greater extent than relatives. In addition, 75% of users affirm that they prefer to spend crises at home and only 5% prefer in the hospital. Likewise, PCC can also be implemented through the use of sensory rooms in psychiatric care settings. Caregivers observe positive consequences in patients when they use them, and they affirm that these rooms are usually used as a self-regulation tool and as a preventive strategy in the face of increased anxiety (Björkdahl et al., 2016). Users, for their part, assert to have experienced a strong calming effect, as well as greater well-being, empowerment, and self-esteem (Lindberg et al., 2019).

Regarding the skills used by professionals to implement PCC, the most notable is the utilization of several "universal" participation skills such as the importance of person-centredness, an adequate communication for engagement, the empowerment of the patient and an easier connection with him (Procter et al., 2015). Also, the worker's attitude seems to be central to the success of the interventions, and those with a "positive attitude" seem to be more effective. However, the stigma of mental health problems and the negative attitudes of others are frequent barriers to establishing such contact networks (Webber et al., 2015) (see Appendix B).

Discussion

The findings of this research show that some authors (Gondek et al., 2016) begin to expose that there is a need, first of all, to create a common definition of PCC and a conceptualization of the policies that support quality results in the provision of services. The application of effective and quality PCC also requires previous training and formation for caregivers and professionals who put it into practice (Eiroa-Orosa & García-Mieres, 2019; Gondek et al., 2016). Likewise, in accordance with other research (Bee et al., 2015), the studies analyzed in this review suggest the urgent need to establish an optimal level of communication between mental health professionals and users, as well as the importance of the promotion of positive relationships and the provision of quality information, in order to correct the imbalance perceived by users, which constitutes the main barrier when applying PCC. Another aspect that seems to be key is the professional care provided at home, since it seems that if institutionalization is avoided, stigma is reduced, and that treatment at home provides patients in crisis with a greater sense of control (Lawrence et al., 2016).

Shared decision-making between the person with MI and the professionals is an essential aspect in PCC. A multitude of studies have shown that this approach improves the quality of life and autonomy of MI patients, that leads them to better participation, greater adherence, and quality of treatment, and that offers them the opportunity to better manage their symptoms and their disease (Slade, 2017). However, studies such as that of Farrelly et al. (2016) show that there are numerous barriers that come mainly from professionals, such as ambivalence about care planning, the perception of many of them that they are already using PCC approach, and the limited availability of options for users. For this reason, direct training of mental health professionals become essential. Another aspect to take into account in PCC is recovery-oriented care. Thomas et al. (2017) tested in a recovery-oriented longitudinal study that patients experienced significant improvement in symptoms and levels of disability. Additionally, this method has also shown to promote empowerment and self-care. However, the degree of use of this approach is often limited only to stabilizing the patient and alleviating his symptoms, which shows that this type of care is far from adequate (Waldemar et al., 2016).

Thus, the implementation of the PCC depends on several factors. An investigation about the failures in the provision of health services highlighted that organizational and governance deficiencies can negatively affect the PCC (Bee et al., 2015). Furthermore, a systematic review carried out in various mental health settings distinguishes a series of factors that influence this aspect (Bee et al., 2015). In particular, professionals blamed users for a lack of interest and ability to participate, as well as the administrative burden and the lack of resources, training and experience in the PCC. On the other hand, users reported the limitations they encountered with regard to communication by the services, with scarce and low-quality information, with lack of emotional support and respect for their autonomy, and with a great imbalance of power with professionals.

As practical implications, several recommendations perceived as key to facilitating PCC are suggested with the aim of developing practical experience of working within this approach: provision of information for users and carers, provided in an understandable way; a shift from a paternalistic to a holistic culture, incorporating patient knowledge, experience, and expectations; better training of professionals; and a greater emphasis on service-user relationships.

This work is not without limitations. There is a high degree of methodological heterogeneity among the articles included in terms of study characteristics. In addition, future research should also explore the evaluation of the effectiveness of interventions. Also, the review was restricted to peer-reviewed publications and, therefore, different arguments may be presented in other sources of information, such as books or gray literature.

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Appendix

Appendix A: Checklist items

Section and Topic	Item #	Checklist item	Page where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	1
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	2-3
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	4-5
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	5
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	6
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	6
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	6
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	6-7
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	7
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	7
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	7
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	7
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	NA
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	6-7
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data	NA

Section and Topic	Item #	Checklist item	Page where item is reported
		conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	NA
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	NA
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	NA
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	NA
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	NA
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	NA
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	7
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	6-7
Study characteristics	17	Cite each included study and present its characteristics.	7-20
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	11-20
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	NA
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	11-20
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	NA
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	NA
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	NA
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	NA

Section and Topic	Item #	Checklist item	Page where item is reported
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	NA
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	21-22
	23b	Discuss any limitations of the evidence included in the review.	22
	23c	Discuss any limitations of the review processes used.	22
	23d	Discuss implications of the results for practice, policy, and future research.	22
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	6
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	6
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	NA
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	23
Competing interests	26	Declare any competing interests of review authors.	23
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	NA

NA: Not applicable.[1]

Appendix B: *Synthesis of revised articles*

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Giménez-Díez et al. (2019) Spain	To assess patients' and their families' satisfaction with the nursing care provided through a home care program offered by a hospital in Catalonia which administers PCC	Cross-sectional Qualitative (semi-structured interviews) and quantitative (questionnaires)	20 patients (7M and 13F) and 20 relatives (unreported)	High levels of satisfaction with the PCC model and with the service, patients to a greater extent than relatives; 75% of the participants prefer to spend their crises at home and only 5% in the hospital	Analysis only from the perspective of patients and relatives, and not from nurses; pressure to give the "correct answer"; difficulty filtering opinions about nursing care in a service that has other facets
Green et al. (2019) Australia	To examine key features of a subacute youth mental health residential service model, *Youth Prevention and Recovery Care* (Y-PARC) service	Cross-sectional Qualitative (semi-structured interviews)	288 patients (93M and 194F; 18-26; personality disorder, depressive disorder, anxiety disorder, psychosis), 14 former residents, 5 family members, 9 stakeholders, and 10 caregivers (unreported)	Practice at Y-PARC aligns with recovery-oriented care. High levels of satisfaction, greater resilience, stronger connections to therapeutic services and a better understanding of mental health and of the importance of seeking help	Low number of qualitative interviews, based on an acceptance strategy, possible sample bias; potential bias in practice reported by staff; the evaluation was conducted very shortly after the first 3 years of Y-PARC establishment
Lindberg et al. (2019) Sweden	To describe patients' own experiences of using sensory rooms in psychiatric inpatient care	Longitudinal Qualitative (interviews)	28 patients (16M and 12F; 15-64; bipolar disorder, depression disorder, ADHD, personality disorder, anxiety disorder, schizophrenia, mental behavioural disorder due to drug use)	Staying in the sensory room decreased emotional distress and muscle tension, there was an increase in well-being, empowerment, self-esteem and self-determination	Unreported

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Lundström et al. (2019) Sweden	To describe mental health nurses' experiences of facilitating aspects that promote physical health and support a healthy lifestyle for people with SMI	Cross-sectional Qualitative (interviews)	15 caregivers (5M and 10F; 30-63; nurse)	Special importance in motivating patients to develop a healthy lifestyle, as well as taking into account the skills and experiences of each of them and joint decision-making	Recruitment of interviews took a long time; possible over-interest in the topic by nurses who participated
Banfield, & Forbes (2018) Australia	To evaluate the processes and outcomes of the *Partners in Recovery* initiative in the Australian Capital Territory	Longitudinal Qualitative (semi-structured interviews) and quantitative (questionnaires)	25 patients (7M, 15F and 3 unknow; ±42.82; unreported), 2 caregivers and 14 service providers (unreported)	Personalized attention was provided to participants with MI, who were satisfied with the dimensions of communication, continuity, coordination, teamwork and sustainability	Low number of recruited participants; those participants who were experiencing an acute episode of MI were not considered in the evaluation
Hornik-Lurie et al. (2018) Israel	To assess the knowledge, attitudes and practices developed following recovery-oriented training of nurses and other staff; to identify the benefits and challenges involved in the implementation of recovery-oriented intervention in psychiatric wards	Longitudinal Qualitative (interviews) and quantitative (questionnaires) Presence of control group	37 caregivers trained in recovery-oriented care and 35 untrained (14M and 58F; ±43; social-worker, nurse, occupational therapist, psychiatrist, psychologist)	Staff trained in recovery-oriented intervention showed significantly more positive attitudes towards recovery care than the control group in most cases	Disproportionate sampling method when trying to compare the small study group (trained staff) with those of the largest group (untrained); source of bias related to Cronbach's low alpha (α = 0.342) of a factor
Paziuc et al. (2018) Romania	To evaluate the impact of a Mental Health Program implemented Campulung Moldovenesc in comparison with standard treatment, on reducing symptoms and improving the overall level of functioning	Longitudinal Quantitative (scales and inventories)	91 patients (41.2% M and 58.8% F; ±50.6; schizophrenia and depression disorder)	Case management was associated with greater improvement in symptoms, fewer days of hospitalization, decreased rates of abandonment of mental health services, improvement in the level of social and global functioning	Unreported

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Reid et al. (2018) Australia	To explore consumer experiences of collaborating in the development of a nursing care plan in an acute mental health unit	Cross-sectional Qualitative (semi-structured interviews)	12 patients (unreported)	Developing the care plan with a nurse was perceived as just useful for recovery as the goals and strategies themselves. Nurses were better able to support participants	Findings may not be directly applicable to other units and their approaches to care planning
Souraya et al. (2018) Ethiopia	To understand the extent of involvement of people with schizophrenia in decision-making relating to their care in Ethiopia in the context of a community-based rehabilitation (CBR) programme and to determine the main influencing factors	Cross-sectional Qualitative (focus groups and in-depth interviews)	18 patients (unreported; 18-70; schizophrenia) and 10 caregivers (4M and 6F; unreported; CBR worker)	Patient involvement in decision-making was limited and coercive practices were evident. Impossibility to execute desired choices due to inaccessible treatment	Non-generalized findings; data were collected at an early stage of the pilot study; possible information bias; users and caregivers may have been reluctant to criticize workers for fear of damaging their relationship
Brooks et al. (2017) England	To explore the potential use of a tool designed to enhance collaborative antipsychotic prescribing from the perspectives of secondary care mental health service users, carers and professionals	Cross-sectional Qualitative (focus groups and semi-structured interviews)	10 patients (5M and 5F; unreported), 10 caregivers (1M and 9F; unreported) and 13 professionals (10M and 3F; unreported; psychiatrist, nurse and pharmacist)	Participants identified a variety of barriers and enablers at micro (dependent on appropriate relationships between the groups), meso (through recovery-based activities), and macro (top-down protocols) levels	Unreported
Bjorkdahl et al. (2016) Sweden	To further understand the experiences of staff who work with sensory rooms in the psychiatric care setting	Cross-sectional Qualitative (open questions) and quantitative (questionnaires)	126 caregivers (unreported; 18-65; nurse and others)	92% of caregivers stated that the effects observed in patients were positive; patients used it as a self-regulation tool and as a preventive strategy in the face of increased anxiety	The chosen design could reach more participants with significant negative experiences; the questionnaire was used without a pre-test procedure

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Dalum et al. (2015) Denmark and USA	To explore health care professionals' experiences when facilitating a recovery-oriented rehabilitation program	Longitudinal Qualitative (in-depth semi-structured interviews)	16 professionals (2M and 14F; unreported; social worker, psychologist, psychiatrist, nurse, occupational therapist)	The results highlight an "optimistic attitude" that includes a change in the attitude of professionals, a "new focus on customer dialogue" about their goals and a "person-centered role"	Unreported
Procter et al. (2015) Australia	To identify the skills and attributes deployed by rural mental health clinicians when engaging with consumers in the community mental health context	Cross-sectional Qualitative (semi-structured focus groups)	9 caregivers (2M and 7F; 30-60; unreported)	There are limitations such as consumer vulnerability and increased risk for physicians and consumers when other support services are lacking; importance of focusing on the person	The generalization of these findings could be limited; insights obtained from other regional settings with different populations (e.g., predominantly indigenous Australians) may differ
Webber et al. (2015) England	To understand how practitioners help people recovering from psychosis to develop their social networks	Cross-sectional Qualitative (semi-structured interviews, observation and informal discussions)	51 patients (32M and 19F; 16-59; unreported) and 73 professionals (30M and 43F; 20-60; social worker, nurse, occupational therapist, psychologist and other)	Workers with a "positive attitude" seemed to be more effective at improving users' social networks. Stigma of mental health problems and negative attitudes were common barriers	Possible bias towards supporting activities to generate social capital; social processes for training and maintaining social relations were not analyzed separately
Buchanan et al. (2014) Australia	To explore the recovery experiences of consumers with MI who had undertaken a pilot shared management, person-centred and SPS	Cross-sectional Qualitative (interviews and questionnaires)	16 patients (44% M and 56% F; ±46; unreported)	Consumers' recovery experiences included greater empowerment and community connections and a better quality of life	Data collected in the past and a small and self-selected sample reduce transferability

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Peterson et al. (2014) Australia	To explore the impact of SPS components, including access to individualised funds, shared management, person-centred relationships, and the opportunity to self-direct their services on the lived experiences of consumers	Cross-sectional Qualitative (interviews and questionnaires)	16 patients (44% M and 56% F; ±46; unreported)	SPS enhanced consumer experiences and enabled access to recovery sources and quality support	The impact of SPS requires further exploration and validation; a self-selected and small sample size limits the transferability of results
Cleary et al. (2012) Australia	To ask acute inpatient mental health nurses about their understanding of recovery and how they are incorporating a recovery paradigm in their day-to-day nursing practice	Cross-sectional Qualitative (semi-structured interviews)	21 caregivers (unreported; nurse)	Positive attitudes, PCC, hope, MI education, medications and their side effects, and recognition of individual recovery pathways are necessary to prevent re-entry	Results may not be generalizable to other settings; very brief survey and open-ended questions, so complete answers were not available for a complex thematic analysis
Nolan et al. (2011) UK	To ascertain how individuals experienced disengaging from inpatient services with a view to determining what improvements could be made to render inpatient care more effective	Cross-sectional Qualitative (semi-structured interviews)	44 patients (18M and 26F; 18-71; unreported)	The main sources of dissatisfaction were with the ignorance of the goals, with not feeling involved in the care plan and with not knowing the available treatments	Unreported

Authors, year and country of study	Aim	Methodology	Participants (gender, age and diagnosis/ profession)	Outcomes	Limitations
Stiles et al. (2008) UK	To replicate a comparison of the outcomes of CBT, PCT and PDT as delivered in routine primary-care mental health practice within the UK National Health Service	Longitudinal Quantitative (scales)	5,613 patients (1,643M and 3,970F; 16-99; anxiety, depression disorder, interpersonal problems, trauma/abuse, addictions, eating disorder, personality disorder, psychosis)	All groups achieved significant improvements (TCC, TCP, TPD, TCC+1, TCP+1 and TPD+1). No significant differences were found among groups	Limited specification of treatments and responsiveness of the therapist; non-random assignment; lack of experimental control; restriction on a self-report measure; possible influence of the researcher; self-regulation as a potential responsible for benefits

M: male; F: female; ±: main age. ADHD: attention deficit hyperactivity disorder.