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Users' Choice and Change of Allocated Primary Mental Health Professional in Community-Based Mental Health Services: a Scoping Review

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Abstract:	Background. The recovery model in mental health care emphasizes users' right to be involved in key decisions of their care, including choice of one's primary mental health professional (PMHP). Aims. The aim of this paper was to provide a scoping review of the literature on the topic of users' choice, request of change and preferences for the PMHP in community mental health services. Method. A search of Pubmed, Cochrane Library, Web of Science and PsycINFO for papers in English was performed. Additional relevant research articles were identified through authors' personal bibliography. Results. 2774 articles were screened and 38 papers were finally included. Four main aspects emerged: 1) the importance, for users, to be involved in the choice of their PMHP; 2) the importance, for users, of the continuity of care in the relationship with their PMHP; 3) factors of the user/PMHP dyad influencing users' preferences; 4) the effect of choice on treatments' outcomes. Conclusions. While it is generally agreed that it is important to consider users' preferences in choosing or requesting to change their PMHP, little research on this topic is available. PMHPs' and other stakeholders' views should also be explored in order to discuss ethical and practical issues.

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Users' Choice and Change of Allocated Primary Mental Health Professional in Community-Based Mental Health Services: a Scoping Review

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	Title	First Author	Year	Journal	Sample population	Results	Conclusions	Sentences/phrases relevant to the choice of the psychiatrist
	CDSR trials							
1	Therapist/patient ethnic and gender matching: treatment retention and 9-month follow-up outcome	Sterling	1998	Addiction	967 African-American cocaine-dependent people referring to community mental health centers	Matching therapists and patients with respect to gender and ethnic group did not decrease the premature dropout rate, but partial support for gender matching was noted.	Matching therapists and substance abusing patients on gender and ethnic group may not be necessary to improving retention and outcome.	*There were some tendencies indicative of a possible gender-matching effect. First, female patients treated by female therapists following discharge tended to continue in outpatient substance abuse treatment. Secondly, retention was approximately 5 days less for patients in the gender-mismatched conditions.*
2	The effect of client choice of therapist on therapy outcome	Manthei	1982	Community mental health journal	14 clients of a community mental health center, divided into three groups for free choice of therapist	Choosing was perceived as a positive act but there were no significant differences among the three groups in their initial reaction to the clinic, number of therapy sessions, type of termination, severity of presenting problems, General Well-Being Schedule scores, Current Adjustment Rating Scale scores, or therapist's satisfaction with therapy.	In the absence of research evidence demonstrating the efficacy of client choice on therapy outcome, support for the notion of client choice remain based on social, ethical, and legal considerations.	*Clients indicated that relationship items (e.g., a therapist who was friendly, understanding, easy to get along with, and able to help clients figure out what to do) were important in making their choice; appearance items (e.g., a therapist who was attractive, reminded clients of someone they knew, was the same age, same sex, and same race) were dearly rated as unimportant.* *Choice clients reported feeling respected, responsible for and in control of themselves, and more willing and hopeful about participating in therapy. Although the final effects of choosing were positive, these effects were not matched by greater improvement scores on outcome measures.* *It may well be that choice of therapist may have an initial positive impact on clients' attitudes to therapy, as was shown in the present study. However, it seems unlikely that this initial favorable impact will be reflected in enhanced long-term outcome.* *In the absence of clear-cut research evidence on the efficacy of client choice of therapy or*

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								therapist on therapy outcome, support for the notion of client choice must be sought elsewhere.
3	The association between continuity of care and readmission to hospital in patients with severe psychosis	Puntis	2016	Social psychiatry and psychiatric epidemiology	323 patients discharged from hospital following compulsory treatment for psychosis	Less frequent changes of care coordintor was significantly associated with lower odds of rehospitalisation and fewer days in hospital. More changes in the patient's care coordinator were associated with more time in hospital.	The study confirmed the expectation that a higher turnover of care coordinator was associated with poorer outcomes and that copying in patients to the communication about them was associated with better outcomes.	*Patients may benefit from stability in their relationships with their community of mental health team in a number of ways. Long-term patient-clinician relationships are believed to contribute to trust and provide a point of stability.* *We found that more frequent changes in care coordinator were associated with longer hospital stays.* *Most patients wish to be engaged with, and informed about, their treatment and patients who receive information about their care report being more satisfied than those who do not.*
4	Enhancing the utilization of outpatient mental health services	Larsen	1983	Community mental health journal	retrospective study of 607 case records of clients of a community mental health center	Early client-therapist interaction significantly reduced the likelihood of no-show, while delay between initial contact & first scheduled appointment increased it. A program for reduction of dropout rate, relied primarily on pre-therapy orientation, tested with 52 clients assigned to experimental or control groups at random, proved pre-therapy orientation effective. Follow-up data after 22 months also reveal benefits from the orientation procedure.	Pretherapy orientation on the mental health care provider can significantly reduce drop-outs rates	*A combination of verbal contact, short delay between this contact and intake appointment, and pre-therapy orientation all contribute to reducing significantly the overall rate of failure to complete treatment.*
5	Racial/ethnic	Ruglas	2014	Communit	224 women	White clients, with severe	Racial/ethnic	*It is possible that when PTSD symptom severity*

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	match and treatment outcomes for women with PTSD and substance use disorders receiving community-based treatment			y mental health journal	who participated in a clinical trial of group treatment for PTSD and substance use disorders.	PTSD symptoms at baseline, who attended treatment groups where they were matched with their therapist, had greater reductions in PTSD symptoms at follow-up than their counterparts who were ethnically mismatched with their group therapist. Ethnic match did not confer additional benefits for Black clients in terms of PTSD outcomes. For substance use outcomes, both Black and White patients who were light substance users at baseline benefited from the individual racial/ethnic match with their group therapist, which resulted in lower odds of heavy substance use posttreatment compared to their racially/ethnically mismatched counterparts.	matching may provide, in some circumstances, a context that facilitates understanding, enhances trust, and strengthens the alliance; under other conditions, racial/ethnic matching may not confer additional benefits or may be negatively associated with post-treatment outcomes.	*is high, the individual racial/ethnic match increased the White patients' level of trust, expectation of relief from symptoms, and perceived therapist credibility and competency. It is possible that, for Black women who participated in this study, the individual racial/ethnic match with their group therapist was less important or irrelevant to the benefits they achieved from the groups.*
	PubMed							
6	Continuity of care as experienced by mental health service users - a qualitative study	Biringer	2017	BMC Health Services Research	10 service users at a community mental health center were interviewed; 8 of these were re-interviewed two years later.	Ongoing personal relationships, choice and flexibility are the most essential dimensions of continuity of care as experienced by service users. Service users in the present study called for mutuality and flexibility in their contact with professional helpers as well as the opportunity to choose the type and location of treatment and support. The experienced rigidity and lack of mutuality	Improving personal continuity of care should be a number one priority. The organization of mental health services should allow for ongoing collaborative partnerships between	*Changes in carer were experienced as setbacks in treatment. These changes sometimes gave rise to feelings of anxiety, frustration, and a sense of being rejected. Several participants appreciated the opportunity they had been given to choose treatment type or place, as well as the opportunity to be involved in deciding when and how the contact with their therapist should happen.*

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						encountered by service users gave rise to feelings of having to 'fight' the system, indifference and exhaustion.	service users and professionals.	
7	Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma (MST): a qualitative analysis.	Turchik	2013	Psychol Services	20 male veterans enrolled in Veterans Health Administration care who reported MST but who had not received any MST-related mental health care.	Veterans identified a number of potential barriers, with the majority of reported barriers relating to issues of stigma and gender. Regarding provider gender preferences, veterans' opinions were mixed, with 50% preferring a female provider, 25% a male provider, and 25% reporting no gender preference.	Veterans reported that the gender of the provider may serve as a barrier. However, veterans were mixed on provider gender preferences. Data suggest that the issue may be important as the majority of the men in this study did have a preference, and could impact a man's likelihood to enter or continue treatment.	*A set of open-ended questions regarding MST were asked, including: Do you think that male veterans would feel more comfortable talking to either a male or female care provider about military sexual trauma, or the same?* ***Prefer female provider.*** ***Veteran 5.*** *I would prefer a woman, but that's just me, because I think they're more compassionate I guess.* ***Veteran 8.*** *Especially if they're homophobic and if they had been traumatized. Um, they would feel insecure or self-conscious about sharing that with another man.* ***Veteran 17.*** *Having a female provider makes it easier for me to share sensitive information.* ***Prefer male provider.*** ***Veteran 1.*** *I would say most men would rather talk to a man about that experience than a woman.* ***Veteran 2.*** *[I]f they [male victim] talk about if somebody got raped or something, and they start breaking down crying or something because it's a very traumatic event for them, that might even be more embarrassing to them that it's happening in front of a female. So if they were to cry in front of a male then the doctor can say that's all right, it's all right. May*

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								not have the same feelings if a female were around, so I think they could kind of be stronger in that situation. ***Veteran 18.*** *I think they would feel more comfortable speaking with the same gender. Because the issues . . . a woman knows a woman's body, and all those details better than a man would, and vice versa.*
	PsycINFO							
8	Do patients prefer optimistic or cautious psychiatrists? An experimental study with new and long-term patients.	Priebe	2017	BMC Psychiatry	100 new and 100 long-term patients	Cautious treatment presentations were strongly associated with a lower mean score compared to optimistic presentations in the whole sample. The mean difference between optimistic and cautious videoclip scores varied significantly between new and long-term patients. New patients had a lower mean score for cautious video-clips whereas there was no difference in ratings of long-term patients between optimistic and cautious video-clips.	Psychiatrists should suggest treatments with optimism to patients with little experience of mental health care. This rule does not apply to longer-term patients, who may have experienced treatment failures in the past.	*(…) patients rated their preferences on a four item scale. The four items were:* *(a). Do you believe this is a good doctor?* *(b). Would you have trust on this doctor?* *(c). Would you like this doctor to be your psychiatrist?* *(d). Would you like to start the new treatment with this psychiatrist?*
9	Boundaries and relationships between service users and service providers in community mental health services	Grant	2016	Social Work in Mental Health	26 mental health services users and 19 service providers	Both groups noted that the relationship feels troubled when they experience a lack of connection. When speaking of its positive characteristics, participants identified that the helping relationship is supportive, flexible, respectful and professional. Service users noted that boundaries in the helping relationship are	Participants prefer a supportive, flexible, and respectful relationship. They highlight the importance of boundaries for increasing safety, and the	*For both service providers and service users, a positive relationship is characterized as supportive, flexible, respectful and professional (although it is not entirely clear as to what "professional" means to each individual). For service providers, a positive relationship is also informal and it is goal-directed.* *According to both service provider and service user participants, it would appear that boundaries are helpful for creating safety within the context of a relationship perceived as well-*

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						important to maintaining personal safety (respecting privacy for users).	danger created when boundaries are neglected or inadequate.	*functioning. The safety that both groups of participants identify as an outcome of ensuring there are boundaries in the relationship seems to contribute to the experience of connection within the helping relationship.*
10	Shared decision making in public mental health care: perspectives from consumers living with severe mental illness	Woltman	2010	Psychiatric Rehabilitation Journal	16 users with severe mental illness being treated in the public mental health care system participated in qualitative interviews	Mental health consumers generally endorse a "shared" style of decision making. When asked what "shared" means, however, consumers describe a twostep process which first prioritizes autonomy, and if that is not possible, defers to case managers' judgment.	Mental health consumers may have a different view of decision making than the literature on shared decision making suggests.	*Consumers clearly view decision making in the broader context of an ongoing relationship with their case managers. Shared decision making in mental health may require an emphasis on the partnership aspect of decision making. The importance of trust and partnership in the context of decision making may be particularly relevant to long-term consumer-provider relationships encountered in the course of chronic illness care.*
11	Client-case manager racial matching in a program for homeless persons with serious mental illness	Chinman	2000	Psychiatric Services	1,785 homeless users with mental illness in an intensive case management program	Although African Americans had more severe problems on several measures and higher levels of service use at baseline, no differences in service use or in the changes in client outcomes were associated with the different pairings of African-American and white clients and case managers. No differences were found between white and African-American clients on the amount of services received over time.	This study found virtually no evidence of a relationship between client race, case manager race, or client-case manager racial matching on either outcomes or service use.	*Homeless mentally ill clients may be more concerned with receiving practical assistance – for example, obtaining stable housing, food, entitlements and mental health services- than with the race with their case manager.*
12	Understanding the role of individual consumer–	Stanhope	2010	Community Mental Health Journal	Dyad between 42 users with long-term	High frequency users expressed a preference for working with a particular case manager over others. Reasons	Teams need to consider how individual relationships	*One consumer expressed some frustration over the need to repeat information to different people "Me and [the case manager]'s relationship, you know, we are close, because I*

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	provider relationships within assertive community treatment				street homelessness, severe mental illnesses and substance use dependence and 9 case managers in assertive community treatment services	given for this were: feeling at ease with them; that they had a particular connection; or simply that they felt they had better results with this case manager. In contrast, users in less service intense relationships were more likely to refer to the case manager and the team interchangeably. The low service intensity relationships could be reflective of not liking a particular case manager.	enhance care for their users. Individual case manager-users relationships are an important tool in engaging and maintaining users in services, even within a team model of service delivery.	*find it hard to talk to a whole lot of different people, you might talk to one person, and they might not know what you're talking about, so they go back and talk…, so I think it is better if actually talk to one person and you keep contact with them and that way so you don't have to worry about all these different people". Whereas within low service intensity relationships, consumers spoke more frequently about being integrated on the team: "I don't talk to one I talk to them all, I can't say I really have any favorites because I like them all".*
13	Patient Preferences for the delivery of military mental health services	Gould	2011	Military medicine	163 patients	5% preferred to be seen by a uniformed mental health clinician, 30% by a non uniformed clinician, and 65% reported no preference. Gender and service were associated with care provider preference and service was associated with location preference.	The Armed Forces need to explore and identify ways of accommodating their patients' preference, especially regarding the uniformed status of their care provider, to achieve good engagement and treatment acceptability.	*Military personnel accessing mental health care did not prefer to be seen by a uniformed care provider at a service off-site from a military establishment. The majority of personnel did not express a preference for the uniformed status of their care provider or the location of facilities. There is an increased fear held by patients about how they will be perceived by their uniformed rather than their nonuniformed colleagues. it is possible that patients perceive seeing a nonuniformed clinician as providing greater freedom to disclose vulnerabilities away from the normal culture that espouses toughness and resiliency, which in a mental health setting might compromise disclosure and engagement. Also, concerns about confidentiality exist in the military and it is possible that patients are more willing to confide in and trust providers perceived to be outsiders.*
14	Racial matching and service utilization among seriously	Blank	1994	Community Mental Health Journal	677 Caucasian and African American	Same-race dyads tended to have greater service utilization as indicated by a greater number of made	Racial matching seems to influence service	

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	mentally ill consumers in the rural south.				seriously mentally ill users of a rural community mental health center in the southeastern United States	appointments over the study period. An interaction was found for failed appointments where African Americans in same-race dyads were more likely to fail appointments, while caucasian consumers in same-race dyads were less likely to fail appointments.	utilization, with differences between African Americans and Caucasian users.	
15	Determinants of anti-psychotic medication compliance in a multicultural population	Ziguras	2001	Community Mental Health Journal	168 clients from diverse ethnic backgrounds. Multiple regression analysis was used to examine the predictors of medication compliance.	The main predictors of greater compliance were greater general cooperation with staff, better insight, and matching clients with a case manager from the same ethnic background. Clients matched with a case manager of the same ethnic/linguistic background had higher rates of medication compliance than those matched with a case manager from a different ethnic background.	A shared cultural and linguistic background could allow greater communication about the illness and the medication. It may be that clients are more willing to accept advice from case managers who they feel have a better understanding of their cultural values and beliefs.	*It could be assumed that a shared cultural and linguistic background between clients and case managers allows greater communication about the illness, and the importance of medication in addressing symptoms. It may be that clients are more willing to accept advice from case managers who they feel have a better understanding of their cultural values and beliefs.*
16	Emergency care avoidance: Ethnic matching and participation in minority-serving programs.	Snowden	1995	Community Mental Health Journal	Users from a county level mental health service system	When clients were matched with an ethnically similar clinician who was also proficient in their preferred language, they had fewer emergency service visits than did clients who were unmatched on the basis of	More research is needed to document the impact of matching along with greater attention to minority	

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						ethnicity and language. Clients in programs serving a relatively large proportion of minority clients had fewer emergency service visits than those in programs serving a smaller proportion of minority clients.	oriented programs.	
17	Black mental health client's preference for therapists: A new look at an old issue	Tien	1985	International Journal of Social Psychiatry	15 male and 15 female Black clients from a community mental health center were interviewed	The 60% of the sample preferred Black therapists, but the result was not statistically significant since the low sample size. Major reasons for preferences were professional competence and attitudes.	With the small sample size the difference between responders and non-responders was within the normal range expected.	*The major reasons for preferences were the perceived professional competence and attitudes, not just the cultural, race and linguistic compatibility.*
18	Consumer evaluation of a community mental health service: II. Perceptions of clinical care	Lorefice	1984	The American Journal of Psychiatry	371 patient self-report and therapist Questionnaires from an Italian Community Mental Health Center	Patients' desire for advice, the perceived helpfulness of therapy, patients' preference for a therapist of their ethnicity, and the usefulness of such evaluations in mental health care delivery, were investigated.	The two groups of patients who most preferred a therapist of their own nationality were those with the least education and those who spoke only Italian.	*Again, such results imply that hiring indigenous staff with an ethnic background similar to that of the community they serve may be less important to patients than previously believed.*
	Web of Science							
19	Likelihood of Attending Treatment for Anxiety Among Veteran Primary Care Patients: Patient	Shepardson	2016	Journal Of Clinical Psychology In Medical Settings	144 non-treatment seeking Veteran primary care patients reporting	Participants indicated clear preferences for individual, face-to-face treatment in primary care, occurring once a month for at least 30 min and lasting at least three sessions.	Primary care programs should take patient treatment preferences into account as	*Clinicians (…), reserachers (…) and administrators should take patient treatment preferences into account as much as possible within the context of clinical judgement.*

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	Preferences for Treatment Attributes				current anxiety symptoms		much as possible. Improving the patient-centeredness of care is likely to improve treatment engagement, retention, adherence, and outcomes.	
20	Patient Preferences of a Low-Income Hispanic Population for Mental Health Services in Primary Care	Herman	2016	Administration And Policy In Mental Health And Mental Health Services Research	Discrete-choice experiment was administered to 604 users of a Community Health Center	Spanish-speaking ability and cultural awareness of the provider influenced patient choices. Variations in the location where services were available exerted more influence on patient choices than any other attribute.	Where patients receive services and the language and cultural awareness of the provider had the largest influence on patient choices.	*Most participants preferred to have a provider who both speaks Spanish and understands their culture. It is interesting that the cultural competency was more preferred than the linguistic competency*
21	Mental Health Service And Provider Preferences Among American Indians With Type 2 Diabetes	Aronson	2017	American Indian And Alaska Native Mental Health Research	218 American Indians/ Alaska Natives	The majority (79%) of participants would prefer a Native provider. Living on reservation lands was associated with increased odds of Native provider preference. Significant gender differences existed in regards to provider gender concordance, with females demonstrating a preference for a female provider.	Racial concordance is important among American Indians / Alaska Natives. Cultural training for providers could improve care.	
22	A need for ethnic similarity in the therapist-patient	Knipsheer	2004	Journal Of Clinical Psychology	82 Turkish and 58 Moroccan outpatients in	The majority of the respondents did not value ethnic matching as important; clinical competence and	Patients from a minority background may prefer to	*When a choice is possible, ethnic-minority patients should be asked for their preferences with regard to the ethnic background of a therapist. However, matching an ethnic minority*

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	interaction? Mediterranean migrants in Dutch mental-health care				the community mental-health care were interviewed.	compassion were considered to be more relevant than ethnic background.	be treated by a therapist from outside their own group.	*patient to an indigenous professional is certainly not by definition a mismatch—as long as the therapist displays "cultural sensitivity".*
23	The importance of ethnic similarity in the therapist-patient dyad among Surinamese migrants in Dutch mental health care	Knipsheer	2004 b	Psychology And Psychotherapy-Theory Research And Practice	96 Surinamese out-patients in community mental health care were interviewed.	The majority of the Surinamese out-patients (in particular recently residing participants) rated ethnic matching as relevant; a considerable minority considered compassion and expertise to be more relevant than ethnic background. Most out-patients reported to be satisfied with the services, especially females and respondents treated by an ethnically similar therapist.	Ethnic similarity is a strong predictor for satisfaction with mental health care services. Possibly, it is the fear of a clash of world views within ethnically dissimilar dyads that underlies much of the preference for ethnic similarity.	
24	Ethnic Matching of Clients and Clinicians and Use of Mental Health Services by Ethnic Minority Clients	Ziguras	2003	Psychiatric service	2935 people who had contact with the mental health service system for one week or more over the two-year evaluation period from 1997 to 1999 in the	Clients with a non-English-speaking background were matched with a bilingual, bicultural case manager, in comparison with another group of clients that were not matched. Ethnic matching was associated with higher frequency and longer duration of contact with community services, lower level of need for crisis intervention and, in some cases, with fewer	The results of this study suggest that mental health programs serving culturally and linguistically diverse communities can achieve better service use outcomes	

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					western region of Melbourne	inpatients interventions. The effect of ethnic matching may be more pronounced for more recently arrived groups or those with poorer English language skills.	by recruiting bilingual staff.	
25	Hispanic client-case manager matching: Differences in outcomes and service use in a program for homeless persons with severe mental illness	Ortega	2002	Journal of Nervous And Mental Disease	242 Hispanic and 2333 white users who received assertive community treatment.	When treated by a Hispanic clinician, Hispanic clients showed less improvement in symptoms of psychosis.	These results do not support the hypothesis that ethnic and racial matching improves outcomes or service use.	
26	Patient preference for gender of health professionals	Kerssens	1997	Social Science and Medicine	961 participants of the Dutch Health Care Consumers Panel, a panel resulting from a random sample of Dutch households	For female in the mental health field the preferences shift more towards female care provider and there are slightly more preferences than in the field of somatic medicine. Preferences of male service users for the gender of their psychiatrists and psychologists were equally spread over the two sexes.	Preferences for the gender of therapist are stronger among female patients than among male patients, and more explicit for the domains of nursing and obstetrics than for the domains of medicine and mental health care.	*Within the field of mental health, there are slightly more preferences then in the field of somatic medicine, and the preferences shift more towards female care providers. Men show less gender preferences over a range of disciplines. Male preferences for psychiatrists and psychologists are equally spread over the two sexes. The rather strong gender preferences for psychiatrists and psychologists, because evaluating the mental health status constitutes a very intimate situation.*
	Grey Literature							
I	Patient Choice Survey in	Simon Hill	2006	Psychiatry On Line	111 patients	For 42.2% choice of clinician was 'very important' or	It is important for many	*Most patients felt that having choice over whom they were seen by and when and where they*

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	General Adult Psychiatry					'essential'; for 26.7% was 'very important' or 'essential' to be able to choose the time they were seen, for 31.7% was 'very important' or 'essential' being able to choose the venue that they were seen by a clinician. 48% wanted to be seen at home. 88.8% would choose for the clinician seeing them to dress either 'casually' or 'smart but casual'.	psychiatric patients to have choice concerning where they are seen and particularly who sees them.	*were seen was important. Choice of clinician was particularly important to patients.* *One suspects that in most mental health teams patients do not have much choice over who is allocated to them. This is particularly true for consultant psychiatrists who often cover a geographical 'patch' and would have all the patients in this area under their care. Patients can ask to change consultant but this clearly requires the agreement of a psychiatrist covering a different 'patch'.* *There is little incentive to take on more patients within the NHS so often patients find it very difficult to change consultant.*
II	What influences patients' decisions when choosing a health care provider?	Groene woud	2007 ?	Health Services Research	616 patients with knee arthrosis, 368 with chronic depression, 421 carers of patients with Alzheimer's disease.	Patients with chronic depression chose health care providers on the basis of the continuity of care and relationship with the therapist.	A proportion of patients will benefit from comparative quality information about care providers.	*We think these results are relevant for policy makers and organizations in the health care sector interested in patient preferences for care providers, for example, because they are involved in developing patient information ... or because they purchase or supply health services and want these to be demand-oriented.*
III	Incentive effects of choosing a therapist	Ersner-Hershfi eld	1975	Journal of Clinical Psychology	10 staff therapists and 55 individuals who consulted a community mental health center in northern California.	A significantly higher proportion of patients who could choose their therapist on the basis of information on therapy style kept their scheduled appointments in comparison with patients who could not make a choice. However, no significant differences were found on client and therapist evaluations of the initial interview.	The opportunity to exercise choice from the very first clinic contact appears to have bolstered clients' investment in following through with their initiative.	*During the last few years, the notion that clients have rights and privileges as consumers has been advanced with increasing emphasis. The opportunity to make informed choices about a therapist remains largely confined, however, to individuals who can afford to seek out private treatment. Few public clinics routinely solicit clients' therapeutic preferences. Thus, when a suitable client-therapist matching is achieved fortuitously, the client usually has not had input into its creation.*

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IV	Decision making and information seeking preferences among psychiatric patients	Hill S	2006	J of Mental Health	205 patients of a community mental health center	The Autonomy Preference Index (API) was adapted for use in psychiatry and administered. Patients' desire for information regarding their illness and treatment was very high. There was a great variation in the extent patients wanted to make decisions regarding their care. Desire for decision making was greater for the young and for those in employment.	Psychiatric patients appreciated a high degree of information regarding their psychiatric care. Most patients wanted to play some role in decision making.	*Patient choice is a cornerstone of the British Government's health policy (Department of Health, 2003). However patient choice can mean different things to different people. As well as choosing which health provider to go to, it is possible to offer individual patients more choice in their individual treatment, but to make choices patients need information and to be allowed to take part in decision making*
V	The Effects of Working Alliance and Client-Clinician Ethnic Match on Recovery Status	Chao	2012	Community mental health journal	67 patients	Clients in the ethnically matched group reported significantly higher WA (working alliance) compared to the non-matched group. Clients who reported a higher level of WA also reported better recovery status.	Ethnic matching may help to augment WA and address barriers to treatment engagement	*Strong working alliance may help promote clients' recovery.*
VI	Revisiting relationship between sex-related variables and continuation in counselling	Harthet t	2004	Psychological reports	245 college students in individual counseling at a small liberal arts college located in the northeastern USA	Clients' sex was significantly related to counseling duration. Female clients, on the average, attended 1.8 more sessions than male clients. However, neither the therapists' sex nor dyad matching on sex was significantly related to the duration of counseling.	Gender matching has, at best, a negligible relationship to continuation in counseling.	*Therapists' sex and matching on sex were unrelated to counselling duration, and none of the sex-related variables were significantly associated with premature termination from counseling.*
VII	The Effect of Dressing Styles and Attitudes of Psychiatrists on Treatment Preferences: Comparison between	Atasoy	2015	Noro Psikiyatr Ars.	153 patients referred to an outpatient psychiatry center, and 94 psychiatrists	While psychiatrists preferred to dress in a suit, casuals, and white coat, preference order was white coat, casual dress, and suit in the patient group. There was a significant difference between the groups with respect to three	Patients are traditional in terms of their preference of the dressing style of a doctor and doctor–patient	*The patient group was asked 5 Likert-type question (…): "How important is the dress of a psychiatrist for your trust in treatment?",* (…), *"What is your order of importance when evaluating the dress and other behavioral attitudes of psychiatrists?", (…), "Which age group do*

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	Patients and Psychiatrists					dressing styles.	relationship; a white coat is important to enhance the treatment adherence of patients.	*you prefer the psychiatrist to be in?", (…),"What is your preferred gender for the psychiatrist for treatment?", (…), "How would you like the psychiatrist to define you?", (…), "How much do you prefer to refer to the psychiatrist in the picture for treatment?", (…),"How much do you trust the psychiatrist in the picture for treatment?", (…) "How much do you prefer to share confidential matters (social, sexual, and psychological) with the psychiatrist in the picture?".*
VIII	How should psychiatrists dress?-a survey	Nihalani	2006	Community Mental Health Journal	100 patients and 77 psychiatrists responded to a survey	Both the patients and psychiatrists considered dress to be an important part of the doctor-patient relationship. A large proportion of patients stated that white coat had a negative impact on the relationship between the physician and the patients, and that the physician, both male and female, should dress in a comfortable manner.	Personal attire is an important part of being a professional; patients think that a casual and confortable dress could be a good dress for their mental health professional.	
IX	The influence of client's ethnicity on psychotropic medication management in community mental health services	Ziguras, Lambert, Mc-Kenzie, & Pennella	1999	Aust N Z J Psychiatry	168 clients of five community mental health services in Melbourne	Matching for a case manager of the same background had no effect except for route of administration, with matched clients less likely to receive depot medication than unmatched.	The ethnic background of clients had little influence on the quality of medication management they received from community mental health services.	

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X	The effects of culture-compatible intervention on the utilization of mental health services by minority clients	Flaskerud	1986	Community Mental Health Journal	The sample (N=300) was 23.5% Mexican, 22.8% White, 18.1% Black, 17.1% Vietnamese, 16.8% Pilipino, and 1.7% other ethnic group.	A culture-compatible approach was found to be effective in increasing utilization. Three culture-compatibility components were the best predictors of dropout status: language match of therapists and clients, ethinic/racial match of therapists and clients, and agency location in the ethnic/racial community.	Culture matching is effective in increasing utilization of mental health services by minrority users.	
XI	Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy	Flaskerud	1991	Community Mental Health Journal	1746 Asian clients in mental health services	Client-therapist language match and ethnic match significantly increased the number of client sessions with the primary therapist. Ethnicity match had a significant effect on dropout rate. Gain in GAS (Global Assessment Scale) admission–discharge score was not affected by ethnicity or language match. Gender match had no consistent effect on the dependent variables.	Both client-therapist language and ethnicity match are important variables affecting the utilization of treatment.	*It is possible to place too much emphasis on client-therapist ethnicity and language match and thereby to overlook within group ethnic differences in belief system and communication styles.*
XII	Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis.	Sue	1991	J Consult Clin Psychol	thousands of Asian-American, African-American, Mexican-American, and White clients using outpatient services in the Los	Asian Americans and Mexican Americans underutilized, whereas African Americans overutilized, services. African Americans also exhibited less positive treatment outcomes. Furthermore, ethnic match was related to length of treatment for all groups. It was associated with treatment outcomes for Mexican Americans. Among clients who	The hypothesis that therapist-client matches in ethnicity and language are beneficial to clients was partially supported.	*(…) ethnic match appears to have a much greater impact on length of treatment than on outcomes. Perhaps interpersonal attraction is increased when one is working with an ethnically similar therapist, and clients may be more motivated to stay in treatment longer. However, such attraction may not strongly influence outcomes.*

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					Angeles County mental health system.	did not speak English as a primary language, ethnic and language match was a predictor of length and outcome of treatment.		

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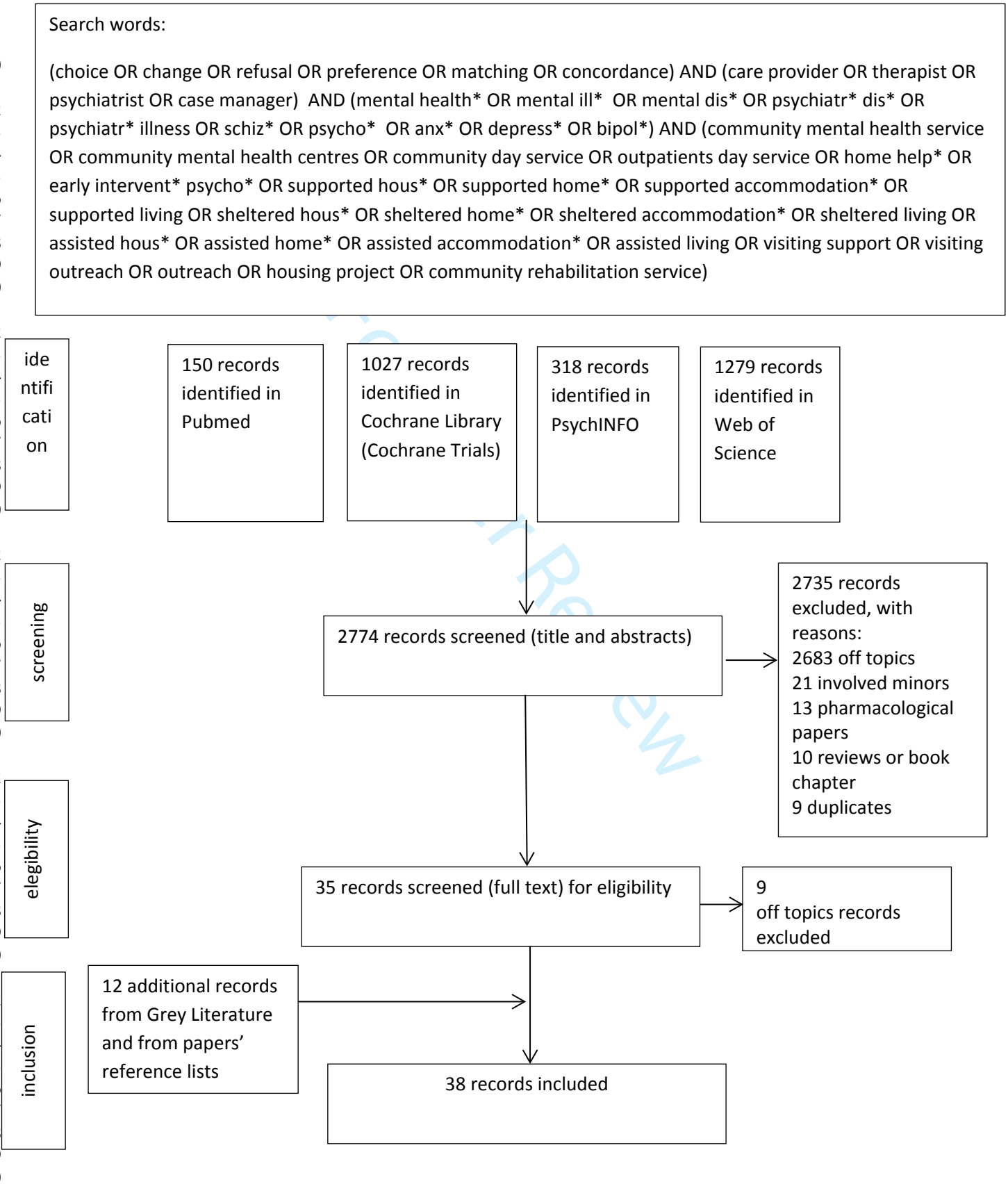
Figure 1. Flow-chart of papers'selection.



Users' Choice and Change of Allocated Primary Mental Health Professional in Community-Based Mental Health Services: a Scoping Review

Introduction

Service Users' choice in the light of the recovery paradigm

The recovery model in mental health, developed from the study of subjective experiences of illness and healing process of persons with mental health problems, has gained wide recognition in mental health policies and practice (Anthony, 2007). This model focuses on the process of care, promoting service users' right to co-produce and choose with carers key decisions of their care (Slade et al., 2014). Increasing choice is expected to create better alignment between what service users want and what services subsequently provide (Piat, Seida, & Padgett, 2019; Aylott, Tiffin, Saad, Llewellyn & Finn, 2018; Samele, Lawton-Smith, Warner & Mariathasan, 2007). Service users' right to choose or be involved in the choice of their primary mental health professional (PMHP) may be another relevant aspect.

The choice of their PMHP: ethical framework

The right for the users of community mental health services to choose their PMHP is in line with the principle of the respect of Autonomy, one of the four fundamental principles of biomedical ethics (Beuachamp & Childress, 1979). This ethical foundation of the freedom of choosing one's PMHP is reflected also in deontological professional codes. For example, article 27 of the Italian Code of Deontological Medical Ethics, entitled "Free

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choice of the physician and of the place where to receive treatment " (Title III, Chapter 2, Art. 27), states: *"The free choice of the physician and of the place where to receive treatment is the basis of the physician-patient relationship. In the professional activity, both in public and in private settings, the free choice of the physician is a fundamental right of the citizen. Any agreement between physicians aimed at limiting citizens' right to free choice is forbidden."* (Ordine dei Medici Chirurghi e degli Odontoiatri, OMCEO, 2014).

Users' choice of PMHP: national health policies

While the right to choose one's primary care physician, subject to availability and to specific geographical boundaries, is nowadays a widespread and accepted practice in many Western countries and several studies have investigated its implications (Tan, Erens, Wright & Mays, 2015; Legarde, Erens & Mays, 2015; Mays et al., 2014; Robertson, Dixon & Le Grand, 2008), this does not appear to be a reality in mental health.

In the UK, the document "Creating a Patient-Led NHS" (Department of Health & National Health Service, DOH & NHS, 2005) stated that the strategic aim of the NHS is to promote patient-centred pathways to care and services not only in primary care, but also in mental health settings. Therefore, in 2012, the right for NHS patients to choose their mental healthcare provider for out-patient treatment was affirmed (Department of Health, 2012). However, several factors prevented the system from working as it was intended, such as lack of information and awareness about this right, of the principle of patient choice for out-patient treatment; misuse of care pathways; lack of direct access by many primary care physicians for out-of-area referrals; delays in authorization for funding. So, parity of care

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between physical and mental health remains problematic and not working in practice (Veale, 2018).

The freedom of choice in health care has become an important topic also in Australia (Peterson, Buchanan & Falkmer, 2014), New Zealand, USA and Canada, where the mental health choice agenda focused in promoting a wider and more informed choice (Warner, Mariathasan, Lawton-Smith & Samele, 2006). In the USA, the list of the ten 'Rules for quality mental health services in New York State' (2004), commissioned by the New York State Office of Mental Health, mentions as first rule that "There must be no uninformed choice". Despite this, true choice is limited by the range of available services and the complexity and lack of coordination between different agencies (statutory, voluntary and private) (Samele et al., 2007).

In Scandinavia, and in Sweden in particular, the “New Public Managements” (NPM) programme promoted reforms which, starting from primary care, have encouraged the exercise of patient choice (Glenngård, Hjalte, Svensson, Anell & Bankauskaite, 2005), in line with the concept of "responsiveness" (Johansson & Eklund, 2003). The organisation of public welfare services was transformed into quasi-markets, with patients no longer strictly referred to their own district’s services as before. However, recent published data shows that such implementations do not necessarily develop in the intended directions, and authors call for more global research on this widespread phenomenon (Fjellfeldt & Markström, 2018).

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In Italy, the Law 833 (1978) and its following implementations protects the right of choosing and changing one's primary care physician and paediatrician, according to the principle of interpersonal trust. Despite a very long tradition of community-based mental health services (Fioritti & Amaddeo, 2014), where the PMHP is still the key figure to coordinate the contribution to care by different professionals, service users cannot generally choose their PMHP (Barbato et al., 2014). Only anecdotal reports exist that some Italian mental health centres have locally implemented operative instructions guiding how to manage users' request for choice and/or change of their PMHP (for example: Department of Bologna, Italy).

Users' choice of their PMHP: views of users and associations of users

Mental health services' users have asserted their right to choose a provider that best suits their individual needs and preferences, and users' organizations are vocal on these issues as part of the drive to achieve parity between mental health and physical health. According to the UK National OCD Charity website, for example, having a 'Right to Choose' the PMHP can be helpful for reasons such as that the user may wish to access treatment closer to work or another location or that the user may wish to access treatment at a neighbouring service provider that has a better track record of treating the specific disorders the patient suffers from or shorter waiting times. (the National OCD Charity, https://www.ocduk.org/overcoming-ocd/accessing-ocd-treatment/accessing-ocd-treatment-through-the-nhs/right-to-choose/). Moreover, several free online platforms are available to provide information to patients on their rights and on the pathways to choose their PMHP

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(NHS Choices, https://www.nhs.uk/; mental health charities like, for example, Mind, https://www.mind.org.uk/ and Rethink, https://www.rethink.org/).

Aim of the Paper

The aim of this paper was to provide a scoping review of the scientific literature on the area of the choice and request of change of the allocated PMHP by users of community mental health services.

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Method

A scoping review of the literature was undertaken according to the framework outlined by Arksey and O'Malley (2005), searching the question: "What is known from the existing research about users' choice, request of change of, and preferences for the allocated PMHP (generally, a psychiatrist) in community mental health services?". The review included the following key phases: 1) identifying the research question; 2) identifying relevant papers; 3) study selection; 4) charting the data; 5) summarizing and reporting the results (detailed review protocol available on request). As indicated in the website homepage (https://www.crd.york.ac.uk/prospero/#guidancenotes), PROSPERO does not currently accept registrations for scoping reviews, it was therefore unable to accept our application or provide a registration number.

Search strategy and data sources

An effective combination of search terms breaking down the review question into 'concepts' was constructed. For each of the elements used, possible alternative terms were considered. Since community mental health care includes various services with

different names, our review adopted the search strategy described by Bonavigo and colleagues (Bonavigo, Sandhu, Pascolo-Fabrici & Priebe, 2016) to assure a range of service settings were represented.

Pubmed, Cochrane Library, PsycINFO and Web of Science databases were searched on the 28th of December 2018 for papers published in English with the following keywords:

(choice OR change OR refusal OR preference OR matching OR concordance) AND (PMHP OR therapist OR case manager OR psychiatrist OR mental health care provider) AND (mental health* OR mental ill* OR mental dis* OR psychiatr* dis* OR psychiatr* illness OR schiz* OR psycho* OR anx* OR depress* OR bipol*) AND (community mental health service OR community mental health centres OR community day service OR outpatients day service OR home help* OR early intervent* psycho* OR supported hous* OR supported home* OR supported accommodation* OR supported living OR sheltered hous* OR sheltered home* OR sheltered accommodation* OR sheltered living OR assisted hous* OR assisted home* OR assisted accommodation* OR assisted living OR visiting support OR visiting outreach OR outreach OR housing project OR community rehabilitation service)

Terms were identified by searching titles, abstracts, keywords, medical subject headings and mapping terms to subject headings. Additional relevant research articles were identified through authors' personal bibliography. Reference lists from relevant papers were also screened.

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Inclusion criteria

Qualitative and quantitative empirical papers and opinion papers were included in the review. The search was restricted to articles published in English and referring to adults with mental disorders. Studies were only included if the setting was related to community mental health services. There were no restrictions on publication status or publication date. We also included studies focused on factors influencing patients' preferences on the investigated topics, since papers exclusively addressing patients' opinions and experience were few.

Exclusion criteria

We excluded papers if they did not clearly focus on our topic of interest in an explicit way (off-topic) and if they referred to minors. Papers on choosing and requesting to change PMHP which were not based in adult community mental health settings and did not mention users' preferences were excluded as well. Finally, reviews, book chapters and editorials, and papers focused on pharmacological treatments were also excluded.

Study selection

Papers were retrieved and included according to PRISMA statement recommendations (Moher, Liberati, Tetzlaff & Altman, 2009). Duplicates were removed and titles and, were available, abstracts were initially screened for inclusion by three authors (AM, GR, RV) independently; disagreements were resolved by consensus with a fourth reviewer (GMG). In cases when a definite decision could not be made based on the title and/or abstract

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alone, the full paper was obtained for detailed assessment against the inclusion criteria. For each selected paper, three authors (AM, GR, RV) screened the full text, extracted and summarised data.

Charting the data

Data extraction was performed for the following study characteristics: year of publication, first author, journal, study design, sample size and population, findings, outcomes of interest about choice (how the concept of choice of the PMHP had been defined, understood or interpreted within different community-based settings). In a modified two-steps narrative synthesis approach, we identified all instances where choice/change of mental health PMHP were used across the included studies and integrated them into a conceptual framework.

Collating, summarising and reporting results

Extracted data from the reviewed studies were reported in tabular material, available as supplementary material. The software used for the data collection was Excel (Microsoft Corporation). The synthesis of the findings was performed according to a thematic analysis method, through the identification of important or recurrent themes. Findings were summarised under thematic headings in the Results section. Mendeley bibliographic software (Mendely Desktop, Version 1.19.3, ©2008-2018) was used to record and manage references. A meta-analysis was not conducted due to the diversity of populations, study designs, and measured outcomes.

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Results

The initial bibliographic search yielded 2774 records, which were reduced to titles and abstracts to be further screened. Of these, 2683 were excluded because off-topic, 21 because concerning minors, 13 were papers about drugs and pharmacology, 10 were reviews or comment or book chapters, 9 were duplicated records. Therefore, 35 full-text papers were eligible. Further 9 off-topic studies were excluded. Additional 12 relevant research articles were included, identified through authors' personal bibliography. Finally, 38 papers were included in the review. Figure 1 shows the flow of articles' selection.

- *Insert Figure 1 about there* -

What follows is the narrative summary of findings derived from the included studies, reported under four main headings: 1) the importance for users to be involved in the choice of PMHP; 2) the importance for users of the continuity of care; 3) the factors of the users/PMHP dyad influencing users' preferences; 4) the effect of choice on treatments' outcomes.

1. The importance of the choice of the PMHP

Several studies have shown that mental health service users would like to have greater freedom of care choice. Hill & Laugharne found that service users rate as very relevant to be informed about their condition and treatments; 31% also stated that they would like to express their preference about their own PMHP in public services (Hill & Laughrane,

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2006). Similarly, a study investigating the opinions of 111 users found that 42.2% of them rated the free choice of their PMHP as 'very important' or 'essential' (Hill, 2006); a similar result was found among 368 subjects with chronic depression (Groenewould, Van Exel, Bobinac, Berg, Huijsman & Stolk, 2015).

2. The change of the PMHP: the importance of continuity of care

Service users generally seem to value the experience of continuity of care and stability in the relationship with their PMHP. A study on 323 patients just discharged from psychiatric hospital following compulsory treatment for severe psychosis showed that more frequent changes in the key mental health professional were associated with longer hospital stays (Puntis, Rugkåsa & Burns, 2016). Accordingly, a qualitative study on 10 service users of mental health centres showed that changes in the allocated PMHP were experienced as setbacks in treatment, giving rise to negative feelings (Biringer, Hartveit, Sundfør, Ruud, & Borg, 2017). Even in team-based mental health services, the continuity of the individual relationship with one case manager seemed to play an important role for users' comfort level; users often expressed their preference for working with a particular case manager over others (Stanhope & Matejkowski, 2010).

3. Users' preferences in the user-PMHP dyad

3.1 Ethnic and language concordance in the user/PMHP dyad

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Self-reports and questionnaires by 371 users of an Italian Community Mental Health service showed that users with the least education and those who spoke only Italian had a strong preference for a therapist of their own nationality (Lorefice & Borus, 1984). In line with this result, Herman and colleagues, who surveyed 604 users of a low-income Hispanic population, found that the language and cultural awareness of mental health workers was one of the main factors influencing users' choices (Herman, Ingram, Rimas, Carvajal, & Cunningham, 2016).

Blank and colleagues examined ethnic matching between mental health professional and user for 677 African Americans and Caucasian seriously mentally ill patients of a rural community mental health centre in the US. In general, same-ethnic group dyads tended to have greater service utilization. African Americans users matched with a therapist of the same ethnicity were more likely to fail appointments; conversely, Caucasian consumers in dyads with a therapist of their own ethnicity were less likely to fail visits (Blank,Tetrick, Brinkley, Smith & Doheny, 1994).

Moreover, many minority group users expressed preference for minority PMHPs. For example, Tien and colleagues investigated mental health users' preference among 15 male and 15 female black users in a community mental health centre in Los Angeles: 60% preferred Black professionals; the major reasons for preferences were the perceived professional competence (98%) and attitudes (97%), not just the cultural, ethnic and linguistic compatibility (Tien & Johnson, 1985). The majority (79%) of a sample of 218 American Indians indicated they would prefer a Native provider (Aronson, Johnson-Jennings, Kading, Smith & Walls, 2017). A study among 26.943 people explored the effect

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of ethnic matching in minorities serving mental health centre programs and showed that ethnic matching seems to be linked to fewer emergency service visits, especially in case of concurrent language matching (Snowden, Hu, & Jerrell, 1995). Knipsheer and colleagues, interviewing 96 Surinamese out-patients in a Dutch community based mental health service, found that ethnic matching was rated as relevant by users and was a strong predictor of satisfaction with the service (Knipsheer & Kleber, 2004a). Conversely, a study by the same authors on Mediterranean migrants (82 Turkish and 58 Moroccan outpatients) in Dutch mental health services showed that most users did not value ethnic matching as important, and that clinical competence and compassion were considered to be more relevant (Knipsheer & Kleber, 2004b).

Finally, Ziguras and colleagues found that ethnic/linguistic matching between user and PMHP was one of the main factors that positively influenced medication compliance (Ziguras, Klimidis, Lambert & Jackson, 2001). It may be that clients are more willing to accept advice from case managers who they feel have a better understanding of their cultural values and beliefs. This interpretation is consistent with findings of many previous studies (Flaskerud, 1986; Flaskerud & Liu, 1991; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).

3.2 Gender concordance between user and PMHP

Manthey and collaborators (Manthey, Vitalo, & Ivey, 1982) found that neither therapists' gender nor gender matching with user was significantly related to the duration of counseling. Several pioneering studies on the topic of patients' preferences for the gender of the PMHP were conducted among male war veterans. A qualitative study among

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veteran men who had experienced military sexual trauma (MST) found that veterans had mixed provider's gender preferences, with 50% preferring a female provider, 25% a male provider, and 25% reporting no gender preference (Turchik et al., 2013).

3.3 The personal style and the attire of the PMHP.

The PMHP' style and attire seem to influence users' preference in different ways. First of all, it seems to affect patient preference. According to Priebe et al. (Priebe et al., 2017), long-term users preferred cautious treatment presentations, while recent users with little experience of mental health services preferred an optimistic style in the presentation of available treatments. Secondly, mental health service users expressed their preference for a supportive, flexible, respectful and professional relationship. Boundaries were identified as helpful for creating safety and respecting personal privacy, contributing to create an experience of connection within the helping relationship (Grant & Mandell, 2016). In long-time consumer-provider relationships, trust and partnership were considered as important in the context of shared decision-making in public mental health services (Woltman & Whitley, 2010). Thirdly, patients seem to have preference regarding the attire of their PMHP. In a study investigating 163 war veteran users in military services on their preferences on how the mental health professional should be dressed, it was established that while only a small portion of participants preferred a physician in uniform (5%), the majority (65%) had no preference (Gould, 2011). According to other studies among users affected by chronic mental illness, users' opinion was that the professional should dress in a comfortable manner (Nihalani, Kunwar, Staller & Lamberti, 2006; Hill, 2006). Conversely, another study concluded that, when the images of the professional were evaluated in

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terms of referral for treatment, trust in treatment, and willingness to share their confidential matters, users preferred the “traditional” white coat (Atasoy et al., 2015), as it is in other medical branches (Cha, Hecht, Nelson, & Hopkins, 2004; Najafi, Khoshdel & Kheiri, 2012; Maruani et al., 2013; Neinstein,Stewart & Gordon, 1985).

4) Effect of choice on treatment outcomes

The opportunity for users to choose the PMHP on the basis of information of her/his therapy style, showed that a significantly higher proportion of users who could choose their professional kept their scheduled appointments in comparison with users who could not make a choice (Larsen, Nguyen, Green & Attkisson, 1983; Ersner-Hershfield Abramowitz & Baren, 1975). Conversely, Manthey and colleagues, in a study among 14 users of a community mental health centre, did not find a statistically significant influence of the choice of the PMHP on therapy outcomes. However, users perceived positively being able to choose their therapist: they reported feeling respected, responsible for and in control of themselves, and more willing and hopeful about participating in therapy (Manthey, Vitalo & Ivey, 1982).

Several studies explored the effects of ethnic matching on treatments’ outcomes. A study of 2935 Australian users showed that ethnic matching was associated with a lower level of contact with emergency crisis assessment and treatment team services for clients with a non-English speaking background. The effect of ethnic matching was more pronounced for more recently settled groups or those with poorer English language skills (Ziguras, Klimidis, Lewis & Stuart, 2003). Chao and colleagues explored the effects of Working

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Alliance (WA) and client-clinician ethnic match on recovery status among 67 patients. Clients in the ethnically matched group reported significantly higher WA compared to the non-matched group, suggesting that, in a multicultural community, ethnic matching may help augment WA and address potential barriers to treatment engagement (Chao, Steffen & Heiby, 2012). Other studies, though, did not support this hypothesis (Ortega & Rosenheck , 2002; Chinman, Rosenheck, & Lam, 2000).

Finally, a study investigating 224 women who participated in a clinical trial of group treatment for PTSD and substance use disorders reported that racial/ethnic match did not confer additional benefits for Black clients in terms of PTSD outcomes; on the contrary, white clients, with severe PTSD symptoms at baseline, matched with their therapist, had greater reductions in PTSD symptoms at follow-up than their counterparts who were racial/ethnically mismatched. For substance use outcomes, both black and white patients who were light substance users at baseline benefited from the individual racial/ethnic match with their therapist, which resulted in lower odds of heavy substance use posttreatment (Ruglass et al., 2016).

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Discussion

Our goal was to review studies investigating users' opinion and preferences about the topic of the choice and the change of the PMHP in community-based mental health services.

While it is generally agreed that it is important to take into consideration users' preferences in choosing or in the request of changing one's PMHP, our review shows that available studies are few, small in size and generally old.

Critics of the choice of care in mental health services express concerns about the practical implementation and the potentially negative consequences to the patient (Samele et al., 2007): they argue that creating the type of infrastructure required to support patient choice could be highly complex (Goodwin, 2006) and also that too much choice can be debilitating and may increase the risk of mistakes in decision-making or have negative psychological consequences to the patient (Bate & Robert, 2005; Valsraj & Gardner, 2007). In spite of this, our review show that there are no studies that assess whether guaranteeing the choice of the PMHP in the real world is really that difficult. Addressing the perceived constraints may result in more choice options to reach therapeutic goals in a collaborative framework with patients (Galeazzi, Mackinnon & Curci, 2007).

Existing research has mostly explored the factors related to the user - PMHP matching. Characteristics of the dyad which seem to influence users' preferences are matching (or differing) in age, ethnicity, language and gender. This trend in international research may represent a positive development highlighting the increasing interest in a collaborative model of care in line with the recovery model (Antony WA, 2007).

Limitations of the study

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A limitation of our review is that we have been restrictive with respect to the setting, including only studies conducted in community mental health services. Moreover, we have focused on public outpatient settings, excluding researches conducted in private practice, where several studies investigating patients' preferences and key aspects of patients/therapist dyads were conducted (Alegrìa et al., 2013). Finally, the methodological differences in outcomes and data collection, and the heterogeneity of the mental health community-based services' organizations, create methodological difficulties that made the comparisons between the included studies not always feasible.

Conclusion

Concerns about practical and organizational aspects (Samele et al., 2007) and prejudices towards people with mental health problems about their capacity to choose their pathways of care (Bate & Robert, 2005, BMJ; Valsraj & Gardner, 2007) could eventually play a role in the neglect of the topic of choice of one's PMHP we have found in this review, undermining what could be a significant opportunity for service users, carers and professionals.

Four main aspects concerning the choice and request of changing PMHP emerged: 1) service users seem to appreciate the option of choosing their PMHP, 2) users stressed the importance of the continuity of care in the relationship with the allocated PMHP; 3) some, inconclusive research is available on the factors of the users/PMHP dyad influencing users' preferences, such as matching (or differing) in education, age, gender, ethnicity,

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nationality, language; 4) research focusing on the effects of the option of choosing and changing one's PMHP on treatments' outcomes is scarce.

PMHPs' and other stakeholders' views on this topic should be further explored also by means of intervention studies comparing different systems for letting service users choose and change PMHP, in order to inform policies regarding choice and to appropriately manage users' requests.

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For Peer Review

Users' Choice and Change of Allocated Primary Mental Health Professional in Community-Based Mental Health Services: a Scoping Review

ABSTRACT

Background: The recovery model in mental health care emphasizes users' right to be involved in key decisions of their care, including choice of one's primary mental health professional (PMHP).

Aims: The aim of this paper was to provide a scoping review of the literature on the topic of users' choice, request of change and preferences for the PMHP in community mental health services.

Method: A search of Pubmed, Cochrane Library, Web of Science and PsycINFO for papers in English was performed. Additional relevant research articles were identified through authors' personal bibliography.

Results: 2774 articles were screened and 38 papers were finally included. Four main aspects emerged: 1) the importance, for users, to be involved in the choice of their PMHP; 2) the importance, for users, of the continuity of care in the relationship with their PMHP; 3) factors of the user/PMHP dyad influencing users' preferences; 4) the effect of choice on treatments' outcomes.

Conclusions: While it is generally agreed that it is important to consider users' preferences in choosing or requesting to change their PMHP, little research on this topic is available. PMHPs' and other stakeholders' views should also be explored in order to discuss ethical and practical issues.

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Key words: recovery; choice; change; service users; primary mental health professional; community mental health.

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