What does dependency on community mental health services mean? A conceptual review with a systematic search

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Abstract

Purpose

Although community mental health services aim to support patients' autonomy and independence, they have repeatedly been criticised for making patients dependent. Yet, it remains often unclear what exactly is meant with dependency in this context. This review aimed to identify the meaning of the term dependency on community services in the literature.

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Methods

A systematic search and conceptual review of papers where dependency is used in the context of community mental health services. Narrative synthesis was used to identify thematic concepts linked to dependency in these settings.

Results

Fifteen papers met the inclusion criteria. The analysis identified five different concepts of dependency on community mental health services: dislocation from the outside world; inflexibility and lack of freedom; obligation as resentment or appreciation; living with or without meaningful activities; and security.

Conclusions

The findings suggest that, distinct from the exclusively negative connotation of the term dependency in a conventional medical context, dependency on community mental health services contains both negative and positive aspects. The different aspects might guide the future evaluation of the care provided in such services.

Keywords

Dependency
Community mental health services
Mental disorder
Deinstitutionalisation
Review

Introduction

Since the 1950s, the deinstitutionalisation movement has led to a marked shift in mental health care from large asylums to community mental health services

[1]. This process was initiated when psychiatric hospitals were regarded as ‘total institutions’ [2], i.e., closed systems set apart from the rest of society and providing custodial care for their patients. Patients in asylums were reported to adapt to the environment of the hospital, and accept the lack of independence and responsibility. This adaptation made patients dependent on the asylum for all aspects of their daily lives from sustenance to socialisation [3]. The institutional dependency hindered effective treatment and rehabilitation back to a more autonomous life [2–4].

Eliminating institutional dependency through a network of alternative institutions has been one of the primary aims of the community care movement [1, 5], which has been supported by the World Health Organisation emphasising the values of autonomy and empowerment of people with mental illnesses [6]. Focusing on the integration of patients within their own community, new services aimed to foster the patients’ self-determination and active participation in decisions about their care [7].

A recent review suggested that although community care system aimed to promote patients’ independence and provide treatment in partnership, such services might also foster dependence [5, 8]. Community-oriented services, such as supported housing or assertive outreach teams, may unintentionally limit patients’ autonomy and generate dependence on these services instead [9–11].

The community-based system of mental health care includes a variety of services with different goals and organisations, i.e., rehabilitation services, day hospitals, mobile crisis teams, residential services, other forms of supported housing, and protected employment schemes [6]. These services differ from the old asylums in a number of aspects that may influence dependency such as the internal organisation, management styles, and the relationship of patients with the broader community [3, 5]. Thus, the kind of dependency developed in community services may not be the same as in psychiatric hospitals. Measures exist to detect the level of patient’s dependence in psychiatric inpatient services [12, 13], but these measures cannot simply be transferred to community services.

The term ‘dependency’—or ‘dependence’—is widely used both in common and

scientific language. It has different meanings, and a recent review reported different ways in which patient dependency has been measured in various medical contexts [14]. However, that review did not focus on patient dependency as a result of engagement with community mental health services. Since the term dependency repeatedly features in debates about community mental health services, it seems important to have a clear understanding of what dependency means in this context and whether that meaning is consistent across services and patient groups. We therefore conducted a conceptual review on how the concept of dependency is understood in the context of community mental health services.

Method

We conducted a conceptual review, with a systematic search of published papers, to identify how dependency on mental health services has been conceptualised in the literature.

Inclusion criteria

Qualitative and quantitative empirical papers and opinion papers were included in the review that explored or described the concept of dependency in community services. We included studies with an adult population aged between 18 and 65 years, with a severe mental illness, such as schizophrenia or bipolar disorder. Studies were only included if the setting was related to community mental health services. We did not apply restrictions with regard to year of publication or study design. We restricted inclusion to papers in the English language, to avoid linguistic complications through translation in a review focusing on the use of a specific term.

Exclusion criteria

We excluded studies if they did not focus on dependency as a result of the treatment they had received in community services (i.e., dependency as a negative symptom in schizophrenia, substance dependency, or residual dependency following a prolonged inpatient stay). We also excluded studies if the setting was not a community one (e.g., inpatient rehab unit), or if having an intellectual disability, a substance or alcohol misuse issue, or being homelessness was the primary qualifier for accessing the service.

Search strategy and data sources

Since community mental health care includes various services with different labels [6], a preliminary search with a generic descriptor for 'community-based care' found an imprecise and unmanageable number of references. Thus, the strategy was revised to include a list of descriptors for services delivering community care. This strategy was tested to assure a reasonable balance between a range of service settings, and sensitivity to capture papers where dependency is identified and discussed.

A systematic search was conducted in the following electronic databases from commencement to April 2015: Medline (via OVID), Cochrane (via OVID), Scopus (via SCOPUS), PsycINFO (via EBSCO), the Allied and Complementary Medicine Database—AMED (via OVID), CINAHL (via EBSCO), and Web of Science. To ensure a similarly comprehensive search strategy for the term 'dependency', we modified the search strategy to include variates of the term such as 'depend*', and antonyms such as 'independ' to capture the absence or loss or independence and support. We added the term 'institutional' as it has been used to describe the phenomenon of the institutional dependency in the psychiatric literature. An example of the search terms and combination of terms is listed in Table 1.

Table 1

Terms combination for the systematic search

Descriptors for mental health disorders ("mental health*" OR "mental ill*" OR "mental disorder*" OR "psychiatr*") AND descriptors for community-based mental health services ("mobile crisis*" OR "home help*" OR "crisis hou*" OR "crisis hom*" OR "early intervent* psycho*" OR "residential car*" OR "residential rehab*" OR "residential service*" OR "residential home*" OR "residential hous*" OR "residential supervis*" 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 "halfway hou*" OR "halfway hom*" OR "floating support" OR "floating outreach" OR "visiting support" OR "visiting outreach" OR "outreach" OR "housing Project" OR "community-base* rehabilitation service*" OR "day hospital") AND descriptors for dependency ("depend*" OR "independ*" OR "institutional*" OR "support*")

AQ3

Terms were identified through searching titles, abstracts, keywords, medical subject headings and mapping terms to subject headings. Filters were placed on adult populations, subject area (i.e., excluding natural sciences) and document type (i.e., excluding thesis) where the options were available, with searches modified for individual databases and interfaces as required. Additional relevant reviews and research articles were identified through Google Scholar. Reference lists from relevant papers were also screened for potentially relevant papers on dependency in community-based services. All references were imported into EndNote version X7 bibliographic software (Thompson Reuters).

Data extraction

Duplicates were removed and titles were initially screened by TB for inclusion. Abstracts and full-text papers were screened by TB and SS independently for their relevance before discarding. Disagreements between reviewers at the abstract and full-text stage were resolved by consensus with a third reviewer (SP).

Independent data extraction was performed by two of the reviewers (TB and SS) for the following study characteristics: objectives, study design, sample population, community-based setting, analysis, findings and interpretations. Extracted data were tabulated on how the concept of dependency had been defined, understood or interpreted within different community-based settings.

Data analysis

In a modified two-steps narrative synthesis approach [15], we identified all instances where dependency was used across the included studies and integrated them into a conceptual framework. A team including a trainee in psychiatry (TB), a clinical academic psychiatrist (SP), and an academic research psychologist (SS) met regularly to review the analysis.

We developed a preliminary synthesis of the concept of dependency based on the key textual descriptions used across the papers. This allowed us to familiarise with the different meanings underpinning the term ‘dependency’, and to start mapping its use within the literature. A tabulation of these conceptualisations guided our regular meetings, where new themes emerged

inductively through an iterative process of discussion and reflection on the topic. Themes were interrogated and reflected on using the full-text papers to explore similarities and differences within and across the studies, in order to ensure that the nuances of the uses and definitions were encompassed in the conceptual themes. This comparing and contrasting led to a better definition of the relationship between the different themes.

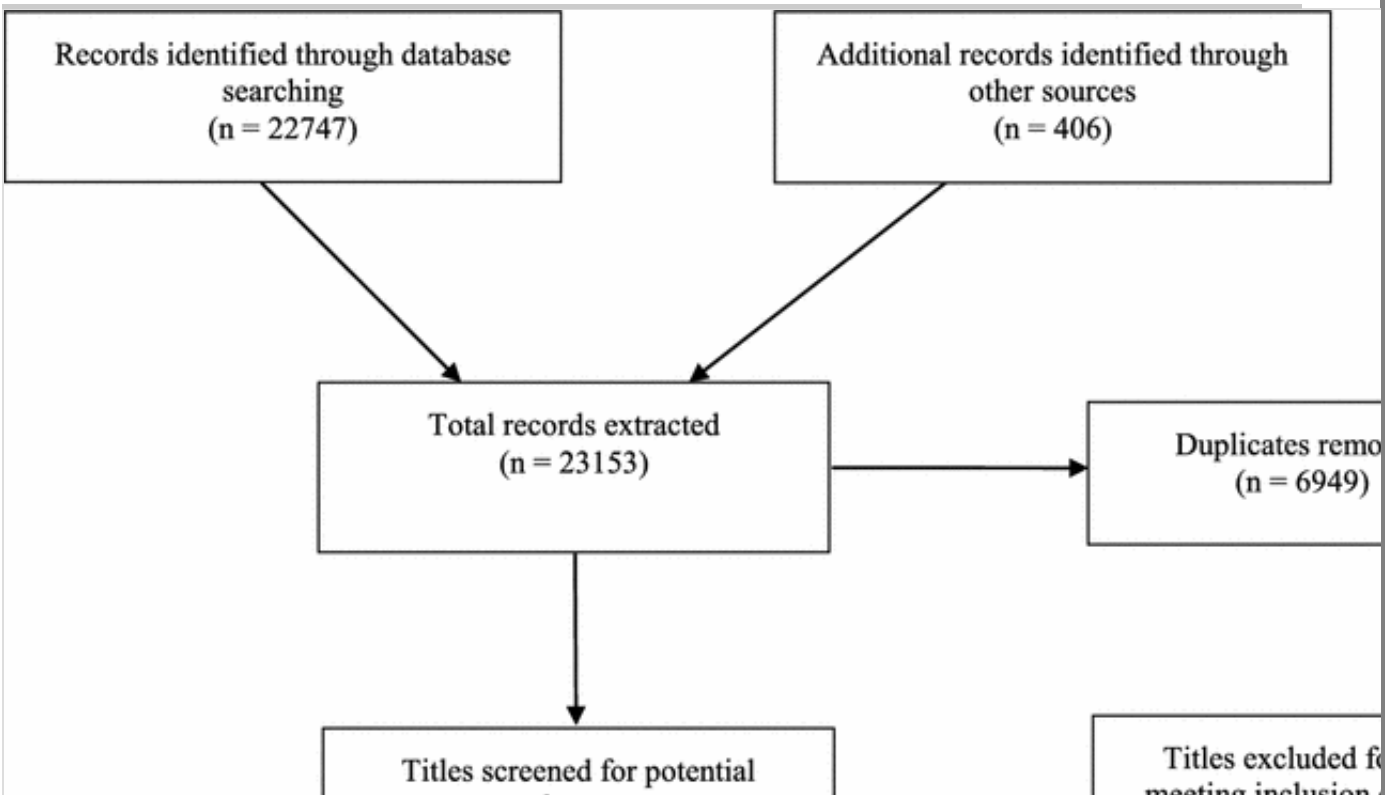
Results

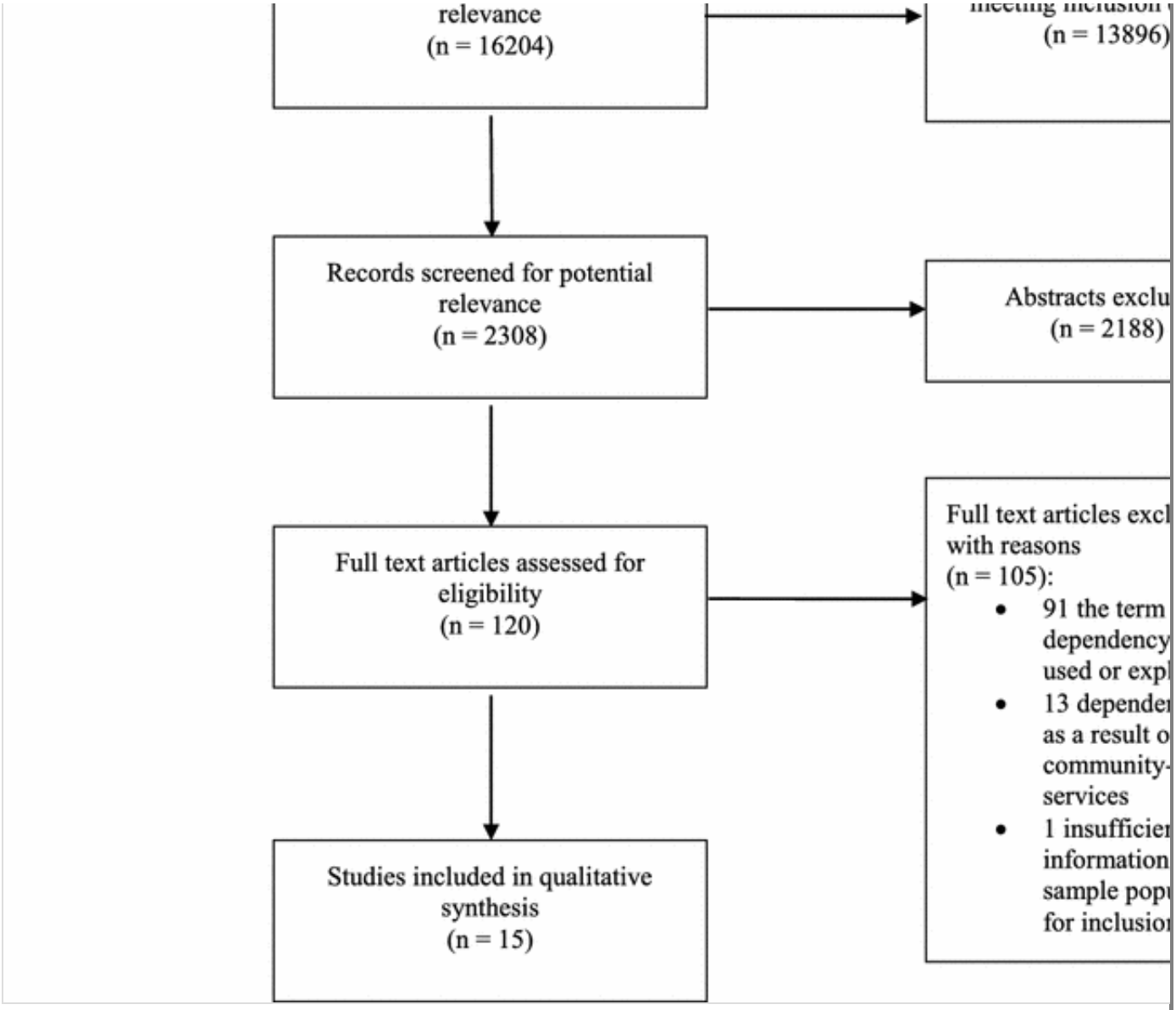
Screening and selection

Literature searches led to the identification of 16,204 unique records. Of the retrieved records, 13,896 were excluded after screening of the titles, and an additional 2188 at the abstract screening stage. After examination of 120 full papers, 92 were excluded for not identifying or explaining the term dependency in enough detail or in any context, or because dependency was not presented as a consequence of community mental health care. Fifteen studies met the inclusion criteria and underwent data extraction and analysis. The flow diagram in Fig. 1 depicts the screening and selection process.

Fig. 1

Flow diagram of study search and selection strategy





Study characteristics

The 15 included papers dated from 1979 to 2015, and studies conducted in countries with developed economies, namely the United Kingdom (6), Sweden (4), Denmark (2), the United States of America (2), and Australia (1). Fourteen studies primarily employed qualitative methodologies, two of them in combination with quantitative methodology [18, 19]. Only one study [5] used an entirely quantitative approach. No opinion papers were found.

The community settings ranged from: accommodation services such as supported housing and board-and-care facilities (8); day services such as day hospitals and day centres (4); community rehabilitation services (2); assertive outreach services (1); and home treatment services (1). Two studies compared

two forms of community-based services [17, 18].

Eleven studies investigated patients only. Two studies included patients and staff members [5, 18], and another study also carers [17]. One study focused exclusively on staff [23]. Sample sizes ranged from six [22, 25] to 733 people [5]. One study did not indicate its sample size [23]. Having a diagnosis of psychosis was explicitly reported as a patient characteristic in half of the studies [16, 19, 22, 25–27, 29]. Table 2 details the study characteristics and concepts of dependency.

Table 2

Study characteristics and identified conceptualisations of dependency on community m

Authors	Year	Country	Participants/setting	Methods
Bengtsson-Tops A, Ericsson U, Ehliasson K [16]	2014	Sweden	12 female and 17 male users with psychosis in a supportive housing managed by private care companies	Inductive approach: latent content analysis [30] of open, face to-face interviews [31], lasting between 20 and 60 min, with two main open questions: 'What do you do during the days?' and 'How do you feel about living here?
Bryant W, Craik C, McKay E [17]	2005	UK	53 users, 18 carers, 15 staff, 9 managers in day services (three community mental health centres, a voluntary sector day centre, and a carers' support group) as well as four accommodation services (a voluntary sector group home, a rehabilitation unit staffed by health professionals, a social services hostel, and a voluntary sector day centre with users who lived in)	Qualitative study of 13 audio-recorded focus groups [32] to explore the views of users, carers and staff. Questioning route [33] was developed by the project team. Data was analysed usin constant comparative thematic analysis to identify recurrent and contrasting aspect and develop

				categories
Catty J, Goddard K, Burns T [18]	2005	UK	98 users (20 day hospital patients from two services and 78 day centre clients from four services), 36 staff (25 day centre and 11 day hospital staff from the same services), and 79 staff of the eight local Community Mental Health Teams (CMHTs)	Qualitative data in the form of open questions about features of day hospitals and day centres, with a sub-group of these clients taking part in longer structured interviews. Semi-structured questionnaire given to staff of CMHTs concerning the differences between the services coded according to a grounded theory approach [34] Quantitative data in the form of questionnaires to all staff at the six services, focusing on management practices, functions and roles. Data was analysed using Chi-squared tests
Chopra P, Herrman HE [19]	2011	Australia	14 patients with primary diagnosis of schizophrenia/schizoaffective disorder admitted to a 20-bed community residential care unit that provides 24-h nursing/allied health support	Combined retrospective and prospective study with quantitative data from: (1) a retrospective review of clinical records using the service's file audit form and the WHO Life Chart Schedule (LCS) [35] and (2) a clinician measure of functioning and disability using the Health of the Nation Outcomes Scale (HoNOS) [36] and the Life Skills Profile

				(LSP-16) [37]. In addition, a qualitative thematic analysis of was conducted on patients' own perspectives, which was assessed in interviews using the Continuity of Life Instrument (COLI) [38]
Firby PA, Boothroyd JM [20]	1994	UK	Convenience sample of 31 service users attending a psychiatric day hospital	Exploratory qualitative framework analysis. Service users' guided conversational-style interviews which were analysed using an inductive approacl to identify persistent words, phrases or themes
Kowlessar OA, Corbett KP [21]	2009	UK	7 service users living in the community either alone or in a shared community rehabilitation scheme	Semi-structured [39] interviews with open, non-leading questions and minimum direction. Analysed using interpretative phenomenological analysis [40], an idiographic case-study approach for identification of shared experiences, unique themes, and hermeneutic reflection [41]
				Constant comparative analysis [34]

Lindström M, Lindberg M, Sjöström S [22]	2010	Sweden	Six residents (four male and two female) living in a supported housing residence. Five diagnosed with schizophrenia, and one with borderline personality disorder	based on 2–4 interviews with each resident about their experiences of successful rehabilitation and the meaning of ‘home’ as a place for personal processes of change. In addition, texts written by the residents and memos written by the interviewer were included in the coding and formation of core categories
Magnusson A, Lützén K [23]	1999	Sweden	Nurses and mental health workers who worked in the home care of persons with long-term mental illness	Focus group (3) within a 3-month period, following the principles of theoretical sampling. Written notes and audio recordings were analysed using grounded theory [42–46] in order to, form a conceptual framework
Parks SH, Pilisuk M [24]	1984	USA	39 residents of board-and-care facilities in the community	Structured and open-ended interviews developed from a theoretical framework of network analysis [47–49] consisting of (a) demographics, (b) quality and quantity of contact, (c) sources of assistance for specific supportive functions, (d) network attributes This was supplemented with

				information gathered from informal discussions with the operators of the board-and-care facilities
Pejlert A, Asplund K, Norberg A [25]	1999	Sweden	Six clients with schizophrenia moved in a home-like setting (The Villa)	Personal tape-recorded narrative interviews [50] (lasting 30–120 min, conducted 1 and 2 years after moving in. Analysis of their stories was carried out on the narrative content (formulated into themes) and the narrative form (structure and language analysis) [51, 52]
Petersen K, Hounsgaard L, Borg T, Nielsen CV [26]	2012	Denmark	Three male and nine female residents in two supported housing schemes, each with 12 residents. Each participant had one or more psychiatric diagnosis, namely schizophrenia (8), manic-depressive disorder (3), obsessive–compulsive disorder (1), and depression (4)	Based on Spradley's ethnographic approach [53], field study was performed in three phases: descriptive phase, focused phase, selective phase, in order to collect comprehensive data material on the user's experience of user involvement. Researcher acted as a participant observer. Spradley's conceptual framework [54] o social situations was employed. Field notes were taken. All 24 residents contributed information about their experience o

				user involvement, 12 residents participated in interviews, and four participated i a group interview. Analysis was performed using a phenomenological hermeneutic approach, informed by Ricoeur's theory of text interpretation [55, 56]
Petersen KS, Friis VS, Haxholm BL, Nielsen CV, Wind G [27]	2015	Denmark	Six male and six female service users suffering from serious mental illness (schizophrenia and bipolar disorder) in three supported housing services practicing recovery-oriented rehabilitation	Qualitative study guided by a phenomenological and hermeneutic approach with individual, semi-structured interviews to explore and gain a deeper understanding of the service users' perspectives on facilitators and barriers associated with the process o recovery. Analysis guided by Giorgi's phenomenological method of text analysis [57] and hermeneutic interpretation [58]
Pinfold V [28]	2000	UK	25 service users and 14 mental health professionals from a rehabilitation and community care service	Semi-structured in-depth interviews
				Qualitative interviews about

Priebe S, Watts J, Chase M, Matanov A [29]	2005	UK	11 female and 29 male patients with functional psychosis from nine assertive outreach teams	experiences of using mental health services from their first contact. Thematic analysis [59, 60] and grounded theory [42] used to analyse the data
Segal SP, Moyles EW [5]	1979	USA	499 (12 %), formerly hospitalised, mental patients residents (self-weighting representative sample) and 234 operators (−10 %) of California's community-based sheltered care facilities at the time of the study	Extensive structured interviews and assessment schedule consisting of: (1) client/managemen scale measured through nine items of the Community Oriented Programs Environment Scale (COPES) [61]; (2) measures of potential dependency through obligation to operator, desire to stay, and obstacles to leaving; (3) residents' evaluation through a consumer assessment measure; and (4) organization characteristics and resident background

Conceptualisation of dependency

Five themes were identified: (a) dislocation from the outside world, (b) inflexibility and lack of freedom, (c) obligation as resentment or appreciation, (d) living with or without meaningful activities, and (e) security. Though these themes are described as distinct concepts there is overlap between them (Table 3).

Table 3

Thematic concepts of dependency on community-based services

Paper	Dislocation from the outside world	Inflexibility/lack of freedom	Obligation	Living with or without meaningful activity	Securi
Bengtsson-Tops et al. [16]	✓	✓	✓	✓	✓
Bryant et al. [17]		✓		✓	
Catty et al. [18]		✓			
Chopra and Herrman [19]	✓	✓	✓	✓	
Firby and Boothroyd [20]	✓			✓	✓
Kowlessar and Corbett [21]		✓			
Lindstrom et al. [22]			✓	✓	
Magnusson and Lützén [23]		✓			✓
Parks and Pilisuk [24]	✓		✓		
Pejlert et al. [25]		✓			✓
Petersen et al. [26]		✓			
Petersen et al. [27]			✓	✓	✓
Pinfold [28]					✓
Priebe et al. [29]		✓		✓	

al. [29]					
Segal and Moyles [5]	✓	✓	✓		✓

AQ4

Dislocation from the outside world

This theme encompasses dependency on services as patients' feelings of being dislocated from the outside world and having the community service 'as the centre of their universe' [20, p. 305]. Dislocation can be conceptualised as a perceived physical separation from the outside world, or as a sense of social isolation from interpersonal relationships with other people. This social dislocation was accompanied by a feeling of inequality, with comparisons made to 'normal' people. The perceived limit to engage and connect with the outside world, and to social contacts without mental illness, fostered an overreliance on the service that was conceptualised as dependency.

Dependency on the service was associated with the patients' perception of being physically separated from the outside world and their previous life, by virtue of geographical distance or because the organisation of the service did not support patients' personalised engagement with the wider community. The geographical distance of an accommodation service from the local community compel patients to depend on staff availability for transportation to towns to deal with personal errands [24]. Other authors reported a risk of dependency for patients when community services organised themselves on a principle of 'enforced togetherness' [16, p. 412]. Patients were forced to passively congregate with unknown others 'in a place and in a system of organised care and support' [16, p. 412] which fostered dependency on staff for help and support [16, 20].

Dependency on the services was associated with social isolation from other people. In the day services patients were reported to rely primarily on staff members for social relationships, and did not develop stable social contacts outside the service, again with an increased sense of social isolation from the outside world [19, 20]. On the other hand, gathering people with mental illness in a single place might contribute to develop a 'deviant group' [20, p. 306], which perpetuates feelings of stigma and social isolation from people outside of the group. This division of the social world between 'us' (patients and staff of a

community services) and ‘them’ (outside world) may further support an ‘iatrogenic dependency’ [20, p. 306] on the service.

Experiences of unequal standing in relation to the outside world was described as fostering dependency. In comparison with ‘ordinary people’ [16, p. 412], patients perceived a sense of inequality in material, social, and economical terms. Experiencing feelings of exclusion and dissatisfaction with outside life, patients were driven to rely on the service for support [16, 19]. Dependency was observed when the support became an obstacle to leaving the service, because patients perceived life outside the service as less attractive than life inside [5, 20]. Firby and Boothroyd (1994) provide insights into the ‘dangers of becoming too reliant’ [20, p. 305] on the services emerged in patients who were in remission and longed for reintegration into the ‘real world’.

Inflexibility and lack of freedom

The majority of the studies conceptualised dependency within the broad theme of inflexibility and lack of freedom. The organisational structure and functional restrictions within community services leads to inflexibility. These are perceived as restrictive, with a lack a choice and freedom. Dependency was associated with the rigidity in the service, and the perceived lack of choice to depart from the current structures and rules of the service.

The organisational structure may foster dependency on the service because of excessive inflexibility in the way the service is structured. Two forms of inflexibility have been described. On one hand, day services fostered dependency because they restrict independent scheduling and timing of activities [17, 18]. On the other hand, when a service gave too much choice and promotion towards educational and employed activities [29], this reduced the patient’s desire or availability to seek alternative independent activities elsewhere, therefore creating a reliance on the service for this domain of their life. Even lack of clarity about the service’s aim may foster dependency [17]. When staff did not agree on the therapeutic aims and rules for attending a service, conflicting messages to the patients might lead patients to extend their attendance.

Some studies described dependency as a feeling of having lost freedom, which

might result from an awareness of being dependent on staff commitment for help and support [16]. Three more specific losses of freedom are noted in this conceptualisation. The first occurred as a consequence of sharing the personal spaces with other patients in accommodation services [21], which restricted privacy and independence. A second loss was found between a state of dependence in a home-like setting and the lack of free expression, when patients showed reluctance to talk about their relationships with their care providers for fear of expressing opinions on those they relied on for support [25]. Finally, a sense of dependency was linked to a loss of financial independence, when receiving a disability support pension associated with receipt of a community service [5, 19].

A controlling environment [5, 26] with service staff making decisions 'for' patients, and limiting the scope for patients to decide 'with' the staff member, or decide for themselves, fostered patients' feelings of dependency. Patients did not develop trust in the staff freely, because their choice and authority were restricted by staff making decisions for them [19, 23, 26]. Patients were, in this respect, at the mercy of the staff who 'are the real authorities' [26, p. 64], as opposed to being involved in the decision-making process. This resulted in feelings of dependency for the patients, and duty of care dilemmas for the staff [23].

Obligation as resentment or appreciation

Half of the studies conceptualised dependency at the interpersonal level, focusing on the therapeutic and supportive relationships between patients and staff members. Patients rely on staff for help, and this help is recognised with feelings of obligation towards the staff [5]. The inherent asymmetry in the resources and role allocation between patients and service staff necessitates this, and these feelings of obligation can manifest in both positive and negative ways.

Negative experiences of obligation towards the staff were associated with dependency as: (a) an unpleasant feeling of obliged gratefulness toward the staff for their commitment to help "I try not to be so dependent on the staff, because then you have to be so bloody grateful" [16, p. 412]; (b) "a sense of resentment for having to rely on others for care", [19, p. 537] because they lack

independence and social support.

Conceptualised as positive obligation towards others, dependency was acknowledged and valued by the patients as confirming a sense of acceptance, belonging and stability in the community of the service [19, 27]. Having developed primary social relationships with staff members and peer residents, patients perceived them ‘as their friends and their family’ and ‘cannot imagine living without the presence of the staff’ [27, p. 6]. The authors pointed out the risk that this ‘useful’ dependency may prevent the users from building new relationships in the community, reinforcing a sense of reliance on the service.

Experiences of dependency as obligation may arise when the relationships were either asymmetrical, because the power was held by the staff [5, 16], or when they were structured as a teaching relationship to achieve new capabilities [22]. For the patients, depending on these relationships elicited feelings of vulnerability and lack of recognition. Perceived parental or teacher-type relationships implicitly and explicitly implied dependency. Patients that viewed the service as a family, with staff members taking on parent-like roles, evoked a dependent relationship to the staff and service for physical and emotional support [5, 24]. This led to staff members experiencing feelings of frustration for being overwhelmed by the patients’ demands and dependency.

Living with or without meaningful activities

In seven studies, dependency was conceptualised as the consequence of patients receiving either too little or too much support from services with meaningful activities or activities of daily living. These polar ends of the support spectrum were linked to conceptualisations of dependency. When support is balanced, services that develop activities with the patient can promote independence in their lives. However, when these activities are meaningless and not aimed to help patients’ progress, or staff replace patient initiative and coordinate all the activities for them, then confidence and capabilities are reduced and this creates dependency.

Living without meaningful activities was reported as hindering independence [16, 17, 19]. Patients and carers were reported to value occupation as ‘a way out of dependence’ [17, p. 118]. However staff of accommodation services and

day services were found to devalue these activities [17], and a lack of 'meaningful occupational and recreational pursuit' [19, p. 536] was experienced by the patients.

At the other end of the spectrum, too much support and promotion of meaningful activities was reported to promote dependency too. Services supporting patients to cope with the daily routine, to motivate them to achieve positive results, to learn practical, financial, and social skills, and to develop social contacts could generate dependency instead of promoting independence. Patients became accustomed to relying on staff for practical and learning support [22, 27, 29], and more vulnerable to forming attachments with staff [22], which made life outside of the service less acceptable [20]. Patients expressed the tension between 'wanting to manage without the coach and needing to have the coach around for support' [22, p. 291].

Security

In this theme dependency was conceptualised as a consequence of feeling secure and safe from the risks and harm experienced without the service. The service protected and supported patients, making them feel welcome and safe. This support helped patients to become more confident within the service, but this protection also fostered a level of dependency on the service.

Dependency on the service was conceptualised by patients and staff as a compromise or solution to address safety risks of independent living [20, 23]. Stigma, isolation, and lack of safety in the outside world may lead patients to look for 'a place where they can hide away from the rest of the world' [20, p. 306] in a service, on which they became dependent. Home-visiting nurses also faced this ethical issue of limiting the patient' independence as the 'principle of autonomy at all costs may be harmful for the patients' [23, p. 408]. In this case, nurses knowingly promoted dependency in the patient in order to keep the patient's personal safety.

Feeling protected may result from: (a) living in a calm and relaxed environment [16, 20]; (b) the development of new relationships with staff members and residents within accommodation services [25]; or (c) the perception that being close to others may help to prevent psychotic episodes or other problems from

reoccurring [5, 27]. All these conditions reinforced dependency on the service by reinforcing the positive bonds between patients and others in the service. Only a few patients were aware of the risk of becoming dependent on the service as a safety net: 'you're like in a cocoon, this isn't the real world here' [20, p. 305]. Pejlert et al. (1999) described the awareness of being dependent as promoting fear within the service [25]. Patients feared losing the relationships they had developed and depended on in the service.

Dependency under this theme was conceptualised as an unavoidable 'part of the normal process of individuals coming to terms with their mental health problems' [20, p. 306]. A certain degree of dependency was also the manifestation of the patients' choice, as they decided to place themselves in a socio-spatial middle-ground position along a continuum between 'states of dependency and one of independence'. This positioning may evolve over time and may be preferred to one of absolute dependency or independence [5, 28].

Discussion

Five themes conceptualise dependency on community mental health services in the literature: (a) dislocation from the outside world; (b) inflexibility and lack of freedom; (c) obligation as resentment or appreciation; (d) living with or without meaningful activities; and (e) security. These themes describe how the concept of the patient's dependency is understood at different levels: at the organisational level, at the interpersonal level of the therapeutic relationship between patient and staff, and at the societal level in terms of their relationship with the 'outside world'. Each conceptualisation is thematically distinct, but they still overlap.

At the organisational level, community-based services foster dependency when patients are dislocated from the broader community and are obligated to comply to the rules for admission or attendance to recreational or rehabilitative activities [5, 16–21, 24]. Structured services are useful in providing stability and protection for a patient to develop in. However, when this structure comes at a cost to flexibly, transitioning from the service to life outside of the service is prevented when dependency occurs.

Dependency was also observed at the interpersonal level between patients and

staff [5, 16, 19, 20, 22, 24, 25, 27]. Patient's dependency on staff was more than an asymmetric relationship of the patient relying on the staff for help. It was characterised by real and strong feelings towards staff members. Being dependent on the staff was a solution to social isolation, but at the same time overreliance on staff members could further reduce the opportunities to create new social contacts. Considering the participative goals of rehabilitation practices and the interpersonal dynamics of therapeutic relationships, the concepts of dependency on staff may become one of interdependence [22, 62].

Comparison with other uses of the term dependency

Our understanding of dependency on community services shares some of the features of the common language use of the term dependency, as in 'having existence hanging upon, or conditioned by the existence of something else' and the 'inability to do without someone or something' [63]. However our conceptualisation of dependency goes beyond the negative features of dependency that common language emphasises, i.e., the passive and obligated positioning of needing support, with limited freedom. Across the themes, dependency was not a totally negative or positive concept; instead a gradient exists between negative and positive understandings. Dependency mainly has negative connotations in the first two themes 'dislocation from the outside world' and 'inflexibility and lack of freedom'. Separation, social isolation, inflexible rules, lack of freedom, and controlling environments in services were reported to promote dependency. In the themes 'obligation as resentment or appreciation' and 'living with or without meaningful activities' dependency on services had a more ambiguous understanding, as it originated from a mix of positive and negative experiences during the patient's engagement with the service. Finally in the last theme 'security', dependency on the service was described as a positive condition for patients to feel safe and in a comfortable place.

Two previous studies had described dependency scoring tools used in psychiatric inpatient settings to investigate nursing workload [12, 13]. Dependency in these studied was measured as intensity of care and time required with a patient. In contrast, our review found a more complex understanding of dependency, which does not simply describe dependency as the result of the resources allocated to support a patient with a mental illness.

Our review underlines the positive reasons why patients are drawn to rely on the services (i.e., social contacts, rehabilitative activities and safe environments) and the therapeutic benefits for patients living in the community with some degree of dependency [28].

In the 1960/70s there had been suggestions that a so-called pathological dependency in relationships was an aetiological factor in psychosis. Subsequently, avoiding such dependency—whilst helping patients to achieve greater autonomy- was a founding principle of Stein's Assertive Community Treatment approach [64, 65]. More recently, dependency in community services has been seen as being on a continuum of more or less autonomy [27, 28]. Moreover, it may be an often necessary and helpful temporary phase towards full autonomy [20]. It is the transitory and ever changing state of dependency on community services [28] that contrasts with a static form of institutional dependency, and makes dependency not an entirely negative phenomenon.

Strengths and limitations

To our knowledge this is the first review aimed at conceptualising dependency on community mental health services. The systematic search was broad enough to include a range of studies, utilising different methodologies, based in different settings, and incorporating the experiences and views of both the staff and patients in these services. However, having limited the included studies to English language may have excluded relevant papers. All included studies came from Northern European or English-speaking countries. This may limit the applicability of the findings to other contexts. In addition, the selection of community services in this review was not comprehensive of all possible community services, but covered a spread in terms of staff input and service goals. Furthermore, the theme of dependency on services was not the main topic of the majority of the included studies; therefore there was the potential risk to over interpret the meaning of the concept as it was intended by the studies' authors. Our iterative process for extraction and interpretation with constant reference back to the original text should have alleviated this concern somewhat.

Conclusion

In our review, dependency on community mental health services is not entirely a negative condition of deprivation and loss. There are positive reasons why patients are drawn to depend on these services, such as social contacts, rehabilitative activities, and the safe environments and therapeutic benefits they provide. The findings suggest, that dependency should not necessarily be understood as the contrary to recovery and autonomy. The process of recovery requires the patients to rely temporarily on the service for the rehabilitation work aimed at their re-integration in the community [27], however some of these same components may foster dependency. Dependency on community services as a combination of negative and positive experiences might guide the future evaluation of the care provided in such services, to better understand what interventions need to be implemented to further support patients in their lives and promote their autonomy.

Compliance with ethical standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

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