Community Ment Health J
DOI 10.1007/s10597-017-0117-8

ORIGINAL PAPER

Common Factors in Community Mental Health Intervention: A Scoping Review

Sean A. Kidd[1] · **Larry Davidson**[2] · **Kwame McKenzie**[3]

Received: 15 June 2016 / Accepted: 2 February 2017

Abstract While there is considerable research and commentary devoted to common factors in psychotherapy, their implications for community mental health interventions are much less clear. In response, a scoping review was conducted to answer the question, 'What is the evidence base for common factors in community mental health intervention?' A comprehensive search of MEDLINE, PsycINFO, and Google Scholar was completed. A total of 60 publications were identified in this review with a focus primarily upon therapeutic alliance. Though methodologically diverse, this review supports the likely importance of alliance in the outcomes of community mental health interventions.

Keywords Community mental health · Psychosocial · Psychiatric rehabilitation · Review · Alliance · Common factors

Introduction

A number of converging factors have led to an emphasis upon community based and focused interventions for individuals with severe mental illnesses. These factors include deinstitutionalization, evidence of the limitations of pharmacological and psychotherapeutic interventions upon quality of life and community functioning, longitudinal research in support of the possibility of the recovery of non-illness community roles and identities, and resulting mental health reform efforts (Kidd et al. 2014). This fundamental shift in the orientation of practice has been unfolding for at least 30 years in high income countries and has led to the implementation of a broad array of case management services and the development of evidence bases for interventions such as assertive community treatment, supported housing, and supported employment (Corrigan and Mueser 2012). The common goal of these interventions is to support persons in achieving the highest possible level of independent community functioning. In practice it involves an array of disciplines, services, and combinations of interventions. This constellation of services and practices is variably referred to as community mental health intervention and psychosocial or psychiatric rehabilitation, among other terms.

In contrast with the development of evidence bases for specific psychiatric rehabilitation interventions and models of community-based supports such as first episode programs (Csillag et al. 2015), there has been a lack of attention to the role of common factors in the delivery of community mental health interventions. In the psychotherapy literature, there has been a longstanding and active consideration of so called "non-specific" aspects of how therapists engage clients. These common factors, as they are considered in much of the psychotherapy literature, have consistently been found to be more important predictors of clinical outcome than any of the more technical or specific aspects of psychotherapy (Laska et al. 2014). Elements include the emotional bond between therapist and client, a confiding and amenable setting, a therapist who

✉ Sean A. Kidd
sean_kidd@camh.net

[1] Department of Psychiatry, University of Toronto, 1001 Queen St. W., Unit 2-1, #161, Toronto, ON M6J 1H1, Canada

[2] Department of Psychiatry, Yale University, New Haven, CT, USA

[3] Department of Psychiatry, University of Toronto, Toronto, ON, USA

Published online: 13 February 2017

provides a psychologically and culturally relevant explanation for distress that is adaptive and accepted by the client, and engagement in a set of procedures that allows the client to enact something positive, helpful, or adaptive (Wampold 2001). Meta-analyses consistently indicate moderate-high effect sizes of common factors that are markedly higher than considerations such as differences between treatments and protocol adherence (Laska et al. 2014).

The consideration of such non-specific elements of therapeutic engagement are arguably both more important and more nuanced in the frame of community mental health intervention than is typically the case in the context of psychotherapy. Three ways that this might happen are considered here. At the individual level, people with severe mental illnesses often present with histories of trauma and loss, intense exposure to stigmatization from systemic to individual levels, variable and conflicted engagements with treatment, and levels of illness and adverse life circumstance (e.g., poverty) that complicate engagement. Second, at the service level, there are often in place elements of coercion and enforced conditions (e.g., control over finances, community treatment orders, involuntary hospitalization) that can affect relationships with service providers. Further complexity attends services often provided by teams, rather than a single clinician as in the case of psychotherapy. Finally, at the clinician level, there can be a wide range of approaches that may or may not line up with client goals or be supportive of client recovery. Clinician practice can range widely from risk-averse, largely custodial approaches to recovery-oriented practices emphasizing measured risk taking and illness self-care (Piat and Lal 2012).

Despite this complexity, it is nonetheless important to consider how clinician engagement in community mental health interventions is reflected in process and outcome indicators. This scoping review will be, to the best of our knowledge, the first to attempt to capture the literature to date in this area. Formal scoping review methods have been undertaken to address the question: What is the evidence base for common factors in community mental health intervention?

Methods

Scoping review methods are best suited to identifying and articulating key concepts, types and sources of evidence in instances when the topic of investigation is complex and (or) when the topic is being reviewed for the first time (Arksey and O'Malley 2005). The construct of common factors is very complex, as is the research that attends it in community mental health. Additionally, while Priebe and colleagues conducted a review of longitudinal studies in this area (also folding in studies of inpatient treatment) in 2011 (Priebe et al. 2011), to the best of our knowledge no review to date has attempted to capture the literature in its entirety. As such, we have followed Arksey and O'Malley's (2005) 5-stage scoping review framework of identifying the research question, identifying relevant results, selecting studies, charting data, and reporting results. The question examined in this scoping review is: What is the evidence base for common factors in community mental health intervention?

In the second stage, an *a priori* search strategy was developed to identify the peer-reviewed literature that is relevant to this question. A search was completed from inception through to December, 2015, restricted to the English language employing MEDLINE, PsycINFO and Google Scholar. Key words were searched within three groups using "OR" within groups and "AND" in two separate searches to combine general and specific treatment domains to the therapist effect group. Google and article keyword searches were used to identify all terms related to 'common factors' and 'community mental health'. The resulting search terms included, along with common factors, therapist effects, alliance, therapeutic relationship, therapist factors, general effects, sufficient conditions, processes of change, common principles, therapeutic bond, common strategies, and non-specific effects. The general treatment domain search included the terms community mental health, psychiatric rehabilitation, psychosocial, community treatment, community-based, rehabilitation psychiatry, psychological rehabilitation, and community intervention. To capture treatments that might not have been aligned with more general terms we considered several of the most widely employed and studied intervention types. These included assertive community treatment, supported employment, individualized placement and support, supported* housing and case management*. Duplicates of articles were removed. Stage 3 examined article abstracts to ensure that they focused upon common factors within any type of community mental health intervention. What constitutes a community mental health or psychosocial rehabilitation intervention is not clearly defined as it conflates approach with setting and has unclear boundaries. For this review we employed the most commonly referenced framework as interventions that emphasize independent functioning in the community, typically involving goal setting, skills development, and enhancement of access to community and environmental resources (Anthony and Liberman 1986). We excluded papers that exclusively involved inpatient treatment or solely psychotherapy intervention focusing upon symptom reduction. Also excluded were papers that did not involve data collection (e.g., commentaries). A full text review was completed of all articles selected for the final sample. Subsequently, additional papers were rejected wherein the above criteria were not clear in the

abstract and further papers were identified from reference lists that were not previously captured.

Results

MEDLINE and PsycINFO generated 1,285 results and Google Scholar generated just over 16,000 results. Google Scholar results were reviewed until over 100 subsequent hits yielded no further articles. Titles and abstracts for all papers were reviewed using the criteria outlined above. Of the papers identified in the search, 107 articles were selected. Reference checking generated an additional 5 articles. The full texts of these 112 papers were then reviewed. A total of 60 publications met all inclusion criteria (see Fig. 1). Articles were excluded in full text review because 13 were not research studies, with the remaining 39 not meeting full criteria. Of these 60 studies, 7 were published prior to 1996, 12 from 1996 to 2005, and 41 from 2006 to 2015. With respect to geographic distribution, 38 were conducted in the United States, 6 in the United Kingdom, 4 in Australia, 3 in Canada, 2 in the Netherlands, Denmark, and

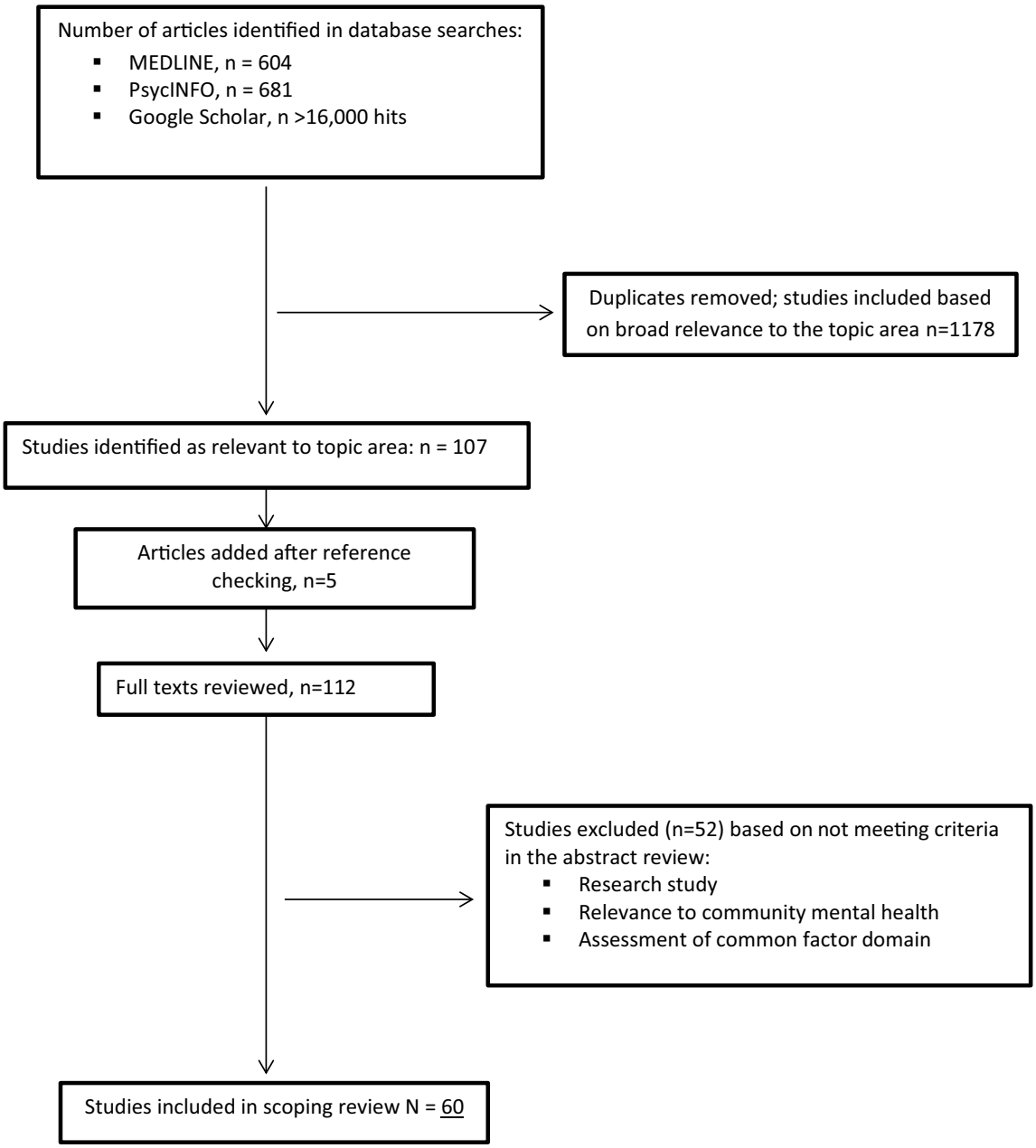

Fig. 1 Article Selection Flow Diagram

multisite Western Europe, and 1 in New Zealand, Poland, and Germany.

Overview

The studies captured in this review qualitatively and quantitatively were concentrated upon client-clinician relationship. This was operationalized in a range of ways, from relatively narrow single client-single clinician alliance measures through to grounded theory explorations of pathways of relationship development with clinical teams over time. This body of literature was diverse both across and within methodological approach (see Table 1). Longitudinal studies, of which there were 27, represented the largest group with a clear increase in number in recent years. This was followed in number by the 20 cross sectional studies. For both types of methods it was apparent that in many instances questions of common factors and clinical relationships were secondary, with these data extracted from clinical trials examining treatment outcome. A total of 13 qualitative studies were identified. As noted above, the majority of studies were conducted in the United States with a marked increase in total publication number in the past decade. This suggested increasing interest in this area, albeit qualified by the general 8–9% increase in academic publications per year across all disciplines and domains of inquiry (Bornman and Mutz 2015). For the sake of clarity in the remainder of the paper the term 'alliance' will be applied to reflect therapeutic relationship. This reflects the literature in which both terms are used, but in which alliance is applied the most frequently.

Quantitative Literature

Considering first the 27 longitudinal studies, a marked range of study designs and metrics become apparent.

Table 1 Publication summary

Longitudinal	Cross sectional	Qualitative
Snowden et al. (1989)	Flynn et al. (1981)	Rosnow et al. (1986)
Priebe et al. (1993)[a]	Solomon et al. (1992)	Hostick et al. (2002)[d]
Gehrs et al. (1994)[a]	Draine et al. (1996)	Kirsch et al. (2006)[d]
Neale et al. (1995)[a]	Tyrell et al. (1999)	Nelson et al. (2006)[d]
Goering et al. (1997)[a]	Neale et al. (2000)	Redko et al. (2007)
Klinkenburg et al. (1998)[a]	Rosen et al. (2001)	Wilson et al. (2008)[c]
Calsyn et al. (1999)[a, b]	Angell et al. (2007)	Gardner et al. (2010)[c]
Chinman et al. (2000)[a]	Skeem et al. (2007)	Jacobs et al. (2010)
Clarke et al. (2000)[a, b]	Coulson et al. (2009)	Thorgerson et al. (2010)
Florsheim et al. (2000)[a]	Stanhope et al. (2009)[b]	Chen and Ogden (2012)[c]
Calsyn et al. (2002)[a, b]	Kondrat et al. (2010)	Nath et al. (2012)[c]
Desai et al. (2005)[a]	Tschopp et al. (2011)[b]	Staudt et al. (2012)[c]
Hopkins et al. (2006)[a]	Catty et al. (2012)	Sullivan et al. (2014)[c]
Sells et al. (2006)[a]	Chao et al. (2012)	
Calsyn et al. (2006)[b]	Kondrat et al. (2012)	
Fakhoury et al. (2007)[a, b]	McNeil et al. (2013)	
Junghan et al. (2007)	Sosnowska et al. (2013)	
Rogers et al. (2008)[a]	Ben-Zeev et al. (2014)	
Kukla et al. (2009)[a, b]	Loos et al. (2015)	
Mohamed et al. (2010)[a, b]	Melau et al. (2015)	
Catty et al. (2010)[a, b]		
Catty et al. (2011)[b]		
Koekkuck et al. (2012)		
Van Vugt et al. (2012)[a, b]		
Tsai et al. (2013)[a, b]		
Wolfe et al. (2013)[a]		
Tejani et al. (2014)[b]		

[a]Longitudinal studies examining clinical/service outcomes predicted by alliance

[b]Studies of specific interventions (e.g., ACT, Supported Employment, Supportive Housing)

[c]Qualitative study of staff only

[d]Qualitative study of staff and clients

Research approaches differ greatly on several dimensions, including objective, timeframe, indicators and measures, along with the more predictable diversity and lack of clarity in intervention type and context that naturally attend community mental health as a field. There emerged two, at times overlapping, study objectives. The majority of studies focused upon alliance as a predictor of clinical outcomes, with some also considering variables that predict alliance development or focused solely upon the latter question (Table 1).

Clinical contact timeframes ranged from 2 sessions (Snowden et al. 1989) to 2 years (e.g., Neale et al. 1995). Timing was also reflected in when measures of therapeutic alliance were made. With few exceptions, these studies have addressed the idea that clinicians need to have a substantive amount of contact with clients before a meaningful assessment of alliance can take place. This consideration included baseline measures taking place several weeks or months after intake, factoring in amount of contact (e.g., Calsyn et al. 1999), or comparing the outcomes of new and established clients (e.g., Fakhoury et al. 2007). The number of times measures of alliance were made varied widely from pre-post measures through to monthly measures over the study period which allowed for a more nuanced consideration of trends (e.g., Junghan et al. 2007). Measures of alliance also varied considerably. The most commonly employed measure was the Working Alliance Inventory (Horvath and Greenberg 1989) used by 10 studies, followed by non-standard instruments employed by 5, the Helping Alliance Scale (Priebe and Gruyters 1993) by 4, and the Therapeutic Alliance Scale (Neale and Rosenheck 1995) by 3 with the remaining tools employed in single instances. The application of these measures typically involved their completion by clients and an individual identified as the "primary" clinician affording the opportunity to compare appraisals (e.g., Calsyn et al. 2006). Some investigators also included consideration of types of service provider. For example, Catty and colleagues (2011) examined ratings by both primary case manager and vocational support worker and Sells and colleagues (2006) considered client ratings of peer support as compared with case managers.

Outside of alliance measures, other outcomes and covariates were markedly diverse both in terms of domains and metrics. Major areas considered included hospitalization, global and community functioning, symptomatology, housing status, life satisfaction and quality, and motivation to change/treatment motivation. Of these areas, the most commonly examined were functional level (6 studies), symptomatology (5 studies), and hospital use (4 studies), with a broad dispersion across other domains. With respect to intervention (Table 1), 9 studies broadly described community-based case management, 7 focused on assertive community treatment, and others varied on treatment model, such as supported employment (e.g., Catty et al. 2011), and supported housing (e.g., Tsai et al. 2013) or clinical foci such as youth delinquency (Florsheim et al. 2000) or substance use (Rogers et al. 2008). Broadly speaking, almost all studies involved some form of community-based case management and/or psychosocial rehabilitation support for adults with severe mental illnesses.

The dispersion of findings as a function of perspective on alliance (client, provider, or type of provider) is extremely difficult to interpret. A great deal of scatter was present within and across studies in point in time ratings of alliance, with significant differences observed often (e.g., Neale et al. 1995; Calsyn et al. 2006), as well as differences in patterns of association with outcomes as a function of rater, be it client, provider, or type of provider and timing of measure in the course of care (e.g., Neale et al. 1995; Catty et al. 2011; Sells et al. 2006). As such, for the purposes of synthesis, we attended to associations involving one or more ratings of alliance regardless of source. Of the 21 studies that focused on alliance as a predictor of outcome, 18 reported on improvements in one or more primary outcome measures as being predicted by alliance (Table 1). Of these 17 studies, 3 indicated substantial discrepancy. Catty et al. (2010) in a study of supported employment, found improvement in life satisfaction but not in functioning in one key alliance association. Tsai et al. (2013) found improvement in aspects of life satisfaction and social support but not in functioning and Florsheim et al. (2000) observed that an early development of alliance was linked to negative outcomes while alliance development over time was associated with improved outcomes. Generally, findings were reported in the form of statistical significance. An exception was Clarke et al. (2000), where it was observed that for every 1 unit increase in alliance rating there was a 6.4% decrease in the risk of homelessness. For the most commonly employed indicators, 5 of the 7 studies examining aspects of functioning observed significant relationships (Calsyn et al. 1999; Catty et al. 2010; Goering et al. 1997; Hopkins et al. 2006; Neale et al. 1995) while Tsai et al. (2013) did not and Catty et al. (2010) did so inconsistently. For symptomatology, 5 of 6 studies found a significant relationship (Catty et al. 2010; Florsheim et al. 2000; Goering et al. 1997; Neale et al. 1995; Rogers et al. 2008) while one did not (Klinkenburg et al. 1998). Considering hospitalization, two studies found significant impacts for alliance (Priebe et al. 1993; Fakhoury et al. 2007) and one did not (Klinkenburg et al. 1998). Three studies failed to show any relationship between alliance and any outcome indicator (Klinkenburg et al. 1998; Kukla et al. 2009; Van Vugt et al. 2012).

Cross sectional studies shared similarities with longitudinal studies with respect to treatment context (primarily case management generically described) and metrics (12

of 20 employing the WAI). Among the 9 studies considering outcomes, there again was a very wide variation in outcome indicators including social relationships/engagement, service satisfaction, and quality of life, among others. Of these 9 studies, 8 reported a significant relationship between alliance and outcome. Examples include positive associations with quality of life (Chao et al. 2012; Kondrat et al. 2012) and negative association with probation violation in forensic services (Skeem et al. 2007). Only Coulson et al. (2009) reported a lack of association, in that case between alliance and non-attendance of treatment.

The second major grouping of studies examined a range of variables that attend and predict alliance ratings. Findings with respect to demographic associations were variably examined and produced variable findings. In some studies no associations were found with alliance (e.g., Tsai 2013), in others variables such as education level (Loos et al. 2015) and matching of provider and client ethnicity (Chao et al. 2012) were highlighted as significant, and there were examples of contradictory findings (e.g., incarceration history; Draine et al. 1996; Tejani et al. 2014). In both longitudinal (Snowden et al. 1989) and cross sectional (Loos et al. 2015) studies, there was evidence that considerations such as greater illness severity and lower quality of life were related with stronger working alliance. There was some evidence that illness type is important. For example, Rogers et al. (2008) observed that Posttraumatic Stress Disorder was found to be negatively related to alliance development. It was found that those in coercive treatment conditions formed alliances as readily as others in a comparative study (Wolfe et al. 2013) though, cross-sectionally, perceived coercion was observed to be negatively related with alliance (Rosen et al. 2001; Stanhope et al. 2009; Tschopp et al. 2011). Finally, gain in treatment in the form of a decreasing number of unmet needs was found to predict alliance improvement longitudinally (Jungham et al., 2007).

Qualitative Literature

The 13 qualitative studies involved collecting information about relationship considerations from clients (n = 4), staff (n = 6), or a combination of both (n = 3) (Table 1). Most involved 1–1 semi structured interviews, with 1 having employed focus groups (Nelson et al. 2006), 1 having used open-ended survey responses (Nath et al. 2012), and 1 a participatory inquiry approach (Hostic et al. 2002). Two identified grounded theory as the framework of inquiry and analysis (Gardner et al. 2010; Wilson et al. 2008). As would be expected, the strength of this modest body of qualitative literature lay in the elucidation of process, context, and system considerations that are very difficult to capture in quantitative designs. All studies presented data that addressed the general importance of effective relationships with clients in the delivery of effective services (e.g., Jacobs et al. 2010), with some extending this point to emphasize their importance in evidence-based practices achieving positive outcomes (Nelson et al. 2006). Across these studies, several more focused themes were present. The importance of the process of relationship development was emphasized, particularly for more marginalized populations such as homeless individuals with severe mental illnesses (Rosnow et al. 1986). This included the need for a gradual, friendly, and patient approach over multiple contacts to begin to establish a connection (Gardner et al. 2010; Redko et al. 2007; Rosnow et al. 1986; Thorgerson et al. 2010). Boundaries and contexts were also discussed. This included, for homeless persons, demonstrating a respect for their dwelling spaces as one would respect a conventional home (Rosnow et al. 1986) and the importance of service interactions taking place in community settings that clients participated in choosing (Kirsch et al. 2006). The inverse of this point was also observed. Thorgerson et al. (2010) reported on client narratives about the damage to alliance that occurred in their experience with assertive community treatment that was felt to be intrusive and disrespectful of their living spaces. From a process perspective, this gradual, patient, and respectful approach was described by service providers as necessary to get to a place in treatment when the relationship could be leveraged to encourage clients to take steps forward with respect to their goals in major life domains such as housing (Chen and Ogden 2012; Gardner et al. 2010). Generating such relationships was highlighted as a key component of staff satisfaction with their work (Wilson et al. 2008). Lastly, both staff and clients highlighted the importance of pragmatic assistance with daily tasks and problems as key to relationship development (Kirsch et al. 2006; Thorgerson et al. 2010).

There also was a considerable amount of discussion about the challenges that attend the development of good alliances with clients. Hostic et al. (2002) noted a dynamic in which clients felt guilty for making requests of providers overburdened with "paperwork" and other demands which, in turn, led to frustration with providers. Providers noted frustrations of their own that can be involved in developing relationships with clients that they perceived as at times lacking motivation and not appreciating the care being provided (Nath et al. 2012). Others described the difficulty of having overly high workloads as not affording the time necessary for engagement in the gradual, intensive, and community-based relationship building described above (Kirsch et al. 2006; Nath et al. 2012; Staudt et al. 2012). Other systemic and service level issues related to relationship development included the role of staff relationships within clinical teams and organizations, and work-life balance in providing the context in which staff can more

effectively develop alliances (Wilson et al. 2008). Barriers to alliance building included having to develop relationships in coercive treatment arrangements (e.g., community treatment orders; Sullivan et al. 2014), and developing relationships with clients who have been become hopeless and self-stigmatize due to custodial treatment histories (Staudt et al. 2012).

Discussion

This review was conducted to describe the current base of evidence related to common factors in the field of community mental health intervention. The impetus behind this review mirrors the psychotherapy literature in which it has been observed that the specific, technical aspects of interventions have been most extensively associated with effects while the variance explained by common factors remains poorly described and accounted for in clinical trials (Laska et al. 2014). This same challenge is present in the field of community mental health intervention (Davidson and Chan 2014). In response, this review is to the best of our knowledge the first to fulsomely summarize all of the available research in this area. Gathering such information is important, as the field of community mental health expands in relevance and investment, is becoming better defined in terms of types of interventions and evidence bases, and increasingly aligns with emerging recovery-oriented practice standards (Slade 2009). Indeed, many core elements of recovery-oriented care such as the cultivation of hope, alignment of provider-client goals, cultural competence, and respectful, individualized engagement map directly onto the core components of common therapeutic factors (Davidson and Chan 2014).

In this scoping review, it was found that the consideration of common factors in community mental health interventions concentrated almost exclusively upon therapeutic alliance. A total of 60 papers met the search criteria with the majority (69%) published in the last 10 years and most studies conducted in the U.S. and other high income English speaking countries. The three most prominent avenues of inquiry that emerged were studies of the relationship between therapeutic alliance and clinical outcome, predictors and correlates of the successful development of therapeutic alliance, and broader systemic considerations. These questions were addressed with varying degrees of depth and rigor across longitudinal studies (n = 27), cross sectional studies (n = 20) and qualitative studies (n = 13).

While the number and nature of the studies identified might on the surface suggest considerable promise for clear synthesis and meta-analytic methods, several dimensions of marked variability detract from the clarity of this literature. Across areas of research question, type of intervention, structure of design, and metrics used, few studies resemble any other. This likely reflects both the early stage of development of this literature as well as the complexity of a field which encompasses a very broad range of types of intervention, contexts, and populations. As such, this review was largely limited to broad conclusions due to the degree of methodological variability that was present. It was further limited by the relatively unclear parameters that attend constructs such as common factors and community mental health.

Despite these limitations, it would seem safe to conclude that across a broad range of community mental health interventions, the development of a positive therapeutic alliance is related to better outcomes. Though there were a small number of exceptions, alliance was predictive of or associated with enhanced outcomes in 18 out of 21 longitudinal studies and 8 out of 9 cross-sectional studies. These findings included improvements in key domains such as community functioning and symptomatology as a function of alliance. For this literature to be able to move beyond such a binary consideration in its review, there will need to be an increase in the reporting of effect sizes rather than reliance upon statistical significance. Furthermore, a greater uniformity of design would be helpful. This could take the form of a more routine integration of commonly used alliance measures in randomized trials which afford greater control, specificity, and structure. Such a program of inquiry would assist in determining if type of community mental health intervention is an important consideration for alliance-outcome associations. For example, it was suggested that in supported housing the technical components of the intervention might be of particular relevance rather than relationships (Tsai et al. 2013). Indeed, arguably moreso than psychotherapy, the experience of relationships with providers in community mental health interventions are tightly bound to the systems in which they are deployed. For example, considerations such as the availability of housing stock and employment, cost of living, and mandatory treatment legislation might need to be accounted for to properly understand and contextualize client-provider alliance. Such work would also point to which outcomes are the most relevant and sensitive to alliance development. For example, the divergent findings regarding hospitalization might suggest it as an indicator influenced to a greater extent by other systemic considerations that dominate predictive variance. Despite these caveats, as in the psychotherapy literature where the alliance-outcome association has been found quite stable across variable study designs (Fluckiger et al. 2012), so to it appears to be the case in community mental health as evidenced in this review.

Considerations in the development of alliance were also examined in this literature both quantitatively and qualitatively. While association with sociodemographic variables

were too scattered across analysis and findings to interpret meaningfully, there was some evidence that individuals with greater illness severity and experiencing more adverse life circumstances may more readily develop alliances with clinicians (Loos et al. 2015; Snowden et al. 1989). There was also some evidence that trauma may complicate alliance development (Rogers et al. 2008). This finding mirrors the psychotherapy literature in which illness severity, alliance, and outcome intersects have been observed (Lorenzo-Luaces et al. 2014), and is an area that warrants further study as it may inform the tailoring of engagement strategy. Further study is also needed to separate alliance from compliance, as those with more severe forms of illness and associated service contacts might generally be more institutionalized, cooperative, and agreeable in service contacts—interpreted as better alliance. Indeed, coercion was a topic of interest in several of the identified studies. Findings suggested no difference in alliance development as a function of coercive treatment structure (mandated treatment, Wolfe et al. 2013), though the consistent finding of lower alliance in relationships perceived by clients as coercive suggests that coercion plays a nuanced role in this context. Further investigation into client characteristics as they relate to alliance development and coercion would seem warranted in line with the need to unpack compliance from alliance. Further investigation into alliance trajectories would also be informative. In the psychotherapy literature, it has been found that therapies in which alliance development is "U" shaped or declines while productive therapeutic challenge occurs and then improves or is otherwise briefly disrupted and repaired have better outcomes (Safran et al. 2001; Stiles et al. 2004).

The qualitative literature identified in this review was more illuminative of the process considerations of alliance development. A key tension was identified across most studies. This was the tension between the need for a very gradual process of relationship development, requiring patience and flexibility across settings and ways of engagement, and institutional pressures to carry large caseloads and complete large and time consuming amounts of documentation (Hostic et al. 2002). Providers expressed the opinion that the "leverage" through which effective support and encouragement to engage in recovery goals was grounded in a carefully cultivated relationship—more so than the technical aspects of the given service (Chen and Ogden 2012; Gardner et al. 2010). Finally, providers noted that the ability to develop effective alliances with clients could not be separated from the larger context, including the quality of relationships between clinical team members, satisfaction with the broader work environment and work–life balance (Wilson et al. 2008). The tension between workload and relationship development suggests the opportunity that might be present in intensive models of case management where caseloads are lower. However, that literature has largely framed the need for low caseloads as a function of risk and acuity rather than an enabler of the development of effective relationships with highly marginalized individuals.

In sum, this review—despite its limitations—suggests the importance of provider-client relationships in community mental health interventions across a broad array of interventions, service structures, and settings. As noted by Davidson and Chan (2014), this finding adds further impetus to the need for administrators and funders to look at common factors in addition to service type and intervention fidelity in implementation and support. Such a consideration would include meaningfully accounting for and assessing alliance and the degree to which services are conducive to the development of same. Advocacy at the policy level might also further highlight the problem of high caseloads fundamentally undermining the effectiveness of services through a hampering of alliance development.

Acknowledgements Appreciation is extended to Shabrina Hyder for her assistance with manuscript preparation.

Funding This review was not supported through any formal granting mechanism.

Compliance with Ethical Standards

Conflict of interest Drs. Kidd, Davidson, and McKenzie declare that none has any conflict of interest related to the development or publishing of this manuscript.

Research Involving Human and Animal Participants This article does not contain any studies with human participants or animals performed by any of the authors.

References

Angell, B., Martinez, N. I., Mahoney, C. A., & Corrigan, P. W. (2007). Payeeship, financial leverage, and the client-provider relationship. *Psychiatric Services, 58*(3), 365–372.

Anthony, W. A., & Liberman, R. P. (1986). The practice of psychiatric rehabilitation: Historical, conceptual, and research base. *Schizophrenia Bulletin, 12*, 542–549.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*, 19–32.

Ben-Zeev, D., Kaiser, S. M., & Krzos, I. (2014). Remote "Hovering" with individuals with psychotic disorders and substance use: Feasibility, engagement, and therapeutic alliance with a text-messaging mobile interventionist. *Journal of Dual Diagnosis, 10*(4), 197–203.

Bornmann, L., & Mutz, R. (2015). Growth rates of modern science: A bibliometric analysis based on the number of publications and cited references. *Journal of the Association for Information Science and Technology, 66*, 2215–2222.

Calsyn, R. J., Klinkenberg, W. D., Morse, G. A., & Lemming, M. R. (2006). Predictors of the working alliance in assertive

community treatment. *Community Mental Health Journal, 42(2), 161–175*.

Calsyn, R. J., Morse, G. A., & Allen, G. (1999). Predicting the helping alliance with people with a psychiatric disability. *Psychiatric Rehabilitation Journal, 22*(3), 283.

Calsyn, R. J., Morse, G. A., Klinkenberg, W. D., Yonker, R. D., & Trusty, M. L. (2002). Moderators and mediators of client satisfaction in case management programs for clients with severe mental illness. *Mental Health Services Research, 4*(4), 267–275.

Campbell, B. K., Guydish, J., Le, T., Wells, E. A., & McCarty, D. (2015). The relationship of therapeutic alliance and treatment delivery fidelity with treatment retention in a multisite trial of twelve-step facilitation. *Psychology of Addictive Behaviors, 29*(1), 106.

Catty, J., Koletsi, M., White, S., Becker, T., Fioritti, A., Kalkan, R., Lauber, C., Lissouba, P., Rössler, W., Tomov, T., van Busschbach, J. T., Wiersma, D., & Burns, T. (2010). Therapeutic relationships: their specificity in predicting outcomes for people with psychosis using clinical and vocational services. *Social Psychiatry and Psychiatric Epidemiology, 45*(12), 1187–1193.

Catty, J., White, S., Koletsi, M., Becker, T., Fioritti, A., Kalkan, R., Lauber, C., Lissouba, P., Rössler, W., Tomov, T., van Busschbach, J. T., Wiersma, D., Burns, T., & EQOLISE Group. (2011). Therapeutic relationships in vocational rehabilitation: predicting good relationships for people with psychosis. *Psychiatry Research, 187*(1), 68–73.

Catty, J., Cowan, N., Poole, Z., Ellis, G., Geyer, C., Lissouba, P., White, S., & Burns, T. (2012). Attachment to the clinical team and its association with therapeutic relationships, social networks, and clinical well-being. *Psychology and Psychotherapy, 85*(1), 17–35.

Chao, P. J., Steffen, J. J., & Heiby, E. M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal, 48*(1), 91–97.

Chen, F. P., & Ogden, L. (2012). A working relationship model that reduces homelessness among people with mental illness. *Qualitative Health Research, 22*(3), 373–383.

Chinman, M. J., Rosenheck, R., & Lam, J. A. (2000). The case management relationship and outcomes of homeless persons with serious mental illness. Psychiatric Services *51*(9):1142–1147.

Clarke, G. N., Herinckx, H. A., Kinney, R. F., Paulson, R. I., Cutler, D. L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research, 2*(3), 155–164.

Corrigan, P. W., & Mueser, K. T. (2012). Principles and practice of psychiatric rehabilitation: An empirical approach. New York: Guilford.

Coulson, C., Ng, F., Geertsema, M., Dodd, S., & Berk, M. (2009). Client - reported reasons for non-engagement in drug and alcohol treatment. *Drug and Alcohol Review, 28*(4), 372–378.

Csillag, C., Nordentoft, M., Mizuno, M., Jones, P. B., Killackey, E., Taylor, M., Chen, E., Kane, J., & McDaid, D. (2015). Early intervention services in psychosis: From evidence to wide implementation. *Early Intervention in Psychiatry*. doi:10.1111/eip.12279.

Davidson, L., & Chan, K. K. (2014). Common factors: Evidence-based practice and recovery. *Psychiatric Services 65*, 675–677.

Desai, M. M., & Rosenheck, R. A. (2005). Unmet need for medical care among homeless adults with serious mental illness. *General Hospital Psychiatry, 27*(6), 418–425.

Draine, J., & Solomon, P. (1996). Case manager alliance with clients in an older cohort. *Community Mental Health Journal, 32*(2), 125–134.

Fakhoury, W. K., White, I., Priebe, S., & PLAO Study Group (2007). Be good to your patient: How the therapeutic relationship in the treatment of patients admitted to assertive outreach affects rehospitalization. *The Journal of Nervous and Mental Disease, 195*(9), 789–791.

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W. C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of Clinical Child Psychology, 29*(1), 94–107.

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59*(1), 10.

Flynn, T. C., Balch, P., Lewis, S. B., & Katz, B. (1981). Predicting client improvement from and satisfaction with community mental health center services. *American Journal of Community Psychology, 9*(3), 339–346.

Gardner, A. (2010). Therapeutic friendliness and the development of therapeutic leverage by mental health nurses in community rehabilitation settings. *Contemporary Nurse, 34*(2), 140–148.

Gehrs, M., & Goering, P. (1994). The relationship between the working alliance and rehabilitation outcomes of schizophrenia. *Psychosocial Rehabilitation Journal, 18*(2), 43.

Goering, P., Wasylenki, D., Lindsay, S., Lemire, D., & Rhodes, A. (1997). Process and outcome in a hostel outreach program for homeless clients with severe mental illness. *American Journal of Orthopsychiatry, 67*(4), 607.

Hopkins, M., & Ramsundar, N. (2006). Which factors predict case management services and how do these services relate to client outcomes? *Psychiatric Rehabilitation Journal, 29*(3), 219.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*, 223–233.

Hostick, T., & McClelland, F. (2002). 'Partnership': A co - operative inquiry between community mental health nurses and their clients. 2. The nurse–client relationship. *Journal of Psychiatric and Mental Health Nursing, 9*(1), 111–117.

Jacobs, B., Bruce, M., Sonigra, K., & Blakesley, J. (2010). Service user experiences of a community forensic personality disorder service: a qualitative survey. *The British Journal of Forensic Practice, 12*(4), 47–56.

Junghan, U. M., Leese, M., Priebe, S., & Slade, M. (2007). Staff and patient perspectives on unmet need and therapeutic alliance in community mental health services. *The British Journal of Psychiatry, 191*(6), 543–547.

Kidd, S. A., Virdee, G., & McKenzie, K. J. (2014). Mental health reform at a systems level: Broadening the lens on recovery oriented care. *Canadian Journal of Psychiatry, 59*, 243–249.

Kirsh, B., & Tate, E. (2006). Developing a comprehensive understanding of the working alliance in community mental health. *Qualitative Health Research, 16*(8), 1054–1074.

Klinkenberg, W. D., Calsyn, R. J., & Morse, G. A. (1998). The helping alliance in case management for homeless persons with severe mental illness. *Community Mental Health Journal, 34*(6), 569–578.

Koekkoek, B., Van Meijel, B., Schene, A., Smit, A., Kaasenbrood, A., & Hutschemaekers, G. (2012). Interpersonal community psychiatric treatment for non-psychotic chronic patients and nurses in outpatient mental health care: A controlled pilot study on feasibility and effects. *International Journal of Nursing Studies, 49*(5), 549–559.

Kondrat, D. C., & Early, T. J. (2010). An exploration of the working alliance in mental health case management. *Social Work Research, 34*(4), 201–211.

Kondrat, D. C. (2012). Do treatment processes matter more than stigma? the relative impacts of working alliance, provider effects, and self-stigma on consumers' perceived quality of life. *Best Practices in Mental Health, 8*(1), 85–103.

Kukla, M., & Bond, G. R. (2009). The working alliance and employment outcomes for people with severe mental illness enrolled in vocational programs. *Rehabilitation Psychology, 54*(2), 157.

Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy, 51*, 467–481.

Loos, S., Arnold, K., Slade, M., Jordan, H., Del Vecchio, V., Sampogna, G., Süveges, Á., Nagy, M., Krogsgaard Bording, M., Østermark Sørensen, H., Rössler, W., Kawohl, W., & Puschner, B. (2015). Courses of helping alliance in the treatment of people with severe mental illness in Europe: a latent class analytic approach. *Social Psychiatry and Psychiatric Epidemiology, 50*(3), 363–370.

Lorenzo-Luaces, L., DeRubeis, R. J., & Webb, C. A. (2014). Client characteristics as moderators of the relation between the therapeutic alliance and outcome in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 82*, 368–373.

McNiel, D. E., Gormley, B., & Binder, R. L. (2013). Leverage, the treatment relationship, and treatment participation. *Psychiatric Services, 64*(5), 431–436.

Melau, M., Harder, S., Jeppesen, P., Hjorthøj, C., Jepsen, J. R., Thorup, A., & Nordentoft, M. (2015). The association between working alliance and clinical and functional outcome in a cohort of 400 patients with first-episode psychosis: A cross-sectional study. *The Journal of Clinical Psychiatry, 76*(1), 83–90.

Mohamed, S., Rosenheck, R., & Cuerdon, T. (2010). Who terminates from ACT and why? Data from the national VA mental health intensive case management program. *Psychiatric Services, 61*(7), 675–683.

Nath, S. B., Alexander, L. B., & Solomon, P. L. (2012). Case managers' perspectives on the therapeutic alliance: A qualitative study. *Social Psychiatry and Psychiatric Epidemiology, 47*(11), 1815–1826.

Neale, M. S., & Rosenheck, R. A. (1995). Therapeutic alliance and outcome in a VA intensive case management program. *Psychiatric Services, 46*(7), 719–721.

Nelson, T. D., Steele, R. G., & Mize, J. A. (2006). Practitioner attitudes toward evidence-based practice: Themes and challenges. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(3), 398–409.

Piat, M., & Lal, S. (2012). Service providers' experiences and perspectives on recovery-oriented mental health system reform. *Psychiatric Rehabilitation Journal, 35*, 289.

Priebe, S., & Gruyters, T. (1993). The role of the helping alliance in psychiatric community care: A prospective study. *The Journal of Nervous and Mental Disease, 181*(9), 552–557.

Priebe, S., Richardson, M., Cooney, M., Adedeji, O., & McCabe, R. (2011). Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychotherapy and Psychosomatics, 80*, 70–77.

Redko, C., Rapp, R. C., Elms, C., Snyder, M., & Carlson, R. G. (2007). Understanding the working alliance between persons with substance abuse problems and strengths-based case managers. *Journal of Psychoactive Drugs, 39*(3), 241–250.

Rogers, N., Lubman, D. I., & Allen, N. B. (2008). Therapeutic alliance and change in psychiatric symptoms in adolescents and young adults receiving drug treatment. *Journal of Substance Use, 13*(5), 325–339.

Rosen, M. I., Desai, R., Bailey, M., Davidson, L., & Rosenheck, R. (2001). Consumer experience with payeeship provided by a community mental health center. *Psychiatric Rehabilitation Journal, 25*(2), 190.

Rosnow, M. J., Shaw, T., & Concord, C. S. (1986). Listening to the homeless: A study of homeless mentally ill persons in Milwaukee. *Psychosocial Rehabilitation Journal, 9*(4), 64.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy, 38*, 406–412.

Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services, 57*(8), 1179–1184.

Skeem, J. L., Louden, J. E., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment, 19*(4), 397.

Slade, M. (2009). 100 ways to support recovery: A guide for mental health professionals. London: Rethink.

Snowden, L. R., Ulvang, R., & Rezentes, J. (1989). Low-income blacks in community mental health: Forming a treatment relationship. *Community Mental Health Journal, 25*(1), 51–59.

Solomon, P., Evans, D., Delaney, M. A., & Malone, R. P. (1992). Assessment of therapeutic relationship of community-agency workers. *Psychiatric Quarterly, 63*(3), 251–264.

Sosnowska, M., Prot-Klinger, K., Scattergood, M., Paczkowska, M., Smolicz, A., & Ochocka, M. (2013). The therapeutic relationship and patient's experience of interpersonal bonds–research conducted in outpatient mental health care. *Archives of Psychiatry and Psychotherapy, 1*(1), 11–18.

Stanhope, V., Marcus, S., & Solomon, P. (2009). The impact of coercion on services from the perspective of mental health care consumers with co-occurring disorders. *Psychiatric Services, 60*(2), 183–188.

Staudt, M., Lodato, G., & Hickman, C. R. (2012). Therapists talk about the engagement process. *Community Mental Health Journal, 48*(2), 212–218.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R., & Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships u-shaped or v-shaped. *Journal of Counseling Psychology, 51*, 81–92.

Sullivan, W. P., Carpenter, J., & Floyd, D. F. (2014). Walking a tightrope: Case management services and outpatient commitment. *Journal of Social Work in Disability & Rehabilitation, 13*(4), 350–363.

Tejani, N., Rosenheck, R., Tsai, J., Kasprow, W., & McGuire, J. F. (2014). Incarceration histories of homeless veterans and progression through a national supported housing program. *Community Mental Health Journal, 50*(5), 514–519.

Thøgersen, M. H., Morthorst, B., & Nordentoft, M. (2010). Perceptions of coercion in the community: A qualitative study of patients in a Danish assertive community treatment team. *Psychiatric Quarterly, 81*(1), 35–47.

Tsai, J., Lapidos, A., Rosenheck, R. A., & Harpaz-Rotem, I. (2013). Longitudinal association of therapeutic alliance and clinical outcomes in supported housing for chronically homeless adults. *Community Mental Health Journal, 49*(4), 438–443.

Tschopp, M. K., Berven, N. L., & Chan, F. (2011). Consumer perceptions of assertive community treatment interventions. *Community Mental Health Journal, 47*(4), 408–414.

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology, 67*(5), 725.

Van Vugt, M. D., Kroon, H., Delespaul, P. A., & Mulder, C. L. (2012). Consumer-providers in assertive community treatment

programs: Associations with client outcomes. *Psychiatric Services, 63*(5), 477–481.

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah. NJ: Erlbaum.

Wilson, B., & Crowe, M. (2008). Maintaining equilibrium: A theory of job satisfaction for community mental health nurses. *Journal of Psychiatric and Mental Health Nursing, 15*(10), 816–822.

Wolfe, S., Kay-Lambkin, F., Bowman, J., & Childs, S. (2013). To enforce or engage: The relationship between coercion, treatment motivation and therapeutic alliance within community-based drug and alcohol clients. *Addictive Behaviors, 38*(5), 2187–2195.