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EPA guidance on building trust in mental health services



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ABSTRACT

Purpose: To advance mental health care use by developing recommendations to increase trust from the general public and patients, those who have been in contact with services, those who have never been in contact and those who care for their families in the mental health care system.

Methods: We performed a systematic literature search and the retrieved documents were evaluated by two independent reviewers. Evidence tables were generated and recommendations were developed in an expert and stakeholder consensus process.

Results: We developed five recommendations which may increase trust in mental health care services and advance mental health care service utilization.

Discussion: Trust is a mutual, complex, multidimensional and dynamic interrelationship of a multitude of factors. Its components may vary between individuals and over time. They may include, among others, age, place of residence, ethnicity, culture, experiences as a service user, and type of disorder. For mental health care services, issues of knowledge about mental health services, confidentiality, continuity of treatment, dignity, safety and avoidance of stigma and coercion are central elements to increase trust.

Conclusion: Evidence-based recommendations to increase mutual trust of service users and psychiatrists have been developed and may help to increase mental health care service utilization.

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1. Introduction

The European Study of Epidemiology of Mental Disorders (ESEMed) [1] indicates a continuing unmet need for more and better mental health care in Europe. The ESEMed study showed that 23% of the respondents reported lifetime use of any professional help for mental health problems. Among these, 56% used a psychiatrist and 68% used a non-psychiatrist provider [16]. The reasons seem to be linked to both individual and organizational aspects [17]. In Germany, within a three-year observation period, only one third of the members of statutory health insurances utilized health care services in connection with mental disorders. This occurred mainly in general practices and not in specialized in- or out-patient mental health services [21]. The ESEMed study indicated that feeling more comfortable talking to a

professional about personal problems was significantly associated with the likelihood of mental health care service use [59]. Thus, due to a higher degree of trust in the mental health profession by persons with mental disorders, this should result in and increase the likelihood of mental health service use avoiding a lack of trust, which increases disengagement from care.

The European Mental Health Action Plan 2013–2020 (MHAP) approved by the World Health Organization Regional Committee for Europe states that “the relationship between the mental health care sector and patients is the key to the effective delivery of mental health services. Staff planning and the delivery of mental health systems must take into account the legacy of communities’ distrust and fear regarding mental health services. Only if people with mental health problems and their families trust that respect for dignity, confidentiality and safety are guaranteed will they have the confidence to approach mental health services for the first time, and to continue to engage with mental health services thereafter”.

To advance the implementation of this objective, a central issue will be building trust in mental health services in the general

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public and patients, those who have been in contact with services, those who have never been in contact, those who care for them, and their families. This increased and better trust can also help reduce stigma and discrimination against the mentally ill and mental illness. Furthermore, trust is bound to affect therapeutic alliance. It is in this context that special focus should be placed upon suicidal persons and their families, who are extremely sensitive to the attitudes of health care personnel towards them. For these reasons, trust in mental health services was chosen as the topic of this guidance, which strives to elucidate the determinants of trust in mental health services, how trust may be modified and applied and if such modifications can improve not only trust, but also help-seeking and mental healthcare utilization in Europe.

1.1. Trust in the interaction between service user and provider

Most definitions of trust stress “the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor’s interest” as well as the “belief that service providers will... be competent and honest, pursue the interests of service users, and protect private information” [63]. Trust is often seen as the main characteristic of the interaction between the service user and provider. It relates positively to service user satisfaction. Patient satisfaction, on the other hand, increases trust in mental health services. Continuity of care and reliability in delivering promises as well as valued listening time have been emphasized by patients as building trust [38] as much as offering emotional support and providing adequate medical information. Participation in decision-making and confidentiality play an equally important role in increasing service users’ trust. Shared decision-making increases patient satisfaction. Clear communication and choice are associated with trust and adherence to medication [41]. Patients given choice of treatment in mental health seem to be more likely to enter treatment and stay in treatment [37]. Attention to patients’ concerns about medication side effects, confidentiality and continuity of care are important to mental health patients in building trust. It is worth emphasizing that these characteristics are culturally influenced. In many cultures, patients will expect the doctors to make the decisions whereas in others equal participation will be expected. With increasing rapid access to the social media, it is likely that more patients and their families will expect closer equal interactions.

1.2. Quality of services

A previously produced EPA guidance on the conflict of interests [30] states that “it is vital to note that another important factor which determines trust in mental health services is quality of services, which include both structures of services as well as processes [20]”. One aspect here is the personal relationship between service users and doctors and nurses. Another aspect is the medical quality of the services and the fit of the services provided to user needs. Persons with serious mental illness reported that they disengaged from services because they were not relevant to their needs [55]. Other quality aspects are the accessibility of mental health care services and short waiting times for receiving a consultation. Due to insurance policies in different countries, quality of services may also play a role in reimbursement of mental health care costs.

1.3. Stigma

Public stigma, i.e. the reaction of the general population to people with mental illness and to mental health services, relates negatively to mental health service users’ trust in mental health professionals and to help-seeking and service use. It is well known

that both social and individual stigmatizing attitudes and the related desire for social distance towards people with mental health problems are associated with decreased willingness to seek professional help. Potent factors increasing the likelihood of treatment avoidance or long delays before presenting for care include:

- lack of knowledge about the features and treatability of mental illnesses;
- ignorance about how to access assessment and treatment;
- prejudice against people who have mental illness;
- expectations of discrimination against people who have a diagnosis of mental illness [61].

Studies also show that poor subjective mental health literacy was associated with more negative attitudes towards seeking help [51] and that the advancement of mental health literacy was shown to be effective in improving help-seeking attitudes [25]. Information about the nature and treatment of mental illness as well as personal contact with people with mental health problems have been shown to be the effective elements in anti-stigma interventions in the public and in specific target groups, resulting in an increase of knowledge about mental illness and reduction of social distance towards people with mental disorders [13].

1.4. Self-stigma

Another important determinant of trust in mental health services is self-stigma, i.e. the prejudice which people with mental health problems turn against themselves. Studies indicate that people with mental health problems with more self-stigma report less trust and are less satisfied with services [63], that self-stigma has been found to be an important mechanism decreasing the willingness to seek psychiatric help [54], and that more shame (as an emotional proxy of self-stigma) was associated with more negative attitudes towards seeking help [51].

1.5. Public trust

A central issue of this guidance is the question whether the public opinion and the trust of the general public (“public trust”) have been assessed, since due to the high lifetime prevalence of mental disorders, many are currently not yet affected by mental disorders. Raising awareness for mental disorders and increasing trust in mental healthcare services may be essential to advance their future use of mental health care services if the individual need arises. Also, increasing public trust in mental health care services may have beneficial effects on persons with mental disorders by effects of general reinforcement.

To develop guidance for the general public and patients, those who have been in contact with services, those who have never been in contact, those who care for them, and their families, we assessed the scientific evidence of the following hypotheses:

- a higher degree of trust in mental health services increases the likelihood of appropriate service use;
- trust in mental health services is influenced by a range of variables (such as, for example, the public image of mental health services, self-stigma, service safety and quality and patient satisfaction);
- the modification of these variables can lead to an increase of trust in mental health services, resulting in increased service use.

This information was then used to develop some major evidence-based recommendations to increase trust towards mental health services.

Table 1

Search terms and syntax of the systematic literature search as performed in October and November 2013. All searches were performed using titles and texts of documents and were performed both as free text searches and as Medical Subject Heading term search. Languages were restricted to English and German.

Hypothesis	Search terms and syntax
A higher degree of trust in mental health services increases the likelihood of service use	"Trust" AND ["psychiatr ^a " OR "mental health services"] AND "service use"
Trust in mental health services is influenced by a range of variables (such as, for example, patient satisfaction, service quality, the public image of mental health services, self-stigma)	"Trust" AND ["psychiatr ^a " OR "mental health services"] AND "satisfaction" "Trust" AND ["psychiatr ^a " OR "mental health services"] AND "quality" "Trust" AND ["psychiatr ^a " OR "mental health services"] AND "stigma" "Trust" AND ["psychiatr ^a " OR "mental health services"] AND ["public image" OR "public attitude"]
The modification of these variables can lead to an increase of trust in mental health services, resulting in increased service use	"Trust" AND ["psychiatr ^a " OR "mental health services"] AND "intervention ^a "

^a Truncation of search term.

2. Methods

2.1. Guidance development process

The process started with a systematic literature review in order to identify the evidence dealing with the hypotheses of this guidance. We searched the databases Pubmed (no time limit), Scopus (no time limit), PsycInfo (from 1966), SciSearch (from 2000) and Embase (from 2000) (Table 1).

Inclusion criteria were:

- trust of the public;
- trust of patients or;
- trust by other stakeholders in mental health services as keywords or topic;
- studies had to be in English or German;
- studies on trust in health services from other areas than mental health if the study was estimated to yield information which could also be valid and useful for mental healthcare research.

Exclusion criteria were:

- study did not deal with trust;
- study was only reported in abstract form;
- study was not obtainable as a full text.

Two authors independently reviewed all articles and discrepancies were resolved by discussion. The flow of articles through this process is detailed in Fig. 1.

Reading the retrieved studies, we identified another 22 studies. One originally included study was excluded during later review stages. Evidence evaluation tables adapted from SIGN50 and NICE templates were generated and abbreviated evidence evaluation tables for the included studies were prepared: eight reviews (Table 2), 25 quantitative studies (questionnaire surveys) (Table 3), and 15 qualitative studies (Table 4).

This information was extracted by relevance for trust in mental or general health care, and the strength, practicality and representativity of the results.

Initial suggestions for recommendations were based on the information from the evaluation tables and from discussion among three of the authors (AB, JZ and WG). Main guiding principles were: relevance of the study results for mental health care, representativity of the study sample, methodological correctness of the analyses, validity of the study conclusions, transferability of the findings into a concrete recommendation, and practicability of the resulting recommendation. Following these criteria, we decided to include only studies addressing trust in mental health services or persons working in mental health services for formulating the recommendations. For formulating recommendations, we did not

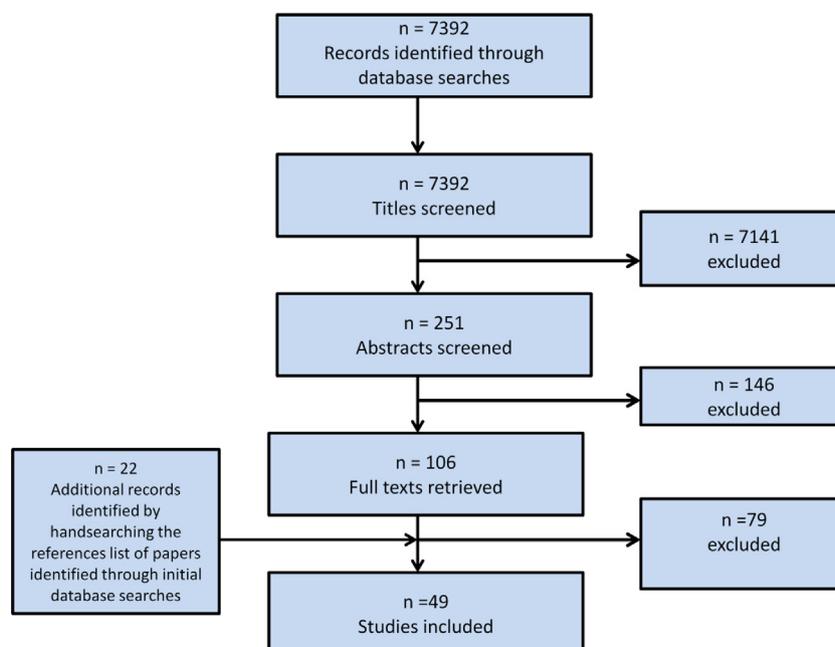


Fig. 1. Flow of studies retrieved by the systematic literature search with the algorithms detailed in Table 1.

Table 2

List of included reviews, their methods and process of analysis, main results and comments by the guidance authors including rating of the grade of evidence.

Reference	Method and process of analysis	Main results	Comments
Brown et al. 2009 [7]	Unsystematic review	Unsystematic review of the role of trust in mental health services. The authors discuss the concept of trust, trust as a communicative, relational process, the salience of trust for mental health services, trust as a determinant of effective engagement with service users (with the three subtopics "approachability of services", "open disclosure and effective diagnosis and management" and "continuing cooperation with treatment plans"). The authors conclude that trust is vital, but there is a paucity of research in this area	Selection bias of the studies reported in this review is highly likely. While the review is interesting and inspires the conceptualization of the guidance, it has no data, which are citable as evidence for the guidance topics. It may, however, serve as a citable reference for the concepts of the role of trust in mental healthcare. Evidence level III
Davies et al. 2000 [15]	Unsystematic review	The authors provide a narrative review about the question which level of trust in physicians is optimal for any given set of circumstances. Studies from a wide range of organizational backgrounds are discussed with a focus on managed care. Arguments for and against increased or decreased trust are brought forward. The organizational framework affects trust. Three main hypotheses emerge: the greater the degree of interdependence between patient and physician, the higher will be the average trust level. Patient-physician interrelationships are interdependent and patients with higher trust will benefit more. In situations of low interdependence, low trust may be associated with higher benefits	No defined search strategy was employed leading to a high degree of potential selection bias. The review still adds the aspect of the question whether too much trust may be detrimental and that the optimal degree of trust depends on the degree of patient-doctor interdependency. Evidence level III
Gulliver et al. 2010 [25]	Systematic review	This systematic review deals with the barriers and facilitators to mental health help-seeking in young people and is based on a comprehensive literature search with very little risk of selection bias. Included and excluded studies are listed. The only methodological drawback is that only a single researcher assessed the study selection. For the topic of the guidance, the systematic review provides two pieces of important information: – six studies dealt with confidentiality and trust, – two studies identified trust and confidentiality in the providers as facilitators for help-seeking. Confidentiality and trust in service providers thus emerged as important topics in the help-seeking process of young people with mental problems	A major limitation of this review is its age-limitation (12–25 years). Another limitation is that the studies dealing with trust could not be identified from the published review, so that the evidence level for this systematic review was only level II. Evidence level II
Hall et al. 2001 [27]	Unsystematic review	The article draws from the work on trust in medical settings to propose a detailed conceptual framework and summarizes the limited empirical evidence. Trust in the medical profession is conceptualized to consist of five domains: fidelity, competence, honesty, confidentiality and global trust. Predictors and consequences of trust in medical settings are described. Two sources of intervention studies are mentioned, but one is an unpublished manuscript and the other was reviewed in [42]	This seminal review considers all aspects of trust in physicians and may therefore be included as a reference about the dimensions of trust and the role of patient or setting characteristics for trust. The authors concede that their five-domain model had not yet been empirically verified in all its aspects. Study only used Medline, not Scopus or other relevant databases for automatic search. Therefore, it is questionable whether all available studies regarding trust in healthcare were retrieved. Evidence level II
Hall, 2002 [26]	Unsystematic review	This review is a comprehensive, unsystematic narrative review and commentary on the topic of the role of trust in health care professionals and health care providers in the field of health care law. The review examines the psychology of trust in medical relationships and states that the psychology of trust has a pervasive influence on all other dimensions of medical relationships. Hall describes how trust confers therapeutic benefit by activating non-specific healing mechanisms or by enhancing the effects of active therapies. Given the central role of trust for effective patient-doctor relationships, Hall investigates the different stances that medical law can take towards trust (predicated, supportive, and skeptical). Hall concludes that there is a stark incongruity between the significance of trust and the lack of attention paid to trust in existing legal analysis. "Health care law can (and does) enforce trust-related expectations, punish violations of trust, facilitate the psychology of trust, and undermine trust." (p. 525). On this background, Hall states that greater flexibility in some existing legal doctrines or practices may be required in order to reconcile formal legal rights with the therapeutic reality of trust	No specific search strategy was employed, so that selection bias is likely. In summary, the review provides a detailed analysis of the psychology of trust in medical health care and how mental law may better consider this factor in the future. Evidence level III

Table 2 (Continued)

Reference	Method and process of analysis	Main results	Comments
Laugharne et al. 2006 [37]	Unsystematic review	The study provides a good overview over nine studies with methods to assess trust and studies in healthcare. The main results of the studies are briefly reviewed but the review does not provide a critical assessment of the merits of these studies. Main findings were that only qualitative studies on trust in mental health settings were identified. Trust is important in building positive therapeutic relationships in mental healthcare and it was shown that service users felt that a trusting clinician-user relationship was central to a good quality service. Also, service users stressed the importance of trusting the clinician to understand and minimize side effects. Other issues that arose were confidentiality, time for consultations and continuity of care. The authors also cite one study, which tested an intervention to increase trust in a randomised controlled trial, but this was unsuccessful. A final study mentioned dealt with public trust in psychiatrists in Switzerland concerning psychiatrists' roles in compulsory treatment. This study showed a high level of trust by the public	A major limitation of this review is that the database of the search was limited to Medline only. Also, it is unclear whether the studies discussed in this review were obtained by automatic search or via hand searching. Therefore, selection bias is likely. Evidence level III
McKinstry et al. 2006 [42]	Cochrane systematic review	The review found three intervention studies (RCTs) all set in Northern American primary care. One trial of a training intervention for family doctors showed no effect. The other two interventions were patient-focused. One studied the impact of disclosing physician incentives and showed no diminution in trust. Another studied the effect of induction visits on health maintenance organization members on trust in their doctors and showed increased trust after group visits. However, the study had many dropouts and analysis was not on intention to treat	In summary, there remains insufficient evidence to conclude that any intervention may increase or decrease trust in doctors. Evidence level I
Mechanic et al. 1998 [43]	Unsystematic review	This review provides a comprehensive but unsystematic overview about five aspects of trust in medical care: technical and interpersonal competence, physician agency, physician control, confidentiality, and open communication and disclosure. The article discusses how the then changing medical care system in the United States affected these areas of trust and how regulatory interventions may have substituted for trust. The author suggests ways of increasing patient-doctor trust by providing clinicians appropriate organizational environments and by improving communication	No explicit search strategy was employed, making selection bias likely. The review conceptualizes trust in the doctor-patient relationship in five domains and shows how regulatory factors may influence trust. Evidence level III

consider studies dealing with trust in general health services, highly specialized somatic settings, or highly specific ethnic groups, because we find it difficult to generalize such findings to mental health care services in Europe. We refrained from using studies in patients with somatic disorders, since transferability of their results to the mental health care setting also was questionable. Therefore, the evidence base for the recommendations are studies dealing with patients with mental disorders or studies dealing with public trust in mental health care providers, including psychiatrists. The recommendations were subjected to a peer review by the co-authors and consultation and consensus with the EPA Board.

2.2. Grading of evidence

We used the form developed by Daly et al. [14] and adapted these criteria for rating the quantitative studies and unsystematic reviews based on SIGN50 and NICE suggestions (Table 5).

2.3. Grading of recommendations

As SIGN mainly uses intervention trial data, but, we found mostly survey data and qualitative studies, we adapted the original recommendation grading form provided by SIGN for our purposes (Table 6).

3. Results

3.1. Systematic evidence search

3.1.1. Trust in health care services

3.1.1.1. Reviews. Trust in physicians and health care services are of central importance for patients to build therapeutic relationships (reviewed by [10] and [26]). In their seminal analyses, Mechanic [43] and Hall et al. [27] proposed partially overlapping dimensions of trust in the medical profession: technical and interpersonal competence, physician agency, physician control, confidentiality, and open communication and disclosure [43]; fidelity, competence, honesty, confidentiality and global trust [27]. Other reviews came to the main conclusions that trust had a pervasive influence on all other aspects of medical relationships [26] that service users felt it was essential for good services [37] and that the organizational framework was another determinant of trust [15].

3.1.1.2. Empirical studies on trust in healthcare. Trust in health care services and physicians emerged as a multidimensional construct [10,11]. Trust in physicians was influenced by past health care experiences and was related to confidentiality, professional care, depth of the relationship, length of the partnership and length of

Table 3
List of included quantitative studies (mainly questionnaire surveys), their instruments, population and sample collection methods, main results, and comments by the guidance authors including a rating of the evidence level using the evidence grading scheme of Table 5.

Reference	Survey instrument	Population and sample collection	Main results	Comments
Altice et al. 2001 [2]	Following a qualitative interview phase, the study used questionnaires (Anderson-Dedrick Trust in Physician scale) to assess the role of trust in physicians and trust in medical institutions	A total of 205 prison inmates who were HIV-infected or were eligible for antiretroviral (ART) treatment	Acceptance of ART was associated with trust in physicians and trust in medical institutions. Patients who mistrusted their physician were more likely to report having seen the doctor fewer times and having spent less time with the doctor. Regarding trust in medical institutions, distrust was high, associated with male gender and non-white ethnicity	The study shows that a higher degree of trust may lead to an increased likelihood for health care service use. However, it is questionable whether this will apply to different settings than the prison setting of this study, and whether it is valid for disorders other than HIV. Evidence level III
Baker 2003 [3]	Questionnaire study employing, among other instruments, the Trust in Physician Scale	Adult patients consecutively attending US family practices ($n = 418$) and UK general practices ($n = 650$)	Consulting the regular doctor, trust in the physician and satisfaction with consultation were associated. Trust in physicians was influenced by past experiences and in turn influenced preferences for consulting the doctor again. $P < 0.0001$ for trust-related to general satisfaction, professional care, depth of relationship and length of consultation (Table 5 in [4]; multiple regression analysis)	Strong study due to high participant numbers and two different countries. The results support the notion that higher degrees of trust in a physician make service use more likely. As the study was observational, no causative relationship between continuity, trust and satisfaction with the consultation can be demonstrated. Evidence level I
Benkert et al. 2009 [4]	Questionnaire study using the Trust in Provider Scale and the Group Based Medical Mistrust Scale	Convenience sample of 100 African American US primary care patients. Predominantly (60%) female participants in three primary care clinics in an urban academic medical center	Significant correlation between trust in physicians and satisfaction ($r = .61$, $P < .01$). Participants simultaneously held moderate cultural mistrust of European American providers and mistrust of the healthcare system, and high levels of trust and satisfaction with their nurse practitioners	The authors conclude that African American patients' own attitudes about racial identity and the client-professional relationship have a significant effect on satisfaction with primary care. Study results support the notion that trust in physicians is related to satisfaction and that mistrust to health care systems is frequent in this special group of patients. Due to the limited setting, it is doubtful whether these results can be transferred to mental healthcare settings. Evidence level II
Calnan et al. 2008 [11]	Two qualitative case studies in type 2 diabetes primary care and hip replacements in secondary care were analysed with the aim to explore how trust between clinicians and managers based in acute settings differ from trust relations in a primary care setting	Twenty-one patients, 23 clinicians/health care workers and 4 managers were interviewed	Main results were that patients' trust in clinicians was conditional and was earned by experiences of care and the nature of the relationship. Competence was a priority of trust building and most patients said that trust was needed if they were to disclose personal information. Individual trust in clinicians did not necessarily affect trust in the healthcare system. The organizational context of the interview influenced the nature of the trust and how it was won	The main conclusion is that trust is important for effective therapeutic and working relationships. The number of interviews was low and it is questionable whether the results can be transferred to the mental healthcare setting. Evidence level IV
Chadda et al. 2001 [12]	Semi-structured questionnaire	Study in India addressing patients of a psychiatric out-patient service with 78 participants	Pathways to reach the mental hospital were drawn and reasons for the first preference of the treatment other than in the mental hospital were "Trustworthiness" of "faith healers" in 20/23 cases, "alternative system of medicine" 1/1, physician 1/9 and psychiatrist 3/11	This study shows that "trustworthiness" is important for Indian patients with mental health problems to initially seek help by "faith healers", while it is less a reason to choose psychiatrists or other physicians. Generalizability is limited due to the low number of participants and the potential special role of alternative healers in India compared to other countries. Evidence level III
Di Stefano et al. 1981 [18]	Questionnaire study. A satisfaction scale and the Interpersonal Trust Scale were administered	Forty psychiatric patients in a state vocational rehabilitation program	The only result reported regarding trust is that trust correlated positively with client satisfaction	The study may serve to document the association between trust and client satisfaction in this specific setting. Evidence level III

Table 3 (Continued)

Reference	Survey instrument	Population and sample collection	Main results	Comments
Donnelly et al. 2011 [19]	Questionnaire study (Interpersonal Trust in Physician Scale). Both patients and carers (nurses and psychiatrists) answered a modified version of the Trust in Physician Scale	Forensic patients in a forensic and a medium secure mental hospital in Ireland before and after mental health review hearings. 83 respondents were recruited before and 75 after the hearings	After the hearings, trust by patients towards doctors and nurses declined. Perceived coercion did not affect the results. Negative perception of the psychiatrist was a determinant of the trust level assigned by the patients. Pre-hearing trust levels predicted the subsequent hearing ratings	Negatively perceived hearings diminished trust by the patient for his/her psychiatric staff. The study indicates that mental health hearings, which are negatively perceived, diminish trust. The study provides interesting data for the role of trust for patient care relationships in forensic or other secure settings but it is questionable whether this can be generalized to all in-patients with mental disorders. Evidence level III
Ghanizadeh et al. 2008 [22]	Self-reported questionnaire	One hundred persons from the general population in Iran, 80 parents with children with psychiatric disorders and 100 school teachers	“Didn’t know who to trust” was one of the barriers to seeking help with mental problems reported in the three groups (general population 6.0%, parents 3.8%, teachers 3%) and was one of the many barriers identified as “barrier related to perceptions of mental health services”. No further analyses regarding trust are provided	This study indicates that there are many barriers and trust – at least in the Iranian population – plays only a minor role. The study is limited by the fact that 34% reported logistic barriers, which seems high compared to other countries, while barriers related to perceptions of mental health problems ranged at about 30%. Limitations like skewed age and educational level are mentioned, but not accounted for. Culturally influenced bias is also mentioned, but not further discussed or addressed in the analysis. The generalizability of the results is doubtful. Evidence level III
Goold et al. 2006 [24]	Questionnaire-based telephone interviews using a newly developed questionnaire to assess trust in insurers	Four hundred telephone interviews with US adults > 18 years with health insurance	Insurer trust correlated strongly with trust in doctors and satisfaction with care. Several domains of trust in insurers could be identified. Administrative competence, clinical competence, advocacy and beneficence, fairness, honesty and openness and one global item emerged as components of patients’/users’/potential users’ trust in insurers	The study shows that trust in insurer depends on similar factors as trust in physicians and that both are connected. Evidence level II
Jang et al. 2005 [31]	In-person interviews	230 Koreans living in the US aged > 60 years	Patient trust in Western medicine was associated with a better perception of one’s health, fewer hospital visits and greater satisfaction with healthcare services	As the setting was limited to higher-aged Koreans in the US, its results cannot be generalized or be directly transferred to the situation in mental healthcare. Evidence level II
Kao et al. 1998 [34]	Telephone interviews. A patient questionnaire was used to assess trust in physicians	292 adult (> 18) in Atlanta (GA, USA), who were all members of a national managed care organization at the time of the study	Patients who had choice of physician, had a longer relationship with their physician, and who trusted their HMO were more likely to trust their physician	This study shows that in an unselected, general population sample, trust in physicians is high and related to choice and continuity of the relationship. Evidence level II
Leisen et al. 2004 [40]	Self-administered questionnaire study	Employees of a southwestern US service organization (241 respondents among 1500 surveyed employees). 214 respondents were analysed	Structural equation modeling was used to delineate the relationships between trust and several organizational features. Patient trust in their physicians correlated with the length of the partnership and satisfaction with the physician. Both trust and satisfaction affected relationship outcomes positively (likelihood of referring to a friend), following the doctor’s recommendation, returning for care and reporting that the quality of care was excellent	Systematic modeling of the relationship between trust and organizational features is a major strength of this study. However, mental healthcare was not addressed specifically and the focus on one regional sampling area limits the transferability to mental healthcare. Evidence level I
Minamisawa et al. 2011 [45]	Cross-sectional questionnaire survey (Trust in Physician Scale)	Five hundred and four adult patients consecutively visiting two Japanese clinics for mental disorders as outpatients	A duration of treatment > 1 year and a clinical expertise of the treating psychiatrist of > 10 years were associated with higher trust levels. Patients with a neurotic disorder (ICD-10 F4) showed significantly less trust than patients with affective disorders (ICD-10 F3)	The authors conclude that close attention should be paid to psychiatric patients who are relatively new to a specific mental health setting. Evidence level I

Table 3 (Continued)

Reference	Survey instrument	Population and sample collection	Main results	Comments
Möller-Leimkühler et al. 2002 [47]	In-person questionnaire survey	Ninety-one in-patients of a psychiatric department in Munich, Germany. Length of in-patient stay had to be at least one week	Trust in physicians and trust in medication are mentioned in one figure and high trust was correlated with patient satisfaction (Table 2 in [47]).	The study is important, as it is one of the few, which deals with psychiatric in-patients. It shows that psychiatric patient satisfaction is correlated both with medication trust and physician trust. Its generalizability is limited due to the single department setting. Evidence level II
Mohseni et al. 2007 [46]	Postal questionnaire survey in southern Sweden	Random sampling, 27,963 respondents (age 18–80 years)	Respondents born outside Sweden, with low/medium education, low generalized trust and low institutional trust, had significantly higher odds ratios of poor self-related health	A highly representative study of a very large sample. Shows that trust in healthcare institutions is correlated with generalized trust, socio-demographical variables and self-rated health. Evidence level I
Musa 2009 [48]	Telephone questionnaire survey. The study used abbreviated trust scales	Older (mean age 74 years) black and white Americans with 1681 respondents	Black people had significantly less trust in their own physician and greater trust in informal health information sources. Greater trust in one's own physician was associated with utilization of routine checkups, PSA screening and mammograms, but not with influenza vaccination	Trust in physicians was related to use of prevention. The study is highly representative of older men, but the generalizability of the results to mental healthcare is questionable. Evidence level II
Plomp et al. 2010 [50]	An explorative, cross-sectional study in which trust and vulnerability were measured quantitatively (questionnaire) and qualitatively (semi-structured interview)	The sample was obtained from a Dutch academic hospital setting with three strata (workers absent at least 6 weeks a year, absent for at least 6 weeks in the year before, and workers with absence of less than one week in two years). Sixty-eight workers participated	The urgency or threat of vulnerability (current reported poor health, high workload and high absenteeism) explained the relationship between trust and vulnerability. The hypothesis of vulnerability leading to lower trust was only applicable to patients with good health and low workload. Although trust was higher in patients with poor health and high workload, the hypothesis that the trust level was higher in more vulnerable persons could not be confirmed	Trust in physicians and the need for trust vary with the character and severity of ill health. Shows the complex interrelationship between trust in physicians and vulnerability to ill health. Limited generalizability and representativity because only one employer was studied and the number of participants was low. Mental healthcare was not specifically addressed. Evidence level III
Safran et al. 1998 [52]	Primary healthcare questionnaire containing items on trust, which are, however, not specified in the published paper	6094 respondents were included and came from a study population of adults subscribed to state worker health plans	Patients' trust in their physicians was strongly associated with adherence, and trust was the variable most strongly associated with patients' satisfaction with their physician	Supports the idea that trust is an important determinant of satisfaction and adherence. Although the associations between trust and provider adherence was strong, the study is limited due to its little information about the assessment instrument regarding trust. Evidence level III
Schneider et al. 2004 [53]	Questionnaire-based study including a trust in physician scale	620 US private practices patients with HIV infection and antiretroviral therapy indication	Trust in physicians was associated with adherence to antiretroviral treatment. Significant associations were found, although other factors than trust had stronger influences on ART adherence (Tables 2 and 4 in [53])	Trust in physicians is one of the factors associated with ART therapy adherence. The study is limited due to the special patient population studied. Evidence level III
Tang et al. 2013 [57]	Questionnaires	Chinese household study in a representative sample of 3306 community-dwelling persons	A probit model analysis showed that trust in doctors, trust in prescription, and trust in recommended medical examination were "considerations" in generating life satisfaction	While the study has a large number of participants, its transferability to mental healthcare issues is questionable Evidence level III
Tarn et al. 2013 [58]	Self-administered cross-sectional questionnaire. Trust in physicians was assessed with 3 questions only	Community-based samples of 539 English-speaking Japanese Americans, 340 Japanese-speaking Japanese Americans, and 304 Japanese living in Japan	There were complex differences in trust between these groups and these showed that religiosity, autonomy preferences, and acculturation were strongly related to trust in one's physician. The strong relation of trust with ethnic match and the loss of trust when patients reported leaving a preferred physician suggested unexpected consequences to patients not able to continue with their preferred physician	Although the generalizability of the results is limited due to the focus on Japanese ethnicity, the study shows the influences of ethnicity on patient trust in physicians. Evidence level II

Table 3 (Continued)

Reference	Survey instrument	Population and sample collection	Main results	Comments
Thom et al. 2002 [60]	Telephone and questionnaire-based interviews including the Patient Trust in Physician Scale	About 732 patients in US managed care settings	Patient trust in physicians was associated with fulfillment of patient service requests, kind of physician (higher for cardiologists than general internists), number of visits, continuity of service for > 6 months, and had a U-shaped relation with age (highest in the age groups 19–29 and 70+). Level of trust was associated with satisfaction with the consultation and there was a positive association between patient trust and symptom improvements after 2 weeks. Higher trust was also associated with an intention to follow medical advice. Patients with lower trust were more likely to report that requested or needed services were not provided	Trust in physicians correlated with service use characteristics. Evidence level I
Van der Schee 2007 [62]	Postal questionnaire survey	Adult general population: in The Netherlands from the Dutch Health Care Consumer Panel ($n = 1415$), in Germany from the Bertelsmann Health Care Monitor ($n = 1514$) and in England and Wales in a random sample ($n = 1155$)	While trust levels in six dimensions (patient focus of providers, confidence in macro level policies, professional expertise, quality of care, information supply and quality of cooperation) were comparable in England and Wales and The Netherlands, they were comparatively lower in Germany (both for health care professions and institutions/services). Mental health services were not assessed in Germany, but in England and Wales and The Netherlands, trust levels in mental health services were lower than trust levels in general hospitals and reached only the trust level of nursing homes	Highly representative study from three European countries. Supports the idea that trust in healthcare professions and health care systems varies between countries, and that trust in mental health care services is lower compared to general health care services. Limitations apply due to translation issues of the term “trust” (“Vertrauen” vs. “vertrouwen” vs. “confidence”) and a recruitment mix of panel members and random sampling. Evidence level I
Verhaeghe 2011 [63]	Questionnaire study. Trust was measured with a modified “Trust in Physician Scale”	Psychiatric patients in Belgium (36 centers: 8 psychiatric hospitals, 7 general hospitals, 8 day activity centers, 7 psychiatric rehabilitation centers, 6 CMHC). 846 respondents of which 650 could be used for the analyses	The main results were: several background variables were related to trust – older patients had more trust in their doctors. Patients with more symptoms, those with psychotic disorders, those with stigma experiences, those with a high degree of self-stigma and those receiving more intensive care had less trust in their carers. For satisfaction with services, trust was the most important determinant, and trust partially mediated the effects of stigma on satisfaction	Supports the notion that trust is important for psychiatric patients and that trust is influenced by several variables Evidence level I
Whetten 2006 [64]	Questionnaire study. Minority vs. non-minority participants were compared. Three items related to trust in their providers were assessed. The questions were: “Your doctors want to give you the best care possible”, “How much do you trust your HIV doctor or clinic to offer you the best medical care they can provide?” and “How much do you trust your HIV doctor or clinic to put your health above everything else?”	Six hundred and eleven HIV patients	Mean rating of trust towards doctors was high (mean 13.5 on a scale up to 15), but distrust in government was high (6.5 on a scale of 2–10). <i>t</i> -Tests showed that minority patients who distrusted their provider were less likely to visit their provider 3 or more times ($P < .05$). Physical health and mental health scored lower if respondents distrusted their provider, but no exact figures were given. Logistic regression analyses showed that trust in doctors was associated significantly with outcome variables: 3 or more HIV related visits, fewer emergency room visits, greater likelihood of taking antiretroviral, better mental and physical health. Taken together, trust was associated with more appropriate healthcare and better health outcome. Trust was significantly associated with service use	Distrust towards doctors and the government was a barrier to service use and impaired healthcare. Transferability to mental healthcare is questionable. Evidence level III

Table 4
List of included qualitative studies, their data collection methods, methods of process and analysis, population and sample collection methods, main results and comments by the guidance authors including a rating of the evidence level using the evidence grading scheme of Table 5.

Reference	Data collection	Method and process of analysis	Population and sample collection	Main results	Comments
Booth et al. 2004 [5]	Focus groups ($n = 81$; average group size 10 members)	Tape-recorded and transcribed sessions were analysed, partly ($n = 51$) with the support of a computer software (NUD*IST)	Quota sampling. Both school attendants and out-of-school adolescents were studied in a qualitative focus group session. The age range was 12–17 years	Adolescents were most likely to seek help from those they trusted and when professional help was sought, they preferred someone they knew and trusted. Barriers to accessing health care were concerns about confidentiality, discomfort in disclosing health concerns, and accessibility and characteristics of services. Although trust emerged as a topic, no further details are evident from the study	This study intended to discover factors which influence access to primary care among adolescents in Australia (New South Wales). A limitation is that this study deals with healthcare in general and not mental healthcare. Also, there are no rich details about the results concerning trust in this study. Evidence level II
Borba et al. 2012 [6]	Face-to-face interviews	Interviews were audiotaped and transcribed verbatim. Transcripts were coded using the NVIVO software and coded for categories by two investigators. A codebook was developed and used for subsequent interviews or recoding of initial interviews	Purposive sample of 30 low income urban women with a diagnosis of a serious mental illness from an NIMH-sponsored parent trial	Women who reported feeling understood and trusted by their mental health provider tended to be more engaged with the healthcare system in general (p. e219). Women who trusted their mental health providers trusted them when they referred them to other medical healthcare services	No quantitative data are provided to strengthen the conclusions. Therefore, the evidence here is weak. Evidence level III
Brown et al. 2012 [7]	Semi-structured interviews	Double-coding of interviews followed by a three-step analytic procedure including software (NVIVO)-supported coding was performed	Eight patients, health care managers ($n = 3$) and professional carers ($n = 10$) in a single location in the UK. Service users were in treatment for a psychotic disorder	Trust was referred to by patients and professionals as fundamental to the openness of communication. High trust relations required less time and resources due to the efficient way of communication, which ensued (p. 257)	Mostly narrative description with a low number of interviews. Limited setting and low number of interviews limit generalizability. The authors conclude: "Findings suggest that while existing foci on risk are at times counter-productive, trust plays a significant role in service users' initial and ongoing engagement, communication and cooperation with professionals. Yet, inherent obstacles to trust within mental healthcare contexts remain, due to cultural pressures on professionals, the nature of the illness experience and negative past experiences of in-patient care." Evidence level III
Gilbert et al. 2008 [23]	Interview study	Audiotaped conversations were analysed using a categorical, inductive thematic analysis procedure by two analysts	Nineteen service users who had all had inpatient stays in psychiatric hospitals in London were interviewed	Trust was a topic in all conversations and important for providing positive service experiences. Trust was linked to safety and coercion. Staffs were trusted if being professional, able to manage situations in which patient safety was at risk, flexible, non-coercive, committed and caring. No quantitative analyses were provided. The authors conclude that a lack of trust is a barrier to positive relationships	This study provides qualitative data on the components of trust from the service users' point of view. The chapter on "trust" is short, gives few figures and therefore it is questionable whether all perspectives were explored. The generalisability of the results is questionable due to the small number of participants and the focus on London patients with admittance to mental hospitals without considering other service settings. Evidence level III

Table 4 (Continued)

Reference	Data collection	Method and process of analysis	Population and sample collection	Main results	Comments
Hem et al. 2008 [28]	Ward observation and interviews	Field notes from participant observation (213 hours) and transcribed interviews	Five patients and six nurses from an open seclusion unit in a Norwegian acute psychiatric department	The authors found that “control” due to security measures was a central topic. Trust itself was not addressed, but the authors interpret the strict control enforced and the distance between patients and nurses as an “expression of the staff’s distrust”. Also, the authors interpret the patients’ various actions as signs of distrust	The study provides interesting insights into the role of control in secure psychiatric settings, but the relation to trust here is an interpretation by the authors and not directly studied here. Also, the methodology of how observations and interviews were analysed is not clearly described. Much of the discussion is centered on a single case description. Evidence level III
Hood et al. 2012 [29]	Interview study	Audio recorded semi-structured interviews were transcribed and coded using NVIVO software. A thematic analysis and template-oriented approach was taken involving teams of analysts. Member checking and peer examination were used to ascertain trustworthiness of the analysis	Middle-aged (40–70 years) African American men (40 interviews) recruited from barbershops	The respondents put trust as a primary factor for choosing a collaborative or active role in health care decision-making processes. Expertise, information sharing, active listening and relationship length emerged as subthemes of trust	The study is of a high methodological strength regarding recruitment and analysis. The study cannot be generalized because of its special setting and the age limit for the participants (40–70 years). Evidence level II
Jesse et al. 2008 [32]	Semi-structured focus group interviews	A multistage evaluation process including several researchers was employed based on content analysis supported by a software (NVIVO) and a coding scheme	Twenty-one pregnant or recently pregnant women with low income in the USA	Lack of trust was identified by participants as one of the barriers to help-seeking by 19 out of 30 African American women and 2 out of 6 Caucasian women. These were composed of concerns about broken confidentiality, lack of trust in relationship with providers, privacy concerns, not sharing everything and lack of provider understanding or rapport. All African American respondents named “facilitating trust” as one of the ways to overcome these barriers	The study is limited by the small sample size and the focus on pregnant women, making generalizability rather unlikely Evidence level III
Kaiser et al. 2010 [33]	In-person interview study	Descriptive statistics, logistic regression analyses	US breast cancer patients with a regular healthcare provider ($n = 704$)	Sixty-five percent of patients trusted their regular provider, 84% their diagnosing doctors and 83% their treatment teams. Black women were less likely to trust their regular doctor and Hispanic women were less trusting of their diagnosing doctors	The authors conclude that trust in breast cancer patients is high and that additional work is needed to increase interpersonal trust among black women. High number of patients assures representativity of the sample. The study’s generalizability is limited due to the restriction to the breast cancer diagnosis. Evidence level II
Keating et al. 2002 [35]	Telephone survey. Among other instruments, a modified version of the Trust in Physician Scale was used	Descriptive statistics, bi- and multivariate analyses, logistic regression	A total of 2052 patients (mean age 46 years, 69% women, 78% white) insured by a large national US health insurer in three metropolitan areas	Each problem experience was associated with lower trust and 5 of 6 with overall ratings. The following problem experiences were correlated with considering to change the physician: physicians not always giving answers to questions that are understandable, not always taking enough time and not always giving enough medical information	Taken together, problem experiences in the ambulatory setting were related to lower trust and some were associated with considering changing physicians. Due to its high number of participants, the study results are representative, but middle-aged white urban women are overrepresented. Also, mental healthcare was not separately assessed. Evidence level II

Table 4 (Continued)

Reference	Data collection	Method and process of analysis	Population and sample collection	Main results	Comments
Langley et al. 2005 [36]	Interviews with borderline personality disorder patients and focus group discussions with members of the mental healthcare teams	Textual data were transcribed and systematically analysed for topics	Twenty patients with borderline personality disorder and experiences as in- and outpatients. Interviews and focus groups with psychiatrists, social workers, nurses; (n = 10)	Participants identified trust as essential for the establishment and maintenance of a therapeutic alliance. The following subthemes related to trust were identified by patients: trust as a foundation, holding and caring, availability and accessibility, listening – trying to understand, professional attitude, hope. Clinicians identified the following subthemes related to trust: a foundation, hook or anchor, knowing the patient, taking time and start slowly, being there – available and accessible, acknowledging the reality of the patients' experience, hope	It is unclear who analysed the text materials from interviews and the focus groups. Few participants. The generalizability of the data is limited because only patients with borderline disorder were interviewed. Evidence level III
Laugharne et al. 2012 [38]	Face-to-face interviews by first author	Based on grounded theory and thematic analysis. Two researchers analysed the interviews based on predetermined topic guides. Thematic chart grids were derived from the interviews	Patients with psychotic illness. The total number of interviews was 22 (16 in London and 6 in Cornwall). 20 interviews were analysed. The sample was purposive, utilizing as selection criteria gender, ethnicity, diagnosis (the patient's own description of their diagnosis was used) and a history of compulsory detention	Factors enhancing patient trust were personal disclosure, caring attitude and small kindnesses, reciprocity of trust, continuity of care, willingness to listen to patients, being positive about the future, honesty in dialogues, reliability and delivering on promises, professional expertise and personal qualities. Factors undermining trust were the nature of the illness, experience of coercive treatment, perceived neglect by services, over-reliance on a scientific model. No quantitative data were given	The study is of value by nominating factors supporting and undermining patient trust. It is limited by the small number of participants and the focus on patients with psychotic disorders. Evidence level II
Leavey et al. 2011 [39]	Questionnaires and focus groups	Two-step mixed methods approach. Descriptive statistics of questionnaire results and software-supported (HyperResearch) coding of transcribed focus group sessions	Questionnaires (n = 298) and focus group interviews of 48 healthy young persons aged 14–15 years about help-seeking if mental problems occurred	Trust was only a topic in the focus group interviews and "privacy and confidentiality" emerged as the strongest area of consensus amongst the participants. Role misperception was another important issue. No quantitative data were provided	The study shows that trust plays a role in help-seeking in case of mental problems, but this was not further evaluated. Evidence level I
Maidment et al. 2011 [41]	Focus groups	A mixture of purposive and convenience sampling was applied. The chief investigator carried out a thematic analysis followed by three coding stages and data were reviewed by a second investigator	A total of 20 participants were included. These were users of mental health services: older adults, adults living in the community, and forensic services	The following main themes related to trust emerged: full communication developed trust, experiencing an adverse event damaged trust, inherent uncertainty and guesswork were barriers to trust, failing to individualize treatment undermined trust, and the use of coercion was related to a lack of trust	The authors discuss that low levels of trust impacted upon medication management, but they do not cite their own data but rather experiences they derived from the scientific literature. Evidence level II
Mechanic et al. 2000 [44]	Face-to face interviews	Objective counts of mentioning. Data were organized using the NUDIST software for analyzing the non-numerical and unstructured qualitative data	Patients with Lyme disease, breast cancer and mental illnesses (30 in each group). Mental illness patients were from community mental health centers and needed to have a severe mental illness for which they had been seen by a psychiatrist at least twice. Diagnoses included "i.e., major depression, bipolar disorder, schizophrenia or schizoaffective disorder, or a serious anxiety disorder"	Patients viewed trust as an iterative process and commonly tested physicians against their knowledge and expectations. Listening was a central focus. Mean patient counts of trust dimensions varied between the three disorders and were highest for confidentiality in mental illness patients. Another central issue for patients with mental illness was the physicians' knowledge of and efforts to reduce medication side effects	The study is of importance in its comparison of different disorders and its objective way of analysis. The low number of patients per diagnostic group limits the generalizability of the study results. Evidence level II

Table 4 (Continued)

Reference	Data collection	Method and process of analysis	Population and sample collection	Main results	Comments
Piippo et al. 2008 [49]	Interviews	Grounded theory approach. The main aim was to identify the factors that make trust possible in two mental healthcare settings in Sweden. A multi-step structured approach of interview analysis was taken involving several researchers. Tape-recorded and transcribed interviews were analysed using the ATLAS software	Twenty-two psychiatric patients who had experienced both a traditional Swedish mental healthcare program and an innovative “Integrated Network and Family Oriented Model” (INFM) for six months	In the INFM context, users' experiences showed that trust was related to a versatile interchange of knowledge and understanding leading to the experience of wholeness and autonomy. Further, a reciprocal process involving honesty and openness emerged as a trust-related category. Being able to accept help from others, which leads to autonomy, was a third category. Mistrust in the INFM context was related to the feeling of being influenced too much by others and excluded, and a decrease of autonomy due to exclusion and confusion. In the traditional context, trust was related to being treated as an individual in a respectful way, and experiencing oneself as an autonomous person in a caring relation. Mistrust in the traditional context was related to the experience that one's own understanding was underrated and when personnel were rigid in their thinking, and that the individual felt “depersonalized”. A third category was being left alone in an incomprehensible, confusing situation. While confusion about care routines and procedures emerged as a topic in both settings, there were differences in the details (in that personnel in the traditional context did not explain enough, while in the innovative setting, personnel tried to attempt too eagerly to get rid of old care rituals). Another common concept was mutual understanding. While this was related to personnel behavior in the traditional care setting, this was more context-related in the INFM setting. Taken together, the INFM setting provided more versatile possibilities for creating trust	The following implications for nurse practicing were derived: – mental health personnel should focus on the patients' expertise concerning their life situations. – nursing personnel should openly discuss different ways of understanding the patients' problems – nursing personnel should avoid routines and rituals – in the traditional setting, nursing personnel should strive to create two-way relations with patients and openly discuss the care and treatment process. No quantitative analysis is provided and the special setting from which the patients were recruited limits the generalizability of the results. Evidence level II

Table 5

Grading of evidence from questionnaire surveys (quantitative studies), qualitative research (abbreviated and modified following Daly et al. [14]), and reviews.

Study type	Features of qualitative research	Features of quantitative studies	Features of reviews
Level I Generalizable studies	Sampling focused by theory and the literature, extended as a result of analysis to capture diversity of experience. Analytic procedures comprehensive and clear. Results can be generalized to settings or stakeholder groups other than those reported in the study	Sampling of a large and representative group of persons from the general population or from a large range of service settings. Analytic procedures comprehensive and clear usually including multi-variate analyses or statistical modeling. Results can be generalized to settings or stakeholder groups other than those reported in the study	Systematic reviews or meta-analyses
Level II Conceptual studies	Theoretical concepts guide sample selection, based on analysis of literature. May be limited to one group about which little is known or a number of important subgroups. Conceptual analysis recognizes diversity in participants' views	Sample selection of a restricted group of persons or a limited number of service providers or settings. May be limited to one group about which little is known or a number of important subgroups. Analytic procedures comprehensive and clear. Results have limited generalizability	Unsystematic reviews with a low degree of selection bias employing clearly defined search strategies
Level III Descriptive studies	Sample selected to illustrate practical rather than theoretical issues. Record a range of illustrative quotes including themes from the accounts of "many", "most", or "some" study participants	Sample is not representative since it was selected from a single specialized setting or a small group of persons. Mainly records experiences and uses only a limited range of analytical procedures, like descriptive statistics. Results have limited generalizability	Unsystematic reviews with a high degree of selection bias due to undefined or poorly defined search strategies
Level IV Single case study	Provides rich data on the views or experiences of one person. Can provide insight in unexplored contexts	Provides survey data on the views or experiences of a few individuals in a single setting. Can provide insight in unexplored contexts. Results cannot be generalized	Editorials

consultations [3,5,25,29,35,40,60]. In several studies, trust in physicians and satisfaction with services were associated: this was shown for primary care African American US patients and consecutively family practices attending adults in the USA and the UK, a representative Chinese household sample, and adolescent Australians [3,4,5,57]. Adherence to health plans and trust in physicians were correlated in adults subscribed to a state worker health plan [52]. Trust in health insurers depended on administrative competence, clinical competence, advocacy and beneficency, fairness, honesty and openness as components [24]. In general, trust in physicians was high in unselected, general population samples [34]. In special settings where trust may be expected to be low, like prisons, distrust was pronounced and distrustful persons had had negative care experiences and had spent less time with doctors [2]. A comparative analysis also showed that trust was different in acute care settings and primary care settings, supporting the notion that the organizational context influences the nature of trust and how it was earned [11]. There were differences between trust in physicians from different specialties (for example, higher for cardiologists than for general internists; [60]). Furthermore, the nature of the disorder and its severity play a role for trust in physicians: in a Dutch academic setting, the urgency or threat of vulnerability (defined as current reported poor health, high workload, and high absenteeism) explained the relationship between trust and vulnerability [50].

Also, ethnicity plays a role. For example, Koreans living in the US had more positive perceptions of their own health if they trusted Western medicine [31]. Non-white ethnicity in the USA was associated with distrust in medical institutions [2,33], which is also seen with ethnic minority groups in other settings. A large, representative Swedish study showed that respondents born outside Sweden with low or medium levels of education, low generalized trust and low institutional trust had higher odds ratios of poor self-rated health [46]. A large study with English-speaking Japanese Americans, Japanese-speaking Japanese Americans, and Japanese living in Japan showed that there were complex differences in trust in physicians between these groups, and that questions of religiosity, autonomy preference and acculturation were strongly related to trust in physicians. There was a strong relation between trust in physicians and ethnic match between doctor and patient, and between continuity of the doctor associated with a loss of trust in physicians if patients were not able to continue with their preferred physician [58].

3.1.1.3. Trust and healthcare utilization. The relationship between trust and health care utilization was addressed by few studies. In a study of older Americans (mean age 74 years), an association was found between trust in physicians and the use of prevention [48]. Pregnant black American women also identified lack of trust as a barrier to help-seeking [32]. A study on HIV-infected persons

Table 6

Grading of recommendations derived from reviews, quantitative studies (mainly questionnaire-based surveys) and qualitative research. Modified following the SIGN grading of recommendations mainly based on intervention studies.

A	At least one meta-analysis, systematic review, or other study rated as I and directly applicable to the target population; or A body of evidence consisting principally of studies rated as I, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as II, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as I or II
C	A body of evidence including studies rated as II–III, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as II–III
D	Evidence level III or IV or Extrapolated evidence from studies rated as III or IV

showed that trust in physicians was one of the factors associated with antiretroviral therapy adherence [53]. Higher trust in physicians was associated with the intention to follow the doctor's advice [60]. Minority patients who distrusted their healthcare providers were less likely to visit their provider and greater trust in physicians was associated with more health-related doctor visits, and better mental and physical health in HIV-infected patients [64].

3.1.1.4. Trust in mental health services. Seven questionnaire surveys [12,18,19,22,45,47,63] and ten qualitative studies [6,8,23,28,36,38,39,41,43,49] addressed the role of trust in patients with mental disorders. Mostly, these studies showed associations of patient satisfaction and trust in physicians supporting the notion that trust was an essential component of the doctor–patient relationship in mental health care. As the settings of these studies, the assessment methods and the focus of analyses were different between the studies; trust in physicians or the mental health care system was associated with many different patient or service variables (detailed further below). Most of these studies were also mentioned in the review articles, which we identified, on the topic of trust in mental healthcare [9,25].

3.1.1.5. Public trust in mental health services. We identified three studies, which addressed the role of trust for mental help-seeking in persons who have no mental disorder. Leavey et al. [39] performed focus group interviews and applied questionnaires to 48 healthy young persons (14–15 years old) and found that distrust was one of the barriers to mental help-seeking. Gulliver et al. [25] performed a systematic review of the published studies on barriers and facilitators of mental health help-seeking in young adults (aged 12–25) and found that public, perceived and self-stigmatizing attitudes to mental illness, and issues of trust in service providers and their confidentiality were important factors.

Another study directly addressed general public trust [62]. In this postal questionnaire survey, public trust in the healthcare system and different healthcare providers in Germany, The Netherlands, and England and Wales was investigated in a general population sample. In general, levels of trust in health care professionals and the health care system were high, but consistently lower in Germany than in the other two countries. While the study showed that levels of trust might vary considerably between different countries, the special area of mental health care services (not further specified) was only investigated in the groups of England and Wales and The Netherlands. The analysis showed that trust levels in mental health care services was at the level of general nursing homes, but lower than for general hospitals or general home care services. No statistical tests of significance for these differences were reported.

We found no studies dealing with the trust of persons who had previously had a mental illness and were not using mental healthcare services at the time of the study. One study investigated the trust, which family members or other relatives or friends of persons with mental disorders have in the mental health care system. This study did not specifically measure trust in the mental health care system, but found that parents of children with mental illnesses in 4.6% stated that they did not know whom to trust when asked about barriers to help-seeking [22].

Another aspect is public trust in the therapeutic efficacy of mental health services. We did not identify a specific study on this topic, but the ESEMEd study came to the conclusion that a low perceived effectiveness of professional mental health care was evident in that a third of the respondents held the view that professional help in mental health help-seeking was worse or equal to no help when faced with serious emotional problems [59]. This correlation persisted even when adjusted for previous service

use. This indicates that both action to increase the efficacy of mental health services is warranted, and also action to increase public knowledge about mental health services and their efficacy.

3.1.1.6. Trust by patients with mental disorders. In a review book, Brown and Calnan [7] show that apparent barriers to trust, like the generally negative portrayal of the competencies and intentions of mental health services and psychiatry can be overcome since trust was an active process in which knowledge was inferred through past experiences. This, however, needed time and familiarity with services by the truster.

Most of the studies, which we identified regarding trust in mental health care, addressed the question whether persons with mental disorders trusted their doctors or the mental health care services. From these studies, we could derive a list of factors which were associated with trust or which were influenced by trust. Among these were “trustworthiness” as an important reason to contact specific mental health care providers [2,39]. Trust in service providers was higher in older service users [63]. Satisfaction with services was shown to be associated with increased trust [18,47]. Reduced trust in physicians was associated with some mental disorder diagnoses more than with others (reduced in patients with ICD-10 F4-diagnoses [44] and in psychotic patients [63]), duration of psychiatrists' professional experience [44] and continuity of treatment with individual psychiatrists [44]. Trust was also reduced in patients in forensic service settings dependent on service experiences [19], in patients with more prominent self-stigma [63], and in those with negative user experiences [8], including perceived lack of interest by psychiatrists or failure to individualize treatment [41]. Being treated in an individual, respectful way and experiencing oneself as an autonomous person were important factors to build trust in psychiatrists in Finland [49]. Most studies reported such associations, but did not analyse the direction of the association or could not clarify whether these were causative associations. An exception is the study by Verhaeghe et al. [63], which – in a large sample of Belgian psychiatric patients – showed that self-stigma, trust and satisfaction were inter-correlated, and that the negative effect of self-stigma on patient satisfaction was partially attributable to reduced trust by patients in service providers and staff members. In the Belgian study, several factors emerged as essential for trust. These were honesty, open communication, continuity of treatment, continuity of being treated by the same psychiatrist, avoiding violence and coercion, and information for the public and patients about the nature of today's psychiatric services. Trust building was a time-consuming process and stigma of mental health professionals and mental health services, but also self-stigma by persons with mental disorders, were other important factors that hampered service use and led to distrust. Similarly, a study in African American women with mental illnesses showed that raising trust in mental health care providers might increase service use [6]. Raising trust also assured a more efficient way of service provision [8]. Several personal features of staff of mental health services were considered by psychiatric in-patient service users to increase trust. These were being professional, being able to manage situations in which the safety of patients was at risk, being flexible, being non-coercive, being committed and being caring about their patients [23]. In psychiatric patients, interpersonal competence involving caring, concern, confidentiality and compassion were important for patient trust in psychiatrists [44]. A similar study from South Africa showed that staff honesty, availability and accessibility, professionalism, empathy and confidentiality were identified by patients with borderline personality disorder as characterizing a trustful patient–psychiatrist relationship [36]. In psychotic patients, professional expertise, a caring clinician attitude, continuity of care and reliability/regularity were factors enhancing trust in physicians [38].

Following the three hypotheses of this guidance, the following results may be summarized based on the systematic literature research regarding trust in psychiatrists and mental health services (derived from [Tables 3 and 4](#)):

- a higher degree of trust in mental health services increases the likelihood of service use;

We identified several studies showing that service use and trust in health services in general are correlated, but it is unsure whether there is a causative association between the two (Level I–II evidence studies). Also, some studies showed or suggested that a higher degree of trust in mental health services increases the likelihood of mental health service use (Evidence level II–III studies) [[6,12,22,47,63](#)].

- trust in mental health services is influenced by a range of variables (such as, for example, patient satisfaction, service quality, the public image of mental health services, self-stigma);

There are many studies in both general and mental healthcare research showing the inter-relationship between trust in physicians or trust in healthcare services and a range of variables, such as age (with highest trust in adolescents and older persons [[63](#)]), patient satisfaction, ethnicity (usually associated with less trust in minority groups), positive personal service experiences, achieving remission, continuity and longer duration of treatment, and the duration of professional experience of the treating psychiatrist (evidence level of most studies I–II) [[8,18,19,44,45,47,63](#)]. Most studies, however, did not study the direction of such interactions. Only one study in general healthcare (evidence level I study, [[40](#)]) convincingly showed that the direction of this interaction was in such a way that trust was influenced by other variables (“The results show that the benevolence and technical competence dimensions of trust have different antecedents. Four variables significantly affect the benevolence dimension of trust: length of patient–PCP relationship, awareness of utilization reviews by insurers, awareness of financial incentives, and patients’ satisfaction with their PCP. The R2 for this part of the model is .85. Two variables predict the technical competence dimension of trust: length of patient–PCP relationship, and patients’ satisfaction with their PCP. The R2 for this part of the model is .80”; PCP = primary care physician). Another study, which provided evidence in this direction, was performed by Verhaeghe et al., which showed that trust in physicians was diminished in mentally ill with increased self-stigma, and that self-stigma mediated distrust in mental health services (evidence level I study, [[63](#)]). In a study not related to trust but dealing with the barriers to professional help-seeking in Japanese high school students for psychological help, a hierarchical multiple regression analysis showed that the image of psychiatry, knowledge of services, and stigma towards mental health problems and services were closely related factors [[56](#)].

- the modification of some of these variables can lead to an increase of trust in mental health services, resulting in increased service use.

Several studies indicate that increased trust by the public or persons with mental disorders may increase mental health service utilization (detailed in [Tables 3 and 4](#)), but no study directly modified any of the variables in an intervention study. A study showing a relationship between trust and service use showed that low income urban women with serious mental illness tended to be more engaged with the healthcare system in general [[6](#)], but this was also not an intervention study. We identified a Cochrane systematic review about intervention studies aimed at increasing trust in physicians, which had retrieved three studies [[42](#)]. This review showed that one study was unsuccessful, another was not directly about increasing trust, and a third study showed some beneficial effects of

induction visits on patient trust in doctors, but had methodological weaknesses. In summary, Mc Kinstry et al. came to the conclusion that there was insufficient evidence in this research area. We found a single study, which was effective in increasing help-seeking in mental healthcare. This was a doctoral thesis in an occupational setting and complex interventions were applied. It is unlikely that these could be transferred to mental health care settings or to the general public (McNamara, 1993).

One observation in the studies was that negative user experiences of mental health services were deleterious for trust by patients in mental health services in general or psychiatrists. Besides the aspects of continuity, confidentiality, honesty and non-coerciveness mentioned before, issues of patient safety and dignity were important elements of trust by users. This became especially apparent in the qualitative studies for both safety [[8,23](#)] and dignity manifesting themselves as comments on the importance of retaining one’s freedom as a patient [[23](#)], the necessity of individualized therapy [[49](#)], and experiences of devaluation and discrimination in mental health services [[6,63](#)].

4. Recommendations

4.1. Selection of studies as the evidence base of the European Guidance

Based on the results of this systematic literature search, we found that five recommendations can be formulated with a firm evidence base.

4.2. Proposed recommendations of the European Guidance Project

4.2.1. Recommendation 1

The European Psychiatric Association considers (Grade of recommendation: C) that increasing trust in mental health care providers and psychiatrists should be regarded as a priority, as it may facilitate the rate of mental health care utilization (evidence level III, [[6,12,22](#)]) and user satisfaction (evidence level I–II, [[47,63](#)]).

4.2.2. Recommendation 2

The European Psychiatric Association considers (Grade of recommendation: B) that using one or a combination of the following measures increases trust in mental health care providers and psychiatrists and should thus be implemented:

- achieve clinical remission (evidence level I–III, [[19,63](#)]);
- assure a long duration and continuity of contact with the psychiatrist (evidence level I, [[45](#)]);
- assure continuity of the psychiatrist caring for a patient and provide experienced psychiatrists as treating physicians (evidence level I–II, [[44,45](#)]);
- reduce self-stigma of persons with mental disorders (evidence level I, [[45](#)]);
- avoid negative user experiences like stigmatization, violence, staff ignorance and coercion (evidence level III, [[6,8,19,63](#)]);
- increase service user satisfaction with services (evidence level II–III, [[18,47](#)]).

4.2.3. Recommendation 3

The European Psychiatric Association considers (grade of recommendation: B) to increase trust by patients through specialty training and continuing medical education to train psychiatrists to emphasize their honesty (evidence level II, [[38,49](#)]), availability and accessibility (evidence level III, [[36](#)]), professionalism (evidence level III, [[28,36](#)]), empathy (evidence level II, [[38,49](#)]), confidentiality

(evidence level II, [25,44]) and flexibility (evidence level III, [23]). This recommendation is of special importance in the context of suicidal patients, as empathetic professionals can contribute to the avoidance of an unnecessary death.

4.2.4. Recommendation 4

The European Psychiatric Association considers (grade of recommendation: B) that healthcare providers, governmental and non-governmental organizations, and psychiatric medical specialty societies are advised to increase trust in mental health care and psychiatrists in the general population by informing the public about the settings and diagnostic and therapeutic procedures of mental health care, as this may reduce distrust as a barrier to help-seeking (evidence level II–III, [6,28,38,41,49]).

4.2.5. Recommendation 5

The European Psychiatric Association considers (grade of recommendation: B) that efforts should be made to improve the quality of mental health care systems in general and specifically mental health services for ethnic minority groups with a view to increase trust, foster safety and assure patient dignity in mental health services by avoiding negative user experiences.

5. Discussion

From our systematic review, trust in mental health care services emerged as an important determinant of user satisfaction and service use. We found that users' trust in physicians and the mental healthcare system is a complex, multidimensional and dynamic interrelationship of a multitude of factors. Its components may vary greatly between individuals and over time. They may be non-modifiable factors, such as age, place of residence, culture, ethnicity, past experiences as a service user and type of disorder, but also modifiable factors, such as public and patient knowledge about mental healthcare providers, the efficacy and safety of the services provided, professional training and experience of psychiatrists, symptomatology, continuity of treatment, attention to patient dignity and prevention or reduction of stigma, discrimination and coerciveness. In analogy, public trust in mental health care services is most likely to be influenced by similar factors.

Strengths of this study are its systematic approach towards evidence retrieval and evaluation, and its consensus-based approach towards formulating recommendations. Another strength is that we focused on implementable aspects of the recommendations. While reviews were informative as background information, we did not use them to formulate recommendations, as most were unsystematic reviews prone to selection bias. The use of different assessment systems, small sample sizes, different and in some studies highly selective patient populations, and different care settings make it difficult to compare the available studies or to generalize their findings – while the point that trust is important for health care seems to be uncontroversial among the study authors.

6. Conclusions and perspectives

Our evidence search showed that trust is a central component of health care in general, including help-seeking for mental disorders. Trust in mental health care may be conceptualized, defined and operationalized in different ways. Issues of confidentiality, providing information about psychiatric services, destigmatization of mental disorders and mental health services, and fostering professional attitudes by mental health care professionals appear to be the major modifiable determinants of trust in mental health care. The recommendations we developed

aim at using such factors to advance the use of mental health care. One major issue of a sometimes heated debate among health care professionals as well as other academics, journalists and, finally, the users (and not only those with an anti-psychiatric attitude), is the (presumed) influence of the industry on treatment regimens or the definition of diagnoses (see, for example, <http://www.psychiatrictimes.com/articles/undue-pharmaceutical-influence-psychiatric-practice> for a more extensive discussion of this topic). Already the perception of or assuming such influences may undermine trust, although this topic did not emerge in the studies which we reviewed. We have therefore not included this issue in the recommendations, but would suggest to review the evidence on this topic again when this guidance is updated since scientific studies objectivating the assumption that such perceptions influence patient trust in psychiatric services may then be available. Follow-up reviews would be warranted in approximately five years given the limited frequency of relevant studies in the last years.

There is a lack of studies showing the direction of the association of factors associated with trust in psychiatric services and future mental health care utilization. Such studies would be highly warranted. Also, while the components of trust mentioned above emerged in different studies, there was a lack of comprehensive studies addressing all these factors together in one sample of the general population or in one sample of persons with mental disorders. Further studies are needed using harmonized definitions of trust in mental health care and unified methods to assess trust in mental health care in different European countries and by different stakeholders, like the general public, relatives of persons with mental illness, and persons with mental illnesses themselves. Also, setting-specific studies with representative samples need to be performed in general psychiatric in- and out-patient care settings, but also general medical health care settings. Sophisticated statistical analytical methods are warranted to analyse the complex interrelationship of trust-related components in such studies with a view to identify further causal relationships between trust and such components. This may open the way to novel interventions in the future to reduce distrust in mental health care services as one of the essential barriers to appropriate mental health care provision in Europe.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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