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REVIEW PAPER

Implementing Community-Based Psychosocial Interventions for Adults with Severe Mental Illness in High-Income Countries: A Rapid Scoping Review

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Abstract
Psychosocial interventions support functional recovery and social integration for people with severe mental illness (SMI); however, their implementation remains fragmented and inconsistent. This rapid scoping review maps the landscape of psychosocial interventions for adults with SMI in high-income countries, identifying their key components, implementation challenges, and strategies to optimise delivery. Following the Cochrane rapid review guidelines, we searched MEDLINE and CINAHL (January 2009 - May 2024) and conducted manual reference screening. Eligible studies focused on non-pharmacological, community-based interventions. Thematic analysis was used to identify implementation barriers and enablers. Of 8,624 screened records, 464 studies met inclusion criteria, covering 15 intervention types. Cognitive-focused interventions (n = 100) supported employment (n = 86), and behavioural therapies (n = 66) were most studied. Outcomes focused on symptom (n = 179), daily living skills (n = 160), and cognitive states (n = 157). Implementation was often constrained by systemic, organisational, and individual-level barriers. Systemic challenges included fragmented services, stigma, cultural and linguistic barriers, and economic constraints, highlighting the need for integrated care models, policy reforms, and culturally responsive approaches. Organisational challenges such as staff resistance, insufficient training, and resource limitations underscored the importance of leadership, stakeholder engagement, and investment. At the individual level, low motivation, logistical difficulties, trauma histories, and goal misalignment reduced engagement and retention, highlighting the need for flexible, person-centred, trauma-informed approaches, strong social networks, and a balance between structure and adaptability. Selecting, adapting, and funding psychosocial interventions remain complex. This review provides a foundation for future systematic reviews of homogeneous intervention subsets to better inform policy and practice.

Keywords Severe mental illness · Psychosocial intervention · Functional recovery · Community-based mental health support

Introduction

Although no single definition is universally accepted, the term *severe mental illness (SMI)* – also referred to as *serious mental illness* or *severe and persistent mental illness (SPMI)* – generally refers to a subset of mental disorders characterised by diagnosis, duration, and functional impairment (Carey & Carey, 1999; Gonzales et al., 2022; Harvey et al., 2023; Ruggeri et al., 2000). Operational definitions further emphasise the interplay of severity, persistence, and disability, typically involving significant psychiatric symptoms (e.g., psychosis, mood instability), ongoing treatment for two years or more, and marked functional impairment

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measured by tools like the Global Assessment of Functioning (GAF) (Ruggeri et al., 2000).

SMI is estimated to affect 4.3% of people in high-income countries (Levinson et al., 2010). Individuals with SMI commonly experience comorbid conditions, including substance use disorders and physical health problems, which can exacerbate their mental health challenges and complicate treatment (Havassy et al., 2004; Pizzol et al., 2023). Additionally, the stigma surrounding mental illness often results in social isolation, discrimination, and diminished self-worth, further hindering recovery and community integration (Fluit et al., 2024; Hajizadeh et al., 2024).

SMI also impacts families and caregivers who provide essential emotional, financial, and practical support. This caregiving role can lead to high levels of stress, emotional strain, productivity loss, and financial hardship (Fekadu et al., 2019, Philips et al., 2023). At the societal level, SMI contributes to social exclusion and strains public resources, as untreated or poorly managed cases can lead to homelessness, repeat hospitalisations, and involvement with the criminal justice system (Nishith et al., 2023). The economic impact includes both direct costs (e.g., healthcare, social services) (Figueroa et al., 2020) and indirect costs (e.g., unemployment, lost productivity, caregiving burdens) (Fasseeh et al., 2018).

Psychosocial interventions are non-pharmacological supports designed to address the multifaceted needs of individuals with SMI, aiming to support personal recovery - defined as *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles… a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness"* (Anthony, 1993). These interventions, often delivered by community-based organisations, integrate various therapeutic, educational, and support mechanisms to promote independence, community participation, and improved quality of life (Gühne et al., 2020). They typically span care coordination, rehabilitation, housing, education, employment assistance, and social engagement (Harvey et al., 2023).

Despite their potential, community-based psychosocial interventions in high-income countries often operate in silos, resulting in fragmented care (Killaspy et al., 2022). Some areas experience overlapping services, while others confront major service gaps. These challenges reflect broader structural issues such as fragmented funding streams, workforce shortages, limited coordination between providers, and policy environments that constrain integration across health and social care systems (Rosenberg & Harvey, 2021). The implementation of comprehensive, holistic, person-centred psychosocial interventions is therefore affected not only by program-level factors such as fidelity, acceptability, feasibility, accessibility, cost, adoption, and sustainability, but also by these systemic conditions, making it critical to identify what enables or hinders effective delivery.

This rapid scoping review addresses a key gap by examining factors that influence the implementation of community-based psychosocial interventions for adults with severe mental illness (SMI) in high-income countries. Specifically, it: (1) outlines the characteristics of existing studies and identifies gaps in the literature; (2) describes and categorise interventions based on their primary targets and delivery modalities; (3) summarises the outcome measures used to assess psychosocial interventions; and (4) identifies implementation barriers and potential remedies reported in the literature.

Methods

Protocol Development

A rapid scoping review was chosen to meet the study objectives and provide timely evidence synthesis to inform policy and practice. The review follows *the Cochrane Rapid Review Methods Guidance* (Garritty et al., 2021), with the exception of the *Risk of Bias Assessment* and *Certainty of Evidence* recommendations, which are not applicable to a scoping review. It also adheres to *the JBI Manual for Evidence Synthesis* (Pollock et al., 2023) and *the PRISMA Extension for Scoping Reviews* (Tricco et al., 2018) reporting format. We collaborated with subject matter experts and service delivery stakeholders to develop the review protocol, which included defining review questions, eligibility criteria (Table 1), search strategy (Table 2), and data extraction items. The classification of *high-income countries* in this review follows the World Bank's income group definitions, as outlined in the World Development Indicators (World Bank, 2024).

Search Strategy

We conducted a systematic search in MEDLINE (via PubMed) and CINAHL (via EBSCOhost) for studies published between January 2009 and May 2024. Our search strategy adhered to the PRESS (Peer Review of Electronic Search Strategies) checklist (McGowan et al., 2016) to ensure comprehensiveness. Additionally, we manually screened reference lists from relevant review articles to capture additional literature.

Study Selection

Two reviewers (JC and JSM) conducted dual and independent screening of abstracts, refining eligibility criteria as needed. Once 80% agreement was reached, single screening was performed. Full-text screening followed the same process (JC and IY). EndNote was used to manage references and remove duplicates, while Covidence facilitated the screening and resolution of discrepancies.

Table 1 Study eligibility criteria

Category	Inclusion	Exclusion
Study Design	• Randomised controlled trial • Non-randomised trial • Before-and-after study • Time series • Qualitative study • Mixed methods • Economic evaluation	• Non-comparative quantitative studies (e.g., case series, case report, cross-sectional study, ecological study) • Case study • Cost analysis
Population	• Adults with SMI, including subgroups such as refugees, veterans, homeless individuals, parents, etc. • Family and informal caregivers of individuals with SMI • Service providers delivering interventions to individuals with SPMI and their families	• Children • Adolescents • Individuals with early-stage or first episode psychosis
Intervention	Non-pharmaceutical interventions aimed at improving function and personal recovery	• Pharmaceutical interventions • Interventions focused only on symptom alleviation • Early recognition or early psychosis interventions • Interventions solely for medication adherence, stigma reduction, or substance use • Post-disaster psychosocial support
Setting	Community-based settings (e.g., outpatient clinics, home-based care, group homes, long-term care, educational institutions, recreational or outdoor settings)	• Hospital inpatient • Emergency services • Acute care • Prisons/correctional centres
Country	High-income countries (e.g., including Taiwan and Hong Kong as per World Bank classification)	Upper-middle, middle-, and low-income countries
Outcomes	Study must report at least one of: • Implementation outcomes (e.g., acceptability, adoption, appropriateness, feasibility, fidelity, penetration, sustainability) • Economic analysis results	Studies focusing solely on symptom alleviation outcomes

SMI = severe mental illness

Table 2 Search strategy

Concept	Search strings
Severe mental illness	"psychosocial disability"[Title/Abstract] OR "psychiatric disability"[Title/Abstract] OR "severe mental ill*"[Title/Abstract] OR "psychosocial"[Title/Abstract] OR "post-traumatic stress disorder"[Title/Abstract] OR "PTSD"[Title/Abstract] OR "bipolar disorder"[Title/Abstract] OR "schizo*"[Title/Abstract] OR "psychosis"[Title/Abstract] OR "psychotic"[Title/Abstract] OR "persons with mental disabilities"[MeSH Terms] NOT "first episode"[Title/Abstract] NOT "early psychosis" [Title/Abstract] NOT cancer [Title] NOT COVID [Title] NOT Communicable Diseases [MeSH Major Topic]
Intervention	"rehabilitation"[Title/Abstract] OR "recovery"[Title/Abstract] OR "psychosocial intervention"[Title/Abstract] OR "psychosocial support"[Title/Abstract] OR "psychosocial intervention"[MeSH Terms] OR "psychosocial support systems"[MeSH Terms] OR "Independent Living"[MeSH Terms] OR "employment, supported"[MeSH Terms] NOT "drug therapy" [MeSH Terms] NOT Psychopharmacology [MeSH Terms]
Setting	NOT "Emergency Service, Hospital" [MeSH Terms] NOT inpatient [MeSH Terms] NOT hospital [MeSH Major Topic] NOT "Developing Countries" [MeSH Terms]
Filter	AND (english[Filter]) AND (alladult[Filter]) AND (2009:2024[pdat])

Data Extraction and Charting

We used both artificial intelligence and human reviewers for data extraction. A structured prompt was developed for ChatGPT (version 4o) (OpenAI, 2024) to extract key data points from full-text articles. KJC conducted pilot testing of the AI-assisted data extraction process, beginning with independent extractions performed in parallel with ChatGPT. Agreement was assessed by comparing human and AI outputs on a variable-by-variable basis, with each item classified as *agree*, *partially agree*, or *disagree*. Percentage agreement was then calculated as the proportion of agreements out of the total number of items extracted. The extraction prompt was iteratively refined after each round to improve accuracy and consistency, until a 90% agreement threshold was reached. The final version of the prompt, along with a reflection on this process, is provided in Supplementary Material 1. Post-pilot, ChatGPT extracted all data, with one reviewer verifying data points for accuracy in every article. Quantitative studies were verified by KJC, FB, and IY; qualitative studies were verified by JSM and JH. Excel was used to store and organise extracted data.

Data Analysis

A narrative synthesis was conducted by KJC to inductively summarise findings related to implementation barriers and

their potential remedies. Key themes were identified through thematic analysis using NVivo 14. These inductively derived findings were further interpreted using Proctor et al.'s taxonomy of implementation outcomes (acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration, and sustainability) in the Discussion section to situate them within an established implementation science framework. A bar chart was created to visualise categories of psychosocial interventions and their study designs.

Results

The search identified 8,624 unique records, with an additional 364 retrieved through manual reference checks. After screening titles and abstracts, 526 records were selected for full-text review. Of these, 62 were excluded for reasons such as: incorrect disease focus (e.g. not SMI; $n=15$), irrelevant outcomes (e.g. studies emphasising symptom relief but not personal recovery; $n=10$), unsuitable study design (e.g. case studies; $n=14$), incorrect settings (e.g. hospital inpatient rather than community-based; $n=8$), pharmacological interventions ($n=8$), wrong stage of illness (e.g. early psychosis or first-episode psychosis; $n=4$), and non-high-income country ($n=3$). In the end, 464 studies met the inclusion criteria and were included in the data analysis (see Fig. 1 for the PRISMA diagram). Detailed study characteristics can be found in Supplementary Material 2. The following results summarise intervention types, study designs and locations, outcome measures utilised, implementation barriers, and potential remedies to overcome these barriers.

Intervention Categories, Targets, and Modalities

Fifteen categories of psychosocial interventions were identified based on their primary targets and modalities (Fig. 2). Some studies used hybrid approaches, such as combining

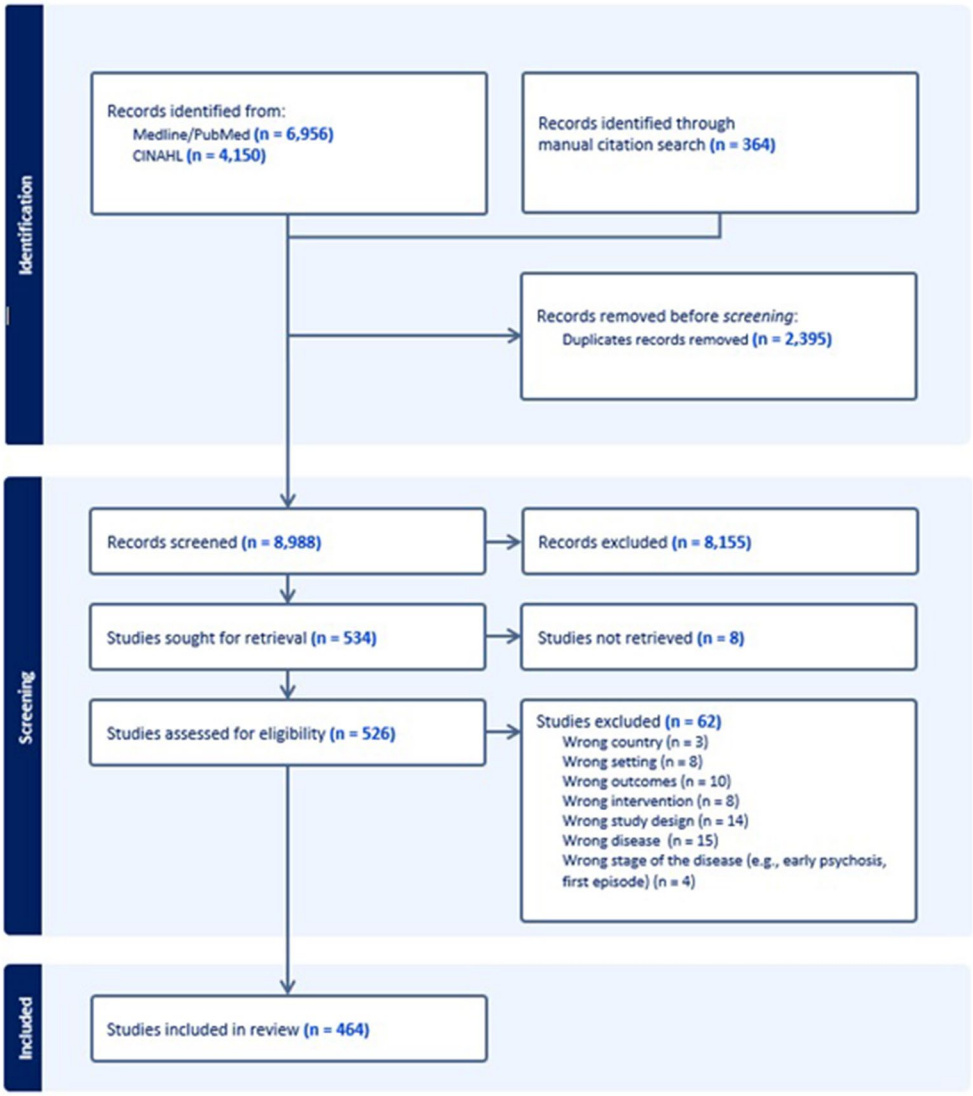

Fig. 1 PRISMA diagram. This figure presents a PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flowchart outlining the study selection process for a rapid scoping review

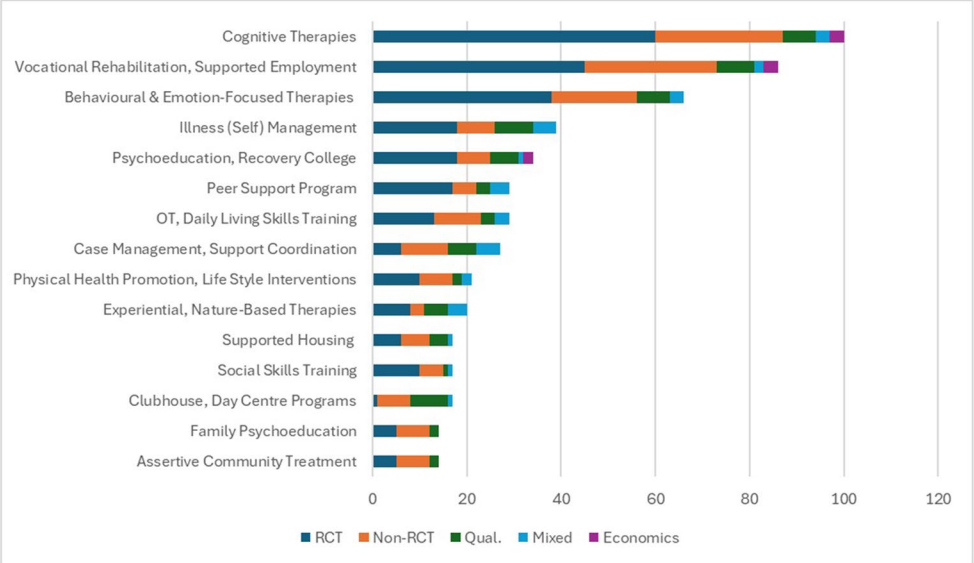

Fig. 2 Intervention categories and study designs. This horizontal bar chart displays the number of studies per intervention category, broken down by study design. Intervention types are listed on the vertical axis, and the number of studies is shown on the horizontal axis, ranging from 0 to 120

cognitive behavioural therapy (CBT) with supported employment or peer support in Clubhouses.

1. Cognitive-focused Interventions (n = 100): e.g., cognitive remediation therapy and metacognitive therapy to improve cognitive functioning, such as memory, attention, and problem-solving.
2. Supported Employment and Vocational Rehabilitation (n = 86): e.g., Individual Placement and Support (IPS) to reintegrate individuals into the workforce.
3. Behavioural and Emotion-Focused Therapies (n = 66): e.g., CBT, mindfulness-based interventions, and positive psychotherapy to address emotional regulation.
4. Illness (Self) Management (n = 39): e.g., psychiatric crisis planning and self-monitoring programs to enhance individuals' ability to manage symptoms and prevent relapse.
5. Psychoeducation or Recovery College (n = 34): e.g., structured educational courses and workshops to increase mental health literacy, self-efficacy, and recovery-oriented skills.
6. Peer Support Programs (n = 29): e.g., one-on-one or group-based support delivered by individuals with lived experience to provide support and mutual understanding.
7. Occupational therapies and Daily Living Skills Training (n=29): e.g., interventions teaching personal care and household tasks to improve independent living and daily functioning.
8. Case Management and Support Coordination (n=27): e.g., service navigation and personalised care planning to ensure continuity of care and better access to resources.
9. Physical Health Promotion and Lifestyle Interventions (n = 21): e.g., exercise programs, sports activities, and dietary education to improve physical well-being and reduce comorbid health risks.
10. Experiential/Nature-Based Therapies (n=20): e.g., art therapy, music therapy, writing workshop, or equine-assisted therapy to enhance emotional well-being, self-expression, and social engagement.
11. Supported Housing (n = 17): e.g., Housing First programs to provide stable and secure living environments that foster independence and recovery.
12. Social Skill Training (n = 17): e.g., structured group sessions to build interpersonal communication and relationship management skills.
13. Drop-in or Day Centre Programs (n = 17): e.g., Clubhouses and psychosocial rehabilitation communities offering a work-ordered day structure, social opportunities, and skill development to promote community participation.
14. Family Psychoeducation (n =14): e.g., educational workshops for relatives and carers to improve their understanding of mental illness, reduce stress, and strengthen family support systems.
15. Assertive Community Treatment (n = 14): e.g., multidisciplinary team-based outreach to provide intensive, ongoing support aimed at reducing hospitalisation and promoting community integration.

A few additional interventions ($n = 3$) involved spirituality, or shared decision-making between service providers and recipients.

Study Designs

Randomised controlled trials (RCTs) were most common in studies on cognitive therapies (60% of total studies) and supported employment (52%). Qualitative methods were notably utilised in Clubhouse (47%) and

experiential therapy (25%) studies. Economic evaluations were sparse, observed occasionally in studies on cognitive therapies, supported employment, and psychoeducation (Fig. 2).

Study Location

The geographic distribution of studies revealed a significant concentration in North America ($n=188$, with 127 studies conducted in the USA) and Europe ($n=184$, including 31 studies from the UK). Asia and Oceania each contributed 41 studies (14 from Japan and 39 from Australia, respectively). Other regions had limited representation: 10 studies from the Middle East (all from Israel), 2 from South America (both from Chile), and none from Africa. This imbalance reflected this review's focus on studies conducted in high-income countries.

North America had the highest proportion of studies on supported housing (71%), peer support (59%), and illness self-management (56%). Europe was significantly represented in studies on CBT (52%), psychoeducation (47%), and cognitive therapies (40%). Oceania showed relatively higher representation in studies on case management (33%) and supported housing (18%), second only to North America. Other regions, such as Asia and the Middle East, had limited or negligible representation across most intervention categories.

Outcome Measures

Most studies employed multiple outcome measures, with up to five extracted from each study. The most commonly used outcome measures were symptom-related measures ($n=179$), which assessed symptom severity, recurrence, and stability. These were followed by measures of daily living skills and functioning ($n=159$), such as independent living skills and global functioning, and measures of cognitive and psychological state ($n=157$), such as memory, attention, cognition, and emotion recognition. Table 3 provides an overview of 15 types of outcome measures, along with examples and commonly used instruments or data collection methods.

Implementation Barriers and Potential Remedies

Barriers to implementation were reported at systemic, organisational, and individual/programmatic levels. Successful interventions often adopted multi-level strategies to mitigate these challenges. A summary of all identified barriers and their corresponding remedies is presented in Table 4.

Systemic-Level Barriers

Systemic barriers included fragmented services, cultural and linguistic mismatches, stigma, and economic constraints, all of which limited access and integration. Addressing them required coordinated care, culturally competent approaches, stigma reduction, and inclusive policies.

Fragmentation and Lack of Integration

Services for mental health, employment, and social support often operated in silos, limiting continuity of care for individuals with complex needs [s82, s91, s101, s109, s144, s193, s439][Footnote 1]. This scoping review identified a number of strategies to remedy fragmentation [s6, s23, s26, s27, s43, s45, s47, s112, s126, s139, s150, s158, s174, s210, s218, s230, s261, s292, s297, s305, s307, s319, s342, s347, s352, s366, s418, s424, s426, s430, s437, s439, s443, s453]. For example, embedding new psychosocial interventions into established systems – such as collocating vocational specialists within mental health clinics [s112] – helped normalise their adoption, improve accessibility, and reduce resource duplication.

Improving integration required multidisciplinary collaboration, clearly defined roles, coordinated care planning, and formal communication protocols [s65, s67, s82, s101, s109, s111-s113, s197, s145, s146, s221, s265, s276, s292, s297, s305, s306, s347, s418]. For instance, the *Emerge* model integrated Assertive Community Treatment with Transition to Independence Process, combining the efforts of community support specialists, licensed clinicians, employment and education specialists to support young adults with SMI transitioning to adulthood [s238]. Similarly, the *Job Management Programme* established collaborative partnerships between employment services and healthcare providers to align vocational and mental health goals [s145].

Stigma and Mistrust

Stigma – both external and internalised – was a persistent barrier to societal engagement [s3, s84, s99, s103, s143, s182, s238, s328, s344, s346, s374, s382, s398, s403, s438], often compounded by fear of association with mental health groups [s320] and by historical mistrust of mental health care systems [s247, s322]. This was especially pronounced

[1] Footnote: The references in this section correspond to the studies included in this scoping review and are separate from those listed at the end of the article. To distinguish them from the main references, a letter prefix 's' has been added to their reference numbers. Readers seeking DOIs or further details on these studies can refer to Supplementary Material 1.

Table 3 Outcome measures adopted in psychosocial interventions

Category	Example Outcome Measures	Common Instruments Used
Symptom-Related Measures (n = 179)	Symptom severity, recurrence, stability, etc.	• Positive and Negative Syndrome Scale (PANSS) (n = 58) • Brief Psychiatric Rating Scale (BPRS) (n = 25) • Hamilton Scale (HAM) (Depression and/or Anxiety) (n = 16)
Daily Life Skills and Functioning (n = 160)	Global functioning, social functioning, independent living skills, financial literacy, etc.	• Global Assessment of Functioning (GAF) (n = 31) • UCSD Performance-Based Skills Assessment (UPSA) (n = 11) • Personal and Social Performance Scale (PSP) (n = 10)
Cognitive and Psychological State (n = 157)	Memory, attention, cognition, emotion recognition, internalised stigma, etc.	• Internalized Stigma of Mental Illness Scale (ISMI) (n = 19) • Brief Assessment of Cognition in Schizophrenia (BACS) (n = 18) • MATRICS Consensus Cognitive Battery (MCCB) (n =15)
Personal Recovery and Resilience (n = 147)	Resilience, empowerment, the personal recovery process, etc.	• Recovery Assessment Scale (RAS) (n = 29) • Empowerment Scale (ES) (n = 22) • Rosenberg Self-Esteem Scale (RSES) (n = 21)
Quality of Life and Well-Being (n = 130)	Broad aspects in life satisfaction and well-being	• Manchester Short Assessment of Quality of Life (MANSA) (n = 23) • World Health Organisation Quality of Life (WHOQOL) (n = 16) • EuroQol 5-Dimension Questionnaire (EQ-5D) (n = 12)
Employment and Vocational Outcomes (n =92)	Job acquisition, job tenure, earnings, etc.	Information was collected through administrative records or self-reports.
Individual Experience with Intervention (n =63)	Subjective opinions and attitudes about the interventions, such as satisfaction, acceptability, usability, etc.	Information was typically collected through custom-made surveys, interviews, or focus groups.
Service Utilisation (n =48)	Hospitalisation rate, outpatient service use, emergency service use, reliance on social support systems, etc.	Information was collected through administrative records or self-reports.
Social Connection and Community Participation (n = 41)	Social interactions, community integration, community participation.	Information was typically collected using surveys and interviews, while a few employed specific instruments, including: • Social Functioning Scale (SFS) (n = 2) • Multnomah Community Ability Scale (MCAS) (n = 2) • Community Integration Scale (CIS) (n = 2)
Physical or General Health (n = 25)	BMI, blood pressure, fitness level, etc.	Information was typically collected using standard health assessments, while a few studies utilised: • 6-minute walk test (n = 2) • International Physical Activity Questionnaire (IPAQ) (n =2)
Economics and Costs (n = 25)	Economic analysis of the interventions	• Cost analysis (n = 5) • Cost-effectiveness analysis (n = 5) • Cost-utility analysis (n = 3)
Implementation Feasibility and Sustainability (n = 22)	Drop-out rate, engagement, fidelity, usability, sustainability, etc.	Information was collected through logbooks, interviews, or custom-made surveys.
Knowledge of the Illness (n = 15)	Understanding and awareness of mental health conditions	• Brief Illness Perception Questionnaire (n = 3) • Birchwood Insight Scale (n = 2)
Housing Status (n = 11)	Living arrangements and stability	• Residential Time Line Follow-Back Inventory (RTLFB) (n = 5) • Administrative records (n = 3) • Surveys or Interviews (n = 3)
Substance Use (n = 10)	Substance use, substance craving, alcohol consumption	• Alcohol Use Disorders Identification Test (AUDIT) (n = 2) • Alcohol Use Scale (AUS) (n = 2) • Drug Use Scale (DUS) (n = 2)

among marginalised populations, such as homeless individuals and ethnic minorities [s247].

Strategies to address these challenges included creating stigma-free spaces through staff training in humanistic and empathetic relational practices, creating a sense of belonging, reducing power differentials between staff and clients, and modelling respectful behaviour [s81]. Building partnerships with community leaders has also helped bridge trust gaps between service providers and marginalised populations. These leaders often act as role models and advocates for programs, normalising help-seeking and fostering a sense of safety and acceptance [s445].

Cultural and Linguistic Mismatches

Interventions that failed to reflect participants' cultural values and linguistic needs were often perceived as irrelevant and inaccessible [s69, s93, s102, s220, s259, s263, s416, s424, s456]. Studies show that culturally tailored materials and bilingual staff improved effectiveness [s10, s164, s259,

Table 4 Key Implementation barriers and corresponding remedies for community-based psychosocial interventions

Level	Key Implementation Barriers	Corresponding Remedies
Systemic	**Fragmented services and lack of integration** - Services for mental health, employment, and social support operated in silos, limiting continuity of care.	Integrate psychosocial supports into existing systems; establish multidisciplinary teams; use shared care plans and formal communication protocols; co-locate services (e.g., vocational specialists in clinics) to normalise adoption, improve accessibility, and reduce duplication.
	Stigma and mistrust – Stigma, fear of association, and historical mistrust reduced engagement, particularly among marginalised populations.	Create stigma-free spaces through staff training in humanistic and empathetic practices; reduce power differentials; build partnerships with community leaders to foster trust and normalise help-seeking.
	Cultural and linguistic mismatches – Programs not reflecting participants' cultural or linguistic needs were seen as irrelevant.	Provide culturally tailored materials, bilingual staff, and region- or gender-specific adaptations; ensure materials align with participants' cultural norms.
	Economic and structural constraints – Labour market discrimination, inflexible welfare systems, and unstable funding limited access and sustainability.	Implement supportive policies such as disability hiring quotas and flexible welfare arrangements; align funding structures with reimbursable services.
Organisational	**Resistance to change and lack of buy-in** – Staff scepticism, entrenched clinical cultures, top-down mandates, and unclear leadership support.	Promote organisational readiness through effective leadership, stakeholder engagement, clear communication, and supportive organisational culture.
	Insufficient training and supervision – Inconsistent training left staff and peer workers underprepared.	Provide structured, role-specific training and ongoing supervision to enhance confidence, maintain fidelity, and ensure inclusivity.
	Resource constraints – Funding, workforce, and infrastructure limitations undermined sustainability.	Integrate interventions into existing services; adopt flexible workforce utilisation; use free materials and community spaces; leverage existing funding and technology.
Individual/ Program	**Low motivation and initial scepticism** – Limited awareness and motivation reduced engagement.	Use motivational interviewing, peer testimonials, and clear information about goals and outcomes.
	Unstable living conditions and logistical barriers – Housing and transport issues disrupted participation.	Deliver services in accessible community settings; address basic needs; provide flexible scheduling and follow-up.
	Psychiatric symptoms, trauma, and comorbidities – Emotional distress, relapse risk, or physical illness hindered participation.	Apply trauma-informed care, gradual exposure, and supportive, non-judgmental environments.
	High cognitive and technological demands – Digital literacy and cognitive challenges limited access.	Offer user-friendly platforms, manuals, technical support, and self-paced activities.
	Irrelevant content and misalignment with personal goals – Content perceived as detached from real-life needs.	Conduct needs assessments; use personalised goal-setting and real-world skill-building; co-produce interventions with service users.
	Balancing structure and flexibility – Rigid or overly flexible models reduced effectiveness.	Combine structured frameworks with adaptable, client-tailored elements.
	Weak social networks and interpersonal factors – Limited family or peer support led to disengagement.	Offer caregiver training; foster peer support; strengthen group facilitation skills to ensure safe and inclusive environments.

s264, s294, s319, s329, s409]. For example, Au et al. (2021) [s10] highlighted the use of traditional Chinese characters and culturally relevant memory aids, such as linking tasks with cues familiar to Chinese culture. Similarly, Lin et al. (2020) [s264] described a team of bilingual mental health professionals who translated and culturally tailored a personal workbook and facilitator's manual to ensure that terminology and examples aligned with Chinese linguistic and cultural norms. Stergiopoulos et al. (2016) [s409] reported that case managers fluent in participants' native languages and sensitive to cultural nuances made the Housing First Adaptation intervention more effective for ethnically diverse homeless adults. Gender-sensitive approaches [s290] and regional adaptations [s96] further enhanced inclusivity.

Economic instability and Broader Structural Challenges.

Economic instability [s53, s96, s201, s206] and structural issues, such as labour market discrimination [s121] and inflexible welfare systems [s8, s26, s145], exacerbated

barriers to the successful implementation of psychosocial interventions. While some welfare systems in high-income societies provided critical support, they also introduced structural barriers to competitive employment. For example, Evensen et al. (2017) identified barriers such as benefit dependency and limited access to supported employment services due to benefit rules in Norway [s145]. In contrast, Japan's legislative reforms mandating disability hiring quotas created an enabling environment [s387]. The country's "place-then-train approach" also significantly improved employment rates and job tenure among individuals with SMI [s460].

Organisational-Level Barriers

At the organisational level, implementation was often challenged by resistance to change, insufficient training, and resource constraints. However, these challenges could be mitigated by fostering organisational readiness, providing comprehensive training, and adopting innovative approaches to resource allocation.

Resistance to Change and Lack of Buy-In

Resistance from management, staff, and clinicians was a recurring barrier to adopting psychosocial interventions [s85, s184, s252, s281, s282, s339, s398]. This reluctance often stemmed from entrenched practices, perceptions of top-down mandates, perceived risks, and scepticism about the relevance or effectiveness of new approaches. For example, a self-esteem enhancement program was viewed by some mental health professionals as imposed rather than collaboratively chosen, leading to disengagement [s49]. Its intensive 24-session format further raised concerns about practicality and patient suitability [s49]. Recovery-oriented practices also encountered resistance rooted in deficit-focused paradigms that prioritised clinical stability over empowerment and social integration [s105]. Technological innovations such as exergames – designed to promote physical activity – were dismissed by staff as clinically irrelevant, especially when compounded by technical issues and limited training [s184].

Many of the facilitators identified were the inverse of the barriers identified. Successful implementation correlated with organisational readiness [s399], characterised by effective leadership [s242, s252, s285, s338, s360, s399, s434, s453], stakeholder engagement [s151, s278, s346, s377, s445], clear communication [s82, s307], and a supportive organisational culture [s85, s142, s252, s317, s318, s339, s347, s396, s400, s416, s428, s459]. For example, Leamy et al. (2014) [s252] noted that structured reflection sessions encouraged staff to critically evaluate their practices, align them with recovery principles, and address concerns such as risk-taking and coercion, thereby enhancing staff buy-in. Marwaha et al. (2014) [S285] highlighted the critical role of senior managers in endorsing and facilitating new programs, fostering timely problem-solving and reinforcing a culture of support. Oudejans et al. (2022) [s338] reported that collaboration with peer workers fostered a shared sense of ownership over the intervention and reduced resistance to change.

Insufficient Training and Supervision

Several studies highlighted that staff and peer workers often lacked consistent and adequate knowledge in certain areas, such as running group sessions, managing group dynamics, handling specific health conditions [s372, s378], supporting individuals in crisis [s82], or knowledge of available services [s372]. This knowledge gap left them unprepared to implement interventions effectively.

Structured training and ongoing supervision tailored to the needs of specific roles - such as employment specialists, care managers, and mental health workers [s425, s429, s456] - enhanced staff confidence, maintained high standards, improved the quality of interactions with clients, and ensured fidelity to the intervention models [s69, s138, s213]. Additionally, anti-oppressive and anti-racist training fostered inclusivity for both staff and clients. For example, *Housing First Adaptation* intervention for ethnically diverse homeless adults included staff training on systemic inequities, culturally competent service delivery, and empowerment-focused interactions [s408].

Resource constraints

Resource constraints – specifically related to funding, time, and workforce – directly impacted the sustainability, effectiveness, and scalability of resource-intensive psychosocial interventions [s38, s52, s152, s159, s160, s167, s179, s192, s252, s411, s437, s438]. For instance, while the Pathways to Community Living Initiative (PCLI) reduced long-term hospital stays, its sustainability was threatened by funding issues [s455]. Time limitations, usually due to resource constraints, limited the extent to which participants could benefit from interventions [s58, s219, s268, s324, s440]. In the ORBIT program, for instance, participants with late-stage bipolar disorder found the three-week online mindfulness course too brief to internalise the skills taught [s324]. Similarly, Varga et al. (2018) [s440] found that six months of community-based treatment – incorporating psychosocial rehabilitation clubs and case management – was often insufficient for individuals with schizophrenia to consolidate

progress and transfer gains to daily life, particularly given the illness's chronic and relapsing course. Workforce shortages further exacerbated these challenges. Many services lacked well-trained staff [s130, s142, s411], existing staff were overburdened [s144, s307, s428], and high turnover disrupted continuity of care [s301, s381, s384]. Operational limitations, including inadequate space and equipment, hindered effective implementation and restricted service delivery [s278, s411, s453].

Despite these challenges, some programs successfully addressed constraints through strategic integration and innovation. Integrating new interventions into existing mental health [s26, s43, s174] or rehabilitation services [s6] helped normalise their use, enhance access, and reduce duplication [s258]. Flexible workforce utilisation and role adaptability also maximised capacity [s81, s93, s99, s428]. For instance, the Clubhouse model employed generalist staff who adapted to diverse member needs, reducing reliance on specialised hires [s81, s99]. Other cost-saving measures included using free materials and public spaces [s274, s275, s368, s377], as well as leveraging existing funding streams by repurposing resources to align with reimbursement policies. The "Our Town" program, for example, adopted the Assertive Community Treatment model to qualify for Medicaid billing in Indiana, securing sustainable funding for youth with severe mental illness [s291]. Technology-based solutions also increased scalability and cut costs [s150, s234]. The App4Independence, for example, integrated with electronic health records, enabling remote monitoring and data collection at a lower implementation cost than traditional case management [s234].

Individual and Program-Level Barriers

Barriers at individual and program levels – such as low motivation, logistical challenges, and mismatches between intervention content and personal goals – often led to disengagement and high attrition. Tailored interventions, flexible delivery, and collaborative design were key to meeting participants' diverse needs and ensuring meaningful outcomes.

Low Motivation and Initial Scepticism

Low motivation [s143, s240, s288, s323, s351], initial scepticism [s266, s267, s278], and limited awareness of intervention benefits [s289, s346] posed challenges to recruitment and engagement. Programs addressed these issues using motivational interviewing [s240], peer testimonials [s25, s186], and clear, accessible information about intervention goals and outcomes. For example, Beentjes et al. (2018) [s25] described how the e-Illness Management and Recovery (e-IMR) program used peer videos to illustrate recovery journeys, encouraging participants to share their own stories and engage more actively in the process.

Unstable Living Conditions and Logistical Barriers

Unstable housing [s152, s190], transportation challenges [s375], and competing commitments [s214, s253, s274, s275, s336, s335, s361, s375, s422] frequently disrupted participation. To reduce these barriers, programs embedded services in accessible locations and addressed basic needs alongside clinical care. For example, the Shelter-Based Mental Health Services program offered mental health support within a homeless shelter, combining short-term residential care with psychosocial services [s445]. PTSD treatments delivered in familiar community settings also improved access and reduced transportation burdens [s228]. Overall, flexible delivery, personalised support, and regular follow-up helped reduce attrition [s59, s78, s185, s305].

Past Adverse Experiences, Psychiatric Symptoms, and Other Health Conditions

Mental health symptoms [s6, s43, s103, s108, s132, s170, s174, s199, s214, s273, s307, s321, s323, s336, s351, s376, s389, s422, s423, s447], physical health issues [s6, s274, s275, s323, s326, s361, s403], and substance use [s46, s141, s247] were frequently cited barriers. Some participants experienced emotional distress when discussing sensitive topics [s134, s205, s236, s250, s260, s378], which in some cases triggered symptom exacerbation [s134, s422].

Programs addressed these challenges using trauma-informed care, gradual exposure, and supportive, non-judgmental environments. For example, MERIT (Metacognitive Reflection and Insight Therapy) prioritised a collaborative therapeutic relationship to promote psychological safety [s115]. Recovery-Oriented Cognitive Therapy (CT-R) helped participants build confidence by setting achievable goals, offering supportive feedback, and celebrating progress [s177]. Cognitive Enhancement Therapy (CET) combined psychoeducation with stress-management and gradual exposure to emotionally challenging material [s132].

High Cognitive Demands and Technological Literacy Barriers

Perceived cognitive and emotional demands [s39, s205], along with technological barriers [s6, s153, s184, s186, s249, s270], hindered participation, particularly among older adults or those with limited digital literacy. Programs responded by offering user-friendly platforms [s32, s144], step-by-step manuals [s129, s435], technical support [s234],

and self-paced content with varied difficulty [s243, s458]. For instance, the HARP program adapted materials to a sixth-grade reading level [s129], and the "Recovery Is Up to You" course provided workbooks for self-paced activities [s435]. Cognitive Remediation Therapy (CRT) used structured tasks that gradually increased in complexity to support skill development over time [s458].

Irrelevant Content and Misalignment with Personal Goals

Participant dissatisfaction often stemmed from a mismatch between program content and individual goals [s18, s155, s182, s442, s448]. Interventions perceived as overly academic or detached from real-life needs were frequently seen as less helpful than practical, hands-on approaches [s419, s424]. To improve relevance, programs used needs assessments, goal-setting, and real-world skill-building. For example, psychiatric rehabilitation programs emphasised independent living, individual coaching, and gradual responsibility increases, aligning recovery plans with participants' aspirations [s225, s237, s423].

Collaboration with service users was critical for creating person-centred, flexible and adaptable interventions, allowing for adjustments in intensity, frequency and content as needed [s144, s151, s209]. Involving consumers at every stage – from conceptualisation through implementation to evaluation – facilitated shared decision-making, self-determination, and empowerment, giving individuals the confidence to take charge of their own recovery [s89, s252, s307, s452, s463]. For example, Zabel et al. (2016) [s463] highlighted co-production in Recovery Colleges - where individuals with lived experience collaborated with professionals - as a key feature that dismantled hierarchical structures and fostered equality, mutual respect, and stronger therapeutic relationships.

Challenges in Balancing Structure and Flexibility

Overly rigid interventions often failed to accommodate diverse participant goals, cognitive ability, and real-world circumstances [s6, s205, s219]. Conversely, excessive flexibility risked a loss of coherence, resulting in confusion, role ambiguity, and inconsistent implementation [s13, s383, s384, s438]. A large number of studies ($n=99$) highlighted the importance of structure in maintaining program quality and fidelity. Clear objectives, standardised protocols, and consistent implementation ensured that both participants and facilitators understood the program's goals, steps, and expectations, reducing ambiguity and enhancing comprehension and retention of critical skills [s136, s138, s142, s166, s293].

Successful programs balanced structure with adaptability. For example, a cognitive rehabilitation program for people with bipolar disorder combined structured sessions on organisation and cognitive skills with personalised schedules and tailored activities [s118]. Similarly, the IPS model designed for homeless veterans adhered to a standardised framework while allowing vocational counsellors to tailor support to participants' goals and barriers [s254].

Interpersonal Factors and Support Networks

Lack of supportive social networks (e.g., inconsistent family involvement) increased the risk of dropout [s214, s390]. Some studies reported that families were disengaged [s194, s390], while others struggled with challenges of their own. To strengthen support, several programs offered caregiver training. For example, Psychosis REACH provided free one- and four-day sessions focused on psychoeducation, self-care, and CBT-informed caregiving skills, along with travel and lodging assistance for families [s242]. Programs like "Just Do You" included family and recovery role models in intake sessions, using arts and storytelling to reduce stigma and build trust in the treatment process [s322].

Peer support also fostered social connectedness [s20, s31, s103, s141, s245, s282, s322]. Peer facilitators helped create understanding environments by sharing lived experiences [s31, s103, s141]. However, Beavan et al. (2017) [s20] noted that while peer leadership roles were seen as empowering, some participants were hesitant due to confidence issues, fear of responsibility, or lack of leadership training.

Group settings offered benefits but also posed challenges. Some participants felt overshadowed by dominant voices [s351, s463], disengaged by didactic facilitation styles [s351], or believed their individual needs were overlooked [s445]. Others found the pressure to participate counterproductive, particularly for those not yet ready or comfortable engaging [s351]. Programs addressed these issues by training facilitators and fostering group dynamics that were safe, trusting, welcoming, and respectful.

Discussion

Implementation Outcomes

This rapid scoping review examined the implementation of community-based psychosocial interventions supporting personal recovery among adults with SMI in high-income countries. In this section, we interpret our findings using Proctor et al.'s taxonomy of implementation outcomes: acceptability, adoption, appropriateness, feasibility, fidelity,

implementation cost, penetration, and sustainability (Proctor et al., 2011). This provides a useful framework to assess how interventions can be more effectively delivered in real-world contexts.

Acceptability

Acceptability refers to how interventions are perceived by service users and providers in terms of their relevance, value, and respectfulness. This review highlights that interventions grounded in recovery-oriented principles, cultural responsiveness, and lived experience were more likely to be perceived as acceptable. Participants valued interventions that aligned with their personal goals, supported autonomy, and recognised the importance of relational safety, particularly in peer-led or co-produced models.

Adoption

Adoption concerns the uptake of interventions at the level of individuals, teams, or organisations. Interventions were more likely to be adopted when they were supported by leadership, aligned with existing service mandates, and offered clearly demonstrable benefits. Conversely, adoption was hindered when interventions were perceived as resource-intensive, externally imposed, or inconsistent with dominant models of care. Resistance from staff was particularly evident in settings where recovery-oriented practices challenged established clinical paradigms.

Appropriateness

Appropriateness reflects the perceived fit or relevance of an intervention to a particular context, population, or need. Many interventions lacked cultural tailoring or contextual adaptation, reducing their relevance for diverse service users. Programs that failed to consider participants' housing insecurity, linguistic needs, trauma histories, or comorbid conditions often struggled to maintain engagement. In contrast, interventions that were flexible and attuned to local contexts were more likely to be experienced as appropriate and meaningful.

Feasibility

Feasibility captures whether an intervention can be implemented with available resources, staffing, and infrastructure. Feasibility was often undermined by systemic and structural barriers, such as limited workforce capacity, staff turnover, and fragmented service systems. Programs that required high levels of cross-sector coordination or sustained engagement from under-resourced teams frequently encountered implementation difficulties. However, some interventions improved feasibility by aligning with existing infrastructure, embedding services within established programs, using generalist staff, or adopting low-intensity delivery models, such as digital or group-based formats, that reduced demands on personnel and space.

Fidelity

Fidelity refers to how closely an intervention is implemented according to its intended design. Interventions with structured frameworks, formal training, and ongoing supervision - such as Individual Placement and Support (IPS) and Cognitive Remediation Therapy (CRT) - were more likely to maintain high fidelity. In contrast, programs lacking clear guidance or relying on loosely defined models were more prone to variation in delivery. Additionally, staff unfamiliarity with recovery-oriented principles, combined with limited time for reflection and supervision, often contributed to inconsistencies and drift from intended practices. Yet, the implementation of psychosocial interventions within complex and dynamic service environments necessarily involves balancing adaptation and fidelity. In such contexts, rigid adherence to protocols and standards may inhibit responsiveness to local needs. Employing a minimum specifications approach - where the essential elements of an intervention (e.g., specific activities delivered at a defined intensity) are maintained while allowing flexibility in form - can promote contextual adaptation, practitioner autonomy, and innovation without compromising core integrity (Mueller, 2020).

Implementation Cost

Implementation cost refers to the financial resources required to deliver and sustain an intervention, including both direct and indirect expenses. Although only a small number of studies conducted formal economic evaluations, many reported that cost was a persistent barrier to implementation, particularly for resource-intensive models such as Clubhouses, Assertive Community Treatment (ACT), or multi-disciplinary team approaches. However, some models found workarounds through funding integration, billing alignment, or use of existing infrastructure.

Penetration

Penetration refers to the extent to which an intervention is integrated into standard service delivery and adopted at scale across settings. This review highlights that many interventions remained confined to pilot sites or short-term initiatives, with limited evidence of system-wide integration

or long-term uptake. In most cases, strategies for scale-up were not well-articulated, and institutional embedding was weak or absent. While some programs demonstrated promise at a local level, few were translated into routine practice across broader service systems. This underscores the need for future implementation efforts to plan explicitly for dissemination, workforce alignment, and policy integration.

Sustainability

Sustainability involves the continued use of an intervention over time. One key finding of this review is that many interventions lacked structural embedding within health and social care systems, making them vulnerable to discontinuation due to funding instability, leadership turnover, or shifting priorities. Programs that relied on temporary grants or external mandates were often not maintained beyond their initial implementation period. Sustained delivery was more likely when interventions were supported by multi-level buy-in, incorporated into workforce planning, and aligned with broader system reforms or policy frameworks.

Structural determinants operating at the system level cascade through every tier of implementation, shaping each outcome within Proctor's taxonomy. Implementation success depends less on discrete strategies and more on the coherence of broader, interlocking systemic determinants, such as high-level priority setting, long-term investments, welfare architecture, integrated governance, cross-sector accountability, and workforce capacity. Several studies included in this review relied on short-term research grants that were not sustainable beyond the pilot phases. As McGinty et al. (2024) emphasised, partnering with policymakers throughout the research process is essential to develop long-term strategies for financing implementation resources. It is also important to recognise that some beneficial effects observed in the included studies - where interventions were standardised and applied to narrowly defined populations - may diminish when scaled across diverse real-world contexts. This attenuation often arises from misalignment between intervention design and the political, cultural, policy, funding, and organisational realities that structure implementation processes (McGinty et al., 2024). Understanding and addressing these system-level dynamics is therefore critical to achieving durable and equitable implementation outcomes.

Evidence Gaps

A central finding of this review is the disproportionate research focus on cognitive and other talk-based therapies compared to other approaches to support. This emphasis may contribute to the relative neglect of services addressing practical, social, and environmental factors that are vital to recovery. Much of the existing literature remains grounded in a clinical model of mental health, prioritising symptom reduction over holistic, real-life outcomes. For instance, supported housing was among the least studied intervention types, despite housing stability being fundamental to mental health recovery and a key concern highlighted in analyses of need (Armoon et al., 2025). Without secure housing, the effectiveness of other supports – such as cognitive therapies, vocational programs, or medical treatment – can be significantly diminished (Baxter et al., 2019).

The review also highlights the need for more research on the role of a "navigator" or case manager to strengthen coordination at the systems level. When grounded in strong rapport and trust, this role can support individuals in identifying appropriate interventions, clarifying their benefits, and overcoming logistical barriers to access (Di Biase & Mochel, 2021; Reid et al., 2020). Importantly, navigators can also assist individuals in stepping up or down in the level of care as their needs change, particularly given the episodic nature of SMI. This role should be embedded within shared decision-making (SDM) frameworks that reflect individuals' goals, preferences, and clinical needs (Hancock et al., 2018).

Another notable gap is the limited number of economic evaluations of psychosocial interventions. This shortfall is not entirely unexpected. Unlike pharmaceutical or standardised clinical treatments, psychosocial interventions are often flexible, programmatic, and tailored to individual needs, making their outcomes more difficult to quantify. Moreover, their long-term impacts are challenging to capture within the short timeframes typical of many studies. Evaluating costs is also complicated by the cross-sectoral nature of these interventions, which often involve health and social services, making cost attribution and tracking more difficult. Despite these complexities, economic evaluations are essential for informing resource allocation and shaping policy (Knapp & Wong, 2020). Future research could consider approaches such as Distributional Cost-Effectiveness Analysis (DCEA), which assesses how costs and benefits are distributed across population subgroups, thereby incorporating equity considerations into decision-making (Cookson et al., 2009); Social Return on Investment (SROI) frameworks, which monetise broader social and community outcomes, including improved functioning, housing stability, and employment participation (Banke-Thomas et al., 2015); and complex modelling approaches such as system dynamic modelling, which can be used to examine the long-term and cross-sectoral costs and outcomes, as well as to identify synergistic effects of combined programs (Crosland et al., 2024).

Another gap concerns the diversity within high-income countries themselves. While this review was restricted to high-income settings, these are not homogeneous contexts; health and social care structures and financing models vary widely (e.g., nationalised health systems versus employer-based insurance). The predominance of studies from North America and Europe further limits the generalisability of findings across different high-income regions, highlighting the need for more research in underrepresented settings.

Study Limitations

This rapid scoping review was designed to provide timely evidence for decision-making. In line with the Cochrane Rapid Review Methods Guidance, we searched two major databases - Medline and CINAHL - to balance comprehensiveness and feasibility. However, this may have limited the coverage of studies indexed primarily in psychology-focused databases, such as PsycINFO, which include literature on behavioural and counselling-based interventions. Consequently, while the review captured a substantial proportion of community-based psychosocial research, some relevant studies from the psychology field may not have been retrieved. To mitigate this, we manually screened reference lists of review articles to identify additional relevant literature.

Another limitation relates to the absence of a universally accepted definition of severe mental illness (SMI). As such, our inclusion and exclusion criteria may not align with those based on alternative conceptualisations. For example, we excluded studies focused solely on developmental disability or substance use disorders, although these are sometimes included within broader definitions of SMI (Gonzales et al., 2022). This review primarily focuses on *persistent* severe mental illnesses, so the findings may not fully apply to individuals in the early stages or those experiencing a first episode.

Finally, given the large volume of included studies ($n=464$) spanning diverse designs and intervention types, conducting a comprehensive quality appraisal was not feasible within the scope of this rapid review. As such, the synthesis focuses on mapping the breadth of available evidence rather than judging study rigour. Nonetheless, variations in study quality and substantial heterogeneity may have influenced the strength and specificity of the implementation findings. Future research should therefore pursue systematic reviews or meta-analyses of more homogeneous subsets - such as by intervention modality, population group, or delivery context - to enable rigorous quality appraisal and generate more targeted, comparable evidence. At the same time, it is important to acknowledge that psychosocial interventions operate within complex adaptive systems characterised by multiple interdependent components whose interactions often produce unpredictable and unintended outcomes. Rather than assuming a linear research-to-implementation paradigm, applying systems science methodologies - such as causal loop diagramming, social network analysis, and systems dynamics modelling - can provide deeper insight into how contextual factors, feedback loops, and dynamic interactions influence implementation processes and outcomes (McGinty et al., 2024).

Conclusions

As mental health systems shift towards more recovery-oriented care, policymakers should prioritise interventions with strong evidence of long-term effectiveness, scalability, cost-effectiveness, and equity, rather than those demonstrating only short-term clinical improvements. Further systematic reviews and meta-analyses of more homogeneous intervention subsets, alongside equity-informative economic modelling, are needed to strengthen comparative evidence to guide policy formulation.

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Declarations

Competing interests The authors declare no competing interests.

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