Defining professionalism for mental health services: A rapid systematic review

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Abstract

Background

Efforts have been made to define professionalism across professions, yet little attention has been paid to the concept in mental health services, where patients' needs differ to that in other healthcare specialties.

Aims

To derive a definition of professionalism for mental health services using the existing literature.

Method

A rapid, systematic review was conducted to identify empirical and non-empirical records that described professionalism in a mental health service context from 2006 to 2017. Studies were synthesised narratively using thematic analysis.

Results

Seventy records were included in the review. Professionalism was described on two levels; at a societal level, a dynamic social contract between professions and society, and; at an individual level, having intrapersonal, interpersonal, and working professionalism. Utilising emerging themes, an operationalised definition of professionalism, suitable for a mental health service context was derived.

Conclusions

Within mental health services, emphasis is placed on the interpersonal aspects of practice such as communication skills, maintaining boundaries and humanity. Themes relating to the vulnerability of patients and the challenge of supporting autonomy and choice whilst maintaining safety and acting in a client's best interest are also evident. 'Practical wisdom' and a flexible approach to working are needed for managing these challenging situations.

Declaration of interest

No competing interests. Declaration of interest and acknowledgements are documented on the title page.

Keywords: Mental Health, Professionalism, Systematic Review, Values, Skills, Professional Attributes

PROFESSIONALISM IN MENTAL HEALTH SERVICES

Professionalism has somewhat tautologically been defined as 'upholding professional values, exhibiting professional behaviours or demonstrating professional attitudes' (Aguilar et al., 2011). There have been many attempts to define professionalism in healthcare (Aguilar et al., 2011; Birden et al,. 2014; Deptula & Chun 2013; Ghadirian et al., 2014; Hordichuk et al., 2015; van de Camp et al., 2004; Zijlstra-Shaw et al., 2012) but there remains a lack of consensus (Birden et al., 2014; Hamilton, 2008; van de Camp et al., 2004). Some argue that professionalism is context dependent (Brody & Doukas, 2014; Rees & Knight, 2007; van de Camp et al., 2004; Wear & Kuczewski, 2004); that attention be paid to the elements of professionalism across healthcare specialties (van de Camp et al., 2004). Whilst elements may vary these could be considered refinements to the same overarching concept (Woodruff et al., 2008). Nonetheless, there is a dearth of literature specific to mental health services.

The American Board of Internal Medicine (ABIM) Foundation cite patient autonomy as one of three fundamental principles of medical professionalism (2002); yet in mental health services, where patients are often deprived of their liberty, the principle of autonomy becomes more problematic. Mental health services are multi-disciplinary, and patients rarely see only one profession. Despite this diversity in the workforce supporting patients and facilitating their welfare is paramount across professions. Service users are vulnerable (Department of Health, 2015) and may be unable to care for themselves or protect themselves from harm or exploitation. Despite national guidance to protect vulnerable adults a scandal at Winterbourne View hospital in 2011 demonstrated that those employed to care for people with learning disabilities instead abused them (Department of Health, 2012). Moreover, in 2015-16 over a thousand complaints were made in mental health trusts, including 199 relating to the alleged abuse of patients (Yeung, 2017).

Each profession has their own generic guidelines and codes of conduct. However, attention must be paid to the mental health service context; where, despite good intentions,

services don't always protect patients. An agreed operational definition of professionalism is needed for educational and regulatory purposes (Cruess et al., 2004). Furthermore, a definition would facilitate values-based recruitment by supporting the development of selection tools, such as situational judgement tests. In situational judgement testing a candidate is confronted with a series of scenarios that depict situations that challenge professional judgement. Candidates must provide the most appropriate response, which may be a related rating or a choice of the optimum behaviour. These tests have been shown to be an effective approach to supporting values-based recruitment and demonstrate improved validity over other selection methods and can be mapped to organisational values (Patterson et al., 2015). Consequently, we conducted a rapid, systematic review to derive an operational definition of professionalism for this context.

Methods

The review formed part of a PhD project; a rapid review was performed to synthesise evidence in a time-efficient manner (Khangura et al., 2012). We used an integrative approach (Whittemore & Knafl, 2005), which is particularly useful for new and emerging issues and more likely to result in the initial and preliminary conceptualisations of a topic (Torraco, 2005). The review sought to identify how professionalism is conceptualised within specialist mental health services and whether the definition varies across professional groups.

Inclusion and Exclusion Criteria

We collaborated with the Centre for Reviews and Dissemination to develop review criteria and a protocol was registered on PROSPERO at the beginning of the review period (registration number: TBC). Empirical and non-empirical records, except books, were included if they (a) provided a definition or description of professionalism within mental health services, (b) were published in English from 2006 to date of final search (02/03/2017), and (c) did not meet the exclusion criteria. The date limit was used in anticipation that we

would retrieve definitions of professionalism applicable to current service provision. We excluded articles that were not written in English, or focused on low- or middle-income countries as we wanted to inform UK practice. Articles focusing on substance misuse, family practice, or a subgroup of people based on diagnosis or symptomatology were also excluded, as they deviate from standard healthcare delivery in specialist mental health services. We additionally excluded records if they discussed characteristics that were not directly attributed to professionalism.

Searching and Selecting Studies

The search strategy was developed by three authors (TBC, TBC, TBC), with support from academic and healthcare librarians. The initial search string was modified from an earlier review (Birden et al., 2014) and pilot testing was performed to improve the sensitivity and specificity of the search. The base search was performed using CINAHL and utilised free-text and subject heading searches (see Table A1). Search strings were adapted for further databases, including Medline; EMBASE; PsycINFO; and HMIC. Additional records were identified from a sample of reference lists (TBC), so long as they met the inclusion criteria (e.g. referred to mental health services).

Study Selection

Titles and abstracts were screened in duplicate, by two reviewers (TBC, TBC). Records that met the inclusion criteria progressed for full text screening and were retrieved using credentials from the University of TBC and the University of TBC (TBC). References were excluded if full texts were not freely accessible (n=24) at time of retrieval. Full text articles were next screened in duplicate by two reviewers (TBC, TBC) and those that met the inclusion criteria progressed for data extraction. Disagreements were resolved through discussion between reviewers, and two topic experts (TBC, TBC) were consulted as needed at each stage of the study selection phase.

Data Extraction

We developed a standardised template for data extraction, with various headings including any definition or description of professionalism provided, and any description of how the record related to mental health services (see table 1 for additional headings). Data was extracted by the lead author (TBC) and the first seven articles (10%) were quality checked by a second reviewer (TBC).

Data Synthesis

Due to resource constraints (including time), a critical appraisal was not performed on the literature. As data were qualitative and heterogeneous, we performed a narrative synthesis (Popay et al., 2006). Using thematic analysis (Braun and Clarke, 2006), one author coded the data (TBC). The author was familiar with the dataset having screened the full-text records. Data were initially coded using Excel at the time of data extraction, dependent on what sections of data appeared most relevant to the author regarding the research question. Next, data were coded manually, having printed out all data extracted. Data were subsequently uploaded onto NVivo (v.11) and sections of the text were highlighted, dependent on meaning and content. Codes were revised upon reading and rereading the data, alongside writing an initial report. Thematic maps were generated by one author; codes were visually compared and contrasted. Codes were organised into a hierarchical structure using NVivo, incorporating themes and subthemes. Taking account of the whole dataset, themes were continually revised in an iterative process, until the author was satisfied that the themes accurately captured the data extracted. In order to limit researcher bias (Bucci et al., 2015), themes were presented to two topic experts (TBC, TBC); through negotiation codes were revised and refined.

Results

In total, 1184 records were identified. After removing duplicates, 779 articles remained. We excluded 573 articles following title and abstract screening and a further 136 articles at the full-text screening stage. Seventy articles were included in the synthesis (see Figure 1; Moher et al., 2009). Records included one meta-ethnography, 24 discussion papers, 20 editorial/opinion pieces, and 25 empirical studies. Of the latter, 15 papers reported on quantitative research, seven reported on qualitative findings, and three employed a mixed methods approach (see Table 1).

INSERT FIGURE 1 HERE

INSERT TABLE 1 HERE

Records focused mostly on psychiatry-a medical profession-with 45 articles being authored by psychiatrists. Additional authorship incorporated (a) psychologists, (b) counsellors, (c) nurses, (d) social workers, (e) therapists, and (f) a former service user. Whilst patient and carer perspectives were evident in the literature, views expressed were predominately that of practitioners and researchers. The two records that presented patients' perspectives focused on recovery promoting competencies (Russinova et al., 2011) and helpful relationships (Ljungberg et al., 2015). Despite the keywords used during the search, there was a scarcity of literature relating to learning disability services. Henceforth, the results are discussed for mental health services only.

Main Findings

The focus on professionalism varied across records, with some articles discussing the concept in detail, yet others using the term in passing. We identified several explicit definitions of professionalism (see Table B1); nonetheless, professionalism also was described as an abstract construct, often misunderstood (Brown & Bhugra, 2007; John et al., 2016). Thematic analysis found that professionalism was conceptualised on a societal and an individual level. On a societal level, professionalism was described as 'a dynamic social

contract between professions and society', incorporating; '*power and purpose*', '*bidirectional expectations*', and '*change and variability*'. On an individual level, professionalism was described as 'individuals representing the profession'; possessing: (a) '*intrapersonal professionalism'*, (b) '*interpersonal professionalism*', and (c) '*working professionalism*' (see Table 2).

INSERT TABLE 2 HERE

Professionalism as a dynamic social contract.

The framing of professionalism as a fluctuating contract between professions and society was manifest throughout the literature. We identified three subthemes: (a) *Power and purpose*, (b) *Bidirectional expectations*, and (c) *Change and variability*.

(a) Power and purpose.

Professionalism is widely cited as a social contract between professions and society (Bhugra, 2008a; Bhugra, 2009; Bhugra & Gupta, 2010; Bhugra & Gupta, 2011; Bouras & Ikkos, 2013; Brendel et al., 2007; Brown & Bhugra, 2007; Ikkos & Mace, 2009; Jain et al., 2011a; Komic et al., 2015; Lapid et al., 2009; Randall & Kindiak, 2008; Roberts, 2009;Robertson & Walter, 2007). Professions use their specialised knowledge to maintain dominance in their areas of practice (Weiss-Gal & Welbourne, 2008) and self-development protects professions from the demands of other more powerful individuals and institutions in the work setting (Crawford et al., 2008). Within professional psychology for example, it was suggested that the focus counselling psychology places on individuals' strengths and assets (Goodyear et al., 2016) helps the specialty maintain its integrity and identity (Lopez et al., 2006). In contrast, it is argued that there is a lack of clarity regarding the nursing role (Blegeberg et al., 2008) and community mental health nurses (CMHNs) struggle to articulate their profession in a way that clearly distinguishes them from other professions (Crawford et al., 2008).

(b) Bidirectional expectations.

Professions must work for the benefit of others, promoting public good (Bhugra, 2008a; Bhugra, 2009; Bhugra & Gupta, 2010; Ikkos & Mace, 2009; Randall & Kindiak, 2008; Roberts, 2009; Robertson & Walter, 2007). This is observed within the ABIM Foundation's three principles of medical professionalism; the primacy of patient welfare, patient autonomy and social justice (Bhugra & Gupta, 2010; Bhugra & Gupta, 2011; Brown & Bhugra, 2007). Professions are expected to self-regulate to maintain and expand their skills and knowledge (Bhugra, 2008a; Bhugra, 2008b; Bhugra & Gupta, 2010; Roberts, 2009; Robertson & Walter, 2007), whilst (a) adhering to standards (Baer & Schwartz, 2011; Bhugra, 2008a), (b) demonstrating confidentiality (Baer & Schwartz, 2011; Talbott & Mallott, 2006), and (c) having transparency and accountability (Bhugra, 2008a; Bhugra, 2009; Randall & Kindiak, 2008; Roberts, 2009). Codes of conduct were denoted as tangible expressions of professionalism (Sox, 2007) as they guide practitioners towards behaviours that align with the profession (Komic et al., 2015). To allow professions to fulfil their obligations, expectations also are placed on society (e.g. professions expect to be granted the ability to self-regulate; Bhugra, 2008a; Randall & Kindiak, 2008; Robertson & Walter, 2007).

(c) Change and variability.

Professionalism is context dependent (Brendel et al., 2007; Harris & Kurpius, 2014; Ikkos & Mace, 2009; Malhi, 2008; Wise, 2008). Moreover, it is a dynamic construct, which shifts across time and professions (Bhugra, 2008a; Bhugra, 2010; Bhugra & Gupta, 2010; Brown & Bhugra, 2007; Malhi, 2008. Variations in regulatory policy are influenced by subtle variations in individuals' beliefs and understanding (Malhi, 2008), which with case studies of professional failure, lead to ethical codes being amended and updated (Gottlieb et al., 2009; Harris & Kurpius, 2014). Mental health services are continually in reform (Bhugra & Gupta, 2011; Malhi, 2008) and clinicians have suggested that the mental health professions

should work with patients, carers and other healthcare sectors to renegotiate the contract with society (Bhugra 2008a; Bouras & Ikkos, 2013; Ikkos & Mace, 2009); asserting their role, enhancing their autonomy and promoting the importance of professionalism (Poole & Bhugra, 2008).

Professionalism at an individual level - representatives of the profession

On an individual level, professionalism was defined as being a representative of the profession, by possessing the relevant attributes to fulfil this role. We identified three subthemes: (a) *Intrapersonal professionalism*, (b) *Interpersonal professionalism*, and (c) *Working professionalism*. We present the subthemes consecutively here, breaking these down by occupation to differentiate between more generic findings and those related to a particular profession. Key terms observed in the literature are italicised for emphasis.

Before discussing these subthemes, we provide an excerpt of an account by Lampshire, whilst she addressed clinicians about her previous experience of using mental health services:

> I invite you to … honour our current Service Users so they may not know the despair of becoming fearful and hopeless for their future but rather relish the prospect. To honour those who are deeply bonded to Service Users by blood, love or both. To honour your professional codes whatever discipline you identify with and to honour yourselves, for that which binds us all is not the dissection and eradication of madness but our regard for human beings. (Lampshire, 2012, p.178)

In this account, Lampshire asks professionals to behave in a certain manner when working with this patient population.

(a) Intrapersonal professionalism.

We observed that there are expectations of individuals working in a profession that align to the professions' core values. Clinicians must have *integrity* and *morality* (Bhugra, 2008a; Bhugra, 2009; Bhugra & Brown, 2007; Ikkos & Mace, 2009; Randall & Kindiak, 2008; Robertson & Walter, 2007; Schwartz et al., 2009; Talbott & Mallott, 2006), being *committed* to their work (Bhugra, 2008a; Ikkos & Mace, 2009; Randall & Kindiak, 2008; Robertson & Walter, 2007). They must have the *skills* and *knowledge* to undertake their role (Bhugra, 2008a; Bhugra, 2009; Bhugra & Brown, 2007; Bhugra & Gupta, 2010; Bhugra & Gupta, 2011; Brendel et al., 2007; Ikkos & Mace, 2009; Randall & Kindiak, 2008; Robertson & Walter, 2007; Wise, 2008); behaving *ethically* (Harris & Kurpius, 2014) and demonstrating *probity*, *objectivity*, *trust*, *benevolence*, *honesty*, *courage*, and *truthfulness* (Bhugra, 2010; Orlinsky et al., 2005). *Self-effacement*, *self-sacrifice*, *respect*, *honour, excellence* and *accountability* must all be demonstrated (Coverdale et al., 2011; Schwartz et al., 2009). In times of distress, patients want professionals that are *secure*, *stable*, *calm* and *confident* (Ljungberg et al., 2015). Professionals must be *self-aware* and monitor their wellbeing to facilitate their competence (Elman and Forrest, 2007; Johnson & Cambell, 2004); they must be aware of the limits to their competence (Gottlieb et al., 2009), keeping their continuing professional development up to date (De Waal et al., 2010).

Psychiatry.

Psychiatrists are expected to possess expertise in mental illness and mental wellness (Jakovljević, 2012). According to McQueen et al, cited by Ikkos et al. the seven E's of psychiatric professionalism include: *attention to evidence, emotions, ethics, engagement, expertise, education* and research for future care, and a commitment to the *empowerment* of patients (Ikkos et al., 2011).

Nursing.

Nurses must be 'appropriately qualified' (Happell, 2006); a study with CMHNs found that they developed skills outside of their profession to make themselves "*more professional as nurses"* (p.1060, Crawford et al., 2008).

Psychology, counselling, and psychotherapy.

It has been suggested that *communication skills*, *self-reflection*, *self-awareness* and *self-discipline* are integral to working with patients (Haverkamp et al., 2011; Orlinsky et al., 2005) and may be crucial for a psychotherapist's competence (Ikkos & Mace, 2009). Clinicians must not bring the profession or its practices into disrepute (Symons et al., 2011).

Social work.

No findings suggested specific attributes for the Social Work profession related to this subtheme.

(b) Interpersonal professionalism.

Coverdale suggests that every interaction with patients will 'never cease to be important' (Coverdale, 2007). Interpersonal professionalism relies on professionals having the ability to relate to others in an appropriate manner; the importance of communication and interpersonal skills is widely cited (Brendel et al., 2007; Dingle & Stuber, 2008; Elman & Forrest, 2007; Haverkamp et al., 2011; Ikkos & Mace, 2009; Roberts et al., 2006; Sanders et al., 2014; Talbott & Mallott, 2006; Wise, 2008;). *Humanity* and *personal nature* are as important in specialist mental health services, as any other skill (Roberts & Termuehlen, 2013), and the practitioner-patient relationship is viewed fundamental to both professionalism and ethics (Groves & Kerson 2011; Schreiber et al., 2016). *Patient benefit* should be the first and foremost concern to professionals (Bhugra & Gupta, 2011; Brendel et al., 2007; De Waal et al., 2010); practitioners are expected to be *honest* (Bhugra & Brown, 2007; Talbott & Mallott 2006), *altruistic* (Schwartz et al., 2009), *demonstrate compassion* (Brendel et al., 2007; Groves & Kerson, 2011; Talbott & Mallott, 2006), and *show respect* to patients, carers

and colleagues (Brendel et al., 2007; Talbott & Mallott, 2006). Professionals must have *healthy relationships* with colleagues and trainees and *maintain appropriate boundaries* with patients (Jain et al., 2010; Jain et al., 2011a; Jain et al., 2011b; Lapid et al., 2009; Sanders et al., 2014; Schwartz et al., 2009), including online behaviours (Peek, 2014; Peek et al., 2015). They must understand the impact of cultural contexts when working with patients (Leppma et al., 2016) and must *value the worth and dignity of all* (Groves & Kerson 2011), treating patients, carers and colleagues equally; regardless of age, gender, sexual orientation, and ethnicity etc (Ikkos & Mace, 2009; Schwartz et al., 2009; Talbott & Mallott, 2006). Moreover, practitioners must be *professional at all times* (Malone, 2012); using their *expertise* to benefit the public, supporting the development of policy, research, and training (De Waal et al., 2010).

Patients want professionals whom they can have a relationship, be offered real choices, and that will facilitate but not dictate treatment (De Waal et al., 2010). Patients find it helpful when practitioners provide positive feedback; are available in times of crisis; and convey hope about treatment success, whilst supporting the patient to look and move forward as well as reach their goals (Ljungberg et al., 2015). Furthermore, patients want professionals that; *portray genuine respect*, help them develop skills to manage their own condition, view them aside from their mental illness, facilitate self-worth, *listen without judgment*, and believe in their ability to recover (Russinova et al., 2011). In mental health services, patients prefer informal social supports rather than technical interventions (Ikkos et al., 2011); therefore, clinicians must be *sensitive* (Schwartz et al., 2009), have *empathy,* and be able to *engage patients* (Malhi, 2008).

Psychiatry.

The psychiatry milestone work group, developing the subcompetencies and milestones defined by the Accreditation Council for Graduate Medical Education, identified

two subcompetencies that focus on professional attitudes and *accountability* (Sanders et al., 2014). Psychiatrists must have *skills* in *communication*, building relationships, and managing behaviour (Baer & Schwartz, 2011). Patients human rights must be respected (Jakovljević, 2012) and clinicians should focus on *patient welfare* and *social inclusion* (Ikkos, 2010, as cited in Bouras & Ikkos, 2013). Psychiatrists must contain the anxieties of patients and colleagues (Bhugra & Gupta, 2011) and those at the top of the profession have additional responsibilities to other members (De Waal et al., 2010). Furthermore, psychiatrists' interactions extend beyond their own discipline to wider society (Schreiber et al., 2016).

Nursing.

CMHNs have described their role as being *kind* and helping to *empower people* and *promote independence* (Crawford et al., 2008). Consequently, an *empathic* and *diplomatic* ability is highly regarded whilst working in mental health services (Blegeberg et al., 2008).

Psychology, counselling, and psychotherapy.

In psychotherapy, an emphasis is placed on the clinician as well as the patient in the practitioner-patient relationship (Ikkos & Mace 2009); and effective therapeutic relationships, the interpersonal relationship, communication skills, *professional rapport* and *self-reflection* are suggested to be in keeping with the counselling psychology fields professional roots (Haverkamp et al., 2011).

Social work.

No findings suggested specific attributes for the Social Work profession related to this subtheme.

(c) Working professionalism.

Working professionalism allows practitioners to make appropriate judgements in times of need, applying *critical thinking*, *reflection* and *situational judgement*. A meta-ethnographic study shown that some helpful actions go beyond professional neutrality and

distance (Ljungberg et al., 2015). Excessive rigidity may be harmful to patients (Zur, as cited by Gottlieb et al., 2009); and whilst practitioners must maintain appropriate boundaries, they also must step outside of their role if it is in the patient's best interest (Brendel et al., 2007; Malone, 2012). Practitioners must deal with ambiguity (Bhugra, 2009; Bhugra & Gupta 2011); requiring *practical wisdom,* a central virtue of professionalism (Crowden, 2003). Practical wisdom allows clinicians to exercise their judgement, whilst still abiding to overarching professional consensus (Malhi, 2008).

Involuntary commitment and boundary violations (Dingle & Stuber, 2008) highlight that in some situations contextual knowledge is needed to establish the best course of action (Malhi, 2008). Identifying, considering, and making decisions in ethical dilemmas are critical components of professionalism (Dingle & Stuber, 2008) and ethical challenges must be managed thoughtfully and ethically; always acting in the patient's best interest (Brendel et al., 2007). Whilst providing a lift home to patients may typically be viewed a crossing of boundaries for example, such action may be ethically justifiable, therapeutic or even obligatory in certain circumstances (Martinez, as cited by Brendel et al., 2007). Noting that professionals' views differ regarding the most appropriate action (Pelto-Piri et al., 2012), and patients' needs differ; practitioners must exercise their judgement, acting appropriately (Ljungberg et al., 2015). Professionals must use (a) '*reflection-in-learning*', (b) '*knowledge-in-action*', and (c) '*reflection-in-action*' to manage situations where uncertainty, instability, and values conflicts arise (Schön, 2002). As Bhugra suggests, "*professionalism implies wisdom in practice"* (p.329, Bhugra, 2008b).

Psychiatry.

Psychiatrists must step into the patient's mind from time to time to identify what is happening for them (Schreiber et al., 2016) and must therefore manage transference and counter-transference issues (Ikkos et al., 2011). Given the complex nature of mental illness

(Bhugra & Gupta, 2011) psychiatrists must manage situations where their contractual obligations with society put them at odds with their patient and the Hippocratic tradition (e.g. detaining an individual in hospital, involuntarily; Robertson & Walter, 2007). Consequently, psychiatry trainees must understand the nuances to psychiatric practice (Schwartz et al., 2009).

Nursing.

No findings suggested specific attributes for the Nursing profession related to this subtheme.

Psychology, counselling, and psychotherapy.

Interpersonal relatedness is core to the psychotherapies and thus *social perceptiveness*, *emotional resonance* and *responsiveness*, *compassion*, *motivation to help others* are essential qualities (Orlinsky et al., 2005). A key trait of psychologists is a '*willingness*' or '*openness*'; students are concerned about the competence of a therapist who is particularly rigid and less flexible in practice (Paprocki, 2014).

Social work.

Alike other professions, social workers must manage ethical dilemmas, and transference and countertransference issues (Groves & Kerson, 2011). Ethical dilemmas reported for Taiwanese social workers include: public security versus personal freedom, medical opinion versus patient will, and the social worker's opinion versus the will of the committee (Wu et al., 2013).

Discussion

We conducted a rapid systematic review of the literature to derive an operational definition of professionalism for specialist mental health services. Seventy records were included; most pertained to psychiatry–a medical profession–but the views of nurses, psychologists,

counsellors, social workers and service users also were evident, reflecting the interdisciplinary nature of specialist mental health service provision.

Summary of Key Findings

We observed a scarcity of patient presence in the literature, which could be due to various factors, including the keywords used. Our findings highlight that professionalism is viewed as the basis of a social contract between professions and society; where professions use their 'expert power' (French et al., 1959) to establish and maintain dominance in their areas of practice. Practitioners are embodiments of their profession and require intrapersonal professionalism, interpersonal professionalism, and working professionalism to fulfil their role.

There is considerable overlap amongst the themes noted. Expectations of professionals are similar to the expectations of a profession (for example, both are expected to self-regulate). Professionals are expected to possess the relevant skills and attributes to honour their codes of conduct yet are given the freedom to act flexibly so long as they work within society's expectations of the profession. In turn, professions amend their codes of conduct, because of cases of professional misconduct.

Similarities and Differences amongst Professions

It is difficult to derive strong conclusions regarding the similarities and differences between professions given the limited literature for some groups. Moreover, many of the themes are likely to apply to professionalism in healthcare in general. A more formal comparison of the conceptualisation of professionalism between mental health and non-mental health settings is beyond the scope of this review; however, we would assume the themes we elicited are important to some degree when working with patients in non-mental health settings, particularly those affected by mental health conditions. Thus, there may not be mental health and non-mental health specific domains to professionalism, but rather it is a

matter of the degree of emphasis placed on each of them. For example, in Western societies, healthcare professionals in all settings would generally agree that they would want to work to support patient autonomy in relation to decision-making about their care. In mental health settings this may be a particular challenge to professionalism where there are questions about a patient's capacity to make decisions in their best interests.

Despite the limited literature available for some groups, it is clear there are many commonalities across disciplines in relation to how they view professionalism. Again, it would seem it is a matter of the emphasis placed on various themes that differs between professional groups, rather than having a specific subset of domains relating to professional behaviours. Our findings highlight that when discussing professionalism the psychiatric literature emphasises overarching competencies, mental capacity and human rights, transference and countertransference, and ethical dilemmas; the counselling and psychology literature emphasises the patient-practitioner relationship, the empowerment of patients, a focus on assets and strengths, and qualities that facilitate interactions with others, including emotional resonance and social perceptiveness; the nursing literature includes empirical studies, which focus on professional identity and a lack of clarity regarding the nursing role; and the social work profession makes reference to the ethical dilemmas that social workers face. These findings must be interpreted with caution however, given (a) the qualitative nature of our review and (b) that the majority of records (n=45) focused on psychiatry as an occupational group.

Patient Preferences

We found that patients expect professionals to adhere to their codes of conduct; yet overly rigid practice is undesired and potentially detrimental for patients. Patients expect clinicians to have the knowledge, skills and experience to undertake their role, and be able to exercise their judgement to navigate the dilemmas they are faced with. Patients want

practitioners that possess empathy and cultural awareness, that protect their human rights, that they can have a relationship, and that instil hope and facilitate empowerment. Consequently, practitioners must be able to form and maintain healthy relationships with patients and colleagues; being able to engage patients, establish trust, promote patient empowerment, instil self-worth and hope, and facilitate treatment and recovery.

Operational Definition of Professionalism for a Mental Health Service Context

We observed similarities between professions and service users regarding the conceptualisation of professionalism in mental health services. Given these, we propose two operational definitions of professionalism that apply to all professions working in a mental health service context.

1. *Professionalism forms the basis of a dynamic social contract between professions and society. This contract (which can have both tacit and explicit elements) specifies that society will remunerate the members and permit the profession to self-regulate on the understanding that the profession use their skills for patient and public good.*
2. *On an individual level, professionalism can be conceptualised as a latent trait, composed of elements of intrapersonal, interpersonal, and working professionalism. This trait may only be observed through manifest behaviours in certain situations. Such behaviours will be in keeping with society's expectations and demonstrate a commitment to ethical practice, cultural-sensitivity, self-awareness and reflection and self-discipline.*

This definition may still appear somewhat abstract. However, this reflects the situation-specific nature of professionalism, in that it may be best captured by applying principles to particular contexts and scenarios. As highlighted earlier, this is acknowledged in the ability to respond flexibly to situations that may challenge professional judgement within mental health services. This is one reason why situational judgement testing may be an effective way of measuring an individual's knowledge of professionalism in that it will present individual scenarios which may require a somewhat flexible response from the respondent. Nevertheless, it is hoped that by deriving themes and overarching principles the generation of such scenarios and tests will be facilitated.

Professionalism at Work

Issues relating to confidentiality and involuntary commitment are particularly controversial in mental health services; when an individual's mental health may result in dangerous or offending behaviour, the safety of patients and the public can take precedence over the individual's preferences and choice (Ikkos et al., 2011). Patients' human rights must be protected whilst a professional balances patient autonomy against the perceived risks presented. In keeping with today's expectations, mental health practitioners will work towards patient welfare, reflecting on their practice and will manage situations appropriately should societal, cultural, and ethical obligations diverge.

Comparisons with the Existing Literature

This is the first systematic review to define professionalism for mental health services. Our review highlights that professionalism is conceptualised on two levels. As previously suggested, professionalism is viewed as the basis of a contract between professions and society. We observed various attributes of professionalism, some align to two themes previously proposed (intrapersonal and interpersonal professionalism; van de Camp et al., 2004). We suggest an additional theme, 'working professionalism'; which

extends beyond first-order cognitive skills–that may result in rigid practice–to second-order thinking, which allows professionals to make appropriate judgements and act according to specific situations they encounter. Thus, the literature highlights the need for flexible response, in contrast to strict adherence to codes of conduct. Our definition thus provides a framework to establish what attributes are desired, by stakeholders, of practitioners working in this setting.

Our review suggests that professionalism is an overarching concept rather than one of several competencies, which is in keeping with framings of professionalism in the United Kingdom (Hafferty, 2017). The five clusters of professionalism: *adherence to ethical practice principles*, *effective interactions with patients and those important to them*, *effective interactions with colleagues in the healthcare system*, *reliability*, and *commitment to self-regulation and continuing professional and service development* (Wilkinson et al., 2009) also were evident in our review, yet we observed an increasing emphasis on the need for situational judgement and flexible practice.

The domain of working professionalism aligns to earlier works which suggest that professionalism is best viewed as a situated construct, dependent on self, context, and the ability to select appropriate behaviours for the situations presented (Burford et al., 2014). The dynamic nature of professionalism that we observed resonates with the literature on 'situated cognition'; behaviour in a particular work context cannot be assumed to be determined by a stable trait or traits but is a response to specific contextual factors perceived at a particular moment (Brown et al., 1989).

Whilst professions may seek to enhance their power by adopting the expertise and practice of other groups, it is suggested that, paradoxically, closer inter-disciplinary working in mental health could both enhance the professionalism and empower all practitioners.

Strengths and Limitations

We performed a rapid review to synthesise the literature, noting that rapid reviews may generate similar conclusions to full reviews (Watt et al., 2008). A strength of our review is that we followed the PRISMA checklist (Moher et al., 2009) for reporting (see Table C1) and have been explicit regarding our methodology (Cook & West, 2012; Ganann et al., 2010; Schünemann & Moja, 2015).

We excluded records focussing on low- or middle-income countries, relating to substance misuse services or family medicine, or concerned with a subgroup of people with specific diagnoses or symptoms. Consequently, the findings may not be transferable to these settings. Articles were excluded if they were not written in English (n=2), or not freely accessible at the time of retrieval (n=24). Whilst this restricted some literature from being included, we considered it a justifiable trade-off to complete the review in a timely manner.

Two reviewers screened title and abstracts independently to minimise the risk of reviewer error and bias. In addition, a sample of the data extracted was checked by a second reviewer. Given the heterogeneous nature of the data, we did not perform a critical appraisal of the literature, which is often the case for rapid reviews that wish to achieve shorter timescales (Hartling et al., 2015). One author performed the thematic analysis; thus, additional topic experts were consulted to ensure the reliability and validity of the review findings.

Our choice of key words may have limited the opportunity to identify literature that expresses the views of patients and carers on this topic. Also, whilst professions frame professionalism differently, we integrated findings to derive an operational definition of professionalism for specialist mental health services. We believe this is appropriate as all professions support individuals within this service and all share the common purpose of patient welfare. The definition presented provides a framework that will facilitate the

teaching and assessment of professionalism as well the development of more robust values-based recruitment measures, including situational judgement tests.

Recommendations for Further Research and Practice

Patient and carer perspectives were manifest in discussions about helpful relationships and recovery promoting competencies; yet the views of practitioners and researchers outweighed these. Future research should seek out the views and preferences of those using these services to confirm the values, attributes and behaviours that patients and carers desire from professionals working in this setting. Using recovery focused terms may help tease out service user and carer perspectives on this topic. The same may also be true using terms with a negative connotation (e.g stigmatization).

Whilst our review focused on mental health services, the findings may be transferable to other healthcare settings. This is yet to be explored. A dearth of literature was found pertaining to learning disability services; future studies may also wish to explore whether these findings are transferable to learning disability settings. Whilst we deemed a rapid approach suitable for this review, a more comprehensive review may generate more conclusive findings. A further review may wish to use additional databases (e.g. Open Grey) to increase the probability that grey literature will be identified.

Conclusion

In keeping with the existing literature on medical professionalism, our review found that in specialist mental health services professionalism is viewed as the basis of a dynamic social contract between professions and society. Given the lack of patient presence observed, we propose an operational definition of professionalism that will encourage the engagement of all stakeholders in renegotiations of this contract.

Our review demonstrates that a practitioner may represent their profession by possessing intrapersonal professionalism, interpersonal professionalism and working

professionalism. Various elements of professionalism are highlighted, and we differentiate between elements that are generic across professions and those specific to one or two professions only. As patients using specialist mental health services may suffer from depression, psychosis, anxiety, and/or other emotional problems, practitioners have a duty to protect patients' human rights, promote recovery, instil hope and facilitate patient empowerment. The ability to satisfactorily resolve such tensions requires a flexible approach and practical wisdom.

Professionalism is influenced by all stakeholders and professions must regularly renegotiate their social contracts with society. Henceforth, the framework we propose offers a strong foundation to determine what behaviours are desired of professionals working in specialist mental health services, and what situations these depend upon.

Appendix A. Search string used for review

Table A1. Base Search (CINAHL Plus via EBSCO)

Database: CINAHL Plus (EBSCO) <searched on 11/02/2017>

Boolean/Phrase searches
(Professionali?m OR professionali?ation OR unprofessional*).m_titl.
("professional competenc*" or "professional skill*" or "professional value*" or "professional role*" or "professional attitude*" or "professional identit*" or "professional practice*" or "professional communication*" or "professional standard*" or "professional accountab*" or "professional dissonanc*" or "professional impair*" or "professional dysfunction*" or "professional malpractice*" or "professional misconduct*" or "professional omission*").m_titl.
((Professiona* ADJ3 (issue* OR behav* OR act* OR ethic* OR humanis*)) NOT (Professional ADJ3 activ*)).m_titl.
*professionalism/
1 OR 2 OR 3 OR 4
("mental health" or psychiatr* or "learning disabilit*" or "learning difficult*" or "learning disorder*" or "intellectual disabilit*").ti,ab.
(AMHP* or counsell* or RMN* or psychotherap* or therap*).ti,ab.
mental health/
psychiatry/
learning disorders/
intellectual disability/
6 OR 7 OR 8 OR 9 OR 10 OR 11
("physical therap*" OR "occupational therap*").ti,ab.
12 NOT 13
5 AND 14
limit 15 to (english language and yr="2006 -Current")

Appendix B. Existing definitions of professionalism

Table B1. Explicit definitions of professionalism noted in the literature

Author	Excerpt
Bhugra (2010)	*'professionalism is dynamic and responds to change.'* (Johnson, 2006, cited by Bhugra, p.323)
Ikkos and Mace (2009)	*'a far from unitary concept.'* (p.166)
Ikkos and Mace (2009)	*'a very complex and fluid construct'* (p.169)
Sims (2011)	*'multidimensional and characterised by change.'* (p.266)
ABIM Foundation (2002)	*'Professionalism is the basis of medicine's contract with society.* (p.244
Bhugra and Gupta (2010) & Joiner et al. (2015)	*'a set of values, behaviours and relationships that underpin the trust the public has in its doctors.'* (p.xi, The Royal College of Physicians, 2005, as cited by Bhugra and Gupta, p.10, and Joiner et al., p.72).
Bhugra (2008)	*'implies knowledge, skills and wisdom in practice.'* (p.327).
Bhugra (2010)	*'is defined as having a scientific or technical knowledge base, skills and altruism, with an emphasis on public good as far as medicine is concerned.'* (p.323).
Dingle and Stuber (2008)	*'manifested through a commitment to performing professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.'* (ACGME, 2007, cited by Dingle and Stuber, p.190).
Jakovljevic (2012)	*'the way how we define and practice fundamental principles and professional responsibilities in psychiatry.'* (Jakovljevic, 2002, cited by Jakovljevic, p.342).
Bouras and Ikkos (2013)	*'the norms that guide the relationships in which physicians engage in the care of patients.'* (Kucsewski, 2006, cited by Bouras and Ikkos, p.23).
Merriam Webster online dictionary (2017)	*'the conduct, aims, or qualities that characterize or mark a profession or a professional person.'* (Merriam Webster online dictionary, 2017).
Evans (2008)	*'professionality-influenced practice that is consistent with commonly-held consensual delineations of a specific profession and that both contributes to and reflects perceptions of the profession's purpose and status and the specific nature, range and levels of service provided by, and expertise prevalent within,*

	the profession, as well as the general ethical code underpinning this practice.' (p.29).
Poole and Bhugra (2008)	*'professionalism is protectionism.'* (p.196).
Bhugra (2008)	*'modern professionalism is both the encouragement and celebration of good practice and the protection of patients and the public from suboptimal practice.'* (Irvine, 2006, cited by Bhugra, p.329).

Appendix C. PRISMA Checklist (Moher, Liberati et al. 2009)

Table C1. PRISMA Checklist for the Systematic Review of defining professionalism for mental health services

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	3
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	4
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	4
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	4
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Table A1 (24)
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	4

Section/topic	#	Checklist item	Reported on page #
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	5
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	5 & Table 1
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	NA
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	NA
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I2) for each meta-analysis.	5
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	NA
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	3
RESULTS)			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	5
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	6 & Table 1
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	NA
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	NA
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	NA
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	NA
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	10
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	15
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	20
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future	22

Section/topic	#	Checklist item	Reported on page #
		research.	
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	Author note

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Asterisk indicates papers included in the review

Figure 1. Flow Diagram for systematic review of defining professionalism for the mental health service context

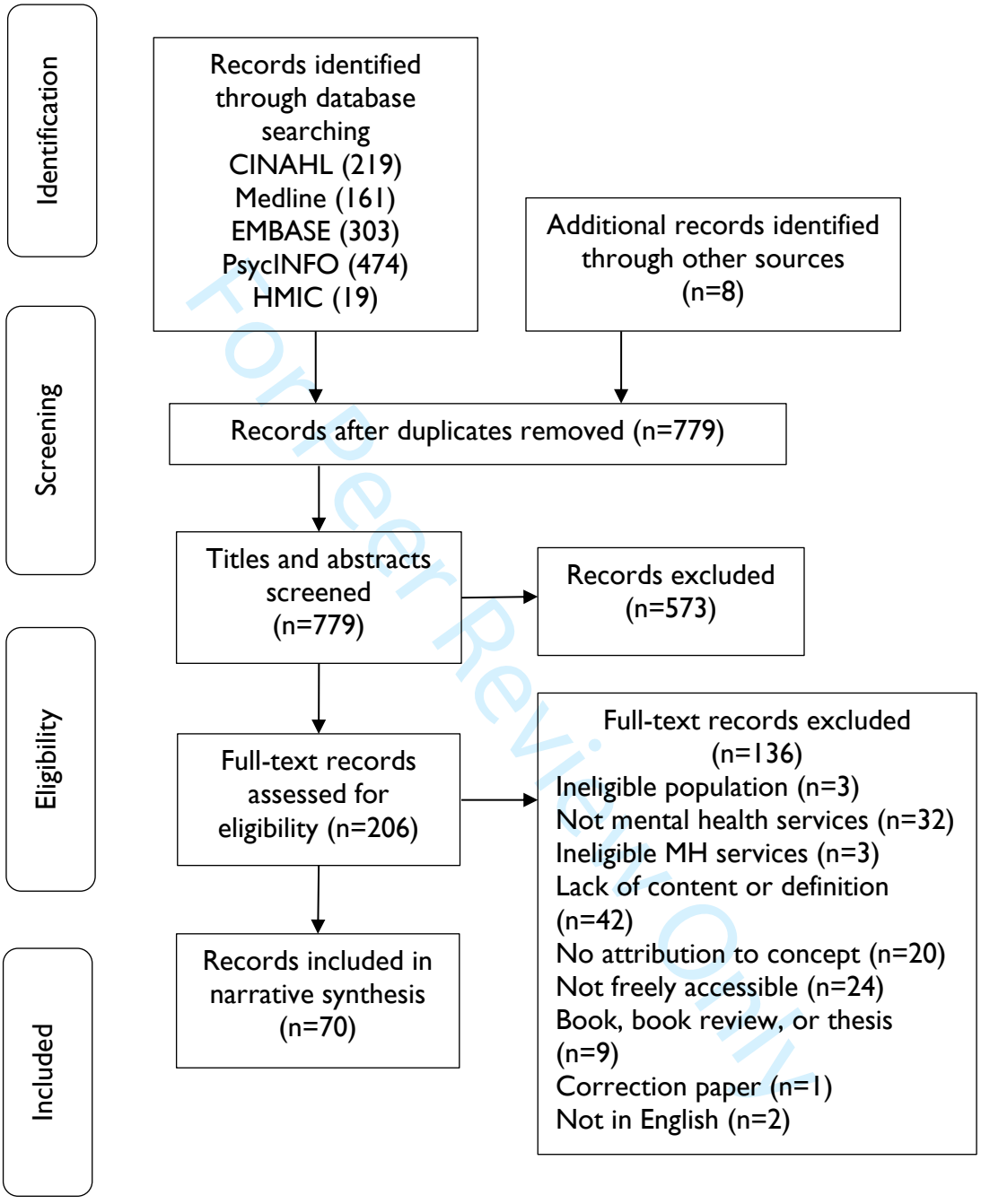

Table 1. Characteristics of Included Records

Article	Type of article	Journal / Source	Profession of author(s)	Country of authorship	Reference made to the mental health service context
Ljungberg, Denhov & Topor (2015) The Art of Helpful Relationships with Professionals: A Meta-ethnography of the Perspective of Persons with Severe Mental Illness	Review article	Psychiatric Quarterly	Social Work / Psychiatry	Sweden / Norway	Review focuses on helpful relationships for people with Serious Mental Illness
Bhugra (2008b) Renewing psychiatry's contract with society	Discussion paper	Psychiatric Bulletin	Psychiatry	UK	Focus on psychiatry's contract with society
Bhugra & Gupta (2011) Alienist in the 21st century	Discussion paper	Asian Journal of Psychiatry	Psychiatry	UK	Focus on the history of the psychiatric profession
Bouras & Ikkos (2013) Ideology, psychiatric practice and professionalism	Discussion paper	Psychiatriki	Psychiatry	UK	Focus on the psychiatric profession with regards to ideology
Brendel et al. (2007) The price of a gift: an approach to receiving gifts from patients in psychiatric practice	Discussion paper	Harvard Review of Psychiatry	Psychiatry	USA	Focus on the psychiatric profession and ethical dilemmas regarding gifts
Coverdale (2007) Virtues-based advice for beginning medical students	Discussion paper	Academic Psychiatry	Psychiatry	USA	Whilst discussing virtues, reports on a survey with the academic psychiatry editorial board
De Waal, Malik & Bhugra (2010) The psychiatric profession: an expertise under siege?	Discussion paper	International Journal of Social Psychiatry	Psychiatry	UK	Focus on threats to the psychiatric profession
Dingle & Stuber (2008) Ethics education	Discussion paper	Child and Adolescent Psychiatric Clinics of North America	Psychiatry	USA	Focus on ethics, specifically within child and adolescent mental health services

Elman & Forrest (2007) From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action	Discussion paper	Professional Psychology-Research and Practice	Counselling Psychology	USA	Focuses on issues with terminology, across counselling psychology
Fay (2013) The Baby and the Bathwater: An Unreserved Appreciation of Nick Totton's Critique of the Professionalisation of Psychotherapy	Discussion paper	Psychotherapy and Politics International	Clinical psychology / Psychotherapy	New Zealand	Focus on the professionalisation of psychotherapy
Gottlieb, Younggren & Murch (2009) Boundary Management for Cognitive Behavioral Therapies	Discussion paper	Cognitive and Behavioral Practice	Psychology/ Psychotherapy	USA	Focus on ethical issues with cognitive behavioural therapy
Haverkamp et al. (2011) Professional Issues in Canadian Counselling Psychology: Identity, Education, and Professional Practice	Discussion paper	Canadian Psychology-Psychologie Canadienne	Counselling Psychology	Canada	Focus on the identity of Canadian counselling psychologists
Ikkos & Mace (2009) Professionalising psychotherapy: Lessons from the development of psychiatry	Discussion paper	European Journal of Psychotherapy and Counselling	Psychiatry / Psychotherapy	UK	Focus on the professionalisation of psychotherapy
Jakovljevic (2012) Professionalism in psychiatry and medicine: a hot topic	Discussion paper	Psychiatria Danubina	Psychiatry	Croatia	Focus on professionalism in psychiatry
John et al. (2016) Training Psychiatry Residents in Professionalism in the Digital World	Discussion paper	Psychiatric Quarterly	Psychiatry	UK	Focus on digital media within the psychiatric profession
Mendelberg (2014) The integration of professional values and market demands: A practice model	Discussion paper	The Psychologist-Manager Journa	Clinical Psychology	USA	Talks about a private practice developed to serve those with mental illness
Paprocki (2014) When Personal and Professional Values Conflict: Trainee Perspectives on Tensions Between Religious Beliefs and Affirming Treatment of LGBT Clients	Discussion paper	Ethics & Behavior	Psychology	USA	Discusses ethical issues related to the delivery of psychological therapy for LGBT clients
Peek, H. S. et al. (2015) Blogging and Social Media for Mental Health Education and Advocacy: a Review for Psychiatrists	Discussion paper	Current Psychiatry Reports	Psychiatry	USA	Focus on digital media within the psychiatric profession

Randall & Kindiak (2008) Deprofessionalization or Postprofessionalization? Reflections on the State of Social Work as a Profession	Discussion paper	Social Work in Health Care	Social Work	Canada	Focus on the professionalisation of social work
Roberts & Termuehlen (2013) (Honest) letters of recommendation	Discussion paper	Academic Psychiatry	Psychiatry	USA	Focus on psychiatric issues
Robertson & Walter (2007) Overview of psychiatric ethics I: Professional ethics and psychiatry	Discussion paper	Academic Psychiatry	Psychiatry	Australia	Focus on ethics in psychiatry
Sanders, Servis & Boland (2014) The four general competencies	Discussion paper	Academic Psychiatry	Psychiatry	USA	Focus on competencies in the psychiatric profession
Schreiber et al. (2016) The Patient-Psychiatrist Relationship on the Axis of the Other and the Same	Discussion paper	Psychiatric Quarterly	Psychiatry	Israel	Discusses the patient / psychiatrist relationship
Schwartz, Kotwicki & McDonald (2009) Developing a modern standard to define and assess professionalism in trainees	Discussion paper	Academic Psychiatry	Psychiatry	USA	Minimal reference made to the field of mental health, but authors work in psychiatry and article published within a psychiatric journal
Young et al. (2013) The EAP Project to establish the professional competencies of a European psychotherapist	Discussion paper	International Journal of Psychotherapy	Psychotherapy	International	Focus on competencies in psychotherapy
Bhugra (2009) Professionalism and psychiatry: past, present, future	Editorial / Opinion piece	Australas Psychiatry	Psychiatry	UK	Focus on the psychiatric profession
Bhugra (2010) Editorial: Teaching Professionalism in Psychiatry	Editorial / Opinion piece	International Journal of Social Psychiatry	Psychiatry	UK	Focus on professionalism in psychiatry
Bhugra & Brown (2007) Editorial: psychiatry: de-professionalisation	Editorial / Opinion piece	International Journal of Social Psychiatry	Psychiatry	UK	Focus on threats to the psychiatric profession

Bhugra & Gupta (2010) Medical professionalism in psychiatry	Editorial / Opinion piece	Advances in Psychiatric Treatment	Psychiatry	UK	Focus on professionalism in psychiatry
Brown & Bhugra (2007) 'New' professionalism or professionalism derailed	Editorial / Opinion piece	Psychiatric Bulletin	Psychiatry	UK	Focus on professionalism in psychiatry
Coverdale, Balon & Roberts (2011) Cultivating the professional virtues in medical training and practice	Editorial / Opinion piece	Academic Psychiatry	Psychiatry	USA	Editorial for an issue in academic psychiatry
Gosselink & de Man (2012) The psychiatric scrapbook: fantasizing from the patient's perspective	Editorial / Opinion piece	Educ Health (Abingdon)	Psychiatry	Netherlands	Focus on a teaching programme in psychiatry
Grounds et al. (2010) Contemplating common ground in the professional ethics of forensic psychiatry	Editorial / Opinion piece	Criminal Behaviour and Mental Health	Forensic Psychiatry	USA / UK	Discusses ethics relating to forensic psychiatry
Happell (2006) Would the real mental health nurse please stand up? The relationship between identification and professional identity	Editorial / Opinion piece	International Journal of Mental Health Nursing	Psychiatry	UK	Discusses psychiatric nurses in comparison to nurses in other specialties
Ikkos, McQueen & St. John-Smith (2011) Psychiatry's contract with society: What is expected?	Editorial / Opinion piece	Acta Psychiatrica Scandinavica	Psychiatry	UK	Focus on psychiatry's contract with society
Lampshire (2012) Living the dream	Editorial / Opinion piece	Psychosis-Psychological Social and Integrative Approaches	Former service user	New Zealand	Talks about their personal experience as a former mental health service user
Malhi (2008) Professionalizing psychiatry: from 'amateur' psychiatry to 'a mature' profession	Editorial / Opinion piece	Acta Psychiatrica Scandinavica	Psychiatry	Australia	Focus on psychiatry and professionalisation
Malone (2012) Ethical professional practice: exploring the issues for health services to rural Aboriginal communities	Editorial / Opinion piece	Rural Remote Health	Psychology	Canada	Discusses ethical issues related to working in aboriginal communities

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Peek (2014) Psychiatry and Professionalism in the Digital Age	Editorial / Opinion piece	Psychiatric Times	Psychiatry	USA	Focus on digital media within the psychiatric profession
Poole & Bhugra (2008) Editorial: Should psychiatry exist?	Editorial / Opinion piece	International Journal of Social Psychiatry	Psychiatry	UK	Focus on the profession of psychiatry
Roberts (2009) Professionalism in psychiatry: a very special collection	Editorial / Opinion piece	Academic Psychiatry	Psychiatry	USA	Editorial for an issue in academic psychiatry
Rogers (2009) Dare we do away with professionalism?	Editorial / Opinion piece	Therapy Today	Counselling	UK	Discusses how professionalisation would be detrimental to the counselling practice
Scott Johnson, Chiu & Czelusta (2015) For residents, technology can put professionalism and reputation at risk	Editorial / Opinion piece	Current Psychiatry	Psychiatry	USA	Focus on digital media within the psychiatric profession
Talbott & Mallott (2006) Professionalism, medical humanism, and clinical bioethics: The new wave-does psychiatry have a role?	Editorial / Opinion piece	Journal of psychiatric practice	Psychiatry	USA	Focus on psychiatry
Wise (2008) Competence and scope of practice: ethics and professional development	Editorial / Opinion piece	Journal of Clinical Psychology	Psychotherapy	USA	Focus on the practice of psychotherapy and mental health
Baer & Schwartz (2011) Teaching professionalism in the digital age on the psychiatric consultation-liaison service	Quantitative study	Psychosomatics	Psychiatry	USA	Focus on digital media within the psychiatric profession
Goodyear et al. (2016) A global portrait of counselling psychologists' characteristics, perspectives, and professional behaviors	Quantitative study	Counselling Psychology Quarterly	Counselling psychology	International	Focuses on counselling psychology internationally
Harris & Kurpius (2014) Social Networking and Professional Ethics: Client Searches, Informed Consent, and Disclosure	Quantitative study	Professional Psychology-Research and Practice	Counselling Psychology	USA	Reports on a survey with counselling and psychology graduate students

Jain et al. (2010) Psychiatry Residents' Attitudes on Ethics and Professionalism: Multisite Survey Results	Quantitative study	Ethics & Behavior	Psychiatry	USA	Reports on a survey with psychiatry residents
Jain, Lapid, et al. (2011) Psychiatric residents' needs for education about informed consent, principles of ethics and professionalism, and caring for vulnerable populations: results of a multisite survey	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatry residents
Jain, Dunn, et al. (2011) Results of a multisite survey of U.S. psychiatry residents on education in professionalism and ethics	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatry residents
Joiner et al. (2015) Medical professionalism education for psychiatry trainees: does it meet standards?	Quantitative study	Australas Psychiatry	Psychiatry	UK	Reports on an audit with psychiatry trainees
Komic, Marusic & Marusic (2015) Research Integrity and Research Ethics in Professional Codes of Ethics: Survey of Terminology Used by Professional Organizations across Research Disciplines	Quantitative study	Plos One	(*unclear*)	Croatia	Focus on research integrity and ethics codes across organisations, including mental health
Lapid et al. (2009) Professionalism and ethics education on relationships and boundaries: psychiatric residents' training preferences	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatry residents
Marrero et al. (2013) Assessing professionalism and ethics knowledge and skills: preferences of psychiatry residents	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatry trainees
Morreale, Balon & Arfken (2011) Survey of the importance of professional behaviors among medical students, residents, and attending physicians	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatry residents, physicians and trainees

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Roberts et al. (2006) Preferences of Alaska and New Mexico psychiatrists regarding professionalism and ethics training	Quantitative study	Academic Psychiatry	Psychiatry	USA	Reports on a survey with psychiatrists
Russinova et al. (2011) Recovery-promoting professional competencies: perspectives of mental health consumers, consumer-providers and providers	Quantitative study	Psychiatric Rehabilitation Journal	Psychiatry	USA	Reports on a survey with consumers, consumer providers and providers of mental health services
Symons et al. (2011) Allegations of serious professional misconduct: An analysis of the British Association for Counselling and Psychotherapy's Article 4.6 cases, 1998–2007	Quantitative study	Counselling and Psychotherapy Research	Counselling / Psychotherapy	UK	Focus on complaints made in counselling and Psychotherapy services
Wu et al. (2013) Professional values and attitude of psychiatric social workers toward involuntary hospitalization of psychiatric patients	Quantitative study	Journal of Social Work	Social Work	Taiwan	Reports on a survey with social workers about psychiatric detention
Bhugra (2008a) Professionalism and psychiatry: the profession speaks	Mixed methods	Acta Psychiatrica Scandinavica	Psychiatry	UK	Reports on a survey with psychiatrists re professionalism in psychiatry
Leppma et al. (2016) Working With Veterans and Military Families: An Assessment of Professional Competencies	Mixed methods	Professional Psychology-Research and Practice	Counselling	USA	Discusses competencies needed for working with veterans in mental health
Sims (2011) Reconstructing professional identity for professional and interprofessional practice: a mixed methods study of joint training programmes in learning disability nursing and social work	Mixed methods	Journal of Interprofessional Care	Health and Social Care	UK	Reports on a survey / interviews with dual trained learning disability nurses / social workers
Alves & Gazzola (2013) Perceived professional identity among experienced Canadian counsellors: A qualitative investigation	Qualitative study	International Journal for the Advancement of Counselling	Counselling	Canada	Reports on a study performed with counsellors that work in mental health
Blegeberg, Bloomberg & Hedelin (2008) Nurses' conceptions of the professional role of operation theatre and psychiatric nurses	Qualitative study	Nordic Journal of Nursing Research &	Nursing	Sweden	Reports on interviews with nurses regarding the psychiatric nursing role

		Clinical Studies / Vård i Norden			
Coy, Lambert & Miller (2016) Stories of the Accused: A Phenomenological Inquiry of MFTs and Accusations of Unprofessional Conduct	Qualitative study	Journal of Marital and Family Therapy	Marriage and Family Therapy Counselling	USA	Reports on interviews with marriage and family therapists that were accused of misconduct
Crawford, Brown & Majomi (2008) Professional identity in community mental health nursing: a thematic analysis	Qualitative study	International Journal of Nursing Studies	Nursing / Psychology	UK	Interviewed community mental health nurses about their role
Gonyea, Wright & Earl-Kulkosky (2014) Navigating dual relationships in rural communities	Qualitative study	Journal of Marital and Family Therapy	Marriage and Family Therapy Counselling	USA	Focus on marriage and family therapy
Groves & Kerson (2011) The Influence of Professional Identity and the Private Practice Environment: Attitudes of Clinical Social Workers Toward Addressing the Social Support Needs of Clients	Qualitative study	Smith College Studies in Social Work	Social Work	USA	Reports on interviews and focus groups with social workers regarding social support for patients
Pelto-Piri, Engstrom & Engstrom (2012) The ethical landscape of professional care in everyday practice as perceived by staff: A qualitative content analysis of ethical diaries written by staff in child and adolescent psychiatric in-patient care	Qualitative study	Child and Adolescent Psychiatry and Mental Health,	Psychiatry	Sweden	Reports on a study with various occupational staff working in child and adolescent mental health services

Table 2. Themes, Subthemes and Elements of Professionalism within a Mental Health Service Context

Themes	Subthemes	Associated elements
On a societal level- a dynamic social contract	Power and purpose	A profession's mission and core values are established; and professional identity is generated via knowledge, skills and expertise.
	Bidirectional expectations	Society expects professions to work towards patient welfare and benefit, patient autonomy, and social justice. In turn, professions must have the appropriate resource to undertake their role
	Change and variability	The social contract must be renegotiated regularly between professions and society
On an individual level- representatives of the profession	Intrapersonal professionalism	Expectations held of individuals in order to meet the expectations of their profession *Honours professional codes of conduct, self, and others, demonstrates a commitment to professional and ethical practice, acting professionally at all times, demonstrates core values including probity, objectivity, courage, and truthfulness, integrity, and self-sacrifice, possesses self-awareness and self-discipline, is responsible and accountable to self and the profession, possesses appropriate knowledge and skills for role and self-regulates, having a commitment to continuing professional development, monitors own wellbeing and possesses a secure, stable, calm and confident persona.*
	Interpersonal professionalism	Possessing the necessary skills to relate to others in an appropriate manner. *Acts in the patient's best interest at all times, facilitates but does not dictate treatment, provides patients with hope and positive feedback, portrays genuine respect, having trust, benevolence, honesty, altruism, respect, self-effacement, compassion and motivation to help others, values the worth and dignity of all and treats all patients equally, possesses concern for others' welfare, has a humane and personal nature with an empathic and diplomatic ability, places an emphasis on the practitioner-client relationship, forming effective therapeutic relationships, focuses on patients' strengths and assets, offering choices, facilitating self-worth and promoting empowerment, listens without judgement and believes in recovery, demonstrates cultural awareness and competence, understands the importance of communication and interpersonal skills, maintains healthy relationships with others and appropriate boundaries, promotes patients human rights, contains the anxieties of patients and colleagues, and shares expertise via training, research and policy development.*
	Working professionalism	Ability to form judgements and act accordingly, thinking critically and using reflection in action *Demonstrates critical thinking skills and acts wisely, possessing practical wisdom and using professional judgement in situations of uncertainty, ambiguity, and/or instability, acts in the patient's best interest and adheres to professional and ethical consensus, using knowledge in action, reflection in action and reflection in learning, demonstrates an openness, willingness, and flexibility in practice, reflects critically on practice and is responsive, having social perceptiveness and emotional resonance, manages transference and counter-transference accordingly, demonstrates appropriate action when societal, cultural and ethical obligations diverge.*