Reviewer's report

Title: Associations Between Provider Communication and Personal Recovery Outcomes

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Reviewer: Jerome Kroll

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BPSY-D-18

This study examines whether two measures of quality of care (shows respect and explains understandably) are associated with mental health outcomes related to personal recovery (as defined by the personal recovery literature), and whether these associations vary according to whether the provider was a mental health professional versus general medical doctor.

The state of the question is clearly defined, including distinguishing between Positive Psychology, Personal Recovery Movement, and Patient Centered Care. Methodology is well described; Results are described by description and tables, and the Discussion provides perspective and the history of research into the Personal Recovery Model.

I have a few questions about the background upon which this study draws its questions and finds results.

1) What types of 'probable' mental illnesses were represented in the population that participated in the California Well-Being Survey (2014) from which this research sample was drawn. I raise first the question of how broadly applicable or generalizable are the findings based upon studying this population. Can we generalize these results to a population characterized as SPMI (serious and persistent mentally ill)? Is it a population of 'walking wounded' who are mostly not SPMI? Did the California survey include the homeless, the incarcerated, and those presently in mental hospitals or wards? I am not implying that the California study should have or could have included the assumedly more ill populations, but, as I indicated, how applicable are the premises and working models of the questionnaires to working with SPMI?

2) Were patients referred to MH professionals rather than to general medical doctors because they were not as seriously ill - perhaps referred for counseling rather than medication, which sometimes can be read as an indicator of seriousness of illness? If so, then the two populations studied (those seen by MH and those seen by medical doctors) may not have been comparable. If so, the population seen by MH may have been able to form a closer working relationship with
the provider and thereby was able to have a more positive treatment experience which was reflected in higher scores given in the 'show respect' item.

3) As someone who sees a more acute and more disturbed population of patients, I sometimes wonder what is meant by the universal approbation for providing care that is responsive to patient preference. Almost every manic patient with whom I have worked wants, and often demands, reduction in anti-manic medications. I provide much respect and long discussions about the nature of the illness, the philosophic questions of what is an illness, discussions about benefits and outcomes and side effects of medications, and the likely consequences of going off medication. When I acquiesce to the patient's preference, the patient more likely than not has a relapse and ends up being brought to the hospital by family, group home staff or police. I sometimes worry about my score on the 'shows respect' tickbox. Lest I just seem like a crank discussing my issues rather than those raised by the authors here, I would like to see the authors discuss the applicability of the principles of patient-centered care (such as patient preference), which are considered a hallmark of quality care, to broader domains of patient populations. If higher approval ratings under the item 'shows respect' depend upon the mental health professional agreeing with the patient to lower medications with subsequent relapse, then the rating item is moving in the opposite direction of patient recovery.

4) I note that there are data on race/ethnicity/language and age and gender demographics (Table 1), which has a footnote that [computer] models included controls for age, gender, race/ethnicity and psychological distress. I assume that no mention is made in the text means that no significant findings were uncovered. However, I would like to see a brief discussion about this, especially since so much attention is paid to cultural sensitivity issues that one might expect differences to show up if the data were available. For example, were the MH professionals or medical doctors same ethnicity or gender as the subjects of the CHIS (2013) or the CWBS (2014)?

5) If allowable, could there be one or two brief narrative histories derived from the telephone interviews that might flesh out the type of responses some subjects volunteered during the telephone interviews that might illustrate the types of responses given in response to the formatted questions.
Are the methods appropriate and well described?
If not, please specify what is required in your comments to the authors.

Yes

Does the work include the necessary controls?
If not, please specify which controls are required in your comments to the authors.

Yes

Are the conclusions drawn adequately supported by the data shown?
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