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Towards a Person-Centered Care Model Among Community Mental Health Services

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Abstract

Mental illness is widespread among adults and remains the foremost cause of years lived with disability. Despite its importance, there is a scarcity of research on person-centered care (PCC) from the viewpoints of mental health service users, particularly within clinical community mental health services. This study sought to investigate the potential for enhancing PCC through the lived experiences of individuals with mental health conditions who use local community mental health clinics (CMHC) in Malta. The goal was to obtain a thorough understanding of the current landscape, evaluate its strengths and weaknesses, and identify strategies for evolving the system towards a more PCC-focused model.

A qualitative research design was utilized, following the principles of Interpretative Phenomenological Analysis (IPA) as described by Smith et al. (2009). Ten participants from Malta, including six women, who frequently visit CMHCs, were recruited through intermediaries. Each participant took part in a one-hour semi-structured interview, conducted at a mutually convenient time and location. These sessions were audio-recorded and transcribed verbatim for subsequent analysis.

The analysis identified three main themes: Quality care, emotional support, and partnership and collaborative care, each comprising various sub-themes. The study illuminated both the strengths and shortcomings of the existing system and their implications for a PCC-oriented healthcare approach. While our findings reaffirm research on the critical role of empathy in care and other relevant factors, results also indicate that cultural factors in Malta, such as strong family ties, significantly influence the delivery of person-centered care (PCC), which may be relevant for other small communities. Furthermore, the research offers healthcare professionals (HCPs) a chance for ongoing professional development in accordance with the latest PCC principles.

Keywords: Person-Centered Care, Mental Health, Lived Experiences, Community Mental Health Services, IPA.

1. Prioritizing Individuals in their Own Care

Person-centered care (PCC) prioritizes individuals in their own care by actively engaging them in the decision-making process. It is a core value in providing high-quality care (QOC) within community mental health services and is essential for achieving universal mental health coverage (WHO, 2022). Research on PCC involving mental health service users not only empowers their rights and improves their health and well-being outcomes but also supports international mental health policies, agencies, and professional organizations (WHO, 2022). The primary aim of this study is to enhance the understanding of PCC by exploring the lived experiences of individuals accessing five major public community mental health services in Malta and to identify the essential requirements for advancing this approach.

According to Malta's Mental Health Strategy for the upcoming years (2019), one of the significant challenges facing the health system in Malta is the need to redistribute resources and activities from hospitals to primary and community care. This transformation seeks to establish mental health community services as the cornerstone of care, with social integration as a primary goal. The World Health Organization (WHO) (2024), in addressing key priorities in mental health, emphasized the necessity of strengthening the workforce while tackling the widespread issues of stigma and discrimination in mental health care. The WHO identified specific actions for the future among 11 small European countries, including Malta, which involve continuous professional development, empowering individuals with lived experiences, and investing in evidence-based campaigns to combat stigma. Therefore, emphasizing the shift towards providing professional mental health services within community care, guided by person-centered care, is essential for developing a more comprehensive and effective program that meets the specific needs of those seeking assistance.

While the terms "patient-centered" and "person-centered" care are often used interchangeably, they represent distinct concepts that require clear differentiation. The transition to person-centered care signifies a more advanced focus on the individual within the broader context of their life, encompassing family, social, and community environments (Starfield, 2011). The WHO defines people-centered care as care organized around the health needs and expectations of individuals and communities, rather than solely focusing on diseases. This approach extends beyond patient-centered care to include individuals, families, communities, and society at large (WHO, 2020b). It encourages proactive participation from patients, who are invited to ask questions and voice concerns regarding their care.

Person-centered care is thus a holistic concept that includes not only clinical interactions but also an ongoing and comprehensive understanding of patients as individuals within their communities—whether that be their family as a microcosm or society as a macrocosm. Ekman et al. (2011) contend that person-centered care results in more favorable health outcomes and higher satisfaction levels compared to patient-centered care.

1.1 An All-Inclusive, Person-Oriented Model

Transitioning from the current disease-focused model to a more personalized, inclusive, and integrated care approach necessitates the cultivation and maintenance of strong individual and social connections to address entrenched inequities within the existing health system. The WHO's Comprehensive Mental Health Action Plan 2020–2030 (2013) stresses that mental health services must prioritize best practices and implement person-centered care to uphold human rights, equality, non-discrimination, legal capacity, and community inclusion. This approach is vital, as many individuals with mental health issues continue to encounter barriers to accessing quality care, face coercive practices, and are often excluded from decision-making processes (WHO, 2022). Person-centered care is founded on respect for individuals, their right to self-determination, mutual respect, and understanding (McCormack et al., 2010).

In Malta, community mental health clinics (CMHCs) cater to a diverse range of individuals, from those with mild mental health concerns to those with complex disorders. These clinics are staffed by healthcare professionals (HCPs) and are publicly funded by the government, providing services free of charge to Maltese citizens and residents. This study aims to enhance awareness, particularly among HCPs, regarding the significance of person-centered care through the lived experiences of individuals with mental health issues utilizing clinical community mental health services in Malta.

2. Significance of the Study

There is a significant gap in research regarding person-centered care (PCC) within community mental health centers (CMHCs), with no local studies identified. The existing literature primarily highlights the importance of the therapeutic relationship between mental health service users and healthcare providers (HCPs). Service users have identified key elements that they value, including empathetic listening, respect for their identity, acceptance without judgment or stigma, a less hierarchical relationship, and the promotion of mental health knowledge to prevent severe mental illness (Maassen et al., 2016; Erin et al., 2018; Youssef et al., 2020).

The implementation of PCC is essential, as it leads to improved clinical outcomes when individuals are actively involved in decision-making and their holistic needs are addressed. Benefits of PCC include decreased reliance on emergency hospital services, better management of complex chronic conditions (De Silva, 2011), enhanced medication adherence (De Silva, 2012; Scerri, 2020), earlier engagement with community services, reduced anxiety and stress, and shorter hospital stays (De Silva, 2012). Thus, PCC not only improves individual health and well-being but also helps alleviate economic burdens at both global and national levels.

Relevant studies have shown that the outcomes of PCC, informed by the experiences of mental health service users, support the implementation of person-centered care in mental health environments (Malmström et al., 2016; Bacha et al., 2020). Additionally, research by Trevillion et al. (2020) and Moore et al. (2017) indicates that PCC can prevent severe mental illnesses, enhance the health and well-being of individuals with mental health challenges, and improve the quality of care in CMHCs. These findings suggest that the field is still developing, highlighting the need for further investigation.

PCC is not a novel concept; it has its roots in psychology. From 1902 to 1987, Carl Rogers, an American psychology pioneer, developed the humanistic theory of client-centered therapy, which he later renamed the person-centered approach. Drawing from his experiences as a psychotherapist, Rogers advocated for viewing individuals as persons rather than patients to promote their autonomy. His approach empowered individuals to become active participants in their therapy, based on the belief that people possess inherent resources for selfknowledge and self-healing, and that personality change and development can occur in a supportive environment (Rogers, 1967).

Rogers articulated that the primary objectives of person-centered therapy revolve around the therapist's ability to foster therapeutic attitudes such as congruence, unconditional positive regard, and empathic understanding of the client's internal perspective (Rogers, 1967). The Person-Centered Practice Framework (PCPF) was revised by McCormack and McCance (2017) to include five interrelated domains: macro context, research influence, workforce development (informing curriculum development), and strategic and policy-level influence through leadership, all aligned with the core principles of person-centeredness in practice.

The movement away from traditional medical models is also evident in other fields, including nursing, as exemplified by Florence Nightingale (1820–1910) (Lauver et al., 2002). Person-centered processes emphasize the activities necessary for delivering care and ensuring the effectiveness of person-centered practice. These activities encompass: a) aligning with patients' beliefs and values (e.g., respecting their values and listening to their narratives, acknowledging their uniqueness); b) engaging authentically (e.g., being honest and transparent, understanding their preferences, concerns, and goals); c) demonstrating care and respect to foster engagement and help individuals achieve their full health potential; d) being sympathetically present (e.g., providing support and a listening ear); and e) sharing decision-making (e.g., promoting self-determination, autonomy, and choice).

Holistic care enhances self-determination in decision-making and overall well-being, resulting in positive outcomes such as improved care experiences, a sense of well-being, and the cultivation of a healthy culture (McCormack & McCance, 2017). This study aims to investigate PCC through the lived experiences of individuals with mental health issues utilizing community mental health services. Furthermore, the interview questions were crafted based on the theoretical framework of person-centered care, specifically focusing on the domain of person-centered processes, to gain a deeper understanding of the outcomes associated with this framework.

3. Method

The study aimed to accomplish two main objectives: first, to enhance the understanding of outcomes within the Person-Centered Care (PCC) framework, and second, to investigate the holistic needs and healing outcomes of service users. Purposive sampling was deemed the most suitable method, as it facilitated the intentional selection of participants capable of providing in-depth and relevant insights pertinent to the research question (Polit & Beck, 2018). A total of ten Maltese adults, including four males, who were receiving support from the Community Mental Health Centre (CMHC) at the time, were recruited through intermediaries after obtaining all necessary ethical approvals and informed consent. The interviews, conducted in either Maltese or English, lasted approximately one hour and comprised eight open-ended questions. All sessions were audio-recorded. Interpretative Phenomenological Analysis (IPA) was selected as the research design (Smith et al., 2009), recognized for its effectiveness in examining how participants interpret their lived experiences, perceptions, and understandings. The analysis adhered to the guidelines set forth by Smith et al. (2009), which included: 1) familiarization with participants' narratives; 2) identification of emerging themes; 3) thematic connections; and 4) narrative writing. At this stage, final themes were translated to uncover relationships between emerging themes, with the analyst pinpointing contextual or narrative elements within the transcripts (see Table 1). Three overarching themes and several sub-themes were identified, culminating in a comprehensive table of themes derived from all participant interviews.

Throughout the study, careful attention was paid to contextual sensitivity, which included theoretical considerations, relevant literature, the sociocultural environment, participants' viewpoints, and ethical factors, as recommended by Yardley (2000). A commitment to rigor, transparency, and coherence was upheld, in line with the literature (Yardley, 2000). This was accomplished through a comprehensive and detailed documentation of the research process, providing justifications for each decision made. The interview guide was developed in both Maltese (the participants' native language) and English, following the Person-Centered Practice Framework (PCPF) by McCormack and McCance (2017). It encompassed five key domains: addressing patients' beliefs and values, engaging authentically, being empathetic, facilitating shared decision-making, and delivering holistic care. The interview questions explored various topics, including a) participants' feelings regarding their visits to the CMHC; b) satisfaction with the responses to their inquiries; c) perceptions of respect and value; d) involvement of participants and/or their families in the care process; e) optimism about the care received; f) holistic aspects of care; and g) assessment of the current system. During the interviews, the researchers practiced reflection to maintain a clear distinction between their roles. Particular emphasis was placed on empathy, full respect, and acceptance of the interviewees' experiences, which involved careful observation of non-verbal cues, body language, and emotional expressions.

Table 1. IPA 6-step method journey developed from Smith et al. (2009).

STEP	METHOD
1.	Immersion in the reading & re-reading of original data, checking transcripts for accuracy against audio tape recordings, ensuring that the participant remains central to the analytical process.
2.	Initial notes registered which explore semantic and language whilst taking into account text associated with visual representations and metaphor
3.	Emergent themes are noted
4.	Searches for connections across emergent themes collated within a table
5.	Repeat process by moving onto the next case
6.	Look for patterns across all participants, whilst considering convergence & divergence alongside shared themes.

Participation in the study was completely voluntary, with informed consent obtained prior to the interviews. The research was approved by the Ethics Board, and all required permissions were acquired. Participants were recruited through intermediaries, and all data collected was pseudonymized by assigning codes to the transcripts to maintain confidentiality. Furthermore, participants were provided with access to complimentary psychological services should any needs arise during the study.

4. Findings

The participants were given the following pseudonyms: Luke, Anna, Daniel, Doris, Carmen, Kevin, Jason, Katie, Maria, and Rose. Excerpts from their contributions are italicized, enclosed in quotation marks, and identified by the corresponding pseudonym.

Three overarching themes emerged from this study: 1. Quality of Care, 2. Empathy, and 3. Partnership and Collaborative Care. These themes are elaborated upon below.

4.1 Quality of Care

The first significant theme identified was the quality of care, which includes three sub-themes: respect, participants' values, and understanding the participants.

Respect

Participants had varying perceptions of respect. For some, like Maria, it meant "being treated with respect and safety because I am being followed." Others found the experience more nuanced, with some expressing dissatisfaction with the care they received. For instance, Daniel felt insecure while waiting at the CMHC due to the aggressive behavior of other patients. Although some healthcare professionals (HCPs) intervened to de-escalate these situations, this was not always consistent.

Participants' Values

Understanding participants' values is crucial for grasping their perception of person-centered care (PCC). The interviews revealed that participants valued being treated with dignity and respect, recognized for their strengths and resilience, and honored for their beliefs and principles. Building strong relationships and being addressed by their first names were also significant to them. Kevin appreciated being called by his first name, while Katie valued HCPs who showed interest in her life beyond her medical condition, which empowered her. Inquiring about a person's life and what they cherish emerged as essential. Daniel noted that he felt happiest when nurses greeted him warmly and asked about his well-being and progress in his college course. Participants emphasized the importance of kindness, friendliness, and attentive listening, which made them feel empowered and dignified. Rose highlighted the need for full attention, while Maria stressed the importance of being treated as an individual rather than a case or condition. These interactions underscored the significance of therapeutic relationships, aligning with person-centered processes within the PCPF.

Table 2. Summary of superordinate and subordinate themes with participant’s excerpts

No.	Superordinate theme	Subordinate theme	Subjects' excerpts
1	Quality Care		
		Respect	“I feel respected and safe as I have been followed-up” (Doris, p.8, l44).
		Values	“I have learned. Now I am independent” (Daniel, p.6, l.38).
		Understand participants	All showed me kindness… they were sensitive and they know how to calm you down” (Rose, p.21, l.132).
2	Empathic support		
		Empathy	“for me it means…listening to me” (Carmen, p.20, l.61).
		Lack of empathy	“I didn’t always feel respected” (Anna, p.3, l.15).
3	Partnership & Collaborative care		
		Care engagement	“I think the care is complete (Rose, p.21, l.137).
		Education about care	“They explained to me what to do” (Doris, p.9, l.51).
		Family involvement	“They call my sister so that I will come for my injection” (Jason, p.11, l.65).
		Integration & comprehensive care	“I feel satisfied with dignity” (Luke, p.1, l.1)

Understanding Participants

Understanding participants involved allowing sufficient time during visits to the CMHC and providing appropriate psychoeducation about their conditions. These factors were seen as strengths that made participants feel understood in their treatment and care. Conversely, a lack of time, staff shortages, and heavy caseloads had the opposite effect. Anna observed that while her treatment began slowly, it improved as she was asked about her life and given information about her medication, making her feel valued and understood. Sharing experiences with HCPs fostered a familial atmosphere, benefiting both parties. For example, Jason felt on equal footing with his HCP when discussing lessons from his past. However, mutual understanding still required improvement in some cases, with issues such as time constraints, excessive paperwork, and staff shortages contributing to challenges. Negative attitudes from HCPs could also be problematic, leading participants to feel like "just a number." As Carmen succinctly expressed, “Sometimes I feel understood, and sometimes I feel like I am talking to a wall.”

4.2 Emotional Support

Emotional support emerged as the second major theme, emphasizing the importance of empathic care, which was either appreciated when present or felt as a loss when absent.

Empathy

Participants indicated that empathy from HCPs, demonstrated through kindness, attention, and active listening, provided them with essential support. This empathic care instilled hope and a positive outlook toward treatment and life, which is vital for healing. Participants like Anna found it easier to confide in their HCPs, especially during anxious moments. Rose noted that when HCPs listened attentively and acknowledged her anxiety and depression, it helped her feel calmer and more relaxed. Many participants looked forward to their appointments, learning not to shy away from their problems, as Luke described.

Lack of Empathy

Conversely, a lack of empathy had detrimental effects. Daniel compared it to a "sword," exacerbating the pain of patients already grappling with difficult issues. This absence of empathy could arise from misunderstandings, as Carmen pointed out, when care felt routine or when side effects were overlooked, as Katie experienced.

4.3 Partnership and Collaboration in Care

The third major theme, partnership and collaboration in care, included four sub-themes: engagement in care, education about care, family involvement, and integrated and comprehensive care. Participants discussed how care was delivered and suggested improvements to enhance the quality of care and clinical community mental health services in Malta.

Engagement in Care

When participants received appropriate information about their care and treatment, their trust and engagement increased. Kevin appreciated timely and unconditional explanations, which enabled him to engage more fully in his care, recognizing the stakes for his health. Rose echoed this sentiment, stating that trust in HCPs is essential for effective care.

Education about Care

Being informed about treatment options, receiving comprehensive information, and being involved in treatment decisions were vital for participants. While many felt involved, there was room for improvement. Katie, for example, believed that greater involvement would have been beneficial, especially given the risk of relapse due to non-adherence to medications. Frequent changes in psychiatrists also caused anxiety, as Carmen described feeling confused when the trust she had built with one psychiatrist was lost with another. Personal traits like shyness could hinder effective communication. Anna, who was shy and reserved, struggled to express her opinions on medication changes. Jason added that some patients might hesitate to voice their concerns to avoid "rocking the boat," even though this might not lead to the desired care.

Family Involvement

Family involvement in care elicited mixed reactions from participants. While some valued their privacy and preferred not to involve family members, others found family support therapeutic and beneficial. Daniel described his family as a team, and Doris appreciated the involvement of her husband and daughter in her care.

Integrated and Comprehensive Care

Many participants expressed optimism about the quality of care at the local CMHC, feeling grateful for the personalized attention they received. Maria appreciated that her questions were heard, understood, and valued, while Anna valued the collaborative approach in deciding when to receive treatment. Holistic care, which addressed not only physical but also psychological, social, and spiritual needs, was also highly regarded. For instance, Maria felt that the HCP’s input helped her better understand and manage her condition. Participants identified three strengths of the CMHC services: prompt action and emotional support from HCPs, the availability of free services, and the integration of physical and mental health care, which helped reduce stigma. However, they also noted weaknesses, such as limited time, lack of empathy, and a desire for more involvement in treatment decisions. Final suggestions for improvement included enhanced training for HCPs to strengthen therapeutic relationships, increased patient and family involvement, and improved logistics, such as consistency in consultants and a more effective follow-up system.

5. Discussion

5.1 Critique of the Findings

The objective of this study was to explore Person-Centered Care (PCC) through the lived experiences of individuals facing mental health challenges who utilize Community Mental Health Care (CMHC) services in Malta. This investigation provided the researcher with a comprehensive understanding of the outcomes associated with PCC and the factors that influence the holistic needs and healing processes of the participants. This chapter will interpret and critically analyze the findings of the study in relation to existing literature, integrating the researcher’s insights with the findings and relevant literature, as guided by Smith et al. (2009). The chapter will conclude by discussing the strengths and limitations of the study.

The literature review indicates a significant gap in research focused on the lived experiences of individuals with mental health issues who engage with clinical community mental health services (Bacha et al., 2020; Malmström et al., 2016). To the authors' knowledge, this study is pioneering in this area, aiming to address this evident gap. The findings reveal a combination of strengths and weaknesses within the current community mental health services system. Specifically, in relation to the study’s objectives, the results suggest potential for a PCC approach, although notable limitations remain. These findings highlight the necessity for substantial improvements at both the micro-level (individual care) and macro-level (system-wide and health authorities), particularly in areas such as enhanced training, increased patient involvement in care, and improved logistics.

Three overarching themes emerged from the results. The first theme, "quality care," was elucidated through three subordinate themes: respect, values, and the understanding of participants by healthcare professionals (HCPs). According to the World Health Organization (2023), quality care encompasses effectiveness, safety, people-centeredness, timeliness, equity, integration, and efficiency. Mutual respect is widely acknowledged as a fundamental aspect of care, particularly within PCC frameworks. Participants reported feeling safer and more respected when they were satisfied with the services received, especially in after-care. This contrasts with findings by Malmström et al. (2016), where patients often felt anxious and burdened by follow-up care due to issues related to access, communication, and logistics. Instances of disrespect from HCPs towards participants in this study align with findings from related studies (Bacha et al., 2020; Malmström et al., 2016; Newman et al., 2015; Trevillion et al., 2022). Moore et al. (2017) noted that HCPs frequently reverted to traditional care models, whether consciously or unconsciously, indicating a lack of interest, knowledge, or commitment. Such tendencies often resulted in more complicated treatment outcomes for the patients involved. Moore et al. emphasized the necessity for ongoing education and practice to effectively implement PCC, as deficiencies in these areas impede its adoption (Moore et al., 2017). Additional recommendations include the incorporation of professional de-escalation techniques to manage aggressive patients, as highlighted by McCormack and McCance (2017).

The study also underscored the importance of values. Participants emphasized the need for HCPs to acknowledge and respect their values, which was crucial for their engagement in care. According to Maassen et al. (2016), treating patients as unique individuals and respecting their value systems are essential for effective care. Participants expressed a desire to be recognized for their individual strengths and competencies. Conversely, Baker (2001) noted that creating a welcoming environment is the first step toward enabling a PCC approach. The study highlighted that HCPs' attitudes, including kindness, friendliness, and a willingness to listen, fostered a non-judgmental environment, a key aspect of PCC. Bacha et al. (2020) found that when HCPs treated patients as equals, it improved their sense of self-worth and dignity. Lastly, the third subordinate theme, "understanding participants," was emphasized by findings indicating that participants experienced positive outcomes, such as feeling safer and more confident in their care, when they perceived their HCPs as understanding and supportive (Bacha, 2020). McCormack and McCance (2017) identified characteristics such as being listened to, actively involved in care, and treated with genuine respect as essential for PCC. A lack of these qualities often led to psychological distress and disengagement between service users and HCPs.

The second overarching theme, "emotional support," was examined through two subordinate themes: the presence and absence of empathy. The American Psychological Association (2019) defines empathy as a sensitive understanding of the patient's feelings, which is crucial for forming a strong therapeutic alliance. Participants who experienced empathy from their HCPs reported feeling valued and more engaged in their treatment. Trevillion et al. (2022) found that empathic listening and validation of experiences enhanced participants' sense of value and engagement in their care. However, some participants, particularly males, expressed that they did not require emotional support, a difference that may be influenced by cultural factors, as noted by Fischer et al. (2018). While some participants reported receiving empathic care, others expressed dissatisfaction, highlighting the need for heartfelt care (Maassen et al., 2016). Malmström et al. (2016) found that a lack of empathy in HCPs led patients to feel misunderstood and uncared for, particularly in community clinics and hospitals. While our findings align with those of Bacha et al. (2020) regarding the importance of empathy in care, our study also revealed that cultural factors in Malta, such as strong family ties, play a unique and crucial role in the delivery of PCC, which could be significant for other small communities.

The third and final overarching theme, "partnership and collaboration in care," was divided into four subordinate themes: engagement in care, education about care, family involvement, and integrated and comprehensive care. Engagement in care was noted when participants felt informed and involved in their treatment, leading to increased trust in their HCPs and better health outcomes. Youssef et al. (2020) found that patient confidence in HCPs was crucial for engagement in treatment and adherence to necessary lifestyle changes. Henderson et al. (2020) highlighted that authentic engagement in care involves congruence, honesty, and transparency, which are essential for achieving optimal health and well-being outcomes (McCormack & McCance, 2017). Education about care emerged as another critical theme, with participants expressing a desire for more information and involvement in decision-making. The literature consistently indicates that mental health patients often lack adequate information about their care (Bacha et al., 2020; Maassen et al., 2016; Malmström et al., 2016). Logistical issues, such as inconsistent care from different doctors and long waiting lists, were also highlighted as detrimental to patient well-being (Newman et al., 2015; Maassen et al., 2016; Trevillion et al., 2022). Family involvement in care was deemed crucial by many participants, particularly in cultures like Malta, where family ties are strong. Malmström et al. (2016) and Trevillion et al. (2022) also found that family involvement provided essential social support and communication assistance. However, one participant felt independent enough not to require family involvement. The final subordinate theme, integrated and comprehensive care, revealed mixed results. Some participants were optimistic about the holistic care they received, while others felt that their care focused too narrowly on medical aspects. Trevillion et al. (2022) similarly found that participants desired more holistic and inclusive care, addressing not just medical symptoms but also broader lifestyle and psychological needs. Maassen et al. (2016) noted a preference among service users for a broader approach to care, including attention to lifestyle, psychological, social, and nutritional factors. Among the strengths identified by participants were the emotional support, availability, and attention provided by HCPs. However, participants also noted weaknesses, particularly the lack of respect, empathy, and patient involvement in decision-making. These areas are crucial for the successful implementation of PCC-oriented treatment.

5.2 Recovery and Person-Centered Care (PCC)

Recovery, like PCC, involves an individual’s exploration of how to find meaning in their reality. This process includes making informed decisions while maintaining control over the situation, often with the support of significant others. Recovery is understood as a journey. Hummelvoll (2012) describes it as a mission along one’s life path. Three key aspects define 'recovery': a) recovery as a natural process, b) clinical recovery, and c) recovery as the ability to hold onto hope and positivity despite ongoing symptoms or functional impairments. Hummelvoll (2012) identifies several factors that contribute to this dynamic process, including intrapersonal elements (such as regaining self-confidence and self-control), interpersonal interactions, the social environment, and the journey of finding meaning. Andresen, Caputi, and Oades (2006) proposed five stages of recovery: a) moratorium (a deep sense of loss and hopelessness), b) awareness (a sense of hope that not all is lost), c) preparation (the recovery process), d) rebuilding (a proactive approach towards regaining control and meaningfulness), and e) growth (living a full life). Leamy et al. (2011), in their systematic review and narrative synthesis, identified an emerging conceptual framework for recovery that includes a) 13 characteristics of the recovery journey and b) five key recovery processes: connectedness, hope/optimism, identity, meaning, and empowerment. Studies focusing on Black and minority ethnic groups highlighted the importance of spirituality and stigma while also emphasizing culture and collective notions of recovery. To apply this to healthcare systems in small countries such as Malta, it is essential to recognize that what applies to other countries may not necessarily apply to small communities. Moreover, small regions may also have unique conditions and systems not found elsewhere.

Stanhope et al. (2021) highlight that person-centered care (PCC) serves as a crucial quality indicator for fostering holistic and recovery-focused services. Both PCC and recovery services strive to instill hope for the future, impart a sense of purpose in life, empower individuals to make informed choices, and encourage a proactive lifestyle. These services are customized to meet the unique needs of each individual, ensuring personalized care. According to Stanhope et al. (2021), the recovery model comprises five fundamental elements: hope, personal responsibility, education, self-advocacy, and support. In a PCC recovery plan, individuals in recovery collaborate closely with their healthcare providers (HCPs). This study's findings underscore that while community mental health care seeks to promote a health system centered on person-centeredness and recovery (WHO, 2021), it is crucial to recognize existing cultural frameworks, particularly the medical model, that may impede this advancement. Furthermore, Galea and Zammit Galea (2024) discovered that adopting a person-centered approach within community mental health services not only empowers individuals but also enhances clinical outcomes, ultimately benefiting the wider community.

5.3 Strengths and Limitations

This study presents several strengths and limitations. It fills existing gaps in both local and international research regarding individuals with mental health issues who sought assistance from community services. Notably, it is the first local study of its kind and one of the few qualitative investigations on this topic globally. The research offers a comprehensive qualitative analysis based on the lived experiences of participants with diverse mental health challenges, focusing on how the care received aligns with Person-Centered Care (PCC) principles.

Utilizing Interpretative Phenomenological Analysis (IPA) enabled participants to articulate their experiences, revealing both the strengths and weaknesses of the current system while providing suggestions for better alignment with PCC principles. Additional strengths include allowing participants to express themselves in their native language or English for improved clarity, employing professional translation to accurately convey participants' views, and maintaining a reflective diary throughout the research and data analysis process to reduce potential bias.

However, the qualitative nature of the study poses limitations, particularly in terms of generalizability. The small sample size may restrict the applicability of the findings, although this is consistent with IPA methodology (Smith et al., 2019). There is also the potential for response bias, especially if participants were aware that the interviewer was a healthcare professional, a concern that may be heightened in a small country like Malta. While the local context may limit the generalizability of the results, the findings indicate that implementing a PCC approach in community mental health services can significantly improve patient outcomes by emphasizing empathetic care and family involvement. It is essential for policymakers and healthcare professionals to prioritize training programs that enhance these aspects, particularly in areas with strong community and family connections.

Future research is recommended to utilize larger and more diverse samples and to compare the implementation of PCC across different regions or countries.

5.4 Recommendations

Several recommendations are put forward to improve the integration of person-centered care (PCC) within healthcare programs:

Education and Training: Current educational programs for healthcare professionals (HCPs) should enhance their curriculum by incorporating updated education and new PCC initiatives. This will facilitate the implementation of humanistic approaches that encourage greater engagement with service users and empower them to achieve their full potential, as described in the person-centered practice framework (McCormack, 2003; McCormack & McCance, 2017).

Continual Practice Development (CPD): CPD courses that emphasize a PCC perspective should be created for existing HCPs. Management should prioritize the enhancement of follow-up systems and, when feasible, ensure that patients are seen by the same consultants. Furthermore, HCPs should be encouraged to apply PCC flexibly to address the unique needs of each patient, thereby fostering partnership and collaboration in care and treatment to improve the overall quality of care (WHO, 2023).

Research Expansion: Given the limited research on PCC from the perspectives of individuals with mental health issues utilizing Community Mental Health Centers (CMHCs), additional studies are necessary. Future research should examine the practices and experiences of PCC from the viewpoints of both HCPs and the relatives and families of patients.

6. Conclusion

In summary, our findings are consistent with existing research highlighting several interrelated factors, including: a) mutual respect for values, b) mutual understanding, c) quality care, d) the necessity of moving beyond traditional care models, particularly the medical model, to provide more comprehensive patient attention, e) patient engagement in care that fosters confidence in healthcare professionals (HCPs), f) the need for enhanced education about care, and g) the appropriate management of logistical issues.

While our findings reaffirm the critical role of empathy in care, they also indicate that cultural factors in Malta, such as strong family ties, significantly influence the delivery of person-centered care (PCC), which may be relevant for other small communities. Family involvement was identified as essential for holistic treatment, especially in cultures with strong familial connections.

These findings underscore a persistent need for advancement and development in this sector, where several issues remain unaddressed, as noted in previous research. This study illustrates that implementing a PCC approach in community mental health services can greatly improve patient outcomes, particularly by prioritizing empathetic care and family involvement.

Policymakers and healthcare professionals should focus on training programs that promote these elements, particularly in areas with strong community ties, which are often characteristic of small countries. Additionally, in alignment with WHO recommendations, this study advocates for increased collaboration among small countries in areas such as continuous professional development and the sharing of techniques and resources to address the specific needs and challenges of each community, while also investing in evidence-based initiatives to combat stigma. Ultimately, further research is essential to develop a comprehensive and effective PCC approach within community mental health services.

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