## Table 1 Characteristics of case studies included in the review

| **Author, Year**<br><br>**Country**<br><br>**Purpose of article** | **Setting**<br><br>**Demographic characteristics** | **Focus of case study** | **Discussion** |
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| 1 Ang et al 2009[148]<br><br>Singapore<br><br>Addresses the challenge of what should be done in the case of people with chronic conditions which impair their capacity | Emergency hospital care of a woman in her 40s with a diagnosis of schizoaffective disorder since her early 20s and with recent end stage renal failure | Ethical issues in EoLC for people lacking capacity to make decisions | Autonomy of a patient with regard to medical treatment, assessment of the patient's decisional capacity, and the process of deciding on the appropriate course to take in a patient without the mental capacity to give consent for required treatment in a potentially life-threatening situation<br><br>Legal frameworks, tools to assess capacity and the use of advanced ('Ulysses') contracts are all addressed |
| 2 Badger and Ekham 2011[116]<br><br>USA<br><br>Ethical conflicts at the end of life for patients with personality disorder, substance misuse and self-harming behaviour | A case of a man in his 40s with long-term MH problems whose physical health declines (liver and respiratory failure) and whose care presents an ethical challenge to practitioners | Ethical issues in EoLC for people lacking capacity to make decisions | Decision-making for people lacking capacity is difficult in the absence of ADs and in the case of people with complex MH and substance misuse problems |
| 3 Bakker 2000[109] | A residential service using DSA for older people with complex mental and | The use of the DSA approach, including in the example of people | The DSA approach is offered as a psychosocial counterbalance to more |

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| Netherlands<br><br>Focuses on the PC of patients in a 'reactivation program', this being a service for older people with complex health problems | physical health problems, in which the case is a woman in her 90s | who end their lives in the DSA service, illustrating the phases of the approach in action | exclusively biomedically oriented approaches to care |
| 4 Boyd et al 1997[117]<br>USA<br><br>The process of care for a hospice patient described as manipulating family, friends, and hospice staff during her EoLC | A hospice service for people at the EoL, with the case being a woman in her 50s with breast cancer who is described as having a pre-existing (but not clearly described) severe MH problem characterised by 'manipulative' behaviour | The challenges faced by hospice staff in providing care to someone perceived as being manipulative, and how these can be addressed using practices informed by psychodynamic thinking | Hospice staff can provide care for people with 'troubled personality' using psychodynamic approaches, including supporting ego functioning; supporting autonomy; setting limits; and assessing and managing staff emotional responses |
| 5 Cabaret et al 2002[146]<br>France<br><br>The provision of EoLC in an inpatient psychiatric hospital setting | An inpatient psychiatric hospital, with the case being a man in his 40s with a diagnosis of schizophrenia and lung cancer | The provision of humane, palliative, care in a MH hospital | Inpatient MH staff are able to provide humane, dignified, care until the EoL for people with SMI |
| 6 Candilis and Foti 1999[118]<br>USA | A case study beginning in an ED and moving to a MH unit, focused on the care of a woman in her 70s with cancer and psychosis | Decision-making in the context of EoLC and psychosis, where the patient's understanding and preferences are not clearly known | Differences in view can exist over the best course of action in cases where patients refuse treatment but do not elaborate supportive, palliative, care or more aggressive intervention |

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| EoLC to someone with psychosis and cancer, where the patient's preferences are not clearly known | | | |
| 7 Clements-Cortes 2004[143]<br><br>Canada<br><br>The use of music therapy in the emotional care of people who are at the EoL | A discussion on the value of music therapy, followed by three case studies all of people using an older people's PC inpatient service, of which two (women in their 70s) have pre-existing MH problems | The value of music in providing emotional support to people with terminal illnesses | Music therapy can facilitate emotional expression, including in people with SMI |
| 8 Doron and Mendlovic 2008[147]<br><br>Israel<br><br>EoLC in inpatient MH wards | Two case studies of people, one in her 40s at her death and the other a woman whose age at death is not stated, cared for near to the EoL in inpatient MH settings, where both had a diagnosis of SMI and cancer | The challenges for both patients and staff of being cared for during a terminal illness in a MH inpatient setting | Information on the patient's condition and prognosis should be given in the context of their capacity to understand, decisions should be made by patients where possible or otherwise by clinicians and home is where people should die meaning that if this is a psychiatric ward staff should be supported to provide care for as long as possible |
| 9 Feely et al 2013[119]<br><br>USA<br><br>EoLC in a hospice for people with borderline personality disorder | A case study of a woman in her 40s with a diagnosis of borderline personality disorder and terminal metastatic pancreatic cancer, being cared for in a hospice | The difficulties for staff in hospices of providing care for people with complex MH problems characterised by impulsive behaviour and difficulties in relationships | There is a lack of evidence to support interventions with people with borderline personality disorder at the EoL, but behavioural interventions should be tailored to the person based on the creation of genuine, respectful, relationships |

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| 10 Feldman and Petriyakoil 2006[120]<br><br>USA<br><br>PTSD at EoL | A case study of a male veteran in his 60s with heart failure and acute onset of PTSD symptoms. | Challenges of recurrence of latent PTSD symptoms seemingly triggered by the threat to life of terminal illness mimicking previous experiences. | Specific challenges in EoLC for people with PTSD may mean they experience psychological symptoms that have been dormant, become anxious and angry, avoid healthcare, distrust medical recommendations leading to nonadherence and refusal of treatment |
| 11 Feldman et al 2014[110]<br><br>USA<br><br>The provision of PC to people with PTSD at the EoL | A re-presentation of a new model of care to people with a diagnosis of PTSD, either pre-existing or post-EoL diagnosis, illustrated by three case studies (men in their 60s) in diverse PC settings | An illustrated model of care for people with PTSD at the EoL, involving therapy over three distinct stages: Palliate Immediate Discomfort and Provide Social Supports; Provide Psychoeducation and Enhance Coping Skills; and Treat Specific Trauma Issues | The SPPC model can be used to support terminally ill patients with PTSD where conventional PTSD interventions are challenged by limited life expectancy, fatigue and other concerns |
| 12 Feldman et al 2017[111]<br><br>USA<br><br>The provision of PC to people with PTSD at the EoL | A case of a male veteran in his 70s with a diagnosis of PTSD and multiple myeloma, admitted for inpatient hospice care at the EoL | How a staged approach to PTSD care is helpful for people at the EoL | A further illustration of how the SPPC model can be used to support terminally ill patients with PTSD where conventional PTSD interventions are challenged by limited life expectancy, fatigue and other concerns |
| 13 Geppert et al 2011[121]<br><br>USA | A detailed case study of a man in his 50s with a pre-existing a diagnosis of schizoaffective disorder who has | The ethical issues around treatment when people have psychosis and lack decisional capacity | Psychosis raises ethical issues for EoLC as it undermines decisional capacity, raises questions about the use of proxies and additional questions about where care ought to |

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| PC and capacity in the context of people with psychosis and terminal cancer | terminal laryngeal cancer and who is admitted to hospital | | be provided (MH services, or ned of life services) |
| 14 Gonzalez et al 2009[122]<br>USA<br>Hospice care of a man with breast cancer and bipolar disorder | A medical case study of a man in his 80s with complex health needs who receives inpatient care, and who has a diagnosis of bipolar disorder, dementia and breast cancer first treated 20 years previously | The complexity of providing care for people with multiple needs, in the context of family members also having significant health needs | Curative care is difficult to provide if treatment is not consistently provided and accepted, and PC is appropriate particularly when caregivers have health needs of their own |
| 15 Griffith 2007[123]<br>USA<br>Palliative and EoLC for a man with heart and lung failure and schizophrenia [pt 1 of 2] | An extended case study of a man in his 60s, focusing on his schizophrenia diagnosis and his lung and heart disease and his care at home until death | The role of the psychiatrist in the provision of integrated care, including at the EoL, to people with SMI and multi-organ failure | Psychiatrists have an important part to play in treating people who have both severe MH and terminal physical health problems |
| 16 Griffith 2007[124]<br>USA<br>Palliative and EoLC for a man with heart and lung failure and schizophrenia [pt 2 of 2] | An extended case study of a man in his 60s, focusing on his schizophrenia diagnosis and his lung and heart disease and his care at home until death | The role of the psychiatrist in the provision of integrated care, including at the EoL, to people with SMI and multi-organ failure | Psychiatrists should have cultural and religious competence and be able to work with families |
| 17 Hill 2005[125]<br>USA | A case of a woman in her 80s described as having borderline personality disorder and hospice care at home | EoLC for people with a diagnosis of borderline personality disorder and complex physical health problems and family histories | Nurses should develop therapeutic relationships, have good supervision, be consistent in caregiving, and have |

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| Hospice at home care for a person with borderline personality disorder | | | good working relationships with families and psychiatrists |
| 18 Irwin et al 2014[26]<br>USA<br>Cancer care, including to EoL, for people with schizophrenia | A detailed review of literature followed by a case study of a woman in her 60s with a diagnosis of paranoid schizophrenia and terminal cancer, whose care moves from home to inpatient hospice | Health inequalities for people with a diagnosis of schizophrenia and cancer | Practitioners need improved understanding of health disparities experienced by people with a diagnosis of schizophrenia and cancer, research is needed to examine factors influencing survival and quality of life and better integration is required between oncology and psychiatric services |
| 19 Kadri et al 2014[144]<br>Canada<br>Care for a person with schizophrenia and advanced kidney disease who lacks capacity and resists treatment | A case of a woman in her 50s with a diagnosis of schizophrenia and advanced chronic kidney disease admitted to hospital as an emergency and who refuses dialysis, then receives supportive care | Ethical issues in the case of people with SMI and who are unable to make decisions, but who actively resist treatment | Two ethical issues are highlighted: the lack of acceptance of treatment, and the risk of doing immediate harm if treatment is continued nonetheless |
| 20. Kennedy et al 2013[114]<br>UK<br>Homelessness and EoLC | A case study of a woman in her 50s with diagnosis of schizophrenia and cervical cancer living semi-independently in a one bedroomed flat. | Treatment refusal in someone with severe mental illness who has the capacity to make decisions and her determination to return home to live. | Providing care for a person in their own home involving multiple professional teams in support of her autonomous decision to remain out of hospital and considering her refusal of active treatment |
| 21 Kunkel et al 1997[126]<br>USA | A discussion of denial of cancer followed by five illustrative cases:<br>a woman in her 30s with a diagnosis of psychosis and breast cancer, who | A review of factors associated with non-compliance in people with cancer, specifically psychoses and cognitive impairment Both are shown to play a role in delayed help-seeking and non- | Key issues affecting cancer treatment are competence, the place for legal intervention, ambivalence towards health care providers and the |

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| Denial of cancer and non-compliance in treatment | misses treatment and dies following an emergency admission;<br><br>a woman in her 50s with presumed 'organic personality syndrome' and squamous cell carcinoma who was psychotic and who died in hospital;<br><br>-a man in his 70s with presumptive pancreatic cancer and pre-existing organic delusional disorder and a diagnosis of major depression with psychosis, who had home hospice care;<br><br>a woman in her 70s with a diagnosis of dementia and breast cancer;<br><br>a woman in her 70s with a diagnosis of schizophrenia, superimposed dementia and lung cancer | compliance with cancer, and EoL, care | importance of early psychiatric intervention |
| 22 Levin and Feldman 1983[127]<br><br>USA (the authors are based in South Africa)<br><br>Ethical issues surrounding the care of people with psychosis and terminal cancer | A case of a woman in her 30s with a diagnosis of schizophrenia and terminal breast cancer who is described as wanting to leave hospital without medical care following the treatment of an acute episode of her mental illness | A discussion of ethical issues associated with the care of people with SMI and terminal illnesses when treatment is refused | People have a right to refuse high-powered medicine at the EoL |
| 23 Lopez et al 2010[128] | The case of a woman in her 30s with a diagnosis of chronic anorexia | Discussion of ethical and legal issues associated with caring for a person with a psychiatric condition who is not | Refusal of treatment can be irrational but must be weighed against workers obligations and duty of care and the |

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| USA<br><br>Explores how medical futility and principles of palliation may contribute to the management of treatment refractory anorexia nervosa | nervosa, treated unsuccessfully for several years | helped by treatment where the condition ultimately leads to her death | autonomy of the individual. Two broad options are considered, 1) involuntary treatment, or 2) attempting to motivate the person until such time as they are willing to engage in treatment. The first option may have kept her alive in the short term but seemed unlikely to reverse the underlying condition |
| 24 Maloney 2014[115]<br><br>USA [blog]<br><br>https://www.thejournal.ie/readme/bipolar-ii-disorder-denial-mental-health-1467162-May2014<br><br>A wife's experiences of her husband's bipolar disorder and terminal cancer | A personal blogpost recording a woman's experiences of her husband's diagnosis with a diagnosis of bipolar disorder, his subsequent terminal cancer and his death at home | A first-hand, narrative, account of long-term experiences ending in the death of a loved one | SMI changes people's lives, and can cause people to lose touch with reality People affected (patients and families) need support |
| 25 Mason and Bowman 2018[112]<br><br>Country unknown (conference abstract)<br><br>The challenges of providing cancer care at the EoL to people with SMI and fluctuating capacity | A conference proceedings abstract describing the care of a man in his 70s with a diagnosis of schizophrenia and fluctuating capacity admitted to hospital for investigations and care into prostate cancer and metastases | An account of the challenges for people with SMI and fluctuating capacity in the context of EoL cancer care | Determining capacity in the context of SMI and acute physical illness is difficult, where standardisation in capacity assessment may help |
| 26 McCasland 2007[129]<br><br>USA | A case of a woman in her 50s with a diagnosis of schizoaffective disorder, alcohol problems, liver damage and | Hospice nurses need better preparation to look after people at the EoL who also have SMI | Communication skills are important for hospice nurses caring for people with SMI at the EoL, and hospice nurses |

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| The care and treatment of people with SMI and cancer, including at the EoL | breast cancer who is cared for in the community until dying in a hospice | | needs more training to care for this group of people |
| 27 McKenna et al 1994[130]<br>USA<br>The treatment with clozapine of people with SMI and cancer, where treatment also includes antineoplastic medication | A letter to the editor describing a man in his 40s with a diagnosis of schizophrenia and lung cancer with a poor prognosis, treated with clozapine, whose care was transferred from a MH to a medical care institution | The combination of clozapine with anti-tumour drugs | Guidance is needed on the combination of clozapine (an anti-psychotic) with anti-cancer drugs |
| 28 Mogg and Bartlett 2005[140]<br>UK<br>The care and treatment of a man with treatment-resistant psychosis and life-threatening renal failure | The case is a man in his forties with a 30-year history of psychosis and multiple admissions to MH hospital, now discovered to have life-threatening renal disease requiring regular dialysis | Different approaches to the assessment of capacity (outcome, status, functional), set in the context of the legal framework | Capacity can fluctuate, and 'best interests' need to be considered which can mean guidance needing to be sought from the courts |
| 29 Moini and Levinson 2009[131]<br>USA<br>The care and treatment of people with simple schizophrenia and medical conditions | A case of a woman in her 40s with a diagnosis of simple schizophrenia who is lost to services following diagnosis of breast cancer with metastases, and who is located at a later point at the terminal stage of her illness | Approaches to working with people with a diagnosis of simple schizophrenia and medical problems | Proactive care is needed so that people stay in touch with services, though people with a diagnosis of simple schizophrenia are also likely to have capacity to decide on their courses of treatment |
| 30 Monga et al 2015[132]<br>USA | The case is of a man in his 70s with a diagnosis of schizophrenia, treated with clozapine, who continues his antipsychotic medication whilst having | The use of clozapine as an atypical antipsychotic alongside the use of chemotherapy | There is limited information to guide management of clozapine treatment during chemotherapy, and close |

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| The use of clozapine in people with psychosis who are also having chemotherapy | hospice care and treatment for oesophageal cancer | | cooperation between psychiatrists and oncologists is needed |
| 31 Muhtaseb et al 2001[141]<br>UK<br>The treatment of people with SMI and advanced, terminal, cancer | The case is of a man in his 70s with a diagnosis of schizophrenia and advanced basal cell carcinoma, who refuses active intervention | Treatment of advanced, life-threatening, cancer in people with SMI who refuse active intervention | Consent must be freely given, and people (including people with SMI) should be considered able to decide for themselves |
| 32 O'Neill et al 1994[142]<br>UK<br>Hospice care for woman with anorexia nervosa | The case of a woman in her 20s with a diagnosis of anorexia admitted to a hospice in poor physical condition after 7 years of anorexia nervosa that was not helped by treatment. | Discusses the treatment and rapid decline to eventual death of a young woman from the complications associated with anorexia nervosa. | Recognises that psychiatric units do not have relevant expertise for providing complex physical healthcare. Says that her condition was identified as incurable by the psychiatric team and when the patient and her family accepted this she was then able to access appropriate care. Says hospice staff are familiar with other EoLC and that this largely worked for this woman helped by an excellent referral letter (no clue how this is judged) and ongoing support from the psychiatrist. They conclude that there is a role for carefully selected non-cancer patients to be cared for in SPC centres |
| 33 Picot et al 2015[15]<br>Australia | The case is of a woman in her 40s who has a diagnosis of bipolar disorder and metastatic breast cancer, | An illustrative case showcasing the work of nurse practitioners involved in the IMhPaCT programme, which is | People with SMI at the EoL face additional problems of isolation, declining physical abilities, pain, and disintegrating selfhood Collaboration |

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| The IMhPaCT, designed to improve care for people with SMI and life-limiting illnesses | who receives integrated MH and PC at home before dying in hospital | designed to bring together MH and PC for people with SMI | across specialities can enhance outcomes, and MH nurses have a role to play |
| 34 Rice et al 2012[133]<br>USA<br>Patient-provider communication in EoLC | The case of a male veteran in his 50s with renal disease and a diagnosis of schizophrenia who refuses dialysis treatment. | The case provides an example of man refusing treatment in line with previous history and is found to lack capacity to decide in his best interests. Involvement of his sister who is ill-prepared to take on proxy decisions | Discussion hinges on challenges of enforcing physical treatments on a person who is refusing, handling autonomy versus coercion, recognition of need for building therapeutic alliances with the person and their surrogates |
| 35 Rodriguez-Mayoral 2018[113]<br>Mexico<br>Integrating MH and PC for people with SMI and cancer | A short conference abstract describing a woman in her 70s with a diagnosis of bipolar disorder and advanced, untreated, colon cancer from which she dies | The case briefly describes how the woman was cared for until her death, free form symptoms of her mental illness | Cancer care regardless of disease stage should be integrated with palliative and MH care to control symptoms and quality of life and death |
| 36 Romm et al 2009[134]<br>USA<br>Managing cancer care for people using inpatient MH services | The case is a man in his 40s with a diagnosis of schizophrenia and osteosarcoma for which amputation was indicated, and who refused surgical treatment but who was judged to lack capacity His mother assumed decision-making responsibility and concurred with her son, and PC was initiated | Treatment of people with acute MH problems and life-threatening cancer, and patients' capacity to understand and made decisions | Psychiatrists have responsibilities to represent the interests of people who are 'mentally compromised', including those who are also irreversibly medically compromised Collaboration with PC practitioners is important, and whilst SMI can impair capacity this is not necessarily so |
| 37 Shah et al 2008[135]<br>USA | The case is a homeless man in his 60s with a diagnosis of schizophrenia and neglected basal cell carcinoma, and who refuses treatment in the | Informed consent is key to the provision of cancer treatment, and in | In the absence of being able to give informed consent interprofessional |

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| The treatment of people with SMI and advanced, terminal, cancer | context of a lack of capacity and is then treated for his mental illness | cases where people lack capacity additional care needs to take | teams need to be involved, along with independent ethics committees |
| 38 Stecker 1993[136]<br>USA<br>Caring for young people with life-threatening cancer on an acute psychiatric ward | The case is of a man in his 20s with presumed bipolar disorder and sarcoma who is admitted to an inpatient psychiatric unit and who causes staff to struggle with the acceptance of death | Staff in MH wards do not routinely care for young people at the EoL, and this case challenged staff | MH nurses need to be able to identify feelings preventing them from working therapeutically with patients |
| 39 Steves and Williams 2016[137]<br>USA<br>EoLC for people with terminal illnesses and SMI | A very brief case of a man, of unknown age, who has a diagnosis of schizophrenia and terminal lung cancer but who has capacity and refuses treatment prior to his death | Services for people with SMI at the EoL are in short supply, MH nurses need training in EoLC, attention needs to be paid to the environment, communication needs to be effective, caregivers needs to be supported, family members may be resistant and other inpatients need to be supported following a death | Investments are needed in services and staff to care for increasing numbers of people with SMI who also have terminal medical conditions |
| 40 Terpstra et al 2014[138]<br>USA<br>EoL hospice care for people with SMI | The case is of a man in his 60s with a diagnosis of schizophrenia living in adult foster care who reports physical symptoms and is found to have bladder cancer and brain masses, moves to an open hospice and whose care and treatment is then described | The complexity of providing hospice care for people with SMI and terminal cancer, and the role of nurses | People with schizophrenia diagnoses are often medically undertreated, have shortened life expectancies, and have care which is challenged by their placements, poor communication and symptom management |

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| 41 Thomson and Henry 2012[70]<br><br>USA<br><br>The challenge for oncology nurses of caring for people with SMI and cancer | A paper on oncology nursing for people with pre-existing SMI, including a series of brief case studies: a woman in her 30s with a diagnosis of major depression and then breast cancer; a man in his 40s with a diagnosis of bipolar disorder and advanced pancreatic cancer and a woman in her 20s with a diagnosis of schizophrenia and breast cancer | Care and treatment of people with pre-existing SMI at the EoL, with a particular emphasis on understanding mental illnesses and its treatment | Medical professionals need to be aware of premature mortality in people with SMI, and need to develop skills and knowledge in caring for people with SMI as an underserved group<br>Practice is advancing in the areas of drug treatments, case management, family work and social support |
| 42 Webber 2012[145]<br><br>Canada<br><br>Caring for a man with SMI in his supported home prior to hospice care | A brief case study of a man of unknown age who has a diagnosis of schizophrenia and metastatic gastric cancer and who was cared for in his supported home for as long as possible until being transferred to a hospice, where he died | Pain control, control over of levels of intervention, control over maintaining meaningful, relationships, outcomes of lost autonomy, lack of resources, restoring justice for patients with SMI and terminal illness, and innovation are all discussed | Autonomy has been diminished for people with SMI and palliative illness, yet people with SMI at the life want the same things as everyone else<br>Services and care need to improve, |

Key: DSA: dynamic system analysis; EoL: end of life; EoLC: end of life care: IMhPaCT: Integrated Mental Health and Palliative Care Task; PTSD: post-traumatic stress disorder; SMI: severe mental illness; SPC: specialist palliative care: SPPC: stepwise psychosocial palliative care

## Table 2 Critical appraisal scores

| Citation | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Score |
|---|---|---|---|---|---|---|---|---|---|
| 1. Ang et al 2009[148] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 2. Badger and Ekham 2011[116] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 3. Bakker 2000[109] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 4. Boyd et al 1997[117] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 5. Cabaret et al 2002[146] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 6. Candilis and Foti 1999[118] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 7. Clements-Cortes 2004[143] | Y | Y | Y | N | Y | Y | N | Y | 6/8 |
| 8. Doron and Mendlovic 2008[147] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 9. Feely et al 2013[119] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 10. Feldman and Petriyakoil 2006[120] | Y | UC | Y | N | N | Y | Y | N | 4/8 |
| 11. Feldman et al 2014[110] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 12. Feldman et al 2017[111] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 13. Geppert et al 2011[121] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 14. Gonzelez et al 2009[122] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 15. Griffith 2007[123] | Y | Y | N | Y | Y | Y | Y | Y | 7/8 |
| 16. Griffith 2007[124] | Y | Y | N | Y | Y | Y | Y | Y | 7/8 |
| 17. Hill 2005[125] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 18. Irwin et al 2014[26] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 19. Kadri et al 2018[144] | Y | N | Y | N | Y | N | Y | Y | 5/8 |
| 20. Kennedy et al 2013[114] | Y | UC | Y | N | Y | Y | Y | Y | 6/8 |
| 21. Kunkel et al 1997[126] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 22. Levin and Feldman 1983[127] | Y | Y | Y | N | Y | N | Y | Y | 6/8 |
| 23. Lopez et al 2010[128] | Y | Y | Y | N | Y | Y | N | Y | 6/8 |
| 24. Maloney et al 2014[115] | Y | Y | Y | N | Y | Y | Y | Y | 7/8 |
| 25. Mason and Bowman 2018[112] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |

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| 26. McCasland 2007[129] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 27. McKenna et al 1994[130] | Y | N | UC | N | Y | N | Y | Y | 4/8 |
| 28. Mogg and Bartlett 2005[140] | Y | N | N | N | Y | N | N | Y | 2/8 |
| 29. Moini and Levenson 2009[131] | Y | Y | Y | N | N | N | Y | Y | 5/8 |
| 30. Monga et al 2015[132] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 31. Muhtaseb et al 2001[141] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 32. O'Neill et al 1994[142] | Y | N | Y | N | Y | N | N | N | 2/8 |
| 33. Picot et al 2015[15] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 34. Rice et al 2012[133] | Y | N | Y | N | Y | Y | Y | Y | 6/8 |
| 35. Rodriguez-Mayoral 2018[113] | Y | N | N | N | N | Y | Y | Y | 5/8 |
| 36. Romm et al 2009[134] | Y | N | Y | N | N | N | Y | Y | 3/8 |
| 37. Shah et al 2008[135] | Y | N | Y | Y | Y | Y | Y | Y | 7/8 |
| 38. Stecker 1993[136] | Y | N | Y | N | N | N | Y | Y | 4/8 |
| 39. Steves and Willliams 2016[137] | Y | N | N | N | Y | Y | Y | Y | 4/8 |
| 40. Terpstra et al 2014[138] | Y | Y | Y | Y | Y | Y | Y | Y | 8/8 |
| 41.Thomson and Henry 2012[139] | Y | Y | N | N | N | N | N | Y | 2/8 |
| 42. Webber 2012[145] | Y | N | N | N | N | Y | Y | Y | 3/8 |

Key: Y=Yes, N=No, UC=unclear