What helps and what doesn't?: Understanding the experience of patients accessing care from Community Mental Health Teams (CMHTs)

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Abstract

Context: Community Mental Health Teams (CMHTs) are central to secondary mental health care in the UK, supporting people with severe and enduring mental health difficulties. Despite this, relatively little has been published about how care is experienced by those who use these services, particularly in the context of system pressures, fragmented pathways and increasing demand.

Aim: This study aimed to understand how service users experience CMHT care, including what they experience as helpful or unhelpful.

Method: Seventeen adults with current or recent experience of CMHT care took part in semi-structured interviews. Participants were recruited through NHS services, social media and lived experience networks. Data were analysed using reflexive thematic analysis within a critical realist framework.

Results: The analysis generated four themes. The first, **Wheel of Intervention**, captured how participants experienced access to support as unpredictable, reactive and conditional. Formal provision did not always translate into meaningful care. The second, **Secure Base from Consistent Care**, highlighted the importance of reliability and continuity. Participants often experienced care as held within relationships with individual professionals, rather than by the team. The third, **Holding onto Personhood within the System**, reflected how care was shaped by whether participants felt involved, recognised and treated with dignity, rather than processed through standardised systems. The fourth, **Care beyond the Clinic**, showed that participants valued support that extended beyond appointments to include connection, participation and belonging.

Discussion: Across the themes, participants distinguished between service provision and the experience of care. Care felt most meaningful when support was timely, relationally consistent, person-centred, and connected to wider life. System pressures could disrupt these conditions, leaving provision available formally but harder to experience as meaningful support. The findings have implications for CMHT design and evaluation, highlighting the importance of considering whether provision is delivered and whether it is experienced as care.

Declaration

I can confirm that this thesis is an original piece of work carried out by the author. It was completed and submitted as a requirement for the author's Clinical Psychology Doctorate at the University of Essex. This thesis has not been submitted for any other academic award.

Katherine Thrasher

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Mission Statement

Before beginning this project, I had become frustrated with how difficult mental health services could be to navigate. I had worked with clients whose needs felt significant, yet finding appropriate support could still be uncertain or complicated. Some service decisions and responses felt difficult to reconcile with the distress people described. I was particularly struck by occasions where professionals spoke about needs-led care, while support still depended on whether a person fitted the criteria of an available service. These experiences left me wanting to understand how services made decisions and how this was experienced by the people seeking support.

Working within mental health services made this harder to understand. I could see that staff often cared and were trying to provide thoughtful support within systems shaped by limited capacity and organisational boundaries. Public accounts of difficulties accessing care and negative experiences of receiving it reinforced these questions. My partner's own thesis, exploring people's experiences of inpatient mental health care, offered another example of services not always working as intended for those using them. Together, these experiences made me question how the care people received could differ so significantly from the intentions of those providing it, and whether mental health services were fulfilling their intended purpose for the people using them.

Learning about the history of community mental health care deepened this uncertainty. CMHTs seemed to have developed partly in response to deinstitutionalisation and to have accumulated responsibilities as services and policy priorities changed. This made me wonder whether their purpose had ever been fully settled and, more importantly, whether the service people received was doing what it was intended to do. I became increasingly interested in how people experienced CMHT care in practice and whether those experiences reflected the aims and responsibilities associated with these services.

When the opportunity arose to develop this project, I was drawn most strongly to hearing directly from people who had used CMHTs. I wanted to understand their experiences in their own terms and what they wished services understood more clearly. My hope was that the project could give greater visibility to these accounts and contribute something useful to discussions about what CMHTs are for and how they might better respond to people who use them.

Introduction

Chapter Outline

This chapter introduces the context and rationale for exploring service users' experiences of care from generic Community Mental Health Teams. It outlines the historical development of community mental health provision and considers how CMHTs have been shaped by deinstitutionalisation, multidisciplinary working, risk management, specialist service development and repeated policy reform. The chapter then examines the position of CMHTs within the wider mental health system and the forms of care they are expected to provide, including coordinated, person-centred, recovery-oriented and trauma-informed support. Attention is also given to the relational, psychological and social needs of people accessing CMHTs, particularly in relation to trauma, attachment, continuity and social exclusion. Existing research on experiences of CMHT care is then reviewed, highlighting recurring concerns around access, relationships, involvement, coordination and wider systemic pressures. The chapter concludes by identifying the need for qualitative research that considers how these aspects of care are experienced together within CMHT provision and presents the aims of the current study.

Introduction to the Topic

Community mental health teams (CMHTs) are multidisciplinary secondary care teams which support people with severe and enduring mental health difficulties, such as psychosis, bipolar, and personality disorders. Although they vary across local services, CMHTs commonly include psychiatrists, social workers, nurses, psychologists, occupational therapists and support workers. Their core functions include assessment, treatment, risk management, care coordination and liaison with wider health and social care services. CMHTs therefore occupy a central position within community-based secondary mental health care, often acting as a key point of ongoing support for people whose needs exceed the remit

of primary care or brief psychological therapy services. These formal descriptions provide an overview of the role of CMHTs, although they reveal less about what it is like to access this support.

Demand for secondary mental health services has increased substantially in recent years. Over 4 million people were in contact with NHS-funded secondary mental health, learning disability and autism services in 2024/25, compared with 2.64 million in 2016/17 (NHS England, 2026a). As of April 2026, almost 900,000 people were recorded as accessing community mental health services per month (NHS England, 2026b), compared to just over 500,000 in March 2023. However, it is difficult to determine from national datasets how many of these individuals were accessing generic CMHTs specifically, as opposed to specialist community services such as Early Intervention in Psychosis, crisis teams or eating disorder services.

Development of CMHTs

It is important to consider the history of CMHTs because current experiences of care are shaped by the way services have developed over time. CMHTs have been influenced by changes in policy, service organisation, risk management and wider cultural understandings of mental health care. Service users' experiences therefore do not occur in isolation from these wider conditions. They are shaped by how services have been designed, resourced, and reorganised.

The development of CMHTs can be understood within the wider movement from institutional care towards community care. Historically, mental health care was predominated by custodial responses, including the development of houses of correction in the seventeenth century (Foucault, 2003). This was followed by the expansion of the asylum system in the nineteenth century, which reinforced cultural associations between mental distress, danger and social exclusion (Moth, 2022). From the mid-twentieth century, there was increasing

policy focus on reducing the use of long-stay psychiatric hospitals and developing support outside institutional settings. This was reflected in the Percy Commission and subsequent mental health legislation (Turner et al., 2015). However, community care did not develop evenly, and in some areas community services did not appear to keep pace with the closure of hospital-based provision. CMHTs began to emerge as specific services around the early 1980s as part of the developing community care model (Turner et al., 2015). Sayce et al. (1991) describes early community mental health centres as aiming to provide more accessible and locally based forms of support, including through community locations that were less visibly institutional.

Over time, the role of CMHTs became more clearly established. Early provision involved both health and social care, although these were often organised across separate systems, which created fragmentation in how support was delivered (Langan, 1990). During the 1990s, CMHTs became increasingly multidisciplinary (Moth, 2022). This model reflected an aim to provide more coordinated support for people living with severe and enduring mental health difficulties. It also reflected the wider movement towards providing care outside hospital, where support could be more connected to a person's local context.

The development of CMHTs has also been influenced by policy responses to concerns about coordination, risk and public safety. The Care Programme Approach was introduced in England in 1991 following concerns that people with severe mental illness were not always receiving coordinated support in the community. It aimed to provide greater structure through assessment, care planning, care coordination and review, and became a central part of how CMHTs organised care (Simpson et al., 2003). The later influence of high-profile homicides and public inquiries further increased the focus on risk assessment, information-sharing and accountability. These changes were intended to improve safety, continuity and coordination. At the same time, they contributed to a service context where care coordination became more

closely linked with procedural, risk-focused and administratively accountable practice (Holloway, 2004).

The role of CMHTs was further reshaped by the development of specialist pathways around them. From the late 1990s and early 2000s, CMHTs worked alongside an increasing number of specialist community services, including crisis and home treatment teams, assertive outreach and early intervention in psychosis services (Burns, 2004). The introduction of IAPT services in 2008 also changed the position of CMHTs within the wider system. Many people with common mental health difficulties, such as anxiety and depression, were increasingly directed towards primary care psychological therapy provision (Clark, 2018). Within this system, CMHTs developed a more concentrated role in supporting people with complex, enduring and higher-risk needs.

Overall, the history of CMHTs reflects a movement away from institutional care and towards community support. It also shows a gradual narrowing and reorganisation of how community care has been understood and delivered. CMHTs were initially linked to a broader vision of care that was local, multidisciplinary and connected to people's wider social contexts. Over time, this role has been reshaped by specialist services, rising demand, care coordination systems, risk management and administrative pressures. Many of these changes were introduced in response to genuine concerns about access, coordination, safety and continuity. At the same time, repeated reorganisation raises important questions about whether changes in service structure lead to improvements in people's everyday experiences of care.

Context of CMHTs within wider mental health services

Generic CMHTs sit within a wider mental health system that includes primary care, specialist community teams, crisis services and inpatient provision. Laugharne et al. (2018) describe CMHTs as secondary care generalist services. This means that they often support

people whose needs are too complex for primary care, as well as people whose difficulties may not fit easily within diagnosis-specific or treatment-specific services. This generalist role can be useful because it allows CMHTs to work with diagnostic uncertainty, co-occurring difficulties and continuity across different aspects of care. However, it can also place pressure on CMHTs, particularly where specialist teams have clearer inclusion criteria and more defined roles (Laugharne et al., 2018).

This position can also make the boundaries of CMHT care difficult to navigate. Research on CMHT referral processes has suggested that access may be shaped by unclear referral criteria, inconsistent decision-making and subjective judgements (Chew-Graham et al., 2007). This is particularly relevant for people with complex needs, who may find themselves moving between services where they are viewed as too complex for primary care, but do not meet thresholds for specialist secondary care support (Dunn et al., 2024). These findings suggest that the generalist role of CMHTs needs to be understood in relation to the wider organisation of referral pathways and thresholds.

Recent service-level evidence suggests that there remains variation in how CMHTs are organised and understood. A rapid review of CMHT service models in Northern Ireland positioned CMHTs as a central part of secondary mental health care for people with moderate to severe and persistent mental health difficulties. The review also highlighted variation in CMHT structures, interventions, pathways and terminology, and identified a need for more consistent and equitable provision (Howie et al., 2025). This suggests that although CMHTs are central to secondary mental health care, there may be local differences in what they offer, how people access them and how their role is understood.

Recent policy frameworks can be understood as attempts to address some of these challenges. The Community Mental Health Framework for Adults and Older Adults (NHS England, 2019a) and the NHS Mental Health Implementation Plan 2019/20–2023/24 (NHS

England, 2019b) both emphasise more integrated, place-based and whole-person models of community mental health care. More recent proposals for 24/7 neighbourhood mental health centres in the Labour government's 10 Year Health Plan also suggest a continued aim to bring community, crisis and inpatient pathways into closer relationship (NHS England, 2026c). These developments indicate that CMHTs remain an important part of secondary mental health provision, while also being located within a system that continues to be reorganised.

The generalist position of CMHTs means that their role involves more than the provision of discrete interventions. They are also expected to hold complexity across diagnostic, social and service boundaries, coordinate support where multiple needs coexist, and maintain continuity in a system where specialist services may have narrower criteria. This suggests that the role of CMHTs cannot be understood only by describing what they provide, but also requires attention to how they are positioned within the wider mental health system.

What is a CMHT supposed to offer?

CMHTs are expected to offer support for people with more complex or enduring mental health difficulties. Their role commonly includes assessment, treatment, medication management, risk assessment, care coordination and review. They may also provide access to psychological interventions, occupational support, social care input, family or carer involvement and liaison with other services (NHS England, 2019a). This means that CMHT care is often broader than one specific intervention.

Care coordination is a central part of CMHT provision. Care coordinators often help to organise a person's care, maintain contact with the service user, review risk and need, and coordinate communication between professionals and services (Dada et al., 2025). This is important because people accessing CMHTs may be involved with several parts of the mental health system at the same time, including psychiatry, psychology, crisis services, inpatient

services, social care, housing or voluntary sector support. Wider healthcare research suggests that having a care coordinator can reduce problems with poorly organised care, conflicting information and lack of follow-up between services (Doty et al., 2012). However, within CMHTs, this role can become demanding where staff are managing complex needs, high caseloads and multiple service interfaces (Dada et al., 2025). CMHTs may also provide duty support, which offers a point of contact when a person's usual care coordinator is unavailable.

Policy frameworks also position CMHTs as services that should provide person-centred, recovery-oriented, trauma-informed and community-based care. Recovery-oriented approaches are based on the idea that people can be supported to live meaningful lives, including where symptoms or ongoing difficulties remain (Tew et al., 2007). Recovery-oriented care has also been critiqued where it becomes vague, professionalised or overly focused on individual responsibility, particularly if social, material and service-level conditions are not addressed (Harper & Speed, 2012). Trauma-informed care has also been described as an organisational change process, requiring attention to safety, trust, transparency, collaboration and the prevention of retraumatisation across service systems, rather than being limited to individual clinician qualities (Sweeney et al., 2018). Together, these approaches suggest that CMHTs are expected to support more than symptom reduction, with care also attending to relationships, social context, and people's wider lives.

However, these approaches can be easier to endorse in policy than to implement in practice. Using validated questionnaires across a range of NHS trusts, Leamy et al. (2016) found differences between team leaders', clinicians' and service users' views of recovery orientation, suggesting that services may be understood as more recovery-focused by those leading or delivering care than by those receiving it. Similar gaps have been identified in relation to service-user involvement in decisions about their care and treatment (Vitale & Mannix-McNamara, 2013). This pattern has also been identified in relation to risk

management, with most participants interviewed in Ahmed et al. (2024) reporting that they were not involved in identifying risks and were unaware of their risk management plans. These findings suggest that policy commitments to person-centred and recovery-oriented care may not always translate straightforwardly into everyday CMHT practice.

One way of understanding this is considering that these aims might be difficult to deliver in services shaped by demand, waiting lists, administrative requirements and limited resources. Recent NHS England data suggest that referrals to adult community mental health teams have increased faster than service capacity, contributing to long waits for care (NHS England, 2025). In response to this, some aspects of CMHT care may become more informational, including assessment, advice, signposting, care planning, risk documentation and information-sharing between professionals. These tasks can be useful, particularly where people need help to understand complex pathways and access support. However, when care becomes mainly organised through information, this can place responsibility on service users to manage their own distress once they have been given advice, a plan or signposting: recovery may be experienced as unsupported when it is not matched by sufficient relational or practical support (O'Keefe et al., 2018). This may be less helpful where distress is relational, social or shaped by material conditions such as poverty, trauma, isolation or housing insecurity. There is a risk, as Moth (2022) suggests, of mental health services increasingly shaped by bureaucracy, data management and depersonalisation, neglecting more relational forms of care.

This reflects wider tensions about what CMHT care should involve. Muusse et al. (2021) suggest that CMHTs can be shaped by different logics of care, including medical treatment, legal responsibility, care for the local community, relational care and bureaucratic accountability. In practice, these different ideas of care may sit alongside each other within the same team. CMHTs may therefore be expected to provide clinical treatment, respect

autonomy, respond to risk, build trusting relationships, coordinate with other services and meet organisational requirements around documentation and caseload management. This suggests that tensions in CMHT care may reflect competing assumptions about whether care is primarily understood as treatment, coordination, risk management, relational support or community connection.

Overall, CMHTs are positioned as services that should provide coordinated, recovery-oriented, person-centred and trauma-informed care for people with complex and enduring mental health difficulties. These aims sit within services shaped by demand, waiting lists, administrative requirements and limited resources. Understanding what CMHTs are supposed to offer therefore requires attention to both policy aims and how care is organised in practice. This is particularly important given that many people accessing CMHT support have relational, contextual and long-term needs that may be difficult to meet through information, signposting or discrete interventions alone.

Relational and Contextual needs of people accessing CMHTs

People accessing CMHTs often experience difficulties that are complex, enduring and shaped by wider relational and social contexts. Although CMHT patients are commonly described in relation to diagnostic categories, people may present with multiple overlapping needs across mental health, relationships, housing, finances, physical health and social support (Collins & Feely, 2018). This suggests that CMHT assessment and care planning need to consider the wider context of people's lives, as distress may be shaped by social adversity and relational difficulties alongside symptoms or diagnosis.

Attachment theory provides one way of understanding why relationships may be central to CMHT care. In its original form, attachment describes the relationship between a child and their caregiver (Bowlby, 1988). In secure attachment, the caregiver can provide a secure base for exploration and a source of safety during distress. Early caregiving

experiences can shape expectations about the self, others and whether support will be available when needed. This is relevant to CMHTs because many service users access support during periods of uncertainty, crisis or heightened vulnerability. For people who have experienced relational trauma, neglect or repeated disruptions in care, contact with services may activate expectations that support will be unavailable, inconsistent, intrusive or unsafe (Adshead, 2018). This means that the reliability and responsiveness of professionals may shape whether care feels safe and usable – and be essential to a positive experience of care.

Attachment theory has also been applied to the design and delivery of mental health services. Bucci et al. (2014) argue that many people with severe mental health difficulties have attachment needs that should be considered within general mental health services. From this perspective, services may provide a form of secure base through continuity, availability, sensitive responses to distress and clear boundaries. This does not mean encouraging dependence on services, but recognising that consistent and responsive relationships may support people to develop trust, manage distress and engage more safely with care. It also suggests that endings, transitions and changes in staff may be particularly significant for people who have experienced previous relational loss, disruption or inconsistency.

This is supported by a growing recognition that trauma and interpersonal adversity are important to identify among people accessing secondary mental health services (Hill et al., 2024), due to high rates of childhood maltreatment and adulthood victimisation among people with severe mental illness (Anderson et al., 2016). However, despite the prevalence of trauma histories among adults referred to secondary mental health services, there remains limited guidance on the most appropriate treatment format, timing and duration for people with complex and varied presentations, such as those who have experienced childhood sexual abuse (Carter et al., 2024). In the absence of clearly defined treatment pathways, the wider relational context of care may be especially important, requiring special attention to how

trauma and attachment histories shape experiences of trust, safety, collaboration and being understood.

These ideas also highlight why continuity may be relevant to CMHT care. Meaningful therapeutic relationships often require time to develop, particularly where people have experienced inconsistent or harmful relationships in the past. This may be especially relevant in CMHTs, where work with complex and enduring difficulties can involve navigating challenging relational dynamics (Kellett et al., 2020). Service users have described valuing empathic and consistent relationships with professionals (Kai & Crosland, 2001), while fragmented care, changes in staff and limited access to non-medicalised support can negatively shape experiences (Chase et al., 2012). In this context, reliability and being known may help support trust and make care feel more accessible. Research suggests that relational continuity can be beneficial for people with serious mental illness, particularly where responsiveness and stability are able to develop over time (Engström et al., 2023). However, these relational processes may be harder to maintain in services affected by staffing pressures, high caseloads, administrative demands, staff turnover, transitions and difficulties with information-sharing (Belling et al., 2011), with more recent research suggesting that such systemic barriers disrupt therapeutic relationships (Iverson et al., 2025). This makes continuity an important context for understanding how people experience CMHTs.

The wider social context of people's lives is also important. People with severe mental illness may experience high levels of social exclusion, including loneliness, unemployment, stigma, reduced access to valued roles and limited community participation (Henderson et al., 2026). Social capital, personal support networks and community participation have also been linked to recovery and wellbeing for people with severe mental health difficulties (Ngamaba et al., 2023). These experiences may be particularly important for people with trauma or attachment difficulties, as social exclusion can reduce access to other sources of safety,

belonging and practical support. Earlier research suggests that services may provide more support with mental health symptoms than with personal, social or practical needs, even where these difficulties may limit improvements in mental health (Wakefield et al., 1998). More recent reviews suggest that these difficulties continue to be insufficiently addressed for people with severe mental health difficulties (Killaspy et al., 2022). This suggests that community-oriented care may need to involve actively supporting access to social networks, valued roles and meaningful activities, alongside signposting to external resources (Webber et al., 2015).

These relational and contextual needs also shape how psychological provision within CMHTs might be understood. If many people accessing CMHTs have difficulties shaped by trauma, attachment, social adversity and disrupted relationships, psychological support may need to attend to more than symptom reduction. It may also need to support meaning-making, emotional regulation, relational safety, identity and connection. This links to the focus of the systematic review within this thesis, which explored experiences of psychological intervention for people with complex or relational trauma. Understanding these experiences is relevant to CMHT care because psychological interventions may offer one way for services to respond to trauma and relational needs, although their usefulness is likely to depend on whether they feel accessible, safe, collaborative and connected to wider care.

Psychological provision within CMHT contexts

Psychological provision is one way in which CMHTs may respond to the complex, relational and contextual needs of service users. This can include individual therapy, group interventions, psychoeducation, formulation, consultation with teams, and supervision for non-psychology staff delivering brief psychological interventions. Psychological input may be integrated within the CMHT or offered through separate secondary care pathways,

meaning that access can vary depending on local service models, referral processes, waiting lists and staffing.

Although psychological therapies can be helpful for people with severe and enduring mental health difficulties (Lincoln & Pedersen, 2019), their availability within CMHTs is often inconsistent. A systematic review found substantial variation in the implementation of CBT for psychosis (CBTp) and family intervention (FI) across routine UK mental health services, with provision frequently remaining below recommended levels, including within CMHTs (Ince et al., 2016). Among the CMHT studies included in the review, offer rates for CBTp ranged from 4% (Lewis et al., 2012) to 15% (Prytys et al., 2011) and offer rates for FI ranged from less than 1% (Lewis et al., 2012) to between 9 and 12% (Kuipers et al., 2011). Prytys et al. (2011) specifically identified barriers within CMHTs including workload and time pressures, limited specialist capacity, gaps in staff knowledge and training, and pessimistic beliefs about recovery. Together, these findings suggest that evidence-based recommendations do not necessarily translate into consistent access to psychological provision in everyday CMHT practice.

Access may also be shaped by assumptions about who is considered suitable or ready for therapy. Research suggests that referrals to psychological therapies can be influenced by ideas about the "ideal" therapy patient, including compliance, initiative and psychological insight, alongside organisational procedures, informal referral systems and resource pressures (Fiddick et al., 2020). This is important because people with complex trauma, social adversity or difficulties with trust may not always fit neatly within these assumptions.

Within pressured services, psychological provision may become shorter, more structured or more focused on stabilisation. Brief psychological interventions have been developed in secondary care settings to increase access and provide targeted support, including a transdiagnostic intervention focused on distress tolerance and skills development

within an adult CMHT (Wright et al., 2020). These approaches may be useful, particularly when people are waiting for more specialist therapy. However, for people with histories of complex or relational trauma, the usefulness of psychological intervention is likely to depend on more than its formal content. Research on psychological therapy within CMHT contexts suggests that timing, trust, emotional safety, flexibility and the wider service context all shape whether therapy feels helpful (Sale et al., 2024). Disengagement from trauma therapy may also be shaped by wider difficulties such as depression and living conditions (Hayward et al., 2023), suggesting that therapy cannot be separated from people's broader context.

Group-based and psychoeducational interventions may offer one way of increasing access to psychological support, while also providing opportunities for shared understanding, normalisation and peer connection. However, for these interventions to be appropriate in CMHTs, it is important to understand how people with histories of complex or relational trauma experience group psychoeducational interventions. The systematic review chapter below aimed to address this gap in the literature.

What does existing research say about experience of CMHTs?

The literature reviewed so far suggests that CMHTs occupy a central but complex position within secondary mental health care. They are expected to provide coordinated, person-centred and community-based support for people with complex and enduring mental health difficulties, while operating within a system shaped by repeated reorganisation, rising demand and fragmented pathways (Sambrook et al., 2025). Existing research has identified recurring concerns about the accessibility, responsiveness, and consistency of community mental health care (Newman et al., 2015). However, much of this research focuses on specific aspects of care (Naik et al., 2025), particular diagnostic groups (Trevillion et al., 2022; Hat et al., 2022), professional perspectives (Henderson et al., 2020) or specialist community teams (Wright et al., 2011). There remains less research exploring how people

experience generic CMHT care, including the role CMHTs play within the wider mental health system.

Understanding service user experience is important because people may be under CMHTs during prolonged, complex and vulnerable periods of their lives. Experience is also more than satisfaction with a service. It may shape trust, engagement, help-seeking, continuity and whether people feel supported by care. A systematic review of mental health service experience suggested that people may report moderate satisfaction while still describing difficulties with access, treatment choice, fear about how services function, participation and continuity of care (Newman et al., 2015). Quantitative measures (Carra et al., 2022), national surveys (Care Quality Commission, 2026) and routine outcome data (Solstad et al., 2019) can provide important information about symptoms, wellbeing and satisfaction, but they may not examine the relational, organisational or contextual processes through which care is delivered and experienced (Murdoch et al., 2023).

This is particularly important during a period of ongoing community mental health transformation. The Community Mental Health Framework for Adults and Older Adults (NHS England, 2019a) has now been in place for several years, while more recent NHS policy continues to emphasise moving care closer to communities (NHS England, 2026c). At the same time, many services are still adapting their models of care, including how care coordination, duty systems, psychological provision and wider community support are organised. The impact of COVID-19 also changed how care was delivered internationally including the UK (Stepanova et al., 2024), with remote and hybrid contact raising questions about therapeutic relationships, continuity and recovery-focused practice. Qualitative research can therefore help examine whether policy and organisational changes are experienced as meaningful improvements in care, and whether longstanding difficulties are reproduced through new service arrangements.

There is also an ethical reason to attend closely to experiences of community care. While institutional harm in mental health services has often been considered in relation to inpatient settings, recent work has argued that neglect and harm in community mental health services require greater attention (Edwards et al., 2025). This does not mean assuming that CMHT care is harmful, but it highlights the importance of understanding how care is experienced by those relying on community services. This is particularly relevant where people may have complex emotional, relational or trauma-related needs, as research with people using community mental health services for complex emotional needs has highlighted the importance of non-stigmatising, individualised, trauma-informed, collaborative and consistent care (Trevillion et al., 2022).

Taken together, this suggests a need for qualitative research that explores experiences of generic CMHT care in depth. Existing studies provide important insights into access, continuity, relationships, decision-making and social context, but these areas are often examined separately. This study therefore aimed to explore how people experience care from generic CMHTs, with particular attention to what is experienced as helpful, unhelpful and meaningful, and how these experiences are shaped by service structures, relationships and wider systemic pressures.

Research Aims and Objectives

This project aims to explore service users' experiences of accessing care from generic community mental health teams and the factors that impact their experiences of care. This includes individual, service-related, and wider systemic factors that impact a person's experience of care.

Areas of interest include the patient experience of being referred to a CMHT, the assessment process, the wait for treatment, transitions between types of treatment, and experiences of treatment itself. This project also aims to explore the interventions offered to

the patient and any additional support that they accessed outside of interventions. It also explores patient experiences of relationships or interactions with staff.

Systematic Review

Chapter Overview

This chapter presents a systematic review and thematic synthesis of qualitative research exploring how adults with histories of complex or relational trauma experience group psychoeducation-based interventions. It begins by outlining the psychological and interpersonal effects of complex trauma and considering the relevance of attachment, safety, trust and emotional regulation to psychological intervention. The chapter then reviews the role of stabilisation, psychoeducation and group-based approaches within trauma treatment, including their use within NHS and secondary care services. Following a systematic search, quality appraisal and thematic synthesis, four themes are presented: Creation of a Safe Space, Finding Understanding, Journey of Developing Skills, and After the Group. The findings suggest that group psychoeducation was experienced as a structured, relational and experiential form of support, in which safety, shared understanding, skills practice and gradual integration worked together to support change. The chapter discusses these findings in relation to phase-based trauma models, attachment theory and trauma-informed care, while also considering the limitations of the evidence base, clinical and research implications.

Introduction

Complex Trauma and Psychological Distress

Complex trauma is commonly understood as exposure to repeated or prolonged traumatic experiences that threaten a person's sense of safety (Harris et al., 2024). It is often distinguished from single-incident trauma, which may involve discrete traumatic events such as accidents, assaults or disasters. Non-interpersonal trauma is also sometimes differentiated from trauma occurring within close relationships or caregiving contexts, which are more strongly associated with difficulties beyond core PTSD symptoms alone (Lewis et al., 2021). Complex trauma is particularly recognised in relation to childhood maltreatment, abuse and

neglect within caregiving relationships (Paivio & Angus, 2017). However, relational trauma may also occur in adulthood, particularly where later experiences recreate or activate earlier attachment patterns (Shaver & Mikulincer, 2014; Barazzone et al., 2019).

Attachment theory provides one way of understanding the psychological and interpersonal impact of complex trauma. Attachment describes the relationship between a child and caregiver, where the caregiver provides a secure base for exploration and a source of safety during distress (Bowlby, 1988). When caregiving relationships are disrupted by abuse, neglect or threat, this can affect how safety, trust and relationships are experienced across development.

Complex trauma has been associated with difficulties in emotion regulation (Carvalho Fernando et al., 2014), dissociative experiences (Dugal et al., 2016), challenges with mentalising (Huang et al., 2020), and a fragmented sense of self (Lim & Seo, 2025). It often impacts a person's interpersonal functioning throughout their life and increases their vulnerability to being further victimised (Thoresen et al., 2015). These difficulties are relevant to psychological intervention because therapy may involve closeness, vulnerability, emotional exposure and trust in others. For some people, therapeutic relationships or group settings may therefore activate fears relating to rejection, dependence, shame or emotional overwhelm, while also creating opportunities for safety, validation and connection.

There remains debate about how complex trauma should be conceptualised, including its relationship to complex post-traumatic stress disorder (C-PTSD), a specific diagnostic category included in the ICD-11 (World Health Organisation, 2019). Some debate relates to whether complex trauma is best understood diagnostically, developmentally or relationally, and how far it overlaps with other forms of psychological distress (Thain et al., 2024). Questions have also been raised about the extent to which experiences associated with diagnoses such as borderline personality disorder may be reframed through trauma-based

understandings, and whether this risks obscuring important differences between forms of distress (Paris, 2023). However, there is broad recognition that traumatic and adverse interpersonal experiences are common among people accessing mental health services and may contribute to severe and enduring mental health difficulties (Mauritz et al., 2013; Alvarez et al., 2011). This makes it important to consider how psychological interventions for complex or relational trauma are experienced by those receiving them.

Interventions for mental health difficulties following complex trauma

A number of psychological approaches are used to support people following complex trauma. Trauma-focused CBT and EMDR are recommended within NICE guidance for PTSD and CPTSD (National Institute for Health and Care Excellence, 2018), although the guidance acknowledges there is less evidence for how interventions should be adapted for complex trauma presentations. This means that clinicians often need to work flexibly, drawing on clinical judgement and adapting interventions. Multicomponent or phase-based approaches have also been recommended for complex trauma (Darby et al., 2023). These approaches are often informed by Herman's (1992) three-phase model of trauma recovery, which begins with safety and stabilisation in phase 1. Phase 2 moves towards processing traumatic memories and associated emotions, while Phase 3 focuses on reconnection with relationships, everyday life and a broader sense of self.

The first phase of treatment often focuses on psychoeducation, emotional regulation, grounding, stabilisation and the development of coping skills. This phase is intended to increase safety and daily functioning before more direct trauma processing may be undertaken. This may be particularly important for people who experience emotional dysregulation, dissociation or interpersonal difficulties, as these may make trauma processing harder to tolerate without sufficient preparation. However, there remains debate about whether phase-based approaches are more effective than trauma-focused approaches that

move more directly into trauma processing (Darby et al., 2023; Svircevic & Berle, 2025). Concerns about tolerability, distress and drop-out have also contributed to arguments for flexible treatment options that can be adapted to the person's presentation, preferences and readiness (Gjestad et al., 2024; Lewis et al., 2020).

Stabilisation and psychoeducational interventions may be delivered individually or in groups. Individual formats can allow for greater personalisation and flexibility, while group formats may offer opportunities for normalisation, peer support and the development of interpersonal skills (Yalom & Leszcz, 2020). This may be particularly relevant for people with histories of relational trauma, where difficulties with safety, trust and connection are central (Herman, 1992). Group psychoeducation may therefore provide both information about trauma and opportunities to experience shared understanding (Deblinger et al., 2016). However, the group context may also involve vulnerability, comparison, emotional exposure and uncertainty about how much to share. For some participants, hearing others' experiences may feel validating and reduce shame or isolation, while for others it may feel overwhelming or emotionally activating. The usefulness of group-based interventions may therefore depend on how safe, paced, collaborative and containing they feel (Yalom & Leszcz, 2020).

Use of Group Interventions in NHS services

Within NHS services, group-based psychoeducational interventions may also have practical benefits. Demand for psychological therapy often exceeds capacity, and group formats may be used to increase access. Group interventions have been described within secondary care and CMHT settings, including compassion-focused, dialectical behaviour therapy skills-based and anxiety management groups (Dafters et al., 2022; Murphy et al., 2018; Rosier et al., 1998). Carter et al. (2024) evaluated a group intervention for women referred to secondary care community mental health psychological services for difficulties relating to childhood sexual abuse, with groups delivered through local CMHT bases. This is

consistent with the researcher's clinical experience that group-based approaches often form part of CMHT-linked psychological provision for people with relational trauma. Their apparent practicality and cost-efficiency may make them particularly appealing within pressured services. It is therefore important to understand whether group psychoeducation is experienced as helpful and meaningful, as well as how it functions as a practical way of increasing access to support.

Rationale for present review

Group psychoeducational interventions are commonly used within services and may represent one of the first psychological interventions offered to individuals with complex trauma. However, outcome studies provide limited understanding of how these interventions are experienced, the processes through which they may support change, and the factors that influence engagement. In addition, group psychoeducation encompasses a wide range of interventions, differing in theoretical model, structure, level of therapist involvement, and emphasis on skills development versus interpersonal sharing, which may shape participants' experiences and perceived usefulness. Given that relational trauma can disrupt experiences of safety, trust and expectations of others (Hickle & Lefevre, 2022), understanding participants' subjective and interpersonal experiences of these group settings is particularly important. Synthesising qualitative research may therefore offer clinically useful insight into how these groups function and for whom they are most beneficial.

The present review aims to systematically identify and synthesise qualitative studies exploring adults' experiences of group psychoeducational interventions for complex or relational trauma. Consistent with a critical realist position, the review seeks to examine both reported experiences and the potential mechanisms underlying them.

Method

The review process was informed by PRISMA guidelines (Page et al., 2021). It consisted of three stages: a systematic literature search, a quality assessment of identified papers, and a thematic synthesis of the included studies' findings.

Search Strategy

A systematic search was conducted on 7th December 2025 through EBSCOhost accessing four databases: MEDLINE Ultimate, APA PsycArticles, APA PsycInfo and CINAHL Ultimate. A SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type) was used to identify core concepts relating to the project and the elements of Sample, Phenomenon of Interest and Research Type were chosen to guide the search strategy (Cooke et al., 2012). Search terms were identified through the review of previous relevant literature and clinical knowledge of the lead researcher and supervisor, particularly when it came to identifying potentially relevant intervention types.

Search String

The search terms were organised into three concepts relating to complex or relational trauma, group delivery, and structured or psychoeducational interventions. The complete search strategy and the combinations used are presented in Table 1.

Table 1
Search Strategy

Search Line	Search Terms
S1: Complex or relational trauma	((Child* OR sex* OR physical* OR relation* OR psych* OR "early* life" OR complex* OR develop* OR interpersonal) N3 (Trauma* OR abus* OR stress* OR advers* OR maltreat*)) OR (post*trauma* OR PTSD) OR (adverse childhood experience* OR aces OR neglect OR victimisation)
S2: Group intervention	group N5 (therap" OR treatment* OR intervention* OR program* OR psycho*education OR skill* OR support)

S3: Psychoeducational group intervention	(DBT OR "dialectical behavio***" OR MBT OR "mentalization-based" OR CBT OR "cognitive behavio*r*" OR "cognitive therap*" OR ACT OR "acceptance and commitment" OR CFT OR "compassion-focused" OR "schema therap*" OR EMDR OR "eye movement desensitizing and reprocessing" OR "STEPPS" OR "systems training for emotional predictability and problem solving" OR "trauma stabilis*" OR "emotion* regulat*") OR (manual* OR structur* OR brief OR protocol OR standard*)
S4:	S2 AND S3
S5: Final search	S1 AND S4
Database limits applied:	adulthood (18yrs and older) Focus group, interview, qualitative study

Study Selection

3,372 studies were retrieved from the initial search prior to deduplication. These were deduplicated automatically when imported into EndNote 25, leaving 3,306 studies. EndNote 25 also scanned for duplications, finding an additional six to be removed. The titles and abstracts of the remaining 3,300 articles were screened, which identified 81 for potential inclusion. The full texts were retrieved for 80 of them (one could not be retrieved), and these were screened against the inclusion and exclusion criteria (See Table 2). Reference and citation searching of included papers and relevant systematic reviews was completed to ensure all relevant papers were identified, leading to one additional paper. In total, 11 papers were identified as eligible for this review. The study selection process is presented in a PRISMA flow diagram (see Figure 1).

Figure 1
PRISMA Flow Diagram

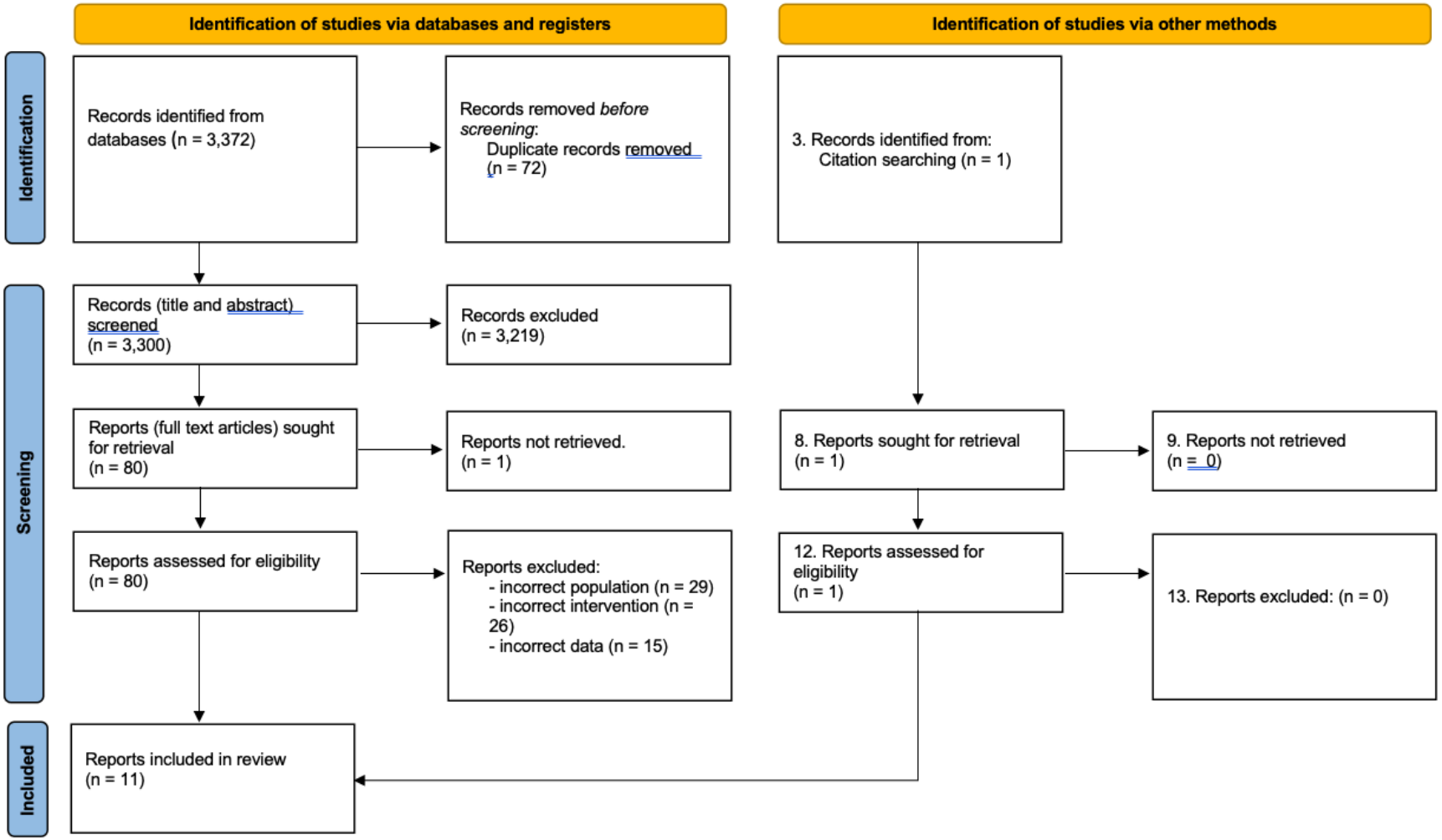


Table 2
Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Adult participants with a history of complex trauma. This was identified through an explicit description of complex trauma or repeated/prolonged interpersonal trauma, such as childhood abuse, neglect or domestic violence. • Transdiagnostic treatment as long as there is an assessment of trauma history to indicate complex trauma • Manualised mental health group intervention with an element of psychoeducation included • Qualitative research • Mixed methods where the qualitative component involves an interview or focus group	• Incorrect population: staff, carers, parents, perpetrators of abuse, veterans, people with intellectual disability • Incorrect intervention: Support groups, psychotherapy groups, parenting groups, intervention focused on physical health, combination of group and individual intervention sessions • Non-peer reviewed research, case studies

Data Extraction and Synthesis

The key characteristics of each study were extracted and are summarised in Table 3. The synthesis followed the approach described by Thomas and Harden (2008), which is designed to integrate multiple sources of qualitative evidence by generating themes across the data. NVivo 15 qualitative analysis software was used to support organisation and management of the data. All relevant sections from included papers labelled as 'Findings' or 'Results' were imported into NVivo as individual sources.

Table 3
Data Extraction Table

Author, Date & Country	Participants	Age	Sex	Ethnicity	Aim of Paper/ Intervention Type	Data collection & analysis method	Key findings
Ashfield et al. (2021) UK	11 people with a diagnosis of complex PTSD in a specialist PTSD service	22-62	11 F	10 White, 1 Mixed race	Compassionate-Resilience group Exploring the mechanisms of change and how being in a group impacts on treatment process	Interviews Constructivist grounded theory	Experiences prior to attending the group The change process Personal changes
Corbett et al. (2024) Australia	11 people with experiences of intimate partner violence	20-70	11 F	9 Caucasian, 2 Culturally and Linguisticall y Diverse	Shark Cage group empowerment program Explore program experience of regional and rural victim/survivors	Participant observations and semi-structured interviews Thematic analysis	The transformative potential of safe space and shared experience Fostering healing and empowerment Navigating materiality
De Boer et al. (2023) Australia	6 people with histories of complex trauma, out of 14 from quantitative data	36.7 (average)	6 F	Unknown.	Women's Trauma Recovery Program Explore acceptability of program and	Semi-structured interviews Mixed methods with interpretive phenomenologic al analysis	Empowerment: the experience in Phase 1 Recovery: an ongoing process "Hey, I'm human": connection through shared experience

					characterised impact of intervention on symptoms		
Gnatt et al. (2025) Australia	5 people with a history of trauma and meeting criteria for an eating disorder	22-60	5 F	Unknown	Compassion-focused group intervention Assess feasibility and acceptability of intervention	Semi-structured interviews Mixed method with inductive content analysis	Factors facilitating engagement Building skills related to both eating disorders and PTSD Changes in symptoms Practical and relationship factors
Hegarty et al. (2022) UK	10 outpatients with CPTSD relating to CSA	26-60	10 F	6 White British, 1 White other, 1 Black Caribbean, 1 Middle Eastern, 1 North African	Recovering from Child Abuse Program Factors influencing the acceptability of the program and potential mechanisms underlying therapeutic change	Transcript of therapy sessions with verbal feedback at the end of each session. Written feedback forms Reflexive thematic analysis	Solidarity of the group context Therapeutic facilitation Adapting to telehealth
Jackson et al. (2024) UK	13 people attending NHS Scotland Adult Psychology Outpatient Service	19-62	13 F	Unknown	Survive and Thrive, a 10 week psychoeducation course for adult survivors or interpersonal trauma Explore experience of	Semi-structured interviews. Interpretative Phenomenological Analysis	Sense of connectedness Journey towards recovery Facing the facts and triggers Initial apprehension Sense of being let down

					understanding female survivors' experiences of psychoeducation courses		
Karatzias et al. (2014) UK	8 completers and 8 non-completers of Survive and Thrive program, out of 37 from quantitative data	Unknown Full sample: 38.3 (average)	Full sample: 4 M 33 F	Unknown	Survive and Thrive, a 10 week psychoeducation course for adult survivors or interpersonal trauma Supplement and explain quantitative data and for information on patient experience of the intervention	Semi-structured interview Mixed methods, with interpretative phenomenological analysis	Apprehension before program Completers identified helpful parts including it being a learning experience and support from other group members Non-completers identified a mismatch between the intervention offer and their preferences and difficulties with group dynamics
Powers et al. (2023) USA	17 people with chronic trauma exposure and symptoms of PTSD, from a wider sample of 33	46.5 (average)	14 F 3 M	17 Black/ African American	8 week adapted mindfulness based cognitive therapy group Examine the feasibility and acceptability of the intervention	Post-assessment interview Mixed methods, with narrative analysis	Satisfaction Acceptability of Intervention Format Perceived Benefits of MBCT Group Participation Barriers to General and MBCT-Specific Treatment Engagement
Røberg et al. (2018) Norway	5 out of 6 people attending a stabilizing trauma group	29-64	5 M	5 Norwegian	22 week psychoeducation trauma stabilization group	Semi-structured interview	Group Atmosphere Learning Motivation

					Examine how male victims experience a male-only trauma-stabilizing group	Interpretative Phenomenological Analysis	Structure Gender
Stige et al. (2013) Norway	13 participants with a history of multiple traumas, starting before the age of 5	18-60	13 F	Unknown	17 week trauma stabilization group. Exploring clients' experiences of participating in an inclusive stabilization group approach	Interviews Hermeneutic Phenomenological Analysis	Dreading and Hoping – preparing for participation Tuning in and staying put Meeting other trauma survivors Acquiring a Stabilizing Ballast Being Receptive to Change
Stige & Binder (2017) Norway	13 participants with a history of multiple traumas, starting before the age of 5	18-60	13 F	Unknown	17 week trauma stabilization group. Experience of the inclusion of skill training and concrete tools in treatment, the way of relating to and using these skills, and how this changed over time	Interviews Hermeneutic Phenomenological Analysis	Being Ready to Find New Ways to Deal with Trauma-Related Problems as a Motivational Starting Point at Intake Finding New Agency Through Skills and Understanding One Year on – Meeting the Everyday World in a New Way

The first stage involved free line-by-line coding of the findings sections of the included studies. Codes were inductively generated from the data rather than from predetermined categories. The synthesis included both first-order data (participants' own accounts, presented as quotations in the primary studies) and second-order data (the original authors' interpretations of participants' experiences). Both were coded, and as the analysis progressed, codes were continually compared across papers and refined to maintain consistency. Second, related codes were grouped together to form descriptive themes, which were reviewed against the original data to ensure they reflected the range of experiences across studies. Finally, analytical themes were developed to go beyond the original findings by considering relationships between these descriptive themes. Early themes focused on relationships, shared experiences, skills, change and the group environment, before being organised around broader processes of safety, connection, understanding, empowerment and growth. The distinction between processes occurring within the group and experiences after it became clearer later in the analysis, contributing to the final thematic structure and overarching narrative.

Results

Study Characteristics

Eleven studies published between 2014 and 2025 met inclusion criteria. These were conducted across a range of high-income countries, including the UK (n = 4), Australia (n = 3), Norway (n = 3), and the USA (n = 1), reflecting some diversity in service contexts while remaining broadly comparable in terms of healthcare systems and resources. Most studies involved exclusively female participants (n = 7), with one study including only male participants and two involving mixed-gender samples, one of which where the intervention was delivered in same-sex groups.

Data collection methods were predominantly qualitative interviews, used in nine studies, with one study also incorporating direct observations of intervention sessions. One further study relied primarily on session observations, supplemented by verbal and written participant feedback. Two studies drew on the same participant cohort but explored different aspects of the experience of the intervention, and one also included additional follow-up interviews after one year. Interventions varied in theoretical orientation and focus, including an empowerment-based programme (n = 1), compassion-focused approaches (n = 2), a mindfulness-based cognitive therapy intervention (n=1), trauma recovery programmes (n = 2), stabilisation-focused groups (n = 3), and the "Survive and Thrive" model (n = 2), which is a manualised group-based psychoeducation intervention developed for adults affected by prolonged or repeated interpersonal trauma.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) checklist was used to evaluate the quality of the included studies (CASP, 2018). Appraisals were completed by the lead researcher. Due to the limited number of qualitative articles looking at patient's experiences of psychoeducational groups, papers were not excluded based on their quality. Instead, the quality assessment aimed to understand the quality of research in this area and use this to contextualise and critique conclusions drawn from this review. Ratings are presented in Table 4. None of the included studies met all CASP criteria: one met 9/10 criteria, five met 8/10, one met 7/10, two met 6/10 and two met 4/10.

All studies provided a clear statement of aims and rationale for adopting a qualitative approach, and all but one adequately justified the research design in relation to their stated aims. Reporting of recruitment procedures was more variable, with three papers providing limited detail, particularly regarding how participants were approached and reasons for non-participation.

Data collection processes were described clearly across all studies. However, only one study explicitly discussed data saturation, with the absence of such consideration in other papers likely reflecting the small and specific participant populations available within clinical services. The relationship between the researcher and the participant was not considered in the majority of papers. Whilst some referred to reflexivity checks without explaining how these influenced analysis, only two studies demonstrated clear reflexivity. Approximately half of the studies did not address reflexivity or researcher positioning. Although this does not necessarily undermine the findings, it limits transparency about how researchers' assumptions, professional roles and relationships with participants may have shaped the interpretations produced.

Ethical considerations were reported inconsistently. Five studies discussed the ethical considerations of their methodology, four only reported that they had received ethical approval, one was conducted as a service evaluation and therefore did not undergo formal ethical review but documented local research and development approval, and one only reported ethical approval in the footnotes.

Analytic procedures were generally described and appeared sufficiently rigorous. Where transparency was weaker, this was predominantly within mixed-methods studies in which qualitative findings were secondary to quantitative outcomes and analysis was more descriptive, with limited explanation of how the interpretations were derived from the data. Findings were usually clearly presented, although two mixed-methods papers reported qualitative findings only briefly within a summary paragraph.

Despite methodological variability, all studies provided useful insights and practical implications relating to participants' experiences of group psychoeducational interventions. No studies were excluded following quality appraisal, as each contributed relevant data. The relative lack of qualitative depth in some mixed-methods studies appeared to reflect the

broader emphasis on quantitative evaluation within intervention research rather than a complete absence of experiential findings.

Table 4

Quality Assessment Ratings using the Critical Appraisal Skills Programme (CASP) Checklist

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Number of criteria met
Ashfield et al. (2021)	✓	✓	✓	✓	✓	✗	?	✓	✓	✓	8/10
Corbett et al. (2024)	✓	✓	✓	✓	?	✗	✓	✓	✓	✓	8/10
De Boer et al. (2023)	✓	✓	✓	✓	?	✗	✓	✓	✓	✓	8/10
Gnatt et al. (2025)	✓	✓	✗	?	?	✗	✓	?	?	✓	4/10
Hegarty et al. (2022)	✓	✓	✓	✓	?	✓	?	✓	✓	✓	8/10
Jackson et al. (2024)	✓	✓	✓	?	?	✗	?	✓	✓	✓	6/10
Karatzias et al. (2014)	✓	✓	✓	?	?	✗	?	✗	?	✓	4/10
Powers et al. (2023)	✓	✓	✓	✓	?	✗	?	?	✓	✓	6/10
Røberg et al. (2018)	✓	✓	✓	✓	?	✗	?	✓	✓	✓	7/10
Stige et al. (2013)	✓	✓	✓	✓	?	✗	✓	✓	✓	✓	8/10
Stige & Binder (2017)	✓	✓	✓	✓	?	✓	✓	✓	✓	✓	9/10

Note. ✓ = criterion met; ✗ = criterion not met; ? = insufficient information to determine.

Thematic Synthesis

Four main themes were generated from the thematic synthesis of the data: 'Creation of a Safe Space', 'Finding Understanding', 'Journey of Change', and 'After the Group'. These were further divided into 12 sub-themes. A summary and distribution of the themes and subthemes is presented in Table 5.

1. Creation of a Safe Space: How a sense of safety allows for exploration

Across almost all of the studies, groups were emphasised as "a space that enabled safe exploration of their symptoms and internal experiences" (de Boer et al., 2023) in a supportive and contained environment. This sense of safety developed through relationships between group members and the structure and facilitation of the intervention, although differences around disclosure could make this harder to maintain.

1.1 Anxiety about exploring traumatic experiences

The studies frequently described participants' anxiety at the beginning of the group. Many participants described feeling fearful of thinking about their traumatic memories and would "avoid" doing it where possible (Powers et al., 2023), including during therapeutic tasks (Hegarty et al., 2022). This also came from the uncertainty of doing this "in front of strangers" (Powers et al., 2023).

Additionally, some studies reported that it could be distressing to listen to other people's experiences (Ashfield et al., 2021). There was a worry about how this anxiety impacted their ability to engage in the group. Some papers explored worries that they would "hold onto everything so tightly. Terrified to say something or to share something" (Stige & Binder, 2017). Another study explored how listening to others' experiences could make it harder to concentrate on the content of the session (Hegarty et al., 2021). However, as the group progressed, many studies reported how a feeling of safety was created, which allowed them to begin to explore these experiences. This feeling of safety was created in two ways:

through the participants' relationships with each other, and through the way that the intervention was structured through codeveloped rules and expectations (Corbett et al., 2024).

Table 5

Summary and Distribution of Themes and Subthemes

	Ashfield, et al. (2021)	Corbett, et al. (2024)	De Boer, et al. (2023)	Gnatt, et al. (2023)	Hegarty et al., (2022)	Jackson et al. (2024)	Karatzias et al. (2014)	Powers et al. (2023)	Roberg et al. (2018)	Stige et al. (2013)	Stige & Binder , (2017)
1. Creation of a Safe Space											
1.1 Anxiety about exploring traumatic experiences											
1.2 Relational Safety											
1.3 Structural Safety											
2. Finding Understanding											
2.1 Connection to others											
2.2 Connection to information											
2.3 Connecting with the present											
3. Journey of Developing Skills											
3.1 Experience of Learning											
3.2 Integrating learning into everyday life											
3.3 Hard work made easier by learning together											
4. After the Group											
4.1 Feeling a change in the real world											
4.2 It takes time											
4.3 Can't help everything											

1.2 Relational Safety

Of particular importance across almost all papers was the importance of building relationships with other group members (Røberg et al., 2018). This may be related to past attempts of exploring their experiences with others that often left them feeling "stigmatized" and "isolated in their struggles" (Ashfield et al., 2021).

Across most papers, this feeling of safety initially appeared to develop through the knowledge that other participants "were there for the same reasons as me" and this gave "me a bit more confidence to speak up in a group because we were there all for the same reason" (Jackson et al., 2023), as it was felt that the people around them understood their experiences. Participants also appreciated that they did not need to share too many details about their experiences to be understood and that they felt that they wouldn't be "judged for being inarticulate" (Corbett et al., 2024).

In some studies, it was felt that participants' shared experiences of adversity were prioritised over their differences, including allowing participants to "transcend cultural differences" in one paper (Hegarty et al., 2022). However, other studies described the safety that was experienced through all participants being the same gender, as it was felt that it was "easier to open up when it is a men only group and stop to think: 'What will she think about me when I say this'" (Røberg et al., 2018).

Additionally, many participants reported that as the group progressed, validating and accepting responses from group members helped them to feel safe whilst sharing as they felt understood and cared for.

> You just knew that we all had the same feeling for each other, that none of us wanted the other person to feel any more pain and if we could take it away we would because we know what it feels like. (Ashfield et al., 2021)

However, three papers spoke about how it was also necessary to navigate the different opinions within the group about the "degree to which group members should be allowed to share their personal experiences" (Hegarty et al., 2022). Some studies reported that participants felt that they would prefer a greater focus on sharing experiences (Karatzias et al., 2014), whereas others reported that they preferred to not share about their experiences (Stige et al., 2013). Another reported that there could be confusion about the purpose of the group as "I'm not sure if this group is for learning or sharing our troubles. I don't want to hear other traumas. I want to learn" (Hegarty et al., 2022). In one paper, some participants also found it difficult to feel heard or acknowledged as "when you talked about what you consider as important things, three of the other participants interrupted you and told things important to them. So, it was too little time for each of us perhaps" (Røberg et al., 2018).

1.3 Structural Safety

These differences highlighted the importance of structural elements of the intervention in helping to create a feeling of safety when exploring their experiences with other people, which was discussed in the majority of the papers.

> The structure, rhythm and repetition of the meetings were things that all participants appreciated and mentioned as important in their experience of a secure frame, repeating a certain pattern every time: We came, we logged on, as we called it, said hello to each other … chatted a little about what we had done at home last week … So it just went that way, and it was very good. (Roberg et al., 2018)

Many papers highlighted the role of the group facilitators, who were felt to provide a compassionate and containing space (Ashfield et al., 2021) that helped to structure sessions and manage the function of disclosure within the space. For many, this helped participants feel able to choose how they participated in the group (Corbett et al., 2024) and "helped with confidence to open up about their experiences" (Jackson et al., 2023). However, in one paper,

some participants felt a sense of pressure “to be more open” (Røberg et al., 2018) from the therapist during group session. Whilst some appreciated this, others “did not see the meaning in being pushed” (Røberg et al., 2018).

Some papers highlighted how clear group rules and boundaries increased feelings of “psychological safeness” (Ashfield et al., 2021), as “it was clear from the start that we weren’t expected to share our absolute story” (Corbett et al., 2024). These rules also allowed other participants to prepare themselves before disclosures and learn to regulate themselves in response (Hegarty et al., 2022). Additionally, group rules often stressed the importance of confidentiality, which helped to increase a sense of “trust”, as “What you tell in the group stays in the group” (Røberg et al., 2018), particularly when there may have been overlapping personal connections (Corbett et al., 2024).

However, a few papers described that there could still be difficulties when it felt that some members of the group would not follow the rules and would “overshare” (Jackson et al., 2023), leading others to feel triggered and compromising the feeling of relational safety “as she didn’t wish to invalidate the other group member’s experience: ‘It triggered me but I felt bad stopping them from talking’” (Hegarty et al., 2022).

2. Finding Understanding: Reconstructing the meaning of their experiences through connection

Across all of the papers, experiences within the group seemed to change how participants understood and made sense of their past traumatic experiences, through both their connections to other members of the group, their present experience, and also through psychoeducation. This particularly contributed to a sense of beginning to feel “normal” (Stige et al., 2013) and a “shift in internalized self-blame” (Corbett et al., 2024).

> Just because I feel guilty about something does not mean that I've caused it. And being able to share my guilt and the shame you have about the abuse has been massive. (Jackson et al., 2023)

2.1 Connection to others

Of particular importance across almost all of the papers was the role of participants' connections with other group members in helping them to make sense of their difficulties by normalising their experiences. The studies reported that meeting other people with similar experiences helped participants to feel "less alone" (Corbett et al., 2024) or that it was "not just me" (Stige et al., 2013) that had experienced violence and abuse,-helping them to feel that their difficulties were "normal" rather than something to be stigmatised (Hegarty et al., 2022). Many studies reported that participants' observations of other group members contributed to shifts in their perspective of themselves and their experiences, as "I would never blame any of those women, so I've had to sort of re-evaluate my own self blame" (Corbett et al., 2024) and Gnatt et al. (2025) described how "being around others and feeling they deserved it (i.e., compassion, recovery) helped them view themselves as deserving, too".

Additionally, participants across the studies shared how interactions with other group members or facilitators also contributed to changes in how they thought about themselves and their experiences, particularly through direct experiences of compassion and understanding. In one paper, this was particularly impactful when the facilitator was male as it allowed for a healing relational experience (Hegarty et al., 2022).

> I've always prided myself on not showing emotion and keeping it buttoned down and now I realise that's something really quite negative to do to yourself, and I remember...I just burst out crying and couldn't stop and she [other group member] gave me a really big hug and it made me cry more but that was what was important (Ashfield et al., 2021)

Many participants seemed to experience a sense of belonging to the group, especially when this was something that they had not experienced before (Jackson et al., 2023). However, some participants struggled to fit in with the group, particularly if they disagreed with narratives that appeared to be held by the group as a whole (Corbett et al., 2024).

> Similar to completers, some noncompleters claimed that the program cultivated a sense of belonging and helped them break isolation and get to know themselves. However, other non-completers described their struggle to fit in and connect with the group, something attributed to a mismatch between their stage in the recovery journey and that of their group peers. They also described their reluctance to associate themselves with a victim identity, often dominant within the group. (Karatzias et al., 2014)

This suggests that groups could provide a corrective experience of connection while also recreating familiar experiences of exclusion, being defined by others or feeling pressure to adapt in order to belong.

2.2 Connection to information

Across all of the studies, participants appeared to connect to the psychoeducational information that was shared with, which helped them to "find explanations for persistent feelings and behaviour patterns which had puzzled them in the past" (Karatzias et al., 2014). Participants found that the information they learned helped "understand yourself a little bit more and that hey I am human", normalising why they had responded to their experiences in that way (de Boer et al., 2023).

> Others emphasized information about the diagnosis and how this information influences self-image and feelings of shame: Yes, earlier I thought that it's something wrong with me, but it is not, it is the things I have experienced that are wrong. This is a huge difference. (Roberg et al., *2018)*

Participants could sometimes struggle to connect with the material presented during the intervention. Sometimes it did not line up with their experience (Corbett et al., 2024) or did not feel relevant to their current needs (de Boer et al., 2023). However, there was a recognition that "the generic character of the material was necessary to appeal to a range of individuals and personal circumstances" (Karatzias et al., 2014).

2.3 Connecting to the present

Within the majority of studies, participants described learning to become more connected to their thoughts, emotions and bodily experiences, which offered an opportunity to notice and make sense of them, rather than pushing them away. This appeared to involve recognising links between their current difficulties and their wider trauma-related experiences.

> I am a champion at pushing things away! In the group you are reminded all the time, so you have to relate to things. You cannot think that you only don't sleep well, or things like that. Maybe it's because you start sorting things out, seeing what is what. And then you have to relate to things (Stige et al., 2013)

Developing this awareness could initially be difficult, as participants were asked to connect with experiences that they previously avoided (Hegarty et al., 2022). However, some papers described how learning to observe and understand their initial responses appeared to reduce participants' fears about their emotional sensations as they learned ways to connect to their emotions and make sense of them, helping them to feel more empowered within these experiences. This appeared to help them to develop a sense of control, as the papers described participants being more able to remain in contact with difficult thoughts and feelings without becoming overwhelmed or "get[ting] caught up in it" (Stige & Binder, 2017).

Connecting to the present therefore appeared to involve more than increased emotional awareness. It supported participants to distinguish between past experiences and

their current circumstances, creating greater space to choose when and how to engage with difficult material. This contributed to a growing sense that thoughts and emotions could be acknowledged and managed, instead of needing to be avoided.

3. Journey of Developing Skills: From supported practice to everyday change

Across all papers, the interventions provided an opportunity to learn new skills that were helpful in participant's daily lives. This included setting boundaries (Corbett et al., 2024), emotion regulation (Stige et al., 2013), mindfulness (Powers et al., 2023), and other coping skills (Gnatt et al., 2025). Developing these skills appeared to be a gradual and active process. Participants benefitted from accessible materials and opportunities to practice their learning, before experimenting with the skills in everyday situations. This process could be emotionally demanding and was shaped by participants' circumstances and access to supportive relationships. Learning alongside others helped to make this work feel more manageable, as group members encouraged and learned from one another.

3.1 Experience of Learning

The way that the information was delivered had an impact on the learning experience. The majority of the groups took place in-person, and it was reported that "most of the group expressed that face-to-face therapy was preferable" among a group who needed to move online during the course of the program (Hegarty et al., 2022). Although one participant found online more practical, another found that it "created complacency" around her approach to sessions (Hegarty et al., 2022). The majority of papers reported the usefulness of "regular in-session practice" of the skills that they had been learning about during the intervention, in a place where they felt safe and supported (Gnatt et al., 2025).

> It was a nice start. You were expressing yourself in regard to something that…you didn't go into…I am a person that reads other people, and maybe a bit afraid to

> say…to hurt other people. To express your views on music, that was very…It didn't hurt anyone. That I could share! (Stige & Binder, 2017)

Across the papers, engagement with the course material was supported by the use of visuals (Corbett et al., 2024) and other practical tools "(e.g., blankets, tactile objects, options to move around) assisted with emotion regulation and coping with distress for some group members" (Gnatt et al., 2025). However, some people shared that they sometimes found it difficult to concentrate on learning the material during group sessions (Powers et al., 2023) and benefitted from time outside of the group to look over the material with worksheets.

> Probably it wouldn't be until a couple of months after it. And then I started going back over the sheets and stuff. And because it wasn't as intense and you weren't in a room with strangers. I was going through things and understood it sort of better and how to apply it and use it. (Jackson et al., 2023)

3.2. Integrating learning into everyday life

The skills learned during the intervention were able to be integrated into everyday lives, enabling "participants to start doing things differently" (Stige & Binder, 2017) when responding to difficult situations. Studies explored how participants were able to notice when they could use the skills in their daily lives and felt confident using skills that they had practiced.

> I was so proud of myself because yeah like in the past I would have got upset if I got unmatched or like things like that. But I was like "Hell yeah. I'm standing up for myself. I don't need this shit." (Corbett et al., 2024)

Some participants spoke about the need to be active in how you engage with the material from the group to integrate it into your daily life, and that this would impact how beneficial participants might find the group.

> Not everyone would be able to benefit from the group at any given time. They underlined the active role they had to take in order to benefit from treatment in terms of being open to change, giving things a go, and being ready to work with oneself with a sense of patience and with respect as to when the many small changes they made would show their influence on their life situations. (Stige et al., 2013)

However, integrating what they had been learning into daily life could be daunting and difficult, particularly if the participants did not have a supportive network that they could practice the skills with in a safe and understanding way, including "women who were still in relationships with people who used violence" (Corbett et al., 2024).

3.3 Hard work made easier by learning together

The majority of papers reported that people found that attending the intervention was often "exhausting" (Stige & Binder, 2017) and emotionally challenging, even when it was felt to be positive or helpful. However, there was a sense of solidarity between members of the group as "a little bunch of warriors", which often helped them to continue to engage (de Boer et al., 2023), as "it amped me up, it gave me the strength that I needed to push through that kind of big brick wall of denial" (Ashfield et al., 2021).

Studies also discussed how group members would offer each other practical support, including working together to make sense of the tools and information that they were being given and how to implement it into their daily lives.

> Some participants described other gains from interacting with fellow group members. For example, Chantal stated that she "[didn't] just gain stuff out of the course content" but that "the other women in the group helped [her] with certain things, too" (de Boer et al., 2023)

The majority of papers spoke about the experience of "witnessing" (Corbett et al., 2024) other group members throughout the intervention, which could often be a source of

inspiration that “encouraged you to progress”, especially if they were finding it challenging to make progress, as “if they can do it, I can do it” (Ashfield et al., 2021). When the group ended, some participants reported a feeling of loss from the ending of relationships between group members, highlighting the important role these relationships played in the journey through the intervention.

> I think when we were kind of put in the group for the 10 sessions and then we were kind of given coping skill and stuff and then we have opened up about stuff that has happened to us and then all of the sudden it just ended. And we have nowhere to turn to (Jackson et al., 2023)

4. After the Group: Accessing the group contributed to meaningful change in participant’s lives

During and after the group, participants in all but one paper spoke about the change in the way that they engaged in the world. This was particularly highlighted by the only paper that followed up with participants one year after the end of the intervention; these participants also found that this change was increasingly automatic, rather than a result of consistently applying specific techniques in a concrete way (Stige & Binder, 2017).

4.1. Feeling a change in the real world

Papers reported a variety of changes in participants’ sense of self and way of being in the world. This included an increased sense of control (Hegarty et al., 2022), empowerment (Jackson et al., 2023), confidence (Ashfield et al., 2021), strength (Stige & Binder, 2017), hope (de Boer et al., 2023), and freedom (Corbett et al., 2024).

Additionally, participants also spoke about differences in the way that they interacted with the world and themselves. They noticed improvements in how they engaged in their relationships (Ashfield et al., 2021), their ability to care for themselves (Hegarty et al., 2022)

and their willingness to seek support (Gnatt et al., 2025), as well as thinking more positively and listening more to themselves (Powers et al., 2023).

> Profoundly it enabled me to help myself that's what it enabled me to do. To identify and help myself I haven't come out as Wonder Woman, I'm not saying that cos you know life aint easy, you know. But a greater insight into the way I think. (Jackson et al., 2023)

4.2. It takes time

A number of studies recognised the importance of needing time and perseverance before participants experienced meaningful change in their lives.

> When you change a tiny thing, eventually, without you noticing, you have changed many little things that make a huge difference! You don't think the little things matter, but they are vital, the little things! (...) So, really, it is about giving it time. You have to give it time! (Stige et al., 2013)

The papers reported that it could be difficult to recognise these changes independently and some spoke about the helpfulness of using things like questionnaires to highlight these changes for them, as "I kind of knew it but I hadn't really connected that until I saw it visually" when comparing their scores between the first and last week (Corbett et al., 2024). However, these appeared to be most helpful for participants when there were longer gaps between questionnaires, as it could be demoralising to see multiple weeks in a row where there was no change.

> One thing that I found a bit boring but I know that they had to do it was the questionnaires. Sometimes because I felt, I felt for a long time the same. (Jackson et al., 2023)

4.3. Can't help everything

Studies found that it was important to think about participants' goals and stage in their journey of healing, as this had an impact in how much they were able to gain from the intervention.

> Group benefits aside, most of the participants stated that the benefits would have not been realized at an earlier time in their lives, when they had been less receptive to change due to an unstable life situation, difficult interpersonal relations, or a poor identification with the role of having a trauma related history. (Stige et al., 2013)

There was a recognition that the psychoeducational nature of the group was useful to reach specific goals, and that some participants continued to experience "fear in certain situations" following the end of the group, despite progress made in treatment (Hegarty et al., 2022). As a result, although psychoeducational intervention "contributed to their recovery", for some it was indicated that "it was not sufficient to meet their needs and that they believed further therapeutic work was necessary" (de Boer et al., 2023).

However, participants also highlighted that treatment can involve a range of different interventions that all relate to different "stages of healing" (de Boer et al., 2023). Although some participants would have preferred a greater focus on trauma-processing during their intervention (Karatzias et al., 2014), others felt that their experiences in the group contributed to feeling more prepared to begin this type of work:

> I do feel that I'm now ready because when I took the sort of guilt and the blame out of it, it makes the whole situation I went through not seem so scary. I guess a part of the fear for me, was how could I have let that happen to myself and 'cause I didn't want to think about it ... now I can stand outside and look at it with the eyes of a more balanced person rather than the person that went into it, I think I would have more empathy with that person. (Ashfield et al., 2021)

Discussion

The aim of this review was to synthesise qualitative research exploring adults' experiences of group psychoeducation-based interventions for complex or relational trauma. Four core themes were developed: Creation of a Safe Space, Finding Understanding, Journey of Developing Skills, and After the Group. Across the themes, group psychoeducation appeared to be experienced as more than an intervention where participants received information about trauma or learned coping skills. Its value seemed to come from the way structured content, relational safety and opportunities for practice worked together over time. When these elements were experienced as supportive, participants appeared more able to feel safe, understand their responses, connect with others and begin applying learning beyond the group.

These findings broadly align with phase-based models of trauma recovery, particularly the emphasis on stabilisation, meaning-making and integration (Herman, 1992). However, reviewed papers suggested that these processes were not always experienced in a clearly linear way. Although many of the groups were positioned as Phase 1 or stabilisation interventions, participants also described experiences that related to early exploration, connection and integration. This does not mean that phase-based models are unhelpful. Instead, it suggests that within group psychoeducation, stabilisation, understanding and reconnection may develop alongside each other. Participants were learning about trauma and practising skills, while also hearing from others, being witnessed, negotiating disclosure and receiving validation. The group itself therefore appeared to become part of the therapeutic context, creating opportunities for processes usually associated with different phases of recovery to overlap (Chouliara et al., 2020).

Safety seemed central to whether these processes were experienced as helpful or overwhelming. Phase-based trauma interventions often emphasise safety and stabilisation as

the foundation for later trauma-focused work (Herman, 1992; Courtois & Ford, 2013). In this review, the theme Creation of a Safe Space showed that participants often needed the group to feel predictable, boundaried and emotionally containing, particularly where personal or trauma-related experiences were shared. The findings suggest that safety within group psychoeducation was developed at several levels. It was supported internally through psychoeducation, grounding and emotion regulation; structurally through boundaries, confidentiality and predictable group practices; and relationally through acceptance, shared recognition and reduced fear of judgement. This is consistent with trauma-informed approaches, which emphasise physical and emotional safety, trust, collaboration, empowerment and the prevention of retraumatisation (Sweeney et al., 2018; Substance Abuse and Mental Health Services Administration, 2014). However, the group could also feel unsafe where participants felt pressured to disclose, struggled with hearing others' stories, or experienced the group as insufficiently containing.

This developing sense of safety also appeared to support a form of exploration. In attachment-informed terms, a secure base provides enough safety for exploration, while also offering a place of return when distress becomes overwhelming (Bowlby, 1988). This may be particularly important in complex or relational trauma, where trust, closeness and emotional vulnerability may feel unsafe (Herman, 1992; Adshead, 2018). In the studies reviewed, exploration did not usually involve detailed trauma processing. Instead, participants described beginning to notice, name and reflect on the impact of trauma on their emotions, bodies, relationships and sense of self. Group psychoeducation may therefore offer a form of supported exploration that sits between stabilisation and more direct trauma processing. This helps explain why the relational quality of the group mattered, as participants needed enough safety to engage with difficult material without feeling overwhelmed by it.

This supported exploration then became a route into connection and meaning-making as shown in the Finding Understanding theme. Many participants described feeling less alone, more normal, or more able to view themselves with compassion when they heard from others with similar experiences. This is consistent with group therapy processes such as universality, normalisation and belonging (Yalom & Leszcz, 2020). However, these processes appeared particularly important in the context of relational trauma, where shame, self-blame and mistrust can shape how people understand themselves and relate to others (Herman, 1992; Courtois & Ford, 2013). For some participants, seeing other group members with compassion also seemed to create space to reconsider the blame they directed towards themselves. Connection therefore appeared to support meaning-making, as participants came to understand their own experiences differently through the experiences of others.

Psychoeducational material also contributed to this process of meaning-making. Psychoeducation is often understood as a key part of stabilisation-focused trauma work, as it can provide information about trauma responses and a rationale for treatment (Whitworth, 2016). In this review, participants described gaining explanations for feelings, behaviours and bodily responses that had previously felt confusing, frightening or shameful. However, information appeared most useful when it connected with lived experience. Psychoeducation became more meaningful when participants recognised it in themselves, heard it reflected in others' accounts, or discussed it within a validating group context, consistent with research on young adults' experiences of trauma psychoeducational groups (Lee & Rawlings, 2023). This suggests that psychoeducation was not experienced only as information transfer. It became useful when it helped participants make sense of themselves in relation to their own histories, bodies and relationships.

The Journey of Developing Skills theme suggested that skills were also experienced as more than stand-alone techniques. Participants described learning to notice and respond

differently to thoughts, emotions and bodily sensations that had previously felt frightening or overwhelming. This is relevant to complex trauma, where difficulties with emotional regulation, dissociation and mentalising can affect how people understand and manage internal experience (Dugal et al., 2016; Huang et al., 2020; Carvalho Fernando et al., 2014). Psychoeducation helped participants understand why these responses occurred, while skills such as grounding, emotional regulation, mindfulness and boundary-setting offered practical ways of responding. However, participants' accounts suggested that understanding the purpose of skills did not automatically make them easy to use. Skills became more usable through practical tools, visual materials, in-session practice, peer support and gradual application beyond the group. Some participants benefitted from practising strategies in a supported setting, while others needed time after the group to revisit worksheets and understand how to apply the material in everyday life. This suggests that skills development was experiential as well as informational, as participants learned through explanation, practice, repetition, reflection and adaptation over time. The group context also appeared to shape this process, as learning alongside others could make difficult work feel more manageable and witnessing others' progress could create hope that change was possible. This aligns with stabilisation-focused trauma interventions, which aim to support safety, emotional regulation and interpersonal functioning before or alongside more direct trauma work (Herman, 1992; Courtois & Ford, 2013).

This gradual movement from understanding to practice helped explain how learning from the group could become integrated into daily life, although the theme After the Group showed that this was often gradual and uneven. Some participants described using skills to respond differently to distress, relationships and situations that had previously felt overwhelming. Others described increased confidence, hope, self-care and willingness to seek further support. These changes resonate with later phases of trauma recovery, where

integration involves reconnection, developing life goals and incorporating traumatic experiences into a broader sense of self (Herman, 1992). However, the group was not sufficient for everyone. Some participants continued to experience fear, wanted further therapeutic work, or felt that more individualised or trauma-processing intervention was needed. This is consistent with literature emphasising the need for flexible trauma treatment based on presentation, needs and preferences (Darby et al., 2023; Harmsen et al., 2025). The ending of the group could also create loss and uncertainty, particularly where participants had developed meaningful relationships and then experienced support as suddenly withdrawn. This suggests that the impact of group psychoeducation may depend on how participants are supported to sustain and apply learning after the intervention ends.

Taken together, these findings suggest that group psychoeducation for complex or relational trauma can be understood as a structured, relational and experiential form of stabilisation. The groups supported trauma-related understanding, emotional regulation and a greater sense of safety, while also creating opportunities for connection and the gradual application of learning beyond the intervention. Phase-based models offer a useful framework for understanding these experiences, but the synthesis suggests that processes such as safety, meaning-making, skills development and integration may overlap within group psychoeducation. These processes were not automatic or sufficient for everyone, highlighting the importance of careful facilitation, flexibility, attention to endings and access to further support where participants need more individualised or trauma-processing work.

Strengths and Limitations

A key strength of this review is its focus on participants' experiences of group psychoeducation-based interventions, rather than on symptom outcomes alone. This is important because stabilisation-focused interventions aim to support safety, emotional regulation and interpersonal functioning, and these processes may not be fully captured

through quantitative outcome measures. The review therefore offers insight into how participants experienced the relational, informational and experiential aspects of these groups, including what helped them feel safe, understood and able to apply learning beyond the intervention. A further strength is that the review synthesised studies across a range of group approaches. Although the interventions varied, this allowed the synthesis to identify common experiential processes across therapeutic models, including safety, shared recognition, meaning-making, skills practice and integration. The relative recency of the included studies also increases the ecological relevance of the findings to contemporary service contexts, where group interventions may be used as part of routine trauma-informed or stabilisation pathways.

However, the review is limited by the quality and scope of the available evidence. Several included studies provided limited discussion of researcher reflexivity, making it difficult to assess how researchers' assumptions, clinical positions or relationships to the intervention may have shaped data collection and interpretation. There were also potential recruitment biases, as participants who completed groups or agreed to take part in research may have been more likely to have found the intervention acceptable or meaningful. Those who dropped out, felt harmed, or found the group unhelpful may be underrepresented. In addition, some mixed-methods studies offered relatively limited qualitative depth, and several studies had small sample sizes.

There were also limitations at review level. The included interventions varied in length, content, theoretical orientation and balance between psychoeducation, skills practice and interpersonal sharing. Studies also differed in how trauma was conceptualised, including domestic violence, intimate partner violence, childhood sexual abuse and broader adverse childhood experiences. While this breadth allowed common processes to be explored across relational trauma contexts, it limits the specificity of conclusions. Finally, most studies were

conducted in Western, educated, industrialised, rich and democratic contexts, often within countries with publicly funded or socialised healthcare systems. This limits the cultural and service-contextual transferability of the findings.

Clinical Implications

The findings suggest that group psychoeducation should not be conceptualised only as an efficient way of delivering information or coping skills. Participants' accounts indicate that the therapeutic value of these groups may lie in the interaction between structured content, relational safety and opportunities for experiential practice. This has implications for how such groups are designed and delivered, particularly in NHS contexts where group interventions may be used as a pragmatic response to high demand and limited access to individual therapy. If the relational dimension of the group is central to its usefulness, then services need to allow sufficient time and structure for trust, recognition and shared understanding to develop.

The findings also challenge assumptions that sharing trauma-related experiences in groups is necessarily unsafe. Participants did describe sharing and hearing others' experiences as difficult or triggering at times, but shared experience also supported normalisation, reduced shame and helped participants feel less alone. This suggests that disclosure itself is not inherently harmful, but needs to be carefully held. Group agreements, confidentiality, clear boundaries around the level of detail shared, predictable session structures and skilled facilitation appeared central to making relational safety possible.

Clinically, these groups may be particularly helpful for people who feel isolated, ashamed or unsure how to understand their trauma-related responses, and who can benefit from learning alongside others. However, group psychoeducation is unlikely to meet all needs. Some participants may require individual preparation, additional support during the group, or further therapy afterwards. Careful assessment of readiness, preferences, current

safety, interpersonal needs and the fit between the person and the group format is therefore important.

Research Implications

Future research should explore group psychoeducation with more diverse populations and in a wider range of cultural and service contexts. Current evidence is limited by the dominance of Western samples, and experiences of disclosure, shame, safety and group belonging may differ across cultures. Further research should also include longer-term follow-up, as participants' accounts suggested that change often developed gradually and was not always visible immediately after the intervention ended. This would help clarify how learning is sustained and integrated into everyday life. Finally, future studies could compare different types of group interventions, including psychoeducational, skills-based, process-oriented and peer-led groups, to better understand which elements are most helpful, for whom, and at what stage of trauma recovery.

Connection to Wider Thesis

In this review, group psychoeducation appeared most meaningful when structured information, relational safety and opportunities for practice felt usable and connected to participants' lives. However, the intervention itself is only one part of a wider experience of care. For people with complex trauma histories and relational needs, how they reach support, how it is connected to wider services, and what happens after it ends may also shape whether care feels helpful or sustainable. The empirical study therefore widens the focus from a structured intervention to experiences of CMHT care as a whole, exploring how people experience care within broader service systems, relationships and contexts.

Method

Chapter Overview

This chapter outlines the methodology used to explore service users' experiences of care from generic Community Mental Health Teams. It begins by describing the study's critical realist position and qualitative exploratory design, including its commitment to treating service users as credible knowers of their own experiences. The chapter then explains how the study was developed through Expert by Experience consultation and details the sampling strategy, participant recruitment, semi-structured interview procedure, data management and transcription. It also describes the use of reflexive thematic analysis, including coding, theme development and key interpretative decisions. Finally, the chapter considers ethical procedures, quality and rigour, and the researcher's reflexive position within the research process.

Epistemological and Ontological Position

Critical Realist Ontology

Ontology refers to assumptions about the nature of reality and what can be understood to exist. This study is informed by a critical realist ontology, which assumes that there is a reality that exists independently of individual accounts, while also recognising that social realities are historically produced, layered and open to change (Bhaskar, 1978). This position allows service structures, organisational processes and experiences of care to be understood as having real effects on people's lives, without treating these structures as fixed, neutral or inevitable.

Within this study, CMHTs are understood as real service systems within the NHS, with thresholds, waiting lists, staffing arrangements, care pathways and treatment options that have material consequences for service users. At the same time, the ways in which CMHT care is accessed, organised and delivered are shaped by wider social, historical and political

contexts, including policy, professional practice, funding arrangements, risk management cultures and societal understandings of mental health care. This is consistent with work that situates mental health systems within broader social and political contexts, challenging the idea that they are neutral or purely technical responses to distress (Pilgrim, 2019). The current CMHT model can therefore be understood as one historically shaped way of organising care, not an inevitable or unchanging system.

This ontological position allowed the study to examine both the material structures of CMHT provision and how these were experienced and made meaningful by service users. It supported attention to concrete aspects of care, while also considering how these experiences were shaped by wider service and policy contexts.

Critical Realist Epistemology

Having outlined what this study understands to be real, it is also necessary to consider how knowledge about these realities can be produced. Epistemology refers to assumptions about knowledge and how it can be produced. Critical realism offered a useful position for this study because it allowed CMHT structures and experiences of care to be treated as real and consequential, while also recognising that knowledge about these experiences is produced through situated and interpretative participant accounts. Within qualitative psychology, critical realism has been described as offering a position between realism and social constructionism, allowing researchers to treat participants' accounts as meaningful accounts of real experiences while also recognising that these accounts are shaped by language, context and interpretation (Willig, 2013). In this study, knowledge about CMHT care is produced through participants' accounts, which are shaped by language, memory, context, power, and the interaction between participant and researcher.

Within this position, participants' accounts were treated as meaningful accounts of real experiences, whilst avoiding reducing them to either objective reports of service quality

or purely subjective constructions arising through dialogue with the researcher. This was important because the study aimed to foreground service users' experiences of care while also recognising that these accounts were situated within wider relational, institutional and social contexts. For example, how participants described assessment, intervention or relationships with staff may have been shaped not only by what happened within services, but also by previous service experiences, expectations of care, professional language, and the interview context itself. This is consistent with critical realist qualitative research, which seeks to understand how accounts may offer insight into real experiences and possible underlying conditions, while recognising that interpretation is always involved (Willig, 2013).

Epistemic Injustice and Service User Knowledge

The epistemological position of the study was also informed by the concept of epistemic injustice. Fricker (2007) describes epistemic injustice as a form of wrong done to someone in their capacity as a knower. This was relevant to the current study because people with mental health difficulties have been historically vulnerable to having their accounts dismissed, pathologised, or interpreted primarily through professional and institutional frameworks (Crichton et al., 2017). Within mental health services, this can create conditions where service users' knowledge of their own experiences is treated as less credible than professional accounts, particularly when their views are understood through diagnostic, risk-focused or symptom-based frameworks. This is particularly relevant in healthcare and psychiatry, where credibility may be shaped by diagnosis, professional authority and institutional power (Carel & Kidd, 2014).

This had important implications for the study. Participants were approached as credible knowers of their own experiences of CMHT care instead of passive recipients of services or as people whose accounts required professional validation. At the same time, the study did not treat accounts as simple or transparent reflections of reality. In keeping with a

critical realist epistemology, participants' narratives were understood as meaningful accounts of real experiences that were also shaped by context, language, memory, power and the interview relationship. This allowed the study to foreground service user knowledge while still analysing accounts interpretatively. This was both an ethical and methodological commitment, as the study aimed to understand CMHT care from the perspectives of those accessing it.

Methodological Implications

These ontological and epistemological assumptions informed the choice of qualitative methodology. A qualitative approach was appropriate because the study sought to explore depth, meaning and complexity in service users' experiences of CMHT care. Semi-structured interviews were selected because they allowed participants to describe experiences in their own terms, while also ensuring that key areas of the CMHT pathway were explored, including referral, assessment, intervention, signposting and relationships with staff.

This epistemological position also informed the use of reflexive thematic analysis. Themes were not treated as findings that simply emerged from the data, but as interpretative constructions developed through the researcher's active engagement with participants' accounts. At the same time, this does not mean that themes were understood as arbitrary or detached from participants' experiences. Instead, themes were developed as grounded interpretations that may offer a way of understanding broader relational, organisational or systemic processes shaping experiences of CMHT care. This was compatible with reflexive thematic analysis, which recognises the researcher's active role in producing analysis while emphasising the importance of coherent, meaningful and well-supported theme development (Braun & Clarke, 2021a).

Research Design

As the study sought to explore how service users made sense of their experiences of CMHT care, a qualitative exploratory design was considered appropriate. It was considered particularly appropriate because the research question was broad and participants were expected to have varied experiences of CMHT care. An exploratory design would allow for a range of experiences to be explored while allowing participants to prioritise aspects of their experience that were most meaningful to them. Semi-structured interviews were used to allow for a balance between covering the aims of the research question whilst also enabling participants to explore their own ideas through open ended questions.

Current and recently discharged service users were recruited so that accounts reflected relatively recent CMHT practice. This was considered important given ongoing service transformations and the potential impact of the Covid-19 pandemic on how care was accessed and delivered.

Data were analysed using reflexive thematic analysis, which was considered appropriate for identifying patterns of meaning across participants' accounts while recognising the active role of the researcher in theme development.

Development of the Study and Patient and Public Involvement

Development of Recruitment Strategy

The initial plan was to recruit directly from multiple NHS CMHTs in the local area through existing professional links held by the researcher and supervisor. This was considered important to reach people currently in contact with services, including those who may not be present on social media or involved in service user networks. With the aim of trying to reach as many service users as possible, an invitation to participate was requested to be included in appointment and discharge letters from supportive CMHTs. Recruitment material was also distributed within consenting CMHT buildings to provide multiple routes to

seeing the study information, recognising that written letters, posters and online recruitment may each reach different groups of people.

Recruitment through the NHS was slower than anticipated due to challenges including engaging service and clinical leads. It is not possible to know how much of this was actually done or how many service users saw recruitment material. This reflected a wider challenge of gatekeeper-mediated recruitment, where the research team had limited control over how consistently recruitment materials were circulated once they had been shared with services. Following discussions with the research supervisor and ethical amendments, recruitment was expanded to social media and then lived experience newsletters. Expanding recruitment beyond NHS sites also allowed the study to include participants whose experiences of CMHT care may have ended, or who may no longer have been reachable through current service pathways. In addition to widening the geographic area for recruitment across the UK, the inclusion criteria were amended to include people who had been discharged from a CMHT within the previous three years. A three-year timeframe was selected to balance recency with recruitment feasibility. This allowed participants to reflect on relatively recent CMHT experiences, while also making it possible to include those who had been discharged and could comment on endings, transitions, and post-discharge support.

However, this also raised additional considerations around managing risk and ensuring participants had access to support, given a lack of knowledge of services within their area. National recruitment also meant that the researcher could not rely on knowledge of local service pathways when considering support and signposting. This was addressed by identifying participants' own support contacts before the interview and providing national support and advocacy information during debrief if required. There were also additional considerations around how to verify eligibility for the project and needing to rely on self-report. Participants were asked to confirm that they met the inclusion criteria and were not

currently under acute crisis, inpatient, home treatment or assertive outreach services through the consent form. Care records were not accessed, both because many participants were recruited outside the local NHS Trust and because accessing records would have introduced additional privacy concerns disproportionate to the aims of the study.

Expert by Experience consultation

Prior to seeking ethical approval, Experts by Experience (EBEs) were consulted regarding the approach of the project, including recruitment methods, study materials, the interview schedule and payment. This consultation was considered important because the research team did not have lived experience of accessing care from a CMHT and therefore sought feedback on whether the proposed approach was appropriate, accessible and acceptable. EBEs were recruited through a Lived Experience Peer Support Worker within the School of Health and Social Care at the University of Essex. Although the original aim was to hold a small focus group with three contributors, recruitment resulted in two individual consultation meetings. One EBE had previously accessed CMHT care, while the other was a carer for someone currently accessing CMHT care. Both EBEs contacted the researcher by email, were sent study materials in advance, and met with the researcher via video call. Notes were taken during the meetings. Contributors were offered £25 in recognition of their time and contributions.

The consultation informed several aspects of the study. In relation to recruitment materials, EBEs recommended that the poster should be concise, genuine and accessible, with brief reference to the potential service-development value of the research, as including too much information could feel overwhelming. As a result, a shorter and more visually accessible recruitment poster was developed. EBEs also recommended that the participant information sheet should have a clearer front page containing the information most relevant to potential participants. This led to the inclusion of a front page, the use of bullet points for

key information, and efforts to make the document appear more approachable than long blocks of formal text. In relation to consent, EBEs advised that the consent form should remain simple and that participants should be offered the option of having it read aloud at the beginning of the interview, to support accessibility and account for potential literacy needs.

The recruitment strategy was also amended following EBE feedback. The original plan had included sending separate study invitation letters through CMHTs, but EBEs suggested that including a short paragraph in existing appointment or discharge letters may feel less intrusive and reduce concerns about how researchers had accessed service users' contact details. A recruitment paragraph was therefore drafted for use in CMHT appointment and discharge letters. EBEs also suggested that participants should be offered telephone or face-to-face contact to discuss the study and arrange interviews, rather than relying on email alone.

The consultation also shaped the interview schedule, support procedures and participant payment. EBEs reviewed the draft interview schedule and supported the inclusion of questions about both helpful and unhelpful experiences, to avoid framing the study solely around negative accounts. They also recommended asking more explicitly about participants' journeys into the service, experiences of signposting, and relationships with staff. These areas were therefore added to the schedule. In relation to participant support, EBEs emphasised the importance of a debrief and immediate support contacts, including both professional services and informal supports such as family or trusted others. Finally, the planned participant payment was increased from £15 to £20 following EBE advice, with vouchers offered due to potential concerns about the impact of direct payments on benefits.

A strength of the PPI process was that consultation took place before ethical submission, meaning that contributors' feedback could be incorporated into the study design rather than only commenting on a fixed protocol. This strengthened the accessibility and

acceptability of the study materials and helped ensure that the research was shaped by perspectives closer to the experiences being investigated. However, there were also practical limitations. Only two EBEs were recruited, meetings were held individually rather than as a group, and it was not possible at this stage to consult directly with someone currently accessing CMHT care. This limited the extent to which the consultation could reflect a broader range of current service user perspectives. Nevertheless, the consultation led to substantive changes to the study materials, recruitment approach, interview schedule and support procedures, reflecting wider evidence that PPI can strengthen the relevance, accessibility and acceptability of health and social care research when involvement is planned and resourced appropriately (Brett et al., 2014).

Participants and Sampling

The study used opportunity sampling to recruit participants within the practical and ethical constraints of the project. This approach was chosen because recruitment through CMHT settings can be difficult, particularly where access to whole caseloads is restricted by confidentiality and where service pressures may limit staff capacity to support research recruitment. It also allowed the study to later recruit through multiple routes, including NHS services, social media and lived experience newsletters. This was consistent with the exploratory nature of the study, where the priority was to generate rich accounts of CMHT care (Patton, 2015).

Quota sampling was not used, although it was recognised that some service users may have been more likely to volunteer than others. The study aimed to understand patterns of experience across generic CMHT care, with no planned comparison of diagnosis or demographic group. Diagnosis-based quota sampling was also considered difficult to apply meaningfully, as many people accessing CMHTs may have multiple, overlapping or changing diagnoses, and diagnostic categories may not fully capture the complexity of service use.

Demographic information was therefore collected to contextualise the sample and support transparency about who took part.

Participants were eligible to take part if they were adults who were either currently accessing care from a generic CMHT and had done so for at least two years, or had been discharged from a generic CMHT within the previous three years. This criterion was chosen to ensure participants had sufficient experience to reflect on access, assessment, intervention, relationships with staff, continuity and transitions within care. Although CMHT support can include shorter-term assessment, referral, signposting or focused intervention, CMHTs also support people with more complex and longer-term mental health needs, where care may involve ongoing coordination, monitoring, intervention and links with wider services (NHS England, 2019a). The two-year criterion therefore helped ensure that current service users had experience beyond initial assessment or brief contact, while the inclusion of recently discharged participants allowed endings and transitions of care to be explored within a relatively recent timeframe. There was no minimum duration of care for those who had been discharged as this was seen to represent a complete episode of care offered by the CMHT.

Participants also needed to be able to give informed consent and to speak fluent English. The English-language criterion was included because the study involved in-depth interviews about sensitive experiences, and interpreter-supported research would have introduced additional methodological and ethical complexities, While considered necessary within the scope of the project, this criterion is recognised as a limitation because it excluded people who may face additional barriers to accessing and communicating within CMHT care.

Participants were excluded if they were currently receiving care from crisis intervention services, home treatment teams, assertive outreach services or inpatient services. This maintained the focus on generic CMHT care rather than acute, crisis-oriented or highly specialist provision. It was also an ethical decision, as people receiving acute or intensive

support may have been experiencing heightened distress, fluctuating capacity or more immediate risk-related needs, making participation in an interview about difficult service experiences less appropriate at that time. Participants were also excluded if they had a cognitive impairment affecting their ability to give informed consent. Eligibility was assessed through self-report during initial contact, as an alternative to using clinical records, to avoid collecting unnecessary identifiable clinical information.

Sample size and Rationale

In total, 17 participants were recruited, generating approximately 16 hours of interview data. The sample size was informed by the aims of the study, the richness of the data, and the practical constraints of doctoral research. In line with reflexive thematic analysis, recruitment was not guided by saturation, as this concept is not always compatible with an approach in which themes are understood as actively generated through the researcher's engagement with the data and not as simply emerging from it (Braun & Clarke, 2021b). The dataset was considered sufficient to support a rich and patterned analysis across participants' accounts, while remaining manageable within the scope of the project.

Demographic characteristics

Demographic information was collected to contextualise participants' accounts and describe the sample, including age, gender, ethnicity, diagnoses, approximate length of CMHT contact, key professionals involved, and recruitment route. Care was taken to avoid over-identification, particularly where combinations of characteristics could make participants more recognisable. The sample captured a range of experiences across current and recently discharged CMHT service users, although it cannot be assumed to represent all people accessing CMHT care. This reflects the qualitative exploratory design, which aimed to develop an in-depth understanding of experience. Participant demographics across the sample are summarised in Table 6 and a summary for each participant can be found in Appendix A.

Table 6
Participant Demographic Overview

Category	Description / Distribution
Age	Mean: 41 years Range: 21–65 years
Gender	Female: 13 Male: 3 Non-Binary: 1
Ethnicity (as defined by the person)	White British: 11 British Asian: 1 Black Caribbean: 1 Mixed Persian European: 1 Mixed White and Asian: 1 Mixed British and Indian: 1 Mixed Other
Main Diagnoses	Complex PTSD/PTSD: 8 Bipolar: 4 Borderline Personality Disorder (BPD)/Emotionally Unstable Personality Disorder (EUPD): 4 Psychosis: 3 Schizophrenia: 2 Schizoaffective Disorder: 1 Depression: 6 Anxiety: 5 Obsessive Compulsive Disorder (OCD): 2 Autism Spectrum Disorder(ASD): 5 (ADHD): 2 Other: Traumatic Brain Injury - 1, Anorexia - 1, Personality Disorder (unspecified) - 1
Length of CMHT contact	Range: 10 months – 30 years[a]
Recruitment Pathway	NHS: 4 Lived Experience Newsletter: 13

Key Professionals Involved	Care coordinator or Key Worker: 11 Community Psychiatric Nurse:10 Psychiatrist: 15 Psychologist: 13 Social Worker: 4 Support Worker: 4 Other: Occupational Therapist – 4, Individual Placement and Support (IPS) – 2, Day centre – 1, Public and Patient Involvement - 1

Recruitment and Procedure

NHS Recruitment

Recruitment initially took place through local NHS CMHTs within one NHS Foundation Trust. Recruitment posters (Appendix B) and participant information sheets (Appendix C) were circulated by email to clinical and service leads within participating teams. Printed posters and leaflets were also placed in consenting CMHT bases. Where invited, the researcher attended team meetings to introduce the study, answer questions from staff, and explain how potential participants could express interest. In some teams where this was agreed locally, a short recruitment paragraph was also added to appointment or discharge letters (Appendix D). Staff were able to share study information with potential participants, but participants were asked to contact the researcher directly through a University of Essex email address. This was intended to maintain separation between research participation and clinical care, and to reduce any perception that taking part was linked to participants' current NHS treatment. Four participants were recruited through NHS routes.

Wider recruitment through social media and lived experience newsletters

Following low recruitment through NHS services, recruitment was expanded to include social media and lived experience newsletters. Ethical amendments were approved before these changes were made, and recruitment materials were adapted to remove NHS-specific wording (Appendix E and F). The study poster was shared through designated social

media accounts and submitted to lived experience organisations and newsletters. Most participants recruited through this wider route contacted the researcher after seeing the study advertised through the McPin Foundation newsletter. Mind also circulated the study after sufficient participants had already been recruited, so no further participants were recruited through this route. Due to the high level of interest following newsletter circulation, eligible participants were recruited on a first-come basis according to who responded to the researcher's follow-up email, provided contact details, and remained eligible after an initial screening. Thirteen participants were recruited through this route.

Expression of Interest and Eligibility Screening

Interested participants contacted the research team directly by email. They were then sent the participant information sheet and consent form and were offered a telephone or video call to discuss the study, ask questions, check eligibility and arrange an interview. Eligibility was assessed through participant self-report, so that clinical records did not need to be accessed. Recruitment through public channels and reliance on self-reported eligibility introduced the possibility that participants could misrepresent their eligibility, either intentionally or unintentionally. This was considered during screening, which included an opportunity to discuss eligibility with the researcher. However, eligibility could not be independently verified without accessing clinical records, which was avoided to protect participants' privacy and maintain separation between research and clinical care. Although no concerns about participant authenticity were identified, the possibility of inaccurate self-report cannot be ruled out entirely.

Not all expressions of interest resulted in participation. One person withdrew after initially making contact due to concerns that taking part might affect their care from the CMHT, and five people did not respond to the researcher's initial follow-up email. A further five people were not eligible, including three carers and two people whose contact had only

been with primary care mental health services. After recruitment had closed, 24 further people expressed interest and were thanked for their interest but informed that no further interviews were being arranged.

Interview procedure

All interviews took place online using Microsoft Teams, although in-person interviews had initially been offered to participants recruited through local NHS services. Interviews were booked for 90 minutes and completed interviews lasted between 20 and 100 minutes. This variation reflected differences in the depth and detail of participants' accounts. One interview ended early due to technical difficulties and could not be rearranged. This participant requested that the interview be included, and the available data were retained in the analysis.

Before recording began, participants were asked for consent to record the interview and could choose whether to use their camera during the interview, with six participants choosing to keep it off. This choice was offered to support participant autonomy and made participation more accessible for those who may have felt anxious or uncomfortable being visually observed. At the same time, camera-off interviews limited access to non-verbal cues and required greater attention to tone, pauses and verbal indications of distress or fatigue. At the start of the recording, consent was confirmed and the consent form (Appendix G and H) was reviewed both verbally and visually to support differences In literacy skills amongst participants. A brief capacity check was also completed in line with the interview schedule, and participants were asked to identify any support contacts or services they could access if they became distressed or if technical difficulties interrupted the interview.

Interviews were audio-recorded and followed the semi-structured interview schedule, while allowing flexibility in the order and depth of topics discussed. After each interview, the recording was stopped and participants were offered a debrief. Participants were also asked

whether they had a preferred pseudonym. Where no preference was given, a pseudonym was selected by the researcher. The payment voucher was sent by email following the interview.

Interview Schedule

The study used a semi-structured interview schedule to explore participants' experiences of accessing care from generic CMHTs. The schedule was developed from the research aims, relevant literature, clinical and service knowledge, and consultation with Experts by Experience. It was reviewed and approved as part of the NHS and university ethics processes. The full interview schedule is included in Appendix I.

The interview schedule was organised around key stages and features of CMHT care. This included participants' experiences of referral, assessment, intervention, relationships with staff, signposting to other services, and views about what could improve CMHT care. Demographic information was collected at the beginning of the interview to contextualise participants' accounts. Participants were also asked brief questions about their understanding of the study and their reason for taking part as part of the capacity check. Follow-up prompts were used within these areas to explore what participants experienced as helpful or unhelpful. This reflected early discussions within the research team and with clinical contacts in services, where there was concern that the study should not frame CMHT care solely through negative accounts and EBE consultation supported this approach. This structure allowed participants to describe each aspect of care in their own terms, while ensuring that both valued and difficult experiences could be explored in depth. Exploring helpful experiences also allowed the study to identify what participants valued in care. This was important because the absence of a difficulty does not necessarily indicate the presence of meaningful care. Asking about what felt helpful therefore supported a more nuanced understanding of care, including the relational, practical or organisational features that participants experienced as supportive.

Although the schedule provided consistency across interviews, it was used flexibly. The order of questions varied depending on the direction of participants' narratives, and not all areas were explored in the same depth with every participant. Follow-up prompts were used to clarify meaning, invite elaboration and explore experiences that appeared particularly significant to the participant. For example, participants were sometimes asked to expand on what made an interaction feel helpful or unhelpful, or to clarify how they understood a particular stage of their care. No changes were made to the interview schedule during data collection, although the use of follow-up prompts varied across interviews in response to participants' accounts. This flexibility reflected the understanding of qualitative interviews as active, interactional spaces, where accounts are shaped by participants' experiences, the questions asked and the meanings developed within the interview context (Kvale & Brinkmann, 2015).

Data Management and Transcription

Interviews were audio-recorded on Microsoft Teams on an NHS laptop provided by Essex Partnership University Trust. Recordings were downloaded after each interview and transferred to the University of Essex's secure Box storage system, before being deleted from the local device. Microsoft Teams generated an automatic transcript during recording, which was checked and corrected against the audio recording by the researcher. In line with the approved study procedure, transcription and checking were completed within 12 weeks of the interview, after which the audio recording was deleted.

Transcripts were anonymised during checking, with names, places, dates, services and professionals removed or replaced with pseudonyms. The pseudonym key was stored separately from the transcripts, and only the researcher had access to identifiable participant information. Pseudonymised transcripts were discussed with research supervisors where

relevant and were uploaded to NVivo 15 for coding and analysis. Data were stored in accordance with University of Essex research data management procedures.

Analytic Approach

Rationale for RTA

Reflexive thematic analysis was chosen because the research questions focused on exploring patterns of meaning across participants' accounts of CMHT care. Braun & Clarke (2006) originally described thematic analysis as a flexible method for identifying and analysing patterns within qualitative data, making it appropriate for examining shared and contrasting experiences across the dataset. This fit with the study's critical realist position because participants' accounts were understood as accounts of real service experiences, while the themes were developed through the researcher's interpretation of patterns across the dataset. This allowed attention to both semantic content, remaining close to the participants' explicit descriptions of referral, assessment, intervention and relationships, and more latent meanings relating to how care was understood, valued, or experienced as absent. In line with Braun & Clarke's (2019) reflexive approach, researcher subjectivity was treated as an inevitable part of analysis requiring reflexive awareness, not as a problem to be eliminated.

Analytic process

Reflexive thematic analysis involves six recursive phases: familiarisation, systematic coding, generating initial themes, reviewing themes, defining and naming themes, and writing up the findings (Braun & Clarke, 2022). The first phase involved listening to recordings to correct the transcript automatically generated by Microsoft Teams. Additional readings were completed during which the researcher made familiarisation notes, which explored early patterns, emotional responses, contradictions and possible assumptions.

During phase two, coding, all 17 transcripts were uploaded to NVivo 15 and systematically coded. An inductive analysis was undertaken by working through each

transcript in detail and assigning labels to sections of data that appeared relevant to the research question or offered insight into participants' experiences of CMHT care. The coding remained as close to participants' language as possible, but also captured more interpretative observations. In total, 1,207 initial codes were generated.

These initial codes were then grouped into initial themes during phase three. Attention was particularly paid to repeated patterns, meaningful divergences, and complementary experiences, where accounts appeared to reflect different sides of a similar process. Early themes explored several overlapping aspects of participants' experiences, including access to support, relationships with staff, continuity of care, collaboration, person-centredness, professional attitudes and wider service pressures.

In the fourth phase, these early themes were checked against the coded extracts and full dataset. During this process, some themes were combined where they appeared to capture related aspects of the same broader pattern. For example, early themes relating to the consistency of professionals and the importance of relationships were brought together within a broader theme concerning the importance of continuity and relational care. Other themes were split, renamed or reworked where they appeared too broad, overly descriptive, or insufficiently distinct. Theme development was iterative, with the researcher moving repeatedly between codes, candidate themes and full transcripts to refine the coherence, analytic depth and fit of the developing thematic structure. This reflected the reflexive nature of the analysis, where uncertainty and revision were treated as part of developing a more coherent and grounded interpretation of the data (Braun & Clarke, 2019).

A particular analytic question concerned how to represent participants' accounts of wider service pressure. Early theme development considered whether service pressure should be presented as a separate theme, as participants frequently referred to overstretched services, limited resources, staff workload and perceived wider NHS pressures. However, during

theme review, it appeared to shape several parts of participants' accounts, including access to intervention, continuity of relationships, flexibility, communication and experiences of being treated as a person. Service pressure was therefore retained as a cross-cutting analytic thread within and across themes, allowing the analysis to show how wider system conditions shaped multiple dimensions of care.

In phase five, the reviewed themes were further refined, defined and named. This involved identifying the central organising concept of each theme, clarifying the boundaries between themes, and considering how each theme contributed to the overall analytic account. Theme names were developed to reflect both participants' accounts and the researcher's interpretation of the broader patterns across the dataset. This phase also involved checking that each theme had a distinct focus, while still contributing to the overall research question of how CMHT care was accessed, organised and experienced.

In phase six, writing up was treated as part of the analytic process. Extracts were selected to illustrate the central organising concept of each theme, while also representing variation and contradiction within the dataset. Decisions about whether to use standalone or integrated quotes were guided by how much of the participant's language needed to be foregrounded to support the analysis. Particular attention was paid to keeping the write-up grounded in participants' own words, especially where specific phrases captured important aspects of experience. Writing, therefore, involved further refinement of the analysis, as explaining each theme helped clarify the relationships between themes and the wider analytic story.

Analytic Boundaries and interpretative decisions

Analytic boundaries refer to decisions about what material is treated as central to the analysis and what is understood as contextual. This was particularly important because participants' accounts of CMHT care were often embedded within broader service histories

and did not always map neatly onto the formal boundaries of the research question. In keeping with reflexive thematic analysis, these decisions were understood as part of the researcher's active role in producing the analysis, as themes are developed through interpretative engagement with the dataset.

Participants sometimes discussed experiences outside generic CMHT care, including contact with primary care, crisis services, inpatient settings, voluntary sector support or previous mental health services. At times, it was difficult to clearly distinguish which experiences related specifically to generic CMHT care and which related to other services, particularly where participants described transitions between teams, overlapping service involvement, or uncertainty about which team held responsibility for their care. These accounts were included where they shaped participants' expectations, comparisons or interpretations of CMHT care. For example, accounts of Early Intervention in Psychosis services were included when they helped explain participants' expectations or comparisons during transition into CMHT care, but were not analysed as accounts of these services in their own right. Material that did not relate to the research aims was not centrally analysed. Decisions about relevance involved researcher judgement and were revisited throughout coding, theme development and writing up. This reflected the need to remain open to participants' narratives while maintaining a clear analytic focus on experiences of access, intervention, relationships, continuity, signposting and care within the CMHT context.

Quality, Rigour and Reflexivity in Analysis

Quality and rigour were supported through reflexive engagement throughout the analytic process. Reflexive notes were kept during familiarisation, coding and theme development to record early interpretations, emotional responses, uncertainties and possible assumptions. Developing themes were also discussed in supervision, which provided space to

consider alternative interpretations, clarify assumptions and review whether themes were coherent and grounded in the dataset.

In line with reflexive thematic analysis, quality was not understood as the removal of researcher subjectivity, but as transparent and reflexive engagement with the analytic process (Braun & Clarke, 2021a). Direct quotations were used to ground interpretative claims in participants' language, and attention was paid to contrasting or divergent accounts that complicated the developing analysis. This was consistent with Yardley's (2000) approach to quality in qualitative research, particularly the importance of demonstrating sensitivity to context and developing interpretations in a transparent, grounded and coherent way.

Ethical Considerations

Ethical Approvals

Ethical approval was obtained before recruitment began. The study received NHS Research Ethics Committee approval on 27 June 2025, following submission through IRAS. Following this, it was also granted by the University of Essex as the sponsor of the research. An amendment to expand recruitment to non-NHS routes, including social media and lived experience newsletters, was approved on 2 September 2025. This amendment was also approved by the University of Essex.

Informed consent and capacity

Participants were provided with a participant information sheet and consent form before taking part and were given time to consider the information, ask questions, and decide whether they wished to participate. They were informed that participation was voluntary and that taking part, declining, or withdrawing would not affect their current or future care. At the start of the interview, consent was confirmed verbally on the recording, and the consent form was reviewed where participants accepted this offer. Participants were reminded that they could pause the interview, skip questions, take a break, or stop the interview at any point

without giving a reason. A brief capacity check was also completed at the start of the interview, based on participants' understanding of the study and their reason for wanting to take part.

Managing distress and minimising harm

The study involved discussion of potentially sensitive experiences of accessing mental health care, including difficult or distressing encounters with services. To minimise harm, participants were informed that they did not need to answer any question they did not wish to answer. Before the interview began, they were asked to identify personal or professional sources of support they could access if they became distressed or if technical difficulties interrupted the interview. A debrief was offered immediately after the interview, once the recording had stopped, and participants were provided with information about relevant support and advocacy services. People currently receiving care from crisis intervention services, home treatment teams, assertive outreach services or inpatient services were excluded because participation may have been less appropriate for people experiencing acute distress or requiring intensive support.

Confidentiality, Anonymity and Data Protection

Participants were informed that information shared during the interview would be treated confidentially, except where there were concerns about serious risk to themselves or others, or where disclosure was required by law. Identifiable information was stored separately from interview transcripts, and only the researcher had access to identifiable participant data. Transcripts were anonymised during checking, with names, dates, places, service names and identifiable references to professionals removed or replaced with pseudonyms. Direct quotations used in the thesis were anonymised, and care was taken when reporting demographic or contextual information that could identify participants, staff or services. Audio recordings were deleted after transcription and checking, and anonymised

transcripts were retained in line with University of Essex research data management procedures.

Participant payment

Participants received a £20 Tesco voucher after the interview as compensation for their time reading study materials, completing the consent process and taking part. They were informed that they would still receive the voucher if they chose not to answer all questions or decided to stop the interview early. The amount was informed by the expected interview length and advice from Experts by Experience and was intended to recognise participants' time without being large enough to create financial pressure to participate or continue against their wishes.

Potential Reputational impact on NHS Services

It was recognised that participants' accounts could reflect negatively on CMHT provision or wider NHS services. However, patient feedback is central to understanding and improving care, and avoiding difficult accounts would risk limiting the value of the research. The interview schedule therefore included open questions and prompts about both helpful and unhelpful experiences, supporting a balanced exploration of care. The analysis aimed to represent the complexity of participants' accounts, including positive, negative and mixed experiences, while removing names of services, staff members and specific locations to reduce the risk of identifying individuals or teams.

Dissemination

Findings from the study will be disseminated to participants, academic audiences and relevant services. All participants and EBEs chose to receive the findings and were offered a choice between the full results chapter and a simplified summary. Following completion and awarding of the doctorate, each contributor will be sent their preferred version.

The research will also be disseminated through the doctoral thesis and may be developed for academic publication. Potential journals include BJPsych Open, Journal of Mental Health, BMC Health Services Research and Health Expectations. Findings may also be submitted to relevant academic, clinical psychology or mental health services conferences with the possibility of oral or poster presentation. Academic dissemination would aim to contribute to wider discussions about how CMHT care is understood and evaluated.

Service-level dissemination will also be considered. Findings may be shared with participating NHS services, CMHT leads, NHS service improvement forums, and local NHS research or governance meetings. A concise summary could be prepared for services, with attention to implications for access, communication, continuity, collaboration and person-centred care. Dissemination may also be considered through local transformation work focused on improving trauma-informed care within the Essex Partnership University NHS Foundation Trust (EPUT). Findings may also be shared with lived experience organisations that supported recruitment, where appropriate. This would aim to support reflection on how CMHT care is experienced by service users and how services might use this learning within ongoing improvement work.

Reflexivity

As reflexive thematic analysis recognises the researcher as actively involved in knowledge production, I use the first person in this section to make my positionality and interpretative role explicit. I am a white, middle-class, queer, late-diagnosed neurodivergent woman. I have not personally accessed CMHT care and have not worked within a CMHT. However, I have worked in adjacent specialist, crisis and primary mental health services, where I have liaised with CMHTs both before and during doctoral training. I was therefore both connected to and separate from the research context, with some familiarity with NHS

mental health systems but without direct lived or professional experience of being within a CMHT.

My role as a trainee clinical psychologist working in NHS services is of particular importance given this insider/outsider role that I play in the context of CMHTs. Although I have not had direct involvement with CMHT services, I am part of the professional structures associated with these services. It is possible that this may have contributed to the perception that I was aligned with services. This was particularly noticeable for one potential participant from local NHS services who decided not to participate due to concerns that the research may interfere with their care from the local CMHT due to my clinical association with these services. This dynamic may have influenced what was shared with me during interviews, particularly around criticisms of care. Additionally, my specific role as a psychologist may also have influenced what was shared with me, with a potential for focusing on psychological interventions that people had received or speaking more positively about their psychology input.

My professional familiarity with NHS culture and mental health language also shaped the research process. The interview schedule was initially structured around stages that may be familiar to professionals, such as referral, assessment, intervention and signposting. However, these categories did not always map neatly onto how participants understood their experiences of care. For example, some participants were unclear about the difference between an assessment, review or routine appointment. This required me to clarify meanings during interviews and remain attentive to the risk of assuming shared understandings. It also shaped the analysis, as participants' accounts often cut across formal service categories and highlighted care as something experienced through relationships, timing, responsiveness and continuity, rather than through discrete stages of a pathway.

My interest in this research was shaped by previous clinical experiences of liaising with CMHTs. In a trauma-focused psychological therapies placement, I worked with people whose access to specialist support depended partly on being under a CMHT and having sufficient care coordination to support risk management and wider care. In practice, this was not always experienced by clients as consistent or relationally supportive. Before doctoral training, I had also observed how neurodevelopmental diagnoses could complicate access to wider mental health support, including through diagnostic overshadowing. These experiences meant that I entered the research with some existing concerns about CMHT care, particularly around whether services were able to provide consistent, relationally supportive and accessible care. I was aware that this could have led me to notice accounts that confirmed these concerns, or to interpret participants' experiences through a more critical lens.

At the same time, I was also working within NHS services and was aware of the pressures that staff and services face, including waiting lists, limited capacity and competing demands. This created a tension between my ideals about what mental health care should offer, my discomfort in response to some participants' accounts, and my awareness of the constraints under which services operate. I recognise this as a familiar part of my personality and clinical identity. I can feel strongly about care being compassionate, thoughtful and relational, particularly where people feel unseen or unsupported, while also needing to hold the reality that services are often trying to provide care within imperfect and overstretched systems. This tension was also present during the ethics process, where I was aware of the need to represent participants' experiences honestly while managing the potential reputational impact of critical accounts of NHS services.

My clinical training and theoretical orientation also shaped how I approached the data. I am drawn to approaches such as ACT, CFT, narrative therapy and CAT, and my clinical work often attends to attachment, relational safety, meaning-making and containment.

This likely sensitised me to relational and emotional aspects of participants' accounts, including experiences of being known, held, dismissed or misunderstood. My own experiences and values also mean that I can be cautious about medicalised understandings of distress, particularly where these risk pathologising or dehumanising people, including neurodivergent and queer people. I therefore needed to remain aware of the possibility that I might attend more strongly to relational and systemic meanings, while giving less emphasis to practical, medical or risk-focused aspects of care.

This reflexive awareness was supported through supervision and reflexive notes during interviewing and analysis. I reflected on the follow-up questions I asked, the parts of participants' accounts I felt drawn to, and the ways I interpreted care as present or absent. However, the relational focus of the analysis did not feel only imposed by my own orientation. Participants repeatedly returned to relationships, continuity, being known and feeling cared for, even when discussing medication, assessment, crisis planning or service processes, often describing distress when care felt reduced to "tick box" tasks rather than recognising their own humanity. I therefore tried to treat the relational emphasis as both something I was sensitised to and something that was strongly present in the data, grounding these interpretations carefully in participants' own words.

The interviews themselves were understood as co-constructed. Participants' accounts were shaped by their experiences, the questions asked, the interview relationship and the broader context in which they were speaking. Follow-up prompts may have influenced which aspects of their accounts were elaborated, particularly where I asked for more detail about what made an interaction feel helpful or unhelpful. During analysis, I made active decisions about what was central to the research question and what was contextual. This was particularly important where participants' accounts moved across different services, professionals and periods of care. Participant quotations were used throughout the write-up to

preserve their language where possible and reduce the risk of flattening complex accounts into abstract themes.

Overall, my position shaped the project in ways that were both helpful and limiting. My clinical background supported my understanding of service processes, language and the pressures surrounding CMHT care. My relational orientation helped me notice the importance of continuity, recognition and trust. At the same time, these positions may have shaped what I noticed, what I asked about, and how I interpreted participants' accounts. Reflexivity did not remove this influence, but it helped me remain more aware of it and use it as part of a transparent and thoughtful analytic process.

Results

Chapter Overview

This chapter presents four themes which describe participants' experiences of care from CMHTs. The first theme, *Wheel of intervention*, explores participants' experiences of accessing intervention, including variability, waiting, reactive care, and the sense of needing to prove eligibility for support. The second theme, *Secure base from consistent care*, considers the importance of continuity, predictability and being known within the service. The third theme, *Holding onto personhood within the system*, explores whether participants felt involved, recognised and responded to as people within care, or whether care felt procedural, conditional or difficult to question. The final theme, *Care beyond the clinic*, considers whether CMHT care was experienced as connected to participants' wider lives, relationships and communities. The first three themes were further divided into sub-themes. Together, the themes show that participants' experiences of care were shaped not only by whether support was available, but by whether it felt accessible, consistent, personal and connected to the contexts of their lives.

Repeated words and fillers (e.g. 'like') were removed from the interview quotes presented to enhance readability. A summary and distribution of themes and subthemes is presented in Table 7. Figure 2 shows a thematic map created to demonstrate how themes related to one another.

1. Wheel of Intervention

This theme captures participants' experiences of trying to access and receive intervention from the CMHT. Across accounts, care was described as difficult to access, variable in what was offered, and at times conditional on how need was understood within the service. Prior to their referral to the CMHT, many participants expected to access a comprehensive

Table 7

Summary and Distribution of Themes and Subthemes

Themes and Sub-Themes	Alice	Jemima	Daniel	Sam	Precious	Maureen	Jess	Grace	Madeline	John	Louise	Paige	Ruth	Mina	Isobel	Laurence	Jayne
1. Wheel of Intervention																	
1.1 The Treatment Lottery																	
1.2 Waiting in Limbo																	
1.3 Reactive State of Play																	
1.4 Burden of Proof																	
2. Secure Base from Consistent Care																	
2.1 A Relational Anchor																	
2.2 (Un)certainty of a Safety Net																	
2.3 The Containment of Continuity																	
2.4 Care Takes Time																	
3. Holding onto Personhood within the System																	
3.1 Paradoxes of Collaboration																	
3.2 “Cookie Cutter” Care																	
3.3 Person vs Process																	
3.4 Care is not a Favour																	
4. Care Beyond the Clinic																	

multidisciplinary treatment that would support them with medication, counselling and risk monitoring. This theme explores what treatment participants were able to access and their experience of the often-difficult journey of accessing some interventions. Encapsulating the theme perfectly, Daniel conveyed the perceived unpredictability of accessing treatment:

> "What I've learned since is it's so hard to get treatment. It's like a lottery win." (Daniel)

1.1. The Treatment Lottery

Participants described a wide-ranging offer of interventions that they received from CMHTs, including medication, talking therapy, care coordination, risk monitoring and social support. However, there seemed to be a great deal of variability in what was available across participants, both between services and between different presentations. Some participants accessed multiple professionals for separate interventions, while others described "just seeing the care coordinator" (Grace). Across accounts, the offer of intervention could therefore appear "fractured" with "limited numbers of sessions" (Alice) and participants not always knowing what support would be available, how long it would last, or whether they would be able to access the intervention they felt they needed.

This was particularly evident in relation to psychological therapy. Several participants described difficulties accessing therapy or reported that certain interventions were not available to them. For some, this appeared to be linked to diagnostic thresholds or service criteria. One participant described only being offered psychology because she "met criteria for, I think complex PTSD or personality disorder" (Jess), while another described accessing "CBT for psychosis" (Grace). However, participants with these diagnoses also spoke about either being denied or having difficulties accessing psychological interventions, suggesting that access was not experienced as consistently determined by diagnosis alone. Instead, participants often understood this variability in relation to difficulties with service capacity,

including funding, resources and staffing levels. This contributed to a sense that intervention depended not only on need, but also on where someone lived, which team they were under, and what the service had capacity to offer at that time.

> Just that the resource isn't there, it's, you know, the psychological service is, you know overloaded, you know, and I've said I'd be really keen in group therapy as well because I like group therapy. Well I like group things but, but that's not an option either. (Mina)

Most participants spoke about the use of assessments to identify what intervention would be most appropriate for their needs. For many, this was "a psychiatrist who explored sort of diagnosis and pathways" (Jess), using information gathered in the appointment and from previous assessments to make treatment decisions. Some participants also spoke about having assessments with the psychology service to decide what type of psychological therapy would be most suitable. However, many participants were unsure about the usefulness of these assessments in exploring and establishing their needs. A few questioned the relevance of the information that was being gathered, especially when "nothing...then came out of that" (Grace).

Additionally, some participants were unsure about the rationale for the intervention decision that was made, particularly if it was based on the needs of the individual person or if it was chosen based on their diagnosis or what was available within the service. Participants also described tensions between clinical decision-making and service constraints, including pressures related to funding, resource allocation, and service thresholds. This sometimes created a sense that decisions about care were influenced not only by clinical need, but also by what was possible within the system. One participant was told:

"We think you meet this criteria for this. Didn't really explain why...didn't really explain sort of what that meant." (Louise)

Similarly, if a CMHT only offered one or two types of therapeutic approach, participants wondered:

"Well, does it actually fit my needs or am I just doing it because there's nothing else?" (Jess)

Interventions could therefore feel determined by availability, with limited explanation of how they had been selected or matched to participants' needs. This reinforced the sense of a "treatment lottery", in which the care offered depended partly on local provision and service capacity.

1.2. Waiting in Limbo

Almost all participants described long waiting times to be able to access different types of intervention. This includes waiting for their initial assessment, a psychiatrist appointment, waiting for a replacement staff member after one leaves, and waiting for more specialist support services, e.g., an employment support service. This was particularly relevant to psychological intervention when it was offered to a participant, with some participants describing being "still on the waiting list for CBT…after three and a bit years" (Ruth) despite having already completed initial assessments.

> People who are struggling and who are on waiting list to see, you know, psychologist or, you know, psychiatrist. And I don't know if you know, but the waiting list in (City) are horrendous. I mean, you'll be talking at least a couple of years if you're lucky. (John)

Participants highlighted the impact that waiting for care could have on their daily lives. Delays were described as contributing to worsening mental health and needing to leave work or education whilst waiting for support. In this way, waiting was experienced as both the passing of time and also the perceived absence of care, as their life was "on pause" whilst

waiting (Daniel). As a result, participants emphasised that “early intervention is key” (Jemima), rather than support only being offered once difficulties had escalated.

1.3. Reactive State of Play

Similarly, many participants described the care offered by CMHTs as being reactive, particularly to risk, rather than proactive to reduce or prevent further distress. This was frequently discussed in the context of accessing the service, with some participants suggesting that it wasn’t until they were admitted to hospital that they were able to access the CMHT.

> Since coming out of hospital, the service from the mental health team has been good. Before hospital, the service from the mental health team...the community mental health team was awful. It's a real night and day contrast between the experiences. (Daniel)

In addition to describing care as reactive at the point of accessing the service, participants also reflected on how this pattern continued within their ongoing care. Several described situations where support was offered in response to deterioration, rather than in anticipation of known upcoming stressors. For example, some participants spoke about receiving increased support only after experiencing a decline in their mental health following significant life events, despite these events being anticipated. This contributed to a sense that opportunities for earlier intervention were being missed, with support not available “when that problem is going on” but only after “carnage has already happened” or the person had “weathered the storm” (Jemima).

Participants also described an expectation that they would initiate contact with services during periods of increased distress. This was experienced as challenging, particularly when unwell, with some participants suggesting that they would only reach out if

their situation became severe. This reinforced the perception for many that support was more readily available at points of crisis, rather than as part of ongoing preventative care.

> I just feel like they've just left me. I don't know if it's because I'm just living my life, getting on with my life. They just see, I don't know, because I'm not a threat or I'm not um high-high risk at the moment but I feel like they shouldn't just wait to step in when things you know they completely deteriorate. (Precious)

However, there were some accounts of more proactive support within the service. These were typically linked to situations where participants had an established relationship with a professional, who was "able to see how I am" and increase support "if things aren't good" (Grace). This linked more proactive care to continuity and familiarity, as staff who knew the participant were described as better able to notice changes and respond without support having to be requested.

1.4. Burden of Proof

Although a few participants described a smooth transition into the service, generally from other acute mental health services like CAMHS or forensic services, around half of participants described a confusing journey into the service. This frequently involved initial referrals being rejected for a variety of reasons, including moving to a new area, being under a specialist service and their distress not being seen as serious enough, leading them to be "bounced between different things" (Isobel).

Participants also described a sense that accessing and maintaining care was not only complex, but at times conditional on how their needs were interpreted within the service. Some felt that they needed to demonstrate that they were unwell enough or engaging in the right way in order to access or continue receiving support. For some, this was described as a "guessing game" (Sam), where they attempted to understand what professionals were looking

for and how best to present their difficulties. This was experienced as particularly challenging when participants felt that their experiences were not fully understood or were dismissed.

> The thing is...if I turn up looking good, they'll tell me that I don't need support. If I turn up looking bad, they'll tell me I'm not trying and don't need support …. As bad as it sounds like, you have to play a game to get the care you need. (Sam)

Participants also reflected on how diagnostic labels or assumptions appeared to shape how their needs were interpreted, with some feeling that certain difficulties were taken less seriously or viewed through predetermined expectations. While this was particularly evident in accounts from participants with a diagnosis of personality disorder, similar concerns were also described by participants with experiences of psychosis, where the "expectation is that you're just gonna have a s*** quality of life" rather than being supported to have "a slightly better quality of life" (Louise).

> He wouldn't get the gravity of how severe I was, because, you know, it was sort of classed as a personality disorder. It wasn't always treated with the same respect as some of the other things…It was when I got a diagnosis of bipolar. That's when they really started helping me better. (Jayne)

Across these accounts, intervention was shaped by more than the availability of specific forms of support. Participants described care as difficult to access, delayed, variable and at times conditional on how their need or engagement was understood. This meant that even when support was offered, it could still feel uncertain. For many participants, whether care felt supportive also depended on what happened after access was gained, and whether there was enough consistency for the service to feel reliable over time.

2. Secure Base from Consistent Care

All participants spoke about how the continuity of the care that they received from the CMHT impacted their experience of feeling supported and cared for, especially during times

of greater crisis. Within this theme, continuity of care involved having sufficient time to build trusting relationship, being known and understood by staff within the service and experiencing consistent information sharing between professionals. Together, these forms of continuity helped participants to feel safer and more contained within the service. Jess highlighted the importance of the relational connection that developed through consistent care:

> "I think that having that sort of bond and relationship is really helpful." (Jess)

2.1. A Relational Anchor

Participants described the importance of having access to consistent and predictable relationships within the CMHT. These relationships appeared to provide a sense of being "in safe hands" (Jayne) within a wider system that could otherwise feel difficult to navigate. For some participants, a consistent member of staff was important not only because of the "positive relational elements" (Mina) they offered, but because they could help "facilitate any contact with other members of the team" (Louise).

However the majority of participants described that it was difficult to build these relationships with staff due to multiple changes in the member of staff that they were in contact with. This was for a number of reasons across participants, including moving around the different pathways of the CMHT and particularly high staff turnover, something that has become more frequent "towards the later years" (John) according to participants who have been under CMHT services for a long time.

Participants used language that conveyed the instability and unpredictability of these relationships, describing contact with "countless professionals" (Alice), a "rotating cast" (Louise) of staff, or "whoever's free" (Ruth) at the time. This made it difficult for participants to know what to expect from the service, or who they would be speaking to at any given point. Rather than experiencing the CMHT as a stable team around them, participants

described how their experience was dependent on whichever individual professional they happened to receive.

> I think that what's made it good and not so good has literally been the the staff that I've had contact with. So I've had good care coordinators and not so good care coordinators, good support workers, not so good support workers….It's so different. Like, according to who you actually get. (Grace)

For some participants, repeated changes in staff also seemed to affect how much they could trust the service to remain consistent. When relationships had ended unexpectedly, participants described feeling more cautious about relying on the CMHT again. Even when it appeared that a new professional would be involved long-term, this did not always feel reassuring, as previous experiences had shown them that contact with staff could change suddenly. This made it harder for some participants to feel settled in the service and meant that they could feel guarded or nervous about opening up, particularly when they "didn't know, you know, if it was going to happen again, was I going to walk in the next week and be told that I'm getting someone else?" (Jess)

> I just feel like it's difficult because I'm comparing to the fact that the last four years I had literally the same care coordinator like I could talk to her about anything, but now it's just. It's like I've lost trust...I feel like I...I can't form these trusting lasting relationships because they keep chopping and changing the care coordinator and it's just leaving me out in the ocean...you know, paddling...just floating or, you know, paddling, you know, for dear life. (Precious)

2.2. (Un)certainty of a Safety Net

Alongside stable relationships, participants described the importance of knowing what support would be available, when it would happen, and who would be responsible for their care. Around half of participants described experiences of endings or transitions in their care,

including changes in care coordinator, endings with therapists, movement between pathways, or possible transfer to another team. Most participants who spoke about these changes described not being given enough information, warning, or opportunity to prepare. For some, staff changes felt sudden, with one participant describing a professional as having "disappeared into thin air" (Alice), while others described being told at short notice that they would now be seeing someone new. Several participants described that "there's never been a handover…so I've never met the old person with the new person" (Grace). This left them uncertain about whether their history, needs, and current support would be carried forward. However, even when a handover meeting occurred, participants could still experience the change as abrupt if it had already been decided and they had not been given time to understand or prepare for it. In these accounts, transitions could feel less like being supported through a planned change and more like being "handed over" (Jess).

Some participants also described changes in support when the service decided that they no longer needed the same level of contact. Many spoke about the frequency of care being reduced over time as part of a move towards discharge or less intensive involvement, usually "once a week at first, then once a fortnight and then once a month." (Maureen). For some, this was experienced as appropriate or "helpful to sort of tailor it off as opposed to suddenly, then nothing" (Jess). However, others described feeling uncertain about the pace of this change. For example, one participant described feeling scared when contact was reduced "as soon as I start to feel better", particularly because this was a change they "didn't really have any control over" and did not yet feel ready for (Madeline). Similar concerns were described in relation to transitions between services. One older participant reflected on the possibility of moving to an older adult team and described a lack of "preparation" or "communication" about what this shift would involve, asking, "where am I going? What's it going to be like?" (Laurence). Across these accounts, uncertainty was not only about the

practical details of transition, but about whether the support, knowledge, or relationships built within the CMHT would continue.

This uncertainty also shaped how participants experienced support during periods of increased distress. When participants had a regular appointment with a consistent member of staff, some described finding it easier to manage a crisis knowing that they had an appointment coming up soon where “I'm going to see somebody, they're going to help me. It's going to get better, you know, it gives you hope” (Jemima). In this way, consistent contact appeared to make crisis periods feel more manageable, not only because support was available, but because participants knew when it would come and who it would be with. This seemed to reduce the uncertainty involved in deciding whether their distress was serious enough to justify reaching out, and lessened the burden of having to repeatedly seek help at times when they were already struggling

> It's just like, literally, if it was in three weeks’ time, that would be fine. But I'd just like to know … because sometimes you might think, well, I really want to talk about this … but when you don't know when you got the appointment, then you feel like you're dealing with it on your own, whereas, when you know that you’ve got the appointment, you can sort of deal with it on your own, but know then you've got someone to offload to. (Grace)

However, this was not the experience for all participants. When participants did not have a care coordinator, or did not feel that they had an established relationship with the person involved in their care, they often described feeling “left” alone and unsure where to turn “even though I might have had people on paper” (John). For some, being under the CMHT did not necessarily mean feeling actively held in mind by the service. Periods of waiting could therefore feel like being forgotten or becoming “irrelevant” within the system. One participant described having a “CPN who sometimes remembers I exist” (Sam), while

another contrasted their current care with previous specialist support and described feeling as though they had been “thrown on the scrap heap” (John).

Several participants described delays in being allocated a new care coordinator after a previous one had left, including delays that lasted many months, and for some, over a year. During these gaps, participants were often unclear who was responsible for their care or who they should contact if they needed support. This made it harder for some participants to seek support when they were struggling, particularly when they were advised to contact duty services. Although this provided a route for urgent contact, participants described this as difficult to use when they “don't know who it's going to be” (Ruth) or whether the person on the phone would know them or understand their distress. For one participant, this uncertainty became particularly clear when they contacted the service in crisis and were told that the team would be in touch when they had been allocated a new care coordinator. This was experienced as frightening, as it left them feeling that “there’s no one in the world here that actually knows me” (Paige). In this account, not knowing who was responsible for their care was also experienced as not being known within the service.

2.3. The Containment of Continuity

A key aspect of consistent care described by participants was the experience of being known by professionals within the CMHT. This was closely connected to having someone clearly involved in their care, but extended beyond simply knowing who to contact. Being known referred to staff having a detailed and nuanced understanding of the participant’s history, difficulties, and individual needs. Participants described how this enabled more personalised and responsive care, particularly when professionals were able to draw on this knowledge to make decisions, notice changes, or advocate on their behalf.

> She knew me and she knew my case so well, she could like she was able to be in a better position to say, OK, I think Precious needs this…how can you act in someone's

> best interest if you don't know them, If you don't- haven't built that rapport, if you don't... I-I don't see how you can really do that. (Precious)

Being known was also described as particularly important in the context of managing risk and responding to changes in mental health. Participants suggested that professionals who had an established understanding of their usual presentation were better able to recognise early signs of deterioration and respond in a way that felt appropriate and supportive. In contrast, where this understanding was absent, participants described concerns that their difficulties might not be fully recognised or taken seriously. One participant described this as professionals "not knowing you", meaning they did not have "any kind of measure" for understanding the seriousness of what was being shared. They suggested that risk needed to be understood individually, including "the real things you need to take seriously" for each person, rather than relying only on generic indicators (Paige).

A lack of continuity in staff was closely linked to experiences of not being known. Participants described needing to repeatedly retell their story to different professionals, which was experienced as both frustrating and, at times, emotionally difficult. This repetition was not only experienced as burdensome but inefficient:

"You'd have an hour appointment, and by the time you've already gone through your previous history with them, you got 10 minutes left" (Jemima).

Participants also questioned the purpose of repeatedly sharing information when it did not appear to be retained or communicated effectively between professionals. While participants recognised that "if you see someone else, they're going to need that information as well" (Jess), they also expected this information to be recorded, communicated, and built on across appointments. Some questioned why they had to repeat their history when it was already "on my record", or described different professionals asking "basically the same questions" (Madeline) on separate occasions. This contributed to a sense that what was

shared with individual professionals did not always appear to inform later contacts with the wider team or the care participants received.

This became particularly important during periods of increased distress. Participants described situations where they needed to provide context in moments of crisis, which was experienced as particularly challenging when they were already distressed. One participant described not wanting to be “faffing about” by “repeating my history” but wanting someone to “be there for me in that moment” and offer the support they needed (Precious). In these situations, the absence of a professional who already understood their history could make support feel harder to access, as participants had to explain and contextualise their distress at the point when they were already struggling.

Across these accounts, being known was not only about information being held by the service, but about participants feeling that professionals understood them well enough to respond in a personalised and appropriate way. This appeared to provide a sense of “containment from having someone who knows me” (Paige), as participants felt less need to explain, justify, or manage their difficulties alone.

2.4. Care Takes Time

Participants’ accounts suggested that being known by professionals developed through time and repeated contact. However, this was not only about the length of time someone had been under the CMHT, but about whether staff used appointments to build rapport, understand the person, and develop a relationship that felt meaningful. When participants felt that professionals were interested in getting to know them, this helped them to feel “safe enough eventually to be able to talk to them” (Jemima). Additionally, the time spent building up a relationship when the person was more well helped to facilitate care “because they know me, when things aren't so good, it's a lot easier to help me” (Grace).

Participants also emphasised the importance of feeling that time within appointments was meaningful. Appointments were experienced as helpful when staff were perceived as present, engaged, and "giving you time when they could" (Maureen). In these accounts, time appeared important not only as appointment length, but as something that could be used to communicate attention, effort, and care. Jayne illustrated this through an occasion when she was too unwell to engage in the planned therapy session. Instead of ending the appointment, her therapist used the time to help her identify what she wanted to communicate to her psychiatrist:

"He didn't just say, 'Okay, we're not having the therapy,' then took the hour for himself. He really did help" (Jayne).

This contrasts to descriptions of appointments or check-ins feeling rushed, brief, or unhelpful. Some described very short contacts where staff appeared to "try to do as little as possible" (Laurence), while others described check-ins that were "very brief" and so infrequent they could not remember whether they were with the same staff member (Daniel). For others, appointments did not allow enough time to connect or build rapport, meaning that the relationship "really wasn't built up" (Jess). This made it difficult for participants to engage in the appointments or find them constructive.

Across these accounts, consistent relationships appeared to shape whether participants felt able to rely on the CMHT and experience support as safe, predictable and responsive. Being known by staff seemed to offer a sense of stability within a service that could otherwise feel difficult to navigate. However, participants' accounts also suggested that the experience of care was shaped not only by whether support was available, but by how it was offered and enacted in practice.

3. Holding onto Personhood within the System

This theme explores whether participants felt recognised as people within their care, rather than primarily as patients moving through service processes. It considers how far participants felt involved in decisions, whether care was adapted to their individual needs, and whether interactions with professionals felt personal, respectful and responsive. Across accounts, personhood was supported when participants felt listened to, understood and involved, but undermined when care felt generic, procedural or difficult to question. Jemima captured this distinction directly:

> "I'm a person. I'm not a number. I'm not a case, you know, I am a person" (Jemima)

3.1. Paradoxes of Collaboration

Participants described differences in whether they experienced care as something that was done to them or done with them, particularly in relation to how treatment decisions were made and communicated. Some people described experiences of being asked about their opinion about what they thought might be most helpful for them and a willingness to "let me lead" (Laurence) on decisions about treatment options, giving them a greater sense of autonomy and ownership.

> I just think the importance of like giving people autonomy when they're accessing support and the need for like services to scaffold that as well and keep people involved in their care as opposed to sort of doing it for them or at them. (Jess)

However, this was not the experience for all participants. Some described decisions about their care happening without their involvement, including referrals being made or changes to treatment being discussed "behind my back" (Grace). This contributed to a sense that decisions "happen elsewhere and then people inform you of what they think, what their views are" (Paige), rather than collaboratively within appointments. Although some people described their notes as "bang on" (Jemima), other participants also described occasions

where there were things “discussed in my notes I knew nothing about” (Jess), which further reinforced a feeling of being outside the full picture of their own care. In these instances, participants were left uncertain about what had been decided, how decisions had been made, and what role they had in shaping their treatment.

Alongside this, participants highlighted a distinction between being “heard not just listened to” (Jemima). While some described being given space to speak, this did not always translate into feeling that their views had been meaningfully considered. Participants described moments where professionals appeared to miss opportunities to understand their perspective before forming opinions or making decisions about their care. This could leave participants feeling that their voice had little influence, and that care was being directed around them rather than developed with them. In contrast, feeling heard was associated with professionals taking time to understand their perspective and demonstrating that their views had been considered within decision-making.

> One key thing is not listening. So they ask a question. They think they know what you're going to say, and they've already write-, they're already writing things down, and they've not necessarily. They're not necessarily taking on board anything is coming out of your mouth, umm, especially if they then, don't even acknowledge some of the words that you have said, or they gloss over things. (Jayne)

Participants also described wanting to have choice within their care, while recognising the importance of being supported to make informed decisions. This included being given clear explanations about their mental health, service policies, available treatment options, and the rationale for decisions, particularly where these differed from their own preferences. Where this information was communicated in an honest and accessible way, participants described feeling more able to engage with their care and make decisions that felt appropriate for them.

> Say I felt that ill and said, I think I'm going to need to go in hospital and he had the opposite opinion, for example, he'd speak to me in a very person-centred way. My voice would count but if he ever thought different to what I wanted, he'd explain properly the reasons behind it...Very good. (Jayne)

In contrast, when information was limited, unclear, or not discussed openly, participants described feeling confused, excluded, or that it was "left for me to make that decision and that felt a bit...that's too big a decision to be making on my own" (Grace). Some emphasised the importance of having time to ask questions, develop understanding and "[go] through things together", rather than being expected to accept decisions without sufficient context and needing to do their own "Googling" (Madeline).

Across these accounts, care felt more collaborative when participants' views were actively sought, taken seriously, and supported by clear information. Where this was absent, participants could feel that decisions were being directed by professionals, reinforcing a sense of care being done to them rather than with them.

3.2. "Cookie Cutter" Care

Participants described flexibility as important to whether care felt possible to access and engage with. This included whether support could be adapted around what the person could manage at the time, such as one participant's assessment being adjusted around a "pretty bad eating disorder relapse" (Sam). However, participants also described care as sometimes following a "prescribed way of doing things", with a "lack of flexibility and that individualised approach" (Paige). In these accounts, flexibility was experienced as uneven, with care sometimes adapted to participants' circumstances, but at other times requiring them to fit the existing structure of support.

This was also reflected in practical arrangements around appointments. Some participants valued adjustments that made care more accessible, such as staff coming "to see

me at home" (Grace) when a participant was unable to attend the service, or being able to bring a trusted support person. However, these adjustments were not always straightforward. Ruth described feeling that she had to fight for her mother to be included, despite feeling unable to attend without her there. Others described practical preferences or needs not being accommodated, such as being expected to meet in a café when they were not well enough to leave the house, or receiving paper letters despite being "asked not to" (Louise). In these accounts, practical flexibility shaped whether participants felt able to attend, feel safe, and engage with support.

Where care was not adapted, participants could feel that difficulties engaging were located within them, rather than in the fit between the support offered and what they were able to manage. Sam described services as quick to say people had not engaged when "they haven't made accommodations", or when they were trying to "cookie cutter everybody into certain things".

Participants also described that the level of collaboration they experienced could vary depending on how their engagement was perceived by staff. When participants were seen as engaging well, professionals were more likely to adopt a flexible and collaborative approach. In contrast, during periods when participants were more unwell and found it more difficult to engage, participants described relationships as becoming more directive and support being "more restrictive" (Jess) with less opportunity to influence decisions. This was experienced as particularly challenging, as these periods often coincided with increased need for support and flexibility.

> Generally at the beginning, like I felt like they were quite positive but then like when I was struggling to respond to things, I felt like it. I felt like a bit more disconnected. But then when I was able to engage again like again, it was the opposite. I started feeling a bit more positive again. (Madeline)

3.3. Person vs Process

Participants described occasions where care felt more focused on service processes than on them as individuals. Appointments were sometimes experienced as task-driven, with professionals appearing to "go through the motions" (Isobel) of asking questions or "ticking boxes" (Ruth). For some participants, these questions did not feel personally relevant or connected to what had already been shared in previous appointments. This could make contacts feel repetitive and formulaic, rather than building towards a deeper understanding of the person or their needs. Participants also questioned whether generic questioning was always effective, particularly when assessing risk, as it could feel disconnected from the specific context of their distress.

> It asks you know quite generic not me specific questions, so it's. You know it's a tool they use and they I guess they have to fill in every so often you know I wouldn't say well it's not a validated tool and it's definitely not the most individualised tool. (Mina)

Some participants described this as a cold, rote, or overly clinical way of being supported. They valued professionals being present in the room, rather than appearing overly focused on an agenda or process. In some accounts, participants described feeling that they were treated as "just another number" (Precious) rather than as a person, particularly when the impact of appointments on them did not seem to be considered. One participant described becoming upset when several students were present in a medical review without their consent, and felt there was "absolutely no understanding there" of what this experience was like for them (John). This was reinforced by other examples where participants felt unseen or unnamed within care, including when a clinician "didn't even know my name" (Ruth) or the wrong name being used in a letter. Although participants recognised that mistakes could happen, what seemed particularly difficult was when these were not acknowledged, or were experienced as reflecting a lack of thought, care, or attention to the impact on the person.

These accounts were contrasted with experiences where participants did feel cared about. Participants valued interactions that felt warm, personable, and "human" (John), rather than overly clinical or robotic. Some valued being able to have "a nice conversation" (Mina) or a "sit down and chat", while still recognising that, for the professional, this could be a "proper medical review" (Jemima). Others described not always wanting generic solutions and skills but "somebody to be with me" and hear how they were feeling (Ruth). This might be particularly important where participants felt that professionals had "run out of skills" to use (Sam), as emotional support could still matter even when there was no clear technique or answer available. Being treated with kindness and understanding also seemed to matter when participants were experiencing aspects of care that they "didn't agree with and didn't want" (Grace). In these accounts, empathy and attentiveness appeared to help participants feel that a staff member "really care[d]" about them (Paige). Isobel described how meaningful it was when staff would "even just acknowledge the fact that you're a human being," adding that this "hasn't happened very much."

Participants often understood these experiences as shaped not only by individual staff interactions, but also by limited staff capacity and wider service pressures. Several participants distinguished between individual professionals and the wider system, describing staff as "brilliant" and "doing their best in a system that can't cope" (Daniel). Staff were often described as appearing to be under "immense pressure" and "very much struggling" before leaving the service (Alice). Some participants therefore understood difficulties in care were shaped by funding, staffing, organisational pressures and service constraints. This could leave participants feeling that staff did not "have a choice about" what they were able to offer (Mina). However, participants also described the impact of these pressures on them as service users. One participant reflected that staff could seem like "workhorses", caught up in forms and demands, but questioned this when it came "at the expense of what you're actually

supposed to be doing" (Isobel). In this way, participants could recognise the pressures on staff while still experiencing process-led interactions as leaving them unseen, unnamed, or treated as another task within the service.

3.4. Care is not a favour

Participants described mixed experiences of care, with some feeling supported and others feeling that the support they received did not meet their needs, or at times caused additional distress. Some participants described a sense that contact with the CMHT was positioned as something they should feel "grateful for", even when this was experienced as insufficient, unhelpful, or simply "the bare minimum" of what the service should provide (Grace). This was particularly evident when staff pressures were communicated in ways that felt like excuses or made the person feel "like the problem" (Sam).

Participants gave examples of feeling like an inconvenience when asking for basic aspects of care, such as confirmation of the next appointment, or when professionals said they were too busy to do things that had previously been agreed. Grace described a professional promising to do something and then becoming "grumpy" when asked about it later, saying they did not have time. This could leave participants feeling as though their needs were excessive, even when they were asking for support that they felt should reasonably be part of care.

Participants also described feeling that expectations around engagement were unevenly applied. They felt expected to attend, respond, and demonstrate commitment to care in the right way, while staff cancellations, delays, or lack of follow-through did not appear to carry the same consequences. John described cancelling appointments with notice, but feeling this was recorded inaccurately as missed appointments, despite also experiencing cancellations from the professional. They felt it could be "easier" for services to describe someone as "not engaging" and "refer them back to their GPs", rather than considering the

circumstances around disrupted contact. In these accounts, participants could feel held responsible for maintaining engagement and managing distress in a way that remained acceptable to the service, even when care was not consistently offered back to them.

> I remember like at the beginning kind of being told like oh you like, you know you need to be more on top of this otherwise you could be like discharged and like I remember that being really quite stressful 'cause, that was when I was at my worst. (Madeline)

Some participants described feeling that needing ongoing or repeated support could be viewed negatively within services. This included feeling like a burden, or that requiring longer-term care was seen as a problem within systems focused on progression and discharge. Participants described feeling caught between needing support and feeling that this need was judged or questioned. Some referred to feeling as though they were “taking up time” (Ruth) or being a “drain” on services (Isobel).

> I was like languishing as I say, it's a very word with lots of negative connotation and I was like, do they think that I'm like, here for fun? Do they think that I travel an hour and a half one way, 3 hours round trip total to get to appointments? Because I think it's= I think it's fun, I think, like, I want to waste their time. (Sam)

This sense of conditionality was also reflected in how participants described raising concerns or disagreeing with care. Although some participants felt able to raise concerns where they had a positive relationship with a staff member, this did not feel possible in all situations. Concerns about being labelled as “this complaining family” (Grace), being “told off” (Jess), or being seen as “difficult” (Jayne) contributed to a sense that speaking up could have negative consequences. This was reinforced by experiences where raising concerns appeared to be met with negative responses, either within direct interactions or in relation to

subsequent care. For some, questioning aspects of care or expressing disagreement was experienced as risky, contributing to a reluctance to advocate for their needs.

Participants also described occasions where their views or preferences appeared to be interpreted as a lack of engagement or "non-compliant" (Ruth). In some accounts, declining or questioning a form of support could be understood by services as a sign of "lacking insight" (Louise) or unwillingness to engage, rather than as a legitimate preference or concern. This could influence how care was offered, including delays, changes in access to interventions, or a sense that participants needed to demonstrate the right kind of engagement before receiving further support. One participant described being told they "might be able to access therapy if I do this course", while another described needing to "pass DBT" before accessing trauma therapy (Sam).

> I think my perception was always if I don't go through things, it seems that I'm not engaging or not wanting help, whereas that never was the case like I was quite sort of active in sort of the care that I received. (Jess).

For some participants, the CMHT was experienced as one of the only available sources of support. While some people described being able to access private therapy when they could not receive this through the CMHT, this was not available or appropriate for everyone. Participants with experiences such as psychosis or schizophrenia described the CMHT as the only realistic option for therapy. Others positioned CMHT involvement as a last resort after being transferred from or being rejected by other more specialist services. This could make even limited contact feel "better than nothing" (Isobel).

However, being part of the service process did not necessarily mean feeling recognised in a human or whole-person way. Participants' accounts suggested that this recognition depended not only on what happened within appointments, but also on whether care connected with the wider contexts of their lives.

4. Care beyond the clinic

Participants described the importance of care that recognised their lives beyond the clinic, including work, relationships, social connection, leisure, community roles, and the everyday contexts in which they were trying to manage their mental health. While some experienced elements of this broader support, many described appointments as focused more narrowly on symptoms, risk, diagnosis, or medication. Care planning processes were understood as having the potential to offer a broader picture of the person, but did not always feel tailored, dynamic, or helpful for future support. For some, "all the conversations were based around mental health", meaning it did not feel like staff got to know "what's important to me" (Ruth). Some participants wanted care planning to include more attention to "who you can turn to externally" and "internally", including friends, family, and wider networks (Maureen). This meant that the 'community' aspect of CMHT care was not always clearly experienced as support for connection, belonging, or participation beyond the service.

> It wasn't didn't feel very like it was personal or that they wanted to really find out my strengths, my weaknesses. What, you know what I had achieved or what I hadn't achieved or what I was, you know, what was what-What was making me happy at that point in time or what-what was I unhappy about or just things like that? (Precious)

The location and format of appointments also shaped participants' experiences of care. Appointments often took place in CMHT buildings, which Ruth experienced as clinical, uncomfortable, or difficult to access, particularly where services were far from home or poorly connected to public transport. Others described being offered home visits, telephone or virtual appointments, or meetings in community settings such as a GP surgery. Some participants met staff in more informal or activity-based ways, such as going for a walk. These forms of contact were sometimes described as helping participants get out of the house, feel more supported to access the community, and experience care as more connected

to everyday life. This contrasted with office-based appointments, which could feel inconvenient, clinical, or disconnected from the contexts in which participants were trying to live and recover.

> They [support workers] are the people that, you know, do the sort of the real engagement with you...will be able to help you with practical things, be able to go on a walk with you, maybe help you cook a meal or maybe go to appointments. (Grace)

Work was also described as an important part of identity, routine, and recovery for some participants, but this was not always reflected in how CMHT care was organised. Laurence reflected that services were theoretically moving towards supporting people into work, but this was not always matched by other participants' experiences of care alongside working life. Practical barriers were also described, including appointments only being offered during working hours, requiring participants to take time off work or lose pay in order to attend contacts that did not always feel helpful. While one participant described being referred for employment support, others would have valued more help to remain in work while managing their mental health. Ruth linked this to assumptions about who uses mental health services:

> "It's quite a outdated like sort of stereotype that people who struggle with their mental health can't work" (Ruth)

For two participants (Louise and Laurence), taking on roles within services or the wider community, such as peer support work or contributing as a lived experience advisor, was described as an important, especially after needing to leave other work roles due to mental health. Participants described this as a different way of engaging with support, where they were not only receiving care but also offering support to others. For one, this was described as being "part of my treatment" (Laurence), suggesting that these roles were experienced as contributing to their overall support, rather than being separate from it.

Connection with others, including peers, family members, and community groups, was described as helping to provide a sense of belonging. For many participants, difficulties with mental health were closely linked to experiences of "being isolated", while "anything that can create connection is key" (Isobel). Group-based and community activities were also described as offering structure, purpose, and opportunities for social connection. For some participants, these forms of support acted as a bridge alongside, or at times in place of, formal interventions, particularly during periods of waiting for or "before my talking therapy like started coming to an end" (Madeline). Group-based support could therefore reduce isolation during waits for other input by offering connection when individual clinical support was not yet available. In particular, participants valued opportunities to "talk to like-minded people that are going through something similar" (Daniel). This offered understanding and validation that "you're not the only people that go through this sort of thing" (Daniel), which was not always available within formal services.

However, access to community-based support was not consistent. Some participants described being signposted to community resources such as a nature group, walking groups or book groups, while others reported receiving little or no signposting. Even where recommendations did happen, participants sometimes felt that staff "don't actually know what they're signposting people to" (Sam), or that the suggested resources were not suitable for their needs or level of wellness at that time. Participants also described community-based resources within the service as under-resourced, with charities and external organisations needing to "pick up the slack" (Daniel) where support was not available within the CMHT. Participants also highlighted the "withdrawal of funding for this very vivacious third sector community of providers" (Ruth) due to austerity, and also particularly following the COVID-19 pandemic. Several participants felt that community support should either be better

resourced within CMHTs or that CMHTs should have stronger links with community organisations, “rather than kind of just being signposted” (Madeline).

These accounts also raised questions about what participants expected from a community mental health team. For some, ‘community’ did not feel like a clearly available part of care, particularly when groups had reduced, external resources were overstretched, or appointments remained largely clinic-based. Community connection often seemed to depend on what participants could access outside the service, or on individual staff who were able to support links beyond appointments. For some participants, this contributed to a sense that “there’s a lack of vision” and “I don't really understand where this service is...where it's going, what it thinks it's doing” (Laurence). In this context, the community aspect of CMHT care could feel unclear, both in terms of available support and in terms of the wider purpose of the service. This tension was captured by Daniel:

> “I think more could be done just engaging people. Getting people meeting with each other. You know, it's meant to be community, then make it about community as well.” Daniel

Discussion

Chapter Overview

This chapter discusses the findings from the results chapter and explores what they indicate about how care is experienced by people accessing a CMHT. It explores tensions between provision and support, care held by teams and by individual professionals, person-centred practice and procedural processes, and the location of care within wider community life. Across these areas, service pressure is considered as a cross-cutting influence on access, continuity, collaboration and connection. The chapter argues that care was experienced as most meaningful when it was timely, relationally consistent, flexible, collaborative and responsive to people's wider lives. It then outlines implications for clinical practice, service development, policy and future research, including the need to protect relational care within pressured systems. The chapter also considers the study's strengths and limitations before reflecting on the researcher's learning across the project and the broader question of what conditions allow provision to become care.

Key Findings

This study qualitatively explored how people experience care from generic community mental health teams. Participants described a range of experiences while under CMHT care, from feeling known, supported and held by individual professionals, to feeling delayed, dismissed, uncertain or left to manage alone. Across the findings, care was experienced as meaningful when provision felt responsive, relationally consistent, person-centred and connected to people's wider lives. However, formal provision did not always translate into felt support. Participants' accounts suggested that experiences of care were shaped by individual encounters with staff, inconsistencies within the service, and wider pressures across an overstretched mental health system.

These findings resonate with existing research on experiences of community mental health care. Trevillion et al. (2022), for example, highlighted the importance of relational practice for people using community mental health services for complex emotional needs, including non-stigmatising, individualised, trauma-informed, collaborative and consistent care. Carter et al. (2024) similarly explored experiences of CMHTs for people with long term experiences of psychosis and identified continuing tensions around power dynamics between patients and professionals, challenges expressing dissatisfaction in care, the importance of connection, and a sense of needing ongoing support due to their complex needs. The present study adds to this literature by exploring experiences across a broader generic CMHT population, rather than focusing on one diagnostic group or service-user subgroup. This suggests that relational, consistent and person-centred care may be important across CMHT care more widely, before being specific to one diagnostic category.

These findings also align with wider literature on service users' experiences of mental health care more generally, where recurring concerns include relationships with professionals, involvement in care, continuity, safety and feeling recognised as a person. These concerns have been identified across multiple settings, such as community mental health services (Newman et al., 2015) and inpatient services (Staniszewska et al., 2019), and also within individual aspects of care, such as mental health assessments (Patel et al., 2025). Similar difficulties with coordination, continuity and navigating fragmented provision have also been identified across integrated physical health and social care services (Davidson et al., 2021). The reoccurrence of these difficulties across different settings suggests that difficulties experienced within CMHTs cannot be addressed by focusing on individual services alone. They also require attention to the wider structures, assumptions and organising principles that shape mental health systems.

Provision vs Support: Is care available?

The theme ‘Wheel of Intervention’ reflects how participants experienced access to CMHT support as unpredictable, delayed, and conditional, with formal pathways into care not necessarily translating into the experience of care as meaningful or timely in practice. This suggests a distinction between provision and care, where formal structures (now referred to as provision) such as referral, assessment, monitoring, and treatment may exist at the level of service organisation, but do not automatically become experienced as an active process of support (now referred to as care) by those using the service. In this way, being “under care” did not necessarily mean feeling cared for.

Participants described a range of different formal interventions offered by the CMHT, including medication, psychological therapy, sessions with a support worker and care coordination. However, the provision available through the service was often shaped by uncertainty about what could actually be accessed, when it would become available, and whether it reflected their individual needs. This fits with a previous systematic mapping review which reported that the availability and appropriateness of services was a significant barrier to accessing mental health services (Lowther-Payne et al., 2023). It is also consistent with other research about the experience of treatment pathways in mental health services involving uncertainty, long waiting times, and a lack of tailored psychological interventions (Quinlivan et al., 2023, Switzer et al., 2019). The present study adds to this by showing that uncertainty was not limited to psychological intervention, but shaped participants’ experiences of CMHT care more broadly, including medication, monitoring, care coordination, crisis support, psychological input, and routine contact. In this sense, the issue was not only access to treatment, but access to care as an active, responsive, and meaningful process.

In particular, participants' descriptions of support arriving only after deterioration or crisis indicate that provision was often organised around responding to immediate risk rather than preventing distress over time. Reactive patterns of care have also been identified in previous research on safe care (Averill et al., 2024), including literature focused on people diagnosed with borderline personality disorder (Ware et al., 2022). While this literature is relevant, reactive care was described by participants across diagnostic groups in the present study. This is important because, despite the particular association between borderline personality disorder and reactive or crisis-led care in the literature, participants with different diagnoses described support becoming available primarily in response to deterioration or crisis. This suggests that reactive provision may reflect a broader organisational pattern within CMHT care, rather than a diagnosis-specific experience. This broader pattern is consistent with Sambrook et al.'s (2025) description of NHS services as focused on "stabilisation not recovery", and with Liberati et al.'s (2022) suggestion that the Covid-19 pandemic intensified the deprioritisation of preventative work across secondary mental health services, including CMHTs. This is supported by the present findings from people who had been under the service for a long time, who described a change in their experience since the pandemic. This focus on stabilisation rather than recovery may reflect the pressures under which CMHTs are operating which can pull services towards crisis containment rather than sustained, preventative support. While stabilisation may meet urgent safety needs, participants' accounts suggest that repeated crisis-led responses meant that access to care was associated with deterioration, rather than experienced as ongoing, meaningful support.

Additionally, participants often described a burden of proof within CMHT care, in which access to support appeared to be conditional based on whether they were perceived to be sufficiently unwell or engaging within the expectations of the service. Previous research has suggested that this experience is often held in a context of poor cooperation between

services and managerial pressures contributing to “excessive gatekeeping” and discharging people before they might be ready (Averill et al., 2024). This moves the issue beyond individual staff decision-making, while still leaving open how such pressures were experienced by service users. Kiely and Warnock (2023) also describe how access to a service could be restricted through “tacit criteria”, including informal and implied judgements about a person’s level of need, perceived deservingness of care, and any anticipated difficulty of supporting them. Although their study focused on a local authority mental health service rather than a CMHT, this parallels some participants’ descriptions of needing to infer how to demonstrate that they were sufficiently in need of care.

Participants’ accounts of long waits, rejected referrals, and uncertainty about what support they were eligible for suggest that service-level inconsistency was a significant barrier to care being experienced as reliable or containing. This was starkly illustrated by the participant who likened accessing the CMHT to a lottery win. These accounts map onto Punton et al.’s (2022) finding that waiting for mental health care can affect functioning and generate negative emotions, thoughts, and beliefs. Participants in the present study described feeling worthless, irrelevant, alone, or left on the scrap heap. Edwards et al. (2025) offer a more critical interpretation of such gaps, arguing that absent, inappropriate, or discriminatory provision may amount to institutional neglect. This framing is useful here because it captures how inconsistency may be experienced not only as logistical difficulty, but as communicating that a person’s distress is not recognised as mattering. However, as the present study cannot determine whether these experiences constitute institutional neglect in a formal or organisational sense, this concept is best understood as a critical lens for considering how repeated delays, rejected referrals, and uncertainty about eligibility could be experienced as a failure of care.

CMHT provision was not absent, but it was often uncertain, delayed, conditional, and reactive. Existing literature helps situate these patterns within wider mental health service pressures, but the present study adds that these were experienced not only as barriers to treatment, but as shaping whether participants felt cared for at all. Given these pressures on formal CMHT provision, participants' accounts suggest that relationships with individual professionals became especially important in enabling provision to be experienced as care.

Team vs Individuals: Who is responsible for care?

The theme 'Secure base from consistent care' reflects how consistency, reliability and being known shaped whether CMHT provision was experienced as care. Although provision was organised at the level of the team, participants often described feeling cared about through relationships with particular professionals. This created an important tension between care being allocated at the level of the team and being relationally held by an individual. Where the wider CMHT shared knowledge, remained accessible and responded consistently, the service itself could offer some continuity when an individual worker was unavailable. Where these structures were fragmented, the sense of being known could become concentrated in one relationship and vulnerable to staff absence, turnover or transition.

This may help explain why similar forms of provision, such as assessment, monitoring or crisis planning, could be experienced differently across accounts. Muusse et al. (2022) suggest that the meaning of community mental health intervention depends on the relationship between the service user, professional and service setting. In the present study, provision appeared more likely to be experienced as care when participants felt known, involved and treated as people, while similar processes could feel intrusive, conditional or controlling when relational trust was absent.

Across all accounts, participants spoke about the importance of access to a consistent relationship whilst under the care of the CMHT. Therapeutic alliance literature has

consistently shown that the quality of the relationship between a practitioner and service user is associated with better outcomes across different therapeutic approaches (Horvath et al., 2011). Although this literature largely focuses on formal psychotherapy, the present findings suggest that relationships with CMHT professionals may also be therapeutic in themselves. Their value appeared to involve care being reliable, responsive and attuned to their needs. These are qualities associated with secure attachment relationships (Adshead, 2018), indicating that these relationships may warrant the same attention and protection as other therapeutic interventions. It also links to attachment-informed understandings of mental health care, suggesting that stable professional relationships can provide a secure base during periods of distress, support engagement with care and are thought to be important for successful intervention (Bucci et al., 2015). This suggests that the relational function of CMHT care depends not only on whether a professional is formally allocated, but on whether there is sufficient time and predictability for the relationship to become trustworthy. Participants' accounts indicated that feeling cared for developed through repeated experiences of being recognised, remembered and responded to, rather than through one-off contacts or the allocation of a named worker. Ideally, these experiences might be supported both within a stable professional relationship and through a coherent team that could retain knowledge and continuity around the person. In practice, however, participants often described the relational aspects of care as held predominantly by one professional, with the wider team less consistently experienced as a secure base.

Participants' accounts highlight the importance of continuity of care, as a sense of reliability and attunement are unlikely to be established through fragmented or unpredictable contact. This resonates with Iversen et al. (2025), who suggested that relational qualities such as trust, reliability and attunement are not simply present or absent, but are developed over time and made vulnerable by fragmented systems. In the present study, continuity appeared to

operate both through relationships and through information sharing. Consistent relationships allowed trust, familiarity and a sense of being known to develop over time, whilst effective information sharing appeared to help sustain this sense of being known across the wider team when consistency with one professional was not possible. This distinction is consistent with research showing that service-user-defined continuity is associated with stronger therapeutic alliances and having more needs met (Sweeney et al., 2012).

However, almost all participants described inconsistency in the staff they had contact with, while poor information-sharing meant that some had to repeat their histories, re-explain their needs, or felt that professionals did not understand them. This is consistent with Belling et al.'s (2011) finding that staff turnover required service users to rebuild relationships and repeatedly retell information to new professionals. The present study adds to this by showing how inconsistent relationships and poor information-sharing within a single CMHT could undermine whether the team as a whole was experienced as supportive care.

This was particularly critical during times of crisis or transition, when the reliability of care was most tested. Participants found that they often had to rely on wider team systems, such as duty services, when a key professional was unavailable. However, these systems did not always appear to hold sufficient knowledge of their history, needs, or preferred ways of being supported. As a result, moments when participants most needed care to feel consistent and containing could instead become times when the absence of relational and informational continuity was most strongly felt. This can also be understood through Circle of Security literature, which emphasises the importance of caregivers being available both as a secure base from which to explore and as a safe haven to return to during distress (Coyne et al., 2019). Participants appeared to need the service to provide both functions, supporting autonomy and day-to-day coping when things were more stable, while remaining accessible, responsive and containing during crisis or transition. A single clinician might provide these

functions while available, but a CMHT would need sufficient shared knowledge and responsiveness for them to survive that person's absence. When care was fragmented, or when wider team systems did not hold knowledge of the person, the CMHT could become less available as a safe haven at the very point when participants most needed support. Although the Circle of Security was developed in the context of caregiver-child relationships (Hoffman et al., 2006), the nature of attachment in patient-staff relationships suggests that it may be applied with caution to community mental health teams.

However, this attachment-informed understanding of CMHT care sits in tension with the wider pressures under which services operate. Participants' accounts suggested that feeling known and supported required time, predictability, and continuity, yet these are precisely the conditions that may be difficult to maintain in overstretched services. Pressures towards short-term intervention, risk monitoring, and throughput may limit the capacity for relationally focused care, while concerns about dependence may make services cautious about offering the consistency that participants experienced as containing (Adshead, 2018; Seager, 2006). This raises questions about how dependence is understood within CMHT care. From an attachment informed perspective, if ongoing contact is viewed primarily as a risk of dependency, services may reduce the very forms of consistency and responsiveness that allow people to feel secure enough to cope more independently (Seager, 2013). Attachment-informed literature offers an alternative understanding that predictable and attuned availability can provide the conditions through which autonomy develops (Ainsworth et al., 1978, Bucci et al., 2015). In this sense, relational continuity may be less a barrier to independence than a foundation for it.

Bion's concept of the container-contained relationship offers a useful way of understanding why consistency matters, in its suggestion that distress may become more tolerable when it can be received and held by a responsive other. In mental health services,

this function may be carried not only by individual clinicians, but also by the structure and predictability of the service itself, including regular contacts, clear and forward looking care plans, flexible service location, the sharing of knowledge and reliable responsive support (Joyce, 2004). From this perspective, the containing function of the CMHT depends on both relationships and systems. Where structural elements of care such as care plans, shared knowledge, availability and coordinated responses were absent or inconsistent, containment became more dependent on individual professionals who were able to offer attuned and responsive relationships.

This raises an important question about what it means for care to be held by a multidisciplinary team. Procter et al. (2015) suggest that multidisciplinary structures do not automatically produce genuinely shared responsibility. A CMHT may include multiple professional roles, but this does not necessarily mean that care feels coordinated, collectively held or continuous. Similarly participants often described care as dependent on particular individuals, rather than a coherent system or pathway. The CMHT itself was not always experienced as a secure or containing base, but as a series of fragmented encounters around one more enduring relationship. This suggests that a team becomes more than a collection of professionals when it can hold knowledge, responsibility and relational continuity collectively, allowing care to remain coherent across changes in staff and points of contact. Where this collective function is absent, it may become harder for the personhood of those accessing CMHTs to be recognised and held in mind throughout the process of care.

Person vs Process: How is care enacted?

This concern is developed in the theme ‘Person vs Process’, which reflects how participants’ experiences of care depended not only on the availability of provision, but on whether they were recognised as people with individual needs, preferences and autonomy. When care was experienced as helpful, participants described support that felt flexible,

collaborative and validating of their right to care. In contrast, participants described less helpful care as “tick-boxy”, formulaic, or as though they were not being treated like human beings. This appeared to reflect a broader tension between care experienced as a relational, person-centred response and care experienced as a procedural task.

Participants emphasised the importance of autonomy and of having their voices respected within their care. Key aspects of this included being actively involved, being treated as equal partners, having their views taken seriously, and having access to information that supported informed choices. These accounts broadly reflect literature on shared decision-making in community mental health settings, where participation in care can be shaped by factors such as capacity, risk, the possibility of disengagement, environmental constraints, power dynamics, and the emotional difficulty of discussing sensitive topics (Ahmed et al., 2021; Ahmed et al., 2024). Several of these issues were also evident in participants’ accounts, particularly changes in their own capacity to make decisions, contextual constraints, and concerns about how engagement might be interpreted by professionals. However, participants tended to describe these issues in more relational and experiential terms, focusing on whether they felt listened to, respected and able to influence decisions in practice. Research in secondary mental health services has also highlighted the relational work required to support shared decision-making, and the difficulties involved in embedding this within practice (Brooks et al., 2019).

These findings also highlight the power imbalance within CMHT care. Decisions about access, treatment, risk planning and discharge were often held by professionals or services, meaning that participation took place within relationships where service users did not always have equal control over what happened next. This was particularly important where participants described decisions being made without them, or where they were unsure how their views would be interpreted by professionals. In this context, involvement was not

only about being asked for an opinion, but about whether participants felt able to influence decisions that affected their care. This also connects with Ahmed et al.'s (2024) study, which found that most participant patients reported not being involved in identifying risks and were unaware of the information included in their risk management plans. Together, these findings suggest that even where collaborative care is emphasised within policy and practice frameworks, important aspects of decision-making may still remain professionally controlled and insufficiently transparent to service users.

Participants' accounts also highlighted flexibility as an important aspect of person-centred care. Helpful care was often described as support that could be adapted to the individual, rather than requiring the person to fit a standardised process. This is supported by Henderson et al.'s (2020) systematic review, which found that professionals in community mental health services also viewed flexibility as important for engagement. In the present study, flexibility appeared particularly relevant where participants described neurodivergence, communication preferences or trauma-related needs. References to adaptations, trauma-informed language and Oliver McGowan training, a UK mandatory training programme intended to improve healthcare staff understanding of learning disability and autism, reflected participants' expectations that care should recognise different ways of communicating, processing information and engaging with services.

Participants valued principles already present in recovery-oriented and trauma-informed frameworks, such as choice, collaboration, trust and empowerment (Leamy et al., 2011; Sweeney et al., 2018). These principles are also reflected in national policy and guidance on recovery-oriented and trauma-informed care (Department of Health, 2011; Office for Health Improvement and Disparities, 2022) The significance of the present findings lies in the inconsistent translation of these commitments into participants' everyday encounters with CMHTs. Participants' accounts suggested that these approaches were not

consistently implemented, shaping whether care felt collaborative, flexible and responsive to their individual needs in practice. This fits with discussions in the literature about barriers to implementing recovery-oriented and trauma-informed care, including systemic pressures on services and difficulties translating broad conceptual principles into everyday practice (Payne et al., 2024; Huo et al., 2023). Although these studies are not specific to CMHTs, the concerns appear to resonate with the experiences described by participants.

Across these accounts, care became person-centred when participants were able to influence, understand and participate in support that was adapted to them, rather than being expected to fit a standardised process. However, participants' accounts also suggested that processes were not inherently unhelpful. Assessments, care plans, risk discussions and care coordination could support care when they were used to understand the person, guide support and share knowledge across the team. The difficulty appeared to arise when these processes were experienced as primarily serving the needs of the system rather than supporting the person. This resonates with previous research suggesting that administrative and procedural aspects of mental health care can reduce opportunities for personalised and recovery-focused work when they become disconnected from therapeutic relationships and meaningful support (Simpson et al., 2016). Similarly, research on risk and safety has suggested that risk assessment and administrative tasks may be experienced as system priorities, particularly when they detract from time available for relational care (Coffey et al., 2016; Averill et al., 2024). The present findings add to this by showing how participants could experience these processes as "tick-boxy" or formulaic when they did not lead to feeling understood, supported or meaningfully involved.

These accounts also highlight the importance of dignity, legitimacy and conditionality within CMHT care, as it was suggested that care felt less person-centred when support appeared contingent on being seen as sufficiently unwell, sufficiently engaged, or willing to

follow the expectations of the service. This connects with recovery-oriented literature which has raised concerns that people may be blamed or perceived as not trying hard enough when they do not progress or engage in expected ways (Onken et al., 2007). Valenti and Giacco's (2022) analysis of influence strategies in community mental health care also offers a useful way of understanding this tension, as they describe how therapeutic influence can become coercive when support is experienced as a conditional offer rather than as a freely chosen process. Although participants did not always describe overt coercion, they did describe more subtle pressures to present, engage, or respond in ways that fitted service expectations. In this sense, conditionality could undermine personhood by making care feel like something that had to be earned, proved, or maintained through compliance, rather than a collaborative process grounded in need, dignity and shared understanding.

This raises a further question about where care is located, as recognising people as whole persons may require CMHT care to extend beyond procedural involvement within services and attend to the wider relational, social and community contexts in which people live.

Located vs Integrated: Where is care orientated?

The theme "Care beyond the clinic" explores participants' reflections that meaningful support extended beyond the walls of the CMHT into peer connection, groups, family relationships, purposeful activity and roles within the community. Care was therefore experienced not only through the treatment offered within services, but through whether the CMHT recognised and supported participants' lives beyond clinical contact. This fits with Brooks et al.'s (2020) longitudinal qualitative study of personal support networks among people with severe and enduring mental health problems, which suggested that support is negotiated through a broader personal community of family, friends, professionals, activities, places, objects and groups. In this sense, supporting people in the community may involve

more than providing appointments outside hospital. It may require attention to the everyday relationships, routines, roles, places and activities that help people sustain identity, manage distress and experience life beyond services.

Community care was therefore not only about whether services were delivered outside hospital or in a local clinic, but whether care connected with the social, relational and practical contexts of participants' lives. Participants' accounts suggested that the location, timing and form of contact could shape whether care felt integrated into everyday life or separated from it. For example, appointments that were organised around clinical buildings or fixed working hours could be difficult to fit alongside work, family responsibilities, transport, or the wider routines through which participants were trying to build stability. This was particularly evident in relation to employment, where some participants described wanting more support to work or maintain purposeful activity, while also finding that appointments could interfere with work or require financial sacrifice, such as losing pay to attend. This is notable given wider policy emphasis on supporting people with mental health difficulties to access or remain in employment, including employment support for people with severe mental illness, such as through IPS Services associated with CMHTs. (Department for Work and Pensions et al.,2024). However, participants' accounts suggested that work was not always actively supported as part of CMHT care, and in some cases could be treated more as a pressure or complication than as a meaningful role that services might help people sustain. This echoes Sharek et al.'s (2022) finding that staff in IPS services described some CMHT staff as doubting people's capacity for work or not recognising pathways to recovery outside a medical lens.

This fits with research suggesting that access to social capital, including social connections, community participation and meaningful activities, is a significant predictor of recovery outcomes for those accessing community mental health teams, both in the UK

(Ngamaba et al., 2023) and internationally (Cano-Prieto et al., 2023). Participants described building connection with others through meaningful activities, including walking or nature groups and groups where they could learn and share experiences. This also links with the systematic review discussed earlier, where psychoeducational groups offered opportunities for shared understanding and connection, while also helping participants make informational content more meaningful and usable through discussion with others who had similar experiences. In this sense, the value of groups appeared to extend beyond simply receiving information, as shared reflection and peer interaction could help participants interpret, apply and emotionally connect with what was being discussed. Across both the review and the present study, groups appeared helpful for some people and could generate benefits that extended into everyday life (Cooley et al., 2021). However, group-based interventions may still require individualised support to help people translate these experiences into their wider lives and care (Bjørkedal et al., 2021)

A few participants also spoke about appointments with support workers from the community mental health team which revolved around activities that supported their integration beyond the service. This resonates with Smyth et al.'s (2011) qualitative study of mental health service users' experiences of community occupations, which found that everyday community activities could support feelings of belonging and inclusion, although participation was shaped by practical and social barriers. Extending this, Killaspy et al.'s (2022) systematic review of community-based social interventions for people with severe mental illness highlights the importance of psychosocial interventions that support social functioning, participation and recovery, suggesting that activity-based support may represent a valuable but potentially under-recognised component of care for people accessing CMHTs.

At the same time, participants highlighted that access to community-based resources was not always consistent. Some described a reduction in support groups and community

resources following the COVID-19 pandemic, which appeared to limit opportunities for informal support, peer connection and activity outside formal appointments. This meant that support beyond clinical contact was often dependent on resources that were not consistently prioritised or available within the CMHT, or on external services that were themselves described as under-resourced and overloaded. This resonates with evidence that support for social and economic needs remains inconsistent across mental health services, and that collaboration between NHS and third-sector services can be hampered by overstretched pathways, limited intervention-focused care and barriers to collaboration (Sambrook et al., 2025). This suggests that while community connection was valued, it was not always clearly held as part of CMHT care.

This apparent narrowing of community-oriented support is important given the historical positioning of community as central to the function of community mental health teams. As discussed earlier, this was historically centred around the location of care being outside of a hospital setting, but there were also aims for wider integration in the local community (Bouras et al., 2018). Participants' accounts suggest that this wider community function was not always clearly available or consistently prioritised. Instead, "community" could become more closely associated with the location of service provision than with active support for connection, participation and belonging beyond the service. This raises questions about whether community-oriented work was understood as a core part of CMHT care, or as an additional form of support dependent on available groups, individual staff interest, or external services. This question was reflected in comments from participants about a disconnection from community, including one who had been under CMHT services for 30 years and felt that the CMHT had lost its vision and sense of focus following the disruption from the pandemic. Some teams have adopted names that no longer explicitly include the term "community", instead going by names like "adult mental health team" (Oxford Health,

n.d.) or “specialist mental health recovery service” (EPUT, n.d.). While terminology alone should not be over-interpreted, such changes may reflect a wider ambiguity about whether these services are primarily community-oriented, clinically specialised, or administratively organised around severity and risk.

Participants’ accounts suggested that this drift was not experienced as an abstract organisational change, but through the loss of groups, reduced opportunities for informal contact, appointments that felt disconnected from everyday life, and a greater emphasis on monitoring or clinical review. This resonates with wider concerns that organisational pressures may move services away from relational and community-oriented care towards more informational or administratively organised forms of care (Moth, 2022). In this sense, the community function of CMHT care may become narrowed when care is organised mainly around appointments, monitoring and documentation, rather than around the relationships, roles and activities that support life beyond services.

Pressure into Culture: What disrupts care?

Across all themes, participants located their experiences within a wider system experienced as under considerable strain. This pressure did not remain abstract, but appeared to shape access, continuity, collaboration and community connection in ways that were directly felt by service users. Care required timely access, continuity, personhood, participation and wider connection; however, participants’ accounts suggested that each of these could be disrupted by service pressures. As a result, care could become harder to experience even where provision formally existed.

This suggests that system pressure may be transmitted interpersonally, moving from wider structural constraints, through service organisation and staff practice, into the experience of care. Previous research has similarly highlighted how complex systemic issues, underinvestment, staffing shortages and unmanageable workloads can shape the safety and

quality of community mental health care (Averill et al., 2024). This may be particularly difficult for generic CMHTs, which are expected to hold complexity across diagnostic, social and service boundaries, while often sitting alongside specialist services with clearer remits and thresholds (Laugharne et al., 2018). Recent staff-perspective research also supports this interpretation. Sambrook et al. (2025) found that staff across NHS and third-sector services described a "community in crisis", characterised by stabilisation rather than recovery, inefficient pathways and barriers to collaboration. This convergence between service-user and staff accounts suggests that experiences of delayed, fragmented or reactive care are not simply matters of individual dissatisfaction, but reflect wider pressures in how community mental healthcare is organised and resourced.

Organisational pressures may also pull services away from relational, recovery-focused and personalised work, towards more administrative or informational forms of care (Simpson et al., 2016; Moth, 2020). In this context, the culture and organisation of work may define care in ways that make relational care less visible, less valued, or less clearly owned. This is important because the kind of care participants valued often required time, flexibility, persistence and attention to wider social and practical needs. Yet previous research suggests that these forms of work are not always supported by role expectations, resources or organisational structures, even though practitioners may view practical help and social support as central to engagement (Henderson et al., 2020). The present findings therefore point to a gap between what services aim to offer and what they are able to provide in practice.

This also raises a wider question about how autonomy is understood within CMHT care. Participants' accounts suggested that independence was not always supported by reducing contact or expecting people to manage alone. Instead, autonomy appeared more possible when people had reliable relationships, clear routes back into support and confidence

that the service would respond if needed. This aligns with attachment-informed literature suggesting that predictable and attuned availability can support exploration, confidence and independence (Bowlby, 1988; Bucci et al., 2015; Adshead, 2018). Within overstretched services, however, pressures towards discharge, throughput and reduced contact may make this form of relational availability harder to sustain. In this context, independence can risk becoming experienced as unsupported responsibility, rather than recovery supported by a secure and responsive system.

Relational care has been identified as important in previous research with specific groups using community mental health services, including people with complex emotional needs. The present study extends this by suggesting that relational, consistent and non-stigmatising care may be important across a broader generic CMHT population, rather than only for one diagnostic group or service-user subgroup. Without sufficient capacity, continuity and shared responsibility, CMHTs may be able to provide assessments, monitoring, treatment and coordination, while still struggling to offer care as an active, relational and meaningful process.

This uncertainty feels particularly important in the context of ongoing service reform. Recent proposals for 24/7 neighbourhood mental health centres suggest a continued aim to bring community, crisis and inpatient pathways into closer relationship, with early models bringing together community mental health services, crisis support and short-stay provision (NHS England, 2026c). These changes may offer opportunities for more accessible and integrated support, but they also raise questions about what kind of care is being created. The present findings suggest that integration may need to involve more than bringing services together within new pathways or buildings. It may also require attention to whether care can feel timely, consistent, personal and connected to people's lives. This leaves a broader

question about how future community mental health services might protect the relational and contextual conditions that allow provision to be experienced as care.

Summary

This study explored how people experience care from generic CMHTs. The findings suggest that CMHT care cannot be understood only through the provision of services, interventions, monitoring or care coordination. From the perspective of people accessing services, care was experienced when support felt timely, responsive, relationally consistent, person-centred and connected to wider life contexts. In pressured systems, this transformation from provision into care could be disrupted. Participants could be formally under the care of a CMHT while still feeling uncertain, unknown, unsupported or disconnected from meaningful help.

The findings also raise questions about how the relational and contextual needs of people accessing CMHTs can be sustained within the organisational conditions of contemporary services. Participants' accounts showed how thresholds, staffing pressures, available pathways and administrative processes shaped their experiences of care. Although this study cannot explain how these pressures were understood or managed within teams, it demonstrates their consequences for people trying to access and rely on support.

At the same time, the findings also showed that CMHT care could be experienced as valuable when professionals listened, remembered, adapted support and helped people feel held within the service. This suggests that the future of CMHT care depends not only on the structures of provision, but on whether services can protect the relational and contextual conditions that allow care to feel meaningful. As community mental health services continue to be reorganised, these findings raise important questions about how care can remain responsive, personal and sustaining for people with complex and enduring mental health needs.

Implications

The findings have implications for clinical practice, service development, policy and future research. These implications are considered across levels because participants' accounts did not suggest that difficulties in CMHT care were located only within individual staff encounters. Instead, experiences of care appeared to be shaped by the interaction between staff relationships, service structures, resource pressures and wider system expectations. Participants were also asked directly what they felt would improve CMHT care. Several of their recommendations are reflected in the implications discussed below, with a fuller summary provided in Appendix J.

Clinical Implications

At a clinical level, the findings suggest that routine CMHT processes may need to be considered in terms of whether they preserve personhood. The study does not suggest that assessments, care plans, risk discussions or reviews are inherently unhelpful. Instead, it shows that these processes could support care when they helped professionals understand the person, guide support and share knowledge across the team. Difficulties arose when processes felt repetitive, procedural or disconnected from meaningful help. This suggests that transparency, dignity, responsiveness and active involvement are central to whether routine CMHT work is experienced as care.

The findings also highlight the importance of continuity and knowledge-sharing. A named care coordinator did not necessarily mean that participants felt known or held by the wider team. Where staff changes, duty systems or crisis contacts were unavoidable, participants' accounts suggest that good information-sharing could help preserve some sense of continuity. This has implications for how teams record and communicate a person's history, preferences, strengths, risks and preferred ways of being supported, particularly during transitions or periods of crisis.

Flexibility was also important. Participants valued support that could adapt to their needs, communication preferences, neurodivergence, trauma histories and changing levels of distress. This does not mean that boundaries are unimportant, but that boundaries may need to be held in ways that are clear, respectful and responsive to context. Flexibility may therefore be understood as a core part of skilled CMHT practice, especially when working with complex and enduring difficulties.

Service and Policy Implications

The findings suggest that CMHTs may need ways of understanding care beyond activity or contact numbers alone. Recording that an assessment, review or intervention has taken place may not show whether care felt timely, consistent, collaborative or useful. Embedded feedback, service-user involvement and co-production may help services understand how pathways, duty systems, care planning and community resources are experienced in practice, particularly during periods of redesign or reorganisation.

Relational care also requires service conditions that allow it to develop and continue. Participants valued being recognised, remembered and responded to, yet these forms of care require time, continuity and shared responsibility across teams. This has implications for caseloads, handovers, reflective practice, multidisciplinary discussion and the design of duty or crisis systems. Care may be less vulnerable to changes in individual staff when knowledge and responsibility is held collectively across the team.

These implications align closely with the recent House of Commons Health and Social Care Committee report on Community Mental Health Services (2025). The report identified timely access, continuity, person-centred care and lived-experience leadership as central to high-quality support and argued that continuity should be built into service design rather than left to chance. It also called for an independent evaluation of the Community Mental Health Framework and emphasised the importance of co-production, workforce

capacity and integrated community provision. The convergence between the report and the present findings suggests that these concerns are not confined to individual services or local experiences but remain relevant to current national reform.

Commitments to recovery-oriented, trauma-informed, person-centred and community-based care therefore require practical implementation support. These principles may be difficult to enact without sufficient workforce capacity, continuity, access to community resources and structures that support relational work. Future service reforms, including more integrated neighbourhood models, may therefore need to consider not only how services are brought together, but whether people experience care as timely, personal, consistent and connected to their lives. Evaluation should attend not only to service activity, access and outcomes, but also to whether reforms protect the relational and contextual conditions through which provision becomes meaningful care.

Research Implications

Future research could explore experiences of CMHT care over time, particularly across referral, waiting, intervention, crisis contact, discharge and re-referral. Comparative research across different CMHT models may help identify how service organisation shapes experience. Further research with staff would also be valuable, particularly to understand how care is provided under pressure and what supports teams to hold care collectively. Co-produced research could help develop service changes that are grounded in both service-user and staff experience.

Strengths and Limitations

A key strength of this study is that it explored experiences of generic CMHT care broadly, rather than focusing on one diagnostic group, intervention type or specific aspect of service provision. This allowed the analysis to consider how access, relationships, care processes and wider community connection interacted within people's overall experience of

care. The sample included participants from different areas of the UK and was recruited through both NHS and non-NHS routes, which supported the inclusion of a range of experiences. The sample size was also at the higher end of the planned recruitment range, despite early recruitment difficulties. The use of open, semi-structured interviews allowed participants to describe what felt most relevant to them, including helpful as well as unhelpful experiences. This supported an analysis that could attend to complexity, including the ways that individual encounters, service structures and wider system pressures shaped care.

The study was also strengthened by expert by experience involvement during the design stage. This helped shape recruitment materials, participant information and the interview process, and supported attention to accessibility, clarity and participant safety. However, the study was not fully co-produced, and expert by experience involvement did not continue throughout analysis or interpretation. Further involvement at these stages may have supported a richer understanding of the findings and may have challenged or developed the researcher's interpretations.

There are several limitations to consider. Although the study included a range of participants, the sample was not particularly diverse in some areas, and the analysis did not systematically examine how social GRACES shaped experiences of CMHT care. This may reflect both the composition of the sample and the way questions were asked during interviews. While participants did discuss issues such as neurodivergence, employment, finances, gendered experiences and social context, these were not analysed through a primary intersectional framework. Future research could explore how experiences of CMHT care are shaped by ethnicity, class, gender, disability, sexuality, age, culture and other aspects of social location in a more focused way.

The findings also need to be understood in relation to variation across services. Participants had accessed different CMHTs, in different areas, and at different points in time.

This supports the breadth of the study, but limits the extent to which findings can be applied to any one service model. The study also relied on people coming forward to take part, which may have introduced self-selection bias. People with particularly strong positive or negative experiences may have been more motivated to participate, while those who were too distressed, disengaged, distrustful or practically unable to take part will be underrepresented.

The use of retrospective semi-structured interviews also shaped the findings. Participants' accounts were based on memory and interpretation, and the study did not include direct observation of CMHT care or comparison with professional perspectives. Quantitative or mixed-methods approaches may have provided additional information about differences between participants, service models or outcomes, but would have been less able to explore the meaning of care in depth. The broad focus of the study also meant that some areas could not be explored in as much detail as they might have been in a narrower study. Finally, as a reflexive thematic analysis, the findings are interpretative and shaped by the researcher's values, assumptions and clinical positioning. This is consistent with the methodology, but means that the analysis represents one possible reading of the data rather than a definitive account of CMHT care.

Reflexivity and Learning Across the Project

Reflexivity and learning were not limited to the analytic stage of this project, but developed across the whole research process, from the early development of the project through to ethics, recruitment, interviewing, analysis and writing up. As outlined at the beginning of the thesis, I entered the project with a clear preference for qualitative research focused on service-user experience. This reflected my interest in forms of knowledge that foreground meaning, relationships and the felt impact of mental health services. Looking back, this early preference is important reflexively because it shows that I did not enter the project as a neutral observer of possible methods. I was already oriented towards lived

experience accounts and towards forms of knowledge that foreground meaning, relationships and the felt impact of services. This shaped the research question, the choice of semi-structured interviews, and the later focus on care as something experienced rather than only provided.

My understanding of what it meant to explore experience developed throughout the project. At different points in the project, I questioned whether a more explicitly phenomenological approach may have been a better fit for exploring lived experience in greater depth, and I still sometimes reflect on this. However, I was also drawn to a critical realist position because I wanted to hold participants' subjective experiences alongside the wider organisational, social and policy contexts shaping CMHT care. Participants' accounts were not only personal or relational, but were often structured by waiting lists, thresholds, staffing pressures, models of provision and broader policy shifts within community mental health services. Using a critical realist approach helped me think about how these wider systems and mechanisms influenced what participants experienced as care, while still taking their accounts seriously as meaningful and valid descriptions of their realities.

These tensions became more apparent during the ethics process, where I was aware of needing to design a study that could hear difficult accounts of CMHT care while also managing possible distress, risk and the potential reputational impact on NHS services. This created an early tension between wanting to foreground service-user experiences honestly and being aware of the pressures and responsibilities surrounding NHS research. This tension continued throughout the project. Participants themselves often acknowledged that services were under pressure while also describing the impact of delays, inconsistency or feeling dismissed. I wondered at times whether my own connection to NHS services made participants more likely to offer these caveats, or whether this reflected participants' own attempts to make sense of care within an overstretched system.

Recruitment also shaped my learning. Initial NHS recruitment was slow, and I had limited control over whether study information reached potential participants. This made the gatekeeping involved in service-based recruitment more visible to me and raised questions about whose voices become accessible in research about services. Expanding recruitment through social media and lived experience newsletters widened participation, but also meant that people who were more connected to lived experience networks, or who felt particularly motivated to speak about their experiences, may have been more likely to take part. These recruitment challenges became part of how I understood the wider project: access to participation, like access to care, was shaped by routes, systems and visibility.

The interviews themselves also changed my understanding. I initially expected participants to speak more explicitly about risk, thresholds and access to intervention. These issues were present, but participants often oriented more strongly towards care, continuity, being known and whether support felt meaningful. Reflecting back, there was something slightly accidental about the way the word care entered the project title in the first place. At the proposal stage, I had largely been using it as a broad shorthand for the concrete structures of CMHT provision: appointments, interventions, referrals, reviews, medication support and pathways through services. I do not think I had fully considered care as a distinct concept in itself. Instead, I assumed it would overlap relatively straightforwardly with treatment or service provision, and that participants would mainly discuss whether interventions were available, timely or effective.

However, as the interviews developed, it became increasingly clear that participants were often using care in a different way. They did speak about practical provision and access to support, but what seemed to matter most was how these experiences felt relationally and emotionally. Participants described care through whether they felt listened to, remembered, responded to, involved and held in mind. In some accounts, relatively small interactions

carried significant meaning because they communicated attentiveness, consistency or recognition. Equally, participants sometimes described technically appropriate or available interventions as uncaring when they felt impersonal, fragmented or emotionally absent.

This gradually shifted my understanding of the project itself. The distinction between provision and care became more analytically important over time, even though I had not entered the study intending to explore that distinction explicitly. I began to notice that participants were often evaluating services less in terms of whether something had formally been offered and more in terms of whether they experienced themselves as genuinely supported or even held in mind within the interaction. This challenged some of my own assumptions about what CMHTs primarily provide and highlighted how easily professional language can flatten relational experiences into procedural categories.

This shift challenged some of the professional categories I had brought into the study. My interview schedule was partly organised around stages that may be familiar to professionals, such as referral, assessment, intervention and signposting. However, participants' accounts often moved across these boundaries and made sense of care through relationships, timing, uncertainty and trust. This made the interviews feel less like collecting information about discrete stages of care and more like listening to people trying to make sense of a complex and often fragmented service journey.

The analytic process was similarly unsettled and iterative. The theme structure changed multiple times because participants' accounts did not fit neatly into a simple account of what was helpful or unhelpful. The same aspects of care could be described very differently depending on whether they were available, consistent and connected to the person's needs. Some participants spoke warmly about individual clinicians, groups or community resources, while others described the absence or inconsistency of similar support as painful, disappointing or unsafe. Participants could also describe valued relationships with

particular professionals while still experiencing the wider system as fragmented, or value community support while also finding it difficult to access or sustain. I found it difficult at times to represent these tensions analytically without flattening one side of the experience in favour of the other.

This was particularly important when developing the final theme structure. I found myself repeatedly returning to the question of community, partly because it is so central to the name and history of CMHTs. There was a pull to ask where "community" was in participants' accounts, and whether its absence or inconsistency was itself analytically meaningful. At the same time, I did not want to force community into the analysis simply because it felt theoretically or politically important to the project. Over time, I came to understand community as part of what meaningful care could involve, particularly where participants spoke about groups, activity, employment, peer connection and support beyond clinical appointments. I had a similar process with service pressure. Because participants referred so often to overstretched services, waiting lists, staffing pressures and wider NHS strain, service pressure remained a separate candidate theme until late in the write-up. However, as I tried to write the themes, it became clearer that pressure was not experienced as one discrete aspect of care. Instead, it shaped access, relationships, processes and community connection across the whole analysis. This helped me understand service pressure as a cross-cutting condition, rather than as a theme in its own right.

This process was sometimes demoralising, and at points felt quite existential. It prompted me to reflect not only on CMHTs, but on mental health services more broadly: what are services being asked to hold, what counts as care, and what happens when staff and service users are both trying to navigate systems where the conditions for care are not always available? These questions felt difficult because participants' accounts often resisted a simple explanation. They described care, kindness and commitment alongside delay, fragmentation

and absence. I had to keep returning to the data to avoid making broader claims than the accounts could support, even when I wanted the thesis to offer a clearer or more decisive answer.

My attachment-informed and relational orientation also shaped the writing-up process. Concepts such as secure base, containment and relational continuity helped me make sense of why consistency and being known appeared so important. However, I needed to remain aware that these concepts could lead me to organise the data around my own theoretical interests. I tried to manage this by grounding interpretations in participants' language and by attending to accounts that complicated a purely relational reading, including experiences of medication, practical support, risk planning, duty systems and community resources. Over time, I came to understand the relational focus as both something I was sensitised to and something that participants repeatedly returned to, even when speaking about formal service processes.

The write-up also involved holding a tension between critique and compassion. I felt discomfort in response to participants' accounts of feeling delayed, dismissed, unknown or unsupported. At the same time, I felt protective of NHS staff working within services under significant pressure, particularly as I was also working in NHS contexts with waiting lists, limited capacity and competing demands. This tension reflects something familiar in my own personality and clinical identity. I can feel strongly about care being compassionate, thoughtful and relational, particularly where people feel unseen or unsupported, while also needing to hold the reality that services are often trying to provide care within imperfect systems. Writing the thesis required me to stay with this tension rather than resolving it too quickly by blaming individual staff or excusing harmful experiences through reference to system pressure alone.

The process also highlighted the value and limits of the public involvement that shaped the study. Expert by experience consultation at the design stage improved the accessibility of study materials and helped shape the interview schedule, particularly the focus on both helpful and unhelpful experiences. However, as the analysis became more complex, I became more aware that further involvement during analysis and interpretation may have challenged or deepened my thinking. More sustained co-production may have helped me think differently about the theme structure, the language used to describe care and the implications of the findings.

Overall, the project has shaped my clinical learning as well as my research understanding. It has reinforced the importance of transparency, continuity and relational responsibility in mental health care, while also making clear that these cannot depend only on individual clinicians. They require service structures that allow care to be timely, personal, consistent and connected to people's lives.

It also prompted reflection on my own clinical practice. I noticed that when I feel anxious or uncertain clinically, I can find myself looking for structure, procedure or frameworks that help me feel more grounded and contained. While these can be important, the project reminded me of the value of simply being two humans in a room together, and of the relational aspects of care that cannot always be reduced to process or technique.

The project did not leave me with a simple answer about the future of CMHT care. Instead, it left me with a clearer sense of the questions that need to be held. What conditions allow provision to become care? How can these conditions be protected within pressured systems? and How can service users remain central in defining what care means?

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Appendices

Appendix A – Participant Demographics Table

Participant	Pseudonym	Age Range	Gender	Ethnicity	Main Diagnosis	Approximate length of CMHT contact	Recruitment Route
1	Alice	20-30	Female	White British	Complex PTSD	5 years	NHS
2	Jemima	40-50	Female	White British	Bipolar and BPD	6 years	NHS
3	Daniel	40-50	Male	White British	Bipolar	5 years	NHS
4	Sam	20-30	Female	White British	PTSD and EUPD	9 years	Lived Experience Newsletter
5	Precious	40-50	Female	Black Caribbean	Schizoaffective Disorder	6 years	Lived Experience Newsletter
6	Maureen	60-70	Female	White British	Complex PTSD	2 years	Lived Experience Newsletter
7	Jess	20-30	Female	White British	Complex PTSD	6 years	Lived Experience Newsletter
8	Grace	50-60	Female	White British	Schizophrenia	11 years	Lived Experience Newsletter
9	Madeline	30-40	Female	Mixed - Other	Bipolar and Psychosis	2 years	Lived Experience Newsletter
10	John	40-50	Male	British Asian - Indian	Psychosis, PTSD and ASD	9 years	Lived Experience Newsletter
11	Louise	20-30	Female	Mixed - British and Indian	Schizophrenia	10 months	Lived Experience Newsletter
12	Paige	40-50	Female	White British	PTSD and EUPD	22 years	NHS
13	Ruth	20-30	Female	White British	PTSD, ASD and ADHD	4 years	Lived Experience Newsletter
14	Mina	50-60	Non-binary	Mixed - Persian-European	Depression, Anxiety and ASD	2 years	Lived Experience Newsletter
15	Isobel	40-50	Female	White British	PTSD, OCD and ASD	2 years	Lived Experience Newsletter
16	Laurence	60-70	Male	Mixed - White and Asian	PD and psychosis	30 years	Lived Experience Newsletter
17	Jayne	40-50	Female	White British	Bipolar, BPD, ASD and ADHD	4 years	Lived Experience Newsletter

Appendix B – NHS Recruitment Poster

Research Opportunity

We are interested in hearing about your experience of a community mental health team.

- What would be involved?
  - An phone call to check you can take part and book your interview session.
  - A 60 minute one-to-one interview either online or in-person.
- You will receive £20 Tesco voucher to thank you for your participation.





You may be able to take part if:

- Age 18+
- Able to complete the interview in English
- Have been accessing care from a CMHT or have recently been discharged from a CMHT
- Are not currently on a mental health ward or under a crisis team

For more information, please contact:
Katy Thrasher, Trainee Clinical Psychologist
kt23130@essex.ac.uk

Appendix C – NHS Participant Information Sheet

University of Essex

PARTICIPANT INFORMATION SHEET

This project hopes to:

- to explore people's experiences of accessing care from community mental health teams (CMHT).
- the different factors that impact their experiences of care.

We want to:

- understand more about the type of support people receive from a community mental health team
- find out whether this support is helpful or unhelpful
- use this knowledge to inform future services

How do I get involved?

- You can let us know if you would like to take part using the email address below.
- If we have not heard from you after a month, then we will contact you by phone to see if you would like to take part.
- If you would like to take part, a date and time for the interview will be booked during a phone conversation with the lead researcher.

What would I need to do?

- Before the interview, you will be given the chance to ask any questions before signing a consent form.
- The interview will be carried out by the lead researcher and you will be asked questions about your experience of accessing care from a CMHT, which will be audio recorded with your consent.
- You can decide that you wish to finish at any time without the need to give a reason for this.
- You will be offered a debrief immediately after the interview and information about support and advocacy services will be provided.

I want to participate but I am nervous about what questions I might be asked

- We plan to ask questions about how helpful or unhelpful you found different parts of your care from the CMHT.
- This includes your experience of being referred to the team, undergoing an assessment, receiving any treatment or being referred to other services outside of the team.

Payment

- You will receive compensation as a £20 Tesco voucher at the completion of the interview session, as a thank you for your time and participation in the project.
- This will be given whether or not you choose to continue with the interview.

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence.

Where could I get more support:

- Contact your GP or Care co-ordinator or the duty team
- Samaritans (24 hours): 116 123
- Shout (24 hours): 85258
- Campaign Against Living Miserably (5pm

University of Essex

Why have you been invited? You have been invited to participate in this study because you have been accessing care from a community mental health team in Essex and, therefore, have valuable experience and knowledge about the topic under investigation.

What are the possible benefits of taking part? Your participation will help us to develop a better understanding of how patient's experience the care offered by community mental health teams. Your experience and thoughts about how the service could be changed could benefit those who experience services in the future.

What are the possible risks of taking part? There are no anticipated risks to your physical safety associated with this study. During the interview we may discuss difficult feelings, which may cause you to feel distressed. If any questions make you feel uncomfortable, you do not have to answer them, and you can stop the interview at any time. If you feel distressed at any time, please speak to the interviewer and they will provide you with support and signposting to relevant services.

How will my information be kept confidential? We will need to use information from you for this research study. This information will include your name, contact details, length of time accessing the community mental health service and which professionals you had contact with. People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. All information collected during the study will be kept confidential. The data will be stored securely and only accessed by the research team. The results will be reported in a way that does not identify any individual participant. Your data will be stored by the University of Essex. If you wish you contact the data controller, you can do so by emailing dpo@essex.ac.uk at the University of Essex.

The interview will be audio and/or video recorded if you give your consent. The audio and/or video recordings will take place on Microsoft Teams on the researcher's University of Essex Microsoft account using an NHS laptop provided by Essex Partnership University Trust. The audio and/or video recordings will be downloaded from the university Microsoft account to a file on the NHS laptop and then immediately uploaded to the University of Essex's secure file storage system, Box. The file on the NHS laptop will immediately be deleted. The audio and/or video recordings with be stored on Box until they have been transcribed, after which time the recording will be deleted. Transcription will take place within 12 weeks of the interview date. If 12 weeks has elapsed and the interview has not been transcribed, the recording will be deleted and your participation will not be included in the study. Transcription of the interviews will be completed by either the chief investigator, or a nominated external contractor. If the transcription is completed by an external contractor, a confidentiality agreement will be in place prior to any data being shared.

What if you want to withdraw? You are free to withdraw from the study at any time without explanation or penalty. Your information that has already been collected will be retained unless you request your information be deleted and not be included in the reports we write.

How will we use information about you? We will need to use information from you for this research study. This information will include your name, contact details, length of time accessing the community mental health service and which professionals you had contact with. People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. The University of Essex is the sponsor of this research and is responsible for looking after your information.

What are your choices about how your information is used? You have the right to ask us to remove, change or delete data we hold about you for the purposes of the study. You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have unless you request that your information be deleted and not be included in the reports we write. If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study in the University of Essex's secure file storage system, Box.

University of Essex

Where can you find out more about how your information is used? You can find out more about how we use your information by asking one of the research team; Katherine Thrasher (kt23130@essex.ac.uk) or Dr Joseph Rehling [jr18520@essex.ac.uk]. You can also contact Pauline Young, Research Manager at Essex Partnership University NHS Foundation Trust (EPUT), [pauline.young3@nhs.net], or ringing her on [07939 008588].

What if I have concerns and complaints? If you have any concerns about any aspect of the study or if you have a complaint, in the first instance please contact the chief investigator, Katherine Thrasher, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the lead researcher, please contact the departmental Director of Research in the department responsible for this project, Professor Kostis Roussos (email: k.roussos@essex.ac.uk). If you are still not satisfied, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk).

What is the legal basis for using the data and who is the Data Controller? The Data Controller is the University of Essex and the contact will be the University Information Assurance Manager (dpo@essex.ac.uk). The legal basis of processing personal data for the primary purpose of research under the lawful basis of processing set out in Article 6 (1)(e) of the UK GDPR, is in the public interest.

Who is funding the research? The research is funded by the University of Essex as part of the researcher's Doctorate in Clinical Psychology.

Who has reviewed the study? This study has been reviewed and approved by the National Health Service (NHS) Health Research Authority, which protects and promotes the interests of patients and the public in health research, and the University of Essex.

What will happen to the results of the study? The results of this study will be written up for the principal researcher's doctoral thesis for their doctorate in Clinical Psychology. A copy will also be sent to participating services. A simplified summary will also be available for all participants, including people involved in the development of the project. Finally, the results will be written up for publication in relevant academic journals. You will not be identified in any reports or publications and you can request a copy of the reports or publications from the researcher or your service.

Who can I contact for more information? If you have any questions or would like more information about the study, please contact:

Katherine Thrasher
University of Essex
kt23130@essex.ac.uk

If you have any concerns about the conduct of this study, you may contact:
Dr Joseph Rehling
University or Essex
jr18520@essex.ac.uk

Thank you for considering to participate in this study.

Appendix D – NHS Recruitment Paragraph added to CMHT letters

We are interested in hearing about your experiences with this community mental health team as part of a research project with the University of Essex. Participation is voluntary, and all information will remain confidential. If you're interested or would like more details, please contact Katherine Thrasher, Trainee Clinical Psychologist on kt23130@essex.ac.uk.

Appendix E – Social Media/Newsletter Recruitment Poster

Research Opportunity

We are interested in hearing about your experience of a community mental health team (CMHT).

This is a team made up of different professionals to support people who have severe and enduring mental health difficulties. In your area, it might also be known as a Recovery and Wellbeing Team, Assessment and Brief Treatment Team or Specialist CMHT (SMHT).

- **What would be involved?**
  - **An phone call to check you can take part and book your interview session.**
  - **A 60 minute one-to-one interview either online or in-person.**
- **You will receive £20 Tesco voucher to thank you for your participation.**





You may be able to take part if:

- **Age 18+**
- **Able to complete the interview in English**
- **Are currently accessing a community mental health team or have been discharged in the last 3 years**
- **Are not currently on a mental health ward or under a crisis team**

scan for a prewritten email:

For more information, please contact me on:
Katy Thrasher, Trainee Clinical Psychologist
kt23130@essex.ac.uk

Appendix F – Social Media/Newsletter Participant Information Sheet

University of Essex

PARTICIPANT INFORMATION SHEET

This project hopes to:

- to explore people's experiences of accessing care from community mental health teams (CMHT).
- the different factors that impact their experiences of care.

We want to:

- understand more about the type of support people receive from a community mental health team
- find out whether this support is helpful or unhelpful
- use this knowledge to inform future services

How do I get involved?

- You can let us know if you would like to take part using the email address below.
- If we have not heard from you after a month, then we will contact you by phone to see if you would like to take part.
- If you would like to take part, a date and time for the interview will be booked during a phone conversation with the lead researcher.

What would I need to do?

- Before the interview, you will be given the chance to ask any questions before signing a consent form.
- The interview will be carried out by the lead researcher and you will be asked questions about your experience of accessing care from a CMHT, which will be audio recorded with your consent.
- You can decide that you wish to finish at any time without the need to give a reason for this.
- You will be offered a debrief immediately after the interview and information about support and advocacy services will be provided.

I want to participate but I am nervous about what questions I might be asked

- We plan to ask questions about how helpful or unhelpful you found different parts of your care from the CMHT.
- This includes your experience of being referred to the team, undergoing an assessment, receiving any treatment or being referred to other services outside of the team.

Payment

- You will receive compensation as a £20 Tesco voucher at the completion of the interview session, as a thank you for your time and participation in the project.
- This will be given whether or not you choose to continue with the interview.

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence.

Where could I get more support:

- Contact your GP or Care co-ordinator or the duty team
- Samaritans (24 hours): 116 123
- Shout (24 hours): 85258
- Campaign Against Living Miserably (5pm to midnight): 0800 58 58 58

University of Essex

Why have you been invited? You have been invited to participate in this study because you have been accessing care from a community mental health team and, therefore, have valuable experience and knowledge about the topic under investigation.

What are the possible benefits of taking part? Your participation will help us to develop a better understanding of how patient's experience the care offered by community mental health teams. Your experience and thoughts about how the service could be changed could benefit those who experience services in the future.

What are the possible risks of taking part? There are no anticipated risks to your physical safety associated with this study. During the interview we may discuss difficult feelings, which may cause you to feel distressed. If any questions make you feel uncomfortable, you do not have to answer them, and you can stop the interview at any time. If you feel distressed at any time, please speak to the interviewer and they will provide you with support and signposting to relevant services.

How will my information be kept confidential? We will need to use information from you for this research study. This information will include your name, contact details, length of time accessing the community mental health service and which professionals you had contact with. People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. All information collected during the study will be kept confidential. The data will be stored securely and only accessed by the research team. The results will be reported in a way that does not identify any individual participant. Your data will be stored by the University of Essex. If you wish you contact the data controller, you can do so by emailing dpo@essex.ac.uk at the University of Essex.

The interview will be audio and/or video recorded if you give your consent. The audio and/or video recordings will take place on Microsoft Teams on the researcher's University of Essex Microsoft account using an NHS laptop provided by Essex Partnership University Trust. The audio and/or video recordings will be downloaded from the university Microsoft account to a file on the NHS laptop and then immediately uploaded to the University of Essex's secure file storage system, Box. The file on the NHS laptop will immediately be deleted. The audio and/or video recordings with be stored on Box until they have been transcribed, after which time the recording will be deleted. Transcription will take place within 12 weeks of the interview date. If 12 weeks has elapsed and the interview has not been transcribed, the recording will be deleted and your participation will not be included in the study. Transcription of the interviews will be completed by either the chief investigator, or a nominated external contractor. If the transcription is completed by an external contractor, a confidentiality agreement will be in place prior to any data being shared.

What if you want to withdraw? You are free to withdraw from the study at any time without explanation or penalty. Your information that has already been collected will be retained unless you request your information be deleted and not be included in the reports we write.

How will we use information about you? We will need to use information from you for this research study. This information will include your name, contact details, length of time accessing the community mental health service and which professionals you had contact with. People will use this information to do the research. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. The University of Essex is the sponsor of this research and is responsible for looking after your information.

What are your choices about how your information is used? You have the right to ask us to remove, change or delete data we hold about you for the purposes of the study. You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have unless you request that your information be deleted and not be included in the reports we write. If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study in the University of Essex's secure file storage system, Box.

University of Essex

Where can you find out more about how your information is used? You can find out more about how we use your information by asking one of the research team; Katherine Thrasher (kt23130@essex.ac.uk) or Dr Joseph Rehling [jr18520@essex.ac.uk].

What if I have concerns and complaints? If you have any concerns about any aspect of the study or if you have a complaint, in the first instance please contact the chief investigator, Katherine Thrasher, using the contact details below. If you are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the lead researcher, please contact the departmental Director of Research in the department responsible for this project, Professor Kostis Roussos (email: k.roussos@essex.ac.uk). If you are still not satisfied, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk).

What is the legal basis for using the data and who is the Data Controller? The Data Controller is the University of Essex and the contact will be the University Information Assurance Manager (dpo@essex.ac.uk). The legal basis of processing personal data for the primary purpose of research under the lawful basis of processing set out in Article 6 (1)(e) of the UK GDPR, is in the public interest.

Who is funding the research? The research is funded by the University of Essex as part of the researcher's Doctorate in Clinical Psychology.

Who has reviewed the study? This study has been reviewed and approved by the National Health Service (NHS) Health Research Authority, which protects and promotes the interests of patients and the public in health research, and the University of Essex.

What will happen to the results of the study? The results of this study will be written up for the principal researcher's doctoral thesis for their doctorate in Clinical Psychology. A copy will also be sent to participating services. A simplified summary will also be available for all participants, including people involved in the development of the project. Finally, the results will be written up for publication in relevant academic journals. You will not be identified in any reports or publications and you can request a copy of the reports or publications from the researcher or your service.

Who can I contact for more information? If you have any questions or would like more information about the study, please contact:

Katherine Thrasher
University of Essex
kt23130@essex.ac.uk

If you have any concerns about the conduct of this study, you may contact:
Dr Joseph Rehling
University or Essex
jr18520@essex.ac.uk

Thank you for considering to participate in this study.

Appendix G – NHS Consent Form

Consent form for Research Project

Title: Experiences of community mental health team patients

Chief Investigator: Katherine Thrasher

	Put an 'X' or your initials in the boxes below:
1. I confirm that I have read and understand the Information Sheet dated 6th June 2025 for the above study. I have had an opportunity to consider the information and ask any questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason and it will not impact any care or future care from services.	☐
3. I confirm that I agree to have my interview audio recorded.	☐
4. I confirm that I agree to have my interview video recorded.	☐
5. I understand that all identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. Confidentiality may only be broken where there is concern around any safety issues.	☐
6. I understand that audio and/or video recordings gathered during the interview will be deleted after they have been transcribed, and these transcriptions will be securely stored until the completion of the study, when they will be deleted.	☐
7. I consent for data from this interview to be used in future research projects..	☐
8. I confirm that I have accessed care from a community mental health team for at least 2 years or I have recently been discharged from a community mental health team.	☐
9. I conform that I am not currently accessing care from a crisis team, including a Home Treatment Team, Assertive Outreach Services or Acute Inpatient Services,	
10. I agree to take part in the above study.	☐

Once you have ticked all the statements on Page 1, please complete the section below to provide your written consent to take part in the study. (There are other methods of providing consent including recording verbal consent or typing your signature on a recorded Teams call).

Participant Name	**Date**	**Participant Signature**
_____	_____	_____

If you are completing this consent form on your own electronic device, please email a copy to the chief investigator: kt23130@essex.ac.uk

To be completed by researcher:

Researcher Name	**Date**	**Researcher Signature**
Katherine Thrasher	_____	_____

After the chief investigator has signed the form, one copy of the form will be provided for the participant and another copy retained by the chief investigator.

Appendix H – Social Media/Newsletter Consent Form

Consent form for Research Project

Title: Experiences of community mental health team patients

Chief Investigator: Katherine Thrasher

	Put an 'X' or your initials in the boxes below:
1. I confirm that I have read and understand the Information Sheet dated 1st September 2025 for the above study. I have had an opportunity to consider the information and ask any questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason and it will not impact any care or future care from services.	☐
3. I confirm that I agree to have my interview audio recorded.	☐
4. I confirm that I agree to have my interview video recorded.	☐
5. I understand that all identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. Confidentiality may only be broken where there is concern around any safety issues.	☐
6. I understand that audio and/or video recordings gathered during the interview will be deleted after they have been transcribed, and these transcriptions will be securely stored until the completion of the study, when they will be deleted.	☐
7. I consent for data from this interview to be used in future research projects.	☐
8. I confirm that I have accessed care from a community mental health team for at least 2 years or I have been discharged from a community mental health team in the last 3 years.	☐
9. I conform that I am not currently accessing care from a crisis team, including a Home Treatment Team, Assertive Outreach Services or Acute Inpatient Services,	☐
10. I agree to take part in the above study.	☐

Once you have ticked all the statements on Page 1, please complete the section below to provide your written consent to take part in the study. (There are other methods of providing consent including recording verbal consent or typing your signature on a recorded Teams call).

Participant Name	**Date**	**Participant Signature**
_____	_____	_____

If you are completing this consent form on your own electronic device, please email a copy to the chief investigator: kt23130@essex.ac.uk

To be completed by researcher:

Researcher Name	**Date**	**Researcher Signature**
Katherine Thrasher	_____	_____

After the chief investigator has signed the form, one copy of the form will be provided for the participant and another copy retained by the chief investigator.

Appendix I – Interview Schedule

1. Background Information:

- Gather basic demographic information
    - Age
    - Gender
    - Ethnicity
    - Any diagnosis?
    - Languages spoken.
    - Time under community mental health service
    - Types of contact (care-coordination, psychology, nursing, psychiatry)
- Brief Capacity Assessment
    - What is your understanding of what this research project is about and what you may need to do as part of this project?
    - What made you want to be involved in the project?

2. Accessing the Service:

- Can you describe how you initially came into contact with the community mental health service?
- Before you were referred to the service, did you have any expectations about what kind of support/treatment you would be given whilst you were in the service?

3. Overall Experience:

- How would you describe your experience with the community mental health service?
- Were there any parts of the service that you found helpful?
- Were there any aspects of the service that you found unhelpful or discouraging?

4. Experience of Assessment

- Were there any parts of your assessment that you found helpful?

- Were there any aspects of your assessment that you found unhelpful or discouraging?

5. Experience of Treatment

- What types of treatment did you access whilst under the community mental health team?
    - How often did you have contact with someone for this treatment?
    - How long did this treatment last for?
- Were there any aspects of the treatment you received that you found helpful?
- Were there any aspects of the treatment you received that you found unhelpful?

6. Relationships with Staff:

- How would you describe your relationships with staff members in the community mental health service?
- What types of interactions did you find helpful or encouraging?
- What types of interactions did you find unhelpful or discouraging?

7. Support and Resources:

- Were you offered any kinds of additional support or resources through the service (e.g., signposting to community services, support with housing/domestic abuse, support for carers)?
- If so, did you feel that this additional support/these resources met your needs?
- What was helpful?
- What was not helpful?

8. Recommendations for Improvement:

- Based on your experience, what recommendations would you make to improve the community mental health service?
- Were there any additional support or resources that you wish were available to you but were not

Appendix J – Summary of Participant Recommendations

Communication, information and transparency

- Explain things in ways service users can understand, with honesty and transparency, especially when something cannot be provided.
- Provide more information at the beginning about the structure of the service, who the person might see, what to expect, and what is possible to access.
- Offer a guide before first appointments, including photos of staff/buildings and what to expect in the initial assessment.
- Use text messages or similar methods to notify people about appointments, instead of relying only on letters.
- Provide a resource handbook, including information about services, self-help resources, books, and newly diagnosed conditions.
- Offer clearer information about what services are available, including community services outside the CMHT.
- Create a form or email option before appointments so people can share things that are difficult to say in person or easy to forget.
- Improve communication about changes in care, including transfers, new teams, or new key members of staff.
- Give adequate notice before significant changes in care.
- Have a duty rota so service users know who may be on call.

Listening, respect and emotional safety

- Listen properly so people feel heard.
- Make people feel that they are being heard.
- Even when someone looks calm, ask questions and explore more deeply what they are struggling with and what that struggle means to them.

- Start by building trusting relationships.
- Avoid asking too many personal questions before helping the person feel safe.
- Train staff in how to speak to service users so they feel respected, valued and believed.
- Provide compassionate conduct training.
- Train receptionists in how they speak to patients.
- Staff should recognise that patients understand the reality of service pressures, while still treating people with kindness and avoiding making them feel like the problem.

Trauma-informed, neurodiversity-informed and individualised care

- Provide more trauma-informed care from staff.
- Provide more training on autism.
- Rehaul training so care is more caring and less punitive, especially for people diagnosed with personality disorders.
- Offer individualised care based on the person, rather than care shaped mainly by diagnosis.
- Provide more holistic care.
- Offer multiple assessments or longer planned assessment times for people with complex needs or histories.
- Offer an initial evaluation from multiple team members.
- Find out as much as possible about the person before engaging with them.
- Use a “my story / this is what doesn’t help me” page for staff.
- Offer the option to see a female or male doctor/professional, or the option not to see particular professionals.

- Offer the option to see someone who is not a psychiatrist, where this may reduce the sense of power imbalance.
- Support older patients without moving them too much into new systems of working.
- Scaffold people's autonomy instead of doing things for them.
- Leave people alone to make their own decisions where appropriate, including avoiding over-assessment around benefits.

Care planning, risk and collaboration

- Develop individual care plans in consultation with service users.
- Use care plans to guide future steps, not only risk.
- Make care plans personalised, relevant to the individual, and focused on the person's life and care.
- Ensure care plans build on each other instead of feeling brand new each time.
- Make care plans useful for the service user, as well as useful for professionals.
- Include who the person can turn to in the community, as well as clinically, within the care plan.
- Share care plans between different parts of services.
- Provide more individualised risk assessment that has practical value for the service user.
- Create a way of sharing information so duty services are aware of triggers, risks and protective information.

Continuity, transitions and joined-up working

- Improve continuity of care.
- Respect existing relationships between service users and staff.
- Improve consistency in how staff hand over information.

- Improve communication between different parts of services.
- Use more in-person MDT working instead of relying heavily on Microsoft Teams, records or AI.
- Have a lived experience expert attend MDTs.
- Hold a meeting, either in person or remotely, to discuss transfer of care.
- Work more collaboratively with private hospitals.
- Involve GPs more in supporting medication management.
- Create a mini-team of multiple staff who the person can contact during crisis, such as two care coordinators, a psychiatrist and a support worker.

Access, responsiveness and practical availability

- Reduce waiting times.
- Intervene earlier.
- Increase access to long-term support, including during periods of stability.
- Offer more proactive relapse prevention work, especially when someone wants to stop taking medication.
- Find ways to offer more regular check-ins, such as through an app, WhatsApp, messaging service or phone call.
- Offer more time face to face with people, in person or online, including in the community.
- Reduce staff caseloads so they can see people more frequently.
- Offer support services outside typical working hours.
- Provide appointments outside office hours.
- Increase access to in-house CMHT support workers.
- Make clinical buildings feel less clinical.

Psychological and therapeutic support

- Increase availability of psychology input, especially for complex trauma.
- Improve access to psychological therapy, such as EMDR and counselling
- Offer groups where people can learn more about their condition.
- Offer in-person groups rather than online groups.
- Curate group support to balance personalities and needs.

Peer support, groups and lived experience

- Increase access to peer support workers.
- Offer access to peers who can share insight about experiences such as different therapies or appropriate appointment lengths.
- Provide formal peer support groups.
- Offer in-house community support groups that are supportive and proactive.
- Create opportunities to meet other people in similar circumstances, including groups co-led by peer support workers.
- Use lived experience input within MDTs and service development.

Community, social support and wider life needs

- Offer IPS and employment support to everyone.
- Provide help with housing.
- Offer more help for people to engage with their local community.
- Provide more social prescribing.
- Signpost to community services outside the CMHT.
- Signpost people to community support while they are still undergoing treatment, so this is securely in place before discharge.
- Help people properly engage with community resources.
- Work to increase connections for people.

- Build stronger ties with VCSE services.
- Develop a strong third sector of providers.

Family, carers and loved ones

- Offer support for how to talk to family about diagnoses and care.
- Offer support for carers and family members.
- Offer involvement of loved ones in appointments.

Crisis support

- Provide a place people can go to manage crisis in the moment, where they can be watched or supported to reduce the risk of hospital admission.
- Offer access to one-to-one support or community-centre-type crisis support.
- Ensure duty services have access to relevant information about triggers, risks and protective factors.

Feedback, accountability and service-user voice

- Create a place to submit feedback.
- Listen to calls to identify what could be improved.
- Create more opportunities to hear service-user voices.
- Ask service users about their experience through feedback forms, questionnaires or conversations that do not put pressure on them.
- Collect feedback regularly, for example every six months during CPA review.

Resourcing and service structure

- Provide appropriate funding across inpatient and community services.
- Reduce staff caseloads so people can be seen more frequently.
- Increase access to in-house CMHT support workers.
- Strengthen community, VCSE and third-sector provision.

Appendix K: Ethical Approval

NHS
Health Research Authority

London - Camden & Kings Cross Research Ethics Committee
2 Redman Place
Stratford
London
E20 1JQ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

27 June 2025

Miss Katherine Thrasher
Trainee Clinical Psychologist
Essex Partnership University Trust
The Lodge
Runwell
Wickford, Essex
SS11 7XX

Dear Miss Thrasher

Study title:	**Experiences of community mental health team patients: A qualitative analysis**
REC reference:	**25/LO/0318**
Protocol number:	**N/A**
IRAS project ID:	**345454**

Thank you for your responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Appendix L: Ethical Approval Health Research Authority(HRA)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Katherine Thrasher
Trainee Clinical Psychologist
Essex Partnership University Trust
The Lodge
Runwell
Wickford, Essex
SS11 7XXN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

01 July 2025

Dear Miss Thrasher

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Experiences of community mental health team patients: A qualitative analysis**
IRAS project ID:	**345454**
Protocol number:	**N/A**
REC reference:	**25/LO/0318**
Sponsor	**University of Essex**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix M: Ethical Approval for Amendment to recruit from outside NHS

NHS
Health Research Authority

London - Camden & Kings Cross Research Ethics Committee

2 Redman Place
Stratford
London
E20 1JQ

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

08 October 2025

Miss Katherine Anne Thrasher
Flat 152 Central House, Eagle Way
Eagle Way
CM13 3GJ

Dear Miss Thrasher

Study title:	**Experiences of community mental health team patients: A qualitative analysis**
REC reference:	**25/LO/0318**
Protocol number:	**N/A**
Amendment number:	**ETH2425-1761**
Amendment date:	**02 September 2025**
IRAS project ID:	**345454**

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents