Staff Experiences of Working in Adult Community Mental Health Teams: Contemporary Perspectives from a System Under Pressure.

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Abstract

Context: Community mental health teams (CMHTs), a service within the National Health Service (NHS), provide evidence-based treatments for moderate to severe mental health difficulties. Neither intended nor designed, CMHTs emerged in the 1990s after the closing of the asylums. As a nationally adopted system of care, they lack a solid evidence base.

Aim: This study aims to investigate the functioning of CMHTs from the perspectives of the staff who work in them. The study examined staff experiences of working in a CMHT, before considering their perspectives on whether, and to what extent, the CMHT was able to achieve its stated aims.

Method: The study used a qualitative design. Semi-structured interviews were conducted with 17 members of staff working at one CMHT in Essex. The sample was comprised of six medics, six psychologists and five care coordinators. Reflexive thematic analysis was used to analyse the data. As one way of exploring the transferability of the findings, additional group interviews were carried out with staff members working at another CMHT in Essex.

Results: The results revealed an overwhelmingly negative experience of working in CMHTs. Staff felt emotionally drained and physically exhausted, and experiences of moral distress were frequent. While staff generally acknowledged the systemic pressures they worked under, they broadly felt CMHTs were failing patients. In particular, CMHTs were felt to flounder under the number of referrals they received, and the service was seen as struggling to meet the relational needs of patients.

Discussion: The results present an urgent need to reform the health service to improve staff wellbeing in CMHTs. CMHTs appeared to have reached a homeostasis whereby they function well to process and discharge referrals. However, staff felt that the system failed to meet the relational needs of its patients, and staffs' desire to provide relationship-based 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.

Anna Cooke-Sutton

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To my daughter, Ellen, and to bump, neither of whom will remember the writing of this thesis but certainly gave me a lot of joy (and sickness) whilst I was doing so.

And lastly to my husband, Ed, who quietly supported me in the background in the most unglamorous of ways and who made the greatest difference. Thank you for all the mugs of coffee and the nappies you changed.

Work is love made visible.

And if you cannot work with love but only with distaste, it is better that you should leave your work and sit at the gate of the temple and take alms of those who work with joy.

For if you bake bread with indifference, you bake a bitter bread that feeds but half man's hunger.

And if you grudge the crushing of the grapes, your grudge distils a poison in the wine.

And if you sing as though angels, and love not the singing, you muffle man's ears to the voices of the day and the voices of the night.

The Prophet

Kahil Gibran

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Mission Statement

At the outset of this study, I had a grand vision that I would be able to work out the key flaws in the CMHT system (which I already expected to be present) and be able to come up with well-considered recommendations that would turn what I thought was a dysfunctional system into a functional one. Three years later, I can now see the naivety of that first-year doctoral student's mission. I have come to realise that the world is far more complicated than I can possibly understand and that a great achievement would be to come to a reasonable understanding of a small corner of it, and to make it a little better.

It is with a far humbler approach that I wrote this, the final thesis. My intention is to provide a glimpse into the life of CMHT staff in Essex. Having worked in CMHTs myself, I feel a strong loyalty to these professionals who choose, every day, to work under pressure, often for modest pay, to help others. They hold an enormous library of knowledge, wisdom, and experience, all of which can, and I believe should, be used to consider any reformation of the existing system. Mental health has never been so present in the public zeitgeist. My hope is that through research such as this, as a society, we may begin to give a little more care and concern to those who care for others.

Language

The terms that are used by those in positions of power, such as medical professionals and academics, to refer to people who use mental health services are of great importance. Words are not neutral; they convey issues of power, status, and hierarchy. This research seeks to centre staff voices in mental health research. Yet there would be no staff were there not the people who use mental health services.

The term ‘service user’ is often promoted within policy frameworks as a more empowering alternative to ‘patient’, which is an overtly medical term. The term ‘patient’ positions a person as the object of a professional’s clinical gaze and, therefore, in terms of their illness. Increasingly, people who use mental health services are viewed as consumers, survivors, and providers, all of which suggest a more active role in the user-carer dynamic (Tait and Lester., 2005). However, the use of ‘service user’ as a term is relatively unsupported in the literature to date and there is little consensus about which of the available terms should be used. For example, the NHS’ 10 Year Forward Plan refers to ‘service users’ on 23 occasions, ‘patients’ on 12 occasions, and ‘clients’ on five occasions (Dickens & Picchioni, 2012). A systematic review by Dickens and Picchioni (2012), which aimed to understand the current terminological landscape internationally found that the terms ‘patient’ or ‘client’ were preferred in the United Kingdom (UK) and United States (US) respectively by those who use mental health services. Studies conducted in London have also shown preferences for the use of ‘patient’ over ‘client’ (McGuire-Snieckus et al., 2003; Ritchie et al., 2000). A study conducted specifically in Hertfordshire also found a clear preference for ‘patient’ (254 out of 350 survey responses) or ‘client’ (151 out of 350 survey responses) over ‘service user’ (79 out of 350 survey responses) (Simmons et al., 2010). Taken together, these studies suggest that people who use mental health services prefer to be referred to as a ‘patient’ or ‘client’. Studies suggest that this preference may reflect the power institutional recognition or legitimacy holds over a person’s distress. Therefore, while far from perfect, the term ‘patient’ is used in this research to reflect the current academic landscape.

Chapter Overview

The chapter begins with an explanation of how mental health services are structured in England. The chapter continues with an overview of how mental health and ill health have been conceptualised over time in Europe. The importance of considering staff wellbeing as a

central component in mental healthcare systems culminates in a systemic literature review investigating factors that affect staff wellbeing in CMHTs. The chapter ends with the aims of this thesis, and a justification for it.

Contemporary Mental Healthcare Provision

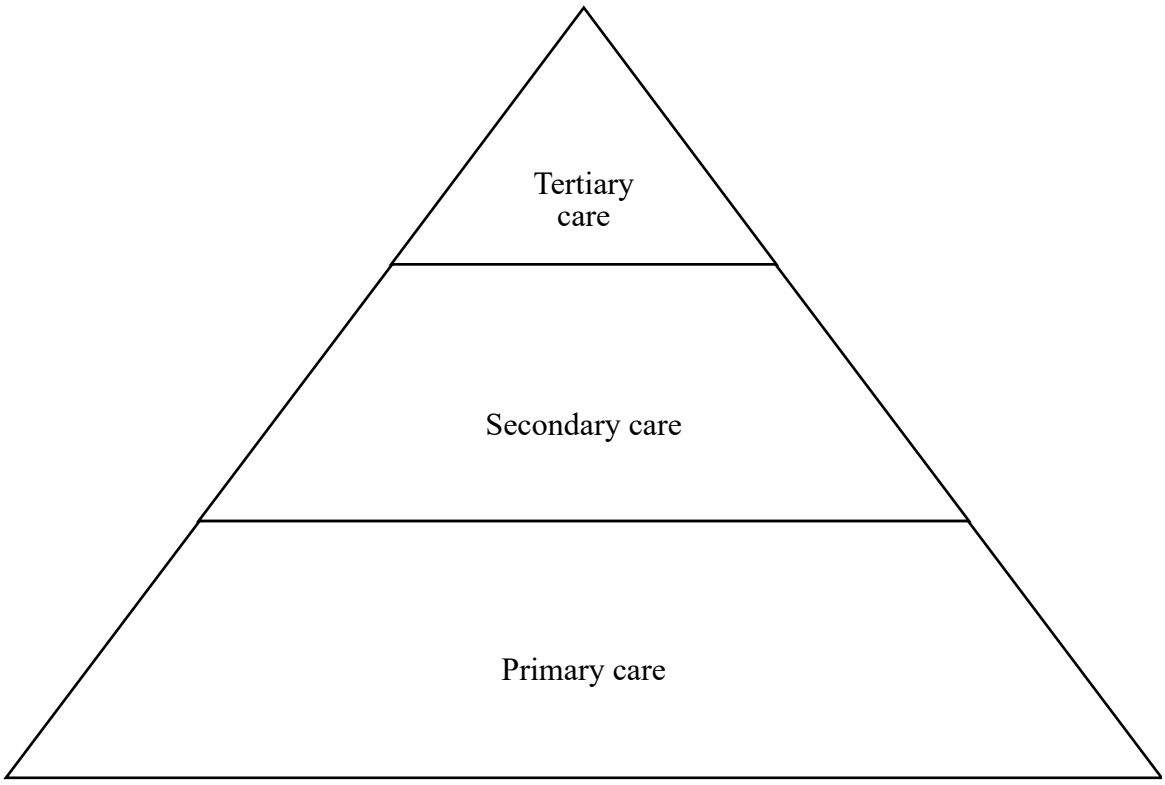
Defining Primary, Secondary, and Tertiary Care

Currently in the UK mental health services are provided by the National Health Service (NHS), local authorities, third sector organisations (e.g. charities), and independent providers (Sambrook et al., 2025). The NHS structures its services according to the level of severity and impairment caused by a mental health difficulty, as shown in Figure 1. Primary care offers support for problems conceptualised as mild to moderate, secondary care to problems considered complex and concurrent, and tertiary care to severe and enduring problems (Sambrook et al., 2025). The NHS works with the Stepped Care Model, which was introduced in an attempt to ameliorate difficulties with access to psychological therapies by broadening the type of care available to reduce reliance on 1:1 therapy provided by highly-trained therapists (Richards et al., 2012). The Stepped Care Model offers individuals the lowest intensity treatment (defined by frequency and type) expected to meet their needs. More intensive or more frequent treatment is offered if care at a lower step was insufficient to meet an individual's needs (Richards et al., 2012). Mild to moderate mental health problems are assessed and treated at steps one to three in primary care services: General Practice (GP) and NHS Talking Therapies (NHS TT) formerly known as Increasing Access to Psychological Therapies (IAPT). Moderate to severe mental illness can be treated at step three in primary care, though complex and more severe needs are typically treated at step four in secondary care services: CMHTs or specialist community teams, such as Autism Spectrum Disorder (ASD) assessment teams. The most acutely unwell patients are assessed and treated at step five in tertiary care services: inpatient wards and highly specialist facilities

(Tameside Metropolitan Borough Council., 2015). Increasingly, referrals to services in each step are made through a single point of access (SPA), which is an independent NHS team that receives referrals, conducts a brief triage, and sends the referral on to the correct service (Chaplin et al., 2022). According to current guidelines, referrals from the SPA should be passed to the CMHT within one working day, or immediately in emergencies (Chaplin et al., 2022).

Figure 1

Diagram to show the levels of healthcare provision in the UK adapted from Sambrook et al. (2025).



Community Mental Health Teams (CMHTs)

CMHTs are multi-disciplinary, non-hospital teams, staffed by psychiatrists, psychologists, nurses, social workers, occupational therapists and administrators. A team comprising different professional groups working together is called a Multi-Disciplinary

Team (MDT). Depending on local commissioning, CMHTs may also employ support workers and other clinical specialists, such as peer support workers (NHS, 2019).

Historical Understandings of Mental Distress and Treatment in Europe

In order to understand the context of CMHTs, a brief history of how mental distress has been understood in Europe is presented below. An anthropological framing is offered to place the current CMHT model, and this research, in the social, political, cultural, and historical context from which it cannot be separated. The researcher's position as an anthropological psychologist researcher meant that CMHTs were viewed as nothing more than the current iteration of a long-evolving attempt to understand and respond to human distress. This is as opposed to an intentionally designed system; a power structure far harder to engage with critically.

From Antiquity to the Middle Ages

The understanding of what mental health and ill health are have evolved throughout the course of human history. The Hippocratic Collection a collection of medical texts written and compiled in Greece in the late fifth century to early fourth century CE, shows that the ancient Greeks believed illness to be caused by humoral (bodily fluid) imbalances of yellow bile, black bile, phlegm, or blood (Totelin, 2008). In ancient Greece, it was philosophers who presented themselves as 'doctors (iatros) of the soul' (psychē), leaving medical doctors to treat physical ailments (Ahonen, 2019). Philosophers treating 'diseases of the soul' principally tried to help followers live a life 'according to nature' and free from self-centred anxieties, as in Stoicism, and free from supernatural suspicions and anxiety about death, as in Epicureanism.

Though not explicitly codified in law, there seems to have been an understanding of the difference between people beset by emotional problems affecting the health of their soul, and those designated 'mad'. In Plato's The Laws, for instance, we see those who are 'mad'

excluded from a legislature seeking to govern the people. While citizens would be held responsible for offences they committed, those described as ‘mad’ were to be cared for by their families at home, and it was their families who were fined if an individual offended. Though effectively excluded from public life, the ‘mad’ were understood to be ill and, therefore, not responsible for their actions (Ahonen, 2019). Throughout Plato’s writings, we find a remarkably familiar idea that no human is inherently evil, and that society, education and physical health exert significant influences over people’s behaviour (Ahonen, 2019).

After the Dark Ages, new ideas about religious demonology appeared, which were used to explain some cases of ‘possession’ and witchcraft (Kemp, 1985). In medieval Europe, there is evidence that the (likely) mentally ill were accused of witchcraft, but contemporary academics generally agree that the extent to which this happened is overstated. There is a view of the medieval world that suggests mental illness was seen as a punishment from God, or the result of supernatural forces such as possession by the devil (Kemp, 1985). Treatment for these illnesses, such as burning at the stake, made sense as the body was destroyed in order that the soul be saved (Kemp, 1985). However, Kroll and Bachrach (1984) argue that this view assumes that medieval people did not draw a distinction between the theological tenet ‘God rewards the virtuous and punishes the sinners’ and evidence from their immediate experience; that virtuous people suffered illness and died, and people that sinned could be rich and live into old age. Kroll and Bachrach (1984) and Kemp (1985) argue that the anti-psychiatry movement has created a negative narrative of medieval understandings of mental illness in order to claim the wrongs of contemporary psychiatry are rooted in medieval cruelty and superstitious belief. Psychologists, they argue, need to feel that they belong to a ‘continuously progressive scientific enterprise’ (p. 508), which creates a vested interest in the creation of an exaggeratedly negative medieval world (Kroll & Bachrach, 1984).

The mentally ill in the medieval and renaissance periods were dependent on their families for care (Hosák & Hrdlička, 2017). Those without money or familial protection were dependent on the church, principally monasteries and cathedrals, to offer charity (Hosák & Hrdlička, 2017). In the early 1400s, the Bethlem Royal Hospital in London, generally considered the earliest recorded ‘lunatic asylum’ in Europe, admitted its first ‘lunatics’ (Andrews, 1997). Asylums, or ‘madhouses’, such as the Bethlem (or Bedlam as it was also known) were unregulated and run for profit by lay people. Individuals could be detained at the request of a family member or official person, and there was no recourse to appeal. There were no regulated treatments, though claims of miracle cures were made, perhaps to encourage business (Dickinson, 1990).

From the Enlightenment to the Twentieth Century

For nearly 400 years, from the opening of Bethlem until the ‘Madhouse Act’ of 1774, detention and treatment in private 'madhouses’ was completely unregulated by the state. This changed in 1774, when new legislation required that madhouses be licensed and regularly inspected by government appointed officials, that the number of people admitted to them be capped, and that incarceration be possible only with medical certification from a physician. However, the protection afforded by the 1774 act was, in practice, scant. Licences appeared to be granted by default, inspections were often superficial, and medical certification was not required for the incarceration of paupers, who constituted the majority of the madhouse population. The act, therefore, provided some protection, particularly to upper-class women, against wrongful detainment but it provided little protection to the majority of the population (Crane, 2013).

The French Revolution of 1789 is widely considered a turning point in the care of the mentally ill. The French physician, Pinel, believed that patients should not be restrained or treated with violence as doing so caused restlessness and aggression. He believed instead that

patients should be treated in a safe environment to reinforce their ‘moral qualities’ (Hosák & Hrdlička, 2017). He did, however, believe that society should be kept safe from asylum patients and, therefore, maintained their segregation.

Psychiatry began to develop as a distinct speciality in the 18th century as a result of three converging factors: the rise of organ-based medicine; the attempt to categorise mental illness; and the creation and proliferation of asylums (Kendler et al., 2022). It was not until 1808 that Reil, a German physician, established psychiatry as a distinct sub-discipline of medicine and large psychiatric asylums were established across Europe (Janssen, 2023) beginning what Foucault called ‘the great confinement’ (Foucault, 1965). The Enlightenment’s enthusiasm for scientific classification extended to the idea of categorising different forms of mental illness. For instance, in 1824 the Scottish physician Morrison classified ‘madness’ as melancholy, mania or dementia, and recommended that patients be treated with medicine and restrictive measures (Ahonen, 2019). In England, the 1845 Lunacy Act required each county by law to have, and to fund, its own asylum. Between 1845 and 1890, when the Lunacy Act was next updated, 60 new asylums opened across the UK and the number of people incarcerated within them rose rapidly (County Asylums, 2018). The treatments offered in these facilities ranged from physical restraint, such as by straightjacket, to keeping patients occupied through work and routine activities. The use of restraints became tightly restricted under the 1890 act and voluntary admission without medical certification became legal. There were no standardised treatments, and admissions were often open-ended, which could lead to a decline in the ability to look after oneself, an effect later called institutionalisation (Hosák & Hrdlička, 2017).

It was not until the 1930 Mental Treatment Act that asylums became known as mental hospitals, and lunatics, patients. The act also enshrined in law some now recognisable features of mental healthcare: patients could be admitted on a voluntary and temporary basis,

it was required that women be on hospital management committees, and doctors assessing patients for certification had to be 'approved' for the role and not the patient's usual doctor (Hilton, 2022). During World War II, beds in mental hospitals were requisitioned by the military. This coincided with greater recognition of mental health problems and the acknowledgement that 'normal' people could become unwell as 'shellshock' became part of national parlance. The writings of psychiatrists such as Lewis introduced ideas about the social causes of mental distress and the role of early intervention in preventing admission (Lewis, 1963). It was under these changing tides in psychiatry that the NHS was established in 1948 (Klein, 2010). Across England and Wales, the NHS took over around 2,600 hospitals and, of the approximately 190,000 beds, around half were in mental hospitals (Royal College of Psychiatrists, 2023).

The Development of NHS Mental Healthcare Provision

The Asylum Era

The treatment of mental illness in the early years of the NHS remained mostly unchanged from the asylum era. Yet as the 1940s came to a close, an appetite for change was felt among the public and policy makers. The development of 'wonder drugs' in the 1950s gave hope that mental illnesses could be cured, as physical ailments could be. This coincided with ideas from the social sciences and psychotherapy about new forms of treatment. Policy makers were also keen to requisition mental hospitals, often on prime real estate, to save public money (Foster and Roberts, 1998). The 1970s then saw the first movements from patients to campaign for the individual rights of the mentally ill (Turner et al., 2015). In 1983, a new Mental Health Act was passed that provided greater protection to patients, including the right to appeal certification.

In 1961 the then minister for Health, Powell, made his famous 'water tower' speech, which put forward the government's intention to close the majority of mental hospitals within

10 years and to replace them with an expanded system of community care (Foster and Vega, 1998). However, it was not until the 1980s that the large mental hospitals were closed. The very last former asylums to close in England were in Essex. Severalls hospital in Colchester closed its last ward in 1997, and Runwell hospital in Chelmsford discharged its final out-patients as recently as 2010 (County Asylums, 2018). For policy makers and for staff, it is important to remember that for many patients, the asylum era is still well within living memory.

The Establishment of Community Mental Health Teams (CMHTs)

In 1990, the National Health and Community Care Act made local authorities responsible for community care and CMHTs were established. Their focus was to support the severely mentally ill who were also deemed potentially dangerous (Turner et al., 2015). They also aimed to improve patients' quality of life by promoting choice and independent living to help individuals reach their full potential (Malone et al., 2007). Despite the intention to re-integrate the former patients of mental health hospitals into the community, social distance generally increased after de-institutionalisation, perhaps due to largely unaddressed public concern about care in the community and public perceptions of risk (Rössler, 2016). The Care Programme Approach (CPA), published in 1991, introduced a framework that aimed to improve care in the community. The CPA recommended a thorough initial assessment of a person's health and social care needs be made. It also recommended that detailed and individualised care planning be conducted and a care-coordinator be allocated to oversee the plan's implementation with regular reviews to revise the plan if required (Goodwin & Lawton-Smith, 2010).

Changing Philosophies of Care

Mental health became one of three priorities in the 2000 NHS plan and was promised greater funding. The remit of NHS mental healthcare provision expanded significantly in

2006 with the introduction of Increasing Access to Psychological Therapies (IAPT) services, recently renamed NHS Talking Therapies (NHS TT) (Turner et al., 2015). NHS TT services were commissioned to assess and treat mild to moderate common mental health problems with the express intention of supporting patients to return to work (Turner et al., 2015). NHS TT services were introduced to broaden the mental healthcare provision in primary care at steps one and two of the stepped care model. Meanwhile, the treatment of moderate to severe mental health problems remained under the remit of general hospitals and CMHTs (Turner et al., 2015). The establishment of NHS TT services marked a turning point in the NHS' mental healthcare provision. No longer would the NHS care exclusively for the severely mentally ill; now it would also be responsible for supporting people with mild to moderate common mental health problems, and (perhaps from a critical perspective) the 'normal ups and downs' of life.

Concurrently, CMHTs working with the moderate to severely mentally ill were encouraged to adopt the recovery model of care (Jacob, 2015). The recovery model emphasises staying in control of one's life, and building and maintaining resilience rather than encouraging the goal of returning to what life was like before a mental health problem began (Jacob, 2015). The MDT works together to provide holistic support: care coordination can support with physical health needs, accessing the community and building social relationships; psychology can aid insight into the origin of a problem, understand its maintenance, and support goal setting and positive change; psychiatry can provide medication support if indicated. More recently, the Community Mental Health Framework for Adults and Older Adults, published in 2019, recommended better integration of primary and secondary care with the voluntary sector to improve experiences of care by reducing referrals and assessments, closing treatment gaps, and considering psychosocial causes of mental distress (Hobson-Merrett et al., 2025). National implementation of this new approach

has not yet been achieved, and there has been no implementation guidance published to date (Hobson-Merrett et al., 2025).

CMHTs are increasingly being encouraged by commissioners to adopt trauma-informed approaches to care, reflecting a growing recognition of the high prevalence of trauma among people using mental health services (Moloney et al., 2018). Trauma-informed approaches aim to prevent re-traumatisation and the exacerbation of symptoms through contact with services. Trauma-informed principles include starting with the assumption that every patient and staff member may have experienced trauma, and working towards creating cultures that feel safe, trustworthy, collaborative, empowering and culturally sensitive (Emsley et al., 2022). The introduction of trauma-informed approaches can, therefore, also be understood as a critique of conventional mental health systems. Rather than locating distress solely within the individual, trauma-informed models emphasise the role of adversity, relational harm, and structures of power in shaping mental health difficulties (Saunders et al., 2023).

Contemporary Understandings of Mental Distress and Treatment

The following section presents a brief overview of contemporary views on understanding and responding to mental distress. The intention of this section is to provide context to the current NHS system and the philosophies of care within which staff work. It begins with an overview of the medical model, along with its common critiques, after which formulation-based and non-diagnostic approaches are explored.

The Medical Model

The medical model has come to dominate European healthcare systems in both physical and mental healthcare settings. In mental health services, the medical model conceptualises problematic thoughts, feelings and behaviours as mental illnesses or disorders arising from an underlying pathology located in the individual. These problematic symptoms

are classified using a system of diagnostic categories, and diagnoses are made through a combination of gathering information, prototype matching to diagnostic categories, following decision trees, and hypothetico-deductive reasoning, deciding the most likely diagnosis and seeking confirmatory evidence (Huda, 2021).

Some clinicians and academics argue that the development of sets of diagnostic criteria, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) has aided the medical model's dominance (Middleton, 2015). The DSM, now in its fifth edition with text revisions (DSM-V-TR), and the ICD, now in its eleventh, are published manuals detailing 'official' diagnoses that are grouped by type and defined by lists of symptoms. Dividing illnesses into discrete categories aids the acquisition of further knowledge through research by making it possible to study patterns across individuals and populations. It also aids the communication of knowledge between professionals and through teaching trainees. In clinical practice, it can provide a way of synthesising and understanding an array of information under time pressure or in emergencies, which aids clinical decision making. For individuals and clinicians, diagnoses can provide information about prognosis, treatments, and may grant access to specialist services. Diagnoses also have a social function in providing access to support from the state, such as welfare payments and housing provision, and giving a short-handed way of explaining one's difficulties (Huda, 2021). The medical model has enabled psychiatry, with its diagnostic system of disease classification and corresponding evidence-based treatments, to work within wider medical systems (Stein et al., 2022).

Critiques of the Medical Model

A specific criticism of the medical model is that it offers no explanation for how factors interact to cause and modulate mental illnesses (Huda, 2021). Timimi, a psychiatrist and a prominent figure in the anti-diagnostic movement, argues that physical medicine seeks

to find and understand the cause of a person's problem(s) and then to match a treatment to resolve an underlying pathology. The problem with psychiatry's claim to an equivalent medical model for mental illness is that the only way to describe, for example, depression, is to use its symptoms, such as low mood, lack of motivation, and fatigue, none of which is able to explain the underlying cause of the depression. While a heart attack could be described in terms of chest pain and shortness of breath, it would also be possible to describe what is happening at the level of changes to the heart itself. There is no 'anti-cardiology' movement because experts generally do not dispute the underlying pathology. Therefore, at the core of the problem is that psychiatric diagnoses do not explain an individual's symptoms, they describe them (Timimi, 2020).

However, Huda (2021) argues that the problem Timimi describes also exists in branches of general medicine and is not a problem limited to psychiatric diagnoses. General medicine recognises the existence of illnesses in the absence of biological disease and calls them 'functional' conditions, for example irritable bowel syndrome. Furthermore, the healthcare system supports changes in physical state which lack symptomatic or biological pathology, such as pregnancy. Although pregnancy is neither an illness nor a disease, a pregnant woman is generally considered a reasonable candidate for medical monitoring due to the risk of complications and the high regard we hold for life. Medical monitoring and overmedicalisation, and overmedicalisation by virtue of monitoring, are problems that exist in all areas of medicine, not just psychiatry. Critics of psychiatric diagnoses that cite concerns, for example, about reliability and validity, and highlight a lack of diagnostic biopsychosocial causes, often fail to acknowledge that these same issues exist in general medicine. Thus, perhaps we should be holding a critical lens to all of our medical system, not just mental health services (Huda, 2021).

An additional complicating factor is where the intellectual line is drawn between health and ill health (Semple and Smyth, 2019). The positioning of the health/morbidity line is important in the medical model as it determines whether a symptom is included in a person's diagnostic profile, which may affect the diagnosis given, and what treatment is subsequently offered, or not. Yet the position of this imaginary line is mutable, a factor the Oxford Handbook of Psychiatry itself acknowledges in its introduction when it states: 'disease is a concept which will tend to change over time and has no real existence in itself' (Semple and Smyth, 2019, p. 6). Another view is that what constitutes wellness or illness, and what it is suitable to seek help for, is socially and culturally determined (Huda, 2021). From this perspective, there can be no prospect of determining any fixed line between health and ill health, as changing cultural norms and public discourses lead to constant reimagining of what might be indicative of 'disorder'.

An example of the shift in the health-illness line is the proliferation and expansion of diagnoses that have occurred through the end of the twentieth century into the twenty-first century. Critics argue that the move has led to psychiatric diagnoses accounting for ever broader aspects of the human experience (Boysen & Ebersole, 2014). A 2014 review found that the then newly published Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM V) had expanded 36% of the previous edition's disorders by loosening or broadening the parameters to allow a greater number of individuals to be diagnosed (Boysen & Ebersole, 2014). This expansion may be seen as a professionally sanctioned shift in the line between health and illness. Others view it as the latest iteration in a long history of institutional attempts to 'govern the mad' (Middleton, 2015).

Moving Beyond the Medical Model

The medical model provides one way of understanding distress and how that distress can be responded to. Yet the early twenty-first century has seen a growing interest in

different ways of thinking about and responding to human suffering. This is partly borne out of a growing movement questioning the validity, utility, and ethics of diagnostic classification systems. For instance, an opinion published in 2013 by the British Psychological Society's (BPS) Division of Clinical Psychology raised concerns about what it saw as the increasing medicalisation of human distress and behaviour (Division of Clinical Psychology, 2013). Without denying the role of biology in some psychiatric diagnoses, for example dementias or moderate to severe learning disabilities, the article calls for new approaches that consider the complexity of biological, social, and psychological factors, and how their interactions give rise to mental distress. It would be outside the scope of this research comprehensively to explore the wealth of models and treatments that have been developed. Therefore, two of the most influential at the time of writing are presented below.

Psychological and Formulation-Based Models

Psychological and formulation-based models may work within or alongside a diagnostic system, but they reject diagnosis as a sufficient explanation for distress. Instead, personalised, theory-informed accounts of a person's presenting problem, their history and their social context are used to inform an understanding of the distress, and to guide the treatment (Johnstone & Dallos, 2014).

In the context of UK mental health services, Cognitive Behavioural Therapy (CBT) has become a widely used and heavily researched treatment for a variety of psychological presentations (Johnstone & Dallos, 2014). CBT models conceptualise mental health difficulties as arising from learned patterns of thinking, emotion, behaviour, and physiology, maintained by feedback loops rather than arising exclusively from an underlying pathology (Johnstone & Dallos, 2014). Formulation usually focuses on current maintaining processes rather than specific diagnoses and formulations are often represented through disorder-specific models, such as Ehlers and Clarke (2000) model of Post-Traumatic Stress Disorder

(PTSD). Formulation is used to inform an intervention by identifying opportunities for cognitive, behavioural, or contextual change.

CBT is not without its critics. For example, while consensus is generally high for surface level assessment, such as the identification of presenting problems, the identification of, for example, core beliefs produces varied results due to the subjectivity involved in making meaning of a person's experience (Kuyken et al., 2005). In this way, a critical perspective might be that CBT formulations present persuasive and perhaps useful stories, but they are not a concrete reality (Kuyken et al., 2005). Critics also argue that CBT has been privileged in western healthcare systems, and in research, as its system of problem-specific formulations and treatment protocols maps closely on to DSM and ICD diagnoses (Rowland, 2024). This provides a psychologically informed way of assessing and treating mental illness that fits neatly with the medical model (Rowland, 2024). However, CBT can be delivered in ways that locate distress inside the individual at the expense of acknowledging wider systemic causes and contributors of distress (Huey et al., 2023). For example, failing to acknowledge the impact of systemic racism and poverty risks implying that individuals are at fault for struggling in a world that treats them cruelly or discriminates against them, which presents a significant ethical problem (Huey et al., 2023).

Non-Diagnostic Models

Linked to explicitly psychological models of formulation and treatment, non-diagnostic models seek first to understand mental distress rather than to classify it. They differ in the emphasis placed on systemic issues and their causal and modulating effects on mental distress.

One such example is the Power Threat Meaning Framework (PTMF), which is an explicitly non-diagnostic approach. The PTMF locates psychological suffering in the operation of different forms of power: biological, interpersonal, social, economic, and

ideological (Johnstone et al., 2018). It suggests that experiences commonly labelled as disorders can be understood as meaningful, adaptive responses to threats arising from adverse life events such as trauma, abuse, discrimination, poverty, or social exclusion. The framework is structured around four central questions: ‘What has happened to you?’ (how power has operated in your life), ‘How did it affect you?’ (what threats this posed), ‘What sense did you make of it?’ (the meanings constructed in response), and ‘What did you have to do to survive?’ (the threat responses adopted) (Johnstone et al., 2018). These threat responses may include behaviours, thoughts, emotions, or bodily states, which are typically described as symptoms in the diagnostic system but are seen as survival strategies in the PTMF (Johnstone et al., 2018).

Criticisms of the PTMF fall under three main categories: philosophical questions, the potential privileging of psychosocial factors at the expense of biological factors, and the real-world applicability of the framework. Morgan (2023) argues that the PTMF does not explain how it judges mental distress as distress, and suggests that were it to, the PTMF would describe distress in a similar manner to the medical model. Morgan (2023) also raises concern about how meaning is conceptualised, suggesting that it privileges a behavioural account of environmental adaption at the expense of existential aspects of the human experience. Whilst the PTMF has been praised for acknowledging the role of biology in the development and experience of mental distress, the privileging of social and relational aspects of distress risks insufficient care being given to those biological factors, such as genetic predispositions and the impact of physical health conditions on mental distress (Atkinson et al., 2025). A final criticism of the PTMF, directly applicable to this research, is in how it could be operationalised in the current healthcare system. This is particularly true of acute settings, such as inpatient wards or forensic services, where decisions may be required

quickly and concerns about risk to the self and others predominate (Nikopaschos et al., 2023; Ramsden, 2019).

The Implications for Health Systems

This thesis began with a brief overview of how mental distress has been conceptualised in Europe since antiquity. The medical model, psychological, and explicitly non-diagnostic models are another step in an evolving understanding of mental ill health. It is important to recognise that patients, staff, and commissioners are all living in that evolving landscape, and themselves will have experienced different conceptualisations of mental distress. For services, this creates existential tension in how to understand and respond to distress. Furthermore, different disciplines are likely to feel drawn to some models over others, as are individual clinicians for their own idiosyncratic reasons. Mental healthcare systems in 2026, therefore, are required to grapple with vastly different languages and approaches to mental health, which may have competing aims.

Systems Under Pressure

Patients

In England, NHS spending on mental health services is projected to rise to £15.6 billion in the 2025-26 financial year, accounting for 8.7% of the total NHS budget (Yau et al., 2025). The Darzi Report (2024) found that mental health problems (MHPs) account for more than 20% of the disease burden but less than 10% of total NHS spending. If mental health was given proportionate funding to the disease burden it currently represents, mental health services would receive £36 billion in 2025/26, £20.4 billion more than projected NHS spending in 2025/26 (Royal College of Psychiatrists, 2025).

The Adult Psychiatric Morbidity Survey (AMPS) collected by NHS digital every seven years reported that in the year 2023/2024, 22.6% of 16-64-year-olds in England

identified with a common mental health condition (Morris et al., 2025). This is up from 17.5% in 2007 (Morris et al., 2025). During the same period, non-suicidal self-harm increased from 3.8% to 10.3% (Morris et al., 2025). Of those surveyed that had a mild to moderate mental health condition, 47.6% were receiving treatment (medication or psychological therapy) in 2023/34 compared to roughly 25% in 2000 (Morris et al., 2025). In community services specifically, 23.2% of those with severe MHPs were receiving psychological therapy in 2023/24 compared to 12.5% in 2000, and 45.8% were receiving psychotropic medication in 2023/24 compared to 28.5% in 2000 (Morris et al., 2025). These figures demonstrate that psychiatry and psychology in community services are in greater demand than they were 25 years ago.

Evidence also suggests that CMHTs in the UK are under increasing pressure as they attempt to support greater numbers of people without proportionate increases to resources and funding. NHS Digital reports that in the year 2021/22, 378,058 more people were in contact with secondary mental health services in England alone than in the year 2019/2020. Across mental health services in England, there was an increase of 16.1% in the number of people accessing services between the years 2020/2021 and 2021/2022 (NHS Digital, 2022). While these figures capture the rapidly changing needs of the population during the Covid-19 pandemic, the number of people accessing mental health services has not significantly decreased following the pandemic. Looking at secondary care services specifically, the number of people who had contact with secondary care services has risen from 2.88 million in 2019/2020, pre-pandemic, to 4.13 million in 2024/25. The number of people admitted as an inpatient while under secondary care services fell from 104.5 million in 2019/20 to 90.19 million in 2025/26 (NHS England, 2025). These figures suggest that secondary care services have experienced a rapid rise in the number of patients for whom they are responsible. At the

same time, reduced admission rates to hospital may also have led to an increase in risk and complexity.

Staff

In recognition of the rising demand for mental health services, the NHS mental health workforce has expanded. Between 2010 and 2023, the total mental health workforce (full-time equivalent [FTE]) grew by 23% (Gilburt & Mallorie, 2024). However, the growth has been uneven across the workforce. The number of psychiatrists has increased by 22%, compared to a 43% increase in doctors across the NHS more widely (Gilburt & Mallorie, 2024). The number of support staff and therapists has increased by 45%, while nursing staff, who make up the majority of the mental health workforce, have increased by only 3% (Gilburt & Mallorie, 2024). The number of nurses in the mental health workforce fell substantially between 2010 and 2017, though the numbers have now increased and are roughly equivalent to what they were in 2010 (Gilburt & Mallorie, 2024).

The number of staff in post has not kept pace with the number of patients. While the total mental health workforce increased by 22% between 2016/17 and 2021/22, the number of patients increased by 44% in the same period (Committee of Public Accounts, 2023). Retaining staff in mental health services is also a challenge for the NHS. In 2021/22 alone, 12% of staff left the mental health workforce (National Audit Office, 2023). Despite the increase in FTE staff, the number of vacancies remains high. In September 2023, there were 28,600 vacancies in England alone, 19% of the total posts in mental health services (Gilburt & Mallorie, 2024). Some specialities in particular are struggling. Psychiatry posts in old-age psychiatry, learning disability and child and adolescent services remain consistently unfilled (Gilburt & Mallorie, 2024). Meanwhile, the workforce has also become less experienced. The number of psychiatrists in junior posts (foundation year 1 and 2, and in core training) has increased from 15% in 2010 to 27% in 2022. A similar pattern is seen with nursing staff. In

2012/13, 60% of staff on inpatient wards were registered nurses and 40% were support workers. 10 years later, the proportions are reversed (Gilburt & Mallorie, 2024). The 2022 NHS workforce survey showed that staff working in community mental health services felt stressed, worn out and frustrated by working in services with unfilled posts (NHS staff survey, 2022). Overall, these figures show that services are struggling to meet the needs of greater numbers of people.

The Effectiveness of CMHTs

Attempting to assess the effectiveness of CMHTs is initially complicated by how to define and measure effectiveness. Effectiveness could be defined in terms of patient outcomes, which could be assessed via standardised outcome measures such as the Clinical Outcome in Routine Evaluation-10 (CORE-10) to produce numerical values. Effectiveness could also be measured in terms of re-admission rates to hospital while under the CMHT, rates of suicide or self-harm, or rates of re-referral to the CMHT following discharge. Effectiveness could also be assessed more qualitatively, for example, looking at patients' experiences of being under and working with the CMHT, or self-assessed quality of life.

Patients

An early systematic review looking at the effectiveness of CMHTs found that while they did not reduce symptoms of mental illness beyond what standard care (most commonly hospital admission or out-patient services) was able to achieve, CMHTs cost less, significantly reduced deaths by suicide, and significantly reduced hospital admissions when compared to standard care (Malone et al., 2007). Interestingly, a study comparing overall hospital use and social and clinical functioning between groups of CMHT patients who were under 'treatment as usual' compared to an 'intensive case management' approach where staff held significantly smaller caseloads, showed that there was no significant difference in

outcomes between the groups. This study, though 25 years old, suggests that reducing caseloads alone does not improve outcomes for patients (Burns et al., 1999).

A qualitative study investigating patient experiences of CMHTs found that continuity of care, validating and compassionate connections with staff, timely support, and flexibility and variety in the therapeutic offer were all valued by patients and identified as therapeutic elements of their journey through CMHT services (Trevillion et al., 2022). The authors centre these themes around the concept of relational practice, which they define as being individualised, non-stigmatising, compassionate, trauma-informed, holistic, collaborative, flexible, and providing continuity of care. However, the study found that the overwhelming experience of CMHTs was negative. Patients felt that staff lacked knowledge about their difficulties, they felt that interventions were largely ineffective, and they felt stigmatised in relation to their diagnoses (Trevillion et al., 2022). Similarly, a recent systematic review synthesising patients' experience globally of secondary care services (not exclusively CMHTs) concluded that there is an urgent need to redesign mental health systems, and to co-design them with patients (Sheridan Rains et al., 2021). The review concluded that patients often require long-term support, reflecting their experience that progress was rarely linear. Many patients felt that recovery meant an improved ability to cope with their symptoms, and a reduction in the impact on their life, as opposed to the absence of any difficulties. Patients also felt that individualised approaches to care were more effective for them when compared to one-size-fits-all approaches, such as dialectical behaviour therapy (DBT) groups, which were felt to be highly standardised and impersonal. Patients felt that specific interventions could be helpful, but they highlighted that if clinicians focussed too much on highly standardised therapies, then their goals could become lost. Patients explained that the relationships they had with clinicians were at the heart of their recovery. Relationships that felt warm, trustworthy, non-judgemental, and open were felt to contribute to recovery.

Conversely, relationships that felt cold, stigmatising, lacking in empathy, and uninterested or authoritarian, were perceived as hindering recovery or being overtly traumatising (Sheridan Rains et al., 2021).

Staff

Literature exploring staff perceptions of the effectiveness of CMHTs often focuses on staff wellbeing and its impact on clinical outcomes. A 2004 study found that staff burn-out and working overtime were associated with a higher probability of patient hospital admission when compared to teams who did not frequently report working extended hours (Priebe et al., 2004). A more recent study comparing staff's self-reported burnout with the quality of care they felt able to provide showed that staff experiencing burnout felt less conscientious at work, and less able to provide 'patient-centred care' (Salyers et al., 2015). Across the NHS more widely, Raleigh et al (2009) found that higher staff stress levels and unplanned extra working hours were associated with worse patient experience. A 2024 study into the impact of nursing staff and resident doctor turnover in the NHS found that high turnover rates were associated with increased mortality rates and longer hospital stays. The authors suggest that high staff turnover negatively affects team functioning and the delivery of care (Moscelli et al., 2024).

These studies provide compelling evidence that staff wellbeing matters, and that it affects patient outcomes. At the time of writing, a relatively small number of studies have been published assessing staff wellbeing in CMHTs and that they have yet to be synthesised.

Staff Wellbeing in CMHTs: a Systematic Review

Background

The term burnout was defined in 1974 by Freudenberger, who described a 'state of mental and physical exhaustion caused by one's professional life' (p. 159). A literature

review conducted in 2000 found that levels of stress and burnout were high among community mental health nurses due to increasing workloads and administrative burden, safety concerns, role conflict and ambiguity, and general working conditions (Edwards et al., 2000). A later review, conducted by O'Connor et al., (2018), found that levels of burnout were high among mental health professionals in the NHS, and noted that staff working in community teams were especially vulnerable to burnout when compared to those working in specialist teams (e.g. crisis teams) due to factors such as high workloads.

Concern about staff morale in the academic literature is largely driven by questions about productivity, individual effectiveness, and rates of staff turnover. However, in the broader Western European zeitgeist, there exists a burgeoning interest in individual wellbeing more generally. Wellbeing is a nebulous concept that has acquired a multitude of definitions, yet most converge to make a statement about emotions, cognitions, behaviour, and relationships being generally positive over time (Jarden & Roache, 2023). For the purpose of this review, the American Psychological Association's (APA) definition will be used to operationalise wellbeing as 'a state of happiness and contentment, with low levels of distress, overall good physical and mental health and outlook, and good quality of life' (APA, 2018). This definition was chosen as it fits the current NHS system and the medical model that the NHS works within, which defines the context in which staff live and work. However, it is acknowledged that a certain richness is lost by privileging this definition over other conceptions of wellbeing that may be more collectivist or are less driven by medical taxonomy.

The systematic review was conducted using thematic synthesis (Thomas & Harden, 2008) to answer the question 'what factors influence staff wellbeing in CMHTs in the UK?'. Four analytical themes are identified and discussed in the context of moral injury and burnout in healthcare settings

Method

Design

The aim of a systematic review is to bring together primary literature examining a specific topic to answer a research question in a way that is not biased or distorted by factors related to the primary research (Thomas & Harden, 2008). This systematic review uses a method called thematic synthesis which is outlined by Thomas and Harden (2008) as a peer-reviewed, well established, method for synthesising qualitative data. Thematic synthesis was chosen as a flexible form of analysis that allows data of different types to be both described and interpreted, while maintaining fidelity to the original research (Thomas & Harden, 2008). Thematic synthesis aims both accurately to describe the primary research using descriptive themes, and to interpret the themes in order to answer a research question or develop a new hypothesis or theory. The research process comprises the following stages: systematically searching for and selecting primary research, quality appraisal, extracting the data, free line-by-line coding, the development of descriptive themes, and the development of analytical themes. Descriptions of these stages are given in the following methodology section.

Article Selection

A systematic search of articles exploring staff wellbeing and experiences of working in CMHTs was conducted using the APA PsycInfo, APA PsycArticles, APA PsycTests, CINALH and MEDLINE electronic databases using the following search terms:

1) staff OR clinician* OR “mental health professional*” OR “psychiatrist*” OR “psychologist*” OR “clinical psychologist*” OR “therapist*” OR “psychological therapist*” OR “psychotherapist*” OR “community psychiatric nurse*” OR “CPN” or “PCN” OR nurse OR “social worker*” OR “care coordinator*” OR “support worker*”

2) “community mental health” OR CMHT OR “community team” OR “community care” OR “specialist mental health” OR “secondary care mental health” OR “secondary care mental health team”
3) interview* OR "structured interview*" OR "semi-structured interview*" OR "in-depth interview*" OR "in-depth" OR "focus group*"
4) “United Kingdom” OR “UK” OR “England” OR “Scotland” OR “Wales” OR “Northern Ireland” OR “NHS” OR “National Health Service” OR “NHS England” OR “NHS Scotland” OR “NHS Wales” OR “NHS Northern Ireland”

The search terms were used to search the databases using the ‘select a field’ option and the limiters ‘peer reviewed’ and ‘English’. As there is no clear date of the establishment of CMHTs, the date range July 1948 – October 2025 was selected to cover the course of NHS history. The search was conducted on 3rd October 2025. An additional hand search of the reference lists of key papers was carried out. Figure 2 presents the results of the search.

The search identified 1,825 studies, which was reduced to 602 after the limiters ‘empirical study, qualitative study, interview, focus group, longitudinal study, follow up study, field study, non-empirical (discussion), prospective study, nonclinical case study, retrospective study’ were applied. Doing so excluded studies marked as a ‘quantitative study, literature review, systematic review, meta-analysis, metasynthesis, mega analysis, mathematical model, brain imaging, scientific simulation, clinical trial, treatment outcome, clinical case study, twin study’. Secondary analyses, such as literature reviews, were excluded as the systematic review was concerned with primary literature only.

Figure 2

PRISMA Flowchart for the Systematic Review Detailing the Search and Selection of Papers

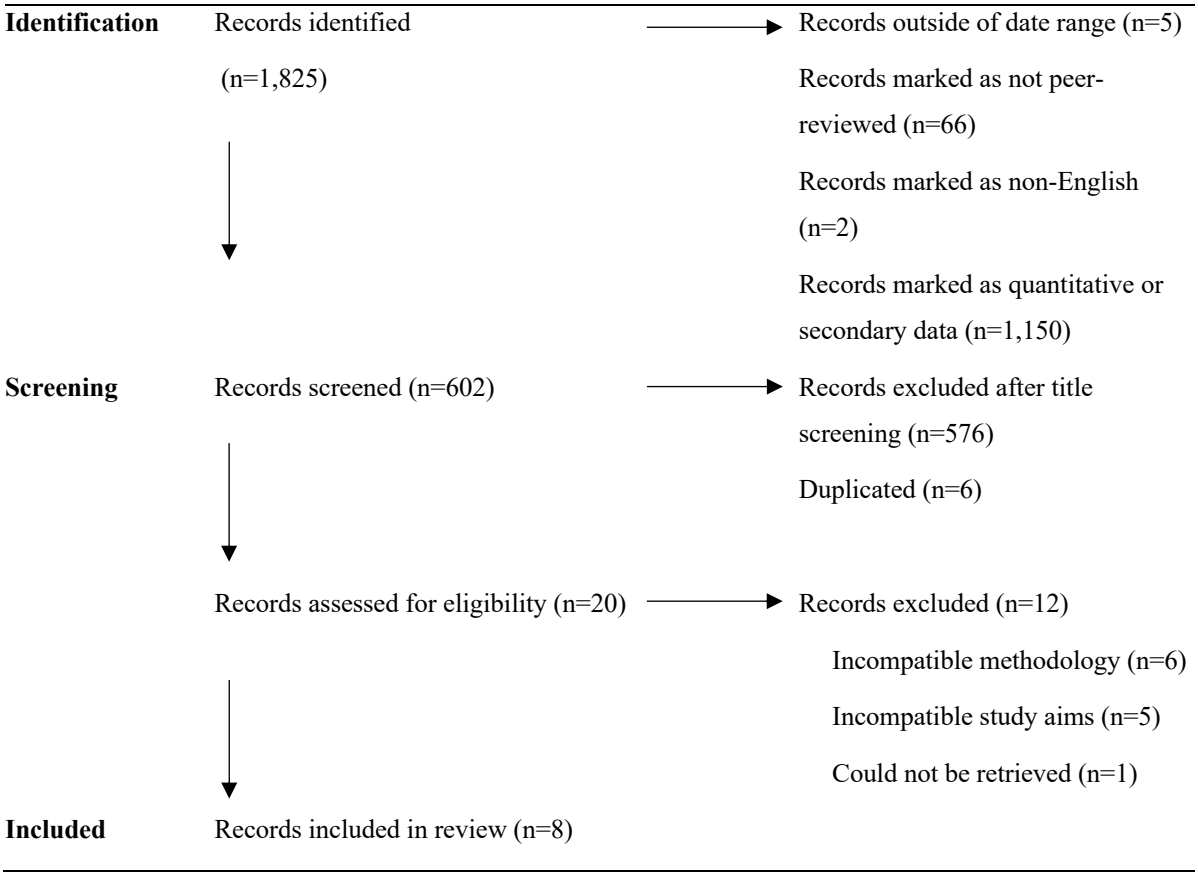


Figure 2 shows that 602 records were screened by title, yielding a total of 20 records, which subsequently underwent full-text screening. Six were excluded due to having incompatible methodologies, five due to having incompatible aims, and one could not be retrieved. In total, eight studies were included in the systematic review (Crawford et al., 2008; McKeown et al., 2024; Reid et al., 1999; Sambrook et al., 2025; Simpson, 2005; Thompson et al., 2008; Uttarkar, 2010; Wall et al., 2024).

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) tool for assessing the quality of qualitative literature is the most widely used quality appraisal tool in health-related research and is endorsed by the Cochrane Qualitative and Implementation Methods Group (Long et

al., 2020). For the purpose of this systematic review, the CASP checklist for qualitative research was applied to each of the eight studies included in the review. Appendix A shows an example of one such appraisal. Table 1 shows a summary of each paper included in the review. The results of the quality appraisal were also used to inform the synthesis. Methods for weighting findings according to study quality are emerging; however, for the purpose of this review, the Cochrane method of including studies marked 'medium' or 'high' quality was used (Noyes et al., 2018). All of the studies were marked as 'medium' or 'high' quality; thus none were removed following the quality appraisal phase. Appendix B shows a summary of the CASP findings.

Table 1

Summary of the Papers Included in the Systematic Review

Study	Participant information	Study aim	Findings	Strengths/weaknesses
Uttarkar (2010)	Staff working in three CMHTs	To understand how staff working in community mental health services cope with working with people with severe mental illnesses. What internal processes allow staff to work in these environments?	Staff were cognisant of psychodynamic issues. They had clear roles and understood their responsibilities. Management co-led teams with clinical leaders. Staff worked hard to keep patients out of hospitals, and there were clear care pathways and available resources to help them do so.	The researcher considers their position as a 'participant observer' and considers what this means using anthropological literature. They acknowledge that their presence is likely to have affected the data in observable and unobservable ways. However, there is a relatively small data set on which the conclusions are made. So while the author clearly has a wealth of experience in the area, the paper lacks an empirical basis.
Crawford et al (2008)	34 nurses working in CMHTs	How do nurses understand their professional status? How do their aspirations and experiences of work affect how they feel about themselves and their work?	The nursing identity was rooted in the wellbeing of their patients, and there was a strong public service identity. Nursing was seen as invisible, and there was a desire for recognition of their hard work and expertise. Nurses wanted additional training to increase their status in teams, and recognised that they felt dependent on the approval of others.	The paper conducts a good Thematic Analysis that answers the research questions and aims. It has a good sample size for a qualitative study and it is able to make meaningful conclusions about nurses' professional role and status. The authors could have given more thought to the ethical implications of the study and the relationship between researcher and interviewee.
Simpson (2005)	23 community psychiatric nurses working in CMHTs as care-coordinators	To identify factors that facilitate or constrain the ability of nurses, working as care-coordinators, to meet the needs of patients and carers.	CPNs felt unclear about their role and they felt restricted in their therapeutic capacity. Their caseloads remained roughly the same, but the complexity of the role and what they were asked to do changed, meaning they had less time to do therapeutic work and the focus in the service moved to crisis management.	The paper uses a variety of qualitative methods over a long time span (2 years) to make meaningful conclusions about the research question. The CPNs interviewed were almost 50% male, which is unusual when compared to other studies interviewing nurses. The study applied its findings to the concept of 'limited nursing' and made a convincing argument that CPNs working as care-coordinators were experiencing difficulties related to their experience of 'limited nursing'.

Study	Participant information	Study aim	Findings	Strengths/weaknesses
Reid et al (1999)	30 mental health staff in hospital and community mental healthcare settings, of whom 24 worked in the community.	To understand how their work affects mental health staff in terms of burnout and psychological wellbeing	Staff in the community talked about aspects of their working life that they found rewarding, such as supportive relationships with colleagues, and being able to work therapeutically with patients and form good working relationships. Nurses enjoyed the variety of their role and the autonomy they were able to work with. However, they were worried about the sense of responsibility they felt to keep patients safe both in and outside of crisis situations. They felt their workload was high, and they struggled with insufficient inpatient beds and a general lack of other community services to refer their patients to. They found that work affected their personal life in, for example, struggling with sleep and irritability.	The study uses established empirical methods to answer research questions related to staff wellbeing in the community and inpatient settings. The results are separated such that findings related to inpatient and community settings can be understood separately. The researcher's position in relation to the staff is not well considered, nor are the limitations of the study.
Wall et al (2024)	21 staff working in CMHTs working in a variety of roles	To understand the impact of the Covid-19 pandemic on staff working in community mental health teams	Staff struggled with 'moral distress' during the Covid-19 pandemic. They were not able to work face-to-face with patients, which limited the therapeutic capacity of the work. They felt isolated and unsupported while working alone at home, and they found it difficult to manage risk in the context of pared-back services more generally.	The study was conducted promptly and, therefore, was able to capture staff experiences of working in a CMHT during the first covid-19 lockdown in the UK. It explains the concept of moral distress, and uses it as a framework to present the results from the interviews. Limitations are considered; however, the authors could have reflected more on whether the staff groups interviewed affected the results. For example, they did not interview Psychology or Psychiatry staff, who could have offered different insights into the CMHT at the time.

Study	Participant information	Study aim	Findings	Strengths/weaknesses
McKeown et al (2024)	10 patients and 13 nurses working in CMHTs	To understand the experiences of patients and nurses providing and receiving care during the covid-19 pandemic, and what helped or hindered good care.	The care provided by CMHTs during the Covid-19 pandemic dramatically changed from what was offered before. While staff and patients saw some benefits to more flexible ways of working and remote, informal contact, the overall experience of the changes in care provided was overwhelmingly negative. Staff were very anxious about the wellbeing of the most vulnerable patients. Nurses also found that remote working affected their wellbeing, and they experienced moral injury in their role.	The study was co-produced at each stage, which clearly created a relevant interview topic guide, creating rich data. The study was limited in its ability to comment on other staff in the CMHT because it interviewed only one professional group.
Thompson et al (2008)	8 nurses working in CMHTs	To understand nurses' experiences of working with service-users who self-harm.	Nurses said that they tried to build therapeutic relationships with patients and tried to understand their difficulties and self-harming behaviours. However, they found the responsibility of containing and managing risk stressful, and were fearful of being blamed if a service-user died or was admitted to hospital. They struggled with boundaries because they felt personally responsible for patients' safety. They talked about working with limited resources and under time pressures, while feeling unsupported by the wider system. Nurses felt the emotional impact of their jobs. They felt anxious, stressed, hopeless, and desensitised in some cases. However, some described the job as rewarding. Nurses talked about an absence of formulation to guide their work.	The study examines in detail the experiences of nurses working with self-harm. There is an equal gender split among interviewees, which is unusual for studies of this topic, though the authors do not reflect on any gender-based differences in the results. The results are clearly explained and well evidenced. However, the authors do not give much consideration to ethical issues, and they do not reflect on their relationship in relation to the interviewees.

Study	Participant information	Study aim	Findings	Strengths/weaknesses
Sambrook et al 2025	26 staff. 11 worked in CMHTs, 11 in crisis cafes and 4 in a crisis line service.	To understand how effective staff think that the current service provision in the third sector is.	Staff described a system focussed on managing crises and stabilisation rather than recovery. They talked about long waiting lists and a lack of therapeutic options for patients while they are waiting. Staff felt care pathways were often inefficient, and that there was a culture of looking for reasons to reject referrals to protect their already overstretched service.	The study presents its results with clear quotations to support each finding. The reader can see which service each interviewee is referring to, which makes it possible to parse the CMHT results from the crisis café results. The researchers did not interview many clinical staff in the CMHT. While the administrative and management staff gave valuable insight into systems and processes, insight from direct clinical work was lacking in this paper.

Extracting the Data, Line-by-Line Coding, and Developing Descriptive Themes

The eight studies were read and re-read, and the findings were entered into NVivo 14. Line-by-line codes were identified using direct quotations from the text, creating a bank of 66 initial codes. Line-by-line coding enabled the process of translation, a key concept in qualitative synthesis, which refers to similar passages from different primary research studies being read and re-read to develop a superordinate category or theme (Thomas & Harden, 2008). Nine descriptive themes were created to capture the initial codes, which were: 'pervasive stress', 'fear of blame and responsibility', 'working in (mis)alignment with personal and professional values', 'constrained therapeutic practice', 'permeable boundaries', 'defensive practice', 'the constancy of crisis', 'feeling nurtured in a stressful environment', and 'feeling recognised and valued'.

Developing Analytical Themes

The purpose of descriptive themes is to create an accurate representation of the findings across studies that remains close to the original texts (Thomas & Harden, 2008). Analytical themes, however, aim to 'go beyond' the descriptive themes using the author's inference and interpretation. For Thomas and Harden (2008), the process of generating analytical themes is the most controversial phase of a qualitative synthesis because it is dependent on the skills, insight, interest and background of the reviewer. The analytical themes developed in this synthesis aimed to answer the research question 'What factors influence staff wellbeing in community mental health teams in the UK?' and to go a step further to consider the broader implications of this for the functioning of CMHTs. Table 2 shows the spread of descriptive themes across the eight studies. Four analytical themes were developed from the nine descriptive themes identified. The results are presented with a definition of each analytical theme before the descriptive themes are explained. A thematic overview is presented in Table 3.

Table 2

Cross comparison of studies by concept

	Uttarkar (2010)	Crawford et al. (2008)	Simpson (2005)	Reid et al. (1999)	Wall et al. (2024)	McKeown et al. (2024)	Thompson et al. (2008)	Sambrook et al. (2025)
Pervasive stress	✓	✓	✓	✓	✓	✓	✓	
Fear of blame and responsibility			✓	✓	✓	✓	✓	✓
Working in alignment with personal and professional values		✓	✓	✓	✓	✓	✓	
Constrained therapeutic practice	✓		✓	✓	✓	✓	✓	✓
Permeable boundaries				✓		✓	✓	✓
The constancy of crisis		✓	✓	✓	✓			✓

	Uttarkar (2010)	Crawford et al. (2008)	Simpson (2005)	Reid et al. (1999)	Wall et al. (2024)	McKeown et al. (2024)	Thompson et al. (2008)	Sambrook et al. (2025)
Defensive practice	✓	✓	✓	✓	✓	✓	✓	✓
Feeling nurtured in a stressful environment	✓	✓	✓	✓		✓	✓	
Feeling recognised and valued		✓		✓	✓	✓	✓	✓

Results

Table 3

Systematic review; themes and subthemes

Analytical theme	Descriptive theme
Heavy burden of responsibility	Pervasive stress
	Fear of blame and responsibility
Moral distress	Working in alignment with personal and professional values
	Constrained therapeutic practice
Structural pressures in community mental healthcare	Permeable boundaries
	Defensive practice
	The constancy of crises
Mitigating systems under pressure	Feeling nurtured in a stressful environment
	Feeling recognised and valued

Heavy Burden of Responsibility

This theme was developed to capture the difficult reality of the work that staff do. The studies suggested that CMHT work often involves strong emotions, which can affect staff's personal life. The studies also revealed that staff feel anxious about working with high-risk patients due to fear about being blamed for serious incidents.

Pervasive Stress

The studies found that staff frequently felt anxious, hopeless, helpless, and angry at work, and that they often felt exhausted (Crawford et al., 2008; McKeown et al., 2024; Simpson, 2005; Thompson et al., 2008; Uttarkar, 2010; Wall et al., 2024). These findings demonstrate an overwhelmingly negative experience of working in the CMHT system. Thompson, Powis and Carradice (2008) found that anxiety about working with high-risk patients affected staff's personal life, for example, by making it difficult to fall asleep at night. Reid et al. (1999) found that staff felt responsible for their patients' wellbeing outside of the working day, which may explain why staff appeared to find it difficult to 'switch off' from work'. Studies conducted during or soon after the Covid-19 pandemic found that the

boundaries between work and home had been eroded, which negatively affected staff wellbeing (McKeown et al., 2024; Wall et al., 2024). Reduced contact with colleagues, with whom staff said they valued informal debriefs, had a similar negative impact (Wall et al., 2024). Wall et al. (2024) also found that staff felt torn between the desire to protect their own families from the transmission of Covid-19 and the moral obligation they felt to see their patients, most especially at a time when they had become more isolated than before. Overall, studies found that anxiety about work does not remain at work; it also impacts personal lives.

Fear of Blame and Responsibility

Studies found that working with patients who self-harm or express suicidality was experienced as stressful and anxiety-provoking, partly due to a fear of blame and scrutiny in the aftermath of risk incidents and especially in the context of patient death (Thompson et al., 2008; Reid et al., 1999). Studies described an additional pressure to document decisions made and actions taken in the context of risk. Reid et al. (1999) found that staff perceived the level of responsibility placed on them by the CMHT to have increased over time, such that they now held near total responsibility for a patient's safety. Thompson et al. (2008) found that staff also felt personally responsible for preventing harm. These findings suggest a dual pressure for staff: the experience both of internal and external pressure to protect patients. Studies also found that 'managing crisis after crisis' was another key source of stress for staff (McKeown et al., 2024; Reid et al., 1999; Sambrook et al., 2025; Simpson, 2005; Thompson et al., 2008; Wall et al., 2024). Thompson et al. (2008) found that the strain of work could lead to staff desensitisation to distress and harm.

Moral Distress

This theme was developed to capture the conflict that studies describe between staff values and the system constraints they work within. The experience of moral distress was felt to differ from the raw, emotional impact of the work, because moral distress arises primarily

from a value-based conflict, whereas burnout is a physical and emotional experience arising from working conditions.

Working in Alignment with Personal and Professional Values

Across the studies, value-based reasons for choosing to work in mental health services were identified (Crawford et al., 2008; McKeown et al., 2024; Reid et al., 1999; Simpson, 2005; Thompson et al., 2008; Wall et al., 2024). The studies found that helping others, connecting with others, and doing public service were important sources of satisfaction for staff. Studies found that staff were committed to helping vulnerable people (Uttarkar, 2010), and felt they had a purpose in their role (Reid et al., 1999). In one study exploring nursing identity, staff identity was defined in terms of relationships with others (patients and staff) rather than by the tasks constituting the nursing role, emphasising the vocational nature of the nursing role (Crawford, Brown & Majomi, 2008). Similarly, another study found that job satisfaction was generated through building relationships with patients and seeing them improve (Reid et al., 1999). Studies found that when staff were not able to work in a way that aligned with their values, they felt hopeless and burnt-out (Crawford et al., 2008; McKeown et al., 2024; Simpson, 2005; Thompson et al., 2008; Wall et al., 2024).

Constrained Therapeutic Practice

Studies found that staff perceived system pressures as restricting their ability to practise in value-congruent ways, which created ethical tension and feelings of distress. The majority of studies found that staff felt it was important they were able to work as a ‘therapeutic agent’ (McKeown et al., 2024; Reid et al., 1999; Sambrook et al., 2025; Simpson, 2005; Thompson et al., 2008; Uttarkar, 2010; Wall et al., 2024). A ‘therapeutic agent’ was loosely defined as a professional who was able to work successfully with patients to contribute to the generation of meaningful change or improvement in symptoms or quality of life. However, a number of barriers were identified in the studies as restrictive of

therapeutic work. Simpson (2005) found that nursing staff working in care-coordination roles felt that the therapeutic remit of their roles had been eroded in favour of case management and crisis resolution, leading to what the authors describe as ‘limited nursing’. Similarly, Thompson et al. (2008) found time pressures reduced the ability to work therapeutically. In the context of Covid-19 restrictions, studies found that staff were unable to maintain regular face-to-face contact with their patients. The impact of restrictions was that staff felt distressed about the wellbeing of their patients and unable to support them in the ways they felt were needed, such as through offering face to face appointments (Wall et al., 2024). Overall, studies suggest a gap between the care that staff want to provide and their actual capacity to provide it. The constraints of service realities created the conditions for the experience of moral distress.

Structural Pressures in Community Mental Healthcare

Results across the studies suggested that staff felt they worked in a chronically under-resourced system, which struggled to cope with increasing numbers of increasingly complex patients. These pressures culminated in CMHTs being felt consistently to work under crisis conditions.

Permeable Boundaries

Sambrook et al. (2025) described the interaction between staff wellbeing and systemic factors outside of the NHS context, which themselves impacted NHS services. For example, the study found that staff felt unhappiness was pathologised in society, which blurred the boundaries of what constitutes a mental health problem. Complicating this, the study also found that CMHTs were seen by staff as the service that picked up ‘everyone else’ who didn’t reach threshold for specialist services. This contributed to a culture of defensive and reactive practice (Sambrook et al., 2025) rather than formulation-based approaches to care (McKeown et al., 2024; Sambrook et al., 2025; Thompson et al., 2008). McKeown et al.

(2024) found that problems with social care meant that staff found themselves working with systemic issues they did not necessarily have the knowledge, or ability, to resolve, such as housing problems. They also felt a lack of places to refer patients to outside of the NHS (Reid et al., 1999) and felt the CMHT had poor connections with social care (McKeown et al., 2024; Reid et al., 1999). The staff interviewed by Sambrook et al. (2025) felt that the system was chronically underfunded, which exacerbated the problems caused by unfilled posts and resulted in a dominant focus on crisis management over actively therapeutic work.

Defensive Practice

Defensive practice was explained as a series of organisational actions, often originating as a reaction to a serious incident or significant pressure, that inadvertently reduced the therapeutic capacity of the service. Examples included seeking to reject referrals and trying to refer to external agencies in an attempt to protect an already overstretched system (Sambrook et al., 2025). Another example was the focus on crisis management that was felt to cause lower risk, more compliant, patients to become forgotten or lost in the system (McKeown et al., 2024). The studies found that CMHT staff adapted to the system pressures they worked within. These strategies made it possible for services to function, but they likely eroded the quality of care provided and at times ran contrary to staff's personal and professional values (Simpson, 2005; Wall et al., 2024). The studies found that pressure in the system was both caused and exacerbated by: inadequate staffing, role ambiguity, homogenisation of roles, high administrative burden with little administrative support, IT issues, poor relationships between disciplines, inefficient and unclear pathways, long waiting times, poor working environments, and working long hours without taking adequate annual leave (Crawford et al., 2008; McKeown et al., 2024; Reid et al., 1999; Sambrook et al., 2025; Simpson, 2005; Thompson et al., 2008; Uttarkar, 2010; Wall et al., 2024). CMHT staff adapted their practice to the system they worked within by prioritising risk, shortening patient

contacts, and focussing on immediate demands. These strategies created a pervasive systems-level effect where defensive practice dominated staff's working life.

The Constancy of Crises

Across the 25-year time span the research covers, studies found staff working in crisis conditions (Reid et al., 1999; Thompson et al., 2008; Wall et al., 2024). In 1999, Reid et al. concluded that increasingly high workloads and constraints on the available resources made staff feel stressed in their roles. In 2005, nurses felt their role was 'narrowed' to crisis management at the expense of doing the therapeutic work for which they had trained (Simpson, 2005). Studies conducted during and after the Covid-19 pandemic found that the pandemic was felt to exacerbate the existing challenges in the system more than creating new ones. For example, Wall et al. (2024) found that staffing shortages, which were already impacting service delivery, worsened during the pandemic as vulnerable staff were required to shield and community staff were redeployed to hospital settings. The redeployment of staff from community services mirrored at a national level the focus on crisis management that had been entrenched in community services for the last 25 years. As a result, staff felt that the CMHT seldom offered hope of recovery (Sambrook et al., 2025).

Mitigating Systems Under Pressure

This theme was developed to capture the protective service-level factors and informal workarounds that studies identified as able to mitigate the harm caused by systemic pressures. Feeling recognised and valued by organisations, colleagues, and patients was described as helping staff sustain a sense of meaning in their work and potentially improve their wellbeing.

Feeling Nurtured in a Stressful Environment

Thompson et al. (2008) found that quality supervision could mitigate the impact of working in a system under extreme pressure, by giving staff a space to 'offload their feelings' and develop their clinical skills (Thompson et al., 2008). Studies found that staff valued having access to further training opportunities (Crawford et al., 2008; Simpson, 2005). Uttarkar (2010) found that staff felt that having clarity on their role and the care pathways they worked within and between helped to contain their anxiety at work. Similarly, McKeown et al. (2024) found that staff valued timely recruitment to vacant posts, and teams with lower staff turnover. Reid et al. (1999) found that staff valued having variety in their work and being able to work autonomously. Informal support from colleagues was described in some studies as a source of containment and resilience (McKeown et al., 2025; Uttarkar, 2010). Transparent, clear messaging from management was also found to be an effective container for staff anxiety (McKeown et al., 2024).

Feeling Recognised and Valued

The studies found that feeling recognised by colleagues and patients made staff feel valued, which helped them to find meaning in their roles (Crawford et al., 2008; McKeown et al., 2024; Thompson et al., 2008). For example, McKeown et al. (2024) found that the provision of wellbeing hubs was valued as they were perceived as a gesture of appreciation. Similarly, Crawford et al. (2008) found that staff felt good about themselves and their work when patients thanked them for their help. The studies also revealed, however, that a particular staff group felt they needed greater recognition. Crawford et al. (2008) found that nurses felt they were 'invisible' because they sat comparatively low in the service hierarchy and were often not acknowledged for the hard work that they did. Other studies found that nurses felt they were not respected in their roles despite their years of clinical experience (McKeown et al., 2024; Reid et al., 1999; Sambrook et al., 2025), and that they were not powerful enough to make meaningful changes in the teams they worked in (Wall et al.,

2024). Overall, feelings of disempowerment within the system were particularly prevalent in nurses who made up the majority of the staff sampled in the studies.

Discussion

Summary of Findings

This review aimed to investigate factors that affect staff wellbeing in adult community mental health teams in the UK. The synthesis revealed that the experience of working in contemporary CMHTs is characterised by emotional burnout caused by the physical and emotional strain the roles place on the workforce. The synthesis also revealed that staff often chose to work in CMHTs for moral reasons: they want to help people, they enjoy connecting with others, and they have a strong sense of the importance of doing public service. These reasons do not seem to have changed significantly over the 25 year span that the primary research covers. However, the studies showed that staff often felt constrained in their therapeutic practices, contributing to reports of moral distress across many studies. The findings suggest an impact of systemic problems on CMHTs, for example specialist services having strict criteria, meaning that CMHTs were expected to accept a wide variety of referrals not accepted elsewhere. The findings indicate that these factors contributed to a CMHT system under strain and practising defensively. Staff felt that the CMHT was in crisis and managed crises at the expense of doing actively therapeutic work. Studies identified a number of organisational factors that helped staff to cope with the pressure of their roles and the systemic challenges they faced, for example utilising the provision of quality supervision. Feeling valued in the role was identified as a protective factor, and conversely, feeling undervalued contributed to feelings of disempowerment.

Discussion of Findings

The synthesis revealed that staff working in CMHTs experience moral distress. This review adds to an emerging literature showing the impact of caring in western healthcare

systems. For instance, a recent systematic review looking at the experiences of health and social care workers found that the experience of moral injury was widespread (Beadle et al., 2024). The review distinguishes between moral distress, a single event where psychological unease or pain is triggered by events where a professional cannot take the moral or ethical decision they believe to be right, from moral injury, which is a more enduring experience caused by multiple events of moral distress. The review identified three interacting factors that caused moral injury: organisational factors, such as staffing shortages, social factors, such as strict hierarchies and poor communication between professional groups, and individual factors, such as a strong sense of public service. The findings from this systematic review fit within the framework identified by Beadle et al. (2024) whereby individual, social, and organisational factors interact to create the experience of moral injury. Studies found that, for nurses especially, individual factors (personal and professional values) interacted with social factors (namely the hierarchy which nurses felt silenced them) and organisational factors (such as high turnover and unfilled posts) to create a morally injurious environment to work within.

A BMA (2021) survey found that 51% of respondents said their experience of working as a doctor led to the experience of moral injury. Junior clinicians, disabled clinicians and those from minority ethnic backgrounds were shown to be more at risk of experiencing moral injury, which may be related to how able clinicians in these groups feel to raise issues and concerns in the workplace (BMA, 2021). In this synthesis, issues of power within NHS systems operated to make nurses feel invisible and unable to make meaningful changes in their roles due to their perception of sitting at the bottom of the service hierarchy. Further research is needed to establish how issues of disciplinary power, potentially interacting with factors such as race and class, impact perceived power and wellbeing in the NHS workforce.

Another recent study of NHS workers in both mental and physical healthcare settings (Denham et al., 2023) found that feelings of sadness, anger, and shame were found to affect functioning outside of the workplace. Staff reported crying at home, and trouble eating and sleeping. The study also revealed that the experience of moral injury could lead to a loss of enthusiasm for the job, and the desire to leave the profession entirely. Staff noted they entertained existential questions around their purpose and their value in the world, both personally and professionally. This synthesis suggests that the experience of nursing staff in CMHTs likely fits with Denham et al.'s (2023) findings. However, further research is required to understand the experience of other disciplines within the CMHT, principally psychological therapists, medics, and administrative staff, and how their experience interacts with personal wellbeing and professional effectiveness.

The synthesis found that a sense of recognition in one's role could be protective against feelings of moral distress. This is in line with previous literature showing that recognition and appreciation are protective for frontline healthcare workers against moral injury (Sharma & Cousins, 2023). An organisational culture that feels supportive and where staff feel heard and valued has also been shown to be protective (Denham et al., 2023). Alahaine et al. (2023) hypothesise that burnout and moral injury are driven by the combination of emotional exhaustion and feeling that nothing has been achieved. Recognition can mitigate burnout because staff who feel recognised feel valued. Feeling valued implies that something valuable has been done and, therefore, that something has been or can be achieved, which provides hope for the future (Alahiane et al., 2023). Recognition also validates emotional and ethical struggles, which reduces the internal conflict between what staff feel should be done and what they can or cannot do (Loyal et al., 2025).

Perhaps most importantly, this synthesis depicted a system chronically under pressure for the last 25 years. Staff had developed strategies to manage working in these

environments. Most notably, practising defensively, rather than in what they felt was an actively therapeutic manner, was felt to prop up the current system. Defensive practice both enabled the focus on crisis management in the system, and it encouraged emotional detachment from patients as a method of coping with the emotional toll of the work. Attachment theory suggests that as inherently social animals, humans need relationships to survive. Early relationships with caregivers create a blueprint from which individuals learn to exist in the social world. Attachment behaviours are things that people do to maintain proximity to their caregivers when they feel anxious or frightened (Adshead, 1998). In mental health settings, it is reasonable to expect that patients who feel unwell may display attachment behaviours, such as self-harm, anger, or aggression in response to threats to their safety, such as near discharge or when a valued staff member leaves. Both situations represent significant losses to the patient of secure attachment relationships to services and staff respectively.

Evidence suggests that staff and services can function as a secure attachment figure for patients by creating a secure base (Salmoiraghi & Zarotti, 2025). A secure base provides the individual with a safe place to hear prior experiences, to develop new emotion regulation skills, and explore their attachment patterns. This approach prioritises ‘being with’ patients over ‘doing to’ them (Adshead, 1998). The results of the systematic review suggest that neither staff nor services were able to consistently function as effective containers. Services, chronically focussed on crisis management, appeared to prioritise ‘doing’ over ‘being alongside’. For staff, their own experiences were poorly contained, reducing their capacity in turn to contain, and staff felt limited in their ability to work therapeutically.

Cybernetic principles may also be used to conceptualise the interplay between individuals and healthcare systems. Stafford Beer, an early Cybernetic theorist who wrote extensively on management cybernetics, developed the foundational principle that ‘the

purpose of a system is what it does' (Beer, 1985). From this perspective, organisations, in this case CMHTs, are best understood by what they actually do – through the experiences and outcomes they repeatedly produce for both staff and service users – rather than purely through their stated aims – for instance to provide person-centred, trauma-informed, recovery-orientated care. Beer's principle helps to conceptualise staff accounts as indicative of deeper structural mechanisms operating in community mental healthcare, rather than as isolated examples of a particularly stressful service. Staff accounts of their working lives point to a system chronically calibrated to manage crises. While from the systems perspective, this may be sufficient unto itself, for the humans involved it seems to feel inadequate.

Limitations

The search excluded non-English language papers, which was deemed acceptable given the synthesis was investigating UK-based NHS services; however, it meant that CMHT models that exist in other parts of the world were excluded from this study, limiting the generalisability of the synthesis outside of the UK NHS context. The search was also conducted across five databases, which may not have contained all relevant studies. The participants sampled by the primary research were overwhelmingly from the nursing field. While the synthesis was enriched by data from peer-support workers, non-clinical administrative staff and those in managerial positions, there was a definite absence of junior doctors, consultants, psychologists and other allied health professionals, and social workers. The results of the synthesis, therefore, may better represent factors affecting the wellbeing of nursing staff rather than CMHT staff more widely and further research is required to assess idiosyncratic factors affecting wellbeing in other core professions.

None of the studies adequately considered the relationship between researcher and participant, and how the relationship may have affected the results. There was also very little

consideration given to ethical issues beyond a brief statement that ethical approval had been granted. As the quality of the synthesis is inextricably tied to the quality of the primary literature, the synthesis is weakened by questions of the credibility of participant responses. Similarly, three of the eight studies directly investigated, or made many references to, the Covid-19 pandemic, which may have overrepresented the crisis narratives in the synthesis. However, references to services in crisis were made across the studies, not just in those conducted in the last five years, which suggests some independent longevity to the narrative of a system under pressure.

Conclusion

This systematic review has investigated the factors that affect staff wellbeing in NHS CMHTs in the United Kingdom. The synthesis revealed that staff experience moral distress due to their personal values of helping people and building relationships being subsumed by a system that demands crisis management, often at the expense of therapeutic work. Furthermore, the synthesis revealed that staff felt burnt-out due to the pressures they experienced at work combined with a feeling of often not being valued or recognised for their contributions. Service-related factors, such as the provision of quality supervision, could help to mitigate the impact of the emotional toll of the work, and the impact of systemic challenges. Further research that explores these themes across the disciplines that comprise CMHTs would be valuable.

Justification for the Thesis

Care in the community via CMHTs evolved from the socio-political climate of the late 20th century, and as a direct reaction to the closing of the asylums. Neither intended nor designed, there exists a model of care providing evidence-based treatments that itself lacks a solid evidence base. This thesis aims to add to emerging research on the effectiveness of CMHTs for patients by adding staff perspectives to the research landscape.

To follow on from the systematic review, which considered primarily nursing staff, this thesis aims to:

1) explore broader perspectives of what it is like to work in a CMHT by considering the core clinical roles that make up the CMHT: psychology, psychiatry, and care coordination.
2) explore the extent to which staff feel that the service meets patients' needs, and the ways in which staff perceive CMHT services as succeeding or falling short in their aims.

Method

Chapter Overview

This chapter details the methodology used in this study. It begins by exploring the epistemological foundations for the research and justifying the chosen position. It subsequently discusses the development of the study and reflects on the researcher's position in relation to the research. The design, sample, materials, and procedure are described before discussion of the chosen analysis type is offered. The chapter ends by considering how the quality of the research was monitored and the ethical considerations that were taken.

Epistemological Foundations

Three overarching ontological and epistemological positions dominate the social sciences: positivism, social constructionism, and critical realism (Alvesson & Sköldberg, 2018). This thesis adopts a critical realist position. To contextualise this decision and explain its implications for the framing of the research, this section will begin with a brief exposition of positivism, social constructionism, and critical realism.

Positivism

The term positivism was introduced by the French philosopher Comte in 1844 (Alvesson & Sköldberg, 2018). Comte argued that human history had progressed through theological and metaphysical stages of development to arrive at positivism. In the theological stage, humans attributed events they saw in the world to the gods (and later a single god), and in the metaphysical stage, to abstract powers or forces, such as nature. Comte argued that humans moved beyond a belief in supernatural causation, as in the first two stages of development, to empiricism; the position that the only authentic knowledge is created from observable and measurable fact (Wald, 2002). The task of the researcher, from this perspective, is to detect phenomena that already exist in the world, and to measure and systematise them (Alvesson & Sköldberg, 2018). Thus, positivism asserts that properties exist in the world regardless of whether we perceive them and that our knowledge of the world should aim to correspond to that objective external reality (Cruickshank, 2012).

At the time of Comte's writing, branches of science such as mathematics, astronomy and physics had already moved from supernatural and metaphysical reasoning to what was described as 'scientific rigour' (Ferngren & Larson, 2015). In the early 19th century, Comte felt that the social sciences were ready for the same move, and he proposed the new science of 'Sociology', the study of social questions using the scientific method (Ferngren & Larson, 2015). In the social sciences then, positivism holds that a social reality exists in the world, that it is both observable and measurable, and that nothing is beyond being codified through scientific observation.

In the twenty-first century, positivism attracted increasing scepticism. Carnap, a leading figure in the logical empiricism movement, argued that theories must be verified by re-testing to find positive or supporting examples (Alvesson & Sköldberg, 2018). Around the same time, the earlier principle of falsification gained popularity. Popper's principle states

that theories can only ever be disproved or falsified through the reproduction of findings to refine theories and advance knowledge; the theories can never themselves be proven (Alvesson & Sköldberg, 2018). This principle underlies null-hypothesis testing, which starts with the assumption that there is no relationship between the variables being studied (Wilkinson, 2013). In the 1960s, historical relativists such as Kuhn and Feyerabend argued that there is no absolute truth; rather scientific knowledge is influenced by the social and historical context in which it was observed and created (Alvesson & Sköldberg, 2018).

Thus, a criticism of positivism is that in measuring the social world in terms of discrete variables, a degree of complexity and richness is lost. It is also probably naive to believe that researchers investigate phenomena in a vacuum free from the influence of funding bodies, societal influences and institutional norms. This is borne out in the very low publication rate of 'negative' compared to 'positive' research (Ioannidis, 2005). Finally, it is also the case that statistical significance testing is inherently vulnerable to chance, a truth rarely acknowledged in the context of the previously ubiquitous acceptance of p-values less than 0.05 (Ioannidis, 2005). Two prominent post-positivist positions in the social sciences are social constructionism and critical realism.

Social Constructionism

If positivism represents one pole of the epistemological positions in social science, social constructionism, the second epistemological paradigm to consider, represents the other. Berger and Luckman, authors of 'the social construction of reality' (1966) are considered the fathers of social constructionism. However, they were heavily influenced by phenomenologists such as Schutz, and earlier writers who questioned the notion of rational, objective knowledge, such as Nietzsche, Marx and Mannheim (Alvesson & Sköldberg, 2018). In very simple terms, social constructionism holds that there is no observable, measurable reality that exists in the world. Instead, what we perceive as real is constructed

through language, our experience of cultural and historical milieu, and the dynamics of power we find ourselves living in. In social constructionism, reality and concepts such as money, race and class, change with time and should be considered in context (Alvesson & Sköldberg, 2018). Social constructionism is often seen as a form of relativism, in that it frames reality, and our knowledge of this reality as a contingency that can change across time and cultures.

Berger and Luckman see society as existing in both objective and subjective reality. Objective reality is created by interactions that happen in the social world becoming routinised and habitualised, freeing the mind up to engage in more innovative ways of thinking. This knowledge is passed down through the generations as children are socialised into the social order. The subjective experience of social reality comes primarily through the assignment of a position and an identity in society (e.g. biological sex, gender, class, race etc.). Language is then used to create thought and concepts as a way of structuring the world around the individual (Andrews, 2012). Putting this together, the task of the social constructionist social scientist is to create meaning and understanding about the way something happens to be, in its linguistic, sociocultural and historical context.

The obvious criticism of social constructionist research is its inherent modesty, that the knowledge created holds validity only in a specific context, which limits its utility in the world of academic and commercial research (Agger, 2017). For if, in the purest sense of the tradition, the knowledge cannot be generalised, few, if any, recommendations can be made and there is nothing to judge the research against. Furthermore, because relativism states that there are multiple realities and multiple interpretations of those realities, social constructionism could be accused of being somewhat circular and limiting as there is no way of judging any account to be better or more accurate than another (Bury, 1986).

Critical Realism

In terms of the realist-relativist epistemological poles, critical realism may be considered a compromise between positivism and social constructionism. The critical realist position states that phenomena exist in the world, but that our understanding of these phenomena is inevitably influenced by social factors acting upon the perceiver: their language(s), social, historical and cultural contexts and the structures of power enacted by and upon them (Alvesson & Sköldberg, 2018). Critical realism began in the writings of the contemporary philosopher Bhaskar and carries with it a more radical intention for research than positivist and constructionist positions; critical realist research should seek both to explain and change the social world (Alvesson & Sköldberg, 2018).

Bhaskar warns against what he calls the ‘epistemic fallacy’, the tendency to conflate epistemology and ontology, confusing what exists with the knowledge we have about it. The critical realist reality is made up of the empirical (what we can observe), the actual (what happens whether we observe it or not), and the real (the mechanisms that produce what happens) (Bhaskar, 2014). The task of the critical realist scientist is to study the real and how it relates to the empirical and the actual. In practice, this means that through scientific study we can seek to uncover explanatory laws that operate, whether or not they are observed (Danermark, 2002). Thus, critical realism shares the positivist interest in finding patterns in objective reality, but it considers this task too simple as it ignores the existence of unobservable mechanisms that operate in the world. Similarly, it shares constructionism's interest in context, but argues that some things happen outside of individual consciousness meaning that the focus on the mind and physical action is likely to miss deeper causal mechanisms (Alvesson & Sköldberg, 2018).

The Critical Realism of this Thesis

This thesis adopts a critical realist epistemology. The study began with the assumption that there is a reality of staff experiences of working in NHS CMHTs that already exists and is reflected in the observable actions that staff take, and the meaning they make of the world they live in. However, because people are also agents in the world and thus a part of their own subject matter (Bhaskar, 2014), any attempt to study this reality will result in an approximation of it influenced by the social context of both participant and researcher. Another researcher seeking to study the same reality will, inevitably, reach a different approximation. This is considered a different approximation of the same reality rather than a different underlying truth.

For the reader, this means that the data will be presented as a window into an NHS system that exists and functions according to its own laws and principles. Staff have given their perspectives on the system, and their perspectives form part of its reality. The reader will inevitably reach, perhaps subtly, different conclusions about the data than the researcher did. What the reader is at the mercy of is the decisions made in order to arrive at the data: the staff groups chosen, the topic areas under inquiry, the questions asked. These decisions were made according to what was felt to be important based on the researcher's experience of working in NHS CMHTs. Through supervision, research, and consultation, it is hoped that the attempt to approximate the underlying reality is (at least somewhat) comprehensive.

Reflexive Statement

In keeping with the critical realist epistemology of the research, the reflexive statement is intended to acknowledge the role that the researcher has played in the research process by making explicit relevant values and biases. Given the personal nature of such a statement, it will be given in the first person.

I started my career in psychology on an inpatient ward, latterly moving to IAPT services in London. My socialisation into the profession was, therefore, in fast-paced, high-risk, high-stress environments. It is perhaps unsurprising that my interests should lead me towards CMHTs, also characterised, in my experience, by the above. 'Luck of the placement draw' meant that four out of my six placements on the doctorate were in CMHT services, both adult and older adult. I do not think that my experiences of working in CMHTs can be separated from this research and the testimony that staff gave. My experience will have shaped every aspect of the project from its inception, the design choices I made, the questions I asked and how I asked them, and the sense I made of what staff told me. Therefore, I will attempt to summarise my feelings about working in CMHTs before I explain how the project developed.

I am afraid that I found adult CMHTs, with their enormous caseloads of people with complex, longstanding difficulties, to be thankless places to work. The patients I worked with often began therapy disillusioned with the system. They had faced long waits for therapy, sometimes of more than five years. They had undergone multiple assessments and told their story to more people than they could remember. They had not built up a working relationship with anyone in the team that had lasted for more than a few months. They felt burdensome – they bounced around between different staff or services, with no individual taking responsibility for them. The environment was also unpleasant and certainly not what one might call therapeutic. One CMHT I worked in was on the floor above the hospital's Psychiatric Intensive Care Unit (PICU). You could hear the screams of those detained echoing through the corridors above. The windows did not open, lest someone try to throw themselves off the first floor. The air-conditioning was controlled centrally, so individual rooms could be sweltering or freezing. Listeria had been found in the pipes meaning the water was not safe to drink. I found it distressing to meet with people for the first time, to

hear their story and to want desperately to help them knowing I could offer only 'risk review' calls while they waited for therapy, which itself would be a maximum of 16 sessions. I felt like I was being asked to sell a lie – that therapy would help while knowing that it was likely to be an incomplete dose of what they needed.

I had a slightly different experience of older adult services. They felt a little less over-stretched and able to give more space and time to people, reflecting their advancing age and changing cognitive abilities. The common thread through both was the quality of the staff. There seemed to me to be two types of CMHT staff. The first group came into the CMHT, worked hard and extremely compassionately, and became burnt out by the system, ultimately leaving within a few years. The second group were the veterans. They had been around the metaphorical block. They had worked through service transformation after service transformation. They held no exaggerated views of what the CMHT might be able to do for people. They were the fabric of the CMHT – they worked hard with what they had available to do the best that they could for their patients, and then they went home.

As I said in my mission statement, I started this project trying to fix the system and quickly realised that I did not have a hope of doing so. Within a few months, my aim became more simply to tell a story about what the life of CMHT staff is like, and I hoped to make at least a couple of meaningful suggestions about how it could be improved for staff and, therefore, for patients. I entered the design phase with the aim of accessing both types of staff I had observed. However, I was concerned about recruitment from the start. As I expected, difficulties with recruitment were ultimately impassable, as described in the following section. What ultimately happened was that staff who knew me through my work in the CMHT volunteered to be interviewed. The additional interviewees were mostly recruited by my walking around the office and approaching staff directly at their desks. In the interviews, therefore, staff assumed knowledge of the CMHT because I worked there. I was already in

the ‘in group’ and I felt at the time that staff were generally candid with me about their experiences. I am sure that those who knew me better were more candid, and I am also sure that concerns about whether I would keep their opinions confidential hindered their honesty for others. Being more akin to a participant observer than a dispassionate interviewer, therefore, conferred both advantages and disadvantages in the research process.

Development of the study

The predominant concern during the design phase was how to recruit participants. Due to an expectation of high levels of staff exhaustion and burnout, which was informed by the researcher’s experience and the results of the systematic review, it was decided that the interviews should take place during working hours so as to avoid placing additional pressure on staff. NHS ethics, however, stipulated that staff could not be paid twice for their time, meaning that staff could not be compensated (monetarily, or with vouchers or gifts) for their participation. This rendered staff participation at the mercy of good will and interest in the topic. Perhaps unsurprisingly, recruitment was slow and data collection spanned July 2025 to January 2026.

In an attempt to alleviate these difficulties, the initial design split the study into two phases. The first would be conducted at one CMHT in Essex where the researcher had been working. Doing so allowed the researcher’s knowledge of the team to aid recruitment. Interviewing in one CMHT also added a richness to the data as the impact of contextual factors (such as staff turnover rates) could be viewed from the perspective of the different professional groups. However, while it was hoped that interviewing in one CMHT would yield rich data, the transferability of that data to other CMHTs would, understandably, be debatable.

Therefore, a second phase of the study was designed to explore the transferability of the findings across the region. All CMHTs in Essex consented to participate. However,

despite many attempts to reach staff working in these CMHTs over a period of six months, only four staff members came forward for interview, three of whom were known to the researcher through previous roles. The inability to reach CMHT staff led to a reimagining of the aim to explore transferability through group interviews in a second phase of the study. Instead, it was decided that the group interviews should be conducted with staff who volunteered their time, and that the conversations had in those interviews would be explored in a transferability section in the discussion, rather than forming part of the data corpus. Ethical approval was granted for both the individual and group interviews.

Design

The majority of the studies included in the systematic review used individual semi-structured interviews to explore staff wellbeing in CMHTs. The use of qualitative methodologies was appropriate to explore a diverse range of experiences difficult to capture by quantitative methodologies. The similarity of this study's aims warranted the use of a similar design.

Prior to ethical approval being sought, Public Patient Involvement (PPI) interviews were conducted at the participating CMHT, which is referred to as CMHT A. Staff who participated in the PPI interviews were also eligible to participate in the semi-structured interviews. Though usually PPI participants would be excluded from the main body of a study principally due to concerns about bias, in this case, inclusion was deemed appropriate as the PPI interviews took place over a year before the individual interviews. Furthermore, as recruitment was anticipated to be challenging, it was felt to be important to broaden the participant pool where possible. For these reasons, PPI participants were able to participate in the semi-structured interviews. In the PPI interviews, staff from CMHT A were provided with an explanation of the study, for which they gave oral consent to participate. Participants were shown recruitment materials including the study poster and information sheet, and the

consent forms. Participants were also asked about what they thought should be included in the topic guide. The participants deemed the materials to be acceptable. Participants expressed concern about the interviews becoming overly negative if the questions were not worded in a balanced manner to elicit both positive and negative aspects of working in the CMHT system. Participants were also keen for their ideas about how the CMHT model could be improved to be heard. A strong theme of misunderstanding between disciplines in the MDT was expressed in the PPI interviews, which was not anticipated. From the information gathered in the PPI interviews, the reviewed literature, and the experience of the researcher, a semi-structured interview guide was created (Appendix C).

Semi-structured interviews were used to strike a balance between covering the topics integral to the research questions while giving participants space to develop their ideas through open-ended questions (Karatsareas, 2022). The results of the systematic review painted a negative picture of the current NHS system. Therefore, it felt important to structure the questions sufficiently so that there was active elicitation of what might also be working well. The interview schedule was refined as the interviews progressed.

The PPI interviews suggested that relationships between disciplines in the MDT were important sources of concern to staff. Therefore, the research aimed to recruit six participants in each professional subgroup to enable between-group comparisons. Data saturation refers to the point at which sufficient information has been gathered to replicate a study and any further information does not meaningfully add to the coding bank (Fusch & Ness, 2015). The aim of recruiting six professionals in each subgroup was based on a study of data saturation in qualitative research by Guest et al. (2006) which tracked the progression of a codebook over the course of transcribing 60 interviews. The study found that 73% of the total codes were present after six interviews. Furthermore, 94% of the high-frequency codes were identified in the first six interviews and 97% within the first 12 interviews. This suggests that

despite the small sample size per subgroup in this study, it is likely that the commonly expressed themes would emerge within six interviews. Moreover, while differences between staff disciplines and relationships between disciplines seemed likely to be pertinent to the findings of this research, the principle aim was to explore staff experiences in general and work towards a unifying understanding. From this perspective, the total sample size of 17 was felt adequate.

Table 4 shows a saturation grid (Fusch & Ness, 2015), which shows that data saturation was reached after five interviews, suggesting that the sample size was sufficient to capture something meaningful about the experience of working in CMHTs. The table also shows the spread of themes across the interviews.

Table 4

Saturation grid

	Participant number																
Subthemes	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Caseload	New	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	
Workload	New		✓	✓			✓	✓			✓		✓	✓	✓	✓	
Stress, anxiety, and trauma	New		✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	
Caring	New		✓		✓		✓	✓			✓	✓			✓		
Moral distress and feeling unable to care		New	✓		✓				✓			✓	✓					✓
Referrals and pathways through the service	New	✓	✓	✓		✓			✓			✓					

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Defining recovery	New					✓	✓	✓	✓		✓	✓	✓				
The dilemma of discharge		New		✓		✓			✓	✓			✓	✓	✓	✓	✓
Referring on		New	✓	✓		✓			✓							✓	
CMHT design	New		✓	✓		✓	✓			✓		✓		✓	✓	✓	
Waiting lists	New	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓			
The ‘mopping up everything’ team	New	✓					✓	✓			✓	✓	✓	✓			✓
The case of ASD and ADHD assessments					New									✓	✓	✓	✓
The tension between ‘serious mental illnesses’ and personality disorder	New	✓		✓	✓						✓		✓	✓	✓	✓	✓

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
The ‘merry go round’ of service improvement	New	✓			✓	✓					✓	✓					
Working with social stressors	New	✓	✓				✓	✓	✓	✓	✓	✓		✓	✓	✓	
Medicalising distress	New	✓	✓		✓			✓	✓						✓		
Intersecting with welfare system				New					✓				✓	✓	✓	✓	✓
Meeting relational needs		New	✓	✓	✓		✓	✓	✓	✓			✓		✓		
Defensive practice		New	✓	✓							✓			✓			✓
Negative attitudes towards personality disorders		New			✓	✓					✓		✓	✓	✓		✓
Relationship-based care	New		✓	✓		✓		✓		✓	✓		✓		✓		

Sample

The study used a combination of purposive sampling, to recruit sufficient staff per sub-group, and opportunity sampling within each discipline. In total, 17 participants from CMHT A volunteered for interview. This comprised six medics, six psychologists or psychological therapists, and five care coordinators (CCs). Throughout the study, participants are referred to by their discipline rather than by their job title (e.g. medic rather than consultant psychiatrist) to protect their confidentiality. Participants were required to have been members of the team for a minimum of six months as this was deemed adequate for staff to have passed their probationary period and to have become acquainted with the CMHT's systems, processes, and patients.

The recruitment methods are described in the procedure section below. Ineligible participants were thanked for their time and informed that they could not participate. For those who were eligible, written consent was gained, and they were assigned a pseudonym where the first letter corresponded to the order in which they volunteered (e.g. the first volunteer was called Alice, the second Bethany etc.). Anonymised participant information is shown in Table 5. Data about biological sex was collected and reported, principally because it was not felt to significantly compromise confidentiality and this data was reported in the studies included in the systematic review. Table 5 shows that the interview samples skews towards women. Indeed, the only men interviewed were medics. There was a good distribution of length of service and across the professions. The limitations associated with the sample are discussed in the Discussion.

Table 5

Participant information from CMHT A

Participant number	Pseudonym	Biological sex	Occupation	Length of time in role	Interview duration (minutes)
One	Alice	F	Psychologist	9 months	64
Two	Bethany	F	Psychologist	3 years	82
Three	Claire	F	Psychologist	9 months	53
Four	Dina	F	Medic	6 years	26
Five	Evelyn	F	Psychologist	7 years	53
Six	Frank	M	Medic	10+ years	24
Seven	Grace	F	Psychologist	19 months	62
Eight	Helen	F	Medic	1 year	60
Nine	Ivy	F	Psychologist	8 years	72
Ten	Jade	F	Care coordinator	25 years	24
Eleven	Kara	F	Care coordinator	3 years	70
Twelve	Lucy	F	Care coordinator	2 years	25
Thirteen	Maureen	F	Care coordinator	23 months	52
Fourteen	Nora	F	Care coordinator	2 years	38
Fifteen	Owen	M	Medic	6 months	69
Sixteen	Pauline	F	Medic	4 years	46
Seventeen	Quinn	M	Medic	3 years	52

Materials

Participants were offered face-to-face interviews at the CMHT A base, or remote interviews via Microsoft Teams. In total, six interviews were conducted face-to-face and the remaining 11 were conducted remotely. All interviews were recorded using Microsoft Teams, and the recordings were securely saved on to the researcher's university cloud storage account called Box.

The interview schedule (Appendix C) was developed from a discussion guide approved by NHS ethics and the University of Essex Ethics Committee. The interview schedule was used to structure the interviews and to ensure that the main research aims or topics under investigation were discussed. The aim was to explore each of the three main

topics in every interview, but the order of exploration was determined by the direction of the conversation in each interview. The interview schedule was intended to explore three main aims: ‘what are staff experiences of working in a CMHT’, ‘how effective do staff think the CMHT is’ and ‘how could the system be improved?’. The questions were revised as the interviews progressed in response to feedback from participants and to probe ideas that had not originally been considered. For example, within the first three interviews it became apparent that staff felt patients with particular diagnoses benefitted more from the CMHT than others, which led to a question being added to the schedule to explore the idea further. There were no major revisions to the interview schedule.

Procedure

Participants from CMHT A were recruited predominantly via internal advertising of the study. The clinical lead circulated the study poster (Appendix D) via email to the relevant professional groups. Printed posters were also placed in the CMHT base. Staff were asked to contact the researcher on their essex.ac.uk email address to express their interest, after which an information sheet (Appendix E) and consent form (Appendix F) were sent to prospective interviewees. Upon receipt of the completed consent form, participants were scheduled for interview. Recruitment also occurred through word of mouth and operated on a rolling basis until the target number of interviews was reached. These methods only generated six participants, which led to a second recruitment drive whereby the study poster was emailed to all staff working in the CMHT with the permission of the head of service, and staff were approached directly at the base. These methods yielded a further 11 participants. Staff were not offered remuneration for their time and the interviews were conducted during working hours. The aim was for each interview to last 60-90 minutes. In reality, not every participant could offer so much time, and some could only offer significantly less. Therefore, a

pragmatic decision was made that if the three topic areas were covered in sufficient detail, the interview would be included.

In total, 20 members of staff from CMHT A came forward for interview and 17 completed the interview yielding 14.5 hours of data. Three were excluded due to no longer working in a care coordination role. Following the first three interviews, the researcher transcribed the interviews and conducted the initial coding using NVivo 14, which enabled familiarisation with the data and allowed the researcher to refine their questioning technique. All subsequent interviews were transcribed and coded by the researcher.

Analysis

From Thematic Analysis to Reflexive Thematic Analysis

The interview data was analysed using inductive Reflexive Thematic Analysis (RTA) as described by Braun and Clarke (2006; 2020). RTA was chosen for a number of reasons. It was the dominant method of analysis used in the studies included in the systematic review, which this study aimed to build upon. It was also suitable for the sample size (Braun & Clarke, 2021). RTA also enjoys relative theoretical freedom as it is compatible with experiential (e.g. critical realist, contextualist) and critical (constructionist, relativist) understandings of data and analysis. While this leaves the research open to the 'anything goes' critique, when applied rigorously as in the method outlined by Braun and Clarke (2006; 2020), RTA is a flexible research tool that can yield a rich and insightful account of the data. Indeed, Braun and Clarke (2020) advocate for researchers explicitly to state their theoretical background and assumptions rather than claiming RTA to be atheoretical.

Very simply, Thematic Analysis (TA) aims to identify and explain patterns that emerge across the data. TA is a bottom-up method of analysis in that themes are generated from codes that directly explain the data, while also being top-down as it permits the use of already existing theories to inform the development of themes (Braun and Clarke, 2006). The

researcher did not begin the analysis with a strong theoretical framework within which codes and themes were sought. As such, this analysis is not a 'theoretical' RTA and is more closely aligned with the inductive RTA approach (Braun and Clarke, 2006). As the topic is relatively under studied, it was felt important to provide a rich thematic description of the entire data set. It is acknowledged that doing so is arguably at the expense of being able to provide a deeper or more nuanced presentation of each theme (Braun and Clarke, 2006).

An oft cited criticism of thematic analysis is that researchers imply, through their use of language such as 'emerge' or 'discovered', that they had a passive role in the research process by revealing themes in the data that already existed, which admittedly fits with the critical realist perspective to some extent. However, Braun and Clarke (2006; 2020) distance themselves from the realist approach to qualitative research, which attempts to 'give voice' to a data set, acknowledging Fine's (2002) argument that the process of 'giving voice' necessitates a personal decision about what data is privileged and how it is used to support a broader argument. Thus RTA rejects the passive (and more positivist) position, in favour of a method that explicitly acknowledges the researcher's role and transparently presents the process of analysis (Ely et al., 1997).

Themes were identified at the sematic (explicit), rather than the latent (interpretive) level. In the semantic approach, the researcher aims to summarise the data using codes and does not attempt to go beyond the data, for example, by looking for the meaning underlying why a participant has made a particular statement. The researcher then attempts to show patterns in the data and to interpret or theorise what those patterns mean in a broader sense, which can happen in relation to other literature (Braun & Clarke, 2006). Identifying themes at the semantic level fits with critical realist epistemology because it assumes a largely unidirectional relationship between language, meaning, and experience. This contrasts with more constructivist approaches where meaning and experience are socially produced rather

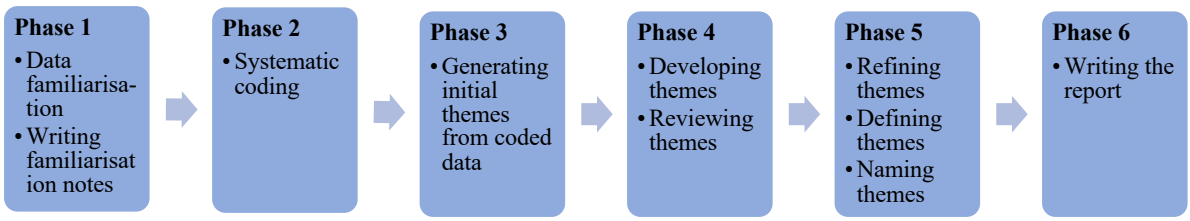
than originating from within individuals, which might map on to themes being generated at more of the latent level (Braun & Clarke, 2006).

Phases of Analysis

RTA, as developed by Braun and Clarke (2006; 2020), involves the phases shown in Figure 3. Phase one was completed via transcription of the data from audio recordings to written text, and by a second reading, during which notes were taken by the researcher. Transcription requires what Braun and Clarke (2006) call 'close-reading' of the text and it was for this reason that the researcher decided not to use a paid transcriptionist to generate the transcriptions.

Figure 3

Phases of the RTA



In the semantic, data-driven form of RTA, a code is a word or short phrase that is used to represent something meaningful in the data (Braun and Clarke, 2006). Nvivo 14 was used to code the 17 transcripts. All of the transcripts were coded, which meant that any data contrary to the dominant emerging narrative was captured. In total 685 initial codes were generated in phase two of the RTA.

Nvivo 14 was also used to conduct phase three, which involved the researcher collating a long list of initial codes (and the related data extracts) into an overarching group, called a theme, that represented them. Themes should have conceptual clarity and there should be clear differences between the themes (Braun and Clarke, 2006). Braun and Clarke

(2006) explain that themes may start to appear hierarchical, such that some codes may form superordinate themes while others appear to fit under these as subthemes. At this stage, where codes did not appear to fit within the emerging themes, the codes were grouped under 'miscellaneous'. A coded extract from one of the transcripts is shown in Appendix G.

Phase four began with a total re-reading of each transcript to ensure accuracy in how it had been coded and grouped into themes. The themes were then conceptualised on two different levels. Subthemes described a specific phenomenon in the data while superordinate themes were created from groups of subthemes which, taken together, explained a broader pattern in the data (Braun & Clarke, 2006). Another full reading of the data set was conducted to ensure the themes accurately reflected the raw data. At this stage, the themes were reviewed by the research supervisor and amendments were made according to the feedback provided. Phase four ended with a list of sub and superordinate themes that were felt to tell a story about the data (Braun & Clarke, 2006). In total, two superordinate themes and five subordinate themes were developed to represent the data from research question one. Four superordinate themes and 17 subordinate were developed to represent the data for research question two. Thematic maps were created to represent the themes and their associations with other themes (Figure 4 & Figure 5).

During phase four, the themes continued to be refined as the 'story' of each theme was created and told as part of the overarching story of the data (Braun & Clarke, 2006). At this stage, the researcher wrote summaries of each sub and superordinate theme to ensure the meaning was clear and that the themes told the story of the data without significant omission. The theme summaries were agreed with the research supervisor before the researcher progressed to writing. The themes were also named according to the guidance provided by Braun & Clarke (2006) that names should be concise and give the reader an indication of what each theme is about without requiring further reading.

Phase six saw the first written draft of the themes created (Braun & Clarke, 2006). As outlined in Braun and Clarke's (2006; 2020) method, the researcher has attempted to write a clear, concise, account of each theme, which together paint a picture of the data collected. The results were written to answer each of the research questions in turn. Data extracts were used to illustrate the line of argument and to indicate the prevalence of the themes.

The critical realist perspective of this research recognises that what the researcher felt to be important, how the data was grouped into themes, named, and presented in the overall narrative was shaped by the researcher's, and research supervisor's, positioning. This is reflected upon in the reflexive statement. Research supervision was used to reflect upon these influences and the implication for the data, while also sense-checking the final results of the RTA. Other issues pertaining to the credibility of the research are considered in the Discussion.

Generalisability

Smith (2018) identify different types of generalisability in qualitative research, two of which are directly applicable to this study. The first of these – transferability – is defined as the extent to which results are transferable to other contexts; that is, the extent to which a reader feels they could take something from the results and apply it to different circumstances (Smith, 2018). Transferability can be assessed through gathering the testimony of readers and reflecting upon it. The aim to explore transferability of the findings led to the idea of conducting group interviews to hear staff testimony from other CMHTs in the region about the extent to which they felt the findings were relevant to their working lives. Reflections on those interviews are presented in the discussion (p. 129-131).

The research also aimed to consider analytical generalisability. Analytical generalisability refers to the extent to which the concepts or theories developed in a piece of research apply to different contexts. Thus, it is the concepts that are transferable rather than

the raw data or specific context (Smith, 2018). The extent to which the results can claim analytical generalisation is discussed in the Discussion (p. 131-141).

Evaluating the Quality of the Research

The quality of the research was monitored by the researcher's academic supervisor throughout the duration of the study. Regular meetings were held to discuss progress with the study, and written work was regularly evaluated. Ethical approval was granted by the NHS ethics committee via the Integrated Research Application System (IRAS). Ethical approval was subsequently granted by the University of Essex as the sponsor of the research.

Ethical Considerations

All participants gave, and were able to give, informed consent to participate. Participants were sent the information sheet and consent form before the interviews began, and the information was discussed at the start of each interview. Participants were offered the opportunity to ask questions before the interview began, and they were made aware that they could withdraw at any time without consequence. Participants were able to consent to audio or video recording. All participant data was stored on password protected devices and saved on cloud storage systems rather than hard drives to add an additional level of protection. Transcription took place within 12 weeks of the interview date, after which time the recordings were deleted from Box (the cloud storage system). The data was anonymised upon transcription through the redaction of any identifiable information such as names, job titles or places of work. Participants were also asked to consent for their anonymised transcripts to be deposited in the University of Essex' Research Repository (for use by researchers in the future) upon completion of the study, which all participants consented to.

The predominant risk to participants was being identifiable in the data. Indeed, this was something that many staff raised concerns about during the PPI phase and during recruitment. CMHT A is a small team that works in a specific geographical region.

Therefore, participant characteristics such as ethnicity were likely to render specific participants identifiable, which presented a social risk to staff. It was for this reason that demographic data (with the exception of biological sex) was not collected in this study. While all attempts were made to anonymise particular details about participants (such as job titles), in reality the opinions expressed in interviews could not be fully anonymised, and this was acknowledged by some staff. For example, one participant commented 'This will definitely identify me for anyone who knows me'. However, all staff were informed about the potential work product resulting from the interviews and gave informed consent to participate. No volunteers declined or withdrew from interview.

A further risk came from the possibility that participants may disclose unsafe or unethical practice during the interviews, leaving the researcher with an obligation to report the information to the service or a statutory body. This was discussed with the ethics officer at the University of Essex, and it was agreed that staff would be briefed at the start of each interview that any unsafe or unethical practice, or practice outside of service guidelines or rules, may need to be reported. This made participants aware of the limits of confidentiality in the interview so that they could decide what information to share. A concern of this nature did arise during the interviews in a discussion about the reporting of risk assessments. It transpired that medics were reporting risk assessments in their clinic letters rather than in the record-keeping system's risk assessment tool, meaning that other clinicians in the MDT struggled to find pertinent information, particularly during crisis situations. The disclosure was discussed in supervision, and it was agreed that no reporting needed to take place as the issue had already been escalated to the Medical Director of the trust, who had taken the matter under consideration. At the time of writing, a decision had not been reached about whether medics were required to complete the standard CMHT risk assessment.

Finally, there was a clear risk that being asked about their work could lead to participants feeling distressed, which was exacerbated by the possibility that participants would be in the office during the interviews. The main concern was that the interviews may contribute to feelings of burnout or moral injury among staff by talking about the causes and reality of such experiences. This concern was raised by participants in the PPI interviews, which led to the addition of questions specifically eliciting positive experiences of the CMHT. Staff were not presented with any information about CMHTs, distressing or otherwise. Thus, it seemed likely that any feelings of distress, moral injury or burnout that emerged would reflect a pre-existing emotional reality rather than be caused by the interviews. Indeed, there were occasions where staff said they felt 'helpless' and 'hopeless'; however, none became visibly distressed or required support after the interviews ended. A few participants said they felt relieved to have had a space to talk about their feelings and concerns. No further support was required after any of the interviews, though a local counselling service had been identified as a place that staff could be signposted to, and the team leads were aware that staff may ask for additional supervision time if they needed it.

Chapter Summary

The chapter began by exploring some of the commonly adopted epistemological positions in qualitative research, leading to a justification of this study's critical realist position. The chapter continued with the design of the study, the sample, materials, procedure, and analysis method used. The method is framed using a reflexive statement. The chapter ended by giving consideration to ethical issues arising from the study.

Results

Chapter Overview

This chapter presents the findings from seventeen semi-structured interviews conducted in an adult community mental health team in Essex (CMHT A).

Table 6

Themes and subthemes

Research question 1: what is it like to work in a CMHT?

Theme	Subtheme
Physically demanding	Caseloads
	Workloads
Emotionally turbulent	Stress, anxiety, and trauma
	The reward of caring
	Moral distress and feeling unable to care

Research question 2. How do staff perceive the CMHT as succeeding or falling short in its aims?

Theme	Subtheme
Managing the journey	Referrals and pathways through the service
	Defining recovery
	The dilemma of discharge
	Referring on
Managing the demand	CMHT design
	Waiting lists
	The 'mopping up everything' team
	The dilemma of ASD and ADHD assessments
	The tension between 'serious mental illnesses' and personality disorder
	The 'merry-go-round' of service improvement'
Working with socio-cultural issues	Working with social stressors
	Medicalising distress
	Intersecting with the welfare system
	Meeting relational needs
Operationalising care	Defensive practice
	Negative attitudes towards personality disorders
	Relationship-based care

The results are presented in relation to the study's research aims: to explore what it is like to work in a CMHT in Essex in the mid-2020s, the extent to which staff feel that the service

meets patients' needs, and the ways in which staff perceive services as succeeding or falling short in their aims. The intention was to produce an exploratory analysis of contemporary CMHTs in the UK. Therefore, the analysis was conducted in a bottom-up manner, intending to provide a thematic overview of participant responses. Comparisons between the disciplines are made throughout the results. Rather than attempting to frame the results by disciplines, the intention was to build a unifying picture of staff experiences and perspectives. The results will be described at the level of themes and the sub-themes that contribute to them. Each theme will be presented individually beginning with a definition, and data extracts will be used for illustration. Table 6 shows the themes and subthemes as organised by research questions. Thematic maps for each research question are shown in Figure 4 and 5.

Research Question One: What is it Like to Work in a CMHT?

Two themes and five subthemes were developed from the interview transcripts to conceptualise the experience of working in CMHT A.

Physically Demanding

The theme of physically demanding was developed to capture the hard work staff explained was involved in CMHT roles. Staff in each discipline talked about the struggle of managing large caseloads. For example, Bethany (psychologist) explained that the team have '*humongous caseloads'.* Staff explained that they struggled, not just with their caseloads, but also with the associated workload and additional duties they were expected to manage. For example, care coordinators (CCs) talked about trying to fit a day on duty into their already demanding schedules. Medics talked about trying to find time to respond to emails and complete administrative tasks. Working with large caseloads, and the high workloads associated with them, was felt to create a physically demanding working reality.

Caseloads

Staff in each discipline explained that their caseloads were too large for them to hold personalised knowledge of their patients. Medics talked about holding caseloads of 200-300 patients, while CCs held caseloads of 35-40 patients. When asked about the caseloads for medical staff, Owen (medic) reflected *'we have so much caseload you cannot give the appointment to everyone'.* Owen's experience was echoed by Dina (medic) who said that she did not know how many people she was responsible for. She explained *'I will have under me more than 200 patients. I don't know maybe 300 by now, I'm not sure'.* That medical staff did not know how many patients they were responsible for is significant given that medics are positioned in the team as the 'lead practitioner' in many cases.

However, it was CCs who appeared to be the most overwhelmed by their caseloads. CCs said that they carried caseloads of around 35, which Lucy (CC) described as '*huge*'. CCs explained that responding to crises took priority often at the expense of routine visits to lower-risk patients. As a result, they struggled to see everyone on their caseload monthly, as they were expected to. CCs also explained that they felt overwhelmed by the variety and intensity of need on their caseload. For example, Nora (CC) explained that *'we're wearing too many hats now where we're housing support, we're legal advice, we're financial advice, we're therapy advisors, we're relationship counsellors. We're literally wearing so many hats'.*

Staff also felt that the size of their caseload limited ability to work therapeutically. Kara (CC) explained:

'It's really difficult to discharge people because you don't have time to give them the intervention they need to make any change. And if you're only seeing somebody once a month and you're just monitoring them, nothing's ever going to change'.

In this excerpt, Kara points to one of the reasons that caseloads have remained so high in CMHT A; that patients are monitored and crisis-managed because there is not the provision to do actively therapeutic work. Interestingly, psychology staff's perception of the

problems caused by large caseloads was exactly this; large caseloads reduced the capacity for individualised knowledge of patients and the provision of individualised treatments. Bethany (psychologist) reflected *'how can you have a really good, personalised knowledge of each of those people?'.* Through these excerpts, we can see how holding large caseloads begets the necessity for large caseloads. The inability to work therapeutically in a meaningful way reduces the likelihood of discharge, which in turn contributes to the number of patients under the CMHT, requiring staff to work with greater and greater numbers of people.

Workloads

While the particulars differed by discipline, the majority of staff interviewed felt that their workload was high. Claire (psychologist) explained that as well as the patients she had on her caseload whom she saw regularly *'psychology can get pulled into other things like consultation, signposting and referring on which obviously takes a lot of time away from other things'.* Grace (psychologist) echoed Claire's sentiment:

'There's a lot to do. It's not just that you're focusing on your clinical sessions. You have things that come out of every session, and you have to follow up with different people and sometimes different teams. Yeah, it feels like a lot basically.'

Psychology, therefore, felt that a good proportion of their time was taken up by non-clinical work. Medics resonated with this experience, for example, Dina (medic) explained:

'Well, the issue is, it's not just clinic, isn't it? So you'll have to deal with hundreds of emails that you get… there are so many other things you will have to do, and then you'll have to supervise your trainees and your own CPD and all those things.'

Similarly, Kara (CC) talked about her difficulty managing the additional duties in the CC role:

'There are other duties to do as well. What they [management] don't take into account is all of the other things like your two days on duty within a month. And you know just other responsibilities. Initial assessments, and you would have four of those people to do in a month as well.'

An additional difficulty identified by CCs was that their role felt undefined, which was further complicated by the fact that the CC role was made up of staff drawn from different core professions. Staff felt that being asked to do work outside of their core training cost the service time, as they could not work as efficiently as a colleague specifically trained to do the task. It also caused staff to feel stressed and frustrated. For example, nurses felt that they were taken away from core nursing duties, and expected to do aspects of social work, such as Care Act Assessments, that they did not necessarily have the training to do. Similarly, Occupational Therapists and Social Workers felt that little of the work they did was related to their core profession and the majority was crisis-management and liaison. For example, one CC (not named to preserve their anonymity) said: *'I'm not really doing OT. With care coordination, you're a lawyer. you're a housing officer, you're a finance officer, you're a therapist, you're a social worker. So yeah, it's difficult at the moment.'*

Staff also described a situation where there were poor boundaries between roles, which created a level of confusion in the team about who should be doing what. This was captured by Maureen (CC):

'If you ask me what my job role is, I can tell you a lot of the things I don't do, but literally I do everything other than the things I tell you I don't do, which is ridiculous. You know, someone wanted to move house and they wanted boxes, and you're going I'm a mental health nurse. I don't get how this is all me.'

The combination of high caseloads and a high workload, some of which was made up of work not related to their core profession and, therefore, skillset, led to a situation where CCs

felt under pressure to work overtime. This overtime was unpaid, and, while they were technically able to take time off in lieu (TOIL), few felt able to. Kara (CC) explained *'there's a lot of working outside of paid hours just to get on top of case notes' while* Lucy (CC) said:

'I do find myself working overtime. Two nights ago, I had work to do. I had to take it home and I was awake till about 4:00 AM doing the work. A lot of staff go home and continue the work and most times we don't even bother to record it. We just do it.'

That CCs appear to be regularly taking work home to complete in their own time points to a demanding workload that exceeds what can be completed in a normal working day. Staff in all disciplines described feeling the pressure of high caseloads and high workloads, though CCs appeared to be under this pressure most acutely.

Emotionally Turbulent

This theme captured staff experiences across the disciplines of feeling stressed, anxious, and sometimes traumatised by their work. Kara (CC) explained *'It's very, very stressful. And when you're in it, you know it's stressful, but you don't know how to get out of it'.* Kara's quote here demonstrates that she struggles not only with the emotional impact of the role, but also something more existential about feeling trapped in it. Staff talked about how their emotional states could impact patient care, and risk repeating harmful relational patterns. Grace (psychologist) explained:

'If you're feeling emotionally detached from patients, what they're probably seeking they don't get. They're seeking connection and comfort and love in places where they haven't found it, so they're recreating relational patterns with the service as well.'

Ultimately, staff felt that the emotional strain they worked under created a situation where they tried to reject referrals and refer on where they could in order to protect the resources that they had available, which felt contrary to their personal and professional values.

However, staff across the disciplines talked about how they cared about their patients and wanted them to recover, which demonstrated both emotional highs and lows in the caring role.

Stress, Anxiety, and Trauma

When describing her role, Nora (CC) said *'I think recently I feel very overwhelmed, and I think a lot of the team feel overwhelmed'.* Staff talked about 'risky' patients whom they would worry about when they went home from work. For example, Alice (psychologist) reflected *'there are times you're working with people and you're like, no, I'm gonna worry about this all weekend.'* Similarly, Ivy (psychologist) talked about *'risky people that make you anxious when you go home at night.'* When thinking about why the work was stressful, Ivy said very simply *'it's really traumatic if it goes wrong'.* Owen (medic) explained '*it's stressful in the CMHT. It's a bit of a struggle here, but of course, you still try to do your best as much as you can'*. Alice (psychologist) reflected on the impact her work had had on her personal life saying *'I probably do less of the things I like socially with friends and family'.* Through telling a story about a colleague, Claire (psychologist) reflected that while staff tried to support each other, they often got swept up in their work and did not have time for pleasantries:

'They hadn't been around for very long and no one said good morning to them because everyone's in, like, this busy, busy state, all those little things, I think they get missed because everyone's just been in, like, kind of doing mode.'

These excerpts reveal that staff across the disciplines feel stressed at work, and that this stress is considerable enough in some cases to also impact their personal life.

Staff talked about the impact on patient care of working with such high levels of stress and anxiety. For example, Claire (psychologist) explained:

'I think some people get cut off as a way of coping and I imagine the patients know that maybe that person's not fully present with them or they're not connecting with them, and then they feel more guarded because they're not getting that relationship.'

Claire is concerned that working conditions in the CMHT are reducing the therapeutic capacity of the service. Staff also reflected on the indirect effects of stress and anxiety in the CMHT system. Kara (CC) talked about the level of turnover in the CC role saying, '*people will leave a team and head off somewhere else hoping that green pastures may be less stressful, but I think any CC role in a CMHT is stressful, no matter where you are*'.

Across the CMHT, it was suggested that psychology existed under a slightly less acute pressure than other disciplines, which was also reflected on by psychologists themselves. For example, Alice (psychologist) said:

'I'm so aware of the pressures in the system. It closes me down because I'm trying to protect the little part of psychology I'm part of. That's a hard thing to admit, right? But if we're honest, there's probably times with referrals where I'm less open minded because I'm so acutely aware of our waiting time pressures.'

Here, Alice reflects that she wants to protect her 'corner of psychology' by rejecting referrals where she can.

The Reward of Caring

It was clear from the interviews that staff cared deeply about their patients and really wanted to help them. This was seen in the reasons staff gave for wanting to work in a CMHT. For example, Alice (psychologist) said:

'Patient work. That's what got me into it. For me, one of the things that's really, really powerful is feeling like you're giving them a different experience they'll be able to internalise and take with them.'

In this excerpt, Alice expresses a sentiment that was widely shared: that staff came into CMHT work to help people. Kara (CC) explained how she does so in her role by saying *'I'm their advocate, if you like. If they don't have a voice, I want to be their voice and help them find solutions to their difficulties'.* Similarly, Owen (medic) explained *'as a clinician you want to do the best you can for the patient and the services. It's good, the fulfilment and seeing the patient doing well'.* It is clear from these excerpts that staff want to build relationships with patients, they want to help them, and they feel fulfilment when they are able to. Staff also acknowledged that their colleagues shared how they felt. For example, Claire (psychologist) said *'I know that's a bit of a generic thing, but I do get a sense that people really care and their values are that, like, they want to do the best by people.'* These value-based reasons for choosing to work in CMHTs appeared to give staff a sense of fulfilment despite the stress and strains of their roles.

Moral Distress and Feeling Unable to Care

Maureen (CC) named what appeared to be the dominant feeling in the CMHT '*we're spread too thin. We've got too many people. We can't help them all*.' Owen (medic) said very simply *'you feel helpless. You feel like I cannot help much'.* The reality that staff often could not help people in the relational way that they wanted to led to feelings of helplessness and hopelessness, conceptualised in this study as moral distress. The majority of staff talked about feeling burnt out, and staff recognised similar feelings in their colleagues. Despite feeling like it was bad for the profession, in order to cope with feelings of burn out, Quinn (medic) reflected that he needed to *'take away the emotion from the job'.*

When reflecting on the wellbeing of the team, Claire (psychologist) said *'I get the impression people are really burnt out. They're really tired and are just trying their best in an imperfect system and getting worn down by it'.* CCs in particular felt their caseloads meant they could not know and work intensively with everyone, and they felt under pressure to

discharge. Maureen (CC) explained *'we are under pressure to discharge to obviously help as many people as possible'.* However, staff felt that the rush to discharge could sometimes harm the therapeutic work, which in turn was difficult for staff because they wanted to help patients. These experiences were captured in Evelyn's (psychologist) reflection:

'I think that the move towards short term working has been very deleterious to staff retention and recruitment. In the past, CCs could be in touch with a patient for quite a while. I think there was a much higher degree of job satisfaction because people who come into mental health services actually want to understand people, they're curious about human nature, and they want to help. And finding that all they can do is administer short psycho-educational courses and never actually get to know anybody. It's not what they came in for.'

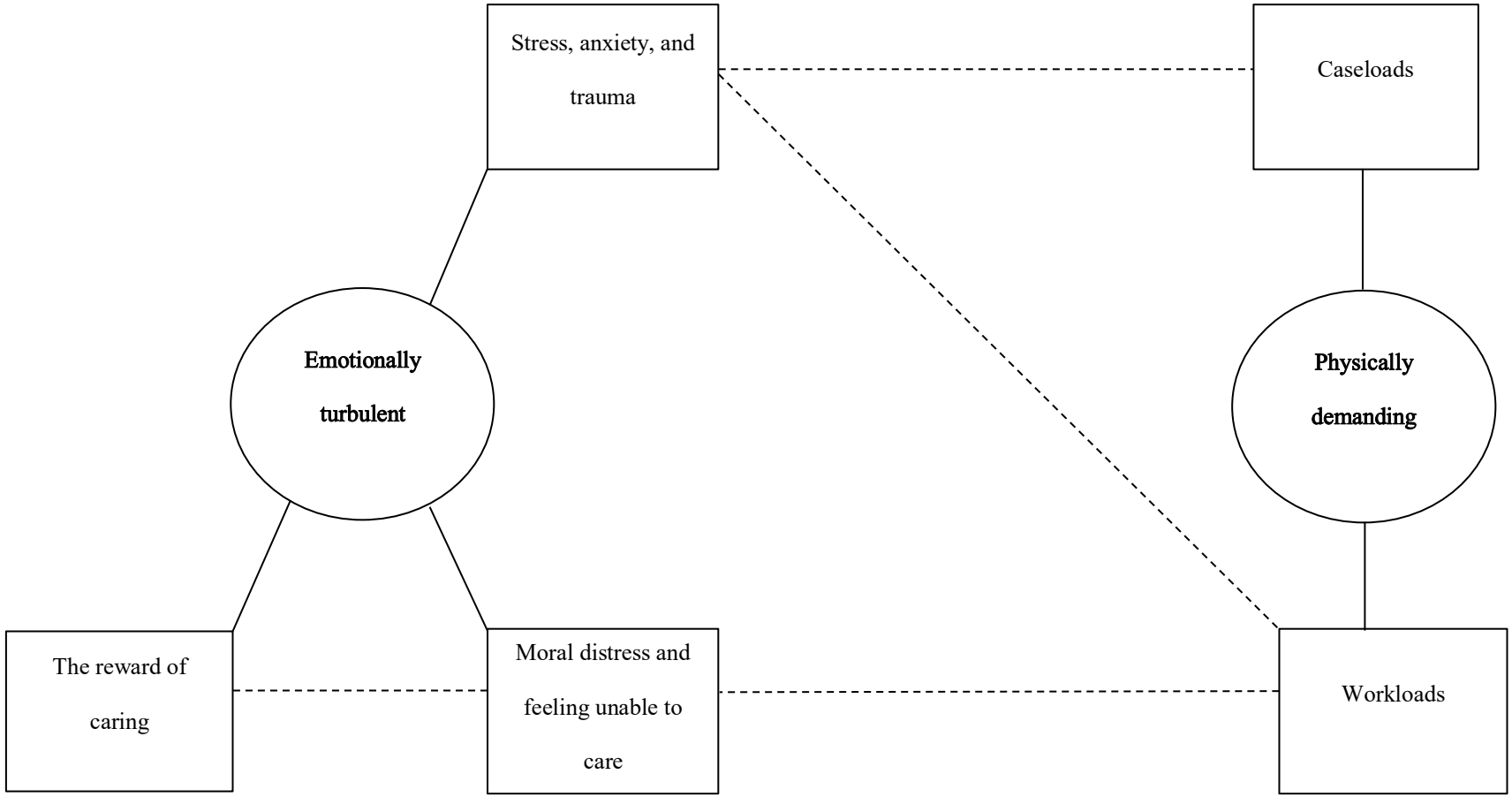
Finding that the job was 'not what they came in for' was felt to affect morale across the CMHT. Lucy (psychologist) felt it was *'demoralising'*, while other CCs felt it was disruptive for patients, and it meant regularly losing valuable knowledge from the team. Improving staff retention in the CC role was felt to be important. The experience of moral distress by staff across the disciplines was felt to be a core feature of what made their roles so emotionally draining, as the desire to care was juxtaposed with a working reality that limited their ability and capacity to care.

Summary and Thematic Map

The picture staff painted of their working lives in CMHT A was overwhelmingly negative. They described roles that were physically demanding as they struggled to manage large caseloads of patients with complex needs. They found their jobs stressful and anxiety-provoking. Staff generally said that they went into CMHT work to help people, and to be able to build relationships with patients over time. However, they often felt constrained in their therapeutic roles, which led to the experience of moral distress for many.

Figure 4

Thematic map for research question one representing themes (ovals) and subthemes (rectangles). Solid lines represent connections between themes and their related subthemes. Dashed lines represent inter-connections between themes and subthemes.



Research Question Two: How do Staff Perceive the CMHT as Succeeding or Falling Short in its Aims?

Four themes and seventeen subthemes were developed from the interview transcripts to conceptualise what staff felt was working well, and what was not working well in CMHT A.

Managing the Journey

Managing the journey was created to conceptualise the difficulty the CMHT was having in creating a coherent, well-planned, therapeutic journey through the service. Staff felt the CMHT was set up to fail by the Single Point of Access (SPA), which gave patients unrealistic expectations of what they would be offered, a problem compounded by the complex referral pathways within the CMHT itself. Grace (psychologist) explained that '*every team [in the CMHT] has a certain criterion for accepting a referral, so I think that becomes something staff need to be mindful of*'.

Staff held different conceptions of what recovery meant in the context of working with people with severe and enduring conditions, which created tension in how staff felt patients should be managed. It also created problems as patients reached discharge as staff had different ideas about where the threshold for discharge should lie. Staff noticed that each discipline had a tendency to refer to another discipline once a piece of work had been completed, a problem which created inter-disciplinary tension and which staff felt passed unhelpful implicit messages to patients. Incoherence appeared to lie at the centre of patient journeys into, through, and out of the service.

Referrals and Pathways Through the Service

Staff explained that the effectiveness of the CMHT was undermined by issues with the way referrals were received, and how the CMHT acted upon them. The CMHT receives

its referrals through the SPA. Ivy (psychologist) felt these initial assessments were poor and set the CMHT up to fail. She explained *'the problem is that the people that are doing those SPA assessments are people that don't work in our team. They have no idea what we do and what we don't do'*. Ivy went on to explain that the SPA often recommended specific treatments or therapies to patients that the CMHT staff disagreed with, putting them in a difficult position where they had to choose to honour a clinical decision they did not agree with or to disappoint their patients. In psychology in particular, Ivy described a situation where *'we're already set up to fail from the beginning. Often it's not a thoughtful, well considered recommendation from anybody that knows anything about therapy'*

Staff also felt that internal referral routes were complex and difficult to understand, which was felt to cause miscommunication between staff and patients. A frequently cited problem was that patients thought a referral had been made but it had not been accepted, and the outcome was not communicated to the patient. This led to situations where patients thought they had been waiting for an intervention, sometimes for years, only later to find their name was not on a waiting list at all. Another issue that staff felt concerned about was the impact on patients of being required to repeat their story to different clinicians. Bethany (psychologist) explained that upon entry to the service, '*the patient will meet with one member of team for an initial assessment, after which they are discussed in an MDT meeting and a care plan is made'*. This assessment acts as a secondary assessment to the SPA assessment, a duplication of clinical time. Alice (psychologist) explained that many of the complaints she hears from patients are about *'how many times they [patients] have to tell their story'*, which she felt made sense given the number of assessments each patient is likely to have experienced. Staff reflected that the system as it currently stands likely benefits, or is more accessible to, those services users who are able to repeat their story time after time to

new clinicians they have no relationship with. Ivy (psychologist) thought about the repetition in terms of service efficiency. She explained:

'We're not good at all working together jointly so that when people come in there's a really clear multidisciplinary care plan that says these are your needs, and clearly delineates who's doing what, and then saying we're going to discharge you when these needs are met. I have no doubt at all that if we did that better at the beginning, we would not have the issues that we have with capacity and problems with delaying people.'

Defining Recovery

It was clear from the interviews that staff held different understandings of what recovery means in the context of moderate to severe mental health conditions. At a high level, Frank (medic) explained that the CMHT should *'discharge them [patients] once they're stabilised and no risk involved. When they make good recovery, the GP should take over'.* Ivy (psychologist) felt similarly, and explained:

'I don't think that the team feel very comfortable talking to people about what recovery looks like, but also being realistic with people that for a team that caters for people with severe and enduring mental health problems. It's not realistic that at the point that we discharge any of our people are going to be symptom free.'

A specific example of a difficulty defining recovery was seen in how staff talked about the management of patients with psychosis. Kara (CC) explained that *'psychosis patients will need care for the rest of their lives.'* Whereas Ivy (psychologist) said, *'I think there is often this unsaid assumption, which is that people with psychosis are never going to really recover and they're a long-term patient and they're always going to need to be under the care of the team'.* Kara (CC) feels that patients with psychosis will require care for the rest of their lives and implies that it is the job of the CMHT to provide that care. Ivy, however, rejects this narrative and instead advocates for what she feels is a more realistic view of recovery: that

symptoms are expected to remit and relapse throughout the lifespan and the role of the CMHT is to support during periods of relapse.

When thinking about the implications of long-term management, staff again expressed different opinions. For some staff, for example Alice (psychologist), there was a concern that the CMHT could inadvertently promote dependence on services. Alice explained *'inadvertently, sometimes I think we end-up harming them [patients] or reinforcing a narrative of, like, you've got this chronic condition there's nothing we can do. That's your diagnosis and that's it'.* The supervisory team were clearly aware of this issue, and Maureen (CC) explained how the team's concern about dependency affected clinical management plans by saying *'we talk about empowerment, which I think sometimes we use almost negatively. You know, we're going to empower you by not answering the phone. We're going to empower you by not giving you a care co'.* In this almost cynical extract, Maureen comments on the empowerment-dependency dichotomy, implying that the CMHT's use of empowerment strategies is more appropriate for some patients than others. She implies that service constraints mean that a lower level of care is provided than is perhaps ideal, and that this is sold to patients as an empowerment strategy rather than a result of a systemic problem. Staff appear to be working to different goals, principally stabilisation and discharge, rather than long-term management.

The Dilemma of Discharge

When thinking about how to operationalise recovery into care plans, staff continued to show different opinions. Ivy felt that each referral should be defined by a goal or piece of work, after which the patient should be discharged. She explained:

'So what you're trying to do is, with someone who has a chronic relapsing condition, be specific about what you're going to do within this episode of care and what would progress look like, then do a specific piece of work.'

Ivy reflected that these might be difficult conversations to have but she felt that staff working in CMHTs should have the ability to do so. When thinking about how to manage patients with a diagnosis of schizophrenia, Pauline (medic) expressed a similar view:

'If they're on injection medication for schizophrenia and if the GP is administering it and we know that when they're on the depot, they should be discharged..'

Here, both Ivy and Pauline are describing a stabilisation and discharge model, whereby the CMHT supports during periods of acute illness, and discharges to primary care when the patient is deemed stable again. Maureen (CC), however, had a different vision for how patients with schizophrenia should be managed:

'Some people will never get better. My paranoid schizophrenia patient that I kept mentioning, she won't. And that's not her fault. That is just her. That's just her illness. So, she'll stay with us. But then sadly, I think they do get to a point where they're stable enough that they are discharged from the team and then they just come back when they go into crisis, the others get stuck.'

In these excerpts, a fundamental difference in management strategies is demonstrated between acute support and long-term management for schizophrenia, corresponding to different ideas of what constitutes recovery. Maureen feels that a re-referral to the CMHT represents a failure to maintain discharge, whereas for Ivy and Pauline, re-referral is often expected.

Referring On

Staff expressed both confusion and frustration at what they saw as a culture of 'referring on' within the CMHT. They explored possible causes of this phenomenon, such as passing on risk and reducing individual responsibility burden. Pauline (medic) said *'they*

[staff] just feel, oh this person is in crisis, I've tried X,Y and Z. Maybe should I pass it to someone else who can look at it, or as a transfer of risk, or I don't know.'

She went on to give a case example:

'I can give you a funny example of a patient with EUPD. I got an email from the care co to say can you offer a medical review for this patient because she put her head inside the oven? So I was like, okay, was the oven hot? And they said, no, she just put it inside the oven. I was, like, what is a medical review to do with that?'

Through this example we can see that the anxiety about managing a patient's risk, and possibly the desire to reduce the individual responsibility burden, has created a drive to refer to other parts of the CMHT. A secondary impact discussed by medics was that they often felt their medical review appointments were inappropriately used to respond to requests such as this. Interestingly, CCs reflected on the impact of the same problem on their team. They expressed frustration over what medics expected them to be able to do with patients when they worked in a role that was predominantly case management rather than doing therapeutic work.

Bethany (psychologist) reflected on the refer on culture broadly within the team:

'People say, 'this is your patient now'. Like the CCs, for example, would say, 'this is psychology's now'. And then when psychology has finished a piece of work, they say, 'this is a CC thing now''.

Claire (psychologist) reflected on the same pattern saying *'I think when people feel stuck or they're not sure, it can sort of be, like, over to you [psychology].* For Ivy (psychologist), the problem was represented by a weekly team meeting she was asked to attend called the 'refer on' meeting. Ivy said that it '*often feels like we're at loggerheads with each other rather than supporting each other to discharge people. We're all internally trying to refer people on to*

other people in the team, and often inappropriately'. However, Ivy's predominant concern was the implicit messaging that was being passed to patients:

'*What does that say to patients, like, they've got to always be going on to the next thing? We see that in psychology, people have an intervention and it's, like, what are you going to do next? There's got to be something that comes immediately afterwards rather than just saying, you've had your therapy, go away, consolidate, come back if you need to.'*

Ivy's quotation harks back to the problem of failing to define the end from the beginning, and staff members holding different understandings of what recovery means.

The culture of referring on within the team created tension between disciplines as staff tried to grapple with who should be doing what. An example of this tension can be seen in the way that Frank talked about the psychology team when discussing managing patients with a personality disorder (PD) diagnosis:

'No offence to anybody, but they [psychology] need to come out with a clear plan about how they're managing these patients. Sometime psychology, they say, oh, in order to access the psychology, they need to have a CC. I do not understand why. Then they [the patient] wait for the care coordination. I feel that psychology is a bit risk averse. They don't want to take the lead responsibility'.

In this excerpt, we can see Frank's frustration that his referrals into psychology have not always been accepted and acted upon in the ways that he expected, which created frustration in the relationship. Ivy (psychologist) spoke on the opposite side of this problem. She explained *'as soon as they [medics] had referred them [patients], they stepped back. In most cases, discharged them from their caseload without discussion with us and then basically leaving us holding them as the only person'.* Ivy went on to explain that the problem with this approach is that if patients did not attend appointments or respond to invitations to, for example, groups, Psychology could not follow their Did Not Attend (DNA) policy as they

did not know the patient's level or risk, meaning they could not discharge the patient. Ivy explained that Psychology had begun to reject referrals that were sent without an up-to-date care plan and risk assessment, which she described as:

'Just a shitstorm, basically. It's caused outrage with the doctors. When my line manager raised it, the psychiatrists went straight to the top of the organisation to the medical director and, you know, it doesn't foster good team working relationships. To me, it feels really disrespectful'.

The culture of referring patients on is seen as causing inefficiencies as clinical time is wasted doing repeated assessments. However, and perhaps more importantly, it seemed to be causing tension between the disciplines while also passing unhelpful implicit messages to patients that the interventions that are offered are insufficient to meet their needs.

Managing the Demand

Managing the demand was created to conceptualise the CMHTs difficulty working effectively with the number of patients it held and the wide variety of presenting problems. Staff felt that the MDT design provided them with access to the disciplines that patients needed. Therefore, in its constituent parts, the CMHT was felt to be adequate for the role it held. However, staff felt that the CMHT was under '*huge pressure' (Jade, CC)* from the number of patients it was expected to support. The CMHT was seen as existing in a space whereby specialist services were able to work with a discrete set of presenting problems, leaving the CMHT to essentially pick up everyone else. A frequently cited example of this problem was managing a surging demand for ASD and ADHD assessments. Staff also talked about a tension they felt between managing the needs of patients with a diagnosis of PD compared to other presenting problems. These problems were felt to be longstanding and had been a major contributor to what Kara (CC) described as the '*merry-go-round*' of service improvement; cycles of transformations intended to improve service delivery.

CMHT Design

The majority of staff expressed the view that the MDT model provided them with access to the disciplines they felt patients needed. Lucy (CC) explained:

'I think the CMHT is a beautiful design because it's a big MDT that is designed to meet the holistic needs of the patient. That's why the doctors are there, the nurses are there, the OT is there, the social worker is there, the psychologist is there, and even the support workers are there.'

Similarly, Jade (CC) explained that the CMHT design offered *'the social perspective, the psychological perspective, the health perspective, all working together in order to work with the patient in a holistic and person-centred way.'* In addition to the core professions of psychiatry, psychology and care coordination, staff felt that the provision of support workers could be useful for patients. Alice (psychologist) reflected:

'I think the support workers we have in our service offer some brilliant, like, lower-level interventions that are really valuable and maybe fills that gap where roles that care cos maybe used to do years ago. I see them build phenomenal relationships with the patients because they have the capacity to do that.'

Nora (CC) also highlighted that administrative staff hold valuable perspectives as they are the first point of contact a patient has with the service. Therefore, they often have insights into how to communicate with patients, as well as valuable observations on how patients interact with others outside of overtly clinical spaces. CCs spoke positively about a Section 75 agreement coming into place with the local authority, which would make the statutory duties of social workers the responsibility of the CMHT to fulfil. This change was felt to offer care that was less fragmented as more of the patient's need could be managed 'in house', reducing the need for inter-agency working. For Kara (CC), it was hoped that Social Workers currently employed in the team as CCs would take back tasks associated with their core profession,

freeing up time from Occupational Therapists and CPNs to do more work associated with their core profession. This change was hoped to make the CC role easier.

CCs and Psychology staff found having access to duty support useful as a method of escalating concerns about patient risk. While Pauline (medic) said that having access to senior management for support outside of medical reviews was helpful for her. The ability to escalate or share clinical responsibility was, therefore, seen as a useful and integral aspect of the model. This was summarised by Nora (CC), who said:

'Sharing the risk – that also helps a little bit so you know that, OK, I'm not the only person working with that person, and you know you can sort of feed off each other. Joint working is really imperative in what we do, especially with patients that are a little bit more high risk.'

Similarly, the MDT space was felt to be a useful place to discuss cases and share decision making. Claire (psychologist) said that the MDT space offered *'the space to come together and talk about cases and to think together. Just having different perspectives'.*

Waiting Lists

Almost every member of staff talked about the extensive waitlist that patients faced for medical reviews, care coordination, and for psychological therapies. Staff explained that the long waiting list was affecting patients' recovery and putting strain of other parts of the CMHT, as well as affecting staff wellbeing. Lucy (CC) explained how she had seen patients she was working with deteriorate on waiting lists:

'Psychological input is the way out, however, it's not available because of the waiting time. I wish this psychological intervention can be done today, or maybe in the next 7 to 10 days. However, this person has to wait for one year or two years to get that support, so there could be a lot of deterioration within two years, there could be suicide.'

In this excerpt, we can see the impact that waiting lists in one part of the CMHT (psychology) has on another (care coordination), as CCs are asked to hold patients whose mental health may deteriorate while they are waiting, putting further strain on their team. Staff explained that patients' difficulties could change and often deteriorate while they are on waiting lists, making subsequent appointments more difficult as re-assessments are required, and staff have to manage patients' anger and disappointment. Staff typically sympathised with patients' plight, which contributed to feelings of moral distress. In Alice's (psychologist) description of her initial psychology assessments, it is clear the impact on her job satisfaction that the long waiting list for psychology has. Alice explained:

'They tell me what's going on, and I have to put them on a wait list, which we say is two years, but I don't really believe it is just two years. It's probably much longer than that and that is really, really heart breaking.'

The 'Mopping up Everything' Team

Staff felt that the CMHT's role was made more difficult by the services that surrounded the CMHT in the NHS system. Staff felt that specialist services had very strict criteria for what difficulties they would and wouldn't accept. For example, Nora (CC) said:

'The forensic services or the eating disorder service or some other services, there is a high threshold now to access these services. So sometimes you're sort of stuck with people that have multiple diagnosis and need multiple agencies, but they're just under the CMHT and coordinated by one person.'

Here, Nora explains that the CMHT is expected to accept patients whose problems do not fit elsewhere. When asked what happens to patients who don't engage with the CMHT, Kara (CC) explained *'they're just kind of in a void. I think they go back to, you know, their GP, or they rock up at A&E all the time, or they're re-referred'.* Kara's comment illustrates a reality where the CMHT works with those people that the specialist services will not accept,

and that without the CMHT, this group of patients is left without support. This problem was felt to contribute to what Alice (psychologist) called *'crushing system pressure'*. This sentiment was echoed by Lucy (CC), who explained that the CMHT was '*overstretched and oversubscribed*.'

There was also a feeling among the medics that the CMHT was now expected to manage problems that previously the General Practitioner (GP) in primary care would have taken the lead on. For example, Helen (medic) explained that *'GPs used to do a lot of that… I don't want to denigrate it, but that kind of low-level just general support and listening'.* While medics acknowledged that GPs were also under pressure, GPs were nonetheless felt to refer too readily to CMHTs. For example, Quinn said *'you see GPs referring to the secondary care very fast because they want to take the trouble to the psychiatrist. It's your trouble.'* When combined with different notions of what constitutes recovery, it is not difficult to see how and why staff feel unclear about the purpose of what they are doing with their patients. Staff felt that the CMHT works reactively with decisions made in surrounding NHS services and 'mops up' those services users who are left needing support.

The Dilemma of Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) Assessments

A specific and oft-cited example of the 'mopping up' everything subtheme was the dilemma of whether the CMHT should conduct ASD and ADHD assessments. As it was raised so frequently in the interviews, it was felt to warrant its own subtheme. Staff explained that societal understandings of ASD and ADHD were changing, and that this was impacting on the work expected of the CMHT. When talking about Autism, Quinn (medic) said:

'That's another big conversation because the concept of autism is so controversial, but it shouldn't be. It's so controversial because people are now exploiting it, and all of this

talk of exploitation is coming from the fact that psychiatry, psychology is not an exact science. There is a lot of subjectivity.'

Quinn is alluding to criticisms of a wider trend in 21st century diagnostics that has broadened concepts of, for example, what constitutes conditions such as Autism. Owen (medic) explained how he thought the trend in diagnostic expansion has affected societal understandings of mental ill health:

'*Now autism is also mental health issue but it never used to be way back. But now everyone is having been over diagnosed with that and is having that issue, I feel now the services are very stretched because they need to deal with the people. And everyone is seeing the impact of this on the mental health services because even as a doctor, there's no medication for them. So what we are doing?'*

The sentiment of 'what are we doing' with them was echoed by Pauline (medic), who described patients she had seen in clinic who were struggling with mental health conditions and undiagnosed neurodevelopmental conditions. Pauline suggested that the CMHT should be offering sensory assessments and teaching *'coping skills'*. When asked if the CMHT was the right service to do that work, Pauline (medic) responded *'I'm not sure where they would go otherwise. That's the thing, isn't it'.* This sentiment echoes the 'mopping up' everything subtheme as Pauline does not think the CMHT is necessarily the right service to be doing the work she suggests, she does not think there is any other service that will.

Staff also felt that an increase in requests for ADHD diagnosis and prescription added additional pressure to the CMHT. Evelyn (psychologist) said '*I think that the vast expansion of the inclusion criteria for ASD and ADHD diagnosis has posed the health service a real problem'.* Owen (medic) described ADHD as '*a big thing now'* and he expressed frustration that a patient he had been working with, whom he believed had undiagnosed ADHD, could not benefit from a formal assessment. Owen explained:

'You can clearly tell. I think anybody can tell, like, he has ADHD. But when it came to the referral I said, like, GP to refer but then there was an eight plus year wait. And this kind of patient, I really feel there's a drug which can really help, but he cannot be started on that until he's seen by a clinic. So I know what the hell they need, but everything is not in the right place.'

With case examples such as these, it is clear why CMHT staff want to be able to do ADHD assessments. However, Pauline (medic) explained the final decision from the Integrated Care Board was that *'we don't do ADHD assessment or any prescription'.* ASD and ADHD assessments present a problem to CMHTs; staff see the value of doing the assessments in house, partly due to extensive waits in specialist services, and they see a benefit of offering specialist support, yet they feel ASD and ADHD assessments add additional pressure to an already stretched system.

The tension between 'serious mental illnesses' and personality disorder

Across the disciplines, staff felt that those more 'stable' patients that Kara (CC) described were those with a diagnosis of, for example, psychosis, schizophrenia or bipolar. These people were described by some as those with 'serious mental illness' (SMI) and were compared to patients with a diagnosis of PD. Bethany (psychologist) explained how patients with PD diagnoses could dominate the available clinical time at what was perceived to be the expense of those with SMI:

'A lot of the resource kind of gets focused on people who are really struggling day-to-day with personality disorder related difficulties and are in and out of inpatient units and a lot of people with the longer-term psychosis presentations go under the radar but are quietly really struggling in the background until it hit crisis point and they're in hospital.'

Maureen (CC) felt similarly, and explained how she felt it commonly played out in her role:

'A typical EUPD patient will call out for help. They're very good at making contact and engaging with services. And then someone, for example, with treatment resistant paranoid schizophrenia who doesn't believe they're unwell? They have no insight whatsoever. That patient doesn't call me. That patient will never call me because they're not unwell. So those patients you have to be proactive and contacting them.'

Similarly, Pauline (medic) explained:

'The people with the SMI, they might be waiting because they don't make noises or the crisis doesn't come up or get exposed. Maybe their medical review appointments can get delayed. It's not just with psychology, it happens with medical reviews as well. Whereas people with EUPD, because it goes to duty and it escalates and then you have to intervene, we tend to squeeze them in quicker.'

In these excerpts, Maureen and Pauline describe, in perhaps controversial terms, how focussed staff are on managing the risk associated with patients with PD. Staff anxiety, combined with the service's focus on mitigating risk, appears to have created a situation where patients with a PD diagnosis dominate the available clinical time at the expense of those described as having SMI.

The 'Merry go Round' of Service Improvement

Staff who had been in their role for a number of years often talked about the various iterations of the CMHT system they had worked in. For example, Bethany (psychologist) described the CMHT she first worked in being similar to the current CMHT structure. She had worked through a transformation that split the CMHT into one team for PD and another for what she described as the more organic problems, such as psychosis and Schizophrenia. She continued to work in CMHTs during the transformation back into an integrated service that is locality-based.

Bethany (psychologist) talked about the impact of transformation on staff teams:

'*When the teams changed again, a lot of the people that worked in the psychosis pathway were quite anxious about it and thinking I know where I'm at here and I don't really want this to change'*.

Kara (CC) who had been in her role for three years explained what transformations felt like to her:

'I think they try different approaches but always with the NHS, it's always, like, a bit of a merry go round where they try something, it doesn't work, they try something else, and then you're back to square one'

She went on to explain that she felt proposing solutions to the current problems in the CMHT would be met with '*we've done that'*.

Working with Socio-Cultural Issues

Working with sociocultural issues was developed to capture the acknowledgement that staff gave to factors affecting their work, and the CMHT more widely, that exist in the wider system and over which it had no direct control. Insecure housing was identified as presenting a particular problem to the CMHT. Staff also felt that a trend in diagnostic expansion risked pathologising normal aspects of human distress and could inadvertently lead to harmful relational patterns being repeated. Staff felt that the way the welfare system intersects with mental health services created difficulties for staff in responding to specific requests and trying to work towards discharge. These factors were felt to exist outside of the CMHT's control, though they exerted significant influence on its effectiveness.

Working with Social Stressors

This theme captured staff's feeling that some of what they were asked to work with could sometimes be better explained by social problems, such as housing needs and social

isolation, rather than a mental health diagnosis. The most widely cited social problem affecting patient's mental health was housing status. Claire (psychologist) explained:

'The CMHT is like a plaster. It's kind of being positioned as a solution to actually a broader issue. We're in a financial crisis. People are under huge pressures. But no, it's the suicide that can be prevented. I mean, one of the biggest predictors of distress is housing status.'

Nora (CC) felt similarly:

'You have those patients that maybe shouldn't even be in mental health services, which then end up taking more of your time because you're dealing with housing, you're dealing with things that could be dealt with outside of being in the mental health team.'

There was a clear acknowledgment in the team that insecure or poor housing impacted patient's wellbeing. However, staff had no control over a patient's housing status. Thus, perceptions about the effectiveness of the service seemed bound up with social care issues outside of its control.

Poverty was also acknowledged by some staff as a significant social stressor. Claire (psychologist) explained *'there's a lot of people living in relative poverty, and people are really worried about benefits cuts.* Claire (psychologist) also identified patients who are also carers as being under particular strain.

The impact of racism was identified in only one interview, with Helen (medic), who discussed the ethnic makeup of consultants in the trust. Helen explained that the majority of psychiatrists in the trust were of South Asian origin, and that she thought they faced particular difficulties with transferring their training to the NHS context. Helen explained that having trained in an overtly medical model, some consultants struggled to adapt to working in a model that gave greater space for psychological therapies and did not always position

psychiatrists at the top of the disciplinary hierarchy. Helen described this adjustment process as *'the additional hurdle that isn't ever talked about'.* None of the staff commented on the impact of racism on their patients.

Staff also explained that their patients faced social isolation, which impacted their mental health. For example, Nora (CC) talked about her patients who are '*lonely, and don't know how to fix it on their own'*. Lucy (CC) explained that often social stressors overlapped:

'Sometimes the needs are interwoven into each other, you could think, OK, this person, it's a financial issue and in the process of solving the financial issue, you begin to discover that, oh, it was issues with relationship that led to the financial breakdown. And while you're trying to attend to that as well, you see that oh, it's a housing issue now. So it can be hard when it comes to complexities of humans and human needs.'

Across the disciplines, staff reflected on what they saw as the salient social stressors impacting the wellbeing of their patients. However, there was a general acknowledgement that while staff could try to help with these issues, they were ultimately limited in what they could do. Grace (psychologist) summarised this by saying:

'Therapy is super important, but sometimes, there are lots of other kinds of social stressors that we don't have control over. As much as we want to help the patients, I think in some things we're not able to, and then again, you're managing a lot of frustration and resentment that they [patients] have towards us.'

Medicalising Distress

Bewilderment over how to work with wider systemic issues was also seen in how staff were asked by the healthcare system to understand and respond to human distress. Staff felt that the diagnostic system had expanded over time to capture broader and broader aspects of the human experience. Evelyn (medic) explained:

'I have been unimpressed by the growth and proliferation of diagnosis in the DSM or the ICD where everything becomes a medical issue. You know, it's like human unhappiness and distress has become medicalised, as if the only normal state is being happy, which is just nonsense. You know the world has never been like that. Then you also hugely increase the number of patients that you're going to have.'

Similarly, Helen (medic) said:

'I just don't really agree with the medical model diagnosis, I think is highly stigmatising, you know, and it's not scientific. They're just made-up categories and the medications we prescribe, the evidence for them is poor so it's like a religion rather than a science because it's not evidence based.'

It is interesting that ostensibly the most medical members of staff, the medics, feel that the operationalisation of the medical model is causing problems for some of their patients, and the wider systems trying to support them. However, not all staff positioned themselves in this way. Ivy (psychologist) said:

'I am probably one of the psychologists that is the least anti-psychiatry, anti-diagnosis, you're ever likely to meet. I know there's been a real steer in psychology of people seeing diagnosis as a really bad thing. I personally think there's a time and a place, and for many people diagnosis and medication is really helpful when it's done in a thoughtful, considerate way.'

Other psychologists in the sample expressed concerns that the system as it currently operates, with stressed, anxious staff trying to support a large number of people, ran the risk of repeating harmful relational patterns, or reinforcing unhelpful beliefs, such as being 'unfixable'. Alice explained:

'I think the CMHT is set up for people who can accept help and take it readily. Patients who maybe have more of a kind of psychosis type presentation, sometimes I think we end up harming them or reinforcing a narrative of, like, you've got this chronic condition. There's nothing we can do, like, it's just that's your diagnosis and that's it.'

Bethany (psychologist) also felt that the CMHT could reinforce unhelpful beliefs about the self:

'If you give people little bits of things that don't necessarily fulfil their needs quite quickly, you're going to build up a belief that services can't help me. And then you're going to be way less likely to be able to do anything useful in the future.'

The predominant concern for psychologists seemed to be that harmful relational patterns would be repeated through interactions with the CMHT, risking not just pathologising through the application of diagnostic labels, but also through repetition of previously harmful relational patterns. CCs were noticeably absent in their comments on this topic.

Intersecting with the Welfare System

Staff discussed the welfare system with both passion and trepidation. While staff acknowledged that the welfare system could be helpful for their patients in some situations, there was a broad consensus across the disciplines that the welfare system kept some people stuck in mental health services. Quinn (medic) explained *'the benefit system is good in a way because it takes away the pressure of patients wanting to go back to work'.* However, Nora (CC) explained that patients could be *'very demanding because they know their rights. So, it's like, no, I want a Care Act assessment because I know that I can get a care package and I can get certain benefits'.* Owen (medic) also noticed that patients requested specific things from him. He explained:

'Many patients want to be diagnosed. They asked, like, will it be written on my letter and I want it to go to the GP. There was just one patient I saw two weeks ago. 21 years old. Male. He wanted PD to be written on the letter and he's, like, because I need to apply for PIP.'

When thinking about recovery and discharge, Ivy (psychologist) felt that:

'Lots of people don't want to be discharged from our team and that's because they rely on it for benefits under scrutiny of PIP and DWP. There's a lot of resistance to people being discharged and it's because practically and financially they need it. It's often not about recovery, people need our team for their very livelihood. And we are always going to battle with people that resist discharge because they've got a lot to lose by being discharged. It's not just the emotional attachment. There is a massive financial implication.'

In this excerpt, Ivy tentatively proposes a difficult reality: that 'recovery', as in symptom alleviation, remission, or resolution, is not in every patient's interest while they also exist in a welfare system that requires them to be ill to be financially supported (and ultimately to survive).

Meeting Relational Needs

Helen (medic) explained what she felt had changed in the wider healthcare system over the course of her career, which was affecting what the CMHT was now expected to do and work with. She explained:

'We're mopping up changes in society generally. Twenty years ago, you might have had the same GP most of your life. He might have known your mum, so that's very containing. I had a lady turn up to our CMHT in her late 60s. I said, 'how come you've never needed mental health help before? What's changed?' And what changed is her GP of 30 years had retired, and so the person who would have said, oh no, she'll be OK, I'll support

her through this wasn't there anymore. Maybe, historically, it could have been the priest. So, we're having to sort of try and fill that gap, but we can't do it very well.'

Through this case example, Helen explains that changes in society and the health system have led to a greater dependency on the CMHT, which it cannot fulfil. Staff also commented on the lack of family support they felt their patients had compared to the general population. Ivy (psychologist) explained that for many patients *'the mental health system is their family'.* Some staff presented almost as helpless in the face of this issue. Owen (medic) said *'the mental health services take all the brunt of everything, like, you know, you're not doing enough, but it's just how society is now'.*

Operationalising Care

The theme operationalising care was developed as a theme to capture what staff seemed to want: the ability to provide care based on relationships with patients, rather than care based on pieces of work completed. This theme was felt to relate to the subordinate theme 'meeting relational needs' as a specific example of the broader move away from relationship-based care in the wider healthcare system. Staff explained that the therapeutic relationship was the key agent of change for most patients they felt had had a good experience of the service. However, they struggled to justify the value of this 'low level' therapeutic work in many cases as a focus on preventing serious incidents dominated the available clinical time. A specific systemic failure to provide relationship-based care was seen with the PD population where some staff expressed very negative, and in some cases derogatory, views about patients with PD diagnoses.

Defensive Practice

Defensive practice was defined as the prioritisation of risk-management strategies over other clinical work. The clinical decision to focus on risk management was driven by three factors: staff caring about their patients and not wanting them to die, the fear of losing

their practising license, and the fear of being called to coroner's court. Kara (CC) explained that the reason the caseload cap of 35 was introduced was because staff were leaving out of fear a serious incident would occur and they would lose their practicing license. Quinn (medic) explained *'your licence is something I think all healthcare practitioners are very concerned about'.* Quinn went on to say that this fear was especially acute for staff who are non-British nationals, as their status in the country depended on their employment. Dina (medic) reflected on what her experience of being called to coroner's court was like:

'It's awful because all of the professionals are trained to save lives, to help people. That's what we do. Despite that, I think you're made to look like a criminal. And the way you're questioned, it is like an interrogation. You feel that you have missed so much and you're not good enough. Even if you come away and you think, actually, I still did everything that I could. You will forget to think that because you are made to feel you have missed a lot.'

The intensely unpleasant experience of coroner's court created a fear that was pervasive throughout the team and beyond. Kara (CC) explained that even when she was training, she was told *'you don't want to end up in coroner's court so make sure that your notes and your risk assessment are up to date. There was always that fear.'* Staff felt there was a fundamental misunderstanding in the system about preventing suicide. Without exception, when asked whether suicide could be prevented, staff explained that yes, in some situations it could be, but there will always be impulsive acts or unpredictable circumstances that could lead to suicide. Claire (psychologist) said *'I don't think we can fully control or predict what people do.'* Similarly, in response to the question about whether suicide could be prevented, Dina (medic) said:

'You won't like it. I feel mental illness is an illness, like a physical illness. Have you ever seen a zero mortality policy in the General Hospital? There are no such matters. So how can you be so sure that there will be zero suicide? You'll do everything possible, but I just

feel it is an impossible thing to achieve. If you have any clue about what they're going to do, you will do something. There will be a group of patients you will not have any clue. In their mind they would have decided, there is no way for me to know, but they'll end up doing what they would have thought about. In that situation with these kinds of policies it is so difficult for us to function and work.'

Dina assumed that her opinion would be unpopular, yet it was the dominant view expressed in the CMHT. Both Dina and Claire (psychologists) talked about the impact on staff of working in a system that expected all suicides to be prevented:

'It creates blame in the system because if someone has died then someone's doing something wrong rather than acknowledging actually there will be a subgroup of situations where this will always happen and thinking what went well and what didn't go well? And actually, is there something we need to do differently next time'.

The implication is that learning from patient deaths is in some cases restricted. Dina felt that the focus on risk management was leading to defensive practice. She explained:

'There's a lot of defensive practice. You want to reject the referral, refer on, in case something goes wrong, I don't blame people. It's the way it is because of everything that's happening, there's a lot of fear'.

The fear of something going wrong was also felt acutely by CCs who felt under pressure to manage risk, and to meet contact time targets with those on their caseload. Kara (CC) explained:

'There's a lot of juggling around and sometimes somebody who was more stable, you might say to them, I can't see you today, something's come up and then you would reschedule. But again, that would push everything out of sync for how you were planning to spend the following day, so there was always that knock on effect.'

Kara's example clearly shows a situation where managing risk is prioritised over more routine, perhaps therapeutically focussed, work. This is at odds with the kind of care that staff generally said they wanted to provide their patients. It is perhaps an understandable reaction to a troubled system struggling to cope with managing a high demand on its available resources.

Negative Attitudes Towards Personality Disorders (PD)

Perhaps partly as a reaction to the frustration some staff felt about what they saw as the prioritisation of patients with a diagnosis of PD, some staff expressed very negative views about PDs. For example, Quinn (medic) suggested that those with a diagnosis of PD are not really suffering:

'The tragedy of it all is the fact that those who are really suffering then get lumped in with the people who are not. If we take away PD patients from the CMHT, then we'd be able to focus on severe mental illness. I don't think PD is severe mental illness, its behavioural.'

Perhaps in response to some of the language used around PD patients, as seen in the excerpt above, some staff expressed concerns about there being unhelpful attitudes towards PD generally in the service. For example, Kara (CC) noticed a stigma attached to the PD label and said that patients could be dismissed by saying '*they're just a PD'*.

The medics interviewed were clear and united in their opinion that there should be a separate PD pathway led by psychology. Frank (medic) explained why:

'NICE guidelines clearly say psychological intervention, therapy, is the main thing for PD and they do not benefit from inpatient admission or medication. They need to have a clear STEPPS or DBT or whatever. They [psychology] need to be front runners taking the lead practitioner for PD because it's an emotional trauma psychological issue, isn't it. That's

what I'm facing as the biggest challenge now. Not having a proper care plan for people with PD.'

The governing trust does in fact have a specialist PD and complex needs team, which is able to augment traditional CMHT delivery through consultation as well as direct clinical work. However, CMHT A did not appear to be actively working with them at the time of the interviews. CMHT A had its own PD and complex needs pathway within psychology. However, the wider CMHT appeared either not to be aware of this pathway or not to know how to refer into it. These problems prevented the delivery of relationship-based care, which this population was identified as being in particular need of, and created inter-disciplinary tension.

Relationship-Based Care

The theme of relationship-based care was developed to capture the type of care that staff generally said they wanted to provide and felt their patients were asking for. Claire (psychologist) explained very simply, *'it's all about relationships. If I think about the people who the service has helped, it was where there was a more positive rapport with them'.* Helen (medic) explained why care based on relationships rather than processes was so critical in her opinion:

'People feel they need to be understood and supported and that we're not just trying to get rid of them, which they do feel, or fobbing them off with medication - their words not mine. Some people do just need long term support, so that's also not very popular. It doesn't have to be a psychotherapist. It could be a support worker.'

Helen feels that what patients need is a form of care based on human relationships, rather than on referrals made and pieces of work done. However, not every member of staff felt like this. For example, Frank (medic) explained his role by saying *'I've done the formulation of the difficulties, then the psychologist can give their expertise to the patient, because I'm not a*

psychologist to talk about their issues'. Here, Frank's explanation of psychiatry appears to have less concern for building relationships and working closely with patients than Helen's. That staff within the same CMHT hold such different views of their purpose and roles points again to confusion at the service level of the aims and mechanisms of change. However, even in Frank's excerpt there is an acknowledgement of the utility of talking in a relationship with someone else, and of that being therapeutic. CCs talked about 'old school nursing', where regular and consistent contact was valued. Maureen (CC) explained *'they [the 'old school' nurses] would do anything. If the patient needs driving to a hospital, they'll do it. And that's completely frowned upon, it is completely different to what we do now*.' Maureen went on to talk about a conflict she is currently in with management over what she is and is not allowed to do clinically. She explained:

'A lot of patients will say 'what I really want is a weekly phone call. I want someone to check in with me and show they care' and I go, 'I hear you. That's not my job'. How awful is that?'

Maureen is saying that she wants to meet her patients' desire for the space and time to build relationships together. However, she is being impeded from doing so. Maureen went on to explain:

'*I've got patients that are struggling to engage. All they need is someone to go out to lunch with, do normal everyday activities with. They don't have anyone else, and I'm not allowed to go with them. I have one patient I do lunch with and that split the management team about whether or not that should be allowed, so something as simple as going for coffee with people, we're being discouraged from doing.'*

Maureen presents a psychologically-informed rationale for doing this 'low level' therapeutic work; that being alongside people aides engagement, and ultimately recovery. However, either she has struggled to communicate the value of this work, or it has not been seen and

heard by those in positions of power. Maureen went on to say she that she has continued to go to lunch with this patient because she can see the therapeutic benefit her regular contact is having. However, she is doing so against an explicit instruction not to, which risks her own position. Jade (CC) also valued being able to provide relationship-based care. She explained:

'I think the most important thing that you can offer someone is to build a therapeutic, with a small T, relationship. You know to be there for someone, for them to be able to trust you, and it doesn't happen immediately. I think the small things can be so important to improve people's daily quality of life.'

In these examples, we can see the tension between relationship-based care, which staff generally seem to want to provide and they think patients are requesting, and a system that does not always see the value of 'low visibility', preventative work.

Helen (medic) shared her views on the problems with the forms of care being offered by the CMHT at present:

'You can't allow a patient to get attached to a member of staff. You know that's seen as bad, and it's all about holding the patient at a distance'.

Helen explains that the CMHT discourages a level of dependency on services, which she feels may be a necessary step in recovery from a mental health condition. Similarly, Ivy (psychologist) reflected on what she saw as the impact of withholding relational care on patient recovery. Ivy explained:

'I think that if someone's in a position where they feel, like, they can't ever be discharged and they need to be under a service for the rest of the life, I don't think we've done a good enough job of helping them with their attachment related difficulties. I genuinely believe that if people have decent quality connections, relationships, and a support network, they wouldn't feel the need to remain under the care of our team. Because who would

voluntarily want to come to our team, to our building? It's not a nice place, and often we don't do a terribly good job because we're all frazzled and overworked and busy. And if that's as good as it gets and you're desperate to hang on to it, that's a really sad state of affairs.'

In this excerpt, Ivy touches on many themes presented in the results. She ultimately speaks with compassion for patients trying to get their attachment needs met by interacting with a system that does not have the emotional capacity to help them, and is physically unpleasant to be in.

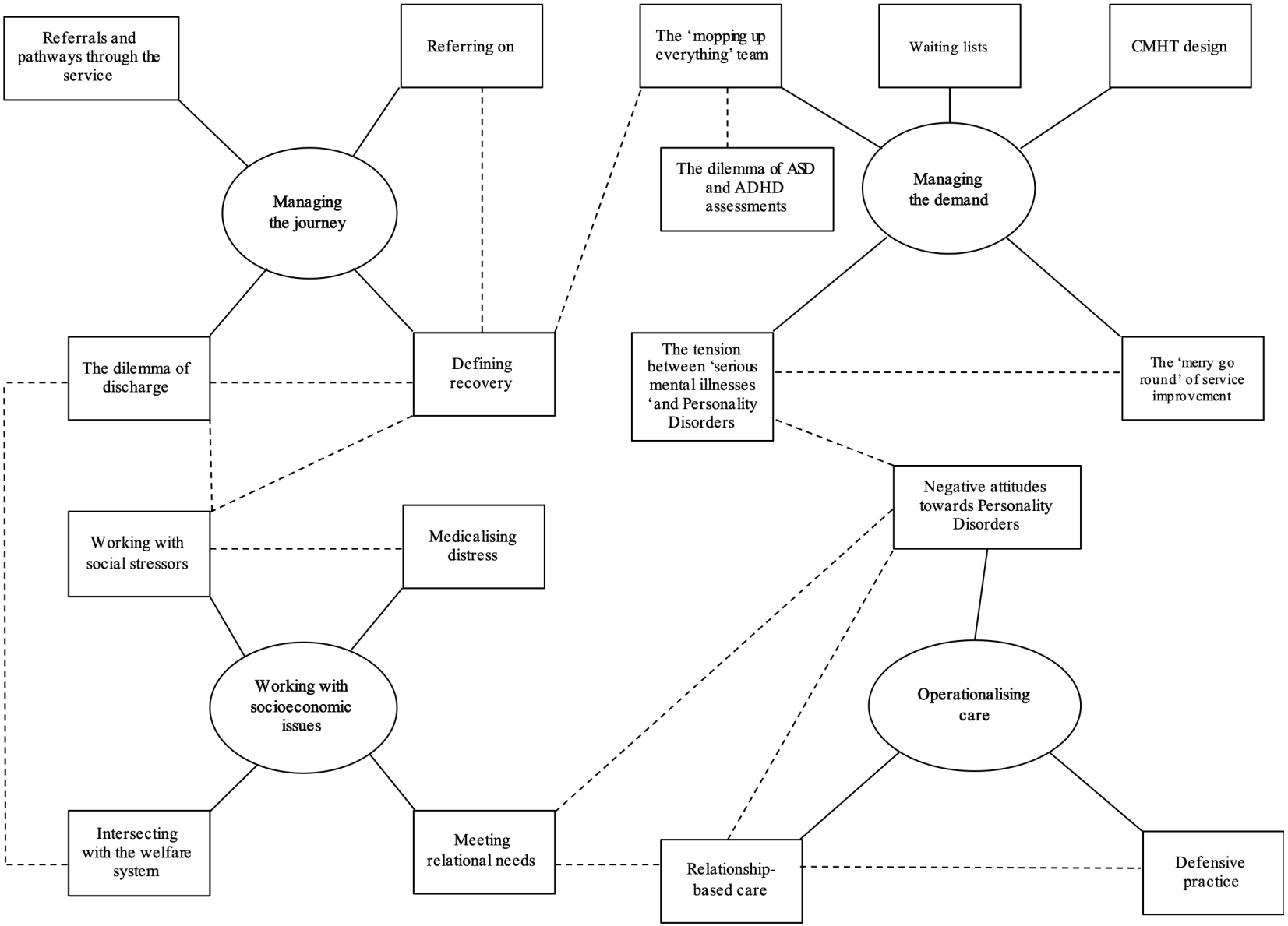
Summary and Thematic Map

Staff broadly felt that the CMHT was failing its patients. Two themes, 'managing the journey' and 'managing the demand' were developed to capture the problem staff felt the CMHT had with creating a therapeutic journey through the CMHT to recovery. The CMHT was felt to be overwhelmed with patients, and failing to manage the competing demands between patients with a PD diagnosis, and the rest of the patient population. This tension led to the expression of overtly stigmatising attitudes towards those with a PD diagnosis. Staff felt the CMHT was impacted by wider socio-cultural issues, and was currently failing to respond to them appropriately. Overall, staff expressed a desire to work therapeutically with patients by building relationships with them. However, they felt defensive practice dominated their working lives, which impeded their capacity to do therapeutic work.

Figure 5.

Figure 5

Thematic map for research question two



Discussion

Summary of Findings

This study investigated the experiences of staff working in CMHTs, and their perceptions of the effectiveness of CMHTs for patients. Interviews conducted with 17 staff members (six psychological therapists, six medics and five care coordinators) painted an overwhelmingly negative picture of the CMHT system for both staff and patients. Yet despite the difficult reality they worked within, many staff retained hope that it could be better, and the care they felt for their patients was a dominant theme in their narratives.

The first research question investigated the experience of working in contemporary CMHTs. Across the disciplines, staff described their roles as stressful, anxiety-provoking, and sometimes traumatising. They described roles that were physically taxing as they struggled to work with large caseloads of patients with complex needs. Some reflected that they distanced themselves from patients as a way of coping with their feelings. Interestingly, psychology was felt to exist outside of the acute pressure felt by the rest of the CMHT to some degree. It was clear from the stories told by the staff that they cared deeply for their patients and wanted to help them get better.

The second research question investigated what staff felt was working well, and not so well, in the current CMHT system. The CMHT appeared to lack a coherent plan for how to guide patients through the service from point of entry to discharge. Staff held different notions of what constituted recovery, which confused care plans while also contributing to experiences of moral distress as staff felt that patients were sometimes being prematurely discharged. Staff felt that referrals to other parts of the CMHT could be unnecessarily complicated, and they had noticed a pattern whereby patients were referred on to other parts of the CMHT, or even external agencies, when they had completed a piece of work or when a

team felt stuck with what to do. Psychology in particular was concerned about the implicit messages this was passing to patients.

The CMHT was described as struggling to manage the demand placed upon it by the number of patients it was expected to support. Staff discussed the problems for both staff and patients caused by extensive waiting lists that the CMHT was currently holding. Staff felt that specialist services held strict criteria, which meant that patients who did not fit elsewhere ended up under the remit of the CMHT. The large volume of requests for ASD and ADHD assessments received by the CMHT was frequently given as an example of a specialist request being made of the service that it was unable to honour. Staff talked wearily about the service transformations they had lived through. This was positioned as a failure effectively to manage the demand, which necessitated further transformation. Rather than reflecting on which iteration they thought was best or proposing what they thought would be a better system, staff came across as disillusioned and burnt-out by cycles of change.

Staff shared that wider, systems-level difficulties, in the current UK context directly impacted the perceived effectiveness of the CMHT. Staff felt that problems with social care, particularly meeting housing needs, and a trend in diagnostic expansion created a toxic combination both for patients and the CMHT. Staff felt that a patient's distress could sometimes be mis-labelled as a mental health problem bringing it, therefore, under the remit of the CMHT which had little power to enact meaningful change. For patients, staff felt this created a stigmatising system, which also risked repeating harmful relational patterns in the way the service interacted with individuals.

With few exceptions, staff expressed the desire to work therapeutically with patients, and they felt that building solid relationships was one of the fundamental facilitators of change. Staff felt that they worked within a culture characterised by defensive practice whereby risk management dominated the available clinical time at the expense of what staff

described as ‘lower-level’ and preventative work. This was discussed most commonly in relation to the perceived prioritisation of patients with a diagnosis of PD, over those with what some staff called ‘serious mental illnesses’, such as psychosis and bipolar disorder. Yet despite the list of dysfunctional aspects of the CMHT, staff were able to hold that some aspects of the system were working well. Staff described the basic CMHT structure comprised of CCs, psychological therapists, medics, support workers, and administrative staff as functional and providing them with what they needed to support patients. That there was no gap perceived in the make-up of the staffing team is an important finding of this study. Care based on relationships and human connection seemed to be at the core of what staff wanted to provide, and what they felt patients wanted and needed. Staff across the disciplines generally wanted to have the space and time to get to know their patients, and they often wanted to have the ability to work with them over the longer-term, if doing so was clinically indicated.

Transferability

The results from CMHT A painted a bleak picture of contemporary CMHT services. In order to explore the transferability of the findings from CMHT A, group interviews were conducted with CMHT staff in February 2026. The remaining four CMHTs in the region consented to participate. NHS and University of Essex ethics applications were granted for the interviews (Appendix J and K). Appendix H and I show the participant information sheet and consent form. In total, four staff members from the same CMHT (CMHT B), who were all psychologists, volunteered for interview. Two interviews were conducted, each with two participants. The limited sample itself raised questions about the extent to which the group interviews were transferable. The absence of CCs or medics from the sample undoubtedly rendered the results biased towards psychological professionals. However, it may be symptomatic of the strain in the CMHT system that some staff could not volunteer their time

for research. That psychology staff either had the time, or valued research highly enough to volunteer what time they had, reflects the results from CMHT A that psychology had a little more space and time for reflection than the other disciplines. It may also reflect something about the reflective nature of psychological training, or the natural bent of those who chose to work in psychology rather than more traditional medicine.

The group interviews broadly revealed that CMHT staff across the region found the results to be applicable to their services, with one key exception. Staff agreed that there was an overwhelming focus on risk management. In particular, staff felt that this affected CCs disproportionately. There was also frustration expressed about the rigidity of services surrounding the CMHT, which was felt to make the work of staff harder as they struggled to support patients whom they did not feel were always appropriate for the CMHT. When discussing the culture of referring on, staff said that they felt it was reflective of overwhelm in each part of the system leading to a breakdown in the ability to work together, and they agreed that it could cause inter-disciplinary tension. They agreed that each professional group frequently appeared stressed and anxious at work, and they felt that CCs were under the most acute pressure. They also felt that the move towards shorter-term working was a contributory factor as patients often received an incomplete dose of what they needed, which necessitated the referral onto another professionals. Ultimately, the CMHT was seen as a service to hold people and stabilise them, rather than a service aiming to do meaningful therapeutic work. This was at odds with what the staff had come into community care wanting to do.

Staff also agreed that the CMHT was significantly affected by systemic factors over which they had little control. For example, the lack of safe, appropriate housing was seen as a significant barrier to engagement in therapeutic work over which CMHT staff had little control. Staff talked about the impact of poverty on mental health conditions, and they

wrestled with their own moral doubts about pathologising understandable reactions to difficult circumstances.

The key finding that differed between the group interviews and interviews in CMHT A was the lack of a coherent PD pathway in CMHT A. Staff explained that their services had something akin to a 'personality disorder and complex needs pathway', which was staffed by people with specific experience and training. The importance of joined up, relationship-based care was explained, and staff talked about how they felt this approach had been successful for the patients they had worked with. Staff felt upset to hear some of the language that was used to describe patients with a diagnosis of PD in CMHT A. They felt it represented an antiquated view of patients with a PD diagnosis that did not have a place in contemporary NHS services.

In conclusion, the group interviews revealed that CMHT staff in the region felt the findings were broadly applicable to their working lives. In particular, they agreed that the CMHT was a stressful place to work and that the focus on risk management, while understandable, limited the therapeutic capacity of the service. Staff also felt that the effectiveness of the CMHT was reduced by broader factors over which they had little control. Notably, however, the lack of a coherent PD care pathway in CMHT A was not felt to be applicable more widely in the region.

Discussion of Findings

The transferability of a study's findings can also be explored by considering the results in relation to existing literature. Therefore, the following section will consider the main findings in relation to existing literature before discussing the implications for NHS policy and practice. The implications of poor staff wellbeing and the ethics of reliance and reform narratives are considered. An exploration of the role of relationships in managing and

recovering from mental illness is presented alongside a cybernetic explanation of the CMHTs functioning.

Poor Staff Wellbeing

Impact on Care, Services, and Budgets

Though staff felt hopeful that they had been able to help some patients, and that the CMHT system would improve over time, staff wellbeing seemed poor across the disciplines, and CCs appeared to be under the most acute pressure. This finding supports a growing evidence base showing that staff in care coordination positions in mental health settings are struggling (Crawford et al., 2008; McKeown et al., 2024; Simpson, 2005; Thompson et al., 2008; Wall et al., 2024). Across the disciplines, staff felt that their jobs were objectively stressful due to holding large caseloads with a large workload attached to them. However, they also experienced moral distress in their roles. These results mirror those in the systematic review (p. 47-54), which also found that negative experiences of CMHT roles were mediated by working under pressure and feeling constrained in therapeutic practice. For instance, Thompson et al., (2008) found that working with patients deemed to be high-risk often made staff feel anxious at work, while also affecting their personal lives as staff worried about those patients when they were at home. Sambrook et al., (2025) found that CMHT services were working under what they called ‘crisis conditions’, and that consequently, staff felt the CMHT rarely offered hope of recovery as the ability to do actively therapeutic work was limited. This constancy of crisis spanned the nearly 25 years the studies covered and was found also to be the case in CMHTs in Essex.

Research from across the health service shows that poor staff wellbeing is associated with workforce instability, lower patient satisfaction, and poorer service delivery. In a study of mortality risk in general hospitals in the UK, Moscelli et al. (2024) found that higher turnover rates among nurses and doctors was associated with higher patient mortality rates.

The authors hypothesised that a loss of continuity of care, less attention paid to preventative measures, and insufficient staffing to carry out necessary tasks, contributed to the overall increase in mortality risk. The evidence also suggests that poor staff wellbeing is associated with an increase in medical errors (Garcia et al., 2019; Hall et al., 2016; Li et al., 2024), while staff who report feeling more engaged in their roles make fewer clinical errors (Janes et al., 2021). Bragge et al. (2025) found that patient experience and satisfaction were impacted by staff wellbeing, principally because staff who felt well were available for patients, they communicated more effectively, and they spent more time with them. This evidence presents a convincing picture of the importance staff wellbeing should hold within healthcare organisations as it is strongly associated with patient satisfaction and clinical outcomes. The results of this study point to poor staff wellbeing in CMHTs in Essex, particularly in care coordination roles, supporting the need for a national focus on improving staff wellbeing.

From a financial perspective, reducing staff turnover also requires urgent attention. In the financial year ending March 2022, the NHS lost 40,365 nurses to retirement, the private sector, or other healthcare systems in other countries, which represents 11.5% of the nurses in the total NHS workforce (Palmer & Rolewicz, 2022). The estimated cost of replacing a fully trained nurse is up to £12,000 per appointment, creating a total cost of up to £484 million each year to replace lost nursing staff alone (NHS Shared Business Services, 2022). As this figure represents only one profession, the total cost to the NHS of replacing lost staff is likely to be substantially higher. The estimated cost of turnover is related to hiring costs, onboarding and training, the loss of productivity during post vacancy and onboarding, and the use of bank and agency staff (De Vries et al., 2023). Estimates for what the use of agency staff costs the NHS vary widely. The government reports that spending on bank and agency staff increased by 51% between the financial years 2018/19 and 2021/22. It reports that in the financial year ending March 2023, NHS England spent £3.5 billion on agency staff alone

(House of Commons Library, 2024). However, a report in the British Medical Journal (BMJ) estimates the total spending on temporary staffing to have reached £8.9 billion in the previous financial year ending March 2022 (Waters, 2022). Total healthcare expenditure in England in the financial year ending March 2023 was £153 billion (NHS England, 2022). Thus, the use of bank and agency staff represents somewhere between 2.3% and 5.8% of total NHS expenditure. While the exact figures are hard to ascertain, it is clear that the cost of using temporary staff is a significant drain on NHS budgets. Interestingly, the use, and impact of, bank and agency staff in the team did not appear in the interviews though a number of posts remained unfilled at the time of data collection. It is not clear why this happened, and future research should seek to understand the impact of bank and agency staff use in CMHT settings as this group of staff were specifically excluded from this study.

Poor staff wellbeing also has an impact on the number of staff absent from work, and how long they are absent for. A recent report estimates that absenteeism caused by sickness costs the NHS £2.4 billion per year. As one of the largest employers in the world, with 1.3 million employees as of 2021, problems in the NHS have a major impact on the UK economy (Adams et al., 2024). Prior to the Covid 19 pandemic, the leading cause of NHS staff sickness was mental ill health, which was reported as the principal reason for absence in 25.4% of cases. This figure peaked at 32.4% during the first wave of the pandemic in 2020 (Adams et al., 2024). Mental health staff have been found to have poorer wellbeing on average compared to counterparts working in physical health settings (Johnson et al., 2018). Evidence also suggests that new graduates entering the workforce have higher psychological needs than previous generations (Hernandez et al., 2020; Stevanin et al., 2018). This suggests that greater support is needed than for previous staff cohorts, particularly during periods of high stress or transition, such as working through a pandemic or transitioning from trainee to qualified roles.

The evidence clearly shows that poor staff wellbeing costs the NHS money in staff turnover, absenteeism and in the use of bank and agency staff. Poor staff wellbeing worsens outcomes for patients also: staff make more mistakes, they are less engaged in their work, and they do not communicate as well with patients. These findings were borne out in the testimony of staff from CMHTs in Essex.

NHS Initiatives to Improve Wellbeing

The evidence clearly shows that poor staff wellbeing negatively affects outcomes for patients and costs the NHS a considerable proportion of its budget. A number of initiatives have been developed across NHS trusts in an attempt to improve staff wellbeing and change organisational culture. Research evaluating these initiatives suggests that they can produce modest improvements in staff wellbeing and workplace satisfaction, particularly where interventions are developed collaboratively with staff and target organisational factors, such as high turnover rates, rather than focusing solely on individual resilience (Ravalier et al., 2022). However, the existing literature also consistently highlights that such initiatives have limited impact when implemented within systems that still struggle with understaffing, excessive workloads, and limited resources. Reviews of wellbeing interventions in healthcare settings therefore conclude that while supportive programmes may provide short-term benefits, they cannot fully address the systemic drivers of stress and burnout that continue to shape NHS working conditions (Bajorek & Holmes, 2020; Teoh et al., 2023). As a result, there is growing recognition that wellbeing initiatives alone are insufficient, and that meaningful improvements in staff wellbeing require broader organisational and structural changes.

The Ethics of Resilience and Reform Narratives

Those in positions of power face the dilemma of whether to allocate resources to programmes aimed at supporting and improving staff resilience, whether to focus on trying to

rectify the root causes of staff and patient distress, or whether to divide the available funding and allocate a smaller amount of resource to both. From an ethical standpoint, supporting staff resilience has several advantages. Healthcare systems inevitably involve difficult trade-offs, such as making decisions about where resources are allocated and managing competing obligations to different patients. These factors in some ways make moral adversity an unavoidable feature of the working life of healthcare staff. In this context, equipping clinicians with the skills to manage the ethical challenges they will face may be necessary to preserve both their wellbeing and high-quality care (Rushton, 2022). If clinicians feel unable to cope with these pressures, the consequences may include staff going off work sick, high turnover, and reduced quality of care (Spilg et al., 2022). Supporting staff to remain engaged and functional within an imperfect system may, therefore, be ethically justifiable as a pragmatic response that protects both patients and the healthcare system.

However, resilience-based approaches have also attracted substantial ethical criticism. Emphasising the importance of individual adaption risks obscuring the structural causes of moral distress over which individual clinicians have little direct control, shifting responsibility from institutions to individuals. In some cases, the resilience discourse can inadvertently reinforce a form of responsibilisation, whereby healthcare professionals expect, or are expected to, compensate for systemic failures through personal coping strategies (Loyal et al., 2025). For example, clinicians report that on top of their normal duties, they feel compelled to over-function, essentially to do extra work, to overcompensate for institutional constraints. Doing so increases physical exhaustion without rectifying the underlying impediments to the provision of quality care, ultimately amplifying moral distress as clinicians continue to experience situations in which they are unable to act in accordance with their professional values (Loyal et al., 2025). It is possible, therefore, that resilience-based approaches risk becoming a mechanism through which organisations implicitly expect

clinicians to tolerate ethically problematic conditions. Tomkow et al. (2024) argue that the concept of moral resilience may unintentionally encourage healthcare workers to endure moral adversity rather than challenge the systems that produce it. In this way, resilience-based approaches operate as a form of oppression for both staff and patients. If resilience training is implemented without addressing underlying organisational problems, such as chronic understaffing, or restrictive policies, it may effectively normalise those conditions.

However, many argue that it is also ethically problematic for NHS leaders to refuse to engage with resilience-based approaches until systemic change occurs because doing so leaves staff entirely without support. In a world where budgets could be stretched without consequence, NHS leaders would likely engage with both resilience-based approaches supporting staff wellbeing in the present, while also allocating resources and funding to enacting meaningful systemic change. Yet this is not the world we live in in 2026.

The results of this study present an urgent case for trying to improve staff wellbeing in CMHTs. Doing so is likely to involve both the provision of direct support to staff, such as through regular supervision and access to wellbeing hubs, as well as materially improving their working lives, such as by reducing workloads and paying staff for overtime.

Effectiveness of the CMHT

The impact of poor staff wellbeing on patient outcomes and NHS budgets is well established in the literature and was supported by the findings of this study. Consistent with the existing literature (Trevillion et al., 2022; Wall et al., 2024) staff felt the predominant failure of the CMHT was the failure to work relationally. The offer of care was described as time-limited, lacking continuity, crisis-focussed, and disproportionately benefiting those who knew to ask, or were able to ask, for help. Staff seemed to share the perception that healing happens predominantly through relationships rather than through specific treatment

protocols, and that the question of ‘what are we doing’ had become a distraction from the importance of being alongside people.

The Role of the Relationship

The results revealed that staff viewed strong therapeutic relationships as a key agent of change for their patients. This finding may be understood through the lens of object relations (OR) theory, which suggests that through the experiences of relationships with caregivers (objects) early in life, humans develop a set of internalised representations of relationships with others, mental representations of others, and mental representations of the self (Flanagan., 2008). These representations work as powerful, usually unconscious, forces guiding how the person moves through the social world (Flanagan., 2008). Winnicott (1955) presents the therapeutic relationship as the ‘holding environment’ or ‘container’ for the patient, a psychologically safe space through which they can move from a place of absolute dependence to relative dependence, and eventually to independence. For the holding environment to do the holding, it must be able to tolerate that which is projected into it (Obholzer & Roberts, 1994). Obholzer & Roberts (1994) argue that the container, be that a person or a service, must be in a depressive position; able to hold both the good and the bad, put simply, of a person’s character. A container in a paranoid-schizoid position splits the world into good or bad, accepting and rejecting accordingly. The authors go on to argue that health and social care organisations often unconsciously adopt the paranoid-schizoid position to avoid the anxiety associated with their central function; trying to heal those with mental health problems (Obholzer & Roberts, 1994). For mental health services, that anxiety is the patients’, the staff’s, the organisation’s, and wider society’s anxiety.

Applying OR theory to the results of this study, the presence of the paranoid-schizoid position can be seen in the way staff groups talked about each other as refusing referrals or responsibility. It can also be seen in the way that some staff talked about those with what they

called ‘serious mental illness’, suggesting this group deserves help which cannot be effectively offered due to the group of patients with PDs who ‘are not really suffering’. In the psychoanalytic frame, the positioning of ‘serious mental illnesses’ at the opposite pole to PDs on the suffering, deserving spectrum is a classic example of splitting, a process by which a person or group of people are seen as, for example, exclusively ‘good’ or exclusively ‘bad’, with any nuances, ambiguities, or ambivalences unconsciously denied.

The general view is that containers require containment from a third party to carry out their role effectively (Flanagan, 2008). For instance, if one container is an infant’s mother, the third party (the container for the container) is the co-parent. Applying this concept to healthcare organisations, Flanagan (2008) argues that staff’s capacity to contain is dependent upon the following: the relationship quality with the service user, staff’s personal resources, the quality of the relationship between staff and management teams, and the resources available to complete the work. The relationship between staff and organisations is particularly pertinent to this research as it is the factor over which policy makers have the most direct power. The results of this study suggest that staff generally lacked the organisational containment required to mirror that containment towards their patients. Staff feared losing their licences if a serious incident occurred. They feared coroner's court, and the blame apportioned through inquest proceedings. They feared losing their patients and having to cope with the grief while their caseload was promptly filled with the next referral. There is, therefore, a clear need to expand upon containing mechanisms for staff in CMHT services in order to improve the offer of care for patients.

There may also need to be a fundamental shift in the way that dependency is viewed in CMHT services. Staff were split over whether they felt dependency was expected in the context of a specific diagnosis, such as psychosis, or whether dependency resulted from the failure of the CMHT to encourage independence. Dependency was not explained on a

trajectory along which patients move. Dependency was explained as a state in which a patient either dwelled or not. This demonstrates the need for a greater understanding of the attachment needs of CMHT patients, and how they might best be met by staff and organisations.

The Role of Modalities

The results of this study showed that many staff wanted to be able to prioritise therapeutic relationships in their work. A large proportion of the research landscape is filled with studies asserting the benefits of a particular therapy modality over another for specific diagnoses. In western healthcare systems, CBT in particular has been the focus of a considerable effort to demonstrate its effectiveness, the result of which is an NHS TT service dominated by CBT protocols. However, the focus on specific modalities has long been questioned. The Dodo Bird Effect suggests that different therapeutic modalities produce ostensibly similar results when pooled and that common factors, such as the therapeutic relationship, are the key facilitators of change (Luborsky et al., 1975). Subsequent meta-analyses have supported these claims (Barth et al., 2013; Wampold et al., 1997). Barth et al., (2013), found that where specific therapies were shown to be marginally more effective than others, the effects were due to larger sample sizes, and the effects being tested more often. Perhaps more troublingly, although psychological therapies are often found to outperform waiting-list control conditions, the effect sizes are frequently modest and may be inflated by the use of waiting-list controls (no intervention) rather than care as usual (CAU) conditions (e.g. another evidence-based psychological therapy) (Cuijpers et al., 2024; Laws et al., 2022). The use of waiting lists as control groups has been considered to reflect the ‘natural course of disease’, however, many argue that waiting lists should be considered ‘nocebos’ because waiting for therapy is not neutral. For example, participants may be motivated, consciously or unconsciously, to remain unwell in order to receive the treatment they originally sought

(Patterson et al., 2016). These findings present a particular problem for psychological therapists, most especially those trained in the scientist-practitioner model: what is it that they have trained to do, and what can they actually do for those people coming to them for help? Giving staff a space to explore and address these questions may be an important step to reduce feelings of moral distress in the role. The Dodo Bird Effect also supports what staff generally felt to be important, the therapeutic relationship. Notwithstanding the utility of specific therapies, a care system focussing on 'what to do' rather than 'how to be' with someone is likely to be less effective.

Approaches to community care outside of the UK

The question of how to be with people who experience mental illness is one that is answered very differently across the globe. It is far beyond the scope of this thesis to systematically consider the similarities, differences, benefits, and drawbacks of those different systems. Nor is it possible to compare the UK system with the systems that some participants trained in, as doing so would likely make them identifiable in CMHT A. However, any attempt to reform the CMHT system should seek to learn from other models of care both in terms of what is possible within a national system of care, and what would meet the needs of an evolving population.

One example of how care in the community can be operationalised differently to the CMHT system is the Trieste model, chosen here to fit within the largely Eurocentric focus this thesis has adopted. The model was developed in the 1970s by the Italian Psychiatrist Basaglia, making it a contemporary of the UK's model of care in the community (Allison et al., 2020). Basaglia argued that the asylums caused and exacerbated the symptoms of severe mental illness through extreme deprivation of liberty and loss of bodily autonomy (Allison et al., 2020). Heavily influenced by thinkers such as Foucault, and Satre, Basaglia's new model of care was based on the principle that 'freedom is therapeutic' (Allison et al., 2020). This

was operationalised as the ‘Trieste model’, a radical alternative to institutional care, which funded only 2.5 beds per 100,000 of the population (compared to 37 per 100,000 in the UK in 2022), and instead prioritised outpatient treatments in 24-hour community mental health centres (Allison et al., 2020; Royal College of Emergency Medicine, 2022). These centres are staffed by MDTs who aim to provide continuity of care, regardless of diagnosis and severity, in a way that prioritises meeting people’s physical, social, and economic needs, and preserves their legal rights as citizens (Sashidharan, 2022) The Trieste model holds a strong value that living a ‘normal’ life with mental illness requires the community to be accommodating of difference while also holding expectations of individuals that they will work and participate in their community (Portacolone et al., 2015). The Trieste model has been widely praised for its successful treatment of the severely mentally ill without the need for restrictive practices (Sashidharan, 2022). Indeed, it led to the closing of psychiatric hospitals in Italy. However, the model’s success in the less affluent areas of Italy has been widely questioned. Trieste’s relative affluence and ageing population allowed for the utilisation of available housing stock, which provided the mentally ill with affordable, comfortable accommodation, a specific set of circumstances that do not apply nationwide (Portacolone et al., 2015). The model has also been criticised for what is perceived as scarce attention being paid to the recording of individual outcomes in a recognised, scientific manner (Carta et al., 2020).

The Trieste model demonstrates that care in the community can be operationalised successfully using strong ethical principles with adequate staffing and funding. Indeed, many of the themes derived from staff testimonies, such as relationship-based care, point towards staff and service users valuing core components of the Trieste model. For example, providing continuity of care, and working with social stressors as an integrated part of recovery from mental illness. The CMHT system as it currently exists could do so by implementing a thorough initial MDT assessment, which is discussed in the policy implications section

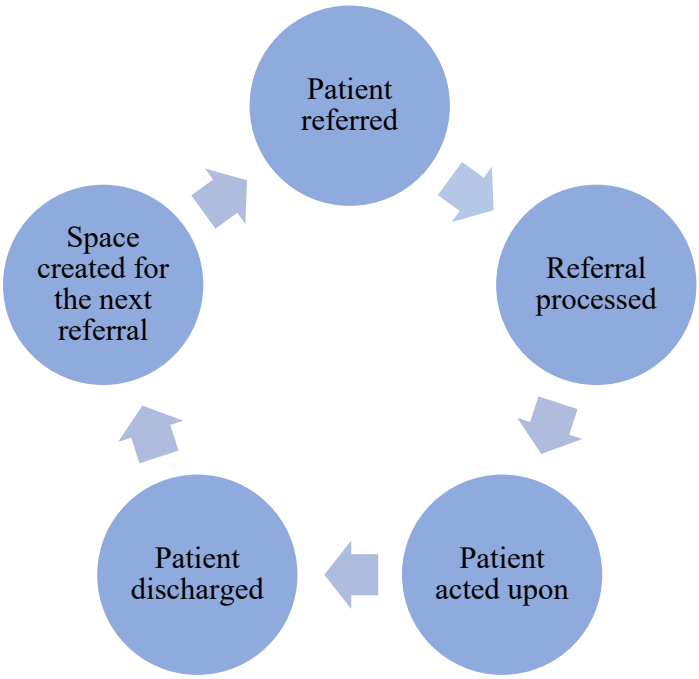
below. This thesis has adopted a largely Eurocentric focus, principally for pragmatic reasons, and in an attempt to provide an anthropological perspective in all its richness to the life of CMHT staff. It is acknowledged that doing so has been at the expense of the diversity of perspective that exists in the global community. Much can and should be learnt (either by way of inspiration or warning) from how the Americas, indigenous communities, the global south, totalitarian states, and those not accounted for within these categories understand and respond to human distress. Future research should seek to elicit those principles in a systematic manner, and to consider how they may inform UK service provision.

Homeostasis

The results revealed that staff felt helpless and hopeless in the CMHT system, which seemed to emphasise throughput over therapeutic intervention. Returning to the principle that 'the purpose of a system is what it does', it might appear that the purpose of the CMHT is to receive, process, act upon, and close referrals (Figure 6) (Beer, 1985). Viewed through this lens, CMHTs can be viewed as producing the conditions in which relational care is compromised. In particular, chronic resource constraints, a dominant risk-management culture, and a highly bureaucratic workload regulate the activities of the CMHT to create an anti-relational care system. In the current system then, any move towards a more relational focus (positive feedback) is likely to increase the backlog of referrals and add to waiting lists, which necessitates a return (negative feedback) to a more procedural focus to maintain homeostasis in the system. In this framing, the negative experiences staff described are not personal failings that occur in a benevolent system, they indicate something important in the system's operation. This framework, therefore, supports a shift from locating distress within individuals to an understanding of how institutions and broader structures of power generate suffering, presenting a need to consider systemic rather than individual change.

Figure 6

Cybernetic diagram



Systemic Change

The results of this study suggest that there can be little meaningful reform of the CMHT system without a much wider, fundamental change in a number of key factors affecting the CMHT. Perhaps inevitably, the study raised more questions than it answered. For example, should patients with psychosis and PD be under the same team? How could the welfare system better support recovery from a period of mental illness? How could 'low visibility' and preventative work become more highly valued?

Large scale 'scrap and rebuild' reform of healthcare systems is rare. Most countries reform incrementally within an existing model rather than replacing the whole system with a fundamentally different one. However, there are several historically important cases where healthcare systems were radically restructured or replaced after political or economic upheaval. Perhaps the most relevant example is the creation of the NHS in 1948. The NHS replaced a fragmented mixture of voluntary hospitals, municipal services, and insurance schemes with a tax-funded, universal, health service. The reform was part of the wider

reforms inspired by the Beveridge Report (Webster, 2002). Beveridge proposed that different forms of social risk should be addressed through distinct institutional systems, with ‘disease’ addressed through a universal national health service while ‘want’ was addressed through social security mechanisms (Beveridge, 1942). Consequently, when the NHS was established, it was designed as a nationally organised universal healthcare system, providing services free at the point of use according to need, whereas social care and welfare benefits developed through separate administrative and funding arrangements, which were often organised by local authorities and subject to means testing (Barr, 2012; Klein, 2013). Social care in particular evolved as a support for daily living and social functioning rather than medical treatment, which reinforced its governance outside the NHS despite the overlap in populations served (Glendinning, 2012).

However, health policy experts have long argued that this structural separation creates fragmentation for patients with complex or long-term conditions who require coordinated support across health and social care (Curry & Ham, 2010; Glasby, 2017). For example, a recent systematic review of research on housing insecurity found consistent associations between housing instability and poorer mental health, including depression, anxiety, and psychological distress (Carrere et al., 2022). Similarly, a large systematic review and meta-analysis looking at the prevalence of mental health difficulties among people experiencing homelessness found that 67% of people experiencing homelessness currently had a mental health disorder, compared to 20-23% of the general population (Morris et al., 2025). These findings fit with staff perspectives in this study that there is a clear link between housing status and poor mental health.

Fragmented systems can lead to duplicated assessments, gaps in care, and inefficient use of resources, such as delayed hospital discharges resulting from insufficient social care provision (Glasby et al., 2006). As a result, a substantial body of policy and academic

literature advocates for greater integration of health, social care, and welfare services in order to deliver more joined-up, person-centred care, and to address the broader social determinants of health (Goodwin et al., 2012). The results of this study support the movement for a more joined up care system. Whether the social care and welfare systems should be integrated into one universal system is outside of the scope of this research and is probably more on the scale of an independent commission. Though radical and ambitious in scale, movements in this direction are already being made. For example, the Independent Commission on Adult Social Care led by Baroness Casey is due to report in 2028. Interim findings seem to point to a call for 'national reckoning' akin to Beveridge's reforms in 1948.

Organisational Transformation

The results suggest that the majority of the factors that influence the effectiveness of the CMHT exist outside of its control. Principally, these factors were the number of referrals received, the number of staff, the criteria of specialist services, housing insecurity and problems linking with social care. Therefore, the implications for CMHTs in terms of what they could do to improve their offer of care and their staff's wellbeing was seen to be limited. However, there were a few key areas where it was felt that CMHTs could exert some agency over their functioning. The areas discussed in this section will be those felt to be reasonably transferable, as explored in the group interviews.

The results revealed that staff generally lacked sufficient experience of containment across disciplines. Therefore, policy makers should seek to introduce or expand initiatives that are known to help contain staff anxiety, such as regular clinical supervision and reflective practice spaces. Staff may also benefit from a structured forum in which to air their grievances with other disciplines as this may help to resolve problems rather than allowing them to fester below the surface of professional interactions. Staff are likely also to benefit from feeling valued by the organisation. This may be demonstrated by, for example, paying

staff for overtime and making it possible to take time off in lieu (TOIL). It may also be demonstrated by allowing staff to take time out of their working day to attend wellbeing hub appointments or individual therapy.

The results suggested that there is a particularly urgent need to review the care of patients with PD diagnoses, a group who may be at greater risk of harm from inconsistent or absent relational care. Significant variations in management plans appeared to exist across the Essex region, creating a postcode lottery. Commissioners in the region should seek to implement evidence-based care pathways for this group of patients, and to ensure services have the capacity to implement them.

Policy Implications

The results also revealed that patients are required to tell their story many times to different, unknown, clinicians in order to receive support. Staff highlighted that this system privileges those who recognise they are unwell and are able to ask for help. A meaningful reform of the wider CMHT or secondary care system, therefore, may be to return to a previous iteration of the system where a thorough MDT initial assessment was carried out at the point of entry to the service. This approach would confer the benefit of familiarising patients with different professionals from the beginning, reducing the number of times they are required to tell their story, and supporting a joined-up approach whereby the service begins with a coherent plan of how to help and work with an individual. This approach may also aid the practice of planning the end of an intervention from the beginning, which may alleviate some of the difficulties this study found in defining recovery and staff feeling compelled to refer on to other professionals to avoid an ending.

The results pointed to an undervaluing of what staff called ‘low-level’ therapeutic work such as meeting a patient for lunch, accompanying them to appointments or calling them to check-in regularly. In a system that is, understandably, so focussed on crisis

management, it is not surprising that these lower visibility activities are not prioritised. However, the results pointed to both the therapeutic and preventative values of these sorts of activities. Future research should seek to establish their value in secondary mental healthcare settings.

Dissemination

It was decided at the inception of the study while discussions were ongoing with the service lead of CMHT A that the results would not be fed back to the service directly. This was borne out of the service lead's concern that individual staff could be identified by their opinions and face difficulties at work. It was therefore decided that direct service feedback would not be undertaken. Instead, it was decided that an article would be written up for publication in a relevant journal. If staff do want to read the final report, they will be able to access it through the University of Essex's Research Repository.

Methodological Critique

Design

The study broadly followed the qualitative design of the papers reviewed in the systematic review. This was because the study aimed to explore the experiences of each participant, and to access their thoughts about what helped and hindered patients. Semi-structured interviews were chosen in preference to structured or unstructured interviews because it was felt that this method would offer the best balance between covering the necessary, relevant topics, while giving participants the freedom to explore their own sequence of ideas.

Strengths

A well-established methodological critique in qualitative research is that many studies fail clearly to articulate their epistemological position. A review of published qualitative

studies using thematic analysis found that many papers failed to explain their theoretical or epistemological assumptions despite the analytic methods depending on them. Without a clear epistemological stance, readers cannot determine how knowledge was produced or interpreted, making it difficult to evaluate methodological congruence between design and analysis (Braun & Clark, 2024). Similarly, Olmos-Vega et al. (2023) argue that reflexivity and philosophical positioning are frequently addressed superficially or entirely omitted, which obscures the role of the researcher in knowledge production. This research has attempted clearly to explain the epistemological positioning of the design and analysis, and to acknowledge the researcher's role in shaping the evolution of the study.

Another strength of the design was the inclusion of a PPI phase early in the research. A growing body of evidence supports the use of PPI in healthcare research as a way of producing higher quality research as the voices of the participants are centred from the very earliest stages of the research design (Modigh et al., 2021). The development of the interview schedule therefore relied heavily on feedback from the PPI interviews. It has also been suggested that the inclusion of PPI interviews can aid dissemination and improve the applicability of findings to institutions and populations of people (Arumugam et al., 2023). This was certainly the case in this research as staff disillusionment with cycles of change in the NHS emerged as a key source of dissatisfaction among staff, clearly highlighting the need for carefully considered service transformations in the future.

The design attempted to privilege equally the voices of different professional groups within the CMHT in order to understand how the groups were affected by pressures in the system, and how they functioned as a whole. Existing literature overwhelmingly focussed on each group in isolation, which was felt to provide rich data for each group but missed something important about group processes and overall functionality of the CMHT. The results were able to show that pressure from the system existed in each group, and there were

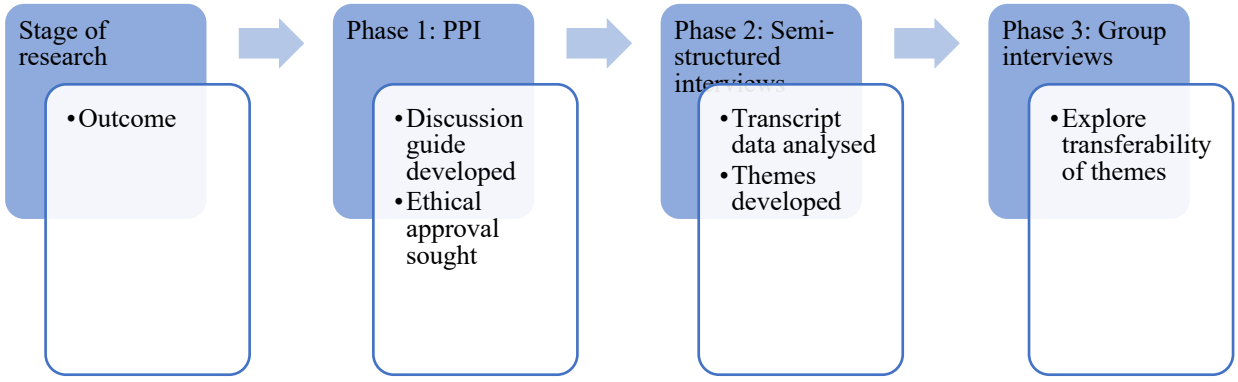
similarities in the way in which it was felt. However, the results also revealed tension between groups and a culture of trying to pass patients on to each other, which is an important contribution to the literature that is unlikely to have been possible if the design had focussed on one staff group alone.

Weaknesses

Perhaps the greatest weakness of the study design is the focus on one CMHT. This came about because the original design had to be scaled back due to difficulties recruiting participants. The original design followed the phases shown in Figure 7. Phase two was designed to be conducted in one CMHT in Essex. Phase three was designed to draw on staff perspectives from across the region by conducting group interviews to assess the applicability and transferability of the findings from phase two.

Figure 7

Phases of the research in the original design



The final study comprised phase one and two as intended, however phase three was significantly smaller than intended. All CMHTs in Essex were contacted about the study, and all consented to participate. However, recruitment was extremely slow and only two groups of two staff members, all of whom were psychological therapists, were able to be put together, significantly scaling back the original design. This meant that the final results skewed towards one service more than was originally intended.

The focus on one CMHT is potentially problematic as it is not known how representative CMHT A is of other CMHTs in the region or nationally. There are several risks to this design in particular. Firstly, it is possible that the organisational culture in CMHT A is particularly poor, affecting staff wellbeing within the team materially more than CMHTs more widely. It is also not known whether there are effects caused by the leadership, such as the denial of TOIL, which disproportionately impact staff wellbeing. Finally, idiosyncrasies of the local area, such as average socioeconomic status of patients and their access to suitable stable housing, certainly affect what it is like to work in CMHT A, yet it is not known to what extent these factors differ between CMHT A and the regional or national average.

It is the researcher's conjecture that the pressure felt by staff in CMHTs created a barrier to voluntary participation in research. Indeed, if staff are under such acute pressure that they feel they need to respond to crises at the expense of doing therapeutic work, it is perhaps not surprising that research participation during working hours would not feel very possible. It is also interesting in this sense that those who did volunteer were psychologists, who were felt in phase two to have more time and space for reflection in their work. The ultimate failure of phase three of the research then may be viewed as symptomatic of the stressors in the system, which were identified in phase two. However, further research is needed to understand the barriers to staff participation in this kind of research, and to understand how those barriers could be ameliorated.

Sample

The final sample comprised 17 interviews with six medics, six psychological therapists, and five CCs.

Strengths

The study aimed to go beyond what already existed in the literature to create a representation of the experience of CMHT work that included the perspectives of the core

professions that comprise the CMHT. The total data corpus comprised 17 interviews, creating 14.5 hours of data, with a further 1.6 hours of group interviews to explore transferability. This was deemed sufficient to reach data saturation as seen in the saturation grid (Table 4). It was not possible to recruit the sixth and final CC, which would have completed the sample. However, it appeared that data saturation had been reached, which suggests that ending with one fewer interview than desired is unlikely to have materially affected the results. While further interviews may have added weight and credibility to the findings, it is unlikely that new themes would have emerged by doing so. This suggests that the research has good content validity and reasonable credibility.

Very limited demographic data was collected in this study. This was an active design choice made to protect the identity of those participating from CMHT A in particular. The PPI interviews revealed that staff, particularly medics, were concerned that they could be identified from the interview data. The team lead of CMHT A was also very concerned about protecting staff's confidentiality. Anecdotally, the researcher was aware that while recording some characteristics, such as biological sex, was unlikely to make any individual participants identifiable, recording ethnicity in particular, would. The decision not to record demographic data has preserved the anonymity of the participating staff but it did so at the expense of exploring the experiences of minority groups in CMHT populations. Further research should certainly seek to do so as a wealth of research from other areas demonstrates that experiences can vary widely between majority and minority groups.

Weaknesses

Recruitment was extremely challenging at every phase of this research. For example, not a single participant volunteered having seen the study poster, which was physically present in CMHT A's base for six months and was distributed by email twice. The largest volume of participants was generated by the researcher being physically present in CMHT

A's base and asking staff to participate directly in person. This leaves the final sample open to the criticism that staff working remotely were likely not captured in the sample, and neither were those frequently out of the office on client visits. It is also likely that staff who recognised the researcher and who already had a working relationship with them were more likely to consider participation. This may explain why the interviews with psychological therapists occurred first, and were generally longer, than those conducted with medics and CCs. It also likely explains the difficulties with recruitment outside of CMHT A as staff across the region did not have a working relationship with the researcher. Indeed, three of those who volunteered for interview were previous colleagues of the researcher. It is difficult to suggest what future researchers may do to combat the problems with recruitment faced in this study. Having personal knowledge of the researcher may just be an integral factor to research of this kind while NHS services face the level of pressure under which they currently work.

In order to balance the desire for a breadth of perspectives with the desired depth of each interview, three professional groups were chosen to be interviewed. This decision left administrative staff out of the sample, which will have impacted the results as research suggests that administrative staff can have valuable insights into patient interpersonal processes and level of functioning. Administrative staff are usually the first point of contact with a service, meaning they frequently speak with patients who are emotionally dysregulated. This means that administrative staff utilise important clinical skills, and they generate valuable insights into patient patterns and experience of care-seeking (Strathmann and Hay, 2009). Future research should, therefore, seek to include administrative staff in collective experiences of working in healthcare systems. The sample also excluded those in training roles, new staff, peer support workers and support workers, and bank and agency staff. This decision was made in an attempt to ensure that staff being interviewed had

sufficient knowledge of the service to comment upon its functionality and reflect on their experience of being part of it. However, this approach meant the data did not capture the experience of onboarding or shorter-term working, both of which are likely to have generated slightly different experiences of CMHT work. As this group of staff are different in a few fundamental ways from permanent staff, it may be more useful for future research to examine their experience specifically.

The final phase of the study was designed to assess the transferability of the findings from CMHT A. However, there was no formal method of analysis used to conceptualise and present the data, leaving it open to methodological criticism. The greatest of these is perhaps the risk of confirmation bias, whereby participants would agree with the themes presented from CMHT A because they heard them explained. This is certainly possible, and it would be naive to suggest otherwise. However, the group interview participants did reflect on aspects of the results that did not feel relevant to their service, principally the lack of a coherent care pathway for patients with a diagnosis of PD in CMHT A. They also strongly opposed the language used to describe these patients and found it personally upsetting in some cases. This suggests that the participants critically engaged with the themes and were able to do more than simply affirm them.

Materials

The interviews were conducted in person and recorded using Microsoft Teams, or remotely, also using Microsoft Teams. A semi-structured interview schedule was used to guide each interview (Appendix C).

Strengths

The interview schedule appeared to provide a useful guide for the discussions. Participants were asked at the end of each interview whether they wanted to add anything that was not discussed, and rarely were any new topics raised at this point. The schedule seemed

to strike a balance between covering the key topics under investigation, while also allowing space for individual experiences to be explored.

The schedule specifically probed the positive aspects of staff's role before asking about the aspects they found more difficult. This approach appeared to work well as staff were generally able to reflect on positive aspects of their role and the system before feelings of disenchantment with it took hold. Therefore, the flow of the questions, which was informed by the PPI phase, worked well. The optional use of Microsoft Teams also appears to have aided recruitment. Some staff chose to do the interviews during admin time, which they did from home. All staff in phase three opted for remote interviews due to difficulties with room availability at their own bases. Therefore, the greater degree of flexibility that remote interviews offered appears to have aided difficult recruitment processes.

Weaknesses

It became apparent within the first few interviews that a question needed to be added to the schedule which specifically asked about whether some patients benefit more from the CMHT than others. This question was not anticipated during the research and design phases of the research, as it was not a clear phenomenon described in the literature. It was this question that generated the theme exploring staff perceptions that patients with a diagnosis of PD benefit more from the available clinical time at the expense of those with a diagnosis of, for example, psychosis. This is an example of a broader consideration of the research, its discursive nature. Though the PPI interviews were used to inform the development of the interview schedule, it was developed with the input of few people, and it is a not a peer-reviewed, validated measure of staff wellbeing or perceptions of effectiveness. For example, this study did not use widely accepted measures such as the Work-Related Quality of Life Scale (WRQoL), which captures workplace conditions, stress, and job satisfaction, all key determinants of healthcare staff wellbeing. (Van Laar et al., 2007). The decision was made to

use an interview schedule of the researcher's making principally because of the qualitative nature of the research. However, it is acknowledged that the researcher's professional experience and personal and academic views will have shaped the interview schedule in ways other academics may find favour or fault with.

Procedure

The individual and group interviews lasted for between 24 and 82 minutes. All of the interviews were transcribed by the researcher.

Strengths

The interviews lasted for as long as staff felt able to volunteer their time. Therefore, the greatest strength of this approach was the flexibility with which the research was conducted, which undoubtedly aided recruitment and participation. It was generally felt that interviews lasting for longer than 30 minutes were sufficient to explore all of the issues under investigation. Four interviews were shorter than 30 minutes, two with medics and two with CCs. While this may have meant that some nuance was lost within the views expressed by these professional groups, every topic in the interview schedule was still covered. Therefore, the interviews were included in the final data corpus as it felt they added important views to the research.

Weaknesses

The greatest disadvantage of the interviews with a shorter duration was that staff did not have the opportunity to debrief with the researcher after the interview ended. Though this information was not included in the data corpus, it was seen as an important act of care for the staff, which closely aligned with the researcher's personal ethics. However, all participants were offered the opportunity to contact the researcher for support if needed, and

staff were offered signposting information to local wellbeing services, though no staff requested them.

Inevitably, those interviews with a shorter duration lack some of the depth and nuance that was able to be explored in those interviews lasting for a longer duration. The only solution to this problem would have been to exclude the data or request a follow-up interview. The former did not feel necessary or respectful to staff who had volunteered their time, and the latter was requested but denied on each occasion. Therefore, the decision was made to include the data. It is acknowledged that this decision may impact the credibility of the findings, particularly those from the medic and care coordination subgroups.

Analysis

Reflexive thematic analysis (Braun & Clark, 2006; 2020), was used to analyse the data produced from individual interviews. The data collected from follow-up interviews was not formally analysed and instead is presented descriptively in the transferability section of the discussion.

Strengths

The data collected painted a detailed, nuanced, and complex account of CMHT life, which the themes reflected in their breadth and depth. This suggests that the analysis was able to capture something meaningful about the data. Verbatim quotes were used throughout the results to illustrate the themes, which adds to the credibility of the research. At times, lengthy quotes were included. This was done to reflect the importance a participant placed on a particular section of the interview to allow the reader an insight into the atmosphere of the interview.

Weaknesses

While the researcher frequently utilised academic supervision throughout the research process, it is undoubtedly the case that the analytic process is vulnerable to the idiosyncratic way in which it was done. The researcher independently read the transcripts, coded them, grouped the codes into themes and grouped the themes into superordinate themes without close scrutiny. The academic supervisor reviewed the themes and suggested some restructuring points, but never reviewed the primary data independently. Therefore, the organisation of the themes was reviewed, but the reflection of the data corpus in the themes was not assessed.

Krefting (1991) suggests a number of strategies for increasing the trustworthiness of qualitative research. Firstly, the analysis should demonstrate a clear connection between raw data and the interpretations, which was achieved in this study through the frequent inclusion of quotes in the results section. An attempt was also made clearly to explain how the themes were developed and refined, and the final themes were presented in a thematic map, which showed how themes related to each other. Krefting (1991) also advocates maintaining an audit trail to preserve the analytic decisions that were made, which was done in NVivo 14. However the research did not follow Krefting's recommendation around triangulation and member checking. The nature of this study required that the analysis be carried out independently but Krefting suggests that best practice should include secondary coding by another researcher, and discussion about and agreement upon, the final themes. It is of course possible that the supervisor could have coded the data and generated different themes. Triangulation was explored to some extent through peer-examination as the researcher regularly presented the method and findings to fellow doctoral students across the duration of the research. Finally, the absence of member checking (reviewing and checking interpretations with participants) is acknowledged by the researcher as a weakness in the analytic process. There was a reticence to do so for fear of contributing to existing

experiences of moral distress. However, retrospectively, the follow-up interviews to explore transferability may in fact have been more useful if the participants had been drawn from CMHT A.

Final Reflections

This project has challenged me in ways that I could not have imagined at the outset. I have had many moments where I have quietly asked myself 'what are we doing here?'. We, the professionals, are trying to help people but is any of what we are doing actually helpful? Is this research adding anything to the evidence base for the effectiveness of CMHTs? Or have I just embarked on a depressing voyage into NHS bureaucracy? Is this paper that I have written going to mean anything to anyone else, or will the pdf sit in an online library for the rest of time, never to be looked at again?

Despite my melancholy, what I have come to feel is a kind of affection for the CMHT system and, in particular, for the staff who choose to work in it. They mostly do so because they genuinely care for their patients. Most have no real control over the pressures they work under, and they plough on in the best way they can. I have come to appreciate the complexity of the mental health arm of the NHS, and I feel an almost manic drive to reform what I can, while also remembering how unhelpful staff feel the cycles of transformation have been. I am aware that the picture I have painted of CMHT services is overwhelmingly negative. I have tried faithfully to represent what staff told me. I think the ultimate call to action from this research is not to reform the CMHT system itself. It is something bigger, and far more nebulous. It is to have a genuine and honest conversation as a society about what we think mental health and ill health is, and how we want to respond to it. I feel that there can be no meaningful reform of the CMHT system without a compassionate and adequate welfare system, which supports people to independence and to find dignity in work, rather than keeping people trapped in cycles of dependency and poverty. While people live in insecure

and inadequate housing, mental ill health will be exacerbated and there will be little hope of meaningfully recovering. Though it was only alluded to in the interviews, I think that while negative immigration rhetoric and systemic racism exist to the extent that they do in society and institutions, minoritised groups will continue to suffer and present to mental health services. While healthcare systems operate with processes that keep staff and patients at arm's length of each other, the care being offered remains fundamentally inadequate and unsatisfying at the core, no matter how much money is spent on mental health services.

Without meaningful changes in these far broader structures, I think the best that we can hope for, recalling Beer's maxim that 'the purpose of a system is what it does', is a CMHT that does pretty much exactly what it does now: accepts referrals, holds them for a few years, and closes them again. In some ways I feel I have failed because it took me three years to reach this conclusion, which was perhaps obvious from the start. But perhaps the failure to be able to suggest significant reforms to a specific part of the mental health system is the contribution to the literature. We need to stop tweaking around the edges of problems, which implies that struggling is a failure of individuals, and spend our intellect, time, and money facing the big problems we have as a society.

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Appendix A: Example CASP Appraisal



CASP Checklist:
For Qualitative Research

Reviewer Name:	Anna Cooke-Sutton
Paper Title:	'A community in crisis': staff qualitative experiences of NHS and third sector mental healthcare in England
Author:	Sambrook et al., 2025
Web Link:	https://pmc.ncbi.nlm.nih.gov/articles/PMC12451547/
Appraisal Date:	15/10/2025

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☒Yes ☐ No ☐ Can't Tell 'We aimed to explore the perspectives of staff working in a variety of mental health services in North-West England, to elucidate the current standard of care provided and highlight areas for improvement.'
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☒Yes ☐ No ☐ Can't Tell Yes, the study was concerned with the experiences of staff working in mental health services, which lends to the qualitative methodology.
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	☒Yes ☐ No ☐ Can't Tell The use of 1:1 semi-structured interviews felt appropriate to investigate the stated aims. However, the study lacked a detailed explanation for why this method was used. There was also no mention of designing in ways to consider generalisability in the research.
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☒Yes ☐ No ☐ Can't Tell The procedure is described and it could be replicated. However, it could have been more clearly stated. For example, how were the participants approached?
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study*	

• *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☒Yes ☐ No ☐ Can't Tell Yes, the ontological and epistemological position is clearly stated, and the authors explain the implications for the analysis. Consideration is also given to the prior experiences of the researchers' and how this may have influenced the results. Consideration is given to data saturation.
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	☐Yes ☒ No ☐ Can't Tell No, while the prior experiences of the researchers are discussed in relation to the research, consideration is not clearly given to the influence these may have had on the interviews. There is also no reference to whether any challenges arose in the research process and how these were responded to.
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐Yes ☐ No ☒ Can't Tell An ethics statement is provided. The study also states that participants were given an information sheet and consent form to sign, though it is not stated whether the researchers went through the information sheet and consent for with participants or whether participants were given the option of asking questions or withdrawing from the study. There is no mention of whether any ethical issues did arise in the research process.
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained*	

• *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	☒Yes ☐ No ☐ Can't Tell The analysis process is described in detail and the results are written in a rich, informative manner.
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☒Yes ☐ No ☐ Can't Tell Yes, for example, this statement appears at the beginning of the discussion: 'Overall findings portrayed a community in crisis, with participants highlighting inefficient care pathways, a lack of intervention-focused care, risk-averse staff attitudes and a lack of genuine collaboration between the NHS and third sector as factors negatively impacting service user recovery and staff job satisfaction.' A statement of findings is also offered in the abstract. The researchers consider the strengths and limitations of the research in the discussion, and they situate the research in contemporary published literature.
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☒Yes ☐ No ☐ Can't Tell The research provides a rich insight in the working lives of mental health staff in community services in 2025. Contributions to existing knowledge are discussed, though policy implications could have been discussed more fully than being put in a table. There is also no discussion about how the implications could be

	implemented. The transferability of the findings is not explicitly discussed.

CONSIDER:

- *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*

Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**
- Qualitative methodology - Design - Procedure - Analysis - Richness of the results - Situating the results in the wider literature - Considerations of the study's strengths and weaknesses.	- No reference to types of generalisability of the findings - Policy implications could have been explored more in the discussion, rather than putting them in a table.	- Ethical considerations - How the researcher's influenced the participants

Appendix B: Summary of CASP Findings

CASP checklist question	**1**			**2**			**3**			**4**			**5**			**6**			**7**			**8**			**9**			**10**		
Yes/No/Can't tell	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**	**Y**	**N**	**C**
Uttarkar, 2010	✓			✓					✓			✓	✓			✓					✓			✓			✓		✓		
Crawford, Brown & Majomi, 2008	✓			✓			✓			✓			✓			✓					✓	✓			✓			✓		
Simpson, 2005	✓			✓			✓			✓			✓				✓				✓	✓			✓			✓		
Reid et al., 1999	✓			✓			✓			✓			✓				✓				✓	✓			✓			✓		
Wall, Burton & Perkin, 2024	✓			✓			✓			✓			✓			✓					✓	✓			✓			✓		
McKeown et al., 2024	✓			✓			✓			✓			✓			✓					✓	✓			✓			✓		
Thompson, Powis & Carradice, 2008	✓			✓			✓			✓			✓				✓				✓	✓			✓			✓		
Sambrook et al., 2025	✓			✓			✓			✓			✓				✓				✓	✓			✓			✓		

Appendix C: Semi-Structured Interview Guide for the Individual Interviews

University of Essex

Phase one: discussion guide

Title: Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.

Example opening questions:

1. What is your current role in the CMHT?
2. What is your core profession?
3. How long have you been working in community mental healthcare?
4. How long have you worked in this CMHT?

Example questions under the topic: what are staff experiences of working in secondary care mental health services in Essex?

1. How would you describe your overall experience of working in secondary care mental health services in Essex?
2. What aspects of your work do you find most fulfilling?
3. What challenges or difficulties have you encountered while working in the CMHT?
4. How well do you feel you understand the roles of other professionals in the CMHT?
5. How well do you think other professionals understand your role in the CMHT?
6. In what ways, if any, has working in a CMHT impacted your personal wellbeing or professional development?

Example questions under the topic: what are staff perspectives on the effectiveness of CMHTs for service users?

1. In your view, how effective are CMHTs in addressing the needs of service users?
2. What aspects of the CMHT model do you believe work particularly well for service users?
3. Are there any specific challenges or limitations you observe in how CMHTs serve service users?
4. How do you think service users perceive the care they receive through CMHTs?
5. Do you think the CMHT model sufficiently balances individual freedoms of service users with managing risks (e.g., self-harm or harm to others)?

Example questions under the topic: what are staff perspectives on how CMHTs be improved for staff and service users?

1. From your perspective, what changes could improve the experience of staff working in CMHTs?
2. How could CMHTs be adapted to better meet the needs of service users?
3. Or, if not CMHTs, what do you think would be a better way of caring for service users? What might that look like?

University of Essex

Example closing questions:

1. Are there any systemic changes you believe would improve the effectiveness of CMHTs as a whole?
2. If you could implement one major change to improve CMHTs for both staff and service users, what would it be?
3. Is there anything else you feel is important to share about your experiences or views on CMHTs?

Appendix D: Study Poster

University of Essex

IRAS project ID: 344304

Would you like to help us with our study?

We want to understand staff experiences of working in CMHTs and how you think the system could be improved.

We are looking for current staff to talk to us. You will be given time from your working day to participate in the study.

Chief investigator: Anna Cooke-Sutton
Please contact: [redacted] *to express your interest.*

Appendix E: Study Information Sheet for the Individual Interviews

University of Essex

Participant Information Sheet: phase 1.

Title: Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.

You are invited to participate in a research study conducted by Anna Cooke, a trainee Clinical Psychologist, from the University of Essex. Before you decide to take part, it is important to understand why the research is being conducted and what it will involve. Please read the following information sheet carefully and ask any questions you may have.

Purpose of the study: The NHS provides care in the community to individuals experiencing mental health difficulties via Community Mental Health Teams (CMHTs). The purpose of this study is to understand, from the perspective of NHS staff, how well CMHTs are currently working in Essex and what, if any, changes, or improvements could be made to this model of care.

Why are we doing this research? It is important to understand whether and to what extent the current model of care is supporting service users. Staff have unique perspectives due to their proximity to service users. The results of this piece of research could be very valuable in informing service development and change in the future.

Why have you been invited? You have been invited to participate in this study because you are currently working in a CMHT in Essex and, therefore, have valuable experience and knowledge about the topic under investigation.

What will participation involve? If you decide to participate, you will be asked to take part in one interview, either face-to-face at your place of work, or online, that will last for approximately 60 minutes. During the interview, you will be asked about your experiences of working in the CMHT and your thoughts about how it could be changed or improved.

Do I have to take part? No, your participation in this study is entirely voluntary. If you choose not to participate there will be no negative consequences for you. You can withdraw from the study at any time without giving a reason and without penalty. You can withdraw from the study by contacting the Chief investigator, Anna Cooke, by email [redacted] or [redacted] by email [redacted]. You can also contact [redacted] Director of Research for the School of Health and Social Care [redacted] or, if you are still not satisfied, please contact the University of Essex Research Integrity Manager, [redacted]

What are the possible benefits of taking part? Your participation will help us to develop a better understanding of how CMHTs work in practice rather than in theory. Your experience and thoughts about how the service could be changed could benefit your service and others in the region.

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 such as stress and burnout, 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, your contact details, your job title and your place of work. People will use this information to do the research, or to check your records to make sure that the research is being done properly. 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 [redacted] at the University of Essex.

University of Essex

The interview will be audio and/or video recorded if you give your consent. The audio and/or video recordings will be stored in the University of Essex's secure file storage system, 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.

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 can also consent for your anonymised data to be deposited in the University of Essex Research Repository for use in future research.

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; Anna Cooke [redacted] or [redacted] You can also contact [redacted] Research Manager at Essex Partnership University NHS Foundation Trust (EPUT), [redacted] or ringing her on [redacted]

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, Anna Cooke, 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 [redacted] If you are still not satisfied, please contact the University of Essex Research Integrity Manager, [redacted]

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 [redacted] 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. Finally, the results will be written up for publication in relevant academic journals. 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:

Anna Cooke
University of Essex
[redacted]

If you have any concerns about the conduct of this study, you may contact:

[redacted]



Thank you for considering to participate in this study.

Appendix F: Study Consent Form for the Individual Interviews

University of Essex

Title of the Project: Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.

Research Team: Doctorate in Clinical Psychology in the School of Health and Social Care

PHASE ONE:		Please tick the box/select an option
1. I confirm that I have read and understand the Participant Information Sheet dated 23/04/25 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.		☐
2. I understand that my participation is voluntary. This means that I am free to withdraw from the project at any time without giving any reason and without penalty.		☐
3. I understand that my data will be processed in accordance with the information in the participant information sheet.		☐
4. I understand that if I feel distressed during the interview, I will be offered emotional and practical support by the researcher and signposted to relevant services.		☐
5. I give permission for my fully anonymised data to be deposited in the University of Essex Research Repository for other researchers to use in the future.		Yes/No ☐
6. I agree to take part in phase one of this research study and to have my participation:		
Audio recorded		Yes/No
Video recorded		Yes/No
Participant Name	Date	Participant Signature

University of Essex

Chief investigator's name	Date	Chief investigator's signature

Appendix G: Coded Extract of an Interview Transcript

Chief Investigator
Do you think the CMHT effectively manages risk?

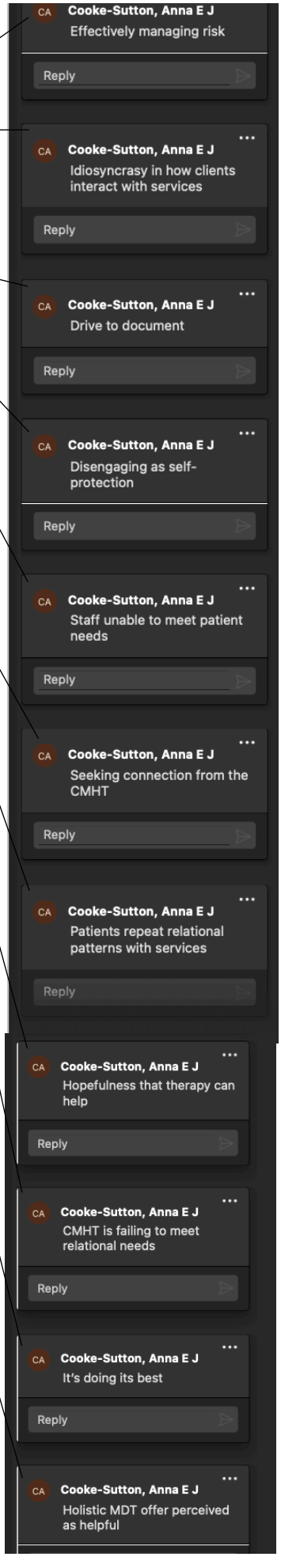
Participant 7
Oh. I think it does manage risk. I think the effectiveness. I don't know. I want to say yes, but I also want to say it's debatable, right? Again, it's going to be such a subjective experience for service users as well because you know, there's a lot of like individual and personal history and background to consider for each client there as well about how they interact with people in the service, you know. Transference and countertransference and you know how we respond to particular clients and stuff as well, of course. But at the same time, again, you know it's subjective because sometimes they're gonna feel supported and sometimes they're gonna feel let down. Of course, on our end, you know, it's like this whole procedure on, you know, we've done this, we've done this, and we've recorded this, and you know it's sometimes it does become a checklist, but how it translates in in subjectivity for that personal experience, we don't know because again it's a very difficult service to work in, so naturally staff can become disengaged. And so if there is a like, yeah, we might be doing something. But if you're feeling emotionally detached from clients, what they're probably seeking, they might not get it, if that makes sense.

Chief Investigator
What are they seeking?

Participant 7
I think you know, clients are just seeking a lot of like connection and comfort and love in places where they haven't found it. And you know, they're recreating relational patterns with the service as well. You know which they've had, you know, in in their in their lifetime. So, you know, if they haven't received form of nourishment. They're gonna seek that in their relationships. And obviously that again effects because there are continued relationships with people at the service and the team. So, the fact that you know, there are boundaries in place, you know, therapeutically, there's a lot that can be done, you know with this kind of dynamic through the process of therapy and relational work. And that's also why there is this continued sense of frustration because there's such a core experience of what they're looking for that really can't be replaced with, you know, like a duty call, right. I don't know if that makes sense. Yeah.

Chief Investigator
So you said that that clients are seeking connection in some way and it's partly that they're recreating patterns that they have had in relationships, but they're also fulfilling a need that isn't being fulfilled in their life as it stands at the moment. Is the service able to fulfil that need in its current iteration or would it need to change to be able to meaningfully meet that need of connection?

Participant 7
I think I would just say it's very hard to answer that in a yes or no format. I would say that I think it's doing its best in how it's created to offer different kinds of support. For example, if they're trying to offer crisis support that's in place, they're trying to offer you know, medical support, that's in place. You know, if they're looking for support in the everyday task



Appendix H: Study Information Sheet for the Group Interviews

University of Essex

Participant Information Sheet: phase 2.

Title: Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.

You are invited to participate in a research study conducted by Anna Cooke, a trainee Clinical Psychologist, from the University of Essex. Before you decide to take part, it is important to understand why the research is being conducted and what it will involve. Please read the following information sheet carefully and ask any questions you may have.

Purpose of the study: The NHS provides care in the community to individuals experiencing mental health difficulties via Community Mental Health Teams (CMHTs). The purpose of this study is to understand, from the perspective of NHS staff, how well CMHTs are currently working in Essex and what, if any, changes, or improvements could be made to this model of care.

Why are we doing this research? It is important to understand whether and to what extent the current model of care is supporting service users. Staff have unique perspectives due to their proximity to service users. The results of this piece of research could be very valuable in informing service development and change in the future.

Why have you been invited? You have been invited to participate in this study because you are currently working in a CMHT in Essex and, therefore, have valuable experience and knowledge about the topic under investigation.

What will participation involve? If you decide to participate, you will be asked to take part in one focus group with 5-7 others, either face-to-face at your place of work, or online, that will last for approximately 60 minutes. Other participants may be known to you through your current place of work, or they may work in other CMHTs. However, should you wish to remain anonymous, you will be offered the opportunity to join the virtual focus group where you can turn your camera off and use a Pseudonym as your screen name. During the focus groups, you will be asked about your experiences of working in the CMHT and your thoughts about how it could be changed or improved. The focus group will be audio and/or video recorded.

Do I have to take part? No, your participation in this study is entirely voluntary. If you choose not to participate there will be no negative consequences for you. You can withdraw from the study at any time without giving a reason and without penalty. You can withdraw from the study by contacting the Chief investigator, Anna Cooke, by email [redacted] or Dr [redacted] by email [redacted]. You can also contact [redacted], Director Research for the School of Health and Social Care [redacted] or, if you are still not satisfied, please contact the University of Essex Research Integrity Manager, [redacted]

What are the possible benefits of taking part? Your participation will help us to develop a better understanding of how CMHTs work in practice rather than in theory. Your experience and thoughts about how the service could be changed could benefit your service and others in the region.

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 such as stress and burnout, 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, your contact details, your job title and your place of work. People will use this information to do the research, or to check your records to make sure that the research is being done properly. 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

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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 [redacted] at the University of Essex.

The focus group will be audio and/or video recorded if you give your consent. The audio and/or video recordings will be stored in the University of Essex's secure file storage system, 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 focus group has not been transcribed, the recording will be deleted and your participation will not be included in the study. Transcription of the focus group 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.

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 can also consent for your anonymised data to be deposited in the University of Essex Research Repository for use in future research.

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; Anna Cooke [redacted] or Dr [redacted] You can also contact [redacted] Research Manager at Essex Partnership University NHS Foundation Trust (EPUT), [redacted] or ringing her on [redacted]

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, Anna Cooke, 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, [redacted] If you are still not satisfied, please contact the University of Essex Research Integrity Manager, [redacted]

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 [redacted] 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. Finally, the results will be written up for publication in relevant academic journals. 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:

Anna Cooke
University of Essex

University of Essex

[redacted]

If you have any concerns about the conduct of this study, you may contact:

[redacted]

Thank you for considering to participate in this study.

Appendix I: Study Consent Form for the Group Interviews

University of Essex

Title of the Project: Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.

Research Team: Doctorate in Clinical Psychology in the School of Health and Social Care

PHASE TWO:		Please tick the box/select an option
1. I confirm that I have read and understand the Information Sheet dated 23/04/25 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.		☐
2. I understand that my participation is voluntary. This means that I am free to withdraw from the project at any time without giving any reason and without penalty.		☐
3. I understand that my data will be processed in accordance with the information in the participant information sheet.		☐
4. I understand that if I feel distressed during the interview, I will be offered emotional and practical support by the researcher and signposted to relevant services.		☐
5. I give permission for my fully anonymised data to be deposited in the University of Essex Research Repository for other researchers to use in the future.		Yes/No ☐
6. I agree to take part in phase two of this research study and to have my participation:		
Audio recorded		Yes/No
Video recorded		Yes/No
Participant Name	Date	Participant Signature

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Chief investigator's name	Date	Chief investigator's signature

Appendix J: Ethical Approval (Eth2425-1239)

University of Essex ERAMS

12/06/2025

Ms Anna Cooke

Health and Social Care

University of Essex

Dear Anna,

Ethics Committee Decision

Application: ETH2425-1239

I am pleased to inform you that the research proposal entitled "Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure." has been reviewed on behalf of the Ethics Sub Committee 1, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

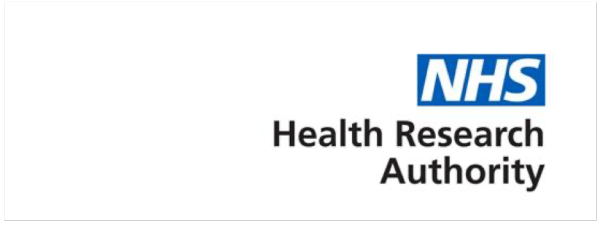
[redacted]

Ethics ETH2425-1239: Ms Anna Cooke

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).

Appendix K: Ethical Approval from the Health Research Authority (HRA)





Ms Anna Cooke
[redacted]

Email: approvals@hra.nhs.uk

06 May 2025

Dear Ms Cooke

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

Study title:	**Staff experiences of working in adult community mental health teams: contemporary perspectives from a system under pressure.**
IRAS project ID:	**344304**
REC reference:	**25/HRA/0870**
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.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

Appendix L: Letter of Support for the Research

Essex Partnership University
NHS Foundation Trust

[redacted]

16th October 2024

Dear Colleague,

Re: Doctoral thesis

I am writing to confirm my support of the plan for Anna Cooke, Trainee Clinical Psychologist, and Dr [redacted] Clinical Psychologist, to conduct research on patient outcomes under the [redacted]

I understand that the project will involve interviewing staff for 60-90 minutes during the working day, onsite or remotely. In understand that the staff will be recruited in the following ways: the researchers will attend team meetings, the study poster will be sent via email inviting expressions of interest, the study poster will be put up in [redacted] The research has potential to improve our understanding of the role and functions of community mental health teams and to contribute to future development in our service.

If you require any additional information please do not hesitate to contact me.

Yours sincerely,

[redacted]

Service Manager

[redacted]