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Community mental health workers' experiences of care-coordinating hospital discharge of patients with a diagnosis of mental health conditions into community mental health integrated services in the Northwest of England

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

Abstract

The significance of community mental health workers' roles in care-coordinating the hospital discharge of patients with a diagnosis of mental health conditions is globally recognised, yet empirical research on their experiences remains scarce. Indeed, no studies were found that specifically explored this important topic to understand the experiences of community mental health workers care-coordinating patient hospital discharge into community mental health services. This study adds to existing knowledge through a qualitative evidence synthesis of literature and an empirical intrinsic case study.

Guided by constructivist inquiry, the study focused on the co-construction of meaning in understanding experiences of community mental health workers who care-coordinate patient hospital discharge and to synthesise existing literature on this topic. Two theoretical lenses informed the study: Ecological Systems Theory, which provided a framework to understand the multi-level influences on community mental health workers' experiences, and Normalisation Process Theory, which was used to provide an in-depth understanding of how care coordination practices are normalised and embedded in discharge processes.

Two interrelated components comprised the study: a literature review and empirical research, The literature review included 16 peer-reviewed papers for thematic synthesis based on relevance to community mental health and contribution to the understanding of community mental health workers' experiences of care coordination of patient hospital discharge. Thomas and Harden's (2008) three-stage thematic synthesis approach was followed to analyse the literature, resulting in the development of four key themes and 15 subthemes: 1. Duties and responsibilities of community mental health workers; 2. Challenges and enablers of care coordination 3. Multidisciplinary team working in care coordination 4. Hospital discharge into community mental health integrated services. These findings indicate patterns and insights across different contexts, providing an in-depth understanding of the experiences and perspectives captured in the studies, which were further explored in the empirical phase.

Empirical data were collected through semi-structured interviews, which were audio-recorded, transcribed verbatim, and analysed using Braun and Clarke's (2024) reflective thematic analysis to enable the identification of patterns across participants' narratives. Data analysis resulted in 13 subthemes and four major themes: 1. Experiences of collaborative working; 2. Challenges and enablers to care coordination; 3. Experiences of organisational system and culture; and 4. Community mental health workers' personal experiences of professional growth.

This study's findings offer a significant contribution, providing information on poor communication, shortage of staff, substantial patient caseloads, lack of community mental health services, and challenges in care-coordination of patient hospital discharge. In addition, the current study highlights the importance of collaborative working while also recognising its limitations, such as the restricted geographical focus. The strengths of the research, underpinned by the use of two theoretical lenses, contribute to the existing body of knowledge. Further studies to inform community mental health practice, as well as implications for community mental health research policy, are recommended.

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List of Abbreviations

APA	American Psychiatric Association
BMA	British Medical Association
CI	Chief Investigator
CINAHL	Cumulative Index to Nursing and Allied Health
CMHISs	Community Mental Health Integrated Services
CMHN	Community Mental Health Nurse
CMHNSF	Community Mental Health National Services Framework
CMHSs	Community Mental Health Integrated Services
CMHTs	Community Mental Health Team (s)
CMHWs	Community Mental Health Workers
COVID-19	Coronavirus Disease 2019
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
DOH	Department of Health
DSM-5	Diagnostic Systematic Manual 5th Edition
HER	Electronic Health Record
EMBASE	Excerpta Medica database
ENTREQ	Enhance Transparency in Reporting Synthesis of Qualitative studies reporting statement for transparency
EST	Ecological System Theory
FHMREC	Faculty of Health and Medicine Research Ethics Committee
GP	General Practice
HCHSCC	House of Commons Health and Social Care Committee
HIC	High Income Countries
HOC	House of Commons
ICD 11	International Classification of Diseases 11th Edition

IRAS	Integrated Research Application System
LIC	Low Income Countries
LU	Lancaster University
MEDLINE	Medical Literature Analysis and Retrieval System Online
MI	Mental Illness
MDT	Multidisciplinary Team
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIHR	National Institute of Health Research
NPT	Normalisation Process Theory
PhD	Doctor of Philosophy
PHSO	Parliamentary and Health Service Ombudsman
PRISMA	Preferred Reporting Items for Systematic Reviews
PROSPERO	Prospective Register of Systematic Reviews
PsycINFO	Database for abstracts literature in the Psychology
PubMed	National Library of Medicine Collection database
PURE	Publication and Research
RCPsychs	Royal College of Psychiatrists
RNMH	Registered Nurse Mental Health
RN	Research Nurse
SLR	Systematic Literature Review
SMHP	Senior Mental Health Practitioner
Soc W	Social Worker
SPIDER	Sample, Population/Intervention, Design, Evaluation, and the Research
TripPro	A clinical research database designed to allow quick identification of high-quality research evidence.
UK	United Kingdom
WHO	World Health Organisation

Definition of terms in this study

Care-coordination:	Care coordination involves the systematic organisation and coordination of health services and resources to meet an individual's mental and physical health needs(McDonald 2007; Skjaerpe et al., 2022), through collaborative efforts including communication, planning, and teamwork with community health care providers, patients, and families(World Health Organisation [WHO],2023; World Health Organisation, 2018).
Community Mental Health Integrated Services:	Integrated care refers to a coordinated approach within the health and care system that emphasises collaboration with clinical commissioning groups, for example in UK general practitioners (GPs) in primary care, provide comprehensive patient care and treatment, while Community Mental Health Integrated Services (CMHISs) include NHS or voluntary sector organisations that provide mental health support in community settings (National Health Service [NHS], 2021; Thornicroft & Tansella, 2013; Timmins, 2019).
Community Mental Health Teams:	These teams play a pivotal role in providing community-based mental health care services, staffed by various professionals to ensure comprehensive treatment and care (National Health Service, 2019a; World Health Organisation, 2022a).
Community Mental Health Workers:	They encompass various professionals, including psychologists, social workers, care coordinators, community mental health nurses, psychiatrists, support workers, pharmacists, and occupational therapists. The term "community mental health worker " is used interchangeably with "participant" throughout this thesis (Royal College of Pyschiatrists [RCPsych's],2015).
Experiences:	In this study refer to the participants' knowledge, skills, attitudes, positive and negative emotions, perceptions, working in different jobs roles and views acquired through caring for patients with a diagnosis of mental health condition in the community (Radley et al., 2021).

Mental Health:	Defined as a "…state of wellbeing that enables the people to cope with stress of life to realise their abilities, to learn well, and work well and contribute to their communities, mental health is integral component of health and wellbeing and is more than absence of mental disorder"(World Health Organisation [WHO], 2022b, p. 7).
Mental illness:	Mental health illness or mental health condition from a medical perspective defined as a mental disorder or syndrome characterised by a clinically significant disturbance in an individual's emotional regulation, cognition, or behaviours. These disturbances reflect dysfunctional biological, psychological, or developmental process that affects mental, behavioural, and social functioning (WHO, 2022b). In this study mental health condition is used to avoid stigmatising mental health.
Multidisciplinary Teams:	This involves professionals from various fields working together to ensure patients receive personalised, efficient, and well-coordinated care. It encompasses collaboration among primary care providers, CMHWs, and other mental health professionals to deliver comprehensive care (Martin & Dixon-Woods, 2022; Williams & Smith, 2019).
Patient:	This term will be used interchangeably with the term service user an individual receiving mental health services from a health care provider in the hospital setting or the community (Biringer et al., 2017; Chow & Priebe, 2013).
Hospital discharge:	This is a process of patient transition from hospital care to receive treatment at home or in another community setting, following evaluation and preparation by medical and mental health practitioners. It involves medical practitioners determining that an individual is well enough to continue recovery at home or another setting, providing necessary

instructions, medications, and follow-up plans (NICE, Alghzawi, 2012; Baxter et al., 2020; 2017).

Reflection: Plays an integral role in the research process of reflexivity, offering opportunities to enhance transparency for readers and allowing researchers to gain deeper insights into the subject of study (Kurylo et al., 2016; Reynolds & Vince, 2004).

Reflexivity: Involves two-way process of reflecting on reflection itself, ongoing internal dialogue and critical self-evaluation by the researcher, acknowledging and recognising how their positionality might influence both the research process and its outcomes (Braun & Clarke, 2021; Corlett, 2019).

Chapter One. Introduction

1.1 Introduction

This chapter outlines the background and research motivation. Second, the structure of subsequent chapters is provided. Third, this chapter highlights the role of community mental health workers in care-coordinating the hospital discharge of patients with a diagnosis of a mental health condition into the community, and why this study is important. Fourth, global trends in community mental health are discussed, followed by the national context, historical and recent developments. Fifth, the two theoretical lenses used to gain an in-depth understanding of community mental health workers' experiences are discussed.

1.2 Researcher's background and motivation

In my previous roles, I have worked as a community mental health nurse (CMHN) and senior mental health practitioner (SMHP), and currently as a research nurse (RN) in the National Health Service (NHS). I have 12 years of experience in various capacities as a registered mental health nurse (RMHN) within forensic inpatient wards treating individuals diagnosed with mental conditions, as well as in community mental health integrated services (CMHISs) collaborating with a diverse range of community mental health workers (CMHWs) from various backgrounds. My main responsibility has been completing case management reviews, providing treatment as prescribed by the psychiatrist, and coordinating the hospital discharge of patients with a diagnosis of a mental health condition during their transition into CMHISs. In addition, my job role has included assessing risks and completing gatekeeping referrals for patients into CMHISs. Alongside my colleagues and other multidisciplinary teams (MDTs), I have faced various experiences and challenges in this role, such as shortages of staff, substantial caseloads, prolonged patient referrals, and poor communication.

Furthermore, other challenges have included lack of information necessary for care-coordination and proper completion of the discharge process to facilitate patient transitions between hospital and community settings. Moreover, the fragmentation of mental health services and inadequate integration with other healthcare and social services systems can hinder the seamless delivery of care. Addressing these challenges is crucial to improving the effectiveness of CMHWs and ensuring equitable access to quality mental health care in the community.

Being part of the NHS Trust organisation allowed me to have an insider perspective, while my ethnic background gave me an outsider view, enabling me to connect with a diversity of CMHWs. Having both perspectives helped me to position myself to understand the organisational culture and to explore and shed light on the intricate nature of care-coordination during hospital discharge within community mental health teams. This led me to reflect on the need for a deeper understanding of CMHWs' experiences of coordinating the hospital discharge of patients in this specific context. In this study, I use the first person "I" to reflect on my role and experiences as an insider and outsider to give my voice (American Psychological Association [APA], 2020). Chapters 3, 4, and 6 go into more detail about how I reflect on my experiences in this research process. The next section outlines the role of community mental health workers.

1.3 Role of community mental health workers in care coordinating patient hospital discharge into community mental health services

Care-coordinating the hospital discharge of patients with a diagnosis of mental health conditions into CMHISs is currently a global problem (Gandre et al., 2020; WHO, 2021b) created by a lack of communication between multidisciplinary teams (MDT) and the shortage of community mental health workers to follow up with patients after they have been discharged, resulting in an increased risk of patient relapse and readmission

(Thornicroft et al., 2016; Thornicroft & Tansella, 2013; World Health Organisation [WHO], 2018). For example, risk of relapse may include suicide, violence, lack of engagement in treatment, lack of care-coordination, and discharge planning with community mental health teams (CMHTs). To ensure continuity of care during care-coordinating patient hospital discharge, effective communication between hospital MDT and CMHTs is needed to minimise patient relapse and hospital readmissions (Healthcare Quality Improvement Partnership [HQIP], 2024).

In the UK, the implementation of care-coordination is not without its challenges, particularly related to working collaboratively and workforce limitations (Baker et al., 2019). One prominent issue is the shortage of CMHWs, which results in increased caseloads and limited availability of services, often leading to burnout among existing CMHWs (Gandre et al., 2020; Liberati et al., 2021). Additionally, CMHWs often face difficulties in accessing up-to-date training and resources necessary to deliver high-quality care to patients in the community. Stigma and inequalities surrounding mental health, both within the community and among some healthcare providers, can impede the effectiveness of CMHWs in reaching and engaging with patients (Lowther-Payne et al., 2023). Furthermore, the fragmentation of mental health services and inadequate integration with other healthcare and social services systems can hinder the seamless delivery of care (Tracy et al., 2019). Addressing these challenges is crucial to optimising the effectiveness of CMHWs and ensuring equitable access to quality mental healthcare in the community (NICE,2021b).

Care-coordination helps in facilitating transitions and continuity of care for patients with mental health conditions into CMHISs through the collaborative work of CMHWs (van Veen et al., 2020). In addition, the care-coordination of patient transitioning from hospital into the community is often a crucial period when patients are most vulnerable

to relapse. It requires comprehensive planning to minimise risk of adverse outcomes, such as relapse (Care Quality Commission [CQC], 2024).

During this patient transitioning period, CMHWs experience multiple responsibilities and collaborate with other service providers (Simpson et al., 2009). For example, CMHWs undertake case management, collaborate with other MDTs to facilitate continuity of care for patients discharged from hospital into the community, arrange appointments with patients at home, clinics, CMHISs, and follow up patients at home (Thornicroft et al., 2016; Williams & Smith, 2019). In addition, CMHWs play a vital role in supporting individuals who are dealing with a range of mental health challenges, including conditions like psychosis, schizophrenia, anxiety, depression, personality disorders, and struggles with suicidal ideation or self-harming behaviours, as well as issues like eating disorders, and substance or alcohol misuse (American Psychiatric Association, 2013; HQIP, 2024; NICE, 2011; World Health Organisation, 2019). CMHWs also address physical health concerns such as diabetes, hypertension, and chronic heart conditions that often coexist with mental health issues (Butcher et al., 2020; Clarke & Walsh, 2009; Department of Health, 2011). Furthermore, CMHWs hold pivotal roles in the provision of community-based mental health care, encompassing a diverse range of responsibilities that includes provision of care (Thornicroft & Tansella, 2013). For example, the CMHW role includes conducting comprehensive risk assessments of clients' mental health needs, collaborating with interdisciplinary teams to develop personalised treatment plans, and delivering evidence-based interventions such as counselling, psychoeducation, treatment, and crisis intervention (Department of Health, 2014; Radley et al., 2021). CMHWs also play a critical role in advocating for patients’ rights; for example, those lacking capacity to choose their treatment and coordinating access to additional support services, including housing, employment, and social resources in the community (Department of Health, 2015; National Health Service, 2019c). They act as a bridge between patients and mental health services in

the broader community, ensuring continuity of care and promoting recovery-oriented approaches (Cherner et al., 2022; World Health Organisation, 2004, 2021a). CMHWs aim to deliver holistic care, offering emotional support and practical guidance to patients, including those with complex mental and physical health issues, while collaborating closely with local community mental health teams (CMHTs) (Reilly et al., 2013; Rugkasa et al., 2020).

Additionally, studies have shown that the issue of CMHWs' participation in MDTs is still a global problem as different healthcare models in different countries have led to different experiences in providing treatments and interventions to promote recovery (Alhamidi & Alyousef, 2020; Baxter et al., 2020; Knapp, 2007). Thus, differences in community mental health models and policies are problematic, resulting in the lack of CMHWs standardisation in care-coordination, decision-making, and service delivery in the hospital discharge process. In many areas, CMHWs encounter difficulties due to regional community mental health practices and national policies that significantly impact their ability to make valuable contributions to patient care in this context (World Health Organisation, 2022b).These differences impact the role of CMHWs in carrying out their work responsibilities and coordinating the discharge of patients from hospital, resulting in varying levels of support and commitment to them among MDTs around the world. As a result, the effectiveness of community mental health services at both global and local levels continues to be compromised by the lack of organised participation in MDTs.

Furthermore, CMHWs within MDTs play multiple roles in providing care to patients with a diagnosis of mental health condition which is often lacking as a result of poor communication between CMHTs to meet patients' needs in a timely manner during their transition into the community (Baxter et al., 2020; Parliamentary and Health Service Ombudsmen [PHSO], 2024). For example, in the UK context, CMHWs who

provide patient care can include members of the multidisciplinary teams such as community mental health nurses CMHN/community psychiatrist nurses (CPNs), occupational therapist (OTs), social workers, psychologists, support workers and psychiatrists (Schadewaldt et al., 2014). These CMHWs roles include planning the discharge from the day the patient is admitted to hospital up to the time of discharge. For example, MDTs meets with the patient and their carers regularly to review the treatment and to identify social needs such as housing and social support when discharged. In addition, CMHWs can help patients, carers, and families by educating planning discharge to prepare the patient for discharge. Moreover, a study conducted by Jokstad et al. (2019) showed that CMHWs are often left out in the planning discharge process to facilitate an efficient patient transition into the community. Consequently, Torseth and Adnanes (2022) noted that MDTs that do not involve CMHWs slow the discharge process. This view is supported by Tambyah et al. (2022) who argue that the discharge process with CMHTs may be hindered at both individual and organisational level. In addition, these challenges are influenced by the historical and current context, as well as by relationships between MDTs and CMHISs (Wainberg et al., 2017).

A study conducted by Brooks et al. (2015) highlighted the barriers and facilitators experienced by health professionals while coordinating healthcare. For the purpose of this study, barriers are defined as circumstances or obstacles that prevent CMHWs from doing their job, while facilitators are circumstances or processes that make it easier for them to do their job (Bach-Mortensen & Verboom, 2020). Furthermore, it is crucial to consider the role of patient and carer involvement in planning for community mental healthcare provision (Alghzawi, 2012; Carbonell et al., 2020). The importance of this current research is because of its focus to address the need for improved care-coordination, a gap highlighted in a review by Storm et al. (2019), which noted that there are limited collaborative practices between hospitals and Community Mental

Health Integrated Services (CMHISs). A collaborative approach that incorporates patient and caregiver insights into decision-making processes can improve adherence and support patient recovery (Henderson et al., 2019; Reilly et al., 2013). Additionally, it facilitates patient-centred care and caregiver involvement, promotes shared decision-making, and ensures care plans address patients' individual needs and circumstances (Alvarez-Rosete et al., 2024). Without such collaborative working, CMHWs are at risk of implementing interventions to support the patient upon discharge from hospital that may not be appropriate (Rugkasa et al., 2020; Sampson et al., 2006).

In the United Kingdom (UK), early discharge planning for coordinating the discharging of patients diagnosed with mental health condition from hospital is considered crucial, aligning with global and local initiatives in promoting community mental health (National Insitute of Clinical Excellence [NICE], 2016). A broadly similar emphasis on a well-planned care-coordination process to improve patient transition into CMHISs has been highlighted elsewhere (Dalton-Locke et al., 2021; House of Commons and Social Care [HOCSC], 2019). However, CMHWs have continued to face challenges in engaging patients discharged from hospital who often struggle with adjustment due to the lack of staff with the requisite knowledge and skills to support the social needs of these patients. This leads to relapse and disengagement with the treatment provided by CMHWs (Knapp, 2007; Tyler et al., 2019). In addition to a lack of suitably trained qualified staff, unevenness is access to psychological therapies (IAPT) and failure to follow up with patients diagnosed with mental health condition upon discharge from the hospital can lead to severe consequences, including increased risks of suicide and homicide, thereby posing significant threats to both the individuals and the broader community (CQC, 2024). For example, lack of access to community resources, family support, and ongoing community mental health services is vital for patient recovery.

A recent Darzi report on the state of the NHS in England recommended the need for community recovery model of treatment and care for patients with a diagnosis of mental health condition whenever possible, to alleviate long patient hospital admissions thus reducing NHS costs and at the same time promoting patient recovery outcomes in their own environment (Darzi, 2024). In contrast to the medical model, which focuses on identifying and treating mental health condition symptoms, the recovery model stresses patient empowerment, self-determination, and holistic wellbeing. Both models are important because they provide complementary perspectives that, when combined, promote holistic patient-centred care (Barker, 2001; Barker & Buchanan-Barker, 2011). Likewise, studies have shown that a dual approach of these models can promote patient recovery outcomes (Klingemann et al., 2020; Thornicroft & Tansella, 2013).

This current study was undertaken at a crucial time when there is a drive for the coordination of community patient care and treatment to alleviate the current challenges faced by the NHS such as patient hospital shortages, staff retention, and systematic failures in care delivery (British Medical Association [BMA], 2024; Ham, 2023). The next section discusses global trends of community mental health services.

1.4 Global trends of community mental health services

Mental health condition remains a major global problem and contributes significantly to disability and death rates worldwide (Mental Health Foundation, 2016; World Health Organisation, 2021b). A key challenge lies in the persistent disparities in the availability of community mental health services and home-based treatment across countries, exacerbating mental health problems and raising the need for community mental health workers to coordinate patient care in the community (Patel et al., 2023; World Health Organisation, 2022b). Despite their crucial role in patient care, CMHWs often have difficulty care-coordinating post hospital discharge for patients with a diagnosis of mental health condition (Kilbourne, 2018). The World Health Organisation (2021b) has

prioritised improving the delivery and coordination of mental health care within communities and emphasised the need to address inequalities in access to community mental health services. Ensuring appropriate support for CMHWs is crucial to improving their ability to provide effective care to patients worldwide (Bradley & Griffin, 2015).

1.4.1 National context of community mental health services

In the UK, mental health services have evolved significantly within the framework of the NHS since its inception in 1948 (Gorsky, 2008; National Health Service, 2015; Seaton, 2023). The transition from institutionalised care to community-oriented services reflects a paradigm shift towards holistic patient care (House of Commons Health and Social Care, 2019). Political decisions and economic factors have led to a community mental health services crisis in the NHS, leading to the emergence of interdisciplinary teams in response to the need to develop strategies for psychiatric treatment in the community (Anandaciva, 2023; National Health Service, 2019a; Patel et al., 2023).

1.4.2 Historical developments of community mental health services (late 1890s to 1980s)

During the late 19th century in the UK, the enactment of the Lunacy Act (1845) initiated compulsory detention of mental health patients. Subsequent legislative reforms, including the Mental Health Act 1959, prioritised community-based care. In the 1960s, a global shift towards community mental health services emerged, promoting deinstitutionalisation (Chow & Priebe, 2013; Ikkos & Bouras, 2021). The 1970s witnessed significant reforms, integrating mental health services into primary care, reflecting a commitment to holistic healthcare provision (Seaton, 2023).

In the 1980s, the Mental Health Act of 1983, was enacted in the United Kingdom, which marked a significant advancement in the protection of civil and human rights for individuals diagnosed with a mental health condition (Department of Health, 2015). This legislation was introduced to address the inadequacies of previous laws and to ensure that patients received appropriate treatment and care while safeguarding their rights. Updated in 2007, the Mental Health Act of 1983 established clear guidelines for the detention, treatment, and discharge of patients, emphasising the importance of consent and the least restrictive environment (Department of Health, 2015). Reinforcing legal protections, the Act aimed to balance the need for treatment with respect for individual autonomy and dignity (DOH, 2015).There are ongoing efforts to further update the Mental Health Act through a Draft Mental Health Bill (DMHB) (Draft Mental Health Bill, 2023) which proposes to update the legislation to better meet the changing needs of patients.

1.4.3 Recent developments (1990s to present)

In the 1990s, initiatives like the Care Programme Approach (CPA) and supervised discharge aimed to enhance community care. Policy frameworks such as "The new NHS: *modern. dependable*" (1997) and the Health of the Nation report outlined goals for mental health service improvements (Department of Health, 1997). Subsequent strategies, including the “No Health without Mental Health” strategy (Department of Health, 2011) and the Mental Health Five Year Forward View (National Health Service, 2016), underscored ongoing efforts to strengthen mental health services. The establishment of Integrated Care Systems (ICSs) in 2022 and the Draft Mental Health Act of 2023 reflect contemporary commitments to patient-centred care and legislative reforms (British Medical Association, 2024).

Historical evolution of mental health services in the UK underscores a transition towards community-based care, shaped by legislative reforms and evolving healthcare

paradigms (Ikkos & Bouras, 2021). Despite progress, persistent challenges highlight the need for ongoing reforms and investment in mental health services to ensure equitable access and quality care for all individuals. Government reports from the DOH (2014) and the Parliamentary and Health Service Ombudsman (Parliamentary and Health Service Public Ombudsman, 2024) have emphasised the significance of addressing mental health disparities and challenges; nevertheless there remains an ongoing need to prioritise essential reforms and close the existing gap in mental health services. A recent report on the state of NHS revealed that there is a significant gap between the capacity of the community mental health workforce and the sheer number of people who require mental health services (Darzi, 2024).

1.5 Theoretical frameworks informing this current study

This section focuses on two theoretical frameworks related to community mental health workers' working practices in this current study. The first part discusses the importance of using a theoretical framework to underpin the theories selected in this study. It includes discussions of the ecological systems theory (EST) and the normalisation process theory (NPT), describing their origins, levels, applications in previous studies, and their strengths and limitations. According to Lincoln and Guba (2013), subscribing to a particular theoretical lens provides an organised framework in guiding the selection of methodology and data analysis. Thus, the application of a theory within a specific study ultimately influences how the research story is presented and how the findings are interpreted (Bryman, 2016; Creswell & Creswell, 2023).

To determine an appropriate theoretical framework for this study, a thorough review of general nursing theories, as well as specific mental health theories, was undertaken. The majority of existing theories are primarily patient-centred and focus on direct care. General nursing theories, such as Henderson's needs theory (Henderson, 2006), and

Nightingale's environmental theory cited in McDonald (2004), provide insightful information about patient care and wellbeing. The complexities of care-coordination related to the provision of mental health services are not adequately addressed in these theories, as they tend to emphasise individual-level interventions, the patient's physical environment, or self-care needs.

Additionally, in mental health care, theories such as Baker's recovery-oriented model (2001), Orem's self-care deficit nursing theory cited in Renpenning (2003), and Peplau (1991) interpersonal relations theory emphasise the critical role of the patient and caregiver relationship and the ability of the patient to self-care in order to promote effective treatment and recovery. Although these theories form the basis of nursing practice due to their emphasis on patient interactions, they are not appropriate to this study's aim of exploring CMHWs' experiences and organisational aspects of patient discharge care-coordination. This highlights the need to identify different theoretical frameworks more aligned with this study's focus.

Two theories were eventually selected, ecological systems theory (EST) (Bronfenbrenner, 1979) and normalisation process theory (NPT) (May et al., 2009), to provide a theoretical lens through which to view the phenomenon being studied and to address the study's aim and objectives. EST is believed to be particularly relevant to this study because it focuses on the different levels of environmental influences, including individual, organisational, and societal factors that shape the experiences of CMHWs. This theory can be a useful theoretical lens in this context to develop an understanding of the challenges associated with the discharge process, because it promotes an understanding of how different systems interact to influence care-coordination when patients are discharged from the hospital (Eriksson et al., 2018). Subsequent sections present an overview of ecological system theory, followed by a discussion of normalisation process theory.

1.5.1 Ecological system theory

The aim of this section on ecological systems theory (EST) is to discuss and contextualise this theory as a framework for exploring the interplay between individual, interpersonal, community, and societal influences on health-related outcomes (Bronfenbrenner, 1979). This section provides a background on EST, defining its core constructs and exploring how these are relevant to the study's focus. This theoretical framework illuminates how the interactions across different ecological levels influence individuals' roles and perceptions, highlighting the need to deepen our understanding of the multifaceted nature of care-coordination of hospital discharge of patients with a diagnosis of a mental health condition to community mental health services.

EST was developed by Bronfenbrenner in 1979 as a theory to explain how various environmental systems impact a person's development. EST posits that individual experiences are shaped by interactions within various systems: the microsystem, mesosystem, exosystem, and macrosystem that vary in terms of immediacy and level (Bronfenbrenner, 1979). These systems not only interact with the individual but also with each other, creating complex, dynamic influences on behaviour and wellbeing. In health-related research, EST has proven instrumental in identifying the layered factors that impact health outcomes and behaviours. For instance, Caperon et al. (2022) applied EST in the UK to build a socio-ecological model for community engagement, focusing on individuals in deprived areas, while Snowdon et al. (2023) explored EST in interventions targeting youth substance abuse.

Most recently, Nolan and Owen (2024) used EST to study medical students' experiences with equality and diversity, showing how multilevel social influences shape professional education. Despite its adaptability, however, EST has limitations, particularly in measuring specific outcomes in intervention studies. Small et al. (2021) noted the need to tailor EST constructs to align with a specific study context,

suggesting integration with other theories, such as normalisation process theory (NPT), to provide an in-depth understanding of the phenomenon being studied.

In this study, EST provides a theoretical lens for exploring CMHWs' subjective experiences in coordinating patient discharge and managing interactions at various levels of influence, including their teams, organisations, families, and caregivers. Adopting EST as a guiding theoretical framework, the research acknowledges the complex, multi-layered environment in which individuals operate and it allows for a holistic examination of how these different levels impact their roles and interpretations of care processes (Eriksson et al., 2018). EST's emphasis on multifaceted influences can allow the study to move beyond a narrow focus on individual-level factors and expand the scope to include broader social, organisational, and cultural contexts that shape CMHWs' experiences in care-coordination. This perspective can be important for understanding how interactions between CMHWs and patients, as well as organisational and societal factors, contribute to both challenges and strengths in providing holistic care.

1.5.2 Levels of ecological systems theory

Bronfenbrenner's EST includes several different levels that capture the full scope of an individual's social environment (Bronfenbrenner, 1979). In this context, these systems have the potential to provide a theory for exploring the experiences of CMHWs to gain a better understanding of the interaction between the individual and multiple levels of influence. At one level, the microsystem represents the individual's immediate environment and personal interactions, which in this context include CMHWs' daily interactions with patients, families, and caregivers. This level can capture the interpersonal relationships that directly influence the CMHWs' work experiences, including the subjective meanings they derive from these encounters. Externally, the mesosystem describes the interactions between different microsystems. This has been

criticised for its complexity and the difficulty of operationalising its broad, multilevel framework in practical research (Onwuegbuzie et al., 2014). For CMHWs, this could include collaboration between team members and interaction with multidisciplinary teams (MDTs), highlighting the interconnectedness of different immediate environments.

The exosystem extends beyond the individual's immediate interactions to encompass broader organisational structures and policies that indirectly impact the roles of CMHWs. For example, elements such as hospital policies, community resources, and organisational level administrative decisions that shape the conditions in which CMHWs work can impact their ability to effectively coordinate patient care. Finally, the macrosystem represents overarching social, cultural, and political influences that shape the broader healthcare environment (Eriksson et al., 2018). In the context of CMHWs' work, the macrosystem could include societal norms related to mental health, health legislation, and national policies that influence resource allocation and health care practices. Together, these levels form a comprehensive model of influence and provide a robust theoretical lens for analysing the complex factors that impact CMHWs' care-coordination of patient discharge from hospital into the community.

Furthermore, EST could serve as the foundational theoretical framework for this constructivist inquiry study, emphasising the dynamic interaction between individuals and their environment across various levels, offering insight into the complexities of CMHWs' experiences in delivering comprehensive care-coordination during patient hospital discharge (see Figure 1).

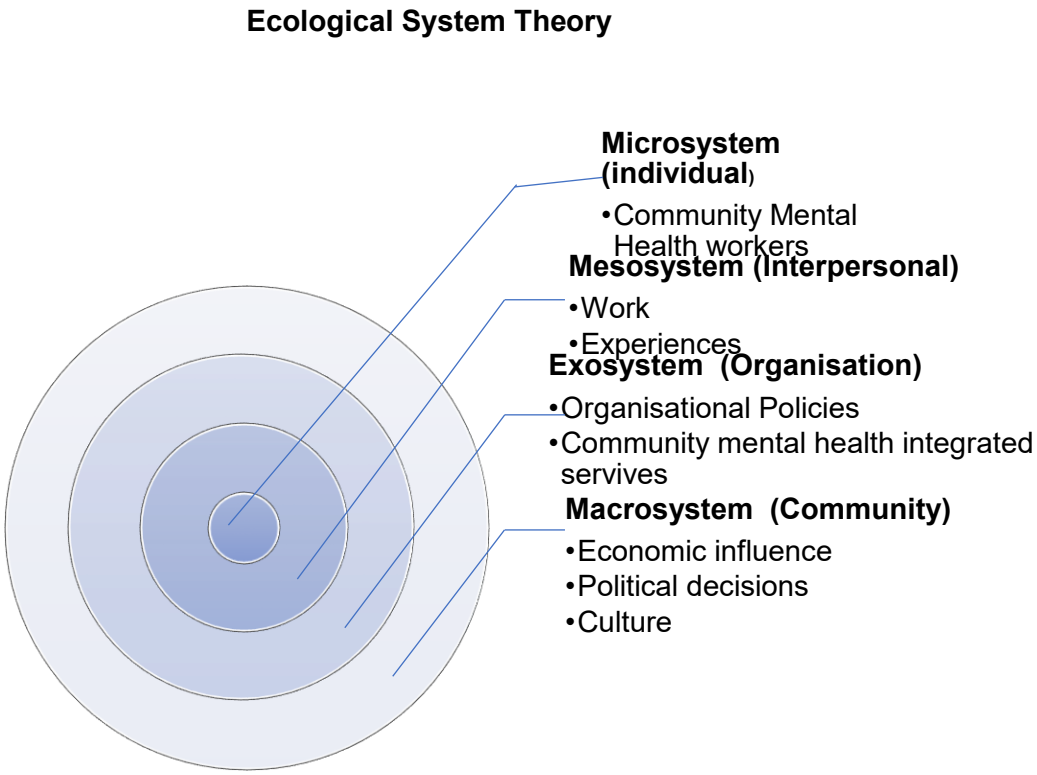

Figure 1.Diagram illustrating Ecological System Theory

Adapted and modified from Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979)

The study's use of the EST is visually represented in Figure 1, capturing the various levels and complexities of CMHW experiences, particularly in care-coordination during patient hospital discharge. Furthermore, in this context, Figure 1 shows how individuals are influenced by both interpersonal dynamics and broader organisational structures.

Defining the EST's levels served as the basis for the selection of the microsystem, mesosystem, exosystem, and macrosystem in this study. Consequently, this theoretical framework enhances this study's ability to capture the complexity of work in healthcare and enable a more comprehensive analysis of the phenomenon being studied (Velez-Agosto et al., 2017); for example, in this context CMHWs' interactions with patients, colleagues, and broader organisational structures. The application of EST, where each level is contextualised with the specific dynamics of CMHWs' work,

creates a comprehensive interpretive perspective through which this study's findings can be understood and supports a more informed understanding of holistic care-coordination in the field of community mental health. This chapter describes how EST can provide an in-depth understanding of the phenomenon under study. The following section now discusses normalisation process theory.

1.5.3 Normalisation process theory

Normalisation process theory (NPT), which evolved from the normalisation process model, provides a valuable framework for understanding how new practices are integrated and normalised in healthcare organisations (May et al., 2007; May et al., 2022). NPT includes four main constructs: coherence, cognitive participation, collective action, and reflexive monitoring. Each construct is now discussed, reflecting on how each is used to gain an understanding of how participants make meaning of the phenomenon under study, as suggested by May et al. (2022). Coherence encompasses the sensemaking processes through which individuals and groups understand and make sense of working practices. This is driven by gaining meaning and shapes the way participants perceive the value and purpose of the working practices. Cognitive participation refers to the processes that promote or inhibit individuals' work practices, driven by collaborative working and engagement, whereas collective action describes the processes through which participants carry out their work, with emphasis on how working practices are implemented and sustained through collective effort. Thus, reflexive monitoring refers to how participants assess and evaluate the impact of working practices and is driven by continuous evaluation and implementation of more efficient practices (May et al., 2007; May et al., 2022).

The strengths of Normalisation Process Theory (NPT) are reflected in its wide application across diverse healthcare settings since its introduction in telehealth assessments in the UK 2003 (May et al., 2003).Building upon this, Sooklal et al. (2011)

examined the role of social systems in health information technology implementation. This study's strength is its employment of a case study method supported by NPT, providing a detailed insight into how socio-technical processes influence the implementation and integration of information systems. Likewise, Browne et al. (2014) applied NPT to examine interactions between patients, caregivers, and healthcare providers in the management of advanced heart failure. The strengths of employing NPT for data analysis rests in its ability to systematically reveal the dynamic mechanisms by which interventions are implemented, integrated, and maintained in practice (Browne et al., 2014). Furthermore, Rapley et al. (2018) used NPT to develop tools to assess barriers to routine work processes in healthcare. Rapley et al (2018)'s study emphasises the effectiveness of NPT as a comprehensive framework for comprehending implementation processes, especially within qualitative studies, showcasing substantial evidence for its descriptive aspect as an implementation theory. As suggested by Struhar et al. (2024), the NPT is particularly useful for examining the experiences of health workers and identifying potential areas for improvement. The application of NPT in mixed-methods evaluations of developmental studies demonstrates its strength by effectively integrating qualitative and quantitative data, illustrating how the mechanisms of coherence, cognitive participation, collective action, and reflexive monitoring collaboratively influence the integration and sustainability of intricate interventions. The use of the NPT in previous studies highlights its versatility and strengths in addressing various health-related challenges in different settings (May et al., 2018). It is clear, therefore, that NPT is adaptable to other healthcare clinical settings (Liang et al., 2018; May et al., 2014).

A key strength of NPT from the aforementioned studies is its flexibility in various healthcare settings, highlighting its importance in both clinical and technological areas. Another significant advantage is its ability to systematically highlight the intricate social and organisational processes that influence implementation, thus offering researchers

a structured but adaptable analytical framework. Moreover, NPT enables the combination of qualitative and quantitative methods, providing a holistic view of how interventions are incorporated and maintained in practice.

However, NPT has its limitations. It does not fully capture the complexity of overlapping data categories, pointing to a possible limitation on the ability of the NPT to accommodate diverse interventions (Blickem et al. (2014). NPT's emphasis on the alignment of individual and collective actions underplays the role of broader institutional or systemic factors that influence the normalisation process. Furthermore, the theory's focus on the micro-level dynamics of practice adoption may obscure the influence of structural and political forces that shape healthcare practices (May et al., 2018). Another limitation is that the NPT constructs can overlap, making it difficult to understand the technical terms of the theory and in turn making it difficult to code qualitative data (Hooker et al., 2015). Furthermore, NPT can be criticised for focusing too much on individual actions and decisions, while giving less attention to the broader context of implementation work practices (Clarke et al., 2013). These examples shed light on how the NPT can offer both strengths and limitations, depending on the context of its application (see Table 5 in Chapter 6).

Providing a perspective from which to consider the challenges faced by CMHWs, NPT can help to develop an understanding of the interaction between healthcare professionals, systems, and patients, all of which are critical to improving care-coordination (May et al., 2011). Thus, integrating NPT and the aforementioned EST is important because it can provide a dual focus: with the NPT helping to understand how CMHWs interact within work practice at the micro level, and the EST revealing how their interactions are shaped by broader ecological influences such as organisational and social factors. Linking these two theories, this study can provide a more holistic understanding of the factors influencing patient discharge coordination by CMHWs. For

example, Liang et al. (2018) used the NPT lens in designing working practices and suggested that a comprehensive understanding requires examining both individual and system-level influences.

In this study, NPT can contribute to future research by developing our understanding of the internal processes of CMHWs, while EST considers external environmental pressures such as institutional policies and social norms that might impact the effectiveness of patient discharge coordination. NPT can be particularly useful for analysing how complex work practices were adopted, implemented, and sustained by healthcare professionals both in individual and organisational contexts (May et al., 2019). This integration can provide a more in-depth understanding of the challenges and facilitators of the hospital discharge process and how these could be managed by CMHWs.

Ecological Systems Theory (EST) can offer an extensive framework to analyse how various layers of influence spanning individual, interpersonal, organisational, and wider societal contexts impact community mental health workers' experiences in managing hospital discharges. Placing participants' roles within these interconnected systems, EST can enable comprehension of the complex interactions and environmental elements influencing care coordination. Normalisation Process Theory (NPT) can add to this by concentrating on the mechanisms through which new work practices, like discharge coordination, are consistently integrated into everyday work. NPT can facilitate the exploration of how CMHWs collaboratively understand, participate in, and incorporate the discharge process into their professional duties. Together, EST and NPT can influence future research design, data gathering, and analysis by offering both broad and detailed perspectives to understand the complex interaction between systemic factors and influencing CMHWs' care coordination of patient hospital discharge

1.6 Chapter conclusion

In conclusion, in this opening chapter, I have introduced the study and provided information about my background, my personal motivation, and my rationale for conducting the research. Additionally, I discussed global trends and the local context of community mental health, along with historical and recent developments in this field. I highlighted the importance of employing two theoretical perspectives to support the selected theoretical frameworks, with a detailed discussion regarding their origins, levels, applications in previous studies, and their strengths and limitations. This chapter serves as a foundation for the literature review in Chapter 2, where existing knowledge on the topic will be explored in-depth. The following sections provides the entire thesis outline of this chapter.

1.7 Thesis outline

Chapter Two. Systematic Literature Review

This chapter provides the background to the systematic literature review, the review question, and explains the method of thematic analysis and, eligibility of studies. It provides the strengths and limitations of the systematic literature review, and the implications for current and future clinical practice.

Chapter Three. Methodology

This chapter sets out the research methodology, the research question, the aim, objectives, research paradigm, ontological, epistemological perspective, and methodological considerations. It also addresses my reflexivity.

Chapter Four. Methods

This chapter explains the rationale for using a case study design and then discusses the study setting, the research population, and eligibility criteria, including recruitment strategy, participants, data collection, and reflexivity. This is followed by a discussion on the reflective thematic analysis process employed in this study.

Chapter Five. Findings

This chapter reintroduces the research question, the research aim, and its objectives. Following a presentation of the characteristics of participant demographics, the findings are provided.

Chapter Six. Discussion and Conclusions

This chapter discusses the research findings through the lens of two theoretical frameworks. It provides conclusion to entire thesis, strengths, and limitations, highlighting its methodological contributions and outlines implications for clinical practice, policy, and education. It also offers recommendations for future studies and presents the researchers' reflexive account throughout the study.

Chapter Two. Systematic Literature Review

Experiences of community mental health workers in care-coordinating patients with a diagnosis of mental health conditions globally: A qualitative evidence synthesis.

2.1 Introduction

This chapter aims is to provide the background of the qualitative evidence synthesis exploring the experiences of community mental health workers (CMHWs) care-coordinating hospital discharges of patients with a diagnosis of mental health conditions globally. This is followed by outlining the aim of carrying out this qualitative evidence synthesis. Subsequently, the method of extracting studies guided by the Preferred Reporting Items for Systematic Reviews (PRISMA) protocol is then described, followed by a thematic synthesis of the main findings, a discussion highlighting possible gaps, strengths, limitations, and clinical implications for future research. In conclusion, the chapter presents a summary of its main findings.

2.2 Background

The challenges CMHWs experience when care-coordinating the discharge of patients with a diagnosis of mental health conditions are a global problem, as presented in Chapter 1. In many countries, CMHWs experience challenges due to the lack of infrastructure and insufficient community mental health resources to provide adequate care-coordinating for patients with a diagnosis of mental health conditions being released to other Community Mental Health Integrated Services (CMHISs). Consequently, CMHWs often experience barriers when attempting to care coordinate patients' access to CMHISs, resulting in a gap in care (WHO, 2018; 2021b).

According to the World Health Organisation's Mental Health Action Plan 2013-2030 although the definition and implementation of such CMHISs varies by country, region, and even individual CMHISs, this should be given priority to promote community mental health (World Health Organisation, 2021b). In the same manner, community mental health workers from various settings play a vital role in facilitating and planning the hospital discharge transition process and providing continuity of care for patients with mental health conditions through collaborative work (van Veen et al., 2020; Xiao et al., 2019). In some cases where a discharge plan is not available, it becomes the responsibility of CMHWs to support the patient in developing and setting up an appropriate discharge treatment plan (National Institute of Clinical Excellence, 2016, 2021). Furthermore, studies into the planning and coordination of community mental health care have been influenced by different policies, as emphasised in a systematic meta-narrative review by Jones et al (2018).This highlights the critical role that CMHWs play in coordinating care of patients with enduring mental health condition and bridging the gap between hospital-based care and community-based services. (Butcher et al., 2020; Williams et al., 2023).

In addition, Alhamidi and Alyousef (2020) and Baxter et al. (2020) advocate for the importance of providing adequate support to CMHWs from multidisciplinary teams (MDTs). This support enables CMHWs to utilise their knowledge, experiences, and skills to assess risk and to plan and care coordinate hospital discharge for their patients into CMHTs to promote recovery (Barker & Buchanan-Barker, 2010). While this role can be challenging, it can also be rewarding as CMHWs can make a huge difference in promoting the recovery of their patients (Bowden et al., 2015; Watson, 2016); for example, by ensuring that patients receive timely interventions and seamless transitions between hospital and community services through the provision of individualised support and care-coordination among MDTs. Hence, this systematic

literature review aims to consolidate the existing evidence of the CMHWs' experiences of facilitating this transition.

As CMHWs encounter difficulties in communicating with other CMHTs during the transition from hospital and discharge to CMHISs for patients with a diagnosis of mental health condition, the continuity and quality of care can be significantly compromised (Cherner et al., 2022). However, most studies have focused on inpatient experiences, leaving a paucity of qualitative studies on the experiences of CMHWs (Xiao et al., 2019). Moreover, qualitative research methods allow for a deeper understanding of the experiences, perspectives, and subjective meanings of CMHWs involved in the care coordinating hospital discharge process for patients with mental health condition (Olasoji et al., 2020).

In addition, studies conducted by Parker et al. (2023); Rugkasa et al. (2020); von Hippel et al. (2019) have revealed that to date there are a limited number of studies that fully explore the experiences of CMHWs, their roles, responsibilities, and care coordination of hospital discharge of patients with a diagnosis of mental health condition and transition into CMHISs. Although scoping review findings from various studies highlight the importance of CMHWs in the global mental health environment, a significant gap remains in understanding their experiences in coordinating the discharge of patients from hospital to community care. Given the skills, roles and responsibilities described in Chapter 1, it is vital to explore how CMHWs approach this aspect of their work. Understanding their experiences can shed light on the challenges they face, providing valuable perspectives on how to improve the transition process for patients moving from hospital to community care.

Of particular importance, CMHWs possess specialised skills, including the ability to assess mental, physical, and emotional health and play a key role in communication between CMHTs and healthcare professionals (Barbui, 2023; World Health Organisation, 2021a). Exploring CMHWs' experiences and their role in facilitating

transition between hospital and accessing CMHISs, my current study can contribute to the development of effective care-coordination practices and strategies for optimising patient integration into CMHISs and promoting improved mental health outcomes and recovery. Therefore, the aim of this qualitative evidence synthesis was to synthesise the available literature exploring the experiences of CMHWs who care coordinate hospital discharge of patients with a diagnosis of a mental health condition transitioning into CMHISs. This review can be characterised as a qualitative evidence synthesis, a form of systematic review that integrates results from primary qualitative studies to deliver a thorough understanding of a specific phenomenon or subject (Flemming and Noyes,2021).

2.3 Aim of this qualitative evidence synthesis

The aim of this review was to identify, review, and synthesise CMHWs' experiences of care-coordinating the hospital discharge of patients with a diagnosis of a mental health condition into CMHISs.

2.4 Review question

The review question is: What are community mental health workers' experiences of coordinating hospital discharges of patients with a diagnosis of a mental health condition globally?

2.5 Method

Thematic analysis was used, adhering to the Enhancing Transparency in Reporting Synthesis of Qualitative Studies (ENTREQ) reporting statement for transparency (Tong et al., 2012) (See Appendix 1). There are several methods for thematic analysis of data (Aveyard, 2019; Aveyard et al., 2021). The reason for choosing thematic synthesis (Thomas and Harden (2008) is that, unlike other approaches, it can be used in a variety

of contexts and allows researchers to extract textual data from qualitative components of mixed method studies. While thematic synthesis is commonly used for qualitative systematic literature reviews, it is also suitable for mixed methods studies and helps identify common themes (Aveyard et al., 2021). An integrative review is a comprehensive type of review that includes experimental and non-experimental studies. Whittemore and Knafl (2005) narrative review focuses on storytelling and theory development. Whereas Ritchie et al. (1994)'s framework analysis which is more suitable for developing a theory was not suitable for this review, therefore thematic synthesis was determined to be suitable for this literature review.

Given the diverse nature of studies exploring the experiences of CMHWs, it was deemed appropriate and beneficial to compare themes from the findings extracted from various primary qualitative studies (Creswell & Creswell, 2023). In this review, the three stages of thematic analysis, namely line-by-line coding, development of descriptive themes, and generation of analytical themes, were followed (Thomas & Harden, 2008). The current literature review did not use theories to guide the thematic analysis; instead, the analysis was conducted inductively, allowing themes to be developed directly from the data without the influence of pre-existing theoretical frameworks. This approach was justified as the literature review aimed to explore participants experiences and ensure that findings were grounded in the data rather than shaped by theoretical assumptions.

2.6 Eligibility Criteria

I systematically identified relevant literature for the review process, as illustrated in Figure 2, adhering to the SPIDER framework (Sample, Phenomenon, Intervention, Design, Evaluation, Research type) as recommended by Cooke et al. (2012) and Korstjens and Moser (2017). Initially I had considered population, intervention, control/comparison, and outcome PICO framework: however its focus on comparison and control, which is more suitable for quantitative studies and did not fit the scope of

this study (Cherry et al 2023). Instead, the SPIDER framework was chosen as the basis for deciding which qualitative studies to include or exclude in the literature review (see Figure 2).

Characteristics of the review question based on the SPIDER Framework

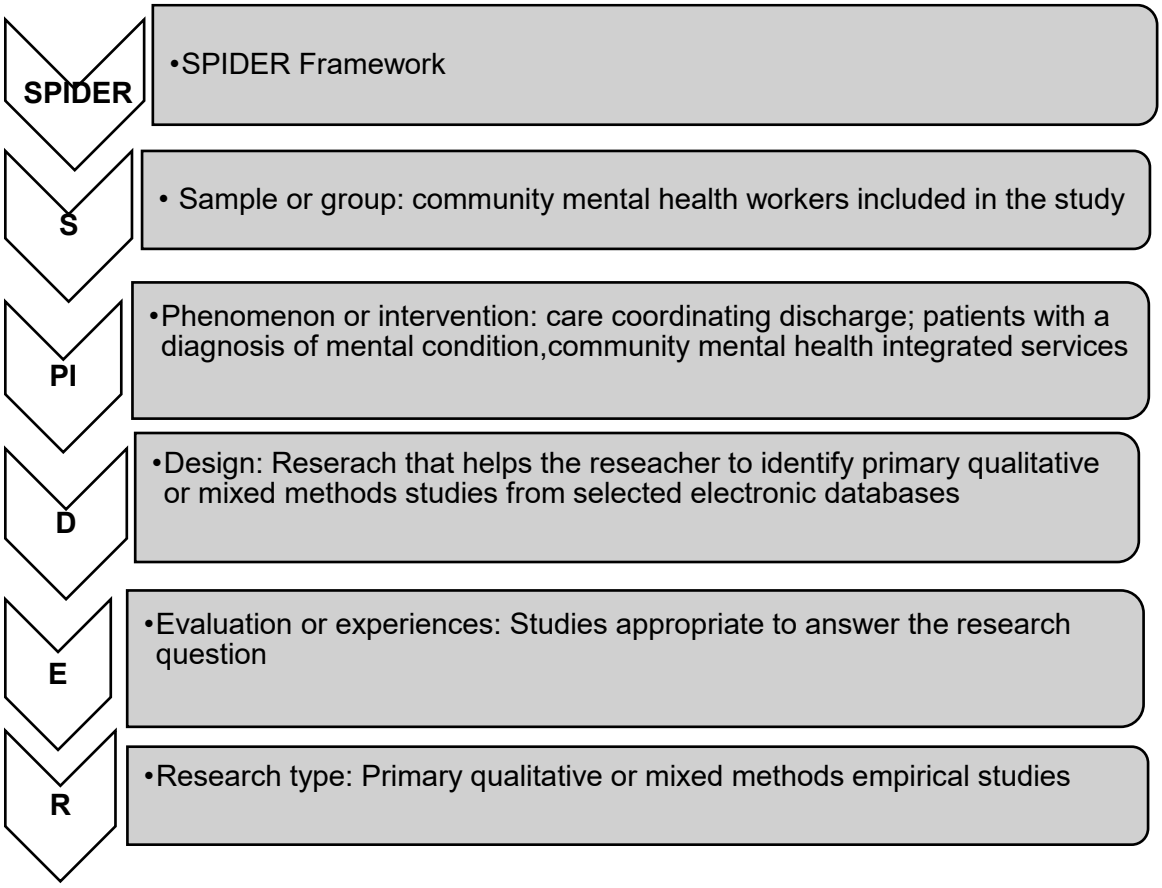

Figure 2. SPIDER Framework

Note: Adapted from and modified from Cooke et al. (2012) and Korstjens & Moser (2017).

In addition, SPIDER Framework's suitability for qualitative mixed method studies as highlighted by Methley et al. (2014) reinforced its utility for identifying relevant qualitative and mixed method studies. Moreover, studies concentrating on experiences of patients only in hospital settings were excluded as they did not meet the review aim as illustrated in Table 1.

Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria	Rationale
Qualitative studies and mixed methods studies whereby qualitative data can be extracted	Quantitative methodology	This was a qualitative component only studies were included because they offered extractable narrative data appropriate for thematic synthesis, while studies using only quantitative methods were not included
Qualitative studies that focus on experiences of CMHWs working in the CMHSs were included	Qualitative studies focusing on health workers working in hospital settings	Only community-based experiences were relevant; hospital settings differ in context and dynamics
Inclusion of qualitative methodology of primary studies that focus on the phenomenon being explored.	Mixed method studies that are not published in English	There were no resources for translation
From inception to November 2023		No date limitation was applied to capture a wide range of relevant studies, avoiding excluding potential earlier or recent literature due to publication year.

2.7 Information sources and electronic database searches

Through consultation with the university faculty librarian, the search terms were adapted to other databases to expand the search and ensure that the terms used in the qualitative evidence synthesis search were consistent and appropriate for the selected databases. This search was conducted using the following 10 databases: CINAHL, MEDLINE, PsycINFO, Proquest, Embase, PubMed, Trip Pro, Scopus, Open

Athens, and NHS Knowledges Services. The search was first run from inception to July 2022 (see Figure 3 and Appendix 2).

Furthermore, the search strategy used both controlled keywords and synonyms from each database (CINAHL and MEDLINE), medical sub-heading terms (MeSH) from selected databases, and free-text key terms, while PsycINFO has a different thesaurus, as presented in Appendix 3. This strategy is crucial for a more thorough and reliable literature search and can reduce the possibility of missing relevant studies (Cherry et al., 2023). Search limiters were applied at the last stage of each search, combining all synonym searches based on key terms derived from the research question (Boland, 2017). The PRISMA flow diagram (as previously presented in Figure 4) was for the systematic review strategy to ensure consistency, transparency, and integrity (Page et al., 2021).

In addition, a table of characteristics and a summary of studies that includes demography, context, methodological underpinnings, and other information congruent to this review are illustrated in Appendix 4. The protocol for this review was registered on the Prospective Register of Systematic Reviews (PROSPERO) portal, Centre for Reviews and Dissemination to prevent chances of duplication, thereby reducing research waste (CRD) ID 42020213893 (Centre for Review Dissemination, 2016; Pieper & Rombey, 2022). A systematic review protocol is essential to ensure the integrity, transparency, and accuracy of the systematic review process (Covidence, 2024).This qualitative evidence synthesis used a PRISMA flowchart to illustrate how the decision was made to include papers for review. This PRISMA flowchart is important because it ensures methodological rigour and improves the reproducibility of the review process, thereby strengthening the reliability and validity of the findings in answering the research question (see Figure 3).

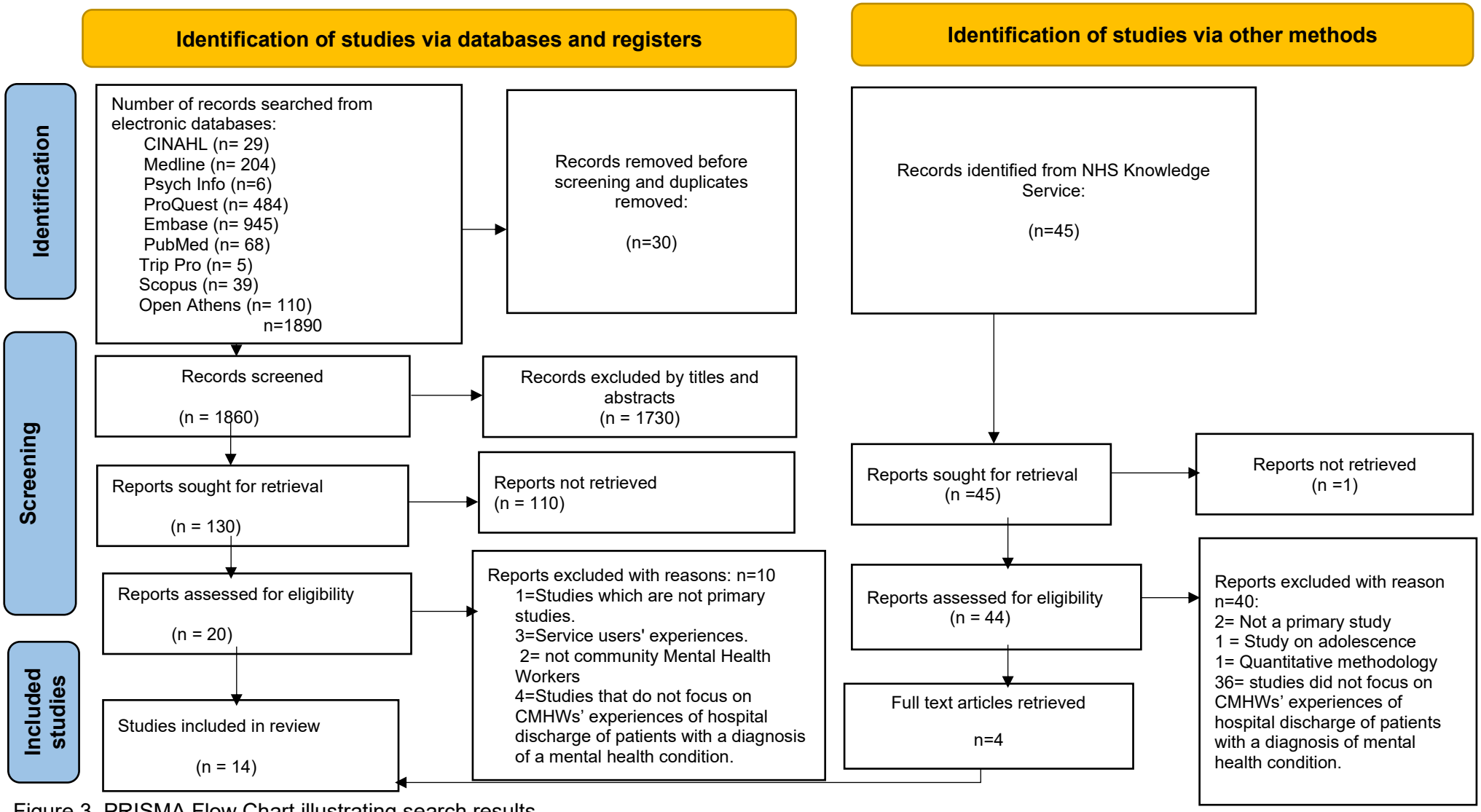

Figure 3. PRISMA Flow Chart illustrating search results

NB. Adapted from Page et al. (2021)

2.8 Search results retrieved from electronic databases

The search run yielded 1890 articles from 10 databases, which were transported to the EndNote software library, and from there duplicates were removed (see Figure 3). Following Ouzzani et al. (2016)'s recommendation, I exported articles to the Rayyan software, which produced 1,860 publications due to its high sensitivity in de-duplicating references. This resulted in 1730 articles being excluded by title and abstract, with 130 articles retrieved. After screening titles and abstracts, 20 full-text studies were assessed for eligibility, based on the literature review question, and ten studies were included. Identified records were then exported to the EndNote software folder according to their electronic databases.

An additional search from 45 articles identified by searching the NHS Evidence Knowledge Services database through consultation with the Local NHS Trust librarian was undertaken, and four articles were included. The NHS Evidence Knowledge Service was used to ensure no other studies had been missed. There are limitations to the NHS Evidence Knowledge Service, and the search may not have returned all papers available on the topic. The initial search yielded 14 studies that were included in this review, as shown in the PRISMA flowchart as shown in Figure 3. After a second electronic database search in November 2023, two more studies met inclusion criteria, bringing the total to 16 papers. Furthermore, Appendix 4 provides an overview of the characteristics all 16 studies included in this review. To enhance the rigour, credibility, auditability, and transparency of the review, Rayyan was used to invite a second PhD Post Graduate Researcher to check the selected articles and consensus was achieved.

Table 2. Summary of international studies included in the systematic literature review

Country	Number of papers retrieved
Australia	2
Canada	2
China	1
Dominican Republic	1
Ghana	1
Malaysia	2
Mexico	1
Nepal	1
Netherlands	1
Singapore	1
Somalia	1
United Kingdom	1
United States of America	1
Total	**16**

2.9 Descriptive characteristics of studies included for review

The studies included originated from 13 countries covering different types of CMHWs, as illustrated in Table 3. The varying approaches used for data analysis included thematic analysis (five studies), content analysis (two studies), constructivist inquiry guided by grounded theory (one study), framework analysis (two studies), and Collaizzi's seven step analysis (one study). Five studies Agyapong (2016), Beckers et al. (2019), Caplan et al. (2018), Forchuk et al. (2020), and Priebe et al. (2012) used mixed methods enquiries.

2.10 Data extraction and synthesis of findings

The characteristics of the studies included in the qualitative evidence synthesis search were managed using the Atlas.ti and EndNote 21 software, tailored to the aim of the search, and recorded manually in a data extraction table as illustrated in Appendix 5. To enable a synthesis of the textual data, individual participant quotes and original researchers' findings, including thematic examples, were extracted from primary qualitative and mixed-methods studies to ensure a comprehensive representation of the qualitative evidence in the synthesis (Cherry, 2023). I independently extracted and synthesised the findings, checking in with supervisors to make sure there was agreement on the process.

2.11 Quality assessment of studies

This qualitative evidence synthesis quality assessment process commenced with the adaptation and application of the validated Mixed Method Appraisal Tool (MMAT) comprising of 26 items (Pluye et al., 2018). This tool is recommended for systematic literature reviews to assess qualitative and mixed methods papers for their strengths and weaknesses, enabling the researcher to evaluate the methodological quality of each study. No papers were excluded based solely on quality; inclusion depended on relevance to the research question (Cherry, 2023). The quality assessment results were tabulated in an Excel spreadsheet and discussed with supervisors (see Appendix 6). Any discrepancies in assessment were addressed through reflection and discussion in supervision meetings.

2.12 Findings from thematic synthesis

Thomas and Harden's, (2008) thematic synthesis was employed to analyse and integrate content from various studies. This approach has been applied in reviews that focus on inquiries regarding lived experiences (Booth et al., 2012). Owing to the interdisciplinary aspect of the studies incorporated in this review, thematic synthesis was considered appropriate due to its capability to translate findings from diverse literature into shared themes for comparative analysis (Thomas & Harden, 2008). According to this method established by Thomas and Harden (2008), it involved three phases: The initial phase of the thematic synthesis included open line-by-line coding of the findings section from each study that was incorporated. Every sentence and paragraph were thoroughly examined to determine underlying themes and concepts. Text was marked if deemed to reflect the experiences of CMHWs in care coordinating hospital discharge of patients with a 42 of a mental health condition, and a code was developed to encapsulate its message. A code was represented as a single word like "facilitators" or themes, "experiences of positive" and "barriers" or a short phrase, "lack of community mental health resources" to summarise and convey a sentence or paragraph of text. A total of 195 initial codes were developed from data across 16 studies, then categorised into 4 themes and 14 subthemes using Atlas.ti software 23.

In the second phase, codes were placed side by side and compared across studies, with similarities clustered to form descriptive themes. Quotes from CMHWs were extracted from the studies included to further reinforce the descriptive themes. The third phase consisted of creating analytical themes by merging the descriptive themes as descriptive themes with evident similarities were transformed into analytical themes. This was to ensure that CMHWs' patients' hospital discharge remained central to the literature review. Table 3 summarises the papers that created a matrix which enabled thematic synthesis (Harden & Thomas, 2008).

Table 3. Illustration of descriptive themes across the studies included in the review

Descriptive themes / Study citation	Priebe et al. (2012)	Brenman (2014)	Goscha & Rapp (2015)	Hanafiah & Van Bortel (2015)	Agyapong et al. (2016)	Ion et al. (2017)	Martinez et al. (2017)	Caplan et al. (2018)	Murphy et al. (2018)	Beckers et al. (2019)	Forchuk et al. (2020)	Russell et al. (2021)	Petrie et al. (2021)	Goh et al. (2022)	Li et al. (2022)	Nyassi et al. (2023)
Duties and Responsibilities of Community Mental Health Workers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Challenges and enablers of care coordination	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Multidisciplinary Team Working in Care Coordination	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospital Discharge into Community Mental Health Integrated Services	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Ultimately, the process of developing analytical themes allowed me to synthesise the meaning of these patterns and combine data from different approaches to answer the study aim, research question, and gaps in literature.

Based on my interpretive stance in this study, the decision was made to use thematic synthesis as a method of qualitative data analysis to enable systematic identification of codes and synthesis of recurring themes in data sets and their interconnectedness (Aveyard, 2019; Aveyard et al., 2016, 2021). The codes were developed inductively based on review questions, and the researcher's expectations were shaped by the manner in which these codes were combined and analysed (Thomas & Harden, 2008). Patient hospital discharge into integrated community mental health services, as illustrated in Figure 4. From this systematic literature review, four themes and subthemes are now presented (see Sections 2.13.1 to 2.16.4).

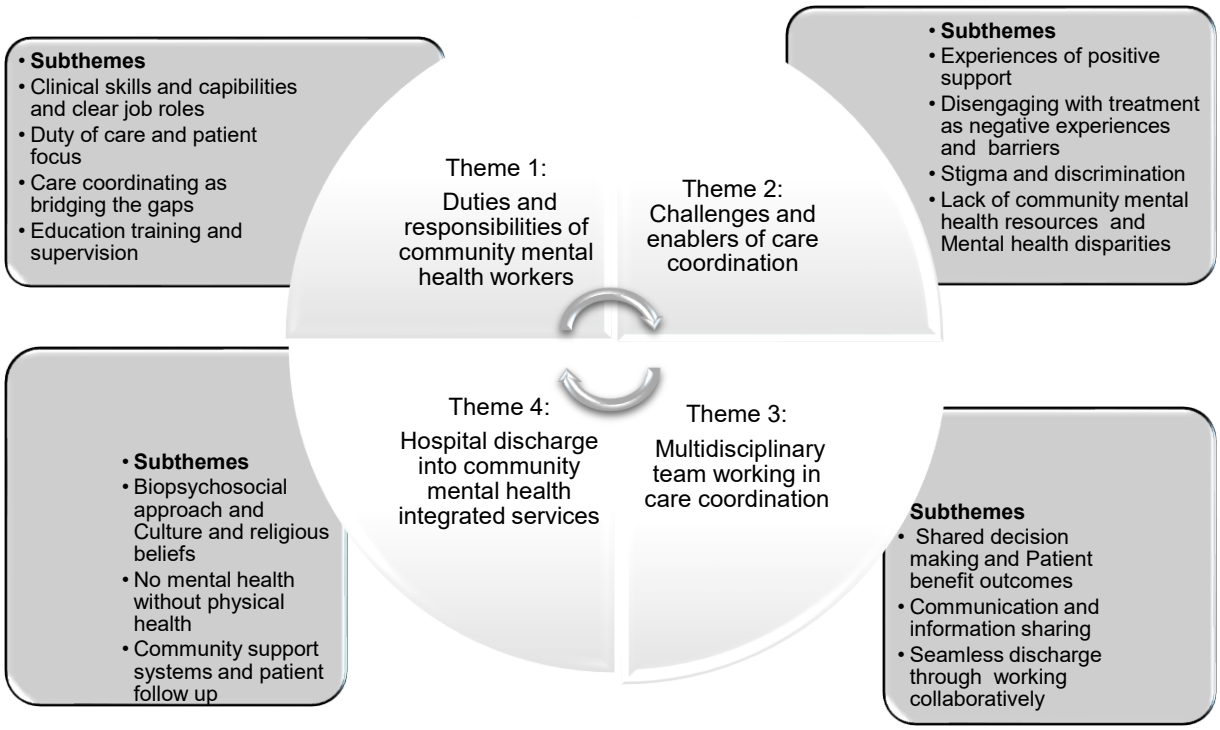

Figure 4.Descriptive themes and analytical themes

2.13 Theme 1. Duties and responsibilities of community mental health workers

Theme 1 describes Community Mental Health Workers' direct responsibilities for care-coordinating patient hospital discharge. For example, assessing patient needs and developing care plans, offering advice, supporting patients and their families, and liaising with other professionals and external agencies are important components of patient care (Priebe et al., 2012).

This theme captures the shared experiences of CMHWs regarding their duties and responsibilities in coordinating the hospital discharge of patients diagnosed with mental health condition into Community Mental Health Integrated Services (CMHISs), as documented in the majority of studies (Agyapong et al., 2016; Beckers et al., 2019; Brenman, 2014; Caplan et al., 2018; Forchuk et al., 2020; Goh et al., 2022; Hanafiah & Van Bortel, 2015; Ion et al., 2017; Li et al., 2022; Martinez et al., 2017; Murphy et al., 2018; Nyassi et al., 2023; Petrie et al., 2021; Priebe et al., 2012; Russell et al., 2021).

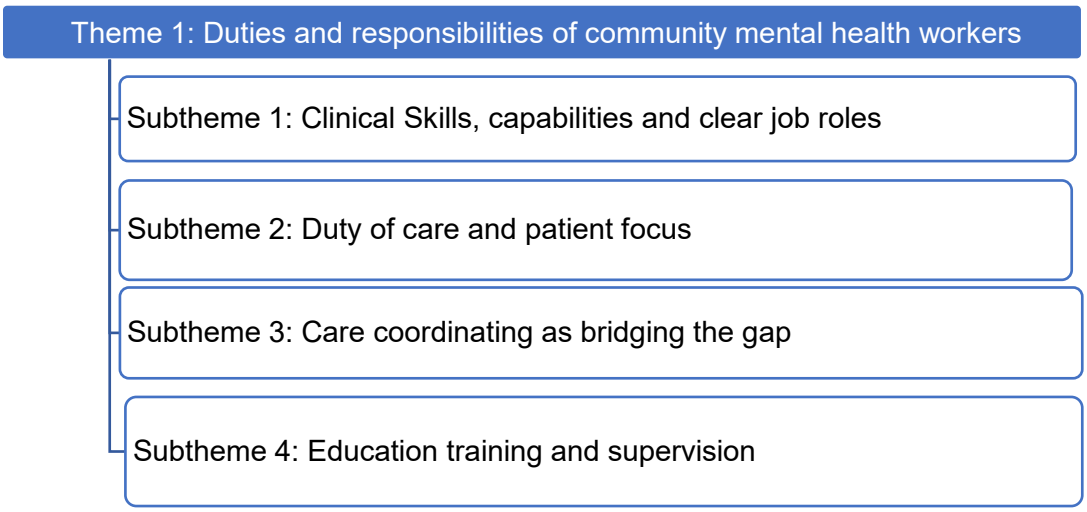

Figure 5. Theme 1: Duties and responsibilities

Subtheme 1.1: Clinical skills and capabilities and clear job roles

There were differences in participants' experiences in some studies regarding the level of skills and knowledge required to perform their duties among CMHWs (Agyapong et

al., 2016; Goh et al., 2022; Goscha & Rapp, 2015). In these studies, psychiatrists working within CMHTs as part of MDTs were responsible for providing guidance on case referrals, diagnoses, treatments, and the clinical skills and capabilities of CMHWs:

> "And I think that's probably one of the most important components of the shared decision-making […] because we're helping people look at activities they do on a daily basis, what they routinely do that will help them". (Goscha & Rapp, 2015, p.5)

The roles of diagnosing, prescribing medication, and counselling were reported by some participants such as Clinical Psychiatric Officers (CPOs) and Community Psychiatric Nurses (CPNs) were assigned roles such as treating and managing anxiety, schizophrenia, and depression, with one participant saying:

> "The CPOs function broadly like the physician, i.e., the management of common psychiatric disorders and they are supposed to be trained to recognise those conditions that they need to send on to the psychiatrist" (Agyapong et al., 2016, p.5)

A study conducted by Goh et al. (2022) highlighted the need for CMHWs to have in-depth knowledge and skills that meet their job roles:

> "I think going in-depth matters because I think we need the depth of knowledge to really call ourselves a professional."
> (Goh et al., 2022, p.596)

Many of the studies reviewed highlighted that clinical skills and capabilities included facilitating supported hospital discharge, providing home visit follow-ups and care planning, triaging and signposting to other services, medication monitoring and administration, providing psychosocial support, following discharge legal frameworks, and facilitating communication and bridge-making between hospital and CMHISs (Beckers et al., 2019; Brenman, 2014; Caplan et al., 2018; Forchuk et al., 2020; Li et al., 2022; Martinez et al., 2017; Russell et al., 2021). This subtheme demonstrates the important role CMHWs play in providing holistic, comprehensive care for those with mental health needs.

Hence, Forchuk et al., (2019) suggested ways of clarifying some CMHWs' job roles among other CMHWs stating:

> "There is a necessity to make it blacker and whiter and to identify exactly who is doing what."
> (Forchuk et al., 2019, p.504)

In another study, one participant highlighted that CMHWs lacked training on how to help patients with a diagnosis of mental condition, saying:

> "[In relation to mental health] I am not trained and if I receive one month of training this is not going to be sufficient to understand and to be able to help those patients with mental problems."
> (Martinez et al., 2017, p.4)

Furthermore, in another study doctor's role in the community was outlined:

> "Doctors in primary care are authorised to prescribe a restricted number of psychotropic medications, but nurses are not permitted to independently diagnose and treat mental disorders in primary care."
> (Russell, 2021, p.2)

Subtheme 1.2: Duty of caring and patient focus

CMHWs in a study conducted by Beckers et al. (2019) highlighted aspects of care such as following up patients after discharge, monitoring patients on prescribed antipsychotic medication, and how this benefits the patients:

> *"*I get that some cannot have those patients [with Clozapine and Lithium] in primary healthcare, but some of them are very stable. Their recovery is very good."
> (Beckers et al., 2019, p.6)

Whereas in a study conducted by Murphy et al. (2018), a community pharmacist listened to a patient story and referred them for emergency treatment:

> "…We called the crisis line together and ended up taking her to the emergency room. The patient came back in a few weeks ago, which was months after our first knowledge of her thinking of suicide, with bandages on her wrists. She feels as though no one is listening to her."
> (Murphy et al., 2018, p.1178)

Participants also emphasised the importance of follow-up care for patients after hospital discharge and transition into the community, to monitor mental health, medication compliance, and assess for other social care needs (Agyapong et al., 2016; Caplan et al., 2018; Beckers et al., 2019; Brenman, 2014; Forchuk et al., 2020; Goh et

al., 2022). This was illustrated by the role of CMHWs in shadowing and learning from experienced co-workers to facilitate client discharge follow-ups:

> "It's important if we can have job shadowing programme for a short period of time. This way we may know how the cases are managed and what can be done to facilitate the transition into the community… the practical aspects." (Goh et al., p.596)

> "There is something about being able to follow clients...you see the recovery." (Forchuk et al., 2020, p.503)

Participants highlighted the need for full assessment of social care needs during the discharge for successful and safe transitions from inpatient to community care (Russell et al., 2021).

In two studies conducted by Goh et al. (2022) and Forchuk et al. (2020) participants believed that patient-focused care helped to promote a good relationship with patients in the community. In addition, in another study one participant said:

> "Mental health care professionals should be aware that it is often essential to invest time in establishing a good relationship with a patient before treatment can be started." (Priebe et al., 2012, p.5)

Subtheme 1.3: Care coordinating as bridging the gaps

Participants in studies conducted by Agyapong (2016) and Nyassi et al. (2023) reported that CMHWs have a vital role to play in bridging the gaps during the patient transition into the community. Similarly, it was suggested that CMHWs could act as a bridge for communities who lack trust in external sources of care (Brenman, 2014).

> "… yea trying to bridge the gap between the hospital and community …, so that we're just working through as far exactly where we fit… figure out from inpatients as to who how you get those people the supports…" (Forchuk et al., 2020, p.503)

In studies conducted by Forchuk et al. (2020), Goh et al. (2022) and Ion et al. (2017), participants highlighted that they bridge the gap between hospital discharge and consequently patients felt supported.

> "…the clients are feeling supported, through the discharge model and having the staff bridging and peer support bridging as well. They [clients] are enjoying being connected and knowing that it [TDM] will be a helpful piece for them once they are discharged." (Forchuk et al., 2020, p.503)

> "Another goal of [integrated care] is to have the patient have more of a voice, that the patient can set the agenda…" (Ion et al., 2017, p.276)

> "There really has to be a network. Otherwise, each party will just pass the buck. Social services say it's psychiatric and will not provide care, psychiatry says it's a homeless person and they do not handle that and while we're busy going back and forth, nothing gets done..."
> (Priebe et al., 2012, p.7)

Subtheme 1.4: Education, training, and supervision

The role of CMHWs in managing patients with a diagnosis of Mental health condition was explored in a qualitative study conducted by Goh et al. (2017) and to identify the following: risk of patient relapse, and the need for training to improve their skills. As one CMHW stated:

> "I think going in-depth matters because I think we need the depth of knowledge to really call ourselves professionals."
> (Goh et al., 2017, p.596)

Furthermore, another CMHW highlighted the importance of practical experience, highlighted that people living in rural areas are more accepting of mental health conditions, their strong collective community lifestyle (social capital) as demonstrated in the following quote:

> "Orang kampung (people living in rural areas), as long as you don't bother or affect them, it (mental illness) doesn't matter to them." (Hanafiah & Van Bortel, 2015, p.6)

These insights provide valuable information to inform the development of training programmes for CMHWs in order to ensure that they are adequately equipped to support patients diagnosed with a mental health condition. Similarly, in a study conducted by Petrie et al. (2021), some participants expressed the view that training would improve knowledge and skills in community mental health workers.

> "If more CMHWs are trained and dispatched into the communities, it would improve on mental health care and reduce psychotic patients roaming in our streets." (Agyapong et al., 2016, p.6)

2.14 Theme 2. Challenges and enablers of community mental health workers

This theme refers to CMHWs' range of experiences, including workload pressures, lack of resources, and difficulty in obtaining access to specialist services in the community. Positive facilitators include support from the organisation, colleagues, and supportive team culture. This theme has the following four subthemes:

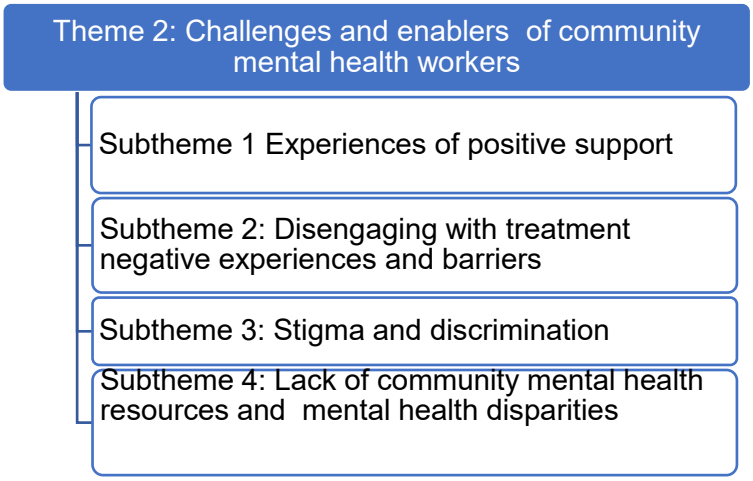

Figure 6. Theme 2: Experiences, barriers, and facilitators

Subtheme 2.1: Experiences of positive support

The findings of five studies (Forchuk et al., 2020; Goh et al., 2022; Goscha & Rapp, 2015; Murphy et al., 2018; Russell et al., 2021) suggest that the transition discharge model and the associated communication strategies are beneficial in improving the discharge process and ensuring the safety and success of patient transitions. These strategies include communicating using case conference, phone calls, and emails; using shared decision-making; assisting patients with medication issues; and discussing patient discharge with primary care clinicians face-to-face.

Goh et al. (2022) found that, during the COVID-19 pandemic, participants in their study reported positive experiences of training via Zoom, citing convenience and time

efficiency. Participants in the study noted the importance of support from their organisations in helping to boost morale and reduce burnout:

> "I think support has been good. The seniors have been very, very supportive. Even after work hours, they'll still answer to the group chat. They don't leave us in the lurch." (Goh et al., 2022; p.596)

Subtheme 2.2: Disengaging with treatment as negative experiences and barriers.

Whereas studies conducted by Agyapong et al. (2016) and Goh et al. (2022) highlighted a shortage of psychiatrists, inadequate training, lack of clear treatment frameworks, and heavy patient caseloads, participants were still willing to accept nurses providing mental health care, despite some concerns that it could compromise care. Additionally, CMHWs' experiences, barriers, and facilitators to coordinating discharge and referring patients to other services were also highlighted in the studies. However, in some circumstances CMHWs' mistreatment of patients with mental health condition has resulted in patients disengaging with treatment:

> "Sometimes the bad behaviour of the people of the health posts problems would also result in people stopping treatment." (Brenman et al., 2014, p.7)

Experiences of CMHWs differed across studies, with some feeling empowered by their knowledge and skills to provide a more holistic approach to care, while others felt they lacked the necessary expertise to do certain job tasks or felt incompetent to perform certain duties. Psychiatrists also expressed concerns that some CMHWs were doing jobs beyond their competence (Agyapong et al., 2016).

Subtheme 2.3: Stigma and discrimination

In studies conducted by Li et al. (2022), Beckers et al. (2019), Brenman (2014), Caplan et al. (2018), Hanafiah and Van Bortel (2015), and Martinez et al. (2017), participants reported experiencing stigma as a barrier to accessing resources such as housing and job opportunities. Particularly, family members and community services were found to

be reluctant to provide such facilities to those with a diagnosis of mental health condition.

> "There are many patients in the community, but because.…it is a disgrace for the family to have a psychiatric patient, then you better hide them, or avoid saying anything, or move to another environment, to another community where they aren't known." (Caplan et al., 2018, p.886)

Caplan et al. (2018) found that mental health care providers often held stigmatising attitudes towards people with a diagnosis of mental health condition, and families often hid or avoided discussing the issue due to stigma. This indicates the need for increased public education and awareness of mental health issues, more support for families, and better training for healthcare providers in how to address and support people with mental health issues.

Subtheme 2. 4: Lack of community mental health resources and mental health disparities

Most studies have emphasised the importance of CMHSs in facilitating successful transitions between MDTs, patients, and their careers. However, studies by Martinez et al. (2017), Nyassi et al. (2023), Petrie et al. (2021) and Caplan et al. (2018) reveal a lack of mental health resources and services available to meet patients' needs upon discharge:

> "In 2015, 10 years after the collection of the data utilized by WHO-AIMS report, there remains a great need for resources dedicated to mental health services in the DR. This lack of resources falls into four main areas: (a) insufficient budget for mental health services; (b) lack of essential medications; (c) lack of treatment facilities; and (d) lack of human resources." (Caplan et al., 2018, p.881)

CMHWs expressed concern that understaffing of their units before the implementation of the Transitional Discharge Model (TDM) could compromise community integration (Forchuk et al., 2020). Additionally, studies conducted by Goh et al. (2022) and Petrie et al. (2021) have reported that lack of human resources and funding have further

inhibited the delivery of care to patients. This was echoed in an interview with one of the CMHWs who stated:

> "The issue most frequently identified by HPs was a lack of sufficient funding – for programmes, services, rebates, and system resources at all levels – but particularly in the public system and for community mental health. This was perceived as being a key cause of common gaps in mental health service provision." (Petrie et al., 2021, p.319)

These findings underscore the need to prioritise mental health funding in order to ensure that all individuals have access to quality mental health care.

2.15 Theme 3: Multi-disciplinary team working in care coordination

The 'multidisciplinary team working' theme addresses better ways of communication and shared decision-making between CMHTs and other agencies to enable improvements to care coordination. This theme has the following three subthemes:

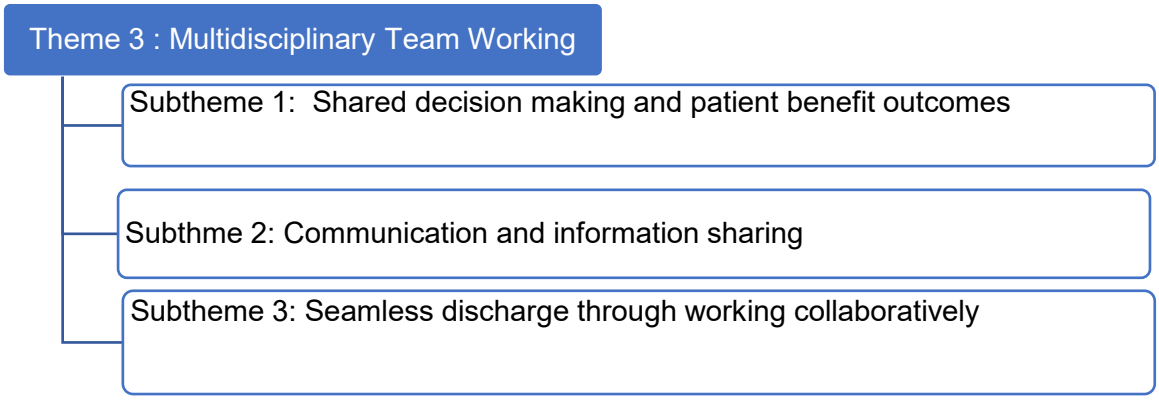

Figure 7. Theme 3: Multidisciplinary Team Working

Subtheme 3.1: Shared decision making and patient benefit outcomes

The findings from studies conducted by Forchuk et al. (2020) and Goh et al. (2022) highlighted some of the challenges faced by CMHWs during the discharge planning process. In particular, CMHWs raised concerns about the lack of MDT involvement in their work. In response to this, the same studies suggested the importance of "collective action" in the MDT, such as ward meetings (also known as 'rounds'). These

rounds are meetings held to ensure that all team members including CMHWs patients and their careers are consulted during the discharge planning process:

> One health professional participant said, "...coming to rounds... [has] made the difference." (Forchuk et al., 2020, p503)

Subtheme 3.2: Communication and information sharing

Studies conducted by Brenman (2014), Caplan, et al. (2018), Goh et al. (2022), and Li et al. (2022) demonstrate the importance of CMHWs communication and information sharing within MDTs to ensure the continuity of care. These studies found that CMHWs highlighted the importance of organisations creating more networking opportunities for CMHWs, hospitals, and partnering organisations to improve mutual understanding of different work processes. As one CMHW reported:

> "I encountered hospital staff who see value with connecting with the CMHWs. We work very closely...through case conferences, emails, and calls to update about our cases." (Goh et al., 2022, p. 594)

While appreciating the need to protect patient information, participants in a majority of the studies highlighted that communication and information sharing is a bedrock to a seamless discharge process. In addition, other studies identified challenges in communicating over the phone and engaging with patients after discharge as a barrier, as illustrated in the quote:

> "Another barrier to the interaction was that it was over the phone, thus making it more difficult to gauge the patient's response and build rapport. I felt that I could have asked more specific questions and be more engaged if it were face-to-face." (Murphy et al., 2028, p.1176)

Subtheme 3.3: Seamless discharge through collaboratively working

This subtheme captures CMHWs' involvement in the discharge and planning process, as highlighted in three studies (Forchuk et al., 2020; Goh et al., 2022; Li et al., 2022). Participants in both studies described the vital role CMHWs play in providing continuity of care by saying, for example:

> "…I found myself, you know, a week before discharge scrambling to kind of like get clients engage[d] in conversation about discharge and realising that something like you pretty much have to start addressing right from the beginning the routine working relationship but all the way through." (Forchuk et al., 2020, p.503)

The studies conducted by Goh et al. (2022), Russell et al. (2021), and Priebe et al. (2012) all demonstrated that participants experienced good collaboration and competence when it came to the discharge process, allowing for a smoother transition:

> "We have excellent collaboration with the social workers. Their competence allows us to understand better where to place the patient. Their understanding of the patient's needs helps us to find the solutions." (Priebe et al., 2012, p.8)

On the other hand, a study conducted by Russell et al. (2021) reported that participants experienced a lack of collaboration during the discharge process and that barriers to information sharing with other CMHSs jeopardised collaboration, thus compromising patient care.

2.16 Theme 4: Hospital discharge into community mental health integrated services

This theme highlights the challenging areas such as lack of care-coordination and poor communication between CMHWs and other health care professionals that need improvement. This theme has the following three subthemes.

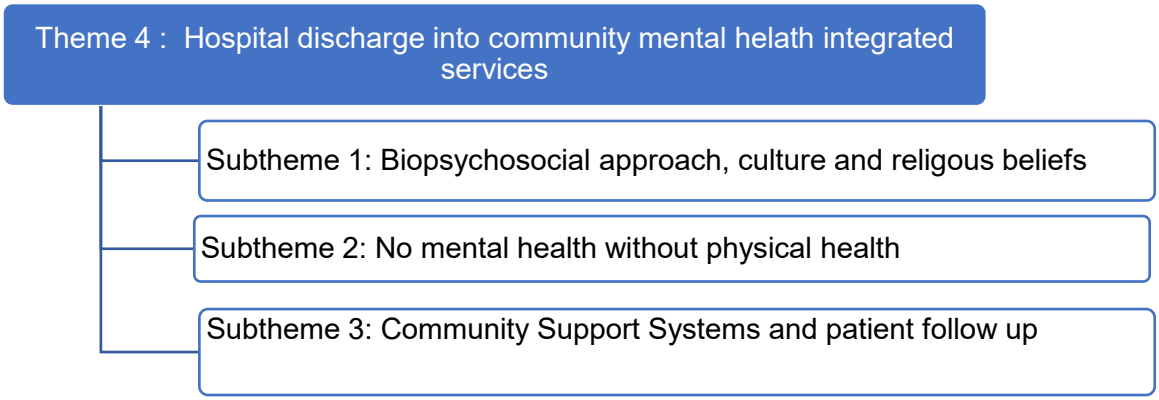

Figure 8. Theme 4: Hospital discharge into community mental health integrated services

Subtheme 4.1: Using a biopsychosocial approach, culture, and religious beliefs

The importance of the biopsychosocial approach in the discharge process has been highlighted in recent studies conducted by Beckers et al. (2021), Russell et al. (2021), Priebe et al. (2023), and Nyassi et al. (2023). Participants in these four studies reported the importance of psychological support and cultural and religious beliefs:

> "I value it when professional support is involved, like home care or any other professional support. It takes away distress from the patient." (Beckers et al., 2019, p.6)

> "Mental health services make sense, and psychological support in particular, in places where there are other services that people usually attend, for example to get their documentation." (Russell et al., 2021, p.6)

> "Services have to acknowledge the holistic issues, and link with other organisations dealing with those clients." (Priebe 2012, p.7)

> "Some people take the patient to the Sheikhs. Particularly our elderly people believe in taking the person to the traditional healer's centre." (Nyassi et al., 2023, p.8)

Studies conducted by Caplan et al. (2018) and Hanafiah and Van Bortel (2015) have revealed the experiences of individuals working with patients and their families who have cultural and religious beliefs regarding mental health condition:

> "Every family needs to return to faith, understanding and assurance that there is a God, and that He can help us to move forward… Many of these things happen because families don't believe in God… and we should lay the foundation for our family." (Caplan et al., 2018, p.888)

Participants showed an understanding of the social, cultural, and religious influences that may affect a client's mental health and strive to integrate care that is respectful of the client's beliefs and in line with their confidentiality (Ion et al., 2017). Additionally, participants recognise the power of storytelling in providing mental health care, as stories can create a better understanding of the individual's mental health journey (Hanafiah & Van Bortel, 2015).

Subtheme 4.2: No mental health without physical health

Studies conducted by Russell et al. (2021), Li (2022), and Hanafiah & Van Bortel (2015), highlight the importance of holistic patient care among patients with a diagnosis of mental health condition. This approach seeks to raise awareness of the need to consider physical health and social care needs in mental health assessments, which are often overlooked:

> "Cos this is community health, a health clinic, I am not in a speciality clinic, so I have to see every case that comes and see the patient as a whole." (Russell et al., 2021, p.6)

Participants highlighted that an integrated approach to the patient's care is essential, as physical, and mental health issues are often intertwined.

> "I am both a family physician and I also manage mental health services. But I manage mental health services only part-time. I manage 151 people with mental illnesses, and more than 200 people with chronic illnesses." (Li et al., 2022, p.7)

> "…Because the staff think mentally ill people can never recover, they seem to pay less attention to their wellbeing. Sometimes when patients complain of physical illness, the staff can just ignore because they think the patient is acting out. It's dangerous. Can even lead to death if serious enough." (Hanafiah & Van Bortell, 2015, p.5)

Participants in these studies demonstrated that CMHWs play an essential role in providing holistic care and emphasised the importance of supporting patients beyond simply treating illnesses that impact physical health.

Subtheme 4.3: Community support systems and patient follow-up

Participants in various studies have reported a lack of support systems during the discharge and care-coordination of patients (Beckers et al., 2019; Forchuk et al., 2020; Goh et al., 2022; Goscha & Rapp, 2015; Hanafiah & Van Bortel, 2015; Ion et al., 2017; Martinez et al., 2017; Murphy et al., 2018; Petrie et al., 2021; Priebe et al., 2012). In

contrast, CMHWs have recognised the importance of establishing relationships with community support systems to facilitate successful post-discharge care:

> "…I think what we are seeing is a lot of supportive relationships being developed and just to see that shift in roles... I sort of take the step back and the volunteers [peer supporters] take that role..."
> (Forchuk et al., 2020, p.502)

Participants across multiple studies Beckers et al., (2019); Brenman, (2014); Forchuk et al., (2020); Goh et al., (2022); Ion et al., (2017) have highlighted the benefits of referrals to other services for mental health recovery:

> "Yes, and it [the referral from specialist mental health services to primary health care] gives them the feeling that they have accomplished something—to be trusted again. It gives their confidence a giant boost."
> (Beckers et al., 2019, p.6)

Participants in one study by Nyassi et al 2023 believed that patient-focused care helped to promote a good relationship with patients in the community. For example,

> "If the family refuses to take the patient to the hospital, we call the doctor, so the patient can get treatment them in their home." (Nyassi et al 2023, p1056)

2.17 Discussion

The systematic literature review explored CMHWs' experiences of care-coordinating hospital discharge of patients with a diagnosis of mental health condition into community mental health integrated services (CMHISs) globally. Following Thomas and Harden's (2008) approach to thematic synthesis, the findings from the 16 studies fell into four themes: duties and responsibilities; experiences, challenges, and enablers; MDT approach; and hospital discharge into CMHISs, as presented earlier.

In all 16 studies, the initial theme regarding duties and responsibilities was developed from the real-life experiences encountered by CMHWs. Although this first theme suggests an emphasis on roles and responsibilities, it was reported ambiguously in different studies, particularly in the context of CMHWs. This increases the need to

further develop our understanding of how CMHWs experience role conflict and how it can affect the relationship between MDTs (Agyapong et al., 2016). For example, three studies, Forchuk et al. (2020), Goscha and Rapp (2015), Murphy et al. (2018), out of 16 studies highlighted that some CMHWs were performing multiple roles. However, some studies showed consensus and gave guidance to CMHWs to work within their clinical skillsets and capabilities (Goh et al., 2022). These findings align with the argument presented by Baxter et al. (2020), which asserts that establishing clear boundaries for job roles and providing adequate training are essential for promoting safe patient hospital discharge and ensuring high-quality care.

Agyapong et al. (2016) found that Ghanaian psychiatrists and policy directors who work in CMHSs perceived a lack of government commitment to mental health care and that CMHWs had a significant role to play in improving service provision. One study which was conducted by Goh et al. (2022) during the COVID-19 pandemic highlighted that some CMHWs benefited from using online training to improve their skills. Studies conducted by Agyapong (2016), Brenman (2014), Forchuk et al. (2020), and Murphy et al. (2018) have shown similarities with respect to facilitators and barriers. Moreover, Ion et al. (2017) assert that a robust discharge plan is essential for patients with mental health or physical health conditions. Furthermore, participants in these studies have highlighted barriers such as long waiting times for patient appointments, lack of essential medication, lack of communication, and delays in being accepted by other services in primary care, and other community organisations such as GP and psychological therapies (Brenman, 2014; Forchuk et al., 2020; Martinez et al., 2017).

These findings resonate with those illustrated in a study conducted by Petrie et al. (2021) exploring the challenging experiences of health professionals and gaps in mental health services. However, for example in the studies by Agyapong et al. (2016), Russell et al. (2021) and Petrie et al. (2021), CMHWs adopted a humanistic approach, emphasising the importance of patient-centred care, dealing with work pressures, and

clarifying job roles to improve patient transition into the community. Moreover, the humanistic approach places more emphasis on the individual's experiences, preferences, and social context than on diagnosis and treatment. This method promotes a more holistic view of mental health by focusing on the individual's overall wellbeing rather than just treating symptoms.

Two studies, Goh et al. (2022) and Beckers et al. (2019), showed that some CMHWs experience anxieties and stress due to the long referral processes. They also expressed concerns about personal safety and wellbeing when helping patients with a diagnosis of mental health condition during discharge process, especially when risk assessments have not been shared with them. Goh et al. (2022), as well as Hanafiah and Van Bortel (2015) showed that CMHWs play a vital role in helping patient hospital discharge into CMHISs, facilitating inclusion and practical support, and reducing barriers such as stigma and discrimination. Furthermore, a study conducted by Priebe et al. (2012) found out that the role of CMHWs was viewed as double-edged sword in that, as they bridge the gap, they are also acting as patient voice and advocate using a patient-centred approach. For example, studies conducted by Goscha and Rapp (2015), Beckers et al. (2018), Caplan et al. (2018), Forchuk et al. (2020), Petrie (2021), and Roth et al. (2021) have highlighted that CMHWs take on multiple duties and responsibilities in care-coordinating of the hospital discharge of patients or service users in the community, including: discussion with MDTs, communication between different CMHISs, and referrals to other specialist services such as primary care services. The findings highlight the importance of integrated CMHT being given an opportunity and conditions in which to help reduce long mental health hospital stays (Ion et al., 2017). Similarly, communication and sharing of patient information during transition into the community helps to establish a therapeutic relationship and engagement with patients and their carers, rather than making decisions for them in their absence (Beckers et al., 2018; Brenman et al., 2014; Forchuk et al., 2020).

This literature review demonstrated that CMHWs value the multidisciplinary team approach during the discharge process and appreciate collaborating with other organisations in the community (Goh et al., 2022). This current study echoes these findings, revealing that CMHWs often feel excluded and uninformed about decisions made regarding patient care post-discharge (Caplan et al., 2018; Forchuk et al., 2020).

Additionally, strategies are required to enhance the involvement of CMHWs in the patient hospital discharge process, as well as to evaluate their potential impact on patient care. This is consistent with Forchuk et al. (2020) and Goh et al. (2022) who argue that CMHWs raise concerns when they are not involved in MDT meetings to plan and care coordinate hospital patient discharge. Human interaction and collaboration in community mental health settings are fundamental for shared decision-making and actively engaging the patient and their carers in the discharge planning (Murphy et al., 2018). The findings of this review highlight CMHWs' experience of work which encourages CMHWs within MDTs to put the patient in the centre of their care (Forchuk et al., 2020).

Priebe et al. (2012), Martinez et al. (2017), Murphy et al. (2018) and Forchuk et al. (2020) showed the need for discharge planning from the time the patient is discharged from hospital until they are stable in the community. Thus, CMHWs have to take into consideration patients' biological, psychological, and social care needs, as well as their cultural and environmental needs when planning discharge because they are assumed to have a positive effect on the individual's social re-integration into the community (Russell et al., 2021). Similarly, a study conducted by Murphy et al. (2018) highlighted the following as important during MDT: assessment of risk, formulating management plans, follow-ups, and monitoring medication adherence.

CMHWs' observations of some care models are that they can be more expensive when patients are having a long stay in hospital for treatment. This may need to be explored further in future research. This review has revealed that CMHWs' experiences of care-

coordination of discharge planning was not commonly described in most studies. However, studies conducted by Goh et al. (2022), Goscha and Rapp (2015), Ion et al. (2017) and Martinez et al. (2017) have highlighted the importance of discharge planning as essential for promoting patient recovery during transition back into the community. For example, this included discussion with multidisciplinary teams, communication between different mental health services, and referrals to other specialist services, such as GPs. Although some CMHWs had the skills and experience of care-coordinating patient hospital discharge, they highlighted concerns about the lack of a clear framework for treatment and lack of mental health resources in the community to which they could refer patients (Petrie et al., 2021).

Furthermore, the importance of integrating CMHSs was also emphasised by Ion et al. (2017) and Forchuk et al. (2020). This theme resonates with themes that were developed from a study conducted by Martinez et al. (2017) which suggested that CMHISs play a key role in treating patients in the community but experience many barriers. In addition, results from a study conducted by Murphy et al. (2018) also indicated that community pharmacists experienced barriers regarding gaps in the system to communicate a patient's medication to receiving teams in the community post-discharge. Similarly, findings from a study conducted by Goscha and Rapp (2015) have revealed that CMHWs experience a lack of care-coordination and knowledge sharing during the discharge process which may lead to post-discharge medication errors. Findings from a study conducted by Priebe et al. (2012) highlighted that care-coordinating of patients with a diagnosis and those from marginalised groups can face barriers if there are no services available. These barriers to care-coordinating patient hospital discharge echo those of studies conducted by Goscha et al. (2015), Ion et al. (2017), Martinez et al. (2017), Beckers et al. (2018), and Russell et al. (2021) and are consistent with themes that were developed across all studies in exploring discharge planning in a healthcare setting.

Although the findings from the 16 studies in this review explored experiences of CMHWs in other areas, such as communication education, training, their knowledge and skills barriers and the facilitators of providing care in the community mental health services, little is known about CMHWs' experiences of the care-coordinating discharge process (Russell et al., 2021). Moreover, studies conducted by Caplan et al. (2018), Goh et al. (2022), and Hanafiah and Van Bortel (2015) have highlighted the lack of education and awareness of mental health conditions amongst mental health workers, emphasising the need for better care-coordination and discharge processes. To address this, gaining knowledge and understanding of mental health condition may help CMHWs to effectively provide interventions and treatment that promote recovery (Nyassi et al., 2023).

In addition, one study conducted by Murphy et al. (2018) included experiences of a pharmacist, whereas the majority of studies ignored the vital role of pharmacists in care-coordinating that bridges the gap and links between the patient with CMHT services and other important social connections. Furthermore, it is well established that discharge without proper coordination of patient care is likely to lead to poor patient care (Murphy et al., 2018; Forchuk et al., 2020). In addition, findings from studies conducted by Caplan et al. (2018) and Forchuk et al. (2020) identified gaps in knowledge that seek to explore CMHWs' experiences of care-coordinating hospital discharge of patients with a diagnosis of a mental health condition into the community. Therefore, the study conducted by Goscha and Rapp (2015), which used constructivist naturalist inquiry as a framework to explore CMHWs' experiences of decision-making around patient hospital discharge, provides a valuable foundation for further research.

2.18 Strengths and limitations of the systematic literature review

The systematic literature review has both strengths and limitations. One of the strengths is that this systematic literature review included studies conducted across

multiple countries, the utilisation of mixed methods studies, and incorporation of digital technology for data collection and storage. Combining diverse health contexts and practices, this global perspective strengthens the body of evidence and increases the transferability of the results. Most studies address trustworthiness issues such as transferability, credibility, dependability, and confirmability (see Chapter 4, Sections 4.12.10 – 4.12.12.14). This review provides a deeper understanding of the factors that influence the roles of CMHWs by reviewing studies from different regions that capture a wide range of challenges and strategies for care-coordination. Furthermore, combining qualitative and mixed methods research enriches the study and allows for a more complex and diverse study of care-coordination of patient hospital discharge practices. Studies conducted by Agyapong (2016), Brenman (2014), Goscha and Rapp (2015), Ion et al. (2017), Li et al. (2022), Petrie (2021), Priebe et al. (2012), and Russell et al. (2021) demonstrated strengths in employing software for data management, analysis, auditability, and transparency. In addition, this systematic literature review identifies common themes, reports clinical implications, and suggests directions for future research.

However, the studies reviewed also suffer from limitations that include inadequate discussion and weaknesses of incomplete reporting of methodological approach. This is important as it can help to ensure transparency and enhance the credibility of the research. However, these are all vital in providing a structured foundation for understanding, interpreting, and analysing the phenomena under study, thereby guiding the research design and methodology.

Notably, the majority of the reviewed papers did not specifically explore the experiences of CMHWs, instead concentrating primarily on challenges and strategies for service improvement. Only a minority of the studies conducted by Brenman (2014), Caplan et al. (2018), Martinez et al. (2017), and Murphy et al. (2018) used thematic analysis as a potential avenue for enhancing textual data analysis. This is a weakness

because omission of participant diversity can lead to a lack of depth of information in understanding the qualitative data, potentially overlooking significant patterns and themes. Moreover, the inclusion of low-quality papers was deemed necessary to capture a comprehensive range of perspectives and data, despite potentially compromising to the overall quality of the review. This approach ensures that critical information and insights which might otherwise be excluded are considered in the analysis (Byrne, 2022; Cooke et al., 2012). Variability in study designs and populations, lack of clarity in meeting criteria, lack of theoretical underpinnings in the majority of the studies, and restriction to English language publications may limit the transferability of findings. Despite these limitations, the review offers a comprehensive overview of CMHWs' experiences, emphasising the need for further research in this area.

2.19 Implications for clinical practice and future research

The literature review has significant implications for clinical practice, policy, and education. The findings highlight a variety of barriers in care-coordinating the discharge process, including limited communication with hospital staff, difficulty accessing patient records and data, and lack of resources. From a policy perspective, the review underscores the necessity for policies that support seamless care transitions and integrated mental health services. Policymakers should consider the study's findings to inform the development of guidelines that facilitate effective care-coordination because it can help patients to receive the support, they need from different community mental health providers. Overall, this review reveals several gaps in research practice across studies on community mental health and care-coordination, which quantitative methods could not adequately capture. Consequently, a qualitative intrinsic case study design was selected to enable an in-depth exploration of CMHWs within their natural work settings, aligning with the review's emphasis on the importance of contextual richness and participant voice.

Agyapong et al. (2016) identify a lack of adequate training and resources for CMHWs in Ghana, stressing the need for comprehensive policy guidelines and ongoing support, , stressing the need for inclusive policy guidelines and ongoing support, which underscores the systemic barriers in equipping these workers to deliver effective mental health care delivery. Similarly, Priebe et al. (2012) emphasise gaps in healthcare access for marginalised groups in Europe, including the necessity for tailored mental health services and improved social inclusion, highlighting the persistent organisational disparities that hinder equitable service delivery across diverse populations. Moreover, Murphy et al. (2018) highlight the insufficiency of training for pharmacists in suicide risk management and the need for targeted research on prevention and intervention strategies, suggesting that without such organisational support, pharmacists may be unprepared to contribute efficiently to suicide prevention efforts within community mental health services. In a similar vein, Russell et al. (2021) call for attention to the disconnect between mental health policy and clinical practice, underscoring the need for enhanced leadership and training that promotes effective patient care, thereby revealing how systemic inconsistencies can undermine the translation of policy into meaningful patient recovery outcomes. Other studies, such as those by Beckers et al. (2019), Brenman (2014), Caplan et al. (2018), Forchuk et al. (2020), Li et al. (2022), and Nyassi et al. (2023) collectively reveal gaps in stigma reduction, mental health service provision, care-coordination, education, and communication. These gaps suggests that there is a critical need for further research to address care-coordination deficiencies, such as lack of adequate training in risk management to better prepare CMHWs for effective care-coordination of patient hospital discharge to CMHISs and relapse prevention, policy implementation, and access to mental health services globally.

Furthermore, it is important to highlight that the reviewed studies took place in various countries and cultural settings, uncovering both common and context-specific

experiences among community mental health workers. Although global challenges like communication issues during discharge and resource constraints were apparent, differences surfaced in the organisation of community mental services, cultural views on mental health, and support systems for the workforce. For example, countries with more cohesive care models such as community mental health neighbourhood teams and community mental health services noted smoother transitions, while others pointed out fragmentation and unclear roles. These international variations highlight the significance of situating community mental health service delivery models within local cultural, policy, and systemic contexts.

2.20 Chapter summary

From this review, four main themes were generated: duties and responsibilities; CMHWs' experiences of barriers and facilitators; MDT working approach; and patient hospital discharge into CMHISs. This review contributes to existing knowledge by enhancing our understanding of CMHWs' experiences in care-coordinating the hospital discharge of patients with mental health conditions. It underscores the need for further research in this area, particularly focusing on effective strategies for care coordination of patient hospital discharge. Future studies should actively involve CMHWs in the coordination process and explore the collaborative involvement of MDTs, patients, and their caregivers from admission to discharge. Such research is crucial for developing evidence-based practices to improve the transition from hospital to CMHISs for patients with a diagnosis of mental health conditions. Chapter three presents the methodology employed in this research.

Chapter Three: Methodology

3.1 Introduction

The purpose of this chapter to provide the methodology employed in this study, which aims to explore the experiences of CMHWs regarding the care-coordination of hospital discharge for patients diagnosed with mental health conditions into the community. The initial part of this chapter outlines the research question, the aim, and objectives, followed by the study's paradigms, ontology, epistemology, rationale for qualitative methodology, highlighting strengths, weaknesses, and surrounding debates or research controversies. The chapter also provides the study's philosophical stance, the rationale for using constructivism, positionality, reflexivity, and a summary.

3.2 Research question

The research question addressed in this study is: "What are community mental health workers' experiences of care-coordinating patients with a diagnosis of mental health condition discharged from hospital into community mental health integrated services?"

3.3 Research aim

The aim of this research is to explore CMHWs' experiences of care-coordinating patients with a diagnosis of mental health conditions discharged from hospital into CMHISs. Exploring the experiences of CMHWs through a qualitative inquiry approach, this study aims to generate insights that can inform future clinical practices, recommendations, and policies designed to enhance the quality and effectiveness of care-coordination during patient hospital discharge within the community mental health context. Through this exploration, using a constructivist qualitative inquiry lens, this study aims to gain an in-depth understanding from CMHWs' experiences to inform future working practices, and provide recommendations for policies aimed at

enhancing the quality and effectiveness of care-coordination of patient hospital discharge within the community mental health context.

3.4 Research objectives

1. To explore the duties and responsibilities of CMHWs who coordinate care packages for patients with a diagnosis of mental health conditions discharged into CMHISs.

2. To identify barriers faced by CMHWs during the discharge process of patients with a diagnosis of mental health conditions discharged from hospital into CMHISs.

3. To explore the challenges CMHWs face and to establish if these have affected their wellbeing.

4. To examine CMHWs' involvement in the discharge process under the current community mental health framework and CMHISs.

To address the research question, aim, and objectives, I examined various research paradigms, which are not discussed in detail due to the scope of this study, before deciding which philosophical assumptions that are most suitable, as presented in the following sections.

3.5 Research paradigms

The term "paradigm" refers to a set of underlying assumptions, beliefs, experiences, and values that guide a specific scientific or research approach (Bunniss & Kelly, 2010; Pilarska, 2021). Research paradigms include fundamental assumptions about the nature of reality (ontology), the nature of knowledge (epistemology), and methods of inquiry (methodology) (Creswell & Creswell, 2018, 2023). In this regard, research paradigms provide theoretical and conceptual frameworks that help researchers interpret and understand the phenomena under study (Gupta & Awasthy, 2021).

Furthermore, research paradigms can influence data collection and provide essential theoretical and conceptual frameworks that assist researchers in interpreting and understanding the phenomena under study (Grix, 2002). Delineating the underlying beliefs and principles that shape the research process, paradigms provide a structured lens through which data is collected, analysed, and interpreted (Durham 2015). For instance, positivist paradigms emphasise objective measurement and empirical evidence, while constructivist paradigms focus on subjective experiences and contextual understanding of individual subjective worldviews.

I chose the constructivist paradigm because it is consistent with the belief that reality is subjective, dynamic, and shaped by individual experiences, meaning that there is no single ultimate truth (Bunniss & Kelly, 2010; Crossan, 2003). This paradigm supports the study's constructivist, qualitative methodology, which focuses on understanding through inductive reasoning and constructing meaning through interactions between researchers and participants in natural settings (Pilarska, 2021). Furthermore, the constructivist approach emphasises the use of qualitative methods such as narratives and interviews to collect different interpretations of a phenomenon (Creswell & Creswell, 2018; Durham 2015). However, it is crucial to be aware that within the constructivist paradigm there are many social realities that exist due to varying individual experiences and have potential to influence researcher positioning, as discussed in Chapter 6, Section 6. The following section focuses on the nature of multiple reality.

3.6 Ontological perspective

Ontology refers to the branch of philosophy that examines the nature of multiple reality and existence (Daniel & Harland, 2017; Grix, 2002). In this study, I adopt a subjective relativist ontological position, recognising that reality is constructed by individuals and influenced by contextual factors (Bunniss & Kelly, 2010). As an interpretivist, I make

sense of how multiple realities, beliefs, and meanings associated with CMHWs' experiences of care-coordinating hospital discharge are acknowledged, highlighting the context-specific nature of their realities. The use of this ontological position provided an avenue for the presentation of multiple realities through the inclusion of quotations and extracts that captured the actual voices of different CMHWs and their distinct worldviews (Bassot, 2022) for example, experiences and interpretations of meanings associated with the process of care-coordinating hospital discharge of patients with a diagnosis of health condition. However, I am aware of other perspectives such as subjective relativist stance which contrasts with a realist perspective, as the choice between these two philosophical positions carries different beliefs and implications for the acquisition of knowledge (Durham 2015). The following section discusses the nature of knowledge.

3.7 Epistemological perspective

Epistemology is the branch of philosophy concerned with the nature of knowledge, how we can know about things, and the criteria for determining what can be considered as true or justified beliefs (Crossan, 2003; Grix, 2002; Niebauer et al., 2020; Pilarska, 2021). In this study, my epistemic position recognises that knowledge is unique to each individual and is co-constructed through active engagement and exploration with participants during the process of coordinating the hospital discharge of patients (Bagnoli, 2013; Daniel & Harland, 2017). In addition, the use of semi-structured interviews provided me with an opportunity to use my constructivist position to generate and interpret meaning from this study's findings. Therefore, my epistemological stance highlights the theoretical lens through which the research was to be conducted, reinforcing the alignment with the overall aim and research question. The following section provides the rationale for using qualitative methodology in this study.

3.8 Rationale for qualitative methodology

My ontological and epistemological stance aligns with a qualitative methodology. A methodology is a framework that helps us with going about acquiring knowledge and explaining the approaches used in a research project, whereas methods are techniques of gathering data to acquire knowledge (Durham 2015; Grix, 2002). I used qualitative descriptive methodology because it allows for an in-depth exploration of participants' experiences, perceptions, and understanding of the findings central to the research questions (Squires & Dorsen, 2018). Qualitative descriptive methodology was consistent with the constructivist paradigm (Creswell & Creswell, 2023).

My previous experiences in community mental health care-coordination informed the development of a conceptual framework that integrated practical and theoretical insights, thereby informing the methodological decisions for this study (Crawford, 2020; Gibson & Owens, 2023). Drawing on lived experience, I was able to adapt a study design, ensuring that the methodology not only addressed the research questions but also captured the contextual complexities of care-coordinating patient hospital discharge. Although quantitative techniques grounded in positivist perspectives are valuable for research emphasising deduction and objective measurements (Aspers & Corte, 2019; Walshe & Brearley, 2020), they do not capture the intricate personal experiences and context-dependent significances that are vital for comprehending a professional field (Breakwell, 2020; Gupta & Awasthy, 2021). Focusing on participants' subjective experiences, this qualitative methodology enables a deeper understanding of the research context. The application of qualitative methodology in this research, using semi-structured interviews, was vital in collecting the experiences of CMHWs (Creswell & Creswell, 2023).

Nonetheless, it is essential to recognise that quantitative studies provide an alternative approach to research enabling collecting numerical data. They enable the generalisation of results to broader populations, assist in comparing different studies or demographic groups, and are particularly useful in analysing numerical data using statistical connections among key variables (Bryman, 2016; Creswell & Creswell, 2023; Johnson & Onwuegbuzie, 2004). The input from quantitative studies is still in some wider empirical research and comparative research settings. Consequently, a qualitative methodology was best suited for the objectives of this study, underpinning the intrinsic case study design, which is discussed in Chapter 4. The introduction of my philosophical position fundamentally shaped my qualitative methodology in understanding human experiences in their contextual reality, by enabling me to explore and co-construct knowledge alongside myself and participants. The following section discusses my philosophical stance.

3.9 Philosophical position in this study

In order to conduct any research, it is important to outline philosophical assumptions because this can help to design strategies underpinning the research and decide which research methodology and methods are appropriate for the development of knowledge (Bender et al., 2021; Daniel & Harland, 2017). In this study, I took a constructivist philosophical position discussed in Section 3, which views language as a human product and acknowledges that it can have various subjective meanings connected to personal experiences (Gupta & Awasthy, 2021). This philosophy takes the stance that reality is co-constructed as a continuous process of analysing and interpreting social reality (Pabel et al., 2021). Consequently, constructivist paradigm assisted me in establishing a philosophical position within this study (Leshem & Trafford, 2007). The next section discusses the reasons for using constructivism as an alternative philosophical perspective for this study.

3.10 Rationale for using constructivism

Constructivism is a school of thought that helps in developing an understanding of the multifaceted nature of phenomena; for example, in health research seeking out new concepts and new knowledge (Creswell & Creswell, 2023; Denzin, 2021; Lincoln & Guba, 2013; Onuf, 2012). Constructivism is an orientation to fields of social inquiry used to obtain the subjective interpretations through co-construction of practical knowledge from participants' experiences (Appleton & King, 2002; Bagnoli, 2013).

In addition, a constructivist stance posits the active participation of individuals in seeking knowledge and understanding of the surrounding world in which they live or work (Boyland, 2019; Creswell & Creswell, 2023). Furthermore, it emphasises the importance of social, cultural, and historical factors in shaping knowledge and recognises the role of language and experiences in maintaining subjective social realities (Pilarska, 2021). The constructivist approach allows for an in-depth exploration of the subjective and interpretive nature of CMHWs' experiences, contributing to in-depth understanding of their different worldviews (Creswell & Creswell, 2023).

Constructivism offers a philosophical position for exploring the subjective nature of individual experiences (Durham 2015; Lincoln & Guba, 2013). Adopting a constructivist approach, this study acknowledges the importance of individual experiences and their influence on the understanding of coordination of patient care in the working environment, and obtaining qualitative findings (Boyland, 2019; Onuf, 2012; Squires & Dorsen, 2018). Consequently, a constructivist approach informed the intrinsic case study employed in this study to gain a comprehensive understanding of the experiences of CMHWs regarding the discharge of patients diagnosed with a mental health condition into the community within one NHS Trust in the Northwest of England.

Additionally, the constructivist inquiry allowed for a direct exploration of CMHWs' experiences as a case study rather than relying solely on participants' reflections, ensuring a more in-depth understanding of how they coordinated the hospital discharge of patients (Yazan, 2015). Therefore, this provides my rationale for using constructivism, linking it back to the aforementioned research question and aim (see Section 3.10). The following section now discusses my positionality in this study.

3.11 Positionality

Positionality refers to how my own experiences and identity might influence this research process (Holmes, 2020). Building on my background as a research nurse, community psychiatric nurse, and care coordinator, with experience in employing qualitative methodology, this study is informed by a deep understanding of both clinical practice and qualitative research techniques. Furthermore, my ontological and epistemological position, beliefs, experience, knowledge, personal reflection, and reciprocal relationship with different participants' experiences was used throughout the research process to co-construct knowledge emerging from the collected data (Mason-Bish, 2018). In addition, my positionality enabled me to identify and reflect on the data interrelationships at different stages of this research process (Berger, 2015; Denzin, 2021).

This aforementioned process allowed me to recognise the influence of my ontological and epistemological stance shaped by my educational, professional background, and social interactions (Berger, 2015). In addition, my positionality significantly influenced the construction of this study and present research findings, highlighting the importance of these philosophical perspectives. My positionality had several advantages. It helped in locating and enrolling participants; in particular it gave me easy access to the participants who considered me a part of the organisation's workforce, and it meant I

had an opportunity ask more insightful questions related to the study. Participants may also have felt more able to be honest in answering questions because they knew and trusted me as someone who understood their working culture and the care-coordination of patient hospital discharge. Moreover, it put me in a better position to understand the language and jargon used by community mental health workers.

On other hand, Holmes (2020) highlight that insider strengths can become the insider's weaknesses and vice versa. For example, I may have been unconsciously subjective on being sympathetic to participants' responses. The participants may have been over familiar and assumed that I knew the working culture regarding care-coordinating hospital discharge and may have not answered questions in detail thinking that I knew what they were talking about. Due to my position, some participants may have felt that I had better knowledge than them and that their understanding was the same as mine, which was not the case. Some participants may have been less willing to reveal sensitive information than they would have been if speaking to an outsider they were not likely to be in contact with in future. Thus, my positionality is aligned to the qualitative descriptive methodology of my study that drives the methods utilised for data collection as presented in Chapter 4. The next section now provides the researcher's reflexivity using the first person.

3.12 Reflexivity

Reflexivity is described as "conscious self-examination" and encourages the researcher to continually be self-aware and critically examine their perspectives (Corlett, 2019; Mason-Bish, 2018). In this study, I used personal voice as it serves to assert ownership of the work, as advocated by Trafford and Leshem (2012). Hence, I employed reflexivity in this qualitative inquiry methodology to critically reflect on my position, preferences, and preconceptions (Corlett, 2019; Crawford, 2020). It also

involved examining the impact of the research relationship on the participants and how it influenced their responses to the questions presented in Chapter 4. Furthermore, I recognised my insider position and prior experience and employed bracketing as a strategy to ensure the trustworthiness of the research (Berger, 2015; Yanto & Pandin, 2023). Bracketing involves engaging in a self-reflective process and consciously setting aside, but not abandoning, my pre-existing knowledge and assumptions (Grajzel, 2025). I did this by putting emphasis on trying to gain an understanding of care-coordination patient hospital discharge through the CMHWs' eyes. The goal was to approach the participants' accounts with an open mind during the analysis phase, as recommended by Braun & Clarke (2024).

3.13 Chapter summary

In summary, this methodology chapter has outlined the research question, the aim and objectives, and the philosophical, epistemological, and ontological positions. Aligned with a qualitative constructivist inquiry approach, underpinned by a relativist ontology and subjectivist epistemology, this study adopted reflective thematic analysis techniques. The chosen qualitative descriptive methodology is underpinned by my philosophical stance in this study, developing an in-depth understanding of CMHWs' subjective experiences and establishing a foundation for data collection and analysis in the following chapter, Chapter 4. The subsequent chapter four provides methods of specific details on the intrinsic case study design, participants, procedures, and data analysis using reflective thematic analysis, and presents ethical considerations.

Chapter Four: Methods

4.1 Introduction

Chapter 4 provides the rationale for using a single intrinsic case study design and then sets out the study setting, population, eligibility criteria, sampling and sample size, participants, and recruitment. The methods employed for data collection and analysis, utilising reflective thematic analysis, and culminating in the presentation of the findings are presented. This is followed by a description of the study setting, and ethical considerations which include information on the location and context in which the study was conducted, together with trustworthiness, credibility, a dissemination plan, and a summary.

4.2 Study design

A single intrinsic case study design is a form of research that allows for an in-depth study of a specific phenomenon in its real-world context (Yin, 2018). The selection of a single intrinsic case study design aligns with the philosophical foundations of constructivist research, which highlights the collaborative creation of knowledge via a particular contextually rooted phenomenon being explored. It is one of the several ways of conducting research in social science and other fields of research aiming to understand individuals' worldviews in their social context by interpreting their experiences as a single group community or single case (Gaber, 2023; Takahashi & Araujo, 2019). The decision to use an intrinsic case study was influenced by my constructivist ontology, epistemology, and methodology as discussed in Chapter 3, which emphasise the subjective nature of human experiences and the importance of contextual understanding of a particular group of individuals (Takahashi & Araujo, 2019). It is important to recognise that, while intrinsic case studies can be used in

positivist and post-positivist research due to their structured approach (Yin, 2018), they are equally valuable for studies within the constructivist paradigm that examine subjective human experiences in this context (Merriam 1998). The strengths of intrinsic case study design include its ability to enable recognition of multiple constructed realities and provide a comprehensive understanding of the complex factors that shape the research context, including physical, social, economic and cultural dimensions (Creswell & Creswell, 2023). For example, in this intrinsic case study, the ecosystem in which CMHWs operate, as well as the specific geographical area studied, were well suited to the particularistic nature of the case study research. Intrinsic case study boundaries were drawn by purposefully selecting a single NHS organisation, thereby situating the study within a clearly defined and naturally occurring context. This boundary-setting was guided by the study's focus to explore experiences of CMHWs care coordination practice as it unfolds within their everyday realities of a specific institutional environment. In addition, this intrinsic case design facilitates an in-depth, comprehensive exploration of the phenomenon as it exists within its actual context, acknowledging that meaning arises from the active interaction of contextual elements and the worldviews of CMHWs. Concentrating deeply on a single NHS Trust, the study adheres to the constructivist principle of profound, detailed understanding rather than simplistic explanation, facilitating a more genuine connection with the actual experience of the system being explored.

Furthermore, the study is uniquely positioned to provide the detailed descriptions necessary to understand the complexities of care-coordination from the worldviews of diverse community mental health workers. Hence, it is consistent with the moral imperatives of constructivism by authentically representing local constructions, identifying influential voices, and promoting a deep understanding of a particular group of participants' experiences (Merriam, 2009). Moreover, Yin (2018), highlights that case study design serves both investigative purposes and has the potential to stimulate local

action by participants. Furthermore, the intrinsic case study design proves to be a robust approach that allows the researcher to act as a facilitator, enabling local impacts that resonate with different participants, for example, a particular group of CMHTs in this context. This approach is particularly suitable for conducting constructivist research as it allows for an in-depth investigation of the experiences of individuals or groups in a specific context, thus enabling a deep understanding of the phenomena under study (Merriam, 2009; Onuf, 2012; Pilarska, 2021).

The nature of this study setting, the participants, the research question, aims and objectives were all considered appropriate for an intrinsic case study approach because of its utility to provide an in-depth understanding of the phenomenon being explored within a specific setting (Takahashi & Araujo, 2019). On the contrary intrinsic case study approach has its limitations, despite being suggested by Simons (2009) and Merriam (2009) as a methodologically sound and justified way to explore participants' experiences in qualitative descriptive research. Limitations include difficulty in generalising findings, which is inconsistent with the constructivist paradigm's focus on transferability and depth, as this paradigm prioritises context-specific understanding over broad applicability (Pilarska, 2021; Takahashi & Araujo, 2019).The single intrinsic case study represented a specific group characterised by a particular context of CMHWs, and period that facilitated a thorough analysis of intricate social dynamics. Consequently, these limitations were established according to the significance of participants, incidents, and interactions that were directly involved in the phenomenon being studied, maintaining contextual consistency and analytical focus. The following section now discusses the study setting.

4.3 Study setting

The research was conducted within a single NHS Foundation Trust located in the

Northwest of England, encompassing various sites involving CMHWs. Due to time constraints, restrictions imposed by the COVID-19 pandemic, and resource limitations, the study was confined to this specific NHS Trust, thereby limiting its geographical scope concerning CMHWs. The next section discusses the research population.

4.4 Research population and eligibility criteria

The study's participants were drawn from a specific geographical setting in England and included CMHWs aged from 18 to 65 years who had worked in CMHTs for more than a year, spoke English, and provided informed consent. Participants who did not meet these criteria were excluded from the study. The next section focuses on recruitment strategy.

4.5 Recruitment strategy

Following ethical approval from Lancaster University, participant information sheets (PIS) were distributed via password-protected email specifically addressed to potential participants in the Trust. I achieved this by contacting potential community mental health worker participants with whom I had existing links in conversation or by phone to obtain consent to use their Trust email addresses. Advertising materials which included a flyer, participant information sheet, and consent form were advertised on the NHS Trust intranet (see Appendix 7, 8). The recruitment strategy was designed to ensure that participants joined up to this study voluntarily. Participants were provided with the participant information sheet and consent form and were given at least 24 hours to read this information and raise any questions or concerns via email before deciding to take part (Offredy & Vickers, 2013). For face-to-face interviews, participants were given an opportunity to read and sign the consent form during the interview itself. For participants who had not been able to email the consent form before the interview,

I read it to them at the beginning of the telephone interview, established their agreement, and recorded this as a separate file (see Appendix 9). These participant information sheets, and consent forms were securely disposed of after data collection.

Adaptations to accommodate the study's operation during the Covid-19 pandemic, included contacting participants and providing consent forms only after they had expressed interest in participating. Participants were purposively selected from different community mental health teams to ensure a diverse group of participants (Emmel, 2013). Confidentiality and anonymity were prioritised to protect participants' privacy, as recommended by Miller et al. (2012). Although the recruitment period was originally scheduled between 1st October 2021 and 31st March 2022, it was extended to 30th June 2022, due to COVID-19 constraints, as approved by Lancaster University's Ethics Committee (see Appendix 10 through to Appendix 15). To ensure the effectiveness of the semi-structured interview, two pilot interviews were conducted using CMHWs. No adjustments to the interview questions were found necessary, and these pilot interviews were subsequently incorporated into this study's recruitment process. The following section focuses on sampling and sample size.

4.6 Sampling and sample size

Purposive sampling was used as the method for participant selection in this qualitative study, which allowed for the selection of participants based on the inclusion criteria that are most relevant to the research question (Pope & Mays, 2020). Also, purposive sampling was used because it can capture participants with a wealth of in-depth experience. Vasileiou et al. (2018) claim that this approach makes it possible to choose participants who are most likely to offer rich, pertinent data that supports the objectives of the study. In addition, in this study CMHWs were purposively selected based on the inclusion criteria as presented earlier, by communicating with team managers at host community mental health teams to gain access to participants (Dutta, 2024).

In this study, a sample of 16 participants was initially proposed which, following the recommendations of Baker and Edwards (2012), was deemed sufficient to ensure the richness of data defined by Tenny et al. (2023). The richness was achieved by capturing the research context, supported by participant quotes from a specific environment and consideration of possible fluctuations. The sample size fell within the generally acceptable range of 5 to 50 participants. The final sample size for this study of 14 participants was justified as appropriate for this qualitative research using case study design exploring participants' different and similar worldviews. This sample size ensured the depth and transferability of the qualitative data and facilitates the collection of comprehensive participant reports. It allowed for detailed exploration while maintaining manageable data for analysis (Boddy, 2016).

Additionally, it was acknowledged that sample size in research varies depending on the type of study. It is still up for debate how large a sample size is appropriate for qualitative research (Hennick & Kaiser, 2022; Young & Casey, 2018). In qualitative research, sample sizes tend to be smaller compared to quantitative studies (Vasileiou et al., 2018) as qualitative research focuses on in-depth exploration and understanding of phenomena, rather than statistical generalisation (Sandelowski, 2000). Sample size was not viewed as a limitation in itself; instead, the value was placed on the depth and richness of the data collected and the insights gained from thorough analysis (Emmel, 2013). In this study, recruitment challenges caused by COVID-19 rather than saturation, guided sample size determination (Vasileiou et al., 2018). The next section discusses the recruitment of participants.

4.7 Participants

In this study, fourteen participants were recruited from one NHS Trust in the Northwest of England through email contact and by word of mouth. Those who expressed interest in participating were required to give consent, either through face-to-face interaction or

via researcher-recorded Microsoft Teams sessions, prior to the commencement of the interview. No responses were received through the NHS Trust intranet. Two potential participants, a psychologist and a support worker, did not attend booked online interviews, but no reason was provided in either case. The characteristics of the participant sample are discussed in Chapter 5. At the end of the interview, participants were informed that they would receive a summary of the research when the research is completed. The following section focuses on data collection.

4.8 Data collection

I used qualitative, semi-structured interviews to interview 14 CMHWs between the ages of 18-65 years in one NHS Trust in the Northwest of England. Semi-structured telephone interviews lasted up to 45 minutes (see Appendix 16). I collected data both face-to-face and online, using platforms such as Microsoft Teams. Interviews were recorded with participants' consent and supplemented with recording notes in a reflective journal (see Appendix 17) to ensure that collected data were both high-quality and comprehensive. The study faced some travelling constraints and CMHWs' workloads and personal circumstances, which resulted in some participants not attending online interviews. The sample size would have been greater had they attended. Consequently, this rationale supports the selection of the data collection methods used in this study to answer the research question.

This empirical study set out to answer the following research question:

What are community mental health workers' experiences of care-coordinating patients with a diagnosis of a mental health condition discharged from hospital into community mental health integrated services?

I asked the following four semi-structured interview questions:

i. Can you tell me about your duties and responsibilities as a community mental health worker care-coordinating of patients with a diagnosis of a mental health condition discharged from hospital into community mental health integrations services?

ii. What are your experiences and barriers as a community mental health worker in care-coordinating patients with a diagnosis of a mental health condition discharged from hospital into community mental health integration services?

iii. Can you describe your challenges in care- coordinating and managing patients with a diagnosis of a mental health condition discharged from the hospital?

iv. Could you describe your involvement in the discharge process of patients diagnosed with a mental health condition discharged from the hospital into community mental health integrations services?

The semi-structured interviews were audio recorded and transcribed verbatim by the researcher for analysis and then transferred to Altas.ti software for data management. This method allowed for flexibility for the participants to provide rich and detailed descriptions of their experiences, perceptions, and challenges encountered during the hospital to community discharge process (Flick, 2022). The following section now discusses the researcher's reflexivity.

4.9 Reflexivity

Reflecting on my role as a research nurse with experience in Community Mental Health Nursing and as a senior mental health practitioner, with over 12 years of experience, I recognised the potential influence of my past experiences on the interpretation of data in this study. I actively facilitated reflexivity of the research findings. It was important to base the analysis on the data itself, rather than interpreting it based on personal reflexivity, because this not only reduces the risk of subjectivity in qualitative research, but also increases the credibility of the analysis by ensuring that the conclusions drawn

are firmly rooted in the perspectives and experiences of the participants, thus enriching the overall understanding of the phenomenon under study. The reflexive journal served as a valuable tool for documenting decisions and justifications and promoting transparency of the study. The next section discusses reflective thematic analysis process.

4.10 Reflective thematic analysis and process

Reflective Thematic Analysis (RTA) was chosen because it emphasises the researcher's active engagement and interpretive role in data analysis, as outlined by (Braun & Clarke, 2024). For this reason, RTA helped me to identify, analyse, and report patterns and themes generated from the study data (Braun & Clarke, 2024). Unlike content analysis, discourse analysis, conversational analysis, and narrative analysis, reflective thematic analysis is much more flexible due to the lack of a specific theoretical or epistemological approach (Howitt, 2013). The RTA approach chosen for this study is theoretically flexible and different from the previous two approaches. RTA is justified because it aligns with my philosophical assumptions and values within the qualitative and constructivist approach (Byrne, 2022). It is also justified because only one coder is required (Braun & Clarke 2024). RTA allowed me to conduct subjective interpretive work, which fits with my ontological and epistemological assumptions.

Although RTA has been criticised for shortfalls, such as the previously mentioned lack of a universally accepted protocol in conducting research and a lack of theoretical boundaries, Braun and Clarke’s (2024) approach is now widely used in analysing data. The six stages are as follows: familiarisation with data by immersion; generating initial code; searching for themes; reviewing themes; defining and naming themes; and producing a report (Braun & Clarke, 2024). The six stages of reflective thematic analysis are discussed under the data analysis in this chapter. Also, to mitigate the

challenge of lack of theoretical boundary, the documentation of the theoretical and epistemological positions for this current study have been made explicit (Braun & Clarke, 2006; 2024). Reflective thematic analysis allows the researcher to generate transcripts and become immersed with the data, finding keywords, selecting relevant codes, developing themes, conceptualising the data by interpreting categories, codes, themes, subthemes and ultimately constructing a conceptual framework.

Reflective thematic analysis was appropriate because of its inductive process which enabled the researcher to gain an in-depth understanding of the collective or shared meanings and experiences of CMHWs' experiences of the care-coordinating hospital discharge process (Bryman, 2016). RTA played a crucial role in identifying, analysing, and reporting patterns or themes generated from this study data (Braun & Clarke, 2024). In comparison to other methods such as content analysis, discourse analysis, conversational analysis, and narrative analysis, RTA offers greater flexibility due to its lack of a specific theoretical or epistemological approach (Howitt, 2013). This method allows for its utility across a wide range of research approaches, as opposed to methods like IPA that were not appropriate for this study. The next section discusses approach to data analysis in first person to give my voice.

4.11 Approach to data analysis

The approach to data analysis was based on Braun and Clarke (2024). RTA aligned to my ontological and epistemological position of the constructivist paradigm, which uses co-construction to generate themes from participants' experiences (Braun & Clarke, 2024; Creswell & Creswell, 2023; Flick, 2022). I transcribed verbatim by immersion in the data (see Appendix 18). Once transcription was completed, I migrated data to Atlas.ti software for coding. While Atlas.ti software facilitates the management of large qualitative data, as illustrated in Appendix 19, its effectiveness depends on the researcher's ability (Friese, 2019). The themes I developed for coding and analysis

were related to the main and sub-research questions and guided by Braun and Clarke's (2024) six stages, as presented in Appendix 20-22 and described in the following sections.

4.11.1 Familiarisation with the data

I began by reading the interview transcripts and actively engaging with the content to achieve an in-depth immersion in research data. This process enabled me to gain familiarity and develop a comprehensive understanding of the data. Through repeated reading of the dataset, I identified key ideas, concepts, and initial patterns that could be further developed into themes.

4.11.2 Generating initial codes

I conducted the initial coding manually and by using Atlas.ti, software then extended this process by employing open coding to assign labels or codes to meaningful units within the data. The software facilitated the organisation and retrieval of codes, ensuring they remained accessible throughout the analysis process.

4.11.3 Searching for themes

Through iterative coding and constant comparison, I started identifying potential themes. Atlas.ti software's advanced search functionalities enabled me to retrieve relevant coded segments and assisted in the identification of connections and relationships between codes and preliminary themes.

4.11.4 Reviewing themes

I engaged in a continuous process of reviewing and refining the identified themes. Atlas.ti software helped me to develop and visualise coded data through network views

and mind maps and supported the identification of patterns and subthemes within the data, aiding in the development of a coherent conceptual and theoretical framework as illustrated.

4.11.5 Defining and naming themes

As the analysis progressed, I focused on refining the thematic structure, ensuring that each theme accurately captured the essence of the data. Atlas.ti software's annotation and memo features proved invaluable, as they enabled me to record my reflections and rationale for each theme, promoting transparency and auditability of the analysis process.

4.11.6 Producing the final report

In the final stage, I consolidated the findings and presented them in a flow chart presented in Figure 9 in Chapter 5. To ensure efficient data management, I utilised Atlas.ti software to store extracted data and organise quotations associated with each theme, facilitating the integration of supporting evidence into the final report (Creswell & Creswell, 2023). This report included a detailed description and analysis of the themes, supported by relevant excerpt quotes from the interviews illustrating relationships of themes developed from CMHWs' experiences as presented in Chapter 5. The findings were discussed in the context of normalisation process theory embedded in ecological system theory as discussed in Chapter 1 and Chapter 6. Table 5 provided a lens to understand the interplay between various levels of the healthcare system and the role of CMHWs as care coordinators. The next section discusses ethical considerations.

4.12 Ethical considerations

Ethics play a crucial role in research by emphasising the importance of prioritising the wellbeing, rights, and dignity of participants in study design, ultimately upholding the integrity and societal trust in the research process (Offredy & Vickers, 2010). Adhering to an ethical code can help to guarantee that the study is conducted safely without causing harm to participants (DeRenzo & Moss, 2006). The following section discusses how this study adhered to an ethical code in practice, guaranteeing informed consent, permission to record an audio interview, psychological support for discomfort and distress, anonymity and confidentiality, voluntary participation, and the right to withdraw from the study.

4.12.1 Ethical approval

I obtained ethical approval from Lancaster University FHMREC, NHS Integrated Research Application System (IRAS) (2021) and the NHS Department of Research and Innovation approved the study to be conducted within the NHS Trust before the research commenced.

4.12.2 Informed consent

Ethical considerations were followed, and the study adhered to the main principles proposed by the (The British Psychological Society, 2021). I ensured that participants provided informed consent, there was no deception, anonymity was preserved, audio recording of interviews was only done with permission, participation was voluntary, and participants had the right to withdraw at any time. For the purpose of protecting the privacy and dignity of participants, informed consent was obtained in accordance with the Nuremberg Code (1947) cited in (British Medical Journal, 1996). For participants

contributing to the study remotely, their consent was obtained verbally at the beginning of the interview and recorded.

4.12.3 Permission to audio record interviews

Permission was obtained to audio record interviews, and the recorded audio was safely stored on Lancaster University's information management system (PURE) and OneDrive. The data were erased by the researcher when the research was completed. Participants were required to give consent via email returning to the researcher completed and signed consent forms depending on the circumstances, for the recording of interviews before the interview date (Health Research Authority, 2020b). I informed participants of their rights regarding the audio recording of interviews and their rights to withdraw, without giving a reason.

4.12.4 Psychological discomfort and distress

Although there was no psychological distress anticipated in this study, I took precautionary measures to ensure that participant involvement would not lead to any psychological harm. Nevertheless, participants were provided with contact information as an additional safeguard, allowing them to seek assistance in the event of distress. This step was taken to ensure the wellbeing and safety of the participants throughout the study (Helsinki Declaration, 2020; Shrestha & Dunn, 2019).

4.12.5 Anonymity and confidentiality

The participants' anonymity and confidentiality were ensured by clarifying the boundaries at the outset (British Sociological Association, 2017). They were informed of their right to reject the use of any data-gathering device and pseudonyms were used to separate personal details from code-identified data (Health Research Authority,

2017). Furthermore, the was used to keep the participants anonymous and precautionary measures were taken to protect their electronic data, with password encryption and by limiting access to the researcher and research supervisors only.

I ensured that participants were informed of the confidentiality and anonymity of their information during the study. Participants were made aware that the content of the interview would be kept confidential and would not be shared with anyone else. I acknowledged the potential risk of participant data identification even after anonymisation due to the small sample size. Therefore, the accessibility of data would be allowed on a case-by-case basis and would be shared upon request from the Lancaster University Division of Health Research through the designated Data Protection Officer, following General Data Protection Regulations (GDPR) (General Data Protection Regulation, 2018). I followed the Lancaster University FHMREC and NHS Integrated Research Application Research System (IRAS) and Development protocols to request ethical approval to conduct research using NHS participants.

Participation in this study was entirely voluntary, and individuals had the right to terminate their involvement at any time without any repercussions. Individuals could discontinue their participation at any point without facing penalty or any form of disadvantage. All participants retained the right to withdraw their consent and all data collected prior to withdrawal from the study remained confidential.

4.12.6. Interview schedule guide

I used a semi-structured interview guide schedule for data collection, as previously discussed. The rationale for using a semi-structured interview schedule was to construct in-depth understanding of the CMHWs' experiences (Pope & Mays, 2020). The interview format, or guide, was developed and piloted with two participants to

ensure the semi-structured interview questions were suitable. No changes were required after the pilot, highlighting the effectiveness of the guide in capturing relevant information to answer the research question.

4.12.7 Instruments for data collection

I collected data using semi-structured interviews from participants who had given consent to participate in the study. Interviewees were contacted via Microsoft Teams or face-to face and probing questions were used as required to extract more information (Saarijärvi & Bratt, 2021). I also used a reflective diary to write down some reflections. The interviews were recorded on Microsoft Teams and Olympus Tape Recorder and lasted for an average of 25 minutes. All tape-recorded files, transcripts, and informed consent forms were stored anonymously in secure password-protected digital storage on Lancaster University's PURE and on One Drive.

4.12.8 Data management and storage

E-documents require secure storage, and it is important for researchers to be aware of the particular precautions needed to uphold data security when utilising digital documents. Participants were informed that data would be securely stored, and only shared when requested by accredited researchers approved by the Lancaster University Data Protection Officer, and that data accessibility would be permitted on a case-by-case basis by the Lancaster University Division of Health Research

A password was required for an encrypted laptop and external hard drive. Any sensitive data were anonymised and summarised to cover the project themes, and any analysis conducted off-site pertained only to anonymised data. Participant codes and

pseudonyms were used where appropriate (General Data Protection Regulation, 2018).

4.12.9 Trustworthiness and rigour

Prioritising trustworthiness is a cornerstone of qualitative research to ensure the credibility, transferability, dependability, and confirmability of its findings (Adler, 2022; Daniel, 2018; Squires & Dorsen, 2018). These criteria, while widely recognised, offer pragmatic choices for researchers aiming to establish the usefulness of their work for diverse research fields (Squires & Dorsen, 2018). This is grounded in the epistemological and ontological lens of this qualitative research (Yadav, 2022). An insider perspective enhances trustworthiness and rigour in a study by leveraging a deep contextual understanding and established rapport with participants, which can give an in-depth understanding of study findings (Yanto & Pandin, 2023). However, it is crucial to remain vigilant about potential subjectivity in qualitative research and ensure reflexivity throughout the research process (Berger, 2015). The following discussion explains how the study adhered to specific criteria that ensure the trustworthiness of its findings, encompassing credibility, transferability, dependability, and confirmability (Howell, 2013; Nowell et al., 2017; Squires & Dorsen, 2018).

4.12.10 Credibility

This study ensured credibility by piloting interview questions and checking by aligning of participants' experiences with their representations in quotes; and adhering to ethical issues (Lindheim, 2022). The alignment of participants' experiences with their representation in quotes ensures a fitting and authentic portrayal, contributing to the credibility of the study. Furthermore, checking helped ensure the data reflected experiences and perspectives of participants in studies included in the qualitative evidence synthesis review.

4.12.11 Transferability

In this study, thick descriptions and diverse participant backgrounds enhance research transferability, enabling assessment of applicability (Daniel, 2018; Howell, 2013). Comprehensive descriptions empower readers to judge relevance (Daniel, 2018; Lindheim, 2022). Inclusion of CMHWs from varied backgrounds enriches the study (see Chapter 5, Table 3), increasing potential applicability (Tierney et al., 2018). By incorporating diverse experiences, the study provides valuable insights so far lacking in current literature. Detailed descriptions and thematic analysis enhance transferability, allowing extrapolation to similar settings (Lincoln & Guba, 2013). Findings resonate with previous research, highlighting shared experiences in care-coordination (Agyapong et al., 2016; Li et al., 2022; Nyassi et al., 2023).

4.12.12 Dependability

In this study, dependability and rigour are assured through a logical, traceable, and well-documented research process (Guba, 2013; Lincoln & Guba, 2013). The study's adherence to the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement and the Reflective Thematic approach recommended by Braun and Clarke (2024) enhances the dependability research by supporting it with data obtained from participant. The systematic documentation and audit trail provide readers with a clear understanding of the decision-making process, offering transparency and enabling judgement of the research's dependability (Daniel, 2018).

4.12.13 Confirmability

Confirmability, crucial in qualitative research, ensures interpretations are firmly grounded in data (Howell, 2013; Lindheim, 2022). The researcher's systematic

approach in deriving findings and articulating choices underscores confirmability and theoretical-methodological alignment enhances trustworthiness, as illustrated in Table 5. Maintaining a reflective journal as highlighted earlier and documenting literature search processes helps to ensure transparency (Tong, 2012). An audit trail assures auditability and replicability by providing a record of the study process that can be used by other researchers. Engaging with audio recordings and supervision sessions enhance credibility and dependability (Lincoln & Guba, 2013). This study ensures credibility, transferability, dependability, and confirmability, deepening understanding of the phenomenon under study (Squires & Dorsen, 2018; Yadav, 2022).

4.14 Dissemination plans

The research findings were presented at the Royal College of Nursing International Nursing Research Conference, September 19, 2024. The final PhD thesis manuscript will be available electronically at Lancaster University Division of Health Research from where data may be disseminated to other researchers through Lancaster University, internal/external research conferences, and staff development meetings within the NHS Trust. Plans are in process to publish some parts of the PhD thesis in both academic and professional journals such as *International Journal of Mental Health Nursing*, and the *British Journal of Mental Health Nursing*. In the following section a summary of this chapter is presented.

4.15 Chapter summary

Data collection involved semi-structured interviews with 14 participants selected purposively from various (CMHTs) within one NHS Trust, spanning five boroughs, each offering support to discharged patients in the community. Ethical considerations have been discussed. Furthermore, a discussion on the justification of using reflective

thematic analysis and the case study design has been addressed and interview questions outlined. The specifics of how the research was conducted, who participated, the flexibility of the analysis was crucial in understanding the complexities of care-coordination and the CMHWs' contributions to it. Recruitment of participants and methods of data collection has been discussed. The following Chapter five provides findings to address the research question.

Chapter Five: Findings

5.1 Introduction

This chapter presents the findings from an exploration of the experiences of CMHWs during the process of coordinating the discharge of patients with mental health conditions from hospitals to CMHISs. The study used semi-structured interviews with CMHWs to gather data. The chapter begins by providing the research question, followed by the research aim, objectives, and participants' demographic information. The chapter then presents the research findings. Tables and figures are included to illustrate the themes and subthemes that were developed from the interviews using reflective thematic analysis. The chapter concludes by summarising the empirical findings of the study, addressing, and aligning the conclusions with the research question.

5.2 Research question

"What are the experiences of community mental health workers when it comes to facilitating the hospital discharge of patients diagnosed with mental health conditions into integrated community mental health services?"

5.3. Characteristics of participant demographics

The majority of participants were British women, and participants were drawn from a range of job roles. The demographic details presented in Table 4 (using pseudonyms) provide an overview of the participants' characteristics, enabling a better understanding of the participant group composition.

Table 4. Participants' table of demographic characteristics

Pseudonyms	Gender	Community mental health workers' Job roles	Ethnicity
Hannah	F	Community Psychiatric Nurse/ Care Coordinator	British
Jessica	F	Consultant Psychiatrist	British
Julie	F	Occupational Therapist/Care coordinator	British
Kate	F	Occupational Therapist/ Care coordinator	British
Mary	F	Senior Mental Health Practitioner	British
Ola	F	Social Worker/ Care coordinator	Black British
Rose	F	Community Psychiatric Nurse / Care Coordinator	British
Rudo	F	Pharmacist	Black British
Ruth	F	Team Manager	British
Susan	F	Consultant Psychiatrist	British
Bongani	M	Senior Mental Health Practitioner	Black British
John	M	Team Manager	British
Naresh	M	Consultant Psychiatrist	Asian British
Richard	M	Senior Mental Health Practitioner	British

Key: F- Female; M- Male

Six of the 14 participants who provided information about their work experience had an average work experience of 10.8 years. Additionally, five of the participants had experience in dual roles as care coordinators.

In terms of the interview process, 10 were conducted via Microsoft Teams and four were conducted face-to-face. The interview length ranged from 12 minutes to 48

minutes across all 14 participants. The recruitment period for the participants extended from 7th October 2021 to 30th June 2022. These demographic details provide an overview of the participants' characteristics, enabling a better understanding of the study's sample composition.

5.4 Study findings

After completing the reflective thematic analysis and familiarisation with the transcript according to Braun and Clarke (2024), I uploaded 14 interview transcripts into Atlas.ti 24 software. From these interview transcripts, I generated 1,034 quotations, developed 124 codes, and organised them into 14 categories (Illustrated in Appendix 20). During the coding phase, relevant data segments connected to the research questions were manually labelled, incorporating reflexive engagement to recognise the impact of the researcher's viewpoint. The codes were subsequently grouped into possible categories to develop themes on conceptual similarity and frequency in participants' quotations. By employing an iterative approach to revise and improve, key themes and subthemes were developed to encapsulate both common trends and differences found in the data. The ultimate reflective thematic analysis was shaped by both semantic and latent content, intending to reflect the intricacy of the participants' experiences while staying anchored in the data (Braun and Clarke, 2024).

Utilising reflective thematic analysis guided by Braun and Clarke, (2024) as described earlier in Chapter 4, four main themes and subthemes were identified from the interviews: 1) Experiences of collaborative working, 2) CMHWs' experience of challenges and enablers, 3) Experiences of organisational system and culture, 4) CMHWs' personal experiences of professional growth (illustrated in Figure 9).

The use of diagrammatic illustration of themes and subthemes helped to give a visual picture and outlining thematic relationships across themes as presented earlier finally led to the in-depth understanding of their interconnectedness (Byrne, 2022; Saldaña,

2021). Further details about the coding process and excerpts from Atlas.ti software illustrated by Sankey diagram can be found in Appendix 23. Ultimately, this led to the development of a thematic map visualising empirical findings of this study, as illustrated in Appendix 24 and a poster presented in Appendix 25.

Excerpts from participants' interviews are used to illustrate each theme and subtheme. Textual omissions are shown using "[...]". The term "sic" shows that the quoted text is reproduced exactly as it appeared in the original source, including any mistakes or errors, and the clarification is provided to acknowledge and address the mistake within the quote. Each of the four themes and subthemes is illustrated in Figure 9 and will be described in-depth with supporting quotes in the next section.

5.5 Themes and subthemes developed from empirical study findings

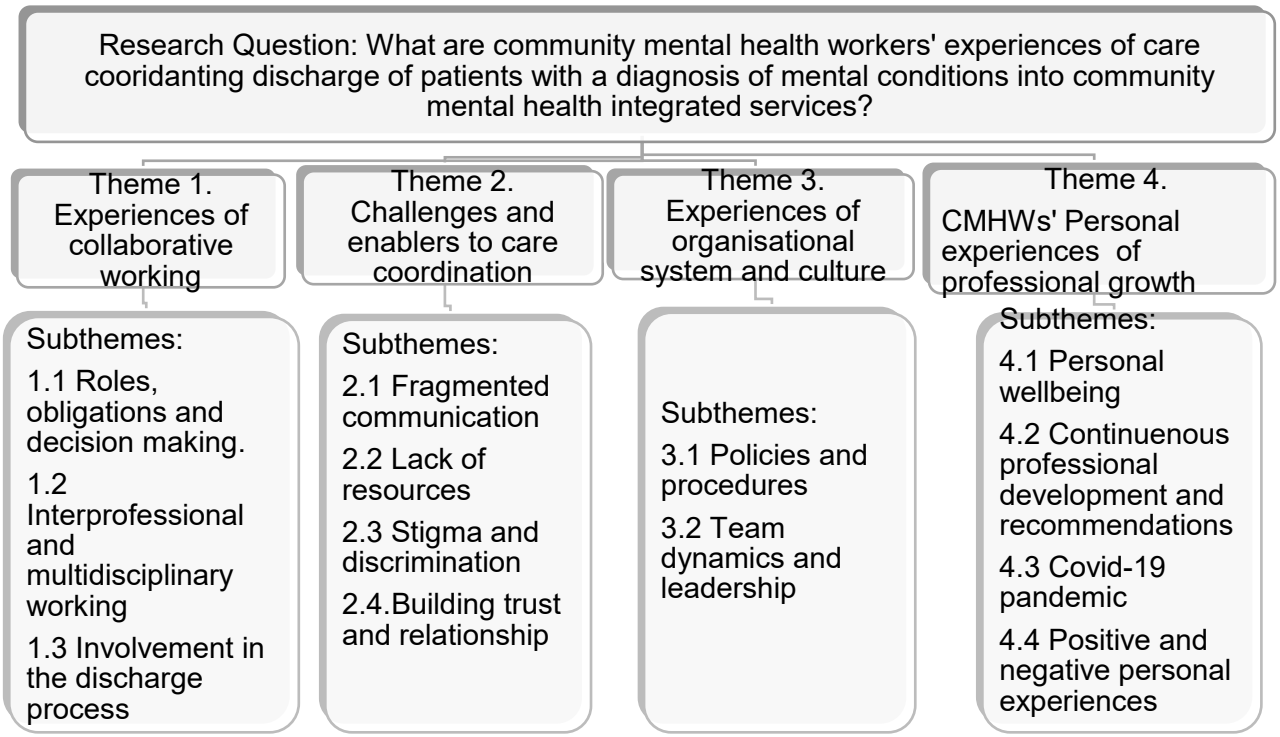

Figure 9.Themes and subthemes identified across the fourteen interviews

5.5 Theme 1 – Experiences of collaborative working

Collaborative working significantly influences the experiences of CMHWs, particularly through interactions and coordination among various CMHSs. Effective collaboration refers to facilitated communication among MDTs and shared decision-making processes, which collectively enhance the provision of care of patients in the community. There are three subthemes to this theme: roles obligations and decision-making, and interprofessional and collaborative working illustrated in Figure 10.

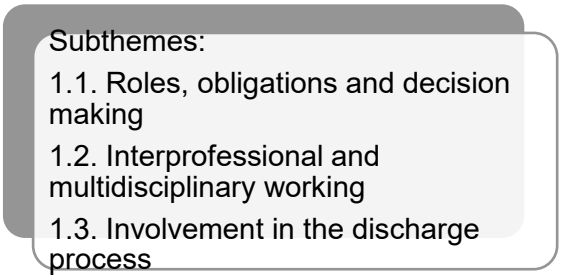

Figure 10. Theme1. Experiences of collaborative working

Subtheme 1.1 - Roles, obligations, and decision making.

The first subtheme roles, obligations, and decision-making showed that CMHWs had diverse experiences in their roles and responsibilities, with a notable emphasis on the aspect of decision-making during care-coordination of patient hospital discharge.

A number of CMHWs expressed their experiences of duties and responsibilities when collaborating with community mental health teams and other organisations. They emphasised the need for effective communication, shared decision-making, and coordination of patient hospital discharge among CMHWs, including doctors, nurses, pharmacists, social workers, and other members of the multidisciplinary team (MDT).

One CMHW shared his experience of care-coordinating patient hospital discharge, outlining his primary responsibilities, which include risk assessment, risk management, and planning for patients:

> My duties and responsibilities involve mainly risk assessment as well as managing risk as well as planning […] It is also involving a discussion with their nearest relative or their carers. In terms of treatment discussing with the consultant and other teams and if there are some things like medication review and other psychological treatment required. [Bongani]

Whereas another CMHW recognised the importance of decision-making in MDT, valuing input from and experiences of working with CMHWs during patients` hospital discharge, saying:

> Well, I suppose I am the consultant, so ultimately, it's my decision whether the patient is ready to go home or not but obviously, we'll make decisions as an MDT and we discuss how the nurses are feeling about the patient and what I'm thinking, what other people are thinking, what the patient is thinking […]. I think the discharge system works fine, works better now than it used to work. [Jessica]

In addition, the majority of CMHWs highlighted the holistic and varied nature of their role, involving risk assessment, therapeutic interventions, provision of equipment, social inclusion, work-graded exposure, crisis management, safety planning, and psychoeducation:

> So, my duties and responsibilities involve assessing risk and ensuring that the patient has... It is risk is monitored, but in addition to that, you also provide therapeutic interventions in the community as well... And it's quite holistically and it's quite varied at the OT role within the community Home Treatment Team. [Julie]

Similarly, one CMHW shared her experiences of participating in the discharge process and contributing to decision-making for future arrangements prior to a patient's hospital discharge, saying:

> My involvement in the discharge process is attending ward rounds to develop a plan with the patient and the ward team, attending zoning at the Early Intervention Team to update the Multidisciplinary Team and put the plan, establish different plans and then act on them and then update

> the team and then it might be helping the patient with practical things when they're an inpatient. [Kate]

This quotation captures a variety of cases met by the CMHWs when making referrals of patients to other services. Furthermore, another CMHW highlighted the complexity of her duties as a care coordinator saying:

> Yes, my duties are to function as care coordinator to a designated number of people. My caseload now stands at 46 people. I will review their care packages, I will monitor their mental health, I'll liaise with different agencies, [...] do some Care Programme Approach (CPA) work and as a clinician I also do medication administration and help other teams with their clinical duties. [Rose]

This quote highlights the multifaceted role of the care coordinator, engaging in both clinical duties, such as medication administration and helping other teams, while also being involved in Care Programme Approach (CPA) work, illustrating their multiple roles and dedication within CMHTs. CMHWs face a range of complex responsibilities as part of their role; for example, establishing therapeutic relationships with patients and offering assistance throughout the process of coordinating patient discharge from the hospital.

Subtheme 1.2 - Interprofessional and multidisciplinary team working

Within this subtheme, CMHWs showed a collective recognition and understanding of the significance of interprofessional and MDTs working in the context of discharge planning. The majority of CMHWs shared similar experiences about this subtheme. For example, a CMHW reported his experiences of interprofessional and collaborative working with MDT:

> So, my responsibility, I am a senior mental health practitioner with the Home Treatment Team [...]. And my responsibility is to work as part of a team, which is essentially facilitating potential discharge, or early discharge, or supported discharge, is to help facilitate discharge and supported leave and in the process work with the MDT. So that would consist of us as a team, the consultant, the ward staff, to liaise in that process. [Richard]

Some CMHWs described their experience of involvement in the discharge process with MDT by arranging for patients to have a Section 17 home leave (under the Mental Health Act) for an agreed period:

> Yeah, and then when at a point whereby the patient is going to be gradually discharged, which means their consultant want them to go on Section 17, leave for a week, and let us monitor how things are going at home. I will do the home visit […] reporting back to the consultant and attending the ward round on the discharge and then the person got discharged and then continue to monitor them until other services takes over. [Bongani]

Similarly, other CMHWs shared their experience in working within MDTs, noting that, when a patient is admitted to an acute ward, the care planning process should already consider the discharge plan as part of the overall pathway, starting from the moment of admission*:*

> My understanding is that when a patient is admitted onto an acute ward, part of their care planning pathway is about what I'm going to do on discharge, they should be planning their discharge from the point of admission. [John]

In addition, one CMHW narrated the experience in her role with the Care Programme Approach (CPA) and MDT, particularly focusing on discharge planning when patients are leaving specialist hospitals:

> Oh, my dealings with the Care Programmed Approach (CPA) tends to be on discharge from when patients are discharged from specialist hospitals. So, I will get involved in CPA meetings which are usually every three months for patients who are in hospital settings. That's a platform where we do discharge planning, ongoing care and just ensure that any after care needs will be put in place and we're prepared for them [...]We deal with patients who are usually they're not on CPA and they've got, they're well established in the community, and they've got support and care packages. [Rose]

Another CMHW outlined her experiences, mentioning that much of her role involves negotiation with supported accommodation providers and ensuring care coordinators are present for discharge planning:

> Well yes it's a lot of the time like I've said about you know negotiating with the supported accommodation trying to get care coordinators to come for discharge planning, quite often doing it […] Care Coordinator is picking up and running with this then it's a very streamlined, efficient process but it can be a real problem with the out-of-area patients I would say because they're the most complex patients. They are in the supported accommodation already and they've got you know the, a lot of problems so things can be very time consuming […]. [Ruth]

In addition, one CMHW, conveyed his similar experiences, highlighting that once a patient's condition improves, the focus shifts towards discharge planning. He emphasised that, ideally, the process of planning for discharge should start from the very day the patient is admitted:

> …patient starts improving and then we start looking into discharging patients and planning for discharge. And to be honest, the planning for discharge ideally starts from the day they are admitted. [Naresh]

Whereas another CMHW shared her expectations to allow her to check the prescription promptly and dispense the required medicines without causing any patient discharge delays:

> So, I would be expecting for them to let me know that Joe Bloggs is, "Well we plan to discharge Joe Bloggs next week, on Monday." And ideally maybe a day before, or maybe even 48 hrs beforehand, I expect to see the discharge prescription written, so that I can check it in a timely manner, get the medicines dispensed […] Without needing to delay them and asking them to come back a few hours later is what I would expect. [Rudo]

Some CMHWs believed that MDTs and various agencies should be informed about patient hospital discharge where there are issues about child and family services being involved due to child protection concerns. One CMHW narrated her experience:

> So, because this lady was returning home where there was child and family services involved, I had to ensure that they were informed because it was part of child protection. I also had to inform the people who she had a care package with to see if that could be re-started. Unfortunately, it couldn't but I don't think she, she needs it any longer anyway which actually turned out to be a good thing. So those would be the other agencies and of course you have to send seven day follow up to Home Treatment Team which I did. [Rose].

Whereas another CMHW highlighted her responsibility to prevent patient hospital readmissions and enable prompt discharges:

> Right, my role is to prevent admission and facilitate early discharge […] So one of our regular roles is liaising with people while on the ward attending ward rounds and building a relationship and then supporting that person through the discharge process and then we'll keep them for as long as we need to assess as to whether they need longer term workers or we can give a short period of work and then discharge. [Hannah]

The majority of CMHWs highlighted the importance of effective communication within care-coordination and their involvement in ward rounds to ensure a smooth transition from hospital to community services.

Subtheme 1.3 - Involvement in the discharge process

Another important aspect explored relates to how CMHWs are engaged in patients leaving the hospital, known as the discharge process. This subtheme examines various aspects of how CMHWs participate and contribute during the discharge process.

One CMHW described her experience in collaborative care-coordination for patient hospital discharge. She actively took part in discharge planning, attending ward rounds, and conducting home visit assessments to assess the need for a care package before the patient's return home. She described her experiences highlighting the importance of multidisciplinary teamwork and shared responsibilities during care-coordinating patient hospital discharge:

> Yes, certainly, […], so I often get involved when I was on the ward, I used to get involved in a lot of discharge planning and I would attend the ward rounds and sometimes I'd be asked to do a home visit assessment and see if that person needs a package of care before they return [...]. [Julie]

The reported value of involvement in care-coordinating patient hospital discharge was described by CMHWs who shared their experiences. One CMHW described his

experience of participating in patient discharge meetings to assess patients for supported discharge finding those suitable for the service:

> We could attend two or three business meetings a week to screen all the patients for supported discharge. To see who might be appropriate, to then be able to speak to the patients on the ward, tell them what we've got to offer. And kind of show them that once they're discharged from the ward there is something on offer and they will be supported. Which in time and the length of stay in hospital is shorter. [John]

Similarly, some CMHWs narrated their experiences, explaining that patients are gradually prepared for discharge by first assessing their improvement and managing risks in the community. This involves testing with supervised leaves and progressively transitioning to unsupervised and longer periods, such as day or overnight leave:

> …when we all feel that they have improved to a significant level and the risks could be manageable in the community then we start testing out with leaves. Initially you might just give them an escorted leave and then gradually on their own. And then for longer periods, maybe a day leave and then overnight leaves. And if everything goes well, yes, they can be discharged into the community. With either, if a care coordinator is already there yes, they will take over. Otherwise, we discharge them with the support of the Home Treatment Team. [Naresh]

Conversely, one CMHW shared her recent experience of lack of collaborative working where a patient was discharged without an adequate supply of their medication, Clozapine. As a result, there was a risk of the patient missing their medication dosages, which could lead to the need for re-titration. The CMHWs experience highlights the importance of ensuring proper medication management and discharge planning to avoid potential complications for patients:

> Recently we actually had a patient who was discharged. They were on Clozapine, but I don’t know what happened in that process, but they seem to have been sent home without enough supply of their Clozapine. So of course, Clozapine, if you miss it for 48 hrs then you need to be retitrated. And at the moment most of our retitrations are taking place in hospital, so that would require for the patient to be readmitted unnecessarily, if I may say that […]. [Rudo]

Consequently, theme one explored experiences of CMHWs' roles, obligations, and decision-making, and interprofessional and collaborative working involved in the discharge process. CMHWs shared their valued experiences about their interprofessional and collaborative working involvement in the discharge process to ensure patient-centred care. The second theme of the study explored experiences of CMHWs in relation to the challenges and facilitators they met when undertaking the crucial task of coordinating care and effecting the discharge of patients from hospital settings to community integrated services.

5.5 Theme 2 – Challenges and enablers to care coordination

Theme two, Challenges and enablers to care coordination, comprises three subthemes: Fragmented communication, Lack of resources, Stigma and discrimination, and Building trust and relationships. These arose from participants' experiences on the challenges faced by CMHWs in care-coordination of patients discharged from the hospital (illustrated in Figure 11).

Figure 11. Theme 2. Challenges and enablers to care coordination

Subtheme 2.1 - Fragmented communication

CMHWs identified a number of barriers they experienced in helping care-coordination of patient hospital discharge. One CMHW highlighted broken communication and the

need for clear communication during handover as being vital in interpersonal communication skills between ward staff and community mental health workers:

> […] I find communication can be really fragmented […] and then I'll go into ward round, and it won't reflect what has been actually handed over. It, can be very much focused on what the clinician and consultant think rather than what actually day to day nursing has been handed over. [Rose]

Another CMHW expressed her concern about the fragmented and non-integrated care model and highlighted the need for a more cohesive approach to ensure better continuity and quality of care:

> So the fractured care model or the non-integrated care model is where you have community consultants who do clinics all the time, which frankly, would drive me potty, and you have consultants who sit on wards, and I understand nursing staff love it because they have someone sat on the ward, more, there all the time, and they feel they have got the consultant there and they haven't got lots of consultant ward runs. [Jessica]

Ultimately, many CMHWs felt that communication was a critical facilitator in the care-coordination process, enabling efficient patient discharge. A consultant psychiatrist, Susan, emphasised the importance of effective communication with care coordinators:

> So, I think the role of the care coordinator is really important. So, if you have got a care coordinator who the communication process is good with […] You can get the patient out of the hospital a lot quicker, and things work much more efficiently. [Susan]

Furthermore, a majority of CMHWs highlighted a significant barrier arising from communication issues with the ward staff:

> A big barrier again is communication from the ward but again they're busy. We often ring up and get told the answer of, "We don't know." Like if you ask about a patient's pain relief or "How were they on the ward?" the answer often is, "I don't know I've not been on shift." So lack of communication, but I think it's more the staff are just so ridiculously busy that I can't see asking them to be more organised would change anything. I think what they just need is somebody to look at the workload on the ward or maybe more staff [....]. [Hannah]

Similarly, one CMHW shared the difficulty she encountered with communication in the context of patient discharge and medication, expressing:

> So that communication element I think is a challenge. And I just think, as I say, because it's almost like the last part in a patient's journey, that discharge and medication element. I think it tends to be a bit of a rush to process if I'm honest. [Rudo]

A majority of CMHWs identified communication as a significant barrier, mentioning the lack of access to clinical notes affecting their coordination efforts:

> We didn't have access to the clinical notes. Now we've got access to the clinical notes so we're a little bit more in the loop but usually it's communication. [Rose]

Similarly, another CMHW highlighted the importance of effective communication as a facilitator to speed up care-coordinating patient hospital discharge planning, stating:

> So, I would think the ideal would be if you know those out-of-area patients might have the consultant, the same consultant and the same CMHT I think that would be better for the patients. [Susan]

In contrast to other participants, Naresh, a consultant psychiatrist, seemed to have a more positive outlook on his experiences, suggesting that he finds his role relatively manageable without significant obstacles or difficulties:

> I don't think there are too many challenges around. [Naresh]

However, the majority of CMHWs faced other challenges in coordinating patient hospital discharge, particularly concerning the scarcity of available resources in the community.

Subtheme 2.2 - Lack of resources

CMHWs expressed concerns about the limited availability and accessibility of resources in the community, which presented challenges in delivering adequate support and services to individuals in need. One CMHW highlighted shortage of funding for mental health services and said:

> Probably it's obviously funding issues because if I am Minister of Health, I would say give the mental health teams more funding. [Bongani]

In addition, another CMHW reported her personal and professional experiences, such as loss of client resources, such as services, benefits, and inadequate social support for patients, saying:

> Right, one of the biggest challenges is over the past 13 years, no 14 years I have been working in this job, is the loss of services. Housing Benefits, everything you used to be able to get and now you can't […] So we're seeing people now they're in crisis because they're living in squalor, they're in crisis because their benefits have been cut in half and their mental health condition is there but all the social stresses alongside that we can't support them with like we used to. [Hannah]

Furthermore, some CMHWs found lack of resources as barriers hindering the effectiveness of care-coordinating patient hospital discharge:

> So, first thing I will say is lack of resources […] So, lack of resources for the staff, lack of resources for the patient in the sense that there is no accessibility really for services. Most of the services has been shut down and government are now looking into reopening it. So that as well is lack of resources for them. We cannot even refer them to places that can help them in their recovery process. [Ola]

Other CMHWs shared similar views on improving the patient discharge pathway. One CMHW highlighted the lack of resources that meet of patient needs such as finding suitable accommodation especially for patients with complex needs:

> I think the two things I would say is to change the way the process for you knows identifying the patient needs and finding the accommodation [...]. So, I think looking at making the discharge pathway for patients with complex needs more efficient would you know be better for patients and solve some of the bed crisis. [Susan]

One CMHW described specific experiences on challenges met, including the complexities of working with patients lacking a stable place of residence, necessitating the task of securing suitable accommodation for them and supervising their treatment:

> My experiences have been things like working with patients who are of no fixed abode and then having to organise appropriate accommodation for

> them and when people need an increase in care on discharge […] So most recently that's been somebody I've been working with who required an increase in, well she needed a package of care, she'd not had one before and it had to be quite thorough of two visits every day to prompt for medication. [Kate]

The experiences of resource scarcity resonated among the majority of CMHWs, highlighting a pervasive concern within the community mental health teams.

Subtheme 2.3 - Stigma and discrimination

This subtheme underscores the need for improved education and the reduction of societal stigma surrounding mental health condition within the community and emphasises the importance of fostering understanding and empathy. Ola, Richard, and Hannah mentioned the lack of education and stigma in the community as barriers to care-coordinating patient hospital discharge.

Furthermore, one CMHW highlighted the lack of education about mental health in the community and the resulting stigma for patients with a diagnosis of mental health condition:

> And I will say lack of education as well about mental health condition and stigma in the community. So that one as well are the things that we do face, is one of the barriers because people don't have the proper knowledge of what is what and how we can offer the support really to ensure that everything goes most smoothly from being discharged from the hospital back to the community. [Ola]

In addition, participants highlighted that certain community service providers hesitated to extend their services to individuals diagnosed with mental health condition, primarily due to the presence of societal stigmatisation:

> So, in this, in stigma, I guess, well stigma in mental health as in people, you know, I guess, well it is quite a broad, what is stigma in mental health? I think this idea, this negative idea of what mental health is […] That could be, in this case, a contributing factor towards that, but I think in this case she may have felt that she was not as understood. [Richard]

Subtheme 2.4 Building trust and relationship

Some CMHWs shared their experiences on the challenges in building relationships with patients during the discharge process. One CMHW mentioned that the transition from the ward to the community brings other unique challenges, and finds it difficult not to compare the two settings:

> Yeah, Yeah, Yeah, I think it is not easy to build a rapport when we go into their own homes we are only there for an hour and to build that trust and rapport it would take so many visits […]. [Bongani]

The quotation underscores the experiences and beliefs of CMHWs, emphasising that patients' experiences of stigma can contribute to their feelings of being misunderstood. Theme 2 explored CMHWs' experiences in coordinating patient hospital discharge, highlighting the significance of challenges such as fragmented communication, insufficient resources, and the presence of stigma and discrimination. The next theme will further explore their experiences within organisational systems and assess the impact of the prevailing culture on them.

5.5 - Theme 3. Experiences of organisational system and culture

This theme explores the experiences of CMHWs on the effectiveness of their respective organisations in supporting care-coordination during patient hospital discharge illustrated in Figure 12.

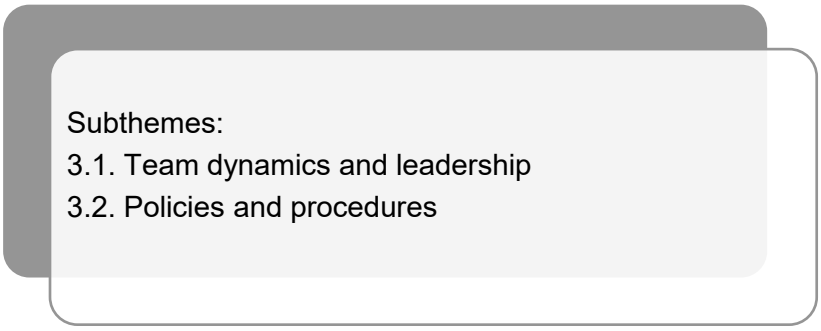

Figure 12.Theme 3. Experiences of organisational system and culture

Subtheme 3.1 - Team dynamics and leadership

This subtheme pertains to understanding how community health workers work together as a team and the role of leadership when they are helping to coordinate the discharge of patients from the hospital after receiving care. It involves looking at how team interactions and effective leadership influence the process of transitioning patients from the hospital to their homes or community mental health services. The majority of the CMHWs described their roles in care-coordinating patient hospital discharge. One CMHW outlined the duties assigned to them based on team dynamics and leadership:

> I think my main duty and responsibilities are around safety and treatment of patients, so I think it's about working with not only the patient but with the team, with the families […]. And I think my sort of responsibilities and duties within the team are also about deciding whether somebody requires admission, what kind of support they need and that entails me sort of going in speaking to consultants, managers, family, other people on the team who have worked with patients because we share our caseload. [Mary]

Whereas another consultant psychiatrist demonstrated her leadership ability by providing a detailed explanation of the functioning of the CMHISs' care model and sharing her positive experiences with its implementation, saying:

> Okay. So well, where I work, here, we would use an integrated model which means that I cover a patch and my outpatients, if they need to come into hospital, I will make that decision and they are under my care in the hospital […] So I will follow them up. So, in a way, it is a good experience [...] Occasionally, I will see people sooner if I am very worried about them. [Jessica]

A majority of the CMHWs shared a similar perspective on policies and the model of care, reinforcing the shared belief that these aspects require attention and potential improvements within the context of care-coordinating hospital discharge of process.

Subtheme 3.2 - Policies and procedures

The subtheme policies and procedures focus on how participants' work is influenced by strict organisational policies, limited resources, and bureaucratic procedures within

the broader ecological system. Other participants stressed the need for supportive systems that promote patient-centred care, provide adequate resources, and prioritise medication safety.

One CMHW highlighted the impact of organisational administration and lack of resources making it difficult to refer patients to other services during care co-ordinating patient hospital discharge:

> But with regards to bureaucracy and social, yes I think, you know, if a service is stretched, if it is understaffed for example and it's got referrals coming in left, right and centre […] they would want to be kind of […], very, very strict with the criteria of what comes into their service. [Richard]

Some CMHWs acknowledged that the challenges they experience are influenced by organisational policies and procedures, resulting in crisis management practices. One CMHW shared the same view on policies and model of care and said:

> Let us go into management [...] I think it's got to be clear that this isn't, I am not pointing at any individual for example, it's more the model of care that's provided the structure of crisis management. But I think one of the biggest challenges, and I think it is a challenge that sometimes we share as practitioners as well. [Richard]

The majority of CMHWs shared similar views on improving the patient discharge pathway suggesting that the process of identifying patient needs and finding suitable accommodation should be changed to make it more efficient. One CMHW suggested that greater efficiency in the discharge pathway would improve patient care and potentially alleviate some of the issues related to bed availability in the healthcare system:

> I think the two things I would say is to change the way the process for you knows identifying the patient needs and finding the accommodation [...]. So, I think looking at making the discharge pathway for patients with complex needs more efficient would you know be better for patients and solve some of the bed crisis. [Susan]

For some CMHWs, organisational policies have had impact on CMHISs, such as issues with vacancies and staff shortages leading to increased workload for the

community staff. In addition, the lack of access to other support services, such as Social Services and support groups, puts a higher demand on CMHWs to provide care and support to patients. One of the CMHWs highlighted a combination of the above-mentioned issues around limited resources perceived to be adding further delays in care-coordinating hospital discharge:

> Yes. I guess alongside vacancy and recruitment problems it culminates in additional workload for community staff, and you know a lot of our work is obviously around preventing admission but there are patients […]. You know Social Services lots of things closed you know access to lots of support groups […]. I think you know the demand on us was higher because other services weren't available. [Ruth]

Furthermore, participants emphasised policy and procedures stressing that discharged patients should be visited at home within 72 hours:

> Well in our work we have the seventy-two-hour follow-ups and then if we don't see them within the seventy-two hours, keep trying before a seven-day breach. But ideally if any patients refer to the Home Treatment Team from a community, it would be within twenty-four hours, you know, that's our criteria […] Which I think is very appropriate. [Richard]

Some CMHWs shared their individual experiences of having difficulties with organisational procedures, especially concerning documentation and incomplete information from the ward during the coordination of patient discharge. One CMHW said:

> I think it links in a little bit with number two when I was saying from like a bureaucracy side of you know the paperwork that you would use the information that you receive from the ward may not be as detailed as you'd like it to be sometimes, and I know that's due to pressures that they face and staffing. [Mary]

Another CMHW shared her experiences of the changes in CMHISs over the past few years. She mentioned that services used to run more smoothly and were more focused on the needs of clients. However, due to cuts in services, many resources that were once available are no longer accessible, which has affected the quality and focus of care provided to patients:

> Things ran a lot better over 10 years ago. A lot of it is cuts in services. What used to be available is not available anymore. We're finding things aren't client focused anymore. Services don't seem patient-focused […] We'll have carers saying, "I've got half an hour and if I, [noise in background] oh, and in that half an hour if I don't do what I need to do then the person afterwards won't get their care needs met." [Hannah]

In this theme, CMHWs shared their experiences of working within different structured and culturally influenced CMHSs with one NHS organisation. They highlighted challenges related to organisational policies, limited resources, and bureaucratic procedures, which affected their ability to efficiently provide care and coordinate patient hospital discharge.

5.5 Theme 4 - CMHWs' personal experiences of professional growth

This theme highlighted the importance of personal and professional growth, focusing on the interplay between individual development, organisational support, and the broader CMHS context. It also shed light on the impact of the Covid-19 pandemic on CMHWs and their need for adequate support during challenging times. Within this theme, the following subthemes, as illustrated in Figure 13, were found, and are related to the personal experiences and professional growth of CMHWs:

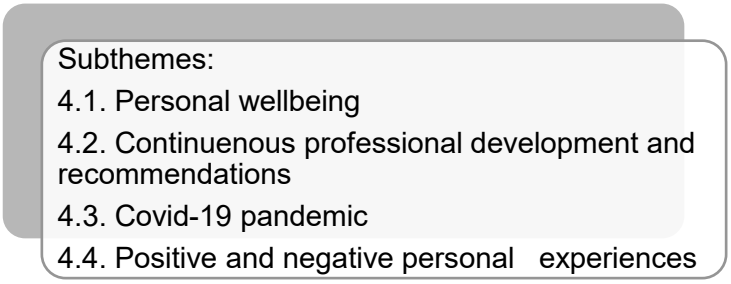

Figure 13.Theme 4. CMHWs' personal experiences of professional growth

Subtheme 4.1 Personal wellbeing

In this study, CMHWs recognised the importance of enhancing the personal wellbeing of staff, emphasising the need for improved support and resources within the workplace. One participant noted:

> Yes, I think care for staff […] really needs improving. I think you know everybody has mental health not just our patients we all have it, and we all have to be aware of it so I think it would be beneficial for there to be more things available for staff at work things […] or somebody on hand to speak to regularly really you know we're make sure we check up on each other as colleagues I think that's important […] [Mary]

In addition, the significant psychological drain and self-esteem challenges experienced by CMHWs was also highlighted:

> Oh yes. So psychologically it is really, really like draining. It's draining, you lack self-esteem as well because there's no way because you doubt yourself you find that you cannot even remember how many people that is on your caseload […]You're tired, you burn out […] So I think overall it just affects you mentally, physically, emotionally, psychologically you know all, I would say all. [Ola]

Some CMHWs suggested that providing more resources and amenities at work, such as a relaxation area or a comfortable room with a television, could be beneficial in promoting the wellbeing and mental health of the staff. This shows the importance of creating a supportive and conducive work environment for mental health professionals to thrive and deliver quality care to patients. For example:

> Yes, I think care for staff […] needs improving […] I think it would be beneficial for there to be more things available for staff at work things for - Just simple things like a relaxation area or you know a room that you can sit and watch television that's comfortable. [Mary]

These experiences, rather than solely being about the personal wellbeing of CMHWs, were perceived as indicative of a broader issue characterised by limited resources and insufficient provisions for regular staff support.

Subtheme 4.2 - Continuous professional development and recommendations

This subtheme focuses on how CMHWs can keep learning and growing in their field and suggestions they provided. It explores ways in which they can enhance their skills in coordinating care for patients and helping them leave the hospital. This is important

because it helps these CMHWs to improve their abilities, leading to better care-coordinating of patient hospital discharge. One CMHW highlighted how lack of continuous professional development in specialised areas is a drawback:

> So, the other challenges include, I suppose, not having enough training in specialist areas, so because I am not nurse, I'd often have to go back to my work colleagues and ask about medication to clarify. [Julie]

Furthermore, another CMHW emphasised the significance of educating colleagues, particularly those in the wards and ward managers, about making prompt referrals. This highlights the importance of continuous learning and promoting professional growth among healthcare workers.

> I've tried to educate the wards, the ward managers and a lot of the staff who work there about them making these referrals in a timely manner." [John]

Conversely, other participants expressed concerns about the lack of specialised training and support for staff wellbeing. Julie highlighted the need for more specialised training in certain areas:

> But certainly, the medication side. I've not got the specialist knowledge […] so that can be a barrier. [Julie]

Based on their individual experiences, the majority of the CMHWs highlighted the importance of effective communication among team members and early discharge planning to ensure a smooth and coordinated process for patient discharge. Their recommendations emphasise that clear communication ensures all relevant parties are informed and ready, enhancing the overall discharge experience. For instance:

> My recommendations, I would say the key word that I can give is communication. So, communication of everybody, well to everybody who needs to know the information relating to the patient being discharged. [Rudo]

Subtheme 4.3 -COVID-19 pandemic

The COVID-19 pandemic has had a profound impact on personal mental health, overwhelming healthcare systems, leading to significant challenges in patient care, and causing global disruptions that extended across various sectors and countries. Several participants illuminated the impact of COVID-19.

A majority of CMHWs reflected on the emotional challenges faced during the pandemic, where concerns about personal wellbeing, as well as the impact of COVID-19, have added to the complexities of care-coordination. One CMHW shared her experiences:

> I think the pandemic has been challenging emotionally you know with care-coordinating because we've had our own worries about that and you know our own worries about Covid and what it actually is, what it can do if you catch it and patients have had that as well and they've been coming to asking us for information […].[Mary]

Other CMHWs shared similar experiences on the negative impact of COVID-19. One CMHW commented:

> And I think as well with the COVID-19 been going on, relatives and carers have been unable to attend ward rounds and have their views heard. [John]

In addition, some CMHWs shared similar experiences and believed that the disruptive impact of service closures during the COVID-19 pandemic, had impacted care delivery:

> Most of the services has been shut down and government are now looking into reopening it. So that as well is lack of resources for them. We cannot even refer them to places that can help them in their recovery process. [Ola]

The COVID-19 lockdown policies and regulations resulted in widespread service closures, and the government is now focused on reopening them, but limited resources

hinder their efforts, making it challenging to provide necessary support and referrals for patients with a diagnosis of mental health condition in need of recovery help.

Subtheme 4.4 - Positive and negative personal experiences

This subtheme involves understanding both the positive and negative aspects of participants' experiences in coordinating the discharge process and supporting patients during their transition into the community:

One CMHW remarked that his feelings are unchanged by the situation:

> No, it does not affect me emotionally. No, it is in terms like I say you go to work and help someone, and they are happy you feel good about yourself. [Bongani]

Some CMHWs emphasised the value of their manager's open-door policy, characterising it as a supportive environment in which managers consistently made themselves accessible to provide help and guidance to their colleagues. One CMHW shared her remarkable experience:

> Well, supervision, absolutely supervision. We've got a new Manager at our team now and she's really good and she's very keen on supervision. Her door is always open, and she's really good at dissecting what's stress and what's a genuine concern. [Rose]

In summary, Theme 4 centred on various aspects, including personal wellbeing, continuous professional development, recommendations provided by CMHWs, experiences during the COVID-19 pandemic, and a spectrum of positive and negative personal encounters. This theme covered ongoing efforts for professional development, including suggestions for enhancement, while also addressing the diverse personal experiences amid the challenges posed by the COVID-19 pandemic.

5.6 Chapter summary

In this study, the experiences of 14 CMHWs involved in coordinating the discharge of mentally ill patients into CMHIs were explored. The analysis resulted in the identification of a connection between four themes: collaborative working, challenges and enablers, organisational systems and culture, and personal and professional growth (see Figure 9). These findings offer valuable insights into CMHWs' experiences and the challenges they face in community mental health care-coordination of patient hospital discharge. Furthermore, these findings contribute to the existing literature and help inform the development of strategies and interventions for improved care coordination and enhanced patient hospital discharge. This study uncovers novel insights, for example, highlighting that certain CMHWs found rigid hierarchical structures, professional satisfaction in patient recovery despite systemic challenges, such as inconsistent communication pathways, emphasising the importance of intrinsic motivation in maintaining involvement. In addition, highlighting resilience, especially during COVID-19 and in environments with limited resources, showcases the ability to adapt at the microsystem level, alleviating wider institutional limitations. The dual aspects of communication, disjointed in certain situations but successful via teamwork, provide fresh insights into the active relationship between personal, community mental health teams, and organisational processes, a topic further discussed in Chapter Six.

Specifically, it highlights the emergence of informal support networks as critical enablers of emotional resilience, and inconsistent communication pathways as persistent barriers to care coordination of patient care practice and innovation.

Chapter Six. Discussion Of Study Findings And Conclusions

6.1 Introduction

This chapter aims to discuss the empirical study's key findings. First, the chapter provides the focus of the discussion on four themes: collaborative working, barriers and facilitators, organisational system and culture, personal experiences and professional growth. Table 5 depicts theoretical frameworks and discussion of empirical findings structured under thematic headings discussed through the perspective of the normalisation process theory (NPT) embedded within the ecological system theory (EST). Next, the chapter discusses contextualisation of the study with existing evidence, theory, and policies. Finally, the chapter presents the conclusions of the entire thesis, along with its strengths, limitations, methodological and theoretical contributions, implications for clinical practice and education within both local and international contexts, recommendations for future studies, and my reflexivity.

To address this study's research question and aim, this study centred on the experiences of community mental health workers (CMHWs) in coordinating patient hospital discharge, focusing on four key themes: Experiences of collaborative working, CMHWs' experiences of challenges and enablers, experiences of organisational system and culture, and personal experience and professional growth. These empirical findings highlight the pivotal role of CMHWs' experiences in shaping and enhancing the quality-of-care coordinating patient hospital discharge to community mental health services as outlined in Chapters 1 and 5. In the subsequent sections, underpinned by Bronfenbrenner's (1979) EST and May et al.'s (2018) NPT, this discussion enables a comprehensive exploration of CMHWs' experiences of care-coordination. I now discuss these themes through the theoretical lens of the NPT embedded within the EST, aiming to deepen our understanding of CMHWs' experiences as illustrated in Table 5.

Table 5. An application of Ecological System Theory embedded with Normalisation Process Theory

Ecological System Theory Levels	Key Themes	Normalisation Process Theory Constructs	Description in this study context
Macrosystem	CMHWs' experience of challenges and enablers	**Cognitive Participation**	CMHWs cognitively navigate, participate, and normalise challenges while working with CMHTs across all system levels.
Exosystem	Experiences of organisational system and culture	**Collective Action**	CMHWs actively, collectively act to sustain new working practices in organisational and cultural contexts.
Mesosystem	Experiences of collaborative working	**Coherence**	CMHWs make sense of their work and experiences in joint efforts across CMHTs and CMHSs.
Microsystem	CMHWs' personal experiences of professional growth	**Reflective Monitoring**	CMHWs and researcher engage in self-evaluation and reflection on work practice and personal development.

Adapted and modified from (Bronfenbrenner, 1979; Macfarlane & O'Reilly-de Brun, 2012; May & Finch, 2009; May et al., 2018)

Note:

Fluid interaction: *The Ecological System Theory* is not hierarchical or fixed, CMHWs may move between levels, influence across them, and experience overlapping dynamics.

Constructs are interrelated: *Normalisation Process Theory* elements like *coherence or collective action* do not belong to just one level, they interact fluidly with the realities of CMHWs working practice.

Reflection and collaborative working occur simultaneously across ecological system levels: CMHWs and researcher's experiences and *reflections on personal and professional growth* through interaction during data collection.

The two theoretical frameworks shown in Table 5 further develop the information presented in Chapter 1 that included Bronfenbrenner's EST (1979) and May et al.'s NPT (2018). Thus, a detailed synthesis of the themes developed in the previous chapter encompassing obstacles and facilitators, organisational structures, and culture, as well as individual experiences and personal development, is essential for a comprehensive understanding of CMHWs' experiences. Through the integration of EST and NPT, I provide this theoretical framework to help explore how CMHWs

navigate these complex local policies and work processes to understand their personal experiences. As noted in Chapter 1, Section 1.5.1 to 1.5.3, and supported by CMHWs' narratives in the literature and in this study's findings, EST offers a perspective for comprehending the various environmental and systemic elements impacting CMHWs, whereas NPT helps in dissecting the integration of new practices and roles in these environments.

Using the EST and NPT lenses helps us better understand how CMHWs collaborate, overcome organisational obstacles, and care coordinate hospital discharge planning for patients in the community. The following sections now discuss this study's findings under subsequent themes: experiences of collaborative working, challenges and enablers, organisational system and culture, and CMHWs' personal experience of professional growth.

6.1.1 CMHWs' experiences of collaborative working

This theme, collaborative working, was generated from this study's findings and, through the lens of EST and coherence shapes our understanding of CMHWs experiences of and the holistic nature of care-coordination as illustrated in Figure 9 and Table 5. The findings of this study suggests that collaborative working among CMHWs is influenced by individual, community, organisational, social, and economic factors as previously presented in Chapter 1. Moreover, coherence, as conceptualised in NPT, refers to the sense-making work that CMHWs work collaboratively with other teams understand and operationalise complex work practices within their organisational contexts. These findings are consistent with results obtained by Forchuk et al. (2020) highlighting that collaborative working is crucial among multidisciplinary teams. Similarly, Li et al. (2022) found that working collaboratively promoted efficient care-coordination of patient transitions into the community.

The findings of this study align with that of by Goh et al. (2022), and Petrie (2021) who identified that, globally, CMHWs experienced challenges to work collaboratively with both MDTs and other external organisations due to poor communication. Moreover, Hodge and Raymond (2023); Huddlestone et al. (2020) suggested that collaborative working can foster team working, fostering improved communication and a comprehensive understanding of the dynamic interactions between individual, interpersonal, and organisational factors shaping the care-coordination process. This alignment can inform work practices and strategies to enhance coherence between CMHWs, helping to improve collaboration and communication in care-coordinating patient hospital discharge in this context (National Institute of Clinical Excellence, 2021).

The study's findings revealed that participants consistently highlighted the importance of effective collaboration with shared decision-making among multidisciplinary teams (MDTs) being essential for successfully coordinating patient discharge from hospital admission to community transition, as detailed in Chapter 5. Hence, NPT, illuminated in this study findings on CMHWs' experiences of working collaboratively in care coordination within multidisciplinary teams (MDTs) as illustrated in Table 5. The next section explores CMHWs' experiences of barriers and facilitators in coordinating patient hospital discharge.

6.1.2 CMHWs' experience of challenges and enablers

The experiences of CMHWs in coordinating patient discharge involves navigating various barriers and facilitators, emphasising the cognitive participation aspect of the NPT within EST to normalise the complex discharge process (See Table 5). According to May et al. (2018), cognitive participation refers to the efforts and activities individuals undertake to encourage their involvement with the new practice and helps to build knowledge and understanding the ongoing problems in their work, emphasising the

need for further attention, and addressing systemic issues. This study's findings resonate with previous study findings by Chen et al. (2021) and Russell et al. (2021), highlighting the common barriers experienced by liaison psychiatrists, nurses, physicians, and matrons, including issues such as staff shortages and the impact of government policies. In addition, cognitive participation refers to the efforts and activities individuals undertake to encourage their involvement with the new practice and helps to build knowledge and understanding of the ongoing problems in their work, emphasising the need for further attention and addressing systemic issues for improving CMHSs (Goscha & Rapp, 2015; Nyassi et al., 2023).

The history of community mental health service discourse aligns with community-based treatment because it mirrors the historical developments of CMHWs outlined in chapter 1. The change from institutionalised care to community-based services reflects a paradigm shift towards deinstitutionalisation and person-centred support (Ikkos & Bouras, 2021). This shift, situated within the broader EST, as illustrated in Figure 5 that shows how, at the macro-level, such as policy or organisational system cuts across meso- and micro-system interactions, thereby reshaping both the barriers and enablers that influence nurses' practice and engagement within their immediate professional contexts. The role of CMHWs, positioned across these ecological layers, is deeply embedded in the broader discourse on deinstitutionalisation and the global movement toward person-centred, community-based mental health care.

Furthermore, it resonates with the literature review presented in Chapter 2, illustrated by studies such as Li et al. (2022) and Nyassi et al. (2023) that underscore the importance of multidisciplinary collaborative working in enhancing the effectiveness of care coordination efforts in providing community care.

Finally, the findings illuminated in the previous chapter shed light on the experiences of CMHWs, revealing instances of both barriers and facilitators encountered in their daily practice, as exemplified by quotes illustrated in Chapter 5 from participants highlighting challenges such as resource constraints and the importance of effective communication strategies. Similarly, the literature review found studies (Li et al., 2022; Russell et al., 2021) that highlighted barriers in care-coordination such as lack of resources and poor communication. This current study findings revealed frustrations among CMHWs due to resource limitations, challenging patient interactions, and inadequate services, resulting in delayed discharge planning, care package challenges, and obstacles in timely community service referrals. Similar observations were made in the following reviewed studies: Agyapong et al. (2016) in Ghana; Beckers et al. (2019) in the Netherlands; Brenman (2014) in Nepal; Forchuk et al. (2020) in Canada; Goh et al. (2022) in Singapore; Petrie et al. (2021) in Australia; Priebe et al. (2012) in the UK; Russell et al. (2021) in Malaysia; and Martinez et al. (2017) in Mexico. These studies explored experiences of health care delivery on addressing issues surrounding care coordinating patient hospital discharge in the community, demonstrating that this is a global problem. Comparing the findings of this study with existing literature by Petrie (2021), and Russell et al. (2021) reveals notable similarities in participants' descriptions of barriers, facilitators, and insights into care-coordination of patient hospital discharge, indicating the influence of ecological systems on their experiences. This convergence of evidence offers valuable input to inform the application of the NPT within EST, for an in-depth understanding of the complex dynamics involved in the studied phenomenon (Bronfenbrenner, 1979; Martinez et al., 2017). Furthermore, Ion et al. (2017) suggests that organisations need to develop practical steps to assist CMHWs in care-coordinating patient hospital discharge while promoting smooth and safe patient transition into the community. Similarities can be observed in a study by Murphy et al. (2018) in which pharmacists highlighted their experiences of caring for at risk patients in the community, stressing organisational

barriers to preparing of medication prescriptions for the patients during the time of discharge. Furthermore, the impact of first-hand experiences on the professional growth of CMHWs in enhancing patient care during care-coordinating patient discharge is essential in identifying areas for improvement. In the context of the present study, the identified insights offer in-depth understanding of the imperative role of collaborative efforts to tackle care-coordinating patient hospital discharge barriers, especially in the field of community mental health.

This study's findings not only underscore the significance of cooperation through cognitive participation among healthcare professionals but also of barriers and facilitators within the system. The recognition of such multifaceted dynamics shows the interconnectedness of individual and systemic factors in shaping the effectiveness of patient care during the critical phase of care-coordination and discharge. As such, these insights not only contribute to academic discourse but also hold practical implications for refining collaborative strategies and fostering a more integrated healthcare approach (Forchuk et al., 2020).

In contrast to previous research, this study adopted a dual approach, merging the EST and NPT to understand CMHWs' experiences in patient care-coordination during discharge, as illustrated in Table 5. By merging these frameworks, this study uncovers CMHWs' shared experiences of challenges, like organisational barriers, and offers insights into collaborative patient care-coordination.

These instances of positive deviance highlight how system-level enablers can promote NPT's mechanisms of reflexive monitoring and relational integration, thereby embedding sustainable change in the work practice. The integrated care model aligns with broader health policy directions, including the UK's commitment to community mental health transformation (NHS, 2021c; NICE, 2016), while also responding to

ongoing criticisms regarding fragmented discharge planning processes (PHSO, 2023; HQIP, 2024).

This study's findings shed light on factors influencing CMHWs' personal and professional growth, such as barriers in coordinating patient discharge due to service unavailability of CMHSs that meets patients' needs. The next section focuses on how CMHWs' experiences are influenced by the organisational system and culture.

6.1.3 Experiences of organisational system and culture

Nevertheless, this study also draws attention to macro-level policy failures that cascade into organisational systems, thereby shaping the exosystemic realities of CMHWs. At the exosystem level, CMHWs experiences of care-coordinating patient discharge, the organisational system and culture play a pivotal role, by working collectively to normalise the discharge process, as highlighted by NPT within the EST and as presented previously. The study's findings illustrate how the experiences of CMHWs within the exosystem, organisational systems, and cultural contexts collectively influence their understanding of the challenges encountered in coordinating patient hospital discharge. This alignment is supported by similarities observed between the experiences of CMHWs in the present study and those documented in a study by Russel et al. (2021), underscoring the imperative of collective action in addressing the allocation of organisational and personal resources to effectively manage barriers. The findings of the current study also showed that most participants' negative experiences of care-coordinating patient hospital discharge stemmed from the rigid organisational or institutional system and culture that needed collective action to be addressed (see Chapter 5 and Chapter 6 Table 5). Indeed, several studies reviewed in Chapter 3, (Beckers, 2019; Brenman, 2014; Ion et al., 2017) indicated negative experiences of CMHWs impacting their work under a stringent organisational system which, in turn, negatively affected the care-coordinating hospital discharge. Consistent with the

literature in Chapter 2, the findings of this study indicate that CMHWs' experiences are attributed at the exosystem level and include problems such as inadequate communication, a lack of teamwork amongst MDTs, a lack of community referral services, and inadequate patient accommodations. These issues negatively affect the coordination of hospital discharges. For instance, it leads to delays in the discharge process to deinstitutionalise patients into the community, making it less effective and causing difficulties for both the CMHWs and the patients involved. The issue of patient deinstitutionalisation into CMHSs is still a challenge to CMHWs globally due to points highlighted by WHO (2022), as referred to earlier in Chapter 1. Conversely, some CMHWs within CMHTs reported positive experiences attributed to collaboration with other teams and colleagues within the organisation, fostering a collective action approach in effectively coordinating the discharge of patients from hospitals to the community setting.

Moreover, one consultant psychiatrist spoke about their experience in the current study and highlighted the importance of collective action in promoting a community mental health integrated care model. The participant alluded that this promotes a quicker and easier transition of patients to other mental health services and other healthcare professionals like GPs. Such views are supported by other studies for example, Ion et al. (2017), which highlights the role of integrated care in promoting continuity of patient care, and recent research by Goh et al. (2022) that highlights the importance of collective action through intersectoral communication and organisational support. In the context of the experiences of CMHWs examined within CMHTs in this current study, facilitating the deinstitutionalisation and treatment of patients at home is essential as they strive to normalise. This approach of a community mental health integrated care model serves as a pivotal strategy in enhancing the organisational system and culture of CMHWs, addressing historical challenges discussed in Chapter 1 and acting as a key mechanism to overcome barriers to patient discharge. It is crucial

to acknowledge that the applicability of this approach varies globally and locally, influenced by socioeconomic factors and policies related to community mental health. By enabling shorter hospital admission stays for stable patients who are suitable for home-based treatment, it not only contributes to the reduction of organisational hospital bed costs but also ensures a seamless and uninterrupted continuation of the care coordination process. This current study reveals that experiences and challenges faced by CMHWs extend beyond their control. Participants frequently attributed service fragmentation and CMHS closures to government-led austerity measures, reflecting similar concerns raised by Priebe et al. (2012). The current national context, as reported by the British Medical Association (2024) and Hodge & Raymond (2023), is marked by workforce shortages, budget constraints, and increasing service demands all of which exacerbate the pressures faced by CMHWs on the ground. Recent reports emphasise the urgent need for healthcare system transformation to address long waiting lists and improve patient outcomes (BMA, 2024; Ham, 2023). Timely care-coordination provision could mitigate relapses within the first few weeks of hospital discharge and reduce strain on healthcare facilities (HQIP, 2024; National Health Service, 2019b). Despite existing guidelines, such as NICE Guidance 2016, effective discharge coordination remains problematic, hindering patient transitions (NHS, 2021c; NICE, 2016; PHSO, 2023).This current study also uncovers challenges faced by CMHWs in supporting vulnerable populations, such as those experiencing self-neglect or homelessness, that aligns with previous research (Caplan et al., 2018; Hanafiah & Van Bortel, 2015; Li et al., 2022;Martinez et al., 2017; Priebe et al., 2012). CMHWs in this study reported struggling with heavy caseloads and complex cases, echoing concerns raised by von Hippel et al. (2019). Aligning with Department of Health recommendations (DOH, 2011b), the study emphasises holistic patient care, the importance of integrating mental health into primary care, and of enhancing public awareness. Moreover, it highlights challenges in diagnosing and treating patients,

particularly those unfamiliar with mental health services, aligning with previous findings (Forchuk et al., 2020; Priebe et al., 2012). Access to patient records poses a significant challenge, hindering continuity of care (WHO, 2022).

Furthermore, the care coordination of patients with a diagnosis of mental health conditions remains a challenge, particularly when dealing with hospital discharge processes into the community regarding their healthcare, accommodation, and social requirements (Searby et al. 2025). Recent research highlights the effectiveness of community mental health integrated care models, such as neighbourhood-based community mental health care (Obegu et al. 2025). These models have demonstrated significant reductions in emergency department attendance, as well as notable improvements in recovery and behavioural health outcomes among patients with complex mental health conditions. However, systemic disintegration continues to hinder progress, especially across the NHS community mental health service and collaborations with local authorities and voluntary sector organisations calling for major reforms (Department of Health and Social Care, Prime Minister's Office, 10 Downing Street, Starmer, & Streeting, 2025). Despite increasing recognition of the need for community mental health treatment and integration reforms, many patients report insufficient support due to provider turnover, stigma and discrimination, and lack of community and centralised mental health services that are easily accessible (Isaac et al. 2025). Moreover, the findings of William et al. (2025) underscore the significance of manageable caseloads for care coordinators, and appropriate antipsychotic medication use was associated with decreased patient relapse risk, whereas physical health initiatives helped lower mortality rates. Additionally, incorporating psychological therapies with medication seemed to improve recovery results, emphasising the importance of a holistic, multi-disciplinary approach for supporting individuals with complex mental health conditions. Furthermore, voluntary organisations often chosen by racially marginalised patient groups remain disconnected from NHS community

mental health services, worsening inequities in community mental health access (Ejegi-Memeh, et al 2025). This study's findings are consistent with those of McSherry, et al (2025), which suggests that while integrated community mental health models demonstrate potential, their success depends on a sustained, inclusive, multidisciplinary trust, organisational system, and culture. Inclusive work practices and structural changes that emphasise equity, while engaging various community stakeholders, are crucial for developing a more sustainable and comprehensive approach to mental health within the community (Castillo et al, 2019).

In summary, the organisational system and culture in which CMHWs operate serve as both a constraint and an enabler in the discharge coordination process. By applying a dual lens of EST and NPT, this study illuminates how exosystemic organisational dynamics intersect with professional practices to shape the efficacy of discharge planning as illustrated in Table 5. The findings underscore the importance of fostering organisational cultures that prioritise collaborative working among CMHTs, resource equity, and structural adaptability. This offers valuable insights for future policy development, workforce planning, and systemic reform to improve the quality and sustainability of community mental health services. The next section explores how these exosystemic and organisational experiences influence CMHWs' personal and professional growth within the microsystem. The next section delves into CMHWs' subjective experiences and professional growth within the microsystem.

6.1.4 CMHWs' personal experiences of professional growth

The personal experiences and professional growth of CMHWs during care coordination involve reflective action on a microsystem, emphasising an understanding of their experiences within the NPT and the broader context of the EST to normalise the discharge process (May & Finch, 2009) as presented earlier. Within the microsystem level of EST, which encompasses the CMHWs' immediate work environments and

interpersonal relationships, individuals engage in reflective practices and navigate role demands that shape their day-to-day professional identity. The embedding of NPT with EST can enhance our understanding of this research's findings, thereby providing valuable insights into CMHWs' reflective action, personal experiences, and professional development within the context of existing literature and theory (See Table 5). Exploring CMHWs' experiences through the lens of NPT and EST offers valuable insights into the subjective experiences and professional development of CMHWs, contributing to a better understanding within the broader context of existing literature and theoretical frameworks. A study conducted by Agyapong (2016) showed that clinical supervision plays a crucial role in supporting staff, particularly by promoting personal reflection and growth. The findings of this study highlight limitations at the microsystem level and acknowledge the emphasis on initiatives such as building teamwork, improving clinical supervision, promoting reflective practices, and establishing mechanisms for personal and professional support of CMHWs. These initiatives are critical to addressing the immediate and interpersonal challenges faced by CMHWs, highlighting the importance of targeted strategies within the microsystem to enhance their wellbeing and effectiveness. While these recommendations aim to improve the quality of care, it is important to recognise potential constraints and areas for further exploration, for example, CMHWs' busy work schedules. Moreover, studies conducted by Beckers (2019) and Caplan et al. (2018) highlighted participants' experiences of lack of knowledge in particular areas, including knowledge on types of medications patients had been prescribed. These studies report a lack of knowledge among CMHWs, particularly regarding pharmacological aspects of care, indicating a need for ongoing professional development embedded in daily practice. This current study confirms that while CMHWs demonstrated motivation to enhance their skills, competing clinical demands and under-resourced systems created significant barriers to engaging with training opportunities. These limitations directly impact NPT's

coherence and cognitive participation dimensions, where practitioners struggle to make sense of, and invest in, new working models amid structural constraints (see Table 5). Both personal and professional development was needed, the studies concluded. In this study, CMHWs' experiences revealed time constraints to be a notable impediment to their active engagement in professional development initiatives aimed at updating knowledge and refining skills.

This study underscores the significance of professional development through training, with managers playing a crucial role in educating CMHWs on care-coordination and patient referrals, highlighting the importance of collaborative efforts and individual experiences in enhancing patient care during discharge coordination (Li et al., 2022; Russell et al., 2021). Despite the scarcity of qualitative studies specifically focusing on CMHWs' experiences, their reflections offer valuable insights, especially amidst challenges posed by the COVID-19 pandemic (Goh et al., 2022; Liberati et al., 2021). However, some workers also reported deriving a sense of purpose and resilience from their work, suggesting the presence of adaptive coping mechanisms and intrinsic motivation. CMHWs' experiences encompass both positive and negative aspects, ranging from emotional fulfilment to frustrations due to inadequate mental health services and vicarious trauma (Forchuk et al., 2020; Jimenez et al., 2021).

This current study illuminates the significance of personal experiences and growth among CMHWs, emphasising the necessity of training for professional development. Managers play a crucial role in imparting skills, such as coordinating referrals and gatekeeping, enhancing collaborative efforts and patient care during discharge coordination (Li et al., 2022). Existing literature often focuses on patients' experiences, revealing barriers to accessing mental health services and issues of stigma (Caplan et al., 2018). However, there is a scarcity of qualitative studies specifically exploring CMHWs' experiences, especially in the context of the COVID-19 pandemic (Liberati et

al., 2021).During the pandemic, CMHWs faced emotional challenges, struggling to provide care and make referrals amidst the global healthcare crises (Goh et al., 2022). It has been reported that some CMHWs may even fail to recognise their own trauma experiences due to the nature of their job, leading to vicarious trauma (Murphy et al., 2018; Nyassi et al., 2023). Despite these challenges, positive experiences emerged, with CMHWs finding fulfilment in contributing to patient recovery and displaying resilience (Forchuk et al., 2020; Goscha & Rapp, 2015). Online training during the pandemic was delivered conveniently and efficiently, mitigating challenges of face-to-face workshops (Goh et al., 2022). From an EST perspective, these findings highlight how mesosystem elements such as interactions between supervision, peer networks, and managerial oversight can mediate the stressors in CMHWs' microsystems and either support or hinder growth. However, this study's findings show that negative experiences persist, including frustrations with inadequate mental health services, such as shortage of staff, emotional exhaustion, and vicarious trauma from distressing encounters from patients sharing their traumatic experiences as presented in Section 5.7. Such experiences, coupled with burnout, have implications for patient care and the wellbeing of CMHWs (Petrie, 2021; Russell et al., 2021). The study underscores the need for operationalised strategies, such as health-oriented leadership interventions and assigning consultant psychiatrists to each team to support CMHWs (Forchuk et al., 2020; Murphy et al., 2018).Organisational changes are imperative to improve care-coordination, aligning with WHO recommendations and the UK Long Term Plan's call to enhance mental health services in the NHS (NHS, 2019b, 2019c, 2021a, 2022; WHO, 2018). Nonetheless, this study shows that care-coordination of patient hospital discharge is lacking when compared to other countries, highlighting the pressing need for change (see Chapter 2, Table 2). The UK National Health Service has outlined the UK Long Term Plan to improve the health service in order to address these issues (NHS, 2021a; 2022). In line with EST, these systemic interventions must

be understood within the macrosystem, acknowledging how socio-political and institutional contexts shape the local conditions of care. Simultaneously, NPT's emphasis on embedding and sustaining change through collective sense-making and action provides a useful lens for evaluating how such reforms could be normalised within work practice (see Table 5). In this context, findings from this study, as shared by participants, provide valuable insights into the challenges experienced by CMHWs and contribute to a conceptual framework that helps bridge gaps in the existing literature.

In summary, exploring themes identified through reflective thematic analysis uncovered analytical tensions in interpreting CMHWs' experiences. Yet, integrating EST and NPT frameworks facilitated an in-depth understanding of the phenomenon. At the micro level, CMHWs derive meaning, purpose, and development through reflection and relational work, yet remain constrained by structural and institutional factors across exosystemic and macrosystemic levels as illustrated in Table 5. These findings suggests that effective care-coordination cannot be achieved solely through individual effort but requires supportive systems, adequate supervision, and sustained investment in professional development. Addressing these challenges will not only improve the well-being of CMHWs but also enhance the continuity and quality of care for patients with a diagnosis of a mental health condition transitioning from hospital to community mental health services.

This study emphasises the importance of personal experiences and growth among CMHWs, acknowledging both the challenges and positive aspects of their roles. In addition, training, support systems, and organisational changes are essential to enhance patient care and CMHWs' wellbeing. By addressing systemic barriers and leveraging individual experiences, healthcare systems can strive towards more

effective care-coordination and improved outcomes for patients transitioning into the community.

6.2.1 Contextualisation of the study with existing evidence, theory, and policies

Despite the alignment of this study's findings with existing literature, theory, and policies in the field of community mental health and patient hospital discharge, my research has shown that challenges persist in care-coordination of patient hospital discharge of patients with a diagnosis of mental health condition into community mental health services. Li et al. (2022) emphasised the importance of collaboration and community-based care in mental health services, a theme echoed in this current study's findings on collaborative working. However, existing challenges in the implementation of collaborative practices, such as interprofessional communication breakdowns and role ambiguities, persist in mental health care systems globally (Petrie et al., 2021). This current study's findings show the need to move beyond the acknowledgement of collaborative working demonstrated by practical barriers that hinder its effective implementation, informing targeted interventions and policy changes both at local and national level as previously discussed in Chapter 1. Additionally, this study's findings align with the recent report by the British Medical Association (2023) underscoring the importance of organisational support in mitigating resource constraints within community mental health settings to facilitate efficient patient hospital discharge. Nevertheless, challenges in resource allocation, staff shortages, long patient waiting lists and systemic issues in healthcare organisations are still prevalent, affecting the provision of best care-coordination during patient discharge (Russell et al., 2021). In this current study, findings have revealed that these challenges cause more profound systemic barriers that hinder organisational support and resource allocation, which requires local Trust policy revisions and practical

interventions that promote efficient care-coordination of patient hospital discharge, resulting in both job satisfaction and better patient outcomes.

The urgency of mental health reform that addresses strategies to alleviate prolonged waiting lists for both CMHSs and patients has been highlighted not only in the current study's findings but also echoed by a Labour Member of Parliament during a UK House of Commons debate held on October 2023 (Khan, 2023). The parliamentarian emphasised that, in England alone, over 1.8 million people (approximately 2.65% of the population) are on National Health Service (NHS) waiting lists, underscoring the imperative for a comprehensive investigation into the systemic obstacles hindering organisational assistance and resource allocation to CMHSs (Khan, 2023). This in-depth exploration will offer essential insights for revising policies and implementing practical interventions aimed at enhancing the efficiency of care-coordination during patient hospital discharge, thereby fostering job satisfaction, and improving patient outcomes.

Furthermore, Agyapong et al. (2016) emphasised the importance of collaboration and community-based care in mental health services, which resonates with the current study findings on collaborative working. Beckers et al. (2019) in the UK underscored the significance of organisational support and resources in effective hospital discharge, aligning with this current study findings on organisational systems and culture. Moreover, the current study findings support the UK Guidance on hospital discharge and community support, as outlined by the NHS (National Health Service, 2021) and the House of Commons Health and Social Care Committee (House of Commons Health and Social Care, 2019) who suggests the need for more comprehensive strategies to support CMHWs in their roles and improvement of mental health delivery.

Moreover, policy recommendations should emphasise the importance of promoting high-quality care-coordination of patients with a diagnosis of amental condition,

through fostering collaborative efforts with various organisations such as Community Mental Health Integrated Services, Primary Care General Practices, Voluntary Sectors, and Social Services (BMA, 2024). Specifically, there is a need for reviewing how NHS policies address current gaps and advocating for enhanced coordination in the care of patients during hospital discharge into CMHISs, emphasising collaboration with organisations such as Social Services (Department of Health, 2022; Ham, 2023).

This current study contributes to a wider evidence base beyond the literature review. The way my study connects from an ontological and epistemological perspective is by giving a deeper understanding of multiple realities of CMHWs when they help care coordinate patient hospital discharge as discussed earlier. In addition, the ecological system theory and normalisation process theory lens are used in this study to shed light on our understanding of CMHWs' experiences of care-coordination during patient hospital discharge. These findings are consistent with those of Li et al. (2022), highlighting the importance of addressing various challenges faced by CMHWs to improve the quality of care for patients in community settings, and emphasising the need for mental health organisations to support CMHWs in overcoming these obstacles and fostering their professional development to enhance the delivery of CMHS. For example, this study highlights how CMHWs' experiences play a crucial role in working together to overcome barriers and support positive factors, setting the groundwork for better care coordination of patient discharge from the hospital into the community.

Most importantly, the findings of this research unveiled numerous surprising insights regarding CMHWs' experiences of care coordination, patient hospital discharge, and their reactions to systemic challenges. Interestingly, in this study, a few CMHWs showed little worry regarding the challenges they encountered, instead finding a sense of satisfaction in witnessing the patient recovering. This implies that intrinsic motivation and personal values might be more crucial for maintaining professional engagement

than external factors by themselves. This resilience was especially apparent in those CMHWs who maintained care during the COVID-19 pandemic and in limited-resource settings, demonstrating the ability of individuals to adjust and endure in challenging circumstances. These experiences correspond with EST, which suggests that individuals are affected by various levels of environmental context; in this case, the microsystem of patient interaction seemed to mitigate the stressors found in micro to macro-system levels, like institutional constraints. Communication surfaced as a dual theme, disjointed in certain cases, but effective in others via teamwork, highlighting the fluid character of interpersonal and organisational dynamics (see Table 5). This variability aligns with NPT, which highlights the significance of collaborative effort and consistency in integrating practices into community mental environments. Moreover, recognising traditional beliefs as an obstacle to care in a particular African study highlights the impact of cultural norms in the macrosystem, emphasising the importance of culturally sensitive strategies (Nyassi et al 2022). Together, these findings question the belief in a consistent effect of systemic obstacles and emphasise the intricate relationship between personal level, societal structures, and cultural factors.

6.2.3 Summary

This chapter has discussed the following themes: collaborative working, barriers and facilitators, organisational system and culture, personal experiences and professional growth. Despite the recognition of the importance of the role of CMHWs in care-coordination of the patient discharge process, they continue to experience many challenges that include communication barriers among healthcare professionals and inadequate resource allocation. This section has focused on the relation of the study to the wider evidence base and positioning its findings to care-coordinating patient hospital discharge by CMHWs. These themes have been discussed through the lenses

of the NPT and EST to provide an understanding of this study's findings. To my knowledge this is the first study to embed NPT in EST, thus making a substantial contribution to the body of knowledge in this area. Additionally, by integrating the NPT into the EST, this study helps to provide a deep understanding of the dynamic interaction between the ecological factors affecting CMHWs' practice and the implementation of work processes. This theoretical framework not only integrates the study's results with established evidence but also enhances the credibility and depth of the analysis by helping to explain certain relationships within a phenomenon being studied. Additionally, the study's adherence to rigorous methodological standards and trustworthiness further supports the authenticity of its interpretations and conclusions. The subsequent sections now present the conclusions of the entire thesis.

6.3 Conclusions of the entire thesis

This study set out to explore experiences of community mental health workers (CMHWs) in care-coordinating patient hospital discharge into community mental health integrated services (CMHISs). I now conclude this thesis by presenting strengths and limitations of the study, methodological contribution and theory, contribution to knowledge, implications for clinical practice and education, recommendations for future studies, and my reflexivity in this study.

6.3.1 Strengths and limitations of the current study

It is important to acknowledge both the strengths and limitations of this study. First, this study's qualitative aspect allowed for gathering of rich data that reflects the complex and detailed experiences of CMHWs. The strength of this study lies in the application of ecological systems theory (EST) and normalisation process theory (NPT) as theoretical frameworks that provide an additional theoretical perspective for

understanding the ecological factors and implementation of normalisation processes that can influence CMHWs in achieving better patient discharge as illustrated in Table 5. This integration of two theories allows for a more thorough exploration that connects individual, organisational, and systemic elements, provides a deeper understanding of care coordination issues, and helps develop more targeted support strategies.

Despite these strengths, this constructivist inquiry study has its own study limitations. The study's location in one NHS Trust and limited small sample size may limit the transferability of findings to diverse regions or contexts (Squires & Dorsen, 2018; Vasileiou et al., 2018). The overrepresentation of certain demographic groups, such as female and White British participants, introduces potential subjectivity that may affect the study's applicability to a more diverse population (see Table 3 in Chapter 5). For instance, in this case, most of the participants were White females, which may not represent the varied experiences of Community Mental Health workers, disregarding the difficulties encountered by their White male counterparts and individuals from ethnic minority groups. The shift to online interviews due to the COVID-19 pandemic may have impacted data collection by potentially overlooking nonverbal cues present in face-to-face interactions (Carter et al., 2021; de Villiers et al., 2021; Lupton, 2020). Recruitment challenges persisted, with the recruitment period extended to 30th June 2022. Despite these constraints, the study's findings provide valuable insights into the complexities of CMHWs' roles, enriching our understanding of community mental health care-coordination. A further limitation of this current study includes my insider positionality and influence, which may have caused insider researcher positionality. Nevertheless, this issue was mitigated through ongoing reflexivity practices, as discussed earlier. Despite these limitations, the study's findings offer valuable insights into the challenges and experiences of CMHWs in coordinating patient discharge, contributing to our understanding of community mental health care-coordination.

6.3.2 Methodological contributions and theoretical framework

This current study employed a qualitative constructivist methodology (Manning, 1997) to explore community mental health workers' (CMHWs) experiences coordinating patient discharge. Focusing on CMHWs' experiences, this methodological approach enabled the exploration of how they construct knowledge within their work environment as presented in Chapter 3. This approach facilitated a deeper understanding of the participants' experiences of care-coordinating patient hospital discharge, allowing their voices to reveal the complexities and challenges they face in their roles. Through this process, CMHWs provided rich insights into the dynamics of their work, offering valuable contributions to the broader understanding of care-coordination of patient hospital discharge (Schwandt, 1998). The study's theoretical foundation, underpinned by the NPT and EST, enabled in-depth interpretation of findings (May et al., 2018; Bronfenbrenner, 1979). While EST, as a theoretical lens, provided an in-depth perspective, on its own it lacked the ability to capture detailed accounts for instance, the varied experiences of participants in navigating the systemic barriers to effective care-coordination of patient hospital discharge (Batten & Brackett, 2022). Chapter 1 summarises previous theories and details the application of EST and NPT in previous studies as well as highlighting some of the limitations.

This current study highlights the value of triangulating the literature review with empirical findings and integrating multiple theoretical frameworks for analysing and interpreting these complex perspectives.

In summary, EST embedding NPT offered a dual perspective that enhanced this study's findings and interpretation of community mental health workers' experiences regarding care coordination during patient hospital discharge. EST provided an in-depth understanding of how CMHWs work together, tackle obstacles, and how factors

from personal connections to organisational and policy structures influence their professional growth. For instance, perspectives on how CMHWs and systemic forces shape collaboration were illustrated through ecological levels of influence, whereas perspectives on embedding new practices were enhanced by NPT's emphasis on routine development and CMHWs' work practices. NPT highlighted how CMHWs understood and interacted with change (coherence and cognitive participation), providing essential insight into why specific initiatives were maintained. EST positioned organisational systems and culture as developing within changing environments, whereas NPT elucidated how change agents promoted shared ownership and legitimacy among CMHWs during care coordination of patient hospital discharge. Ultimately, both theories together illuminate how personal experiences was collaboratively shaped by CMHWs through social frameworks and professional development. Without these theories, this research would have overlooked the multi-layered interaction between structure and agency, as well as how change is perceived, implemented, and accepted by CMHWs. The following section provides this study's contribution to knowledge.

6.3.3 Contribution to knowledge

This current study's findings found important gaps in a number of existing research dimensions, highlighting the study's significance in offering fresh perspectives. Significant gaps in the evidence were identified by the literature review, especially with regard to the complex difficulties CMHWs encounter during the patient discharge process an area that is still not well covered in the literature on the subject as discussed in Chapter 2. This current study also filled in knowledge gaps by drawing attention to the paucity of research on the effects of care-coordination on patient hospital transition into community mental health settings. Because previous studies frequently did not offer substantial information on the experiences of CMHWs in the real world, there

were evident empirical gaps that limited the applicability of their findings in useful contexts. There were methodological gaps in the form of a fragmented understanding of care-coordination due to the inadequate application of theoretical frameworks that integrate theoretical and practical approaches.

My contribution to knowledge lies in addressing the dearth of qualitative research on the experiences of CMHWs in coordinating the hospital discharge of patients with mental health conditions into CMHSs. The findings of this study are a significant contribution to understanding the difficulties in coordinating care for patients with a diagnosis of a mental health condition transitioning into the community, given the lack of previous research in this area.

This current study enhances our understanding by focusing on the specific role and experiences of CMHWs, thus providing new insights into the complexities of their work during the discharge process. This contributes to knowledge by offering evidence that can inform better policies and practices to support CMHWs in ensuring smooth transitions for patients from hospital to community mental health services (CMHSs). In addition, this study informs future research and policy by highlighting specific areas where additional support or resources may be needed for CMHWs, thus laying the groundwork for future research to explore these aspects in more depth. Moreover, this study can inform policy decisions aimed at improving the coordination between hospitals and community services, ultimately leading to better patient outcomes.

Furthermore, only 16 research publications were retrieved and, most importantly, all 16 studies highlighted that there is a noticeable scarcity of qualitative literature focusing on community mental health care planning, particularly in an international and local context as illustrated in Table 2, Chapter 2). Against this backdrop, the significance of my study is important, aligning with the NHS's objective (NHS, 2024) as articulated in the Public Health Service Ombudsman PHSO’s Annual Report (2024) to ensure

collaboration with other MDTs in care-coordination of safe patient-centred discharge from mental health services. Exploring the experiences of CMHWs through the lens of the NPT embedded in EST, my research sheds light on this critical aspect of CMHWs' experiences of care-coordinating patient hospital discharge into CMHSs.

This is the first time an in-depth constructivist inquiry has been undertaken utilising normalisation process theory embedded in ecological system theory in this context (see Table 5). Consequently, the study has allowed for the characterisation and illumination of CMHWs' experiences in care-coordination of patient hospital discharge through four key themes: collaborative working; barriers and facilitators; organisational system and culture; and personal experience and professional growth. My research fills this gap by offering an in-depth understanding of their experiences, which will be invaluable for future studies in this field.

In addition, this study builds upon earlier studies by going beyond broad discourse surrounding care-coordination to offer a detailed, practice-oriented exploration of CMHWs' experiences throughout patient hospital discharge, a viewpoint mostly scarce in current literature, as highlighted by Johns et al (2018). It expands on previous studies by combining theoretical and practical methods, providing a deeper insight into the systemic and interpersonal difficulties associated with transitional care. This study highlights the significance of explicit communication channels and defined roles in the transition of patients with a diagnosis of mental conditions from hospital to community mental health care. This information can support in creating standardised referral protocols at the local level and interagency multidisciplinary team working, ensuring timely and suitable transitions for those individuals with mental health conditions. In addition, this research highlights the first-hand experiences of CMHWs, providing diverse evidence that can inform specialised professional development initiatives,

especially concerning care-coordination skills, discharge planning, and multidisciplinary teams working across CMHTs.

Furthermore, this research enhances the current literature by placing the perspectives and practical experiences of CMHWs at the core of the discussion, thereby connecting abstract policy with actual community mental health service delivery. Although earlier research has frequently ignored the subtle operational difficulties encountered by CMHWs, this research enhances our understanding by placing these challenges in the context of care coordinating hospital discharge of patients with a diagnosis of mental into the community. As a result, it can assist in enhancing local policies intended to bolster community-focused mental health services, particularly through guidance on workforce planning, resource distribution, and integrated service frameworks.

In this study, I have highlighted different CMHWs' experiences in coordinating patient hospital discharge, providing valuable insights into their roles and challenges within CMHTs. This current study establishes the groundwork for enhancing community mental health service delivery, staff wellbeing, and patient outcomes in community mental health care by identifying, synthesising, and triangulating the literature reviewed, which can offer fresh perspectives on the experiences of CMHWs from themes that surfaced. This study has several implications which are now discussed.

6.4 Implications

6.4.1 Implications for clinical practice, policy, and education

This study's findings have significant practical implications for clinical practice, policy, and education. First, clinically, the study highlights the need for developing and refining referral pathways for long-term monitoring to prevent relapse and readmission of patients with mental health conditions. Second, policy wise, it underscores the

necessity for integrating these pathways into standard care protocols, promoting a more cohesive and efficient care-coordination and patient-centred discharge process (Alvarez-Rosete et al., 2024). Third, educationally, the study suggests incorporating these insights into training programmes to better prepare CMHWs for effective care-coordination and patient hospital discharge. The findings suggest the need for targeted working practices and policy development supporting seamless care-coordination of patient hospital discharge (Nursing and Midwifery Council [NMC], 2018; WHO, 2022b).

6.4.2 Recommendations for future studies

I strongly recommend further research into the experiences of a diverse population of community mental health workers (CMHWs), patients, and their carers to identify systemic barriers and improve the effectiveness of care-coordination, ultimately leading to better patient outcomes and more effective implementation of patient-centred community-based mental health services. Despite many advances, challenges remain in providing community-based mental health care, particularly with regard to care-coordination and patient engagement. Future efforts should prioritise addressing disparities in the availability of mental health treatment in the community, improving communication and collaboration among mental health professionals, and promoting patient-centred care to improve mental health outcomes, both locally and globally.

Future research should be undertaken to explore the experiences of CMHWs in diverse contexts, especially longitudinal mixed methods studies to assess long-term impacts and explain care-coordination phenomena. Integrating qualitative insights with quantitative data, such research can provide a more comprehensive understanding of the evolving dynamics in care-coordination, thereby informing best practices and policy development in mental health services.

Additionally, research should focus on developing clear guidelines for CMHWs and healthcare organisations to improve care-coordination processes for patients with mental health condition diagnoses and address limitations in community mental health services (PHSO, 2024). The experiences of CMHWs in this study highlight the complex nature of care-coordination for mentally ill patients discharged from hospitals, suggesting that their experiences should inform future research. Recognising the crucial role of CMHWs and extending inpatient psychiatric treatment beyond the hospital setting can improve patients' health outcomes post-discharge (Royal College of Psychiatrists, 2015). Community mental health services should use the defined attributes and empirical findings of this study to develop discharge planning guidelines for CMHWs. Future studies are required to gain an understanding of CMHWs experiences and enhance practices in community mental health services by addressing areas such as person-centred care (Alvarez-Rosete et al., 2024), safety, professionalism, and trust (Nursing Midwifery Council, 2018). Finally, I present my reflexivity and conclusion.

6.5 My final personal reflexivity in this study

Reflexivity is essential in qualitative research, involving continuous self-evaluation of the researcher's positionality and acknowledgement of its potential influence on the research process and outcomes (Berger, 2015; Braun & Clarke, 2023; Hibbert, 2021). Drawing upon my experiences as a community mental health nurse (CMHN) and research nurse (RN), I adopted the insider position to engage with CMHWs, helping easier access and a deeper understanding of their experiences (Berger, 2015; Corlett, 2019). To mitigate subjectivity, measures such as avoiding assumptions, keeping impartiality during interviews, and employing rigorous data collection methods were implemented (Pabel et al., 2021). Additionally, gaining access to conduct the study

within the specific organisation and among CMHWs allowed for a comprehensive exploration of the research phenomenon.

The reflexivity of this research is fundamentally shaped by my subjective experiences and is consistent with my position as a constructivist researcher who recognises the interplay between personal insights and the co-construction of knowledge (Corlett, 2019). My background as a CMHN and RN facilitated trust and rapport with participants, enhancing data collection. Despite challenges in participant recruitment during the COVID-19 pandemic, the shared professional identity fostered trust and encouraged open discussion of challenges.

My prior knowledge and experience enriched data collection and analysis, narrowing the gap between researcher and participant. Sharing my experiences allowed for more in-depth exploration of the study area and motivated probing questions. However, maintaining reflexivity was crucial to mitigate potential researcher subjectivity introduced by my insider position (Yanto & Pandin, 2023).My role as an insider researcher significantly influenced various stages of the study, underscoring the intricate balance between the advantages and challenges associated with insider positionality (Bourke, 2014). The sharing of my professional background with participants not only facilitated rapport and trust but also influenced their expressions and assumptions during data collection. This familiarity with participants' experiences and challenges provided a scaffold for exploring their roles and barriers in care coordination, enriching the depth of inquiry.

Despite the advantages, conducting online interviews during the COVID-19 pandemic presented limitations such as interruptions and the inability to observe nonverbal cues (Carter et al., 2021; Lobe et al., 2020). As an insider researcher, I remained vigilant about my presence and its impact on the conversation, emphasising the uniqueness

of each participant's experience while acknowledging shared backgrounds (Yanto & Pandin, 2023).

My insider status allowed for a flexible and in-depth understanding of participants' subjective lived experiences, influencing the balance between insider and outsider perspectives (Berger, 2015; Yanto & Pandin, 2023). This was coupled with heightened awareness of implicit content from participants lived experiences and dimensions of data collection and management, which facilitated effective probing and interpretation of research findings using a software program (Ritchie et al., 2009).

However, the insider position also posed risks of subjectivity and boundary maintenance, necessitating ongoing reflexivity throughout the research process (Berger, 2015; Braun & Clarke, 2021). Critically reflecting on my position and its implications, I aimed to mitigate subjectivity and ensure the validity of the research findings (Maxwell, 2012). Moreover, my experiences as a community mental health nurse informed the theoretical frameworks of this study, enabling a comprehensive exploration of participants' experiences as presented in Chapter 1 and in Chapter 6. Table 5. While insider status facilitated sensitive conversations, maintaining clarity regarding individual journeys was paramount to preserving the integrity of the research (Kurylo et al., 2016; Yanto & Pandin, 2023). Adopting a reflexive approach as an insider through a reflective journal further enhanced the rigour and validity of the research findings (Crownover, 2016; Howell, 2013).

Finally, the use of a software program such as Atlas.ti in the qualitative data analysis study has notable advantages in data interpretation. This software offers the ability to integrate different types of data such as text and images, which facilitates efficient organisation and retrieval. In addition, it streamlines the coding process, enabling faster identification of coded passages and making it easier to examine relationships between codes. The knowledge I gained through the use of such a qualitative analysis tools is

valuable as it can be applied to future research, improving data management and analysis.

6. Concluding remarks

In conclusion, my research journey has provided valuable insights into the challenges faced by CMHWs in coordinating patient hospital discharge in CMHISs. Sharing research findings at local events and fostering discourse, I aim to influence policy decisions and drive positive change within the CMHISs. This study's findings call for change in working practices signals a pivotal moment in my journey towards improving the professional working environment for CMHWs. My constructivist inquiry study set out to explore the experiences of CMHWs in care-coordinating patient hospital discharge into CMHSs. Based on the themes that I developed, my study has contributed to our understanding of varied experiences of how CMHWs navigate these intricate environments. In addition, my study has revealed that CMHWs experience tensions and challenges, yet also opportunities for growth and resilience. Built on the experiences of CMHWs highlighted in my study, the aforementioned recommendations emphasise the critical need to evaluate existing policies and practices to improve the coordination of patient hospital discharge within CMHTs.

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Appendices

Appendix 1. ENTREQ checklist used in this literature review

Item No.	Guide and Description	Report Location	Page
1. Aim	State the research question the synthesis addresses	Introduction Chapter 2	26
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of: Methodology- Qualitative Evidence Synthesis Approach-. Reflective thematic synthesis,	Methodology of synthesis Chapter 2	26 - 27
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	Study search strategy and process – *SPIDER.* Chapter 2 Figure 2	27-28
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type)	Literature search and selection - *Inclusion criteria* Chapter 2 Table 1	29-30
5. Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, PsycINFO), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources	Study search strategy and process – *Electronic searches & searching other resources.* Chapter 2 Appendix 2 &3	31 186-189
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	Appendices *SPIDER Table of terms and search strategy* Appendix 2, Appendix 3	186-189
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	Study selection – *Figure 3 PRISMA flow diagram* Table 3	31-33
8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data	*Characteristics of included studies*	190-208

	collection, methodology, analysis, research questions)	Appendix 4	
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	Chapter 2 Table 1 Figure 3	31
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings)	Appraisal of the methodological limitations of included studies Appendix 6	29
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: ENTREQ CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting)	Appraisal of the methodological limitations of included studies Modified McMaster Quality Assessment Tool Appendix 6	210- 214
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required	Appraisal of the methodological limitations of included studies Chapter 2	34
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	Appraisal of the methodological limitations of included studies – *Table. McMaster QA Tool* Appendix 6	34 210-214
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software)	Methodology of synthesis – *“all relevant qualitative data”* Appendix 5	190-208
15. Software	State the computer software used if any	Atlas.23 ENDNOTE	34-35

		Chapter 2 Section.2.8 Rayyan Appendices 5,	
16. Number of reviewers	Identify who was involved in coding and analysis	Methodology of synthesis Thomas and Harden's (2008) three stages, thematic analysis Chapter 2. Section 2.12	35
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	Methodology of synthesis thematic analysis Chapter 2 Section 2.12	35
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	Findings Chapter 2 Sections: 2.12-2.16.	35-36
19. Derivation of themes	Process of deriving the themes or constructs was inductive	Inductive process - *Theme Matrix*	35-36
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	Findings - *Quotations and all sources given. Chapter 2. 12 - 2.16*	38 -51
21. Synthesis output	Present rich, compelling, and useful results that go beyond a summary of the primary studies e.g. new interpretation, models of evidence, conceptual models, analytical framework)	Discussion Chapter 2. Section 2.17	51-60

Source: Enhancing transparency in reporting the synthesis of qualitative research:

ENTREQ Checklist (Tong, et al., 2012).

Appendix 2. Search Strategy from 10 databases

Search Strategy from 10 Databases using SPIDER Tool Search Terms and synonyms												
04/11/2022	SPIDER	CINAHL	MEDLINE	PsychINFO	Proquest	EMBASE	Pubmed	Tripro	Scopus	Open Athens	NHS Evidence Knowledge services
1	**S**	(MH "Mental Health") OR (MH "community Health workers") OR (MH "Mental Health Services") OR (MH "Health Personnel") OR (MH "Mental Health Recovery") OR (MH "Health care Sector") OR (MH "Delivery of Health TX "Community mental health workers" OR "Mental health personnel"	(MH "Mental Health") OR (MH "community Health workers") OR (MH "Mental Health Services") OR (MH "Health Personnel") OR (MH "Mental Health Recovery") OR (MH "Health care Sector") OR (MH "Delivery of Health TX "Community mental health workers" OR "Mental health personnel"	(DE "Health personnel") OR (DE "Mental Health personnel") OR "Community Health Mental Workers" OR TX "Community mental health workers" OR TX "Mental health personnel"	N/8 Mental Health OR community Health workers OR Mental Health Services OR Health Personnel OR Mental Health Recovery OR Health care Sector OR Delivery of Health OR Mental health personnel	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"	"Mental Health" OR "community Health workers" OR "Health Personnel" OR "Health care Sector" OR "Delivery of Health*" OR "Community mental health worker*" OR "Mental health personnel"
2	**PI**	(MH "Mental Retardation. X-Linked") OR (MH "Organic Mental Disorders, Substance-induced") OR (MH "Mental Disorders, Chronic") OR (MH "Organic Mental Disorders. psychotic") OR (MH "organic Mental Disorders") OR (MH "Mental Disorders")	(MH "Mental Disorders") OR (MH "Diagnostic and statistical Manual of Mental Disorders") OR (MH "Mentally Ill Persons") OR (MH "substance-Related Disorders") OR (MH "Neurocognitive Disorders") OR (MH " Mentally Commitment of mentally ill")	DE "Mental Disorders" OR DE "Mental Disorders due to General Medical conditions" OR DE "Mental Health" OR TX "Mental illness"	Mental Retardation OR Substance-induced OR Mental Disorders OR Psychotic OR Organic Mental Disorders	"Mental Disorder*" OR "Mentally Ill" OR "substance* Disorder*" OR "Neurocognitive Disorder*"	"Mental Disorder*" OR "Mentally Ill" OR "substance* Disorder*" OR "Neurocognitive Disorder*"	"Mental Disorder*" OR "Mentally Ill" OR "substance* Disorder*" OR "Neurocognitive Disorder*"	"Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	Mental Disorder* OR "Mentally Ill" OR "substance* Disorder*" OR "Neurocognitive Disorder*"	"Mental Disorder*" OR "Mentally Ill" OR "substance* Disorder*" OR "Neurocognitive Disorder*"
	SPIDER	CINAHL	MEDLINE	PsychINFO	Proquest	EMBASE	Pubmed	Tripro	Scopus	Open Athens	Knowledge services

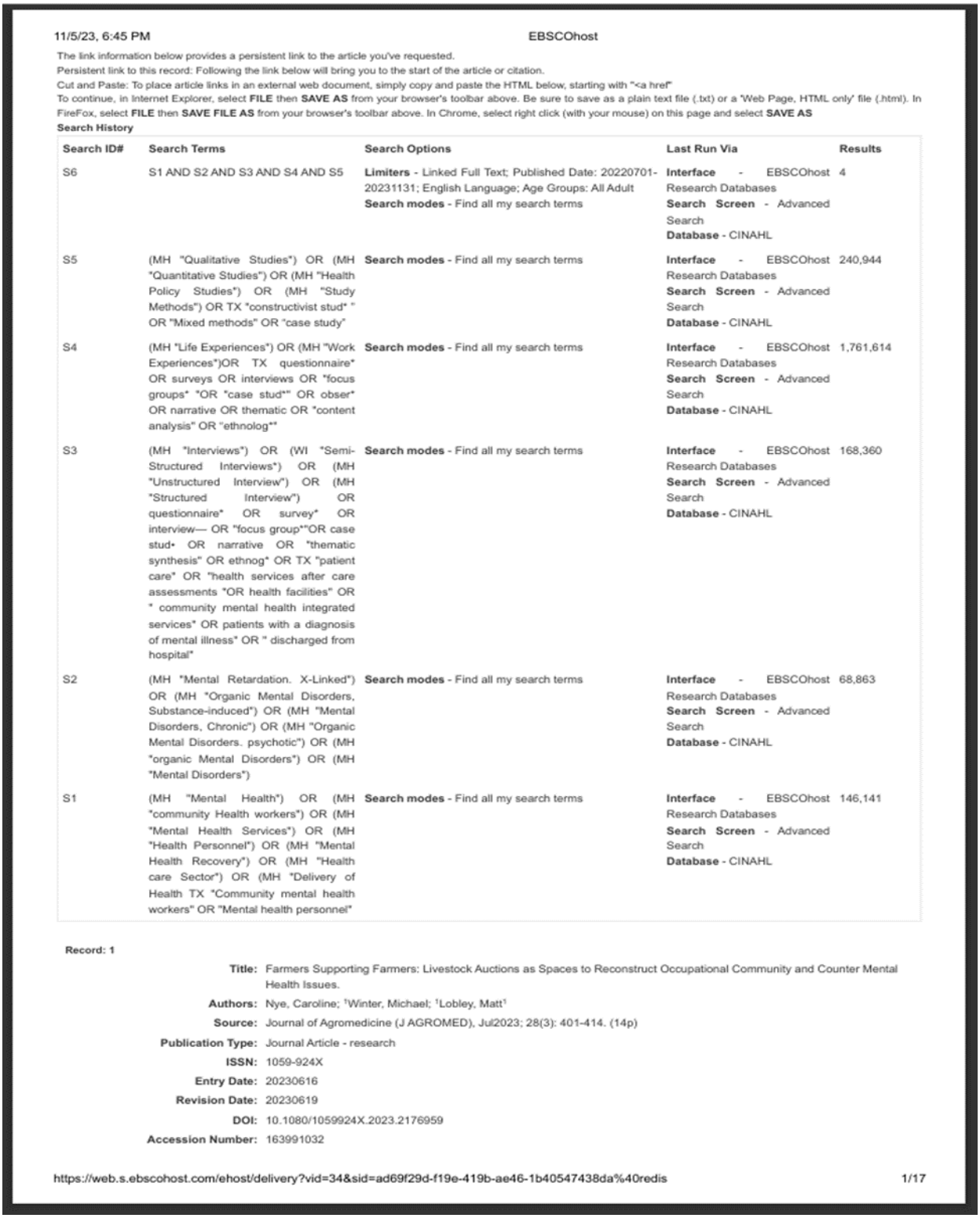
3	**D**	(MH "Interviews") OR (WI "Semi-Structured Interviews*) OR (MH "Unstructured Interview") OR (MH "Structured Interview") OR questionnaire* OR survey* OR interview— OR "focus group*"OR case stud• OR narrative OR "thematic synthesis" OR ethnog* OR TX "patient care" OR "health services after care assessments "OR health facilities" OR " community mental health integrated services" OR patients with a diagnosis of mental illness" OR " discharged from hospital"	(MH "Interviews as Topic") OR (MH "Interview") OR TX "semi-structured interviews" OR "structured interviews" OR questionnaire* OR "surveys" OR interviews* OR "focus group" OR case stud* OR "narratives" OR "thematic synthesis" OR ethnog* OR "after care assessments" OR "health care facilities" OR "community mental health integrated services"	DE "Interviews" OR DE "Data Collection" OR DE "Focus Group Interview" OR DE "semi-structured Interview" OR DE " Interpretative Phenomenological Analysis" OR DE "Narrative Analysis" OR DE "Participant Observation" OR DE "Qualitative Methods" OR DE "Thematic Analysis" OR TX "structured interviews" OR TX questionnaires* OR TX "surveys" OR TX "focus group" OR TX case stud*OR TX "narratives" OR TX "thematic synthesis" OR TX ethnog* OR TX "after care assessments" OR TX "health care facilities" OR TX "community mental health integrated	Interview* OR questionnaire* OR survey* OR focus group* OR case stud* OR narrative* OR thematic synthesis* OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR thematic analysis OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	"Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*
4	**E**	(MH "Life Experiences") OR (MH "Work Experiences")OR TX questionnaire* OR surveys OR interviews OR "focus groups* "OR "case stud*" OR obser* OR narrative OR thematic OR "content analysis" OR "ethnolog*"	TX "Experience" OR experienc* OR "Perception" OR "Experience of working in community mental health integrated services" OR "view' OR "Experience of caring for patient with mental illness in the community"	DE "Life Experiences (Events") OR DE "Experience Level ") OR DE "Knowledge (General)" OR DE Job Experience Level" OR DE "Job Knowledge Lever OR DE "Practice" OR DE "Self- Knowledge•" "Experience" OR experience* OR TX "Perception" OR TX " Experience of working in community mental health integrated services" OR TX "view" OR TX "Experience of care coordinating for patient with mental illness in the community"	"Life Experiences" OR "Work Experiences" OR "questionnaire*" OR "surveys" OR "interviews" OR "focus groups* " OR "case stud*" OR "obser*" OR "narrative" OR thematic OR "content analysis"	("Experience" or experienc* or "Perception" or "Experience of working in community mental health integrated services" or "view'" or "Experience of caring for patient with mental illness in the community").	"experience" OR "perception*" OR "perceiv*" OR "opinion*" OR "attitude*" W/5 ("staff*" OR "nurse*" OR "worker*" OR "doctor*" OR "physician*" OR "hcsw" OR "psychiatrist*") OR "risk assessment*" OR "after care assessment*" OR "integ*" W/5 ("service" OR "ccg" OR "clinical commission" OR "discharg*")	"experience" OR "perception*" OR "perceiv*" OR "opinion*" OR "attitude*" W/5 ("staff*" OR "nurse*" OR "worker*" OR "doctor*" OR "physician*" OR "hcsw" OR "psychiatrist*") OR "risk assessment*" OR "after care assessment*" OR "integ*" W/5 ("service" OR "ccg" OR "clinical commission" OR "discharg*")	"experience" OR "perception*" OR "perceiv*" OR "opinion*" OR "attitude*" W/5 ("staff*" OR "nurse*" OR "worker*" OR "doctor*" OR "physician*" OR "hcsw" OR "psychiatrist*") OR "risk assessment*" OR "after care assessment*" OR "integ*" W/5 ("service" OR "ccg" OR "clinical commission" OR "discharg*")	"experience" OR "perception*" OR "perceiv*" OR "opinion*" OR "attitude*" W/5 ("staff*" OR "nurse*" OR "worker*" OR "doctor*" OR "physician*" OR "hcsw" OR "psychiatrist*") OR "risk assessment*" OR "after care assessment*" OR "integ*" W/5 ("service" OR "ccg" OR "clinical commission" OR "discharg*")	"experience" OR "perception*" OR "perceiv*" OR "opinion*" OR "attitude*" W/5 ("staff*" OR "nurse*" OR "worker*" OR "doctor*" OR "physician*" OR "hcsw" OR "psychiatrist*") OR "risk assessment*" OR "after care assessment*" OR "integ*" W/5 ("service" OR "ccg" OR "clinical commission" OR "discharg*")
	SPIDER	CINAHL	MEDLINE	PsychINFO	Proquest	EMBASE	Pubmed	Tripro	Scopus	Open Athens	NHS Evidence Knowledge services

5	R	(MH "Qualitative Studies") OR (MH "Quantitative Studies") OR (MH "Health Policy Studies") OR (MH "Study Methods") OR TX "constructivist stud*" OR "Mixed methods" OR "case study"	MH "Evaluation Studies as Topic") OR (MH "Qualitative Research") OR (MH "Evaluation studies") OR (MH "Sampling Studies") OR (MH "Longitudinal Studies") OR (MH "Feasibility Studies")OR TX "Quantitative studies" OR "constructivist stud*" OR "Mixed Methods" OR "case study"	DE "Life Experiences (Events") OR DE "Experience Level ") OR DE "Knowledge (General)" OR DE Job Experience Level" OR DE "Job Knowledge Lever OR DE "Practice" OR DE "Self- Knowledge•" "Experience" OR experience* OR TX "Perception" OR TX " Experience of working in community mental health integrated services" OR TX "view" OR TX "Experience of care coordinating for patient with mental illness in the community" DE "Qualitative Methods" OR DE "Quantitative Methods" OR DE" Mixed Methods "OR TX "constructivist stud* "	"Evaluation Stud*" OR "Qualitative Studies" OR "Quantitative Studies" OR " Evaluation stud*" OR "Health Policy Studies" OR "Sampling Stud*" OR "Longitudinal Stud*" OR "Feasibility Stud*" OR "constructivist stud* " OR "Mixed methods" OR " case study"	(Evaluation Stud* or Qualitative or Sampling Stud* or Longitudinal Stud* or Feasibility Stud* or constructivist stud * or Mixed Methods or case study)	"Evaluation Stud*" OR "Qualitative" OR "Evaluation stud*" OR "Sampling Stud*" OR "Longitudinal Stud*" OR "Feasibility Stud*" OR "constructivist stud*" OR "Mixed Methods" OR "case study"	"Evaluation Stud*" OR "Qualitative" OR "Evaluation stud*" OR "Sampling Stud*" OR "Longitudinal Stud*" OR "Feasibility Stud*" OR "constructivist stud*" OR "Mixed Methods" OR " case study"	"Evaluation Stud*" OR "Qualitative" OR "Evaluation stud*" OR "Sampling Stud*" OR "Longitudinal Stud*" OR "Feasibility Stud*" OR "constructivist stud *" OR "Mixed Methods" OR "case study"	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*	Interview*" OR questionnaire* OR "survey*" OR "focus group*" OR "case stud*" OR "narrative*" OR "thematic synthesis" OR ethnog*
	SPIDER	CINAHL	MEDLINE	PsychINFO	Proquest	EMBASE	Pubmed	Tripro	Scopus	Open Athens	NHS Evidence Knowledge services
6		1 AND 2 AND 3 AND 4 AND 5		1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5	1 AND 2 AND 3 AND 4 AND 5
Limiters: Publication by date English language Narrowing by subject age: all adults, full text		Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text	Limiters - Linked Full Text; Published Date: No date – 2022 English Language: Narrowing by subject age: all adults, full text
Number of papers retrieved	Duplicates	29	204	6	484	945	68	5	39	110	45

Electronic database search rerun 24 July to present

Numbeof papers retreived n= 612		4	13	24	405	0	0	11	115	0	40
Duplicates removed n= 576		2	8	5	20	0	0		6	0	
Title Screen n= 576		2	0	0	0	0	0	0	1	0	0
Abstract n= 576		1	0	0	0	0	0	0	1	0	0
Full Text n=2		1	0	0	0	0	0	0	1	0	0

Appendix 3. Example of a literature search strategy



11/5/23, 6:45 PM EBSCOhost

The link information below provides a persistent link to the article you've requested.
Persistent link to this record: Following the link below will bring you to the start of the article or citation.
Cut and Paste: To place article links in an external web document, simply copy and paste the HTML below, starting with "<a href"
To continue, in Internet Explorer, select **FILE** then **SAVE AS** from your browser's toolbar above. Be sure to save as a plain text file (.txt) or a 'Web Page, HTML only' file (.html). In FireFox, select **FILE** then **SAVE FILE AS** from your browser's toolbar above. In Chrome, select right click (with your mouse) on this page and select **SAVE AS**

Search History

Search ID#	Search Terms	Search Options	Last Run Via	Results
S6	S1 AND S2 AND S3 AND S4 AND S5	**Limiters** - Linked Full Text; Published Date: 20220701-20231131; English Language; Age Groups: All Adult **Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	4
S5	(MH "Qualitative Studies") OR (MH "Quantitative Studies") OR (MH "Health Policy Studies") OR (MH "Study Methods") OR TX "constructivist stud* " OR "Mixed methods" OR "case study"	**Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	240,944
S4	(MH "Life Experiences") OR (MH "Work Experiences")OR TX questionnaire* OR surveys OR interviews OR "focus groups" "OR "case stud*" OR obser* OR narrative OR thematic OR "content analysis" OR "ethnolog*"	**Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	1,761,614
S3	(MH "Interviews") OR (WI "Semi-Structured Interviews") OR (MH "Unstructured Interview") OR (MH "Structured Interview") OR questionnaire* OR survey* OR interview— OR "focus group*"OR case stud* OR narrative OR "thematic synthesis" OR ethnog* OR TX "patient care" OR "health services after care assessments "OR health facilities" OR " community mental health integrated services" OR patients with a diagnosis of mental illness" OR " discharged from hospital"	**Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	168,360
S2	(MH "Mental Retardation. X-Linked") OR (MH "Organic Mental Disorders, Substance-induced") OR (MH "Mental Disorders, Chronic") OR (MH "Organic Mental Disorders. psychotic") OR (MH "organic Mental Disorders") OR (MH "Mental Disorders")	**Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	68,863
S1	(MH "Mental Health") OR (MH "community Health workers") OR (MH "Mental Health Services") OR (MH "Health Personnel") OR (MH "Mental Health Recovery") OR (MH "Health care Sector") OR (MH "Delivery of Health TX "Community mental health workers" OR "Mental health personnel"	**Search modes** - Find all my search terms	**Interface** - EBSCOhost Research Databases **Search Screen** - Advanced Search **Database** - CINAHL	146,141

Record: 1

Title: Farmers Supporting Farmers: Livestock Auctions as Spaces to Reconstruct Occupational Community and Counter Mental Health Issues.

Authors: Nye, Caroline; [1]Winter, Michael; [1]Lobley, Matt[1]

Source: Journal of Agromedicine (J AGROMED), Jul2023; 28(3): 401-414. (14p)

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Accession Number: 163991032

https://web.s.ebscohost.com/ehost/delivery?vid=34&sid=ad69f29d-f19e-419b-ae46-1b40547438da%40redis 1/17

Appendix 4. Summary of characteristics of 16 studies included for literature review.

Author/ Year	Country / Setting	Research Aim/objectives	Methodology/ Method of Data collection / Data analysis	Sample characteristics of CMHWs	Findings/ Themes	Strengths/ Limitations	Clinical Implications
Agyapong et al., (2016)	Ghana, Community Mental Health Team in Eastern Region of Ghana	Aim: To examine the perceptions of psychiatrists and health policy directors about the policy to expand mental health care delivery in Ghana through a system of task-shifting from psychiatrists to CMHWs (CMHWs). Objectives: The study did not state the objectives	Mixed Method. Cross Sectional Survey Semi-structured Questionnaires interviews Likert Scales Quantitative data were analysed using descriptive statistics using SPSS version 20. Qualitative data were analysed thematically.	11 psychiatrists and 29 health policy directors	The study showed that 23 (79.3%) of health policy directors were aware of the Government of Ghana's policy to improve mental health through task-shifting, while only half of psychiatrists and 9(31%) of health policy directors perceived some professional resistance to the policy.	Strengths: -Provided an analysis of task shifting for mental health delivery in Ghana -Identified advantages and gaps in service provision -Highlighted reasons for task shifting Limitations: -Limited sample size of policy directors -Non-representative sample of policy directors from 27 out of 216 districts in the Eastern Region -Lack of validated instruments -Small sample size of psychiatrists	This study found that task-shifting arrangements in Ghana's mental health delivery systems is a promising approach for addressing the shortage of mental health professionals. To ensure quality standards, it is important to monitor and assess task-shifting arrangements, as well as provide appropriate training and supervision.

Beckers et al., (2019)	Netherlands: Community Mental Health Team	Aim: To explore the effects of the referral of patients with SMI from a CMHT to primary healthcare by collecting the experiences of these patients and the experiences of their healthcare professionals. Objectives: No objectives reported	Mixed Method Qualitative & Quantitative methodology Software was not described	Sample of N= 6 healthcare professionals (CMHN's, general practitioners and the consulting psychiatrist) and with a sample of (N = 32) patients.	The study found that 84% of participants had retained primary healthcare access after 12 months, yet the focus groups revealed the referral process was often unsuccessful due to excessive reliance on particular mental health professionals and time constraints limiting adequate support.	Strengths: - Mixed-methods design provides insight into the experiences of both patients and mental health care providers - Allows exploration of which patients may benefit from referral from a CMHT to primary healthcare Limitations: - Small sample size, conducted within the catchment area of one specialized mental health service with only three GPs.	This study suggests that reducing the intensity of care can lead to improved outcomes and reduced burden of care for patients. It provides insight for clinical practice and policy decisions making. suggesting that reducing intensity

Author/ Year	Country / Setting	Research Aim/objectives	Methodology/ Method of Data collection / Data analysis	Sample characteristics	Findings/ Themes	Strengths/ Limitations	Clinical Implications
Brenman, (2014)	Nepal, Community, and health facility levels	Aims: 1. To inform the development of this comprehensive care plan by investigating the perceptions of stakeholders at different levels of the care system in the district of Chitwan in southern Nepal: health professionals, lay workers and community members. 2.to identify barriers and potential solutions for reaching	Qualitative formative study Thematic Analysis by Braun & Clarke (2006) QSR Nvivo 9.0 software.	(83 participants in 9 groups)	Research findings identified five main themes surrounding the barriers to providing mental health care: systems-level barriers, provider-level barriers, patient-level barriers, public health issues associated with mental illness,	Strengths: - Use of interviews to identify and understand challenges faced by CMHWs - Data-saturation approach to ensure all relevant data is gathered Limitations: - Findings may not be transferable to other geographical locations	This study highlights the potential of TDM collective inter-professional approaches to reduce hospital readmissions and facilitate smoother transitions to community integration. Clinicians should consider using these approaches in their practice, collaborating with peer supporters, and

		people with priority mental disorders. Objectives: Not reported			and potential solutions. Solutions include increased funding, improved access to medications and services, better coordination of care.	- On-site interviews not possible due to COVID-19 pandemic - Non-verbal cues of CMHWs might have been missed due to camera positioning and clarity - Study limited to CMHWs' experiences	coordinating care between health professionals.
Caplan et al., (2018)	Dominican Republican, Five different regions of the Dominican Republic (DR)	Aims (1) To examine existing mental health care services in the DR and how they have evolved from the WHO-AIMS country-wide assessment, which used data from 2005; (2) To identify barriers to treatment and mental health services delivery for persons with persistent mental illness; and (3) To explore potential strategies to improve mental health services delivery Objectives: Not reported	Mixed Method Purposively sampling/ Five focus groups were used/ seven semi-structured interviews in Spanish and translated into English Thematic Analysis by Braun & Clarke (2006) Software not stated.	37 health care workers	The research identified five main themes in regard to mental health care: (1) systems-level barriers; (2) provider-level barriers; (3) patient-level barriers; (4) major public health issues associated with mental illness; and (5) potential solutions.	Strengths: • This study provides an underrepresented perspective of nursing in Dominican Republic health services research. • It provides key informants with information on the current state of mental health services. Limitations: • It cannot fully explore differences in perceptions among health care providers	This study suggests that reducing the intensity of care can lead to improved outcomes, reduced burden of care, and cost savings. Clinicians should consider individual patient needs when determining the intensity of care, to achieve better outcomes.

						by region or training level. • Some focus groups did not include nurses, which limits the information gathered.	

Author/ Year	Country / Setting	Research Aim/objectives	Methodology/ Method of Data collection / Data analysis	Sample characteristics	Findings/ Themes	Strengths/ Limitations	Clinical Implications
Forchuk et al., (2020)	Canada: Province of Ontario Primary Care and Community Mental Health	Aim: To examine the effectiveness and sustainability of implementing the transitional discharge model (TDM) Objectives: Not reported	Mixed-method design Qualitative and quantitative methodology; Ethnography study using by Leininger (1985); Focus groups. Software not described	216 health professionals across nine hospitals in Ontario. These hospitals included 14 psychiatric units, of which, half were acute care units and half were tertiary care units.	The research found that the TDM collective inter-professional approach had the potential to reduce hospital readmissions, improve patient outcomes, increase patient satisfaction, and save hospitals money. It facilitated collaboration between health professionals, peer supporters, and clients, providing an opportunity for healthcare professionals to share their knowledge and expertise, and was cost-effective.	Strengths: • High sample size and number of participating hospitals • Data collected at two-time points using two focus groups involving 216 health professionals in nine locations in Ontario • Two-year duration of the study • Study involved hospital staff with a wide mixture of expertise and experienced participants • Limitations include may not represent the most hard-to-reach group, results may not be	This study suggests that a team-based approach with mental health professionals and other stakeholders, as well as a TDM approach, can help clients with psychiatric illness transition to the community. Regular communication and engagement are recommended to build a strong relationship between the client and the service provider, and ongoing support should be provided to ensure they have access to the necessary resources.

						applicable across all Ontario hospitals and health systems, and reliance on self-reported data subject to recall bias and other sources of measurement error.	
Goh et al., (2022)	Singapore: Community Mental Health	Aim To explore experiences and challenges faced by CMHWs when providing care to people with mental health conditions Objectives: Not reported	A qualitative descriptive study Purposive sampling; In-depth interview; Thematic analysis Software is not described	18 participants; 13 females and 5 males.	Three themes emerged. 1. The need for supportive partners due to institutional and legal challenges. 2. The need for a supportive organisation. 3. The necessity of advanced training to contribute to professional growth.	Strengths: Interviews used to identify and understand challenges faced by CMHWs in Singapore; data-saturation approach used to gather all relevant data exhaustively. Limitations: Findings may not be transferable to other locations; COVID-19	This study suggests better communication and coordination between hospitals and community-based mental healthcare organisations, with a contact person in the hospital to bridge the gap. More support and resources for CMHWs and research into their experiences is needed.

						pandemic precluded on-site interviews and only allowed use of video conferencing.	
Author/ Year	**Country / Setting**	**Research Aim/Objectives**	**Methodology/Method of Data collection**	**Sample characteristics**	**Findings/ Themes**	**Strengths/ Limitations**	**Clinical Implications**
Goscha & Rapp, (2015)	USA: Community Mental Health Centre in North-eastern Kansas	Aim: explored a newly introduced model of shared decision making (Common Ground) and how psychiatric medications were experienced by clients, prescribers, case managers, and peer support staff Objectives: Not reported	Qualitative methodology: A constructivist or naturalistic inquiry. Grounded theory building: All data was unitised and coded and each unit of data was compared using the constant-comparative method to identify relevant categories, subcategories, and themes (Lincoln and Guba 1985; Software ATLAS.ti	12participants; clients, prescribers, case managers, and peer support staff	The study results showed five notable differences were found between the two groups including the presence of a goal, use of personal medicine, and the behaviour of case managers and prescribers	Strengths - Constructivist inquiry developed a characteristic body of knowledge - Possibility of transferability Limitations: - Limited to one particular mental health centre - Results may not be generalizable beyond this group of professionals and clients	Case managers should help consumers identify personal medicine and power statements, follow-up on clinic results, provide educational materials, engage in open conversations, involve consumers in decision-making, provide monitoring and support, address concerns, and explore alternative treatments if needed.

						- No attempt to make generalizations to other sectors or interventions - Data is self-reported and thus potentially biased - No client perspective included	
Hanafiah & Van Bortel, (2015)	Malaysia: Community Mental Health	Aim: To contribute towards bridging the the current gap in research on stigma and discrimination of mental health conditions Malaysia. Objectives: Not reported	Qualitative methodology Software not described	15 participants, 5 of whom were government psychiatrists. The remaining 10 were private health care providers that included 2 counsellors, 3 psychiatrists, and 5 clinical psychologists.	Results of the study indicated that the stigma of mental health conditions of people with mental health problems was found to be a profound phenomenon in Malaysia.	Strengths: The study used an online survey to collect data from a large and diverse sample size. Limitations: The survey was limited to individuals with access to the internet, which may have excluded certain groups and introduced self-selection bias. Additionally, the study only included individuals practising	Future research is advised to include stakeholder groups in society and the health system such as patients, carers, and policymakers. Investigating participants from rural areas.

						within urban demographic settings in Malaysia, meaning the findings may not be generalisable to other populations or locations.	

Author/ Year	Country / Setting	Research Aim/Objectives	Methodology/ Method of Data collection	Sample characteristics	Findings/ Themes	Strengths/ Limitations	Clinical Implications

Ion et al., (2017)	Canada Ontario Primary Care and Community Mental Health	Aim: To elicit primary care and mental health care provider perspectives on the key components of effective integrated care as implemented in real-world settings, gaps in the adoption of evidence-based practices, and outcomes that are meaningful and Important to those working on the frontlines of care. Objectives: Not reported.	Qualitative methodology Thematic analysis. nVivo10 software.	Integrated care providers (n =13) and clients (n =9)	There results revealed a mounting gap between the empirical support for integrated care approaches and the implementation of these models.	Strengths: Comprehensive insights into integrated care models, broad geographic scope, and diverse participants. Limitations: Self-reported data bias, language limitation, and primary care provider recruitment.	There is a need to clarify the aims of integrated care and the key ingredients required for widespread implementation outside of research settings.

Li et al (2022)	China Wuhan, Hubei Province,	To explore the difficulties and challenges in CMHS from the perspective of CMHWs.	Qualitative study using an empirical phenomenological approach Colaizzi's Seven Step Analysis Nvivo 11.0 Software	Nine CMHWs were recruited from nine communities in Wuhan, Hubei Province,	Three themes emerged: 1) deficiency in role orientation results in role ambiguity. 2) the failure to cultivate a therapeutic trust relationship with patients was identified as a significant theme. 3) inadequate communication and collaboration with different departments and peers emerged as another key theme. 4) seven sub-themes were developed.	Strengths: The study's strength lies in its potential to enhance the development and effective utilisation of community roles in the prevention, treatment, and rehabilitation of mental illness. A limitation of this study is that it focused only on the experiences of CMHWs.	To enhance the depth of insight into the challenges confronted by Community Mental Health Services (CMHS), future research could extend its focus to encompass diverse stakeholder perspectives. A systematic exploration at individual, family, social, and environmental levels would offer a nuanced and comprehensive understanding, contributing to a more robust foundation for addressing the complexities inherent in CMHS.

Martinez et al., (2017)	Mexico, Community-based primary care settings	Aims: To elucidate some of the barriers to integrating behavioural health services reported by staff of community-based primary care clinics in Mexico City. Objectives: Not reported.	Qualitative methodology; Thematic Analysis by Braun & Clarke (2006) Purposeful criterion sampling The qualitative study used semi structured interviews. Data analysis was conducted in Spanish and translated to English, and the quotes included were translated to retain their original, literal meaning. No software was used	The sample included five physicians, three of whom were female (T-1 facility, N=3; T-II facility, N=2); two nurses, both of whom were female (T-I, N=1, and T-III, N=1); eight social workers, all of whom were female (T-I, N=4; T-II, N=1; and T-III, N=3); four psychologists, three of whom were female (T-1, N=1; T-II, N=1; and T-III, N=2); a female psychiatrist (T-III); a male dentist (T-II); and four administrative staff, all of whom were female (T-III).	Thematic categories: service issues, language and cultural issues, care recipient characteristics, and issues with lack of knowledge.	Strengths: -Inclusion of a wide range of professional roles within the Mexican primary care Limitations: -Potential for the perceptions of staff to not include all possible barriers to the implementation of mental health services -Possibility of other barriers existing that were not discussed by staff	This study has important implications for clinical practice, indicating the need for better integration of mental health services in primary care, tailoring services to the population, addressing barriers to access, and providing culturally appropriate care.

Author/ Year	Country / Setting	Research Aim/Objectives	Methodology/ Method of Data collection	Sample characteristics	Findings/ Themes	Strengths/ Limitations	Clinical Implications
Murphy et al., (2018)	Canada: Community pharmacy settings.	Aim: To explore the practice experiences of community pharmacists for those at risk of suicide in Canada and Australia. Objectives: Not reported.	Qualitative methodology Thematic Analysis by Braun & Clarke (2006) Data was collected using Online app was used (https:/203urrent203s.dal.ca/) No software stated	396 participants completed surveys	The findings indicate limited amount of information currently exists, Themes: referrals and triage, access for confiding, emotional toll, and stigma.	Strengths: Strengths of the study were not reported. Limitations: analysis was conducted with free-text responses with no opportunity to further explore participants' responses as would be the case during an interview or focus group Pharmacists' responses between Australia and Canada were not analysed to compare if their experiences were congruent or different.	More research will be required to determine the future of education and training of pharmacists in this area as well as the most effective and efficient postvention supports. Future research in this area is warranted.

Nyassi et al (2023)	Somaliland	This study aimed to describe the experiences of community mental health workers, predominantly female, nurses and doctors providing community-based mental health services in Borama, Somaliland	A qualitative explorative study using focus group discussions was conducted. Inductive approach using content analysis	Three focus group discussions with 22 female community health workers, two medical doctors, and two registered nurses and analysed using content analysis with an inductive approach	Three main categories were identified from the analysis: (1) bridging the mental health gap in the community; (2) working in a constrained situation; and (3) being altruistic	Strengths: This study includes the comprehensive data collection involving all staff, including Frontline Community Health Workers (FCHWs), doctors, and nurses, engaged in implementing community mental health services in the Awdal region, Somaliland. To bolster credibility and confirmability, the analysis was collaboratively conducted by the first and last authors. However, a potential limitation arises from the absence of pilot testing for the interview guide before conducting the focus group discussions (FGDs).	This study illuminated numerous challenges confronted by community health workers. Significantly, it underscored the pivotal role of Frontline Community Health Workers (FCHWs) in bridging gaps within the mental health system, emphasizing the indispensability of fostering an enabling work environment to optimize their productivity. Policymakers and stakeholders are urged to allocate sufficient funding and implement periodic training initiatives for FCHWs to address these

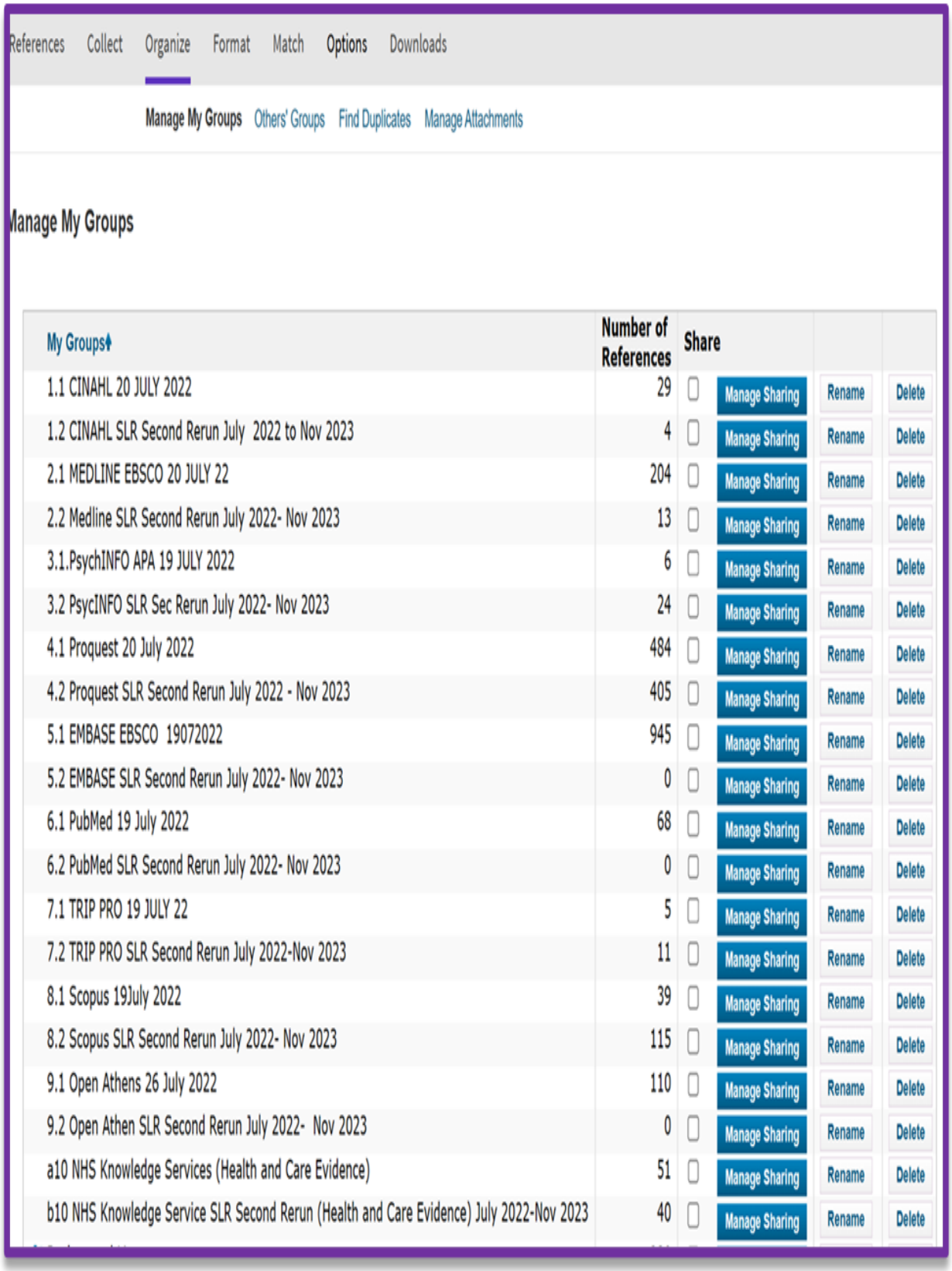
							challenges effectively
Petrie et al., (2021).	Australia: Mental Health Services	Aim: To examine the perceptions of health professionals regarding the gaps in mental health service provision in Australia and their need for assistance in managing patients with mental illness. Objectives: Not reported	Mixed Method; Qualitative & Quantitative methodology Data analysis Descriptive statistics SPSS (v26). and Thematic analysis	570 health professionals	The study revealed eight major themes: Funding; Accessibility; Availability; System wide factor; Population in need; Stages of management; Professional support and communication ; Broader social and cultural issues	• The survey was administered online, which may have limited the response rate. • The sample size was relatively small and may not be representative of the larger population. • The survey was only administered to healthcare professionals, so the results may not be applicable to other groups. • Participants were a convenience sample recruited from social media groups and a mailing list of HPs who had expressed interest in training from the	Future research could also explore perceptions of a wider range of health professionals that are involved in all aspects of care for mental health problems address the under-representation of certain professions.

						Black Dog Institute, potentially introducing sampling bias. • Some particular professional roles were under-represented.	
Author/ Year	**Country / Setting**	**Research Aim/Objectives**	**Methodology/ Method of Data collection**	**Sample characteristics**	**Findings/ Themes**	**Strengths/ Limitations**	**Clinical Implications**
Priebe et al., (2012)	United Kingdom. 14 countries: Austria, Belgium, Czech Republic, France, Germany, Hungary, Ireland, Italy, Netherlands, Poland, Portugal, Spain, Sweden, and the	Aim: To explore the experiences and views of experts in 14 European countries regarding mental health care for six socially marginalised groups: long-term unemployed; street sex workers; homeless; refugees/asylum seekers; irregular migrants and members of the travelling communities. Objectives: Not reported	Qualitative methodology Semi-structured interviews were analysed using Content Analysis by (Hsieh & Shannon 2005) Software: MAXqda (v.10)	(n = 79), general health care positions (n = 19) or academic positions (n = 3). 18 were managers/coordinators of mental health and 32 of social care services. Highly deprived geographical areas, two in each participating capital city.	The study conducted a total of 154 interviews, which identified 13 themes that were grouped into four components of good practice: outreach programmes, facilitating access to general health services, collaboration and co-ordination of	Strengths: A substantial number of experts in 14 countries were interviewed. All experts had actual experience providing care to the specific marginalised group they were being interviewed about. Limitation. Interviews were semi-structured and did not explicitly investigate views on pre-defined components of good practice, negative findings (i.e. if experts did not raise a theme) are difficult, if not impossible, to interpret. Experts were selected based on local knowledge and experience or research teams, but the recruitment	Healthcare providers must invest resources to ensure their services are providing the best possible care, including adequate funding, service organisation, and training of staff, as well as taking into account cultural and social factors to ensure equitable access.

	United Kingdom.;				services, and information.	was still opportunistic and may have been inconsistent.	
Russell et al., (2021)	Malaysia:	Aim: To explore primary care clinician perceptions of barriers and facilitators in delivering care for common mental disorders (CMD) before and after implementation of a consultation-liaison psychiatry service (Psychiatry in Primary Care (PIPC)) in government-operated primary care clinics and to explore the clinicians' experience of the PIPC service itself. Objectives: Not reported	Qualitative methodology Framework analysis Software: Nvivo V.10	17 primary care medical, nursing, and allied health staff in two government-operated primary care clinics in Penang	This study revealed that there are many barriers to participation in PIPC in Malaysia, including time pressures and demands of key performance indicators. It also highlighted the gap between mental health policy and practice, as well as the need for more holistic care and	Strengths: - High level of engagement among participants in pre- and post-intervention interviews - Two clinics located in the same geographical area with different socioeconomic profiles Limitations: - Under-representation of interviewees from non-medical backgrounds - Study confined to consultation-liaison psychiatry service on-site in primary care - Clinicians' direct experience of collaborative care models involving mental healthcare managers not elicited	There is need for potential for full-scale implementation of collaborative care for CMDs in LMICs

					recognition of the potential for change.		

Appendix 5. Example of management of electronic databases for literature review



References Collect Organize Format Match Options Downloads

Manage My Groups Others' Groups Find Duplicates Manage Attachments

Manage My Groups

My Groups	Number of References	Share		
1.1 CINAHL 20 JULY 2022	29	Manage Sharing	Rename	Delete
1.2 CINAHL SLR Second Rerun July 2022 to Nov 2023	4	Manage Sharing	Rename	Delete
2.1 MEDLINE EBSCO 20 JULY 22	204	Manage Sharing	Rename	Delete
2.2 Medline SLR Second Rerun July 2022- Nov 2023	13	Manage Sharing	Rename	Delete
3.1.PsychINFO APA 19 JULY 2022	6	Manage Sharing	Rename	Delete
3.2 PsycINFO SLR Sec Rerun July 2022- Nov 2023	24	Manage Sharing	Rename	Delete
4.1 Proquest 20 July 2022	484	Manage Sharing	Rename	Delete
4.2 Proquest SLR Second Rerun July 2022 - Nov 2023	405	Manage Sharing	Rename	Delete
5.1 EMBASE EBSCO 19072022	945	Manage Sharing	Rename	Delete
5.2 EMBASE SLR Second Rerun July 2022- Nov 2023	0	Manage Sharing	Rename	Delete
6.1 PubMed 19 July 2022	68	Manage Sharing	Rename	Delete
6.2 PubMed SLR Second Rerun July 2022- Nov 2023	0	Manage Sharing	Rename	Delete
7.1 TRIP PRO 19 JULY 22	5	Manage Sharing	Rename	Delete
7.2 TRIP PRO SLR Second Rerun July 2022-Nov 2023	11	Manage Sharing	Rename	Delete
8.1 Scopus 19July 2022	39	Manage Sharing	Rename	Delete
8.2 Scopus SLR Second Rerun July 2022- Nov 2023	115	Manage Sharing	Rename	Delete
9.1 Open Athens 26 July 2022	110	Manage Sharing	Rename	Delete
9.2 Open Athen SLR Second Rerun July 2022- Nov 2023	0	Manage Sharing	Rename	Delete
a10 NHS Knowledge Services (Health and Care Evidence)	51	Manage Sharing	Rename	Delete
b10 NHS Knowledge Service SLR Second Rerun (Health and Care Evidence) July 2022-Nov 2023	40	Manage Sharing	Rename	Delete

Appendix 6. Quality appraisal using Mixed Method Appraisal Tool (MMAT)

Author/ Year / Country	Agyapong et al. (2016) Ghana	Beckers et al., (2019) UK	Brenman, (2014) Nepal	Caplan, et al (2018) Dominican Republic	Forchuk et al., (2020) Canada	Goh et al., (2022) Singapore	Gosch &Rapp, (2015) USA	Hanafiah & Van Bortel, (2015) Malaysia	Ion et al., (2017) Canada	Li et al., (2022) Somaliland	Martinez et al., (2017) Mexico	Murphy et al., (2018) Australia	Nyassi, et al (2023), China	Petrie et al., (2021). Australia	Priebe et al., (2012)., UK	Russell et al., (2021) Malaysia
Study Purpose:																
Was the purpose and /or research question clearly stated?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Literature:																
Was background literature reviewed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Study Design:																
Was theoretical perspective identified?	N/R	N/R	N/R	Y	Y	Y	Y	N/R	N/R	N/R	N/R	N/R	N/R	Y	N/R	N/R
Sampling:																

Was the process of purposeful selection	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was sampling done until redundancy in data is reached?	NR	Y	Y	Y	N/R	Y	N/R	N/R	Y	Y	N/R	N/R	N/R	N/R	N/R	N/R
Was informed consent obtained?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Data Collection:																
Clear and complete descriptions of site	Y	Y	Y	Y	Y	Y	Y	Y	N/R	Y	Y	Y	Y	Y	Y	Y
Clear and complete description of participants	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Role of researcher and relationship with participants	Y	N/R	N/R	N/R	Y	N/R	N/R	N/R	N/R	NR	N/R	N/R	Y	N/R	Y	N/R
Identification of	N/R	Y	Y	Y	Y	N/R	N/R	N/R	N/R		N/R	N/R		N/R	N/R	N/R

assumptions and biases of researcher										N/R			N/R			
Procedural rigor was used in data collection strategies	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Data analysis:																
Data analysis were inductive consistent and reflective of data.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Decision trail developed	Y	Y	Y	Y	Y	N/R	N/R	Y	Y	Y	Y	Y	Y	Y	Y	Y
Process of analysing the data was described adequately	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Did a meaningful picture of the phenomenon under study emerge?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Overall rigor: Was there evidence of the four components of trustworthiness																

Credibility	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Transferability	N/R	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dependability	Y	Y	Y	Y	Y	Y	Y	Y	Y	N/R	Y	Y	Y	Y	Y	Y
Confirmability	N/R	Y	Y	Y	Y	Y	Y	Y	Y	N/R	Y	Y	Y	Y	Y	Y
Study conclusions and implications																
Conclusions were appropriate given the study findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Finding contributed to theory development and future practice/ research	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Qualitative studies documented researcher's influence on the research?	Y	N/R	N/R	NR	N	N	N	N	N/R	N/R	N	N	Y	N	N	N/R

Did include the year the study was conducted?	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Did comment on the study limitations?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Did report ethical approval?	Y	N/R	Y	Y	Y	Y	N/R	Y	Y	Y	Y	Y	Y	Y	N/R	Y
Did comment on participants' gender?	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Total	20/26	22/26	19/26	23/26	21/26	23/26	21/26	21/26	21/26	20/26	18/26	21/26	23/26	20/26	19/26	21/26
%	77%	85%	73%	88%	80%	88%	80%	80%	80%	77%	69%	80%	88%	77%	73%	80%

Key: Y= Yes; N/R= Not reported. Adapted and modified McMaster Quality Assessment Tool (Pluye et al 2018

Appendix 7. Study flyer

Lancaster University

Participants Needed for Research Study on Community Mental Health Workers Care coordinating patients discharged from the hospital.

Can You Say "YES" ? Are you a Community Mental Health worker ? If you answered **Yes** You may be eligible to participate in this study.

You May Qualify If You

- Are between 18 and 65 years old?
- Are care coordinating patients with diagnosis of mental illness discharged from hospital into the community?
- Are a Community Mental Health worker who has more than a year experience ?

Participation Involves

- During telephone ,Teams , Zoom or Skype video call interviews you will be asked four open-ended semi-structured questions.
- Telephone, Teams , Zoom or Skype video call interviews are likely to take 30-45 minutes and will be recorded.

Potential Benefits

There are no incentives or direct benefits, but you may find positive experience in talking about your experiences and how this can help the organisation and other community mental health workers.

Location: Telephone, Teams , Zoom or Skype video call interviews will be conducted at participants place of work or any other place suitable for them.

FOR MORE INFORMATION

Please contact: Chief Investigator: Samuel Ndoro email: s.ndoro@lancaster.ac.uk

Research supervisors:

Dr Caroline Swarbrick, Email: c.swarbrick2@lancaster.ac.uk.

Dr Guillermo, Perez Algorta,Email:g.perezalgorta@lancaster.ac.uk

Lancaster University Department of Health Research Lancaster LA1 4YG Email: dhr@lancaster.ac.uk
Tel: +44 (0)1524 592127

Appendix 8. Participant Information Sheet

Division of Health Research

Participant Information Sheet

Community Mental Health Workers' Experiences of care coordinating patients with a diagnosis of mental health conditions discharged from the hospital. [redacted]

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/dataprotection

My name is **Samuel Ndoro** and I am conducting this research as a student in the PhD Mental Health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

This study will explore the experiences of community mental health workers care coordinating of patients with a diagnosis of mental health condition discharged into community mental health integrated services. Researcher will make recommendations basing on the research findings to NHS community mental health organisations and health policy makers.

Why have I been approached?

You have received this information because you may be interested to take part in this research.

The aims and objectives of this study are:

Main Aim: To explore community mental health workers' experiences of care coordinating patients with a diagnosis of mental health condition discharged from hospital into the community.

Objectives are:

- To explore the duties and responsibilities of community mental health workers.
- To identify barriers faced by community mental health workers during discharge process of patients with diagnosis of mental health conditions discharged from hospital into community mental health integrated services.
- To explore challenges community mental health workers, face and establish if these have affected their wellbeing.
- To examine community mental health workers' involvement in the discharge process under the current community mental health framework and community mental health integrated services.

Do I have to take part?

- No. It's completely up to you to decide whether or not you take part in this study.

What will I be asked to do if I take part?

- Your role will be sharing your experiences of care co-ordinating patients with a diagnosis of mental health condition discharged from hospital into community mental health integrated services with Samuel Ndoro who is a PhD researcher.
- You will be required to give either written via email or verbal consent via telephone depending on the circumstances, for the recording of interviews prior to the interview date. If you were not able to give written consent this will be read to you and recorded before the interview.
- During telephone interviews you will be asked four open-ended and semi-structured questions.
- The researcher will listen ask for clarifications and allow participants to share their interpretations and researcher's views. There will be no right, or wrong answers and interviews are likely to last 30-45 minutes and interviews will be recorded.

Will my data be Identifiable?

- Telephone interviews quotation excerpts will be recited with pseudonyms to avoid identification during result dissemination.
- Identifiers will be removed, however there may be possibilities of identification when verbatim quotation is used in publication. The researcher will summarise the results to maintain anonymity.
- The researcher will inform you about your rights to withdraw, dignity and (when possible) autonomy will be respected; participants may review their

interview scripts. However, after two weeks of the interviews, it will be possible to remove your data from the data analysis.

What will happen to the results?

All identifiers will be removed, there may be possibilities of identification when a verbatim quotation is used in the publication. When summarising the results pseudonyms will be used for anonymity. You can request to access the results of the study. The results of the study will be submitted for publication to both academic and professional journals such as the Journal of Community Mental Health Nursing and the British Journal of Mental Health Nursing.

Are there any risks?

There are no risks are anticipated when participating in the interviews. It is unlikely that the research will cause psychological harm or distress to any participants. However, if you experience any psychological discomfort or concerns, the researcher can stop the interview. You will be offered resources to access in the event of distress.

Are there any benefits to taking part?

There will be no direct benefits, but that taking part and sharing information may be a positive experience and contribute to your continuing professional and organisational development.

Who has reviewed the research?

Prior to publication it is expected that the research will have been scrutinised to exclude bias reporting and approved by both FHMREC and NHS IRAS.

Where can I obtain further information about the study if I need it?

You can contact the Principal investigator Samuel Ndoro, Email: s.ndoro@nhs.net or conduct my academic and research supervisors below:

Dr Caroline Swarbrick, Senior Lecturer, University of Lancaster, Email: c.swarbrick2@lancaster.ac.uk

Dr Guillermo Perez Algorta, Lecturer University of Lancaster, Email: g.perezalgorta@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Fiona Lobban

Division of Health Research, Faculty of Health and
Medicine, Lancaster University, Lancaster LA1 4YX, UK.

Email: f.lobban@lancaster.ac.uk

Tel: +44 (0)1524 592127

If you wish to speak to someone outside of the Department of Health Research Doctorate Programme, you may also contact:

Laura Machin

Chair of FHM REC

Faculty of Health and Medicine

Lancaster Medical School

Lancaster University

Lancaster

LA1 4YG

Email: l.machin@lancaster.ac.uk
Tel: +44 (0)1524 594973

Thank you for taking time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance by visiting Lancaster University Website: https://www.lancaster.ac.uk/student-and-education-services/counselling-and-mentalhealth-service/ or counselling@lancaster.ac.uk or phone +44 (0)1524 592690 or Pennine NHS Trust websites : https://www.penninecare.nhs.uk/nhs-staff-wellbeing or phoning 0800 014 9995

Appendix 9. Consent Form

Consent Form

Study Title: **Community Mental Health Workers' experiences of care coordinating hospital discharge of patients with diagnosis of mental health conditions into Community Mental Health Integrated Services.**

I am asking if you would like to take part in a research project which is aimed at exploring the experiences of community health workers caring for patients with a diagnosis of mental health condition discharged from hospital into community mental health integrated services. Before you consent to participate in the study, I will read the consent form to you on the day of the interview prior to starting the recording. However, you can email the consent form to the researcher if you wish to do so. If you have any questions or queries before signing or giving verbal consent, please speak to the researcher [Samuel Ndoro].

[Please put your initials in the boxes on your right]

1.	I confirm that I have read the information sheet and fully understand what is expected of me within this study	
2.	I confirm that I have had the opportunity to ask any questions and to have them answered.	
3.	I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
4.	I understand that audio recordings will be kept until the research project has been examined.	
5.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my emotional, social well-being and my work will being affected.	
6.	I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	
7.	I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published; all reasonable steps will be taken to protect the anonymity of the participants involved in this project.	
8.	I consent to information and quotations from my interview being used in reports, conferences and training events.	
9.	I understand that the researcher will discuss data with their supervisor as needed.	
10.	I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisor and NHS Team Managers.	
11.	I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
12.	I consent to take part in the above study.	

Name of Participant_____ **Signature**_____ **Date** _____

Name of Researcher _____**Signature** _____**Date** _____

By proceeding to taking part in the research you confirm that:

•The researcher has read the consent form to you on the day of the interview prior to starting the recording if you were not able to email the consent form.

•You confirm that you understand that any responses/information you give will remain anonymous

•Your participation is voluntary

•You consent for the information you provide to be discussed with my supervisor at Lancaster University

•You consent to Lancaster University keeping the anonymised data for a period of 10 years after the study has finished

•By emailing a signed form to s.ndoro@lancaster.ac.uk you consent to take part in the research.

Appendix 10. Ethics FHMREC recommendation letter of approval to conduct the study

Applicant: Samuel Ndoro

Supervisor: Caroline Swarbrick, Guillermo Perez Algorta

Department: DHR

FHMREC Reference: FHMREC20096

17 June 2021

Re: FHMREC20096
Community Mental Health Workers' experiences of care coordinating hospital discharge of patients with diagnosis of mental health conditions into Community Mental Health Integrated Services[redacted]

Dear Samuel,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As Principal Investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained.
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress).
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Tom Morley,

Research Ethics Officer, Secretary to FHMREC.

Appendix 11. Lancaster University Sponsor Letter

Lancaster University

Applicant name: Mr Samuel Ndoro
Supervisors: Dr Caroline Swarbrick & Dr Guillermo Perez-Algorta
Department: Health Research

17 November 2021

Dear Samuel

Re: Community mental health workers' experience of care coordinating

The University of Lancaster undertakes to perform the role of sponsor in the matter of the work described in the accompanying grant application. As sponsor we assume responsibility for monitoring and enforcement of research governance. As principal investigator you will confirm that the institution's obligations are met by ensuring that, before the research commences and during the full term of the grant, all the necessary legal and regulatory requirements are met in order to conduct the research, and all the necessary licenses and approvals have been obtained. The Institution has in place formal procedures for managing the process for obtaining any necessary or appropriate ethical approval for this grant. Full ethical approval must be in place before the research commences and should be reviewed at all relevant times during the grant.

Yours sincerely,

C. O'Donnell

PP Professor Roger Pickup
Deputy Chair Faculty of Health and Medicine Research Ethics Committee.

Appendix 12. FHMREC Ethics Application Form

Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

for additional advice on completing this form, hover the cursor over 'guidance.'

Guidance on completing this form is also available as a word document.

Title of Project: Community Mental Health Workers' experiences of care coordinating hospital discharge of patients with diagnosis of mental health condition into Community Mental Health Integrated Services

Institutional affiliation: Lancaster University

Name of applicant/researcher/chief investigator: Samuel Ndoro

ACP ID number (if applicable) *: N/A **Funding source (if applicable)** N/A

Grant code (if applicable): N/A

***If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [link].**

Type of study

☐ Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

☒ Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

SECTION ONE

1. Appointment/position held by applicant and Division within FHM PhD Mental Health Student Yr 3

2. Contact information for applicant:

E-mail: s.ndoro@lancaster.ac.uk **Telephone**: 07368931602

Address: 4 Sandown Crescent, Manchester M18 7WG

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr Caroline Swarbrick, Lancaster University Email: c.swarbrick2@lancaster.ac.uk

Dr. Guillermo Perez Algorta, Lancaster University, Email: g.perezalgorta@lancaster.ac.uk

3. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the FHMREC website

PG Diploma ☐ Masters by research Ph.D. Thesis ☐ PhD Pall. Care

Ph.D. Pub. Health Ph.D. Org. Health & Well Being Ph.D. Mental Health ☒ MD

DClinPsy SRP ☐ [if SRP Service Evaluation, please also indicate here: ☐ DClinPsy Thesis ☐

4. Project supervisor(s), if different from applicant:

Dr Caroline Swarbrick Lancaster University, Email: c.swarbrick2@lancaster.ac.uk

Dr Guillermo Perez Algorta, University of Lancaster, Email: g.perezalgorta@lancaster.ac.uk

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr Caroline Swarbrick, Senior Lecturer, University of Lancaster, Email: c.swarbrick2@lancaster.ac.uk

Dr Guillermo Perez Algorta, Lecturer, University of Lancaster, Email: g.perezalgorta@lancaster.ac.

SECTION TWO

Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants.

1. Anticipated project dates (month and year)
Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person's language):

Data Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line 'chatrooms' n o

4c. If yes, where relevant has permission / agreement been secured from the website moderator? n o

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users? n o

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security, and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain? n o

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder.

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g., PURE?

7b. Are there any restrictions on sharing your data?

8. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

SECTION THREE

Complete this section if your project includes *direct* involvement by human subjects.

1. Summary of research protocol in lay terms (indicative maximum length of 150 words):

The importance of involving community mental health workers in care coordinating patients with a diagnosis of mental health condition is recognised at the key in facilitating a safe discharge process into community mental health integrated services (CMHIS). It is expected that community mental health workers experiences and time spend in participating in this research will be valuable in identifying areas which needs to be improved in order to provide better discharge process that is patient centred. It is anticipated that a sample size of 16 CMHWs, irrespective of age between 18 -65 years above will be invited to participate from National Health Service (NHS) sites in the Northwest of England. To collect data the researcher will conduct telephone interviews that will be audio recorded. Key themes will be identified from the data to gain an understanding of various CMHWs experiences.

2. **Anticipated project dates (month and year only**)

Start date: March 2021 End date: December 2022

Data Collection and Management

For additional guidance on data management, please go to Research Data Management *webpage, or email the RDM support email:* rdm@lancaster.ac.uk

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

For this study, it is anticipated that the sample size will comprise 16 Community Mental Health Workers aged between 18 and above, will be recruited from National Health Service (NHS) sites in the Northwest of England. Crouch & McKenzie (2006) suggested that a sample size of between 15 and 20 participants can be sufficient and facilitate the management of large quantities of textual data. Creswell (2014) highlights that the sampling strategy for constructivist inquiry may not give an exact sample size for the number of participants.

This will include the following professionals: (i) Community Mental Health Nurses / Care Coordinators, (ii) Occupational Therapists, (iii) Social Workers (iv) Community Mental Health Managers, (v) Psychologists, (vi) Psychiatrists, (vii) Social Worker Mental Health Approved Practitioners, and (viii) support workers (see Appendix). Those participants who will have shown interest to participate will email the researcher on the email provided on the advertising materials. The researcher will distribute a participant information (PI) pack via password-protected email or as hard copies through the post specifically addressed to potential participants who are community mental health workers Trust wide. The pack will contain advertising materials, i.e. flyer, PI sheets, consent forms, demographic questionnaires, and an interview schedule. Participants will be informed that they will receive a summary of the research when the research is completed (see Appendix).

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (e.g., adverts, flyers, posters).

Purposive sampling will be utilised since this method may give the researcher an advantage to approach participants who have relevant experience and expertise (Bryant and Charmaz,2019). Purposive sampling will be utilised since this method enables recruitment of readily available potential participants. Bryant and Charmaz (2019) argued that the advantage of purposive sampling is the ability to target participants who have relevant experience and expertise; thus, they are a source of rich information in a case study.

Inclusion criteria. Participants will be English speaking Community Health Workers who have a minimum of one year of working in community mental health services; thus, they are a source of information (Bradshaw, Atkinson, and Doody 2017). The researcher will recruit participants aged between 18 to 65years ensuring participants are fairly represented to reduce bias in the study sample. This study group may enable the researcher to achieve a variety of sociodemographic data associated with participants concerning community care workers experiences of care-coordinating. This will be collected using a demographic questionnaire Appendix. This will enable the researcher to determine whether the research had representative sample of the target population and generatability of results.

The researcher will contact potential participants who are Community Mental Health Workers by word of mouth with those who have existing links with the research or by phone to obtain consent use their Pennine Care NHS Foundation Trust emails addresses. The initial participant information pack will be distributed via password-protected email or as hard copies through the post to potential participants who work at two NHS CMHTs' sites. The

pack will contain advertising materials, for example, flyers, participant information sheets, consent forms, demographic questionnaires, and an interview schedule.

Flyers will be emailed on the Trust Intranet Website or Emailed to two community mental health teams because of COVID-19 it will not be viable to travel to the two sites to put up flyers in designated areas (see Appendix). The researcher will phone the Team Administration staff and Managers kindly requesting them to print the flyers and put them on the notice boards and designated areas at the two sites.

Thirdly, the researcher will phone, or email recruited participants to arrange a time and venue that suits their work schedule for interviews. Participants will email signed consent forms to the researcher. Participants will be asked to give consent again before the telephone interview begins and this will be recorded and stored in a separate file to the telephone interview recording. This will be performed using telephone /online interviews, if COVID-19 Guidance is still in place or, by offering face-to-face to maximise recruitment. Participants will be informed that they will receive a summary of the research when the research is completed. Lastly, a thank-you email message will be sent to participants. Participants will be informed that they will receive a summary of the research when the research is completed (see Appendix).

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Data Collection

Semi-structured interviews, conducted in two phases at recruits' place of work, will be used for data collection (see Appendix). Community Mental Health Workers will be recruited Trust wide between June and September 2021.It is anticipated that a total of 16 participant interviews with staff from the two sites will be conducted (Baker and Edwards 2012). If the target number is not met an application for extension will be made. The researcher will conduct a telephone pilot interview to test the semi-structured interview questions using two participants one from CMHT Teams (Cassell 2019). Participant will be pseudonymised and identification will be erased so that it can only be identified by the researcher (Denscombe 2007) (see Appendix). The rational of collecting demographic data is to enable the researcher to determine whether the research had representative sample of the target population and generalisability of results.

The interviews will take the following format: (i) an initial question will be posted as an icebreaker, (ii) intermediate questions will be asked, and (iii) closing questions will complete the session (Morris, 2018) (see Appendix). During telephone interviews, the researcher will ask participants four open-ended semi-structured questions according to the interview schedules attached in the Appendix (Bell and Waters, 2014). There will be no right or wrong

answers; telephone interviews are likely to last 30-45 minutes (Bryant, Charmaz, Morse, et al. 2019). All semi-structured interviews will be recorded using an Olympus High Stereo recorder from a speakerphone so that there is no content destruction by writing notes. The researcher will take the following steps:

(i) Welcoming the participants to put them at ease by introducing himself and establish a welcoming

(ii) The researcher will introduce the aims of the study so that the participants are aware of the purpose of the research, their rights to give informed consents; right to participate or option to withdraw from the research and if they want to be audio recorded in stated in the Consent Form see Appendix. If the participants do not consent to be recorded the researcher will ask for consent to write notes.

(iii) The researcher will ask a few general questions in context to the research to initiate conversation.

(iv) The researcher will ask the four semi-structured questions.

(iv) The researcher will remind the participants the time remaining before the interview finishes so that they can prepare to avoid ending the interview abruptly.

(vi) The researcher will thank the participants what will happen to their data and allow them to ask questions and add any final thoughts if they wish to do so.

Due to COVID-19 Guidance (Lupton, 2020) the researcher will mainly use telephone interviews, online interviews or by offering face-to-face if COVID-19 Guidance changes to maximise recruitment as an alternative approach for data collection. It may not be possible to offer face-to-face interviews due to current COVID-19 pandemic (Lancaster University 2021). The researcher will store participant email addresses, telephone numbers, demographic data, consent forms, Audio recorded and handwritten interview files as encrypted data on Lancaster University OneDrive during the research. These will be erased by the researcher from his computer and storage devices when the research is completed.

Data Analysis and interpretation.

Data will be transcribed and analysed by the researcher (Flick and Mertens, 2018). As an alternative, a professional transcriber may be sought and will sign the consent form (see transcriber consent form in Appendix). Data approach and analysis will be based on Braun and Clarke's six steps of reflexive thematic analysis aligned to the researcher's ontological and epistemological position of constructivist paradigm which uses co-construction generate themes from participants' experiences (Braun and Clarke, 2006, 2023; Creswell, 2022; Flick, 2022).The data will be transcribed verbatim by the researcher, in order to immerse in data. Following transcription, the data will be migrated Atlas.ti 23 for coding. Atlas.ti 23 is a software tool for managing extensive qualitative data but depends on the researcher to use it effectively (Friese, 2019). It is crucial to emphasise that although software applications

such as Atlas.ti assists in data organisation and management, their primary function is not data analysis. The responsibility of conducting the analysis rests entirely on the researcher, who is responsible for employing suitable analytical methods and interpreting the findings appropriately (Creswell, 2022).The themes developed for coding and analysis will be related to the main and sub-research questions and guided and followed Braun and Clarke's (2023; 2006). The researcher will use reflective thematic analysis, suggested by Braun and Clarke 2006. The researcher will utilise reflective diary, memo writing, diagrammatic representation using both Altas.ti 23 and manually to develop codes, and themes during data analysis and interpretation. This technique will be very useful in challenging the researcher's views and those of the participants and thus may influence the findings (Flick and Mertens, 2018; Howell, 2015). This technique will be very useful because it will help the researcher find ideas about the relations between codes and theoretical ideas in the data (Braun and Clarke 2006). The researcher will manage text data using both Atlas.ti 23 software and manually. The empirical findings will be based on the constructivist interpretive approach, which involves following Braun and Clarke's six-step process: getting to know your data, coming up with initial codes, identifying themes, reviewing those themes, defining and labelling them, and finally, writing up the report (Braun and Clarke, 2006). Consequently, a conceptual framework will be developed.

6. What plan is in place for the storage, back-up, security, and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Data storage

Data such as participant email addresses, telephone numbers, demographic data, consent forms, Audio recorded and handwritten interview files will be audio recorded and encrypted so that it is not identifiable and stored on Lancaster University OneDrive server for 10 years following the new General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018. The data will be safely stored on Lancaster University Publication and Research (PURE) and OneDrive; this facility can be securely accessed from anywhere. If participant send hard copies of consent forms, these will be stored securely in the researcher's locked cabinet in the researcher's study room which is only assessed by the searcher

7. Will audio or video recording take place? ☐ no ☒ audio ☐ video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

The researcher will store audio encrypted data on a personal computer and USB drive in the short term and transfer this for secure storage on the Lancaster University OneDrive as soon as it is collected. If the researcher uses online interviews videos may be recorded on Teams or Zoom with participants consent. There will be no view recordings, but if this happens this

will be erased. The researcher will keep USB Olympus High Stereo recorder in a locked cabinet only accessible to the researcher. The Principal Investigator will be responsible for storing the data. The interviews will be recorded using an Olympus High Stereo recorder from a speakerphone so that there is no content destruction by writing notes.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Participants will be required to give consent via email and returning signed consent forms to the researcher depending on the circumstances. If they fail to email the consent form consent will be recorded before the interview commence. The researcher will inform participants that their rights to withdraw, by respecting their dignity autonomy; participants may review their interview scripts (The British Psychological Society 2012). If participants are not able to email consent form before the interview the searcher will read the consent form at the beginning of the telephone interview by asking if they agree to each question and record this as separate file. The telephone interview audio-recorded data and encrypted so that it is not identifiable and stored on Lancaster University OneDrive server for 10 years following the new General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Interview audio data recorded interview data will be safely stored on Lancaster University Publication and Research and OneDrive; this facility can be easily accessed from anywhere and will be erased by the researcher when the research is completed, and data has been transcribed and checked by the researcher. Interview audio recorded data 10 years following the new General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder.

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g., PURE?

Following the new General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018 data will be retained in PURE for 10 years (ICO.org 2019).

8b. Are there any restrictions on sharing your data?

The study has a small study sample and there can be a small risk that participant data can be identified if after anonymisation. Therefore, any restrictions to the accessibility of data will be permitted on a case-by-case basis by and shared on request from Lancaster University Publication and Research

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law? yes

The researcher will provide adequate participant information by email such that potential participants can gain an understanding of the purpose of the research, and then sign and return consent forms to the researcher via email (BPS 2012). The researcher will act without deception, coercion, or undue influence. This will include discussion of the potential risks and benefits of taking part in the research, how the data will be used and if there may be any harm to participants (ESRC 2015). Participants will be asked to give consent for interview quotation excerpts to be recited with pseudonyms to avoid identification during result dissemination.

b. Detail the procedure you will use for obtaining consent?

Participants will be required to give written consent by emailing signed consents forms to the researcher, depending on the circumstances, for the recording of interviews prior to the interview date. The researcher will inform participants that their rights to withdraw within two weeks after data collection, dignity and autonomy will be respected; participants may review their interview scripts (The British Psychological Society 2012). Participants will be informed that when the research qualitative findings are published, they will be in the public domain (ICO.org 2019).

10. What discomfort (including psychological e.g., distressing, or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is unlikely that the research will cause psychological harm or distress to any participants. However, participants will be informed that if they have any psychological discomfort or concerns, they can stop the interview. Researcher will signpost participants to appropriate services such as: However, if any distressing or sensitive issues arise during telephone interviews the participants will be given important contact telephone and email below to contact for counselling:

There is support available via email or phone; contact the followings details available on websites provided in the participant information sheet Pennine Care NHS Foundation Trust website:

https://www.penninecare.nhs.uk/nhs-staff-wellbeing or phoning 0800 014 9995.

Participants will be asked to read the participant information sheets voluntarily and without being coerced. They will have the right to withdraw at any stage or after two weeks after the interview after which it will be difficult to remove their data from data analysis. If participants wish to withdraw after the interview stage, they can do so before data is anonymised.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There is no potential risk to the researcher. The researcher will follow gatekeeping arrangements with Pennine Care NHS Trust to gain accessibility and location of participants in the two NHS sites (FHMREC 2020).

12. Whilst we do not generally expect direct benefits to participants because of this research, please state here any that result from completion of the study.

The participants will be informed that there will not be direct benefits to themselves, but that taking part and sharing information may be a positive experience and contribute to their continuing professional and organisational development. In addition, participants will be informed that they will be given a summary of the research findings.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

The participants will be informed that there are no incentives or direct benefits, but they may find positive experience in talking about their experiences and how this can help the organisation and other community mental health workers. The participants will also be informed that sharing their experiences may also have potential benefits to others.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications? yes

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

The researcher will preserve confidentiality and anonymity by removing all identifying information. Participants demographic data and text extracts will be pseudonymised for protection of anonymity. The researcher will also explain limitations of confidentiality if the researcher thinks what the participants have said during the interview may put themselves or at-risk cause harm to others confidentiality will be broken.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

The target group will not be involved in project design.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The final PhD thesis manuscript will be available electronically at Lancaster University Division of Health Research from where data may be disseminated to other researchers through Lancaster University research conferences and staff development meetings within the NHS Trust. Some aspects of the PhD thesis will be submitted for publication to both academic and professional journals such as the International Journal of Community Mental Health Nursing and the British Journal of Mental Health Nursing.

17. What ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Assuming that this research proposal is approved by Lancaster University FHMREC, the study will commence in March 2021 with monthly supervisions. The NHS Health Research Authority coordinated by RECS can take 21 days to approve simple projects and up to 60 days approve more complex research (Fletcher and Dahl, 2013; FHMREC, 2020). However, if the research proposal is not approved in time for the proposed date of commencement, the time scale will be revised to accommodate the new start date. The time given by NHS REC is an estimate, and this may take longer than anticipated. The researcher contacted the Pennine Care NHS Trust Research and Development who confirmed that this research does not need NHS REC approval because Lancaster University FHMREC will only be required. Please see email received from Pennine Care NHS Foundation Trust dated 23/09/2020 attached to this document.

SECTION FOUR: signature

Applicant electronic signature: Samuel Ndoro Date 02/02/2021

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review ☒

Project Supervisor name (if applicable): Dr Caroline Swarbrick Date application discussed 02/2/2021.

Submission Guidance

1. **Submit your FHMREC application by email to Becky Case (**fhmresearchsupport@lancaster.ac.uk) as two separate documents:
    i. **FHMREC application form.**
    Before submitting, ensure all guidance comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line.*
    ii. **Supporting materials.**
    Collate the **following materials for your study, if relevant, into a single word document:**
        a. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
        b. Advertising materials (posters, emails)
        c. Letters/emails of invitation to participate.
        d. Participant information sheets
        e. Consent forms.
        f. Questionnaires, surveys, demographic sheets
        g. Interview schedules, interview question guides, focus group scripts.
        h. Debriefing sheets, resource lists

    Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submission deadlines:
    i. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to Becky Case **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the FHMREC website. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via

telephone) on the day that your application is considered, if required to do so.

ii. The following projects will normally be dealt with via chair's action and may be submitted at any time. **[Section 3 of the form has *not* been completed and is not required].** Those involving:

   a. existing documents/data only.
   b. the evaluation of an existing project with no direct contact with human participants.
   c. service evaluations.

3. **<u>You must submit this application from your Lancaster University email address, and copy your supervisor into the email in which you submit this application.</u>**

Appendix 13. Lancaster University Governance Checklist

Governance checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project, then you do not need to complete any additional LU ethics forms.

Further information is available from the FREC webpage

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Samuel Ndoro **Department**: Department of Health Research

Title of Project: Experiences of care-coordinating patients with a diagnosis of mental health condition discharged from hospital.

Supervisor (if applicable): Dr Caroline Swarbrick

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates or cephalopods.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

☑ Yes - complete Section 1B

☐ No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

Please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project (use the appropriate letter(s), eg a,c,f)

Items: a, c

1.3 Please indicate which committee you anticipate submitting the application to:

☐ NHS ethics committee

☐ Other external committee

☐ LU FASS/LUMS Research Ethics committee

☐ LU FST Research Ethics committee

☑ LU FHM Research Ethics committee

☐ LU AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal.

2.1 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

☐ Establishment of a research ethics committee required

2.2 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

N/A

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on

where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the University Secretary for further details
- Online Research Integrity training is available for staff and students here along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

☑ Confirmed

Section 4: Statement

4.2 I understand that as researcher I have overall responsibility for the ethical management of the project and confirm the following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing to abide by it in relation to the current proposal
- I have completed the ISS Information Security training and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of any relevant funding body; and (c) the Code of Practice and Procedures of the university.

- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here.)
- I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

☑ Confirmed

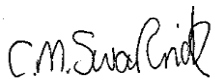
Please note: If you are not able to confirm the statement above please contact Faculty Research Ethics Officer and provide an explanation

Applicant

Name: Samuel Ndoro Date: 18/11/2020 Signature: Samuel Ndoro

***Supervisor (if applicable):**

Name: Dr Caroline Swarbrick Date: 19/11/2020 Signature:



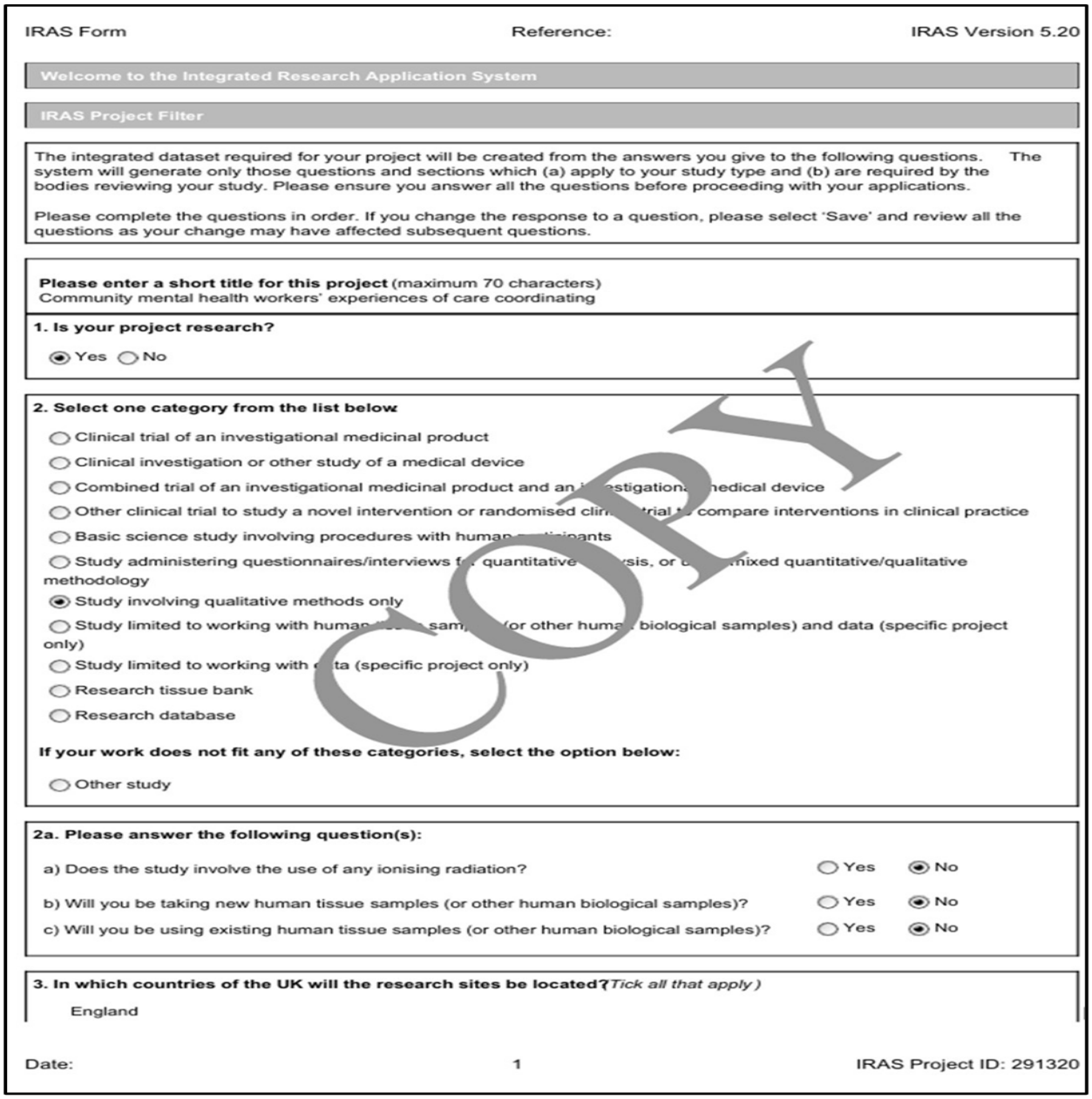
**I declare that I have reviewed this application, and discussed it with the applicant as appropriate. I am happy for this application to proceed to ethical review.*

Head of Department
(or delegated representative)

Name: Catherine Walshe Date: 23.11.20 Signature:

Please return this form to your Faculty Research Ethics Officer

Appendix 14. IRAS Approval Form



IRAS Form Reference: IRAS Version 5.20

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Community mental health workers' experiences of care coordinating

1. Is your project research?

(•) Yes ( ) No

2. Select one category from the list below

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(•) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation? ( ) Yes (•) No
b) Will you be taking new human tissue samples (or other human biological samples)? ( ) Yes (•) No
c) Will you be using existing human tissue samples (or other human biological samples)? ( ) Yes (•) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

England

Date: 1 IRAS Project ID: 291320

☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ◉ No

○ Yes ◉ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number:(maximum 70 characters - this will be inserted as header on all forms)
Community mental health workers' experiences of care coordinating

Please complete these details after you have booked the REC application for re

REC Name:

REC Reference Number: **Submission date:**

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Community Mental Health Worker experiences of care coordinating hospital discharge of patients with diagnosis of mental illness into Community Mental Health Integrated Services. A constructivist inquiry

A2-1. Educational projects

Name and contact details of student(s):

Student 1

Title	Forename/Initials	Surname
Mr	Samuel	Ndoro

Address	4 Sandown Crescent
Post Code	M18 7WG
E-mail	s.ndoro@lancaster.ac.uk
Telephone	07734085547
Fax	

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:

PhD Mental Health

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Caroline	Swarbrick
Address	Lancaster University		
	Division of Health Research		
	D51 Health Innovation One / Sir John Fisher		
Post Code	LA1 4AT		
E-mail	c.swarbrick2@lancaster.ac.uk		
Telephone			
Fax			

Academic supervisor 2

	Title	Forename/Initials	Surname
	Dr	Guillermo	Perez Algorta
Address	Lancaster University		
	Division of Health Research		
Post Code	LA14 YX		
E-mail	g.perezalgorta@lancaster.ac.uk		
Telephone			
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor

Student(s)	Academic supervisor(s)
Student 1 Mr Samuel Ndoro	☑ Dr Caroline Swarbrick ☑ Dr Guillermo Perez Algorta

details are shown correctly.

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- (●) Student
- ( ) Academic supervisor
- ( ) Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Mr	Samuel	Ndoro
Post	Senior Mental Health Practitioner		
Qualifications	M.Sc. Psychiatry, M.Sc Psychol., B.Sc Psychol., PG Cert Ed, Cert Ed, Dip Psych, Dip CTD, N Cert DN, PG Dip MH, Multi-Professional Support for Learning and Assessment in Practice MSLAP Level 7		
ORCID ID	0000 0003 0550 5959		
Employer	Pennine Care NHS Foundation Trust		
Work Address	Tameside Hospital Buckton Building Manchester		
Post Code	OL6 9RW		
Work E-mail	s.ndoro@nhs.net		
* Personal E-mail	s.ndoro@lancaster.ac.uk		
Work Telephone	0161 7163539		
* Personal Telephone/Mobile	07368931602		
Fax			

** This information is optional. It will not be placed in the public domain or disclosed to [illegible] third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Dr	Caroline	Swarbrick
Address	Lancaster University Division of Health Research		
Post Code	LA14 YX		
E-mail	c.swarbrick2@lancaster.ac.uk		
Telephone			
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	Lancaster University
Sponsor's/protocol number:	N/A
Protocol Version:	v2
Protocol Date:	02/02/2021
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number
IRAS Project ID	291320

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

The importance of involving community mental workers (CMHWs) in care coordinating patients with a diagnosis of mental illness is recognised as the key to facilitating a safe discharge process. Recent global health care reforms are encouraging mental health to be community-based. There are a few studies that have focused on CMHWs experiences. It is expected that CMHWs experiences will be valuable in this research to identify areas that need improving to provide a better discharge process that is patient-centred. It is anticipated that a sample size of 16 CMHWs, irrespective of age between 18-65 years will be invited to participate from two National Health Service (NHS) sites in the North West of England and this will be extended Trust-wide if the expected number of participants is not reached. To collect data the researcher will conduct semi-structured telephone, Microsoft Teams, Zoom or Skype interviews that will be audio recorded. Key themes will be identified from the data to gain an understanding of various CMHWs experiences.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Purpose and design

The purpose of this research is to explore community mental health workers experiences of care coordinating patients with a diagnosis of mental illness discharged from hospital into community mental health integrated services.

Ethical Considerations

There are various ethical frameworks used in human research that follow similar principles according to the way they are employed (Vanclay, Baines, and Taylor 2013; Hammersley 2015). The researcher will adhere to the main principles proposed by the British Psychological Society (BPS) (2012) and the Economic and Social Research Council (ESRC,2015; Stark and Hedgecoe 2010). For this study, these encompass issues of informed consent, no deception, preservation of anonymity, permission to audio record interviews, voluntary participation and right to withdraw, the confidentiality of information, recognition of psychological discomfort and distress, reporting procedures, storage and accessibility of data, interpretation and dissemination of research results (Lancaster University Code of Practice 2009).

Recruitment: Purposive sampling will be utilised since this method may give the researcher an advantage to approach participants who have relevant experience and expertise (Creswell, 2022; Bryant and Charmaz,2019). Purposive sampling will be utilised since this method enables recruitment of readily available potential participants. Bryant & Charmaz (2019) argued that the advantage of purposive sampling is the ability to target participants who have relevant experience and expertise; thus, they are a source of rich information.

Inclusion / exclusion

Participants will be English speaking Community Health Workers who have a minimum of one year of working in community mental health services; thus, they are a source of information (Bradshaw, Atkinson, and Doody 2017). The researcher will recruit participants aged between 18-65 years ensuring that targeted participants may be fairly represented to reduce bias in the study sample. This study group may enable the researcher to achieve a variety of sociodemographic data associated with participants concerning community care workers experiences of care-coordinating. Participants who do meet the study criteria will be excluded.

Consent

Participants will be required to give written consent by emailing signed consents forms to the researcher, depending on the circumstances, for the recording of interviews prior to the interview date. However, if participants were not able to email the consent form the researcher will read the consent form to the participant on the day of the interview. This consent giving process will be recorded and saved in a separate file to the main interview recording before starting recording telephone, Microsoft Teams, Zoom or Skype interviews. The researcher will inform participants that their rights to withdraw within two weeks after data collection, dignity and autonomy will be respected; participants may review their interview scripts (The British Psychological Society 2012). After two weeks of the interviews, it will not be possible to remove their data from the data analysis. Participants will be informed that when the research qualitative findings are published, they will be in the public domain (ICO.org 2019).

Risks, burdens and benefits

It is unlikely that the research will cause psychological harm or distress to any participants. However, participants will be informed that if they have any psychological discomfort, distress or concern, they can stop the interview. The participants will be signposted to appropriate services and given important contact telephone and email below to contact for counselling: Pennine Care NHS Foundation Trust website: https://www.penninecare.nhs.uk/nhs-staffwellbeing or phoning 0800 014 9995 or Lancaster University counselling services available on: counselling@lancaster.ac.uk or phone +44 (0)1524 592690.

Confidentiality

The researcher will preserve confidentiality and anonymity by removing all identifying information. Participants demographic data and text extracts will be pseudonymized for protection of anonymity. The researcher will also explain the limitations of confidentiality if the researcher thinks what the participants have said during the interview may put themselves or at risk cause harm to others confidentiality will be broken.

Conflict of interest

There is no conflict of interest in carrying out this research.

What will happen at the end of your study?

Participants will be informed that when the research results are published, and they will be in the public domain (ICO.org 2019). The final PhD Thesis manuscript will be available electronically at Lancaster University Division of Health Research and Lancaster University Publication and Research (PURE) from where data may be disseminated to other researchers through Lancaster University, internal/external research conferences and staff development meetings within the NHS Trust. Some aspects of the PhD Thesis will be submitted for publication to both academic and professional journals such as the Journal of Community Mental Health Nursing and the British Journal of Mental Health Nursing.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☑ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

Research question

This study will be guided by one main research question:

What are Community Mental Health Workers'(CMHWs) experiences of care coordinating patients with a diagnosis of Mental illness (MI) who have been discharged from hospital into Community Mental Health Integrated Services (CMHIs) ?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.* Objectives

•To explore the duties and responsibilities of community mental health workers care-coordinating patients with a diagnosis of mental illness discharged from hospital into community mental health integrated services.
•To identify barriers faced by community mental health workers during the discharge process of patients with a diagnosis of mental illness discharged from hospital into community mental health integrated services.
•To explore challenges community mental health workers, face and establish if these have affected their wellbeing. •To examine community mental health workers' involvement in the discharge process under the current community mental health framework and community mental health integrated services.

These objectives will be answered by questions in the Semi-Structured Interview Schedule.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

The rationale of the study

There is evidence-based research evaluating the success of discharge planning in patients with a diagnosis of Mental Illness (MI)who cannot function independently in the community within the first few weeks of leaving the hospital (Vähäniemi et al. 2018; Ramanuj et al. 2015). A frequent criticism is lack of continuity of care and its coordination during the discharge process, e.g. patients have been sent home unable to perform activities of daily living with no carers or relatives to offer appropriate support and without available long-term management facilities (Morikawa et al. 2017). In addition, Nurjannah et al. (2014) reported that lack of care package coordination, disruption of patient continuity and transfer documentation delay following a suboptimal discharge process leads to compromised care quality. In this perspective globally and in United Kingdom (UK), the majority of both quantitative and qualitative studies in community mental health have focused on patients or service user (SU) experiences.

The current study will be conducted during a time period when the National Health Service (NHS) policy is focused on community treatment of patients with Mental Illness (NHS 2019a). This strategy confronts Community Mental Health Workers with enormous challenges in the management and coordination of care for large numbers of patients with a diagnosis of Mental Illness discharged into the Community Mental Health Integrated Services (CMHIS) (NHS, 2019b; Loch, 2014). Early discharge without assiduous planning may lead to patient relapse and readmission (Fleury, Sabetti, and Bamvita 2019).
Multidisciplinary Teams (MDTs) often encounter difficulties when discharging a patient with Mental Illness; Community Mental Health Teams and ward-based mental health professionals need to work collaboratively (Fleury et al. 2019; Walter et al. 2017). This study will, therefore, explore the experiences of different Community Mental Health Workers to provide insight into the challenges and issues relating to the care coordination of patients with a diagnosis of Mental Illness discharged into Community Mental Health Services in the United Kingdom (UK).

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Research design and methodology

The purpose of this qualitative research is to explore gaps identified in existing knowledge from current literature. The study aims to gain a deeper understanding relating to community health workers' (CMHWs) experiences of care coordinating and managing patients with a diagnosis of mental illness (MI) discharged from hospital into the community mental health integrated services (CMHIS). There is frequent criticism on the lack of continuity of care coordinating and managing of patients during the discharge process. In the United Kingdom (UK), the majority of qualitative studies in community mental health have focused on patients or service user (SU) experiences. This study will use purposive sampling to recruit CMHWs as participants. It is anticipated that a sample size of 16 Community Mental Health Workers (CMHWs), irrespective of age between 18-65 years will be invited to participate from two National Health Service (NHS) sites in the North West of England and if the expected number of participants is not reached the researcher will extend to other sites Trust-wide. Data will be collected from semi-structured telephone interviews that will last about 45 minutes and the researcher may use Microsoft Teams, Zoom or Skype as an alternative approach for data collection and these will be audio recorded on the computer in separate files.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- ☐ Design of the research
- ☐ Management of the research
- ☐ Undertaking the research
- ☐ Analysis of results
- ☐ Dissemination of findings ☑ None of the above

Give details of involvement, or if none please justify the absence of involvement.
The rationale for the absence of patient, service users or their carers or members of the public is that in the United Kingdom (UK), the majority of qualitative studies in community mental health have focused on patients or service user (SU) experiences (Sidey-Gibbons et al. 2019; Titheradge & Galea 2019). Little qualitative data is exploring CMHWs' experiences of care coordination patients with MI discharged from hospitals into community mental health integrated services (CMHIS) (Beere et al. 2019).

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- ☐ Blood
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Congenital Disorders
- ☐ Dementias and Neurodegenerative Diseases
- ☐ Diabetes
- ☐ Ear
- ☐ Eye
- ☐ Generic Health Relevance
- ☐ Infection
- ☐ Inflammatory and Immune System
- ☐ Injuries and Accidents
- ☑ Mental Health
- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender: Male and fema[illegible]cipants

Lower age limit: 18 Years

Upper age limit: 65 Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion criteria
The research will recruit participants aged between 18-65 years irrespective of gender ensuring that potential participants may be fairly represented to reduce bias in the study sample (Robson 2014). Participants will be English speaking Community Health Workers who have a minimum of one year of working in community mental health services; thus, they are a source of information (Bradshaw, Atkinson, and Doody 2017). Participants who not do meet the study criteria will be excluded.

Participants will be recruited over five months from July 2021 to December 2021 from two identified sites within an NHS Trust in the North West of England. The research will be limited to two sites due to the time and resources to conduct the research covering a large geographical location of CMHWS. CMHWs who have a minimum of one year's occupational experience within the NHS CMHIS will be recruited. This will include the following professionals: (i) Community Mental Health Nurses / Care Coordinators, (ii) Occupational Therapists (iii) Social Workers (iv) Community Mental Health Managers, (v) Psychologists, (vi) Psychiatrists, (vii) Social Worker Mental Health Approved Practitioners, and (viii) support workers

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusion criteria

Participants who are not aged between 18-65 years
Participants who are not CMHWs and not English speaking.
Participants who do not work for Pennine Care NHS Foundation Trust.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research,how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
The Chief investigator will seek consent from Lancaster potential participants and conduct one semi - structured interview on community mental health shown interest to participate. telephone or Microsoft Teams , Zoom or Skype as an alternative approach.	1		16 minutes	45 Samuel Ndoro PhD student at University will be chief investigator and will conduct semi -structured interviews using workers who have

A21. How long do you expect each participant to be in the study in total?

Participants will be expected to be in the study for 45 minutes during the interview.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

It is unlikely that the research will cause psychological harm or distress to any participants. However, participants will be informed that if they have any psychological discomfort or concerns, they can stop the interview. If any distressing or sensitive issues arise during telephone interviews the participants will be signposted to appropriate services and given important contact telephone and email below to contact for counselling: There is support available via email or phone; Participants can be advised to use the contact following details available on websites provided in the participant information sheet Pennine Care NHS Foundation Trust website: https://www.penninecare.nhs.uk/nhsstaff-wellbeing or phoning 0800 014 9995 or Lancaster University Student and education counselling services available on https://www.lancaster.ac.uk/student-and-education-services/counse lling-and-mental-health-service/ or counselling@lancaster.ac.uk or phone +44 (0)1524 592690.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

○ Yes ◉ No

A24. What is the potential for benefit to research participants?

The participants will be informed that there will no be direct benefits to themselves, but that taking part and sharing information may be a positive experience and contribute to their continuing professional and organisational development (Marzano, 2014;World Health Organisation 2004).

5]. Participants will be informed that they will receive a summary of the research when the research is completed. Lastly, a thank-you email message will be sent to participants (MacDougall & Fudge,2001). See the Flow chart of the recruitment process in the protocol.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:
The research does not involve patient information,or service users.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Since it will not be viable to travel Trust-wide to put up flyers in designated areas for this reason the research will be advertised on the Trust Intranet. In addition, the researcher will approach administration staff Trust wide by phone and request to email the research advertising material so that they can put it on their notice boards.

A29. How and by whom will potential participants first be approached?

The participants will be first approached by the researcher using their email addresses or by phone after getting approval from Team Managers and Team Leaders. The researcher will inform participants that approval was given by their Manager or Team Leader to approach them if they would like to participate in this research.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

The researcher will obtain informed consent from participants. Before participants consent to participate in the study, the researcher will read the consent form to them on the day of the interview before starting the recording. However, participants can email this to the researcher if they wish to do so. Participation in the study will be voluntary.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

If the expected number of participants is not recruited within two weeks another email with the same participant information will be sent by email as a reminder.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)* All participants will be English speaking.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

◉ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will beassumed.

Further details:

The participant would be withdrawn from the study and no further interviews will be carried out on the participant under the study protocol. No further data will be collected. Subject to ethical approval, and/or the wishes of the participant at the time of consent data already collected in relation to the participant may be retained and used for the purposes for which consent has already been given, provided they are effectively anonymised and no longer identifiable to the research team or any other persons to whom access will be given (Health Research Authority 2020a; Health Research Authority 2020b).

If you plan to retain and make further use of identifiable data/tissue following loss of capacity, you should inform participants about this when seeking their consent initially.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers

☐ Social Care Service computers
☑ Home or other personal computers
☑ University computers
☐ Private company computers ☑ Laptop computers

Further details:

A37. Please describe the physical security arrangements for storage of personal data during the study?

The researcher will make arrangements for give consideration to the arrangements for security and storage of data and ensure that data are pseudonymised or anonymised wherever possible, and that personal data are only collected when needed (known as 'data minimisation'). If you can undertake some or all of your research activities without using identifiable personal data, you should make arrangements to do so. The researcher will take following physical security arrangements and then move on to safe storage of data (UK Data Service n.d). The researcher will a unique identifier or numbers or abbreviations that are uniform and consistent layout throughout a study during data collection. The researcher will use document header or cover sheet with interview or event details such as date, place, interviewer, interviewee details and this will be anonymised MHRC (2021). The researcher will use speaker tags to indicate the question/answer sequence or turn-taking in a conversation and use line breaks between turntakes and numbered pages. In addition, UK Data Service (n.d) recommends that when data is fully transcribed it can be shared with the research team The researcher will use pseudonyms to anonymise all personal identifying information will be encrypted during the study (UK Data Service n.d). During the study period when the researcher is sharing the research data with supervisors to scrutinise for irregularities, they will be provided with a password separately so that they can access the data. The researcher will set out the actions and procedures that include data collection, documentation, storage ethics preservation researcher's responsibilities and submission to Lancaster University repository PURE as explained in the data management plan in Appendix 10 (Lancaster University Library ,n.d).

Data storage for long tern when the study is completed

The research will use meaningful self-explanatory abbreviations, codes or serial numbers on questionnaires and participants text interview responses (UK Data Services n.d). Data such as participant email addresses, telephone numbers will be kept in a separate computer file audio recorded participant consent and audio-recorded interview files will be encrypted so that it is not identifiable and stored on Lancaster University OneDrive server for 10 years following the new General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018. The data will be safely stored on Lancaster University Publication and Research (PURE) and OneDrive; this facility can be securely accessed from anywhere. If participant send hard copies of consent forms these will be stored securely in the researchers locked cabinet in the researcher's study room which is only assessed by the researcher. If participants are not able to email consent forms before the interview the searcher will read the consent form at the beginning of the telephone interview by asking if they agree to each question and record this as separate file. Furthermore, in order to safeguard data the researcher will store encrypted data on Lancaster University OneDrive all the time in the short term during the research; these will be erased by the researcher from his computer and other storage devices when the research is completed (GDR 2018). After the analysis is finalised data will be encrypted and stored on Lancaster University OneDrive server for 10 years. Participants will be informed that when the research results are published, they will be in the public domain (ICO.org 2019).

Access to personal data or storage after the study has ended

The Chief Investigator Samuel Ndoro will be the custodian of data during the study and estimates to collect 0.5TB of digital data in this research and expect to produce some fieldwork paperwork which would equate to one drawer of a filing cabinet. The data will be stored on the Lancaster University shared network OneDrive. Lancaster University, Data Protection Manager, will work closely with ISS Services and will be responsible for the data. All data will be held on Lancaster University Research OneDrive . Data held on Lancaster systems are stored in a resilient storage infrastructure that is dual-homed in the Lancaster University data centre (on-site). There are multiple levels of redundancy built into these storage arrays and backups are automated and taken regularly.

According to GDPR (2018) recommend the researcher to agree on a reasonable retention period to store data, process for any purpose and shall not be kept for longer than is necessary when the study has ended . The researcher will securely delete data from computer devices, laptop and recorder. Research data that is not significant for example research field notes early version of the later study document and personal data will not be retained at the end of this

study. Therefore, this research protocol will aim to store personal anonymised data during the period of the study, and it is anticipated not to be more than 12 months. The researcher will follow GDPR 2018 guidance that demands all data subjects (and therefore all potential research participants) to be able to access the information provided on participant information sheet and are likely to understand it. Participants will be informed that access of research data after the study is completed will be done through the University of Lancaster Data Protection Officer (GDPR 2018).

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Participants will be informed that the discussion content of the interview will remain confidential and will not be shared with other colleagues (Sheehan, Dunn, and Sahan 2018).The study has a small study sample and there can be a small risk that participant data can be identified even after anonymisation. Therefore, any restrictions to the accessibility of data will be permitted on a case by case basis by and shared on request from Lancaster University Division of Health Research through the nominated the Data Protection Officer (GDPR 2018). The researcher will follow Lancaster University FHMREC and NHS Integrated Research Application System (IRAS) protocols to request ethical approval to conduct research using NHS CMHWs (FHMREC, 2020).

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Participants will be made aware that data will only be shared when requested by accredited researchers approved by Lancaster University. Data accessibility will be permitted on a case by case basis by the Lancaster University Division of Health Research supervisors. Following the new General Data Protection Regulation (GDPR) and the (UK) Data Protection Act, 2018 data will be retained in PURE for 10 years (ICO.org 2019).

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be transcribed by the researcher, a task facilitated by his familiarity with the subject will be used for analysis (Flick & Mertens, 2018). The researcher will store encrypted data on a personal computer and USB drive in the short term and transfer for secure storage on the Lancaster University OneDrive as soon as it is collected. After the analysis is finalised data will be encrypted for confidentiality and stored on Lancaster University OneDrive server for 10 years secure storage.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title Forename/Initials Surname
	Mr S Ndoro
Post	PhD Student
Qualifications	M.Sc. Psychiatry, M.Sc Psychol., B.Sc Psychol., PG Cert Ed, Cert Ed, Dip Psych, Dip CTD, N Cert DN, PG Dip MH, Multi-Professional Support for Learning and Assessment in Practice MSLAP Level 7
Work Address	Pennine Care NHS Trust Buckton Building Manchester
Post Code	OL6 9RW

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research
The final PhD Thesis manuscript will be available electronically in Lancaster University Publication and Research (PURE) from where data may be disseminated to other researchers through Lancaster University, internal/external research conferences and staff development meetings within the NHS Trust. Some aspects of the PhD Thesis will be submitted for publication to both academic and professional journals such as the Journal of Community Mental Health Nursing and the British Journal of Mental Health Nursing.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☑ Publication on website
- ☑ Other publication
- ☐ Submission to regulatory authorities

☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committeeon behalf of all investigators

☐ No plans to report or disseminate the results

☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Participants will be informed that the discussion content of the interview will remain confidential and will not be shared with other colleagues (Sheehan, Dunn, and Sahan 2018). The study has a small study sample and there can be a small risk that participant data can be identified if after anonymisation. Therefore, any restrictions to the accessibility of data will be permitted on a case by case basis and shared on request from the Lancaster University Division of Health Research. The researcher will follow Lancaster University FHMREC and NHS Integrated Research Application System (IRAS) protocols to request ethical approval to conduct research using NHS CMHWs (FHMREC, 2020).

Preserving anonymity

Participants' information will be anonymised (Bourgeault et al. 2014). To adhere to the ethics of confidentiality regarding participants' information, data will be protected by storage on OneDrive. Before entry to research sites, the study has to be approved by both the Lancaster University FHMREC and NHS Integrated Research Application Research (IRAS) and Pennine Care Foundation Trust Research and Innovation Development, where the research will be conducted (Sheehan etal.2018).

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
The research report will be shared within the NHS Trust for service improvement. Participants will be informed that they will receive a summary of the research when the research is completed. Lastly, a thank-you email message will be sent to the participants.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review
☐ Review within a company
☐ Review within a multi−centre research group
☐ Review within the Chief Investigator's institution or host organisation
☑ Review within the research team
☑ Review by educational supervisor
☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The study will be reviewed by the researcher being supervised by two research supervisors.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 16

Total international sample size (including UK):
Total in European Economic Area:

Further details:

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

Purposive sampling will be utilised since this method enables recruitment of readily available English speaking CMHWs who have the required experience to participate in the study. Bryant & Charmaz (2019) argued that the advantage of purposive sampling is the ability to target participants who have relevant experience and expertise; thus they are a source of information (Bradshaw, Atkinson, and Doody 2017). Crouch & McKenzie (2006) suggested that a sample size of between 15 and 20 participants can be sufficient and facilitate the management of large quantities of textual data.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The researcher will manage text data using both Atlas.ti 23 software and manually. The empirical findings will be based on the constructivist interpretive approach, which involves following Braun and Clarke's six-step process: getting to know your data, coming up with initial codes, identifying themes, reviewing those themes, defining and labelling them, and finally, writing up the report (Braun & Clarke, 2006). Consequently, a conceptual framework will be developed.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral study research staff.*

	Title Forename/Initials Surname
	Dr Caroline Swarbrick
Post	Senior Lecturer / First Research Supervisor
Qualifications	PhD
Employer	Lancaster University
Work Address	Lancaster University Division of Health Research
Post Code	LA14 YX
Telephone	
Fax	
Mobile	
Work Email	c.swarbrick2@lancaster.ac.uk

	Title Forename/Initials Surname
	Dr Guillermo Guillermo Perez Algorta
Post	Lecturer/ Second Research Supervisor
Qualifications	PhD
Employer	Lancaster University
Work Address	Furness Building Division of Heath Research

Post Code	LA1 4YX
Telephone	
Fax	
Mobile	
Work Email	g.perezalgorta@lancaster.ac.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: ○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or pri... organisation)
○ Other

Commercial status: Non-Commercial

If Other, please specify: NONE

Contact person

Name of organisation	Lancaster Un...ersity
Given name	Claire
Family name	O'Donne...
Address	Researc... nd Enterprise Servi...es
Town/city	Lancaste...
Post code	LA14 YX
Country	United Kingdom
Telephone	
Fax	
E-mail	c.odonnell@lancaster.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation
Given name
Family name

Address
Town/city
Post code
Country
Telephone
Fax
E-mail

A65. Has external funding for the research been secured?

Please tick at least one check box.

- [ ] Funding secured from one or more funders
- [ ] External funding application to one or more funders in progress
- [x] No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ○ Project that is part of a fellowship/ personal award/ research traini[illegible]rd
- ◉ Other

Other – please state:
The project is partial fulfillment of PhD Mental Hea[illegible]h

A66. Has responsibility for any specific research a[illegible]ties or proce[illegible]ures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) *Please give detai[illegible]bcont[illegible]ctors if applicable.*

○ Yes ◉ No

A67. Has this or a similar applicati[illegible]n previou[illegible]y rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title	Forename/Initials	Surname
Mr	Simon	Kaye

Organisation: Pennine Care NHS Foundation Trust
Address: Trust HQ
225 Old Street

	Ashton Under Lyne
Post Code	OL6 7SR
Work Email	simon.kaye2@nhs.net
Telephone	01617163993
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A68-2. Select Local Clinical Research Network for NHS Organisation identified in A68-1:

Greater Manchester

For more information, please refer to the question specific guidance.

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/07/2021
Planned end date: 30/12/2023
Total duration:
Years: 2 Months: 5 Days: 30

A71-1. Is this study?

- ○ Single centre
- ◉ Multicentre

A71-2. Where will the research take pl... (Tick a... propriate)

- ☑ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland
- ☐ Other countries in European Economic Area

Total UK sites in study 2

Does this trial involve countries outside the EU?

○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	2
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	

☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Joint health and social care agencies (eg community mental health teams)
☐ Local authorities
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent (private or voluntary sector) organisations
☐ Educational establishments
☐ Independent research units
☐ Other (give details)

Total UK sites in study: 2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

◉ Yes ○ No

A73-2. If yes, will any of these organisations be NHS organisations?

◉ Yes ○ No

If yes, details should be given in Part C.

A73-3. Approximately how much time will these organisations expect to spend on screening records and/or provision of information to potential participants, and how will the costs of these activities be funded?

Not applicable

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

All monitoring and audit trail of the research will be done by the chief investigator.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: In this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)
☑ Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- ☑ Other insurance or indemnity arrangements will apply (give details below)

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS scheme through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
- ☐ Research includes non-NHS sites (give details of indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ◉ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier | Research site

IN2 NHS/HSC ◉ Site
○ Non-NHS/HS

Investigator Name

Organisation name

Address : Site

PENNINE ACUTE HOSPITALS NHS TRUST
TRUST HEADQUARTERS
NORTH MANCHESTER GENERAL HOSPITAL
DELAUNAYS ROAD, CRUMPSALL
MANCHESTER
M8 5RB
ENGLAND

Post Code
Country

Participant Identifi

PIC | Type

Forename	Samuel
Middle name	
Family name	Ndoro
Email	s.ndoro@nhs.net
Qualification (MD...)	M.Sc. Psychiatry, M.Sc Psychol., B.Sc Psychol., PG Cert Ed, Cert Ed, Dip Psych, Dip CTD, N Cert DN, PG Dip MH, Multi-Professional Support for Learning and Assessment in Practice MSLAP Level 7
Country	United Kingdom

IN3 NHS/HSC ◉ Site
Non- ○ NHS/HS

:ation Centres

Cent	Individual(s)

Organisation name

Address

TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST
TAMESIDE GENERAL HOSPITAL
FOUNDATION STREET
ASHTON-UNDER-LYNE
OL6 9RW
ENGLAND

Post Code
Country

Participant Identifi

Forename	Samuel
Middle name	
Family name	Ndoro
Email	s.ndoro@lancaster.ac.uk
Qualification (MD...)	M.Sc. Psychiatry, M.Sc Psychol., B.Sc Psychol., PG Cert Ed, Cert Ed, Dip Psych, Dip CTD, N Cert DN, PG Dip MH, Multi-Professional Support for Learning and Assessment in Practice MSLAP Level 7
Country	United Kingdom

:ation Centres

PIC Type	Centre	Individual(s)

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply. ◦ May be sent by email to REC members.

11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- ○ Chief Investigator
- ○ Sponsor
- ○ Study co-ordinator
- ◉ Student
- ○ Other – please give details
- ○ None

Access to application for training purposes*(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by MR Samuel Ndoro on 29/06/2021 21:17.

Job Title/Post:	PhD Mental Health Student
Organisation:	University of Lancaster/ Pennine Care NHS F[illegible]n Trust
Email:	

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 2 September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the registration requirements for the UK, or that any deferral granted by the HRA still applies.

Signature: .....

Print Name:

Post:

Organisation:

Date: *(dd/mm/yyyy)*

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr. Guillermo Perez Algorta on 29/06/2021 09:10

Job Title/Post:	Lecturer in Mental Health
Organisation:	Lancaster University
Email:	g.perezalgorta@lancaster.ac.uk

Academic supervisor 2

Signature: .....

Print Name:

Post:

Organisation:

Date: *(dd/mm/yyyy)*

Appendix 15. Letter of approval from host NHS Trust Research and Innovation

Research and Innovation Department

Research Management Approval 10th September 2021

Dear Dr Caroline Swarbrick (acting Sponsor Representative and Academic Supervisor 1,

Dr Guillermo Perez Algorta (Academic Supervisor 2), Mr Samuel Ndoro (Chief Investigator)

Confirmation of Capacity and Capability at Pennine Care NHS Foundation Trust

Re: PCFT ref: 100531 / IRAS ID: 201320

Short study title: Community mental health workers' experiences of care-coordinating

Full title of research: Community Mental Health Workers' experiences of care-coordinating hospital discharge of patients with diagnosis of mental health conditions into Community Mental Health Integrated Services.

This email confirms that Pennine Care NHS Foundation Trust has the capacity and capability to deliver the above referenced study.

Thank you for submitting documentation to support your study which has been reviewed by the Research and Innovation (R&I) Department in regard to the project's impact and suitability for the Trust.

Your study was submitted for review to Lancaster University, Faculty of Health and Medicine Research Ethics Committee and the application was recommended for approval under reference: FHMREC20096 dated 17 June 2021

On this basis, we are able to grant approval, and we agree to start this study immediately, as previously discussed.

Susan Waine (0161 716 3086) and Linda Booth (0161 716 3882) are contacts for research governance. Please keep us informed of any changes to governance arrangements through this email: researchdevelopment.penninecare@nhs.net

If you wish to discuss further, please do not hesitate to contact me or your assigned **Study Lead, Simon Kaye, Research & Innovation Manager.**

Kind regards

Susan Waine

Susan Waine
Research Governance Officer

Study Approvals

Pennine Care NHS Foundation Trust
Research and Innovation Department
225 Old Street, Ashton-under-Lyne OL6 7SR
Email: researchdevelopment.penninecare@nhs.net
Website: www.penninecare.nhs.uk

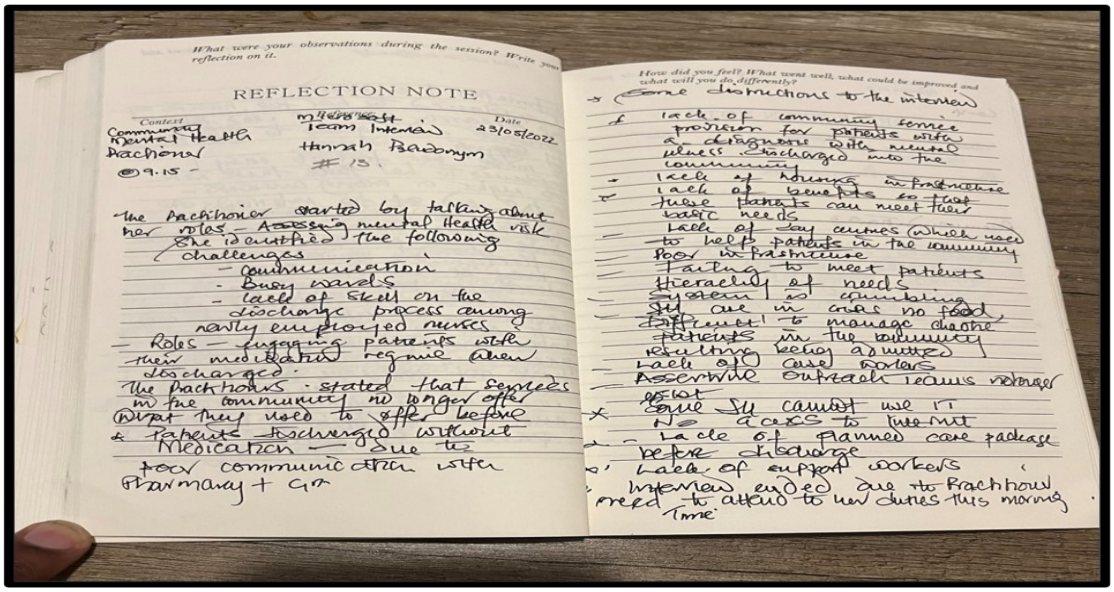
Research Management Approval *February 2021*

Appendix 16. Semi-structured interview guide

Semi-structured interview questions	Semi-structured interview schedule to answer the research question and objectives
1. Can you tell me your duties and responsibilities as a community mental health worker?	1
2. What are the experiences and barriers community mental health workers face in care-coordinating patients with a diagnosis of a mental health condition discharged from the hospital into community mental health integrated services?	2
3. Can you describe your challenges in care-coordinating and managing patients with a diagnosis of a mental health condition discharged from the hospital?	3
4. Could you describe your involvement in the discharge process of patients diagnosed with a mental health condition discharged from the hospital into community mental health integrated services?	4

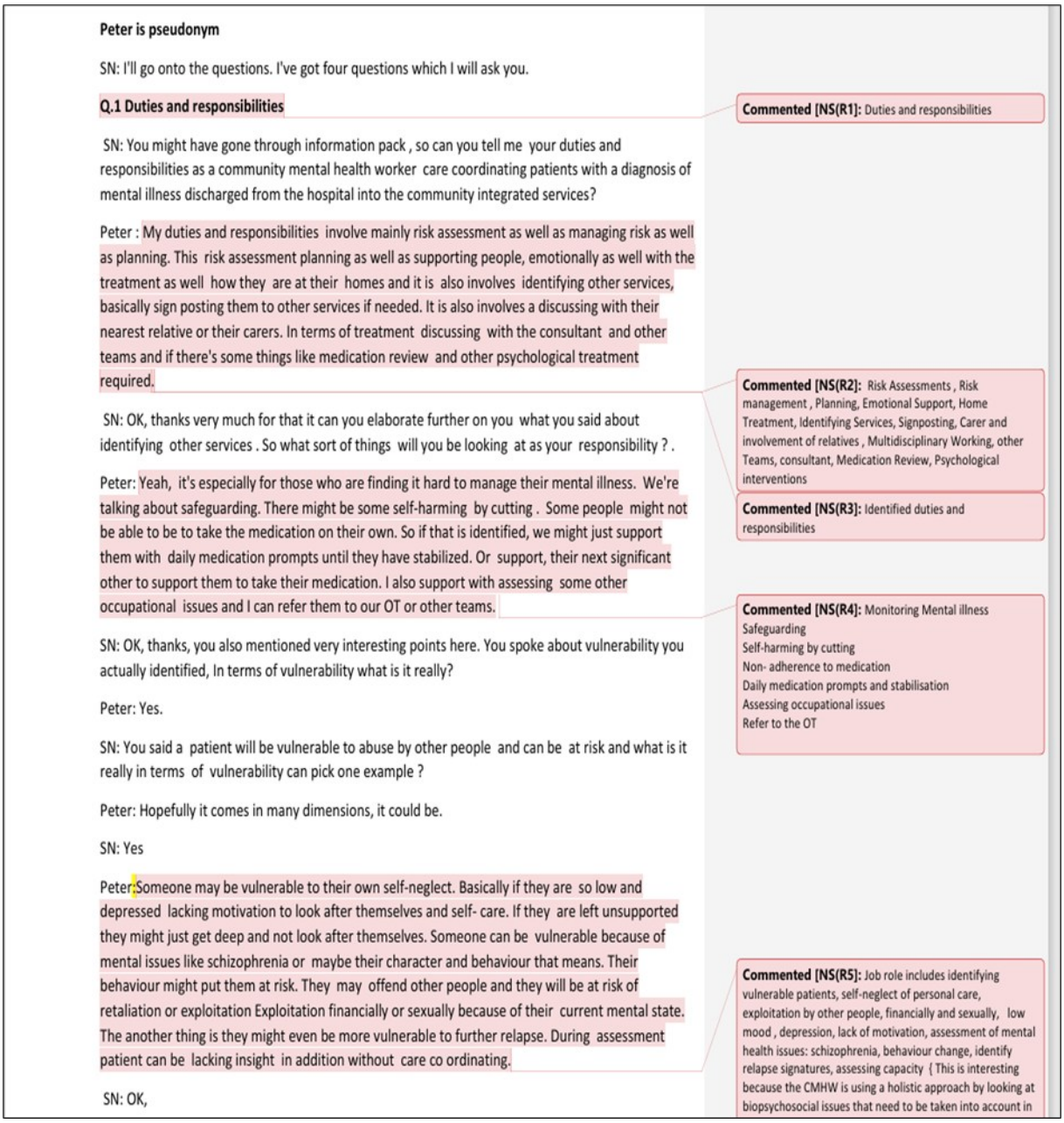
Appendix 17. Data collection instruments and storage

Instruments I used for data collection and management



Excerpt from my reflective journal

Appendix 18. Example of a transcribed interview excerpt from one interview transcript illustration of initial familiarisation and noting with reflecting comments.



Peter is pseudonym

SN: I'll go onto the questions. I've got four questions which I will ask you.

Q.1 Duties and responsibilities

SN: You might have gone through information pack , so can you tell me your duties and responsibilities as a community mental health worker care coordinating patients with a diagnosis of mental illness discharged from the hospital into the community integrated services?

Peter : My duties and responsibilities involve mainly risk assessment as well as managing risk as well as planning. This risk assessment planning as well as supporting people, emotionally as well with the treatment as well how they are at their homes and it is also involves identifying other services, basically sign posting them to other services if needed. It is also involves a discussing with their nearest relative or their carers. In terms of treatment discussing with the consultant and other teams and if there's some things like medication review and other psychological treatment required.

SN: OK, thanks very much for that it can you elaborate further on you what you said about identifying other services . So what sort of things will you be looking at as your responsibility ? .

Peter: Yeah, it's especially for those who are finding it hard to manage their mental illness. We're talking about safeguarding. There might be some self-harming by cutting . Some people might not be able to be to take the medication on their own. So if that is identified, we might just support them with daily medication prompts until they have stabilized. Or support, their next significant other to support them to take their medication. I also support with assessing some other occupational issues and I can refer them to our OT or other teams.

SN: OK, thanks, you also mentioned very interesting points here. You spoke about vulnerability you actually identified, In terms of vulnerability what is it really?

Peter: Yes.

SN: You said a patient will be vulnerable to abuse by other people and can be at risk and what is it really in terms of vulnerability can pick one example ?

Peter: Hopefully it comes in many dimensions, it could be.

SN: Yes

Peter:Someone may be vulnerable to their own self-neglect. Basically if they are so low and depressed lacking motivation to look after themselves and self- care. If they are left unsupported they might just get deep and not look after themselves. Someone can be vulnerable because of mental issues like schizophrenia or maybe their character and behaviour that means. Their behaviour might put them at risk. They may offend other people and they will be at risk of retaliation or exploitation Exploitation financially or sexually because of their current mental state. The another thing is they might even be more vulnerable to further relapse. During assessment patient can be lacking insight in addition without care co ordinating.

SN: OK,

Commented [NS(R1]: Duties and responsibilities

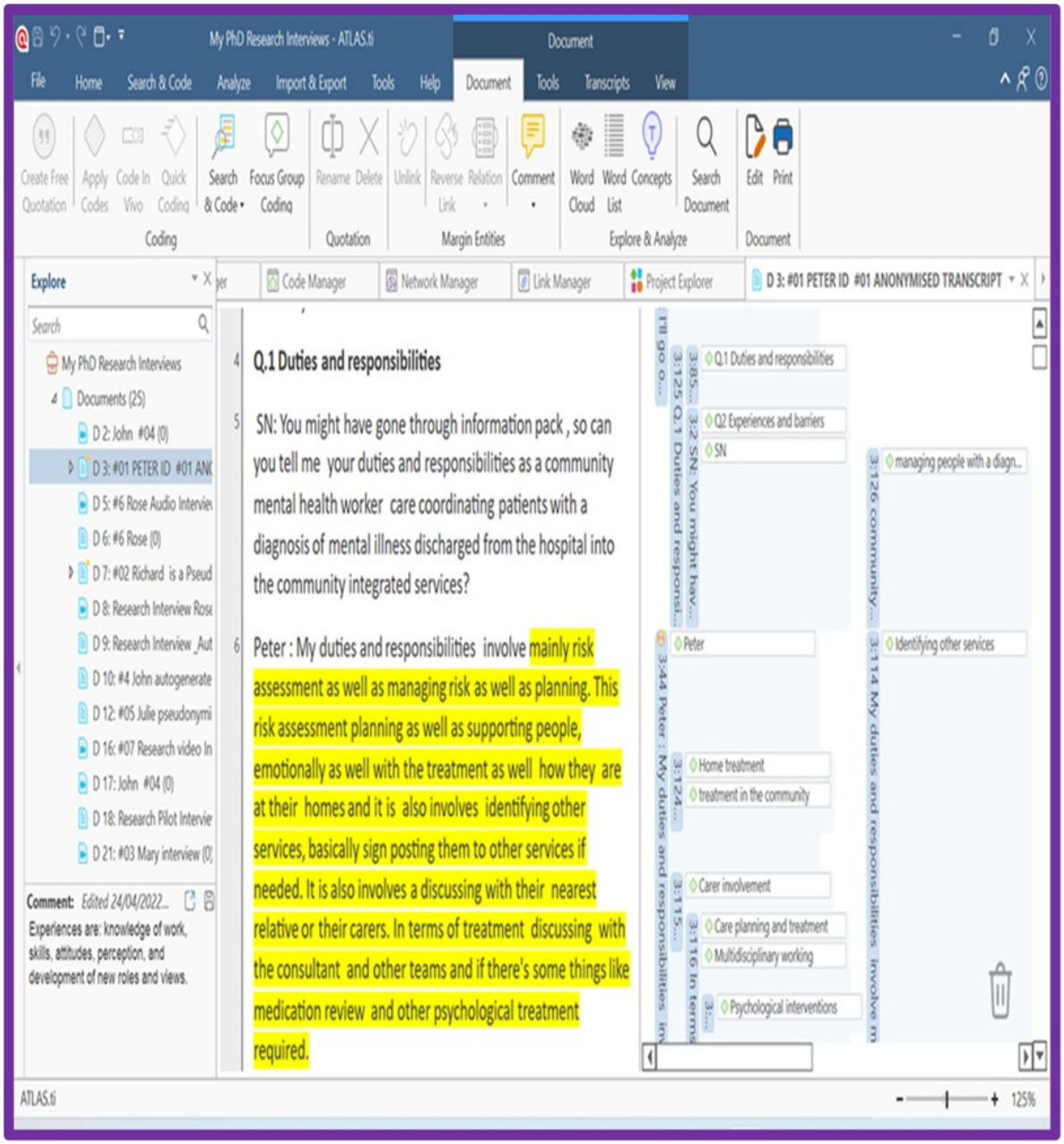
Commented [NS(R2]: Risk Assessments , Risk management , Planning, Emotional Support, Home Treatment, Identifying Services, Signposting, Carer and involvement of relatives , Multidisciplinary Working, other Teams, consultant, Medication Review, Psychological interventions

Commented [NS(R3]: Identified duties and responsibilities

Commented [NS(R4]: Monitoring Mental illness
Safeguarding
Self-harming by cutting
Non- adherence to medication
Daily medication prompts and stabilisation
Assessing occupational issues
Refer to the OT

Commented [NS(R5]: Job role includes identifying vulnerable patients, self-neglect of personal care, exploitation by other people, financially and sexually, low mood , depression, lack of motivation, assessment of mental health issues: schizophrenia, behaviour change, identify relapse signatures, assessing capacity { This is interesting because the CMHW is using a holistic approach by looking at biopsychosocial issues that need to be taken into account in

Appendix 19. Example of data management and initial coding using Atlas ti. software.



Appendix 20. Example of development of themes following Reflexive Thematic Analysis

Step 1 Familiarisation with data	Below are examples of initial interview excerpts from Community mental health Workers to illustrate reflective thematic analysis: *"My duties and responsibilities involve mainly risk assessment as well as managing risk as well as planning […] It is also involving a discussion with their nearest relative or their careers. In terms of treatment discussing with the consultant and other teams and if there is some things like medication review and other psychological treatment required (Bongani)* *With we find, I find communication can be really fragmented. I can go on to the ward and get a handover from the staff on the ward and it might be yes not had a good week, we've got a few problems, this has happened and this has happened and then I'll go into ward round and it won't reflect what has been actually handed over. It, it can be very much focused on what the clinician and consultant think rather than what actually day to day nursing has been handed over (Rose)* *Let us go into management[...] I think it's got to be clear that this isn't, I am not pointing at any individual for example, it's more the model of care that's provided the structure of crisis management. But I think one of the biggest challenges, and I think it is a challenge that sometimes we share as practitioners as well (Richard)* *Yes, I think care for staff is - Really needs improving. I think you know everybody has mental health not just our patients we all have it and we all have to be aware of it so I think it would be beneficial for there to be more things available for staff at work things […] or somebody on hand to speak to regularly really you know we're make sure we check up on each other as colleagues I think that's important. I think staffing levels especially on the wards you know needs to be improved and it would help a lot with discharge processes and like continuity of care (Mary)* Once I had become familiar with the information gathered from the interview excerpts, I moved on to the next step, which involved generating initial

	codes using Atlas.ti software. In this step, I started identifying and labelling key ideas and concepts found in the data.
Step2 Generating initial codes	Example of codes initially identified in the interview excerpts: **1: Duties and responsibilities** *"My duties and responsibilities involve mainly risk assessment as well as managing risk as well as planning […] It is also involving a discussion with their nearest relative or their carers. In terms of treatment discussing with the consultant and other teams and if there is some things like medication review and other psychological treatment required (Bongani)* **2: Experiences and Barriers:** *I think it links in a little bit with number two when I was saying from like a bureaucracy side of you know the paperwork that you would use the information that you receive from the ward may not be as detailed as you'd like it to be sometimes and I know that's due to pressures that they face and staffing. So that can be sort of a difficult thing, a miscommunication but I think sometimes challenges in care-coordinating are that you know sometimes you feel that there aren't enough staff (Mary)* **3: Challenges in care-coordinating:** *Let us go into management[...] I think it's got to be clear that this isn't, I am not pointing at any individual for example, it's more the model of care that's provided the structure of crisis management. But I think one of the biggest challenges, and I think it is a challenge that sometimes we share as practitioners as well (Richard)* **4 Involvement in the discharge process:** *Oh well yes I recently have had a patient admitted on to X Ward in Y and it's a lady that I'm really, really involved with. So I was quite fundamental in her admission as well as her discharge. So it's, I attended the ward rounds prior to discharge, I visited her on the ward, discussed her discharge with the family, made sure the family's voice were heard (Rose)* 5 Effective communication 6: Availability of resources 7: Experience of work 8: Negative experiences 9: Positive Experiences 10: Mixed experiences 11: Improving professional practice 12: Policies and procedures 13: Personal Wellbeing

	Additional categories added after generating initial codes. Categories identified. 1.Duties and responsibilities: Experience of working in the job role and sense of responsibility 2.Experiences of Barriers: feeling either positive or negative experiences 3.Challenges in care-coordinating: Negative and positive 4 Involvement in the discharge process: Experience of working as working as team and been involved in decision-making and planning. 5. Effective communication 6: Availability of resources 7: Experience of work 8: Negative experiences 9: Positive Experiences 10: Mixed experiences 11: Improving professional practice 12: Policies and procedures 13: Personal Wellbeing Throughout the research process, I organised the codes and categories using Atlas.ti software and later transferred them to an Excel spreadsheet for better management. Once I had generated the initial codes and sorted them into relevant categories, I proceeded to the next step of identifying and searching potential themes in the data. Trial is on Atlas.ti (Appendix 26)
Step 3 Searching for themes	At this step searched for themes from categories from excerpts and it was apparent for example that category “roles and responsibilities” was frequently mentioned and appeared to be valuable and needed to be connected to collaborative working The themes were developed from the categories and meaningfully interpret the interview excerpts. Noticing that the following initial themes. Duties and responsibilities, Experiences and Barriers, Challenges in care-coordinating, Involvement in the discharge process. I continued to search for themes and subthemes from the interview excerpts. **Categories Duties and responsibilities** Subthemes: Roles, Obligations and Decision-Making Interprofessional and collaborative working **Category: Experiences and Barriers**

	Subthemes: Fragmented communication Lack of resources Stigma and Discrimination Effective communication **Category: Challenges in care-coordinating** Subthemes: Personal Wellbeing Covid-19 Pandemic and Improving professional Practice **Category: Involvement in the discharge process** Subthemes: Policies and procedures Professional development In the fourth step of reflective thematic analysis, I reviewed the four main themes that emerged from the data. I kept a detailed record of analysis of findings using the Atlas.ti software to ensure accuracy and transparency in the process.
Step 4 Reviewing themes	In this step, I carefully examined the main themes and the smaller subthemes following a reflective analysis method by Braun and Clarke. Additionally, I took into account the feedback provided by my supervisors and reevaluated the themes. During this process, I reviewed the codes extracted from various parts of the interview transcripts, and some subthemes were either eliminated or merged together. Furthermore, I revisited each main theme to ensure that it had enough supporting evidence and that it aligned well with the common characteristics found in the subthemes. For example, experiences of collaborative working were reviewed to capture the experiences of care-coordinating hospital discharge. For example: collaborative working, and this became: ~~Overarching Theme: **"Experiences of collaborative working"**~~ **Theme 1: Collaborative Working** ~~Overarching Theme: Barriers and facilitators to care-coordinating hospital discharge experiences."~~ **"Theme 2 Barriers and Facilitators** ~~Overarching Theme: Personal and professional growth~~ **Theme3: Personal experience and professional growth** ~~Overarching Theme: Experiences of working under stringent organisational culture~~ "Theme **4: Organisational Systems and Culture** Eventually I realised that some subthemes were similar to overarching themes, and these were all collapsed to develop four themes defined in step 5.

Step 5 Defining and naming themes personal wellbeing continuous professional development and recommendations Covid-19 pandemic positive and negative personal experiences	In this step, I worked on defining the themes, I noticed that some of the main themes were related and shared similarities with the smaller subthemes. In this phase, I carefully chose specific examples from the data that best represented and supported the four main themes we identified. For example I remained the following four initial themes and subthemes: **Theme 1** labelled as "Experiences of collaborative working has been renamed to. **‘‘Experiences of Collaborative Working," Subthemes**: Roles, obligations, and decision-making, interprofessional and multidisciplinary working, involvement in the discharge process **Theme 2,** previously referred to as " Barriers and facilitators to care-coordinating patient hospital discharge," is now called **"Enablers and challenges of care coordination." Subthemes:** fragmented communication, lack of resources, stigma, and discrimination **Theme 3**, initially named as “Experiences of working under stringent organisational system and culture has been retitled to “**Experiences Organisational Systems and Culture," Subthemes**: Policies and procedures; team dynamics and leadership **Themes 4**, formerly denoted as "Personal and professional growth," have been changed to **"CMHWs’ Personal experiences of professional growth." Subthemes:** personal wellbeing continuous professional development and recommendations Covid-19 pandemic, positive and negative personal experiences After completing the previous steps, four main themes and subthemes that emerged from the findings. Following this, I proceeded to write a report in the sixth step, findings, and discussion the of the study.
Step 6 Producing a report	In this final step, in Chapter Six of this thesis of this I synthesised the four identified themes and connected with underpinning theoretical and conceptual framework, drawing on the extent literature reviewed in Chapter 2.

Adapted from Braun& Clarke, (2006;2024)

Appendix 21. Example of data extraction table from all participants illustrating interview excerpts, themes, and subthemes

Themes and subthemes developed from 14 Community Mental Health Workers Interviews							
			Themes on experiences of care-coordinating of patient hospital discharge				
Pseudonyms	**Codes**	**Categories**	**Experiences of Collaborative working**	**Enablers and challenges of care coordination**	**Experiences of organisational system and culture**	**Experiences of Personal and professional growth**	**Subthemes**
Bongani	Roles of community mental health workers Positive: Experience Negative: Experience Hospital discharge Home visits Planning Challenge Care Risk assessment and planning Medication Management Support	Duties and responsibilities Experiences and barriers Challenges in care-coordinating Involvement in the discharge process	My duties and responsibilities involve mainly risk assessment as well as managing risk as well as planning […] It is also involving a discussing with their nearest relative or their carers. In terms of treatment discussing with the consultant and other teams and if there's some things like medication review and other psychological	Probably it's obviously funding issues because if I am Minister of Health. I would say give the mental health teams more funding.	Yeah, and then when at a point whereby the patient is going to be this, gradually discharge, which means their consultant want them to go on Section 17, leave for a week, and let us monitor how things are going at home. I will do the home visit […] reporting back to the consultant and the attending the ward round on the discharge and then the person got discharged and then continue to monitor them until other services takes over.	No, it doesn't affect me emotionally. No, it is in terms like I say you go to work and help someone, and they are happy you feel good about yourself.	Roles, Obligations and Decision-making Interprofessional and collaborative working Effective Communication Fragmented Communication Resource availability and accessibility Stigma and Discrimination Policies and Procedures: Team dynamics and leadership

	Timing and planning Experience of work/Job Issue Importance of early discharge		treatment required.				Personal wellbeing Covid-19 Pandemic Continuous Professional Development
Richard	Integrated model 72 hours follow up Vulnerability and risk Diagnosis and treatment Shortage of Beds		Well, I guess from our point of view is that, you know, if we have had a referral through or we have gone to ward round, we have seen the patient in the ward where the risks are well managed, there is a bit of rapport, the treatment is still actually going on.	Let's go into management[...] I think it's got to be clear that this isn't, I am not pointing at any individual for example, it's more the model of care that's provided the structure of crisis management. But I think one of the biggest challenges, and I think it's a challenge that sometimes we share as practitioners as well.	Yes. I think one of the biggest, and I think it's something that we worry about, but it is referring them on to other services, sometimes we may, there may be some blurred lines with what the criteria is. Sometimes some services won't take patients until they are discharged from the crisis team. Sometimes there might be a bit of a wait, for example, if we were to refer them on, particularly in our Trust, to Healthy Minds, I think there might be a bit of a waiting list.	Yes, on the shared caseload, I think when we share the caseload, I think from a practitioner's point of view, I mean my first response is it does take I think a little bit of the pressure off to essentially work them through. I think there are some practitioners however who could quite happily work with the same patient, you know, for the whole entire four weeks. But then saying that I think sometimes we do work with patients who benefit from seeing different people or having that opportunity to meet different staff who they have different rapports with.	

Mary			Yes, I think it's - My responsibilities are about ensuring patients are safe that they are treated well with the right kind of treatment	I think some of the barriers I suppose can be communication and it can be poor communication sometimes from other services so for example you could get a discharge from a ward and it could be quite - It could feel quite rushed so you might find that there's information missing or risk assessments	Yes, I think care for staff is - Really needs improving. I think you know everybody has mental health not just our patience we all have it, and we all have to be aware of it so I think it would be beneficial for there to be more things available for staff	I definitely think psychologically there is challenges, it does impact you know your own mental health sometimes because it can feel a lot of pressure and a lot of responsibility this role
John			So, as a mental health community worker well, I manage a crisis team	The biggest, most obvious barrier which to be fair since the trust has gone onto Paris [...] has reduced somewhat. But that is communication you know, information from when that patient was on the ward.	We then have referrals for patients who are discharged from hospital and who require a one-off follow-up within 72 hours as per the kind of trust guidelines.	So, I registered as a nurse for the first time 10 years ago. I've spent approximately four of those years working in inpatient units, four to five years in inpatient units. Either as a band six charge nurse or when I started as a band five nurse. I then spent nearly two years working in a liaison team at an A&E department and also covering medical wards.
Julie			You know, uh, I'd be able to email some of the consultants about	So the other challenges include, I suppose. Not having enough training in	Uhm? Some of the barriers is that because of the acute nature of the setting. As an	So I was on the acute wards for years, and then the community. But is it very, very different experience and it's

		medication, but I would probably need a bit more clarification on the medicine side of things.	specialist areas, so because I'm not nurse, I'd often have to go back to my work colleagues and ask about medication clarify.	occupational therapist, you're not able to do a big piece of work with that patient, so you have to be quite succinct with your treatment plans.	very new to me. So I'm not I'm not used to the risk element of seeing people in their own homes on my own.
Rose		Yes, my duties are to act as care coordinator to a designated number of people. My caseload now stands at 46 people. I will review their care packages, I will monitor their mental health, I'll liaise with different agencies. I, gosh where do you start, look after people's 117 after care eligibility. I ensure that their care is adequately funded [...]	The challenges are getting services in place quickly enough to support that patient. In my area particularly it's finding things like supported accommodation. That is extremely hard. Also as well another challenge sometimes is if there are safeguarding concerns in the community[...]	Yes that, that is to ensure somebody's, as I understand it to make sure, they've been seen within a set amount of time after discharge. There's seven days and there's 72 hours. This lady was under a 72-hour follow-up, so we had to go and actually speak, see her, and speak to her within 72 hours of her discharge.	I've been an RMN since 2005, I've worked in the community since 2019,

Kate		my involvement is attending ward rounds to develop a plan with the patient and the ward team, attending zoning at the Early Intervention Team to update the multidisciplinary team and put plan, establish different plans, and then act on them and then update the team and then it might be helping the patient with practical things when they're an inpatient.	My experience of the barriers to, to discharge for patients tends to be practical problems which can take a very long time to sort out and rectify. My experiences have been things like working with patients who are of no fixed abode and then having to organise appropriate accommodation for them and when people need an increase in care on discharge and having to sort that out and putting it in place can take a long time.	Yes, I think so. That was ward rounds, practical support for the patient and zoning and then increased monitoring post-discharge and the 72 hours follow-up.	So that could be getting bits from home, clothes, money, bank cards. It could be going home to get post, I've done all kinds of stuff and also then their 72 hour follow-up which needs to be done when they're discharged and then just increased monitoring post-discharge from hospital to make sure their mental health is okay and they're safe and the medication is okay because often changes take place in hospital and the changes that would help in the, in the community would really be better resources in terms of mental health intervention.
Ruth		Yes so, I'm the Team Manager of the CMHT. So I manage a team of social workers, CPNs and Support Workers. We cover a locality area that has about 400 patients open to us	I think the biggest barrier is the lack of inpatient beds which means that patients can get discharged in our opinion too soon and we have a number of examples of patients who would have benefited from a longer admission and even with the support of the Home	Yes. I guess alongside vacancy and recruitment problems it culminates in additional workload for community staff and you know a lot of our work is obviously around preventing admission but there are patients, a number of patients who don't go into hospital and	Yes. I don't think there's anything else. I do think one recommendation would be and this is somebody who's been working in Y as a mental health nurse for many, many years is a day hospital facility which they have for older adults and I think you know [...], that used to be very, very effective at preventing discharges because people actually could go there for five hours you know be

		and about 20 people in assessment. So I personally have a caseload of two, but I attend daily meetings in the team so have an overview of admissions and discharges which get discussed in a weekly zoning meeting as well.	Treatment Team deteriorate because the monitoring on the Home Treatment Team can't really replace you know hourly observations on a ward even if you know you were visited twice a day.	should be having more regular planned interventions [...] Yes and I think the pandemic has probably the pressure has been for us was when other services weren't doing face-to-face appointments.	observed, have access to a doctor and it's basically a hospital, therapies, one to one's and that's far, you know far longer isn't it than somebody from the Home Treatment Team going for an hour so that would be my wish list just based on experience.
Naresh		which covers X and Y area so, any patients in that geographical area come under my care. I look after patients in the community and have regular outpatient appointments with them. And if any of my patients have to be admitted onto the wards either on A Ward or B ward then I'm responsible	At times it is difficult because at times the care coordinators are busy because they are, like everybody else, very much overworked so, they cannot attend ward rounds., So, they are not in the picture of what's happening or how the patient is presenting. So, there is at times that seamless communication between us and the community team is lacking.	When people are admitted obviously, we first have to triage [...] that patient, formulate a diagnosis. [...] So yes once the patient starts improving and then we start looking into discharging patients and planning for discharge. And to be honest, the planning for discharge ideally starts from the day they are admitted.	Personally, I think the discharge process is fairly straightforward and quite robust and I don't see any. Yes, and unlike some other trusts, we don't face that much pressure from the management side to just discharge patients so, we have the time on our side. Yes, we should be discharging people as soon as possible because it is in their best interest as well. But not, it should not be an unsafe discharge just for the sake of it.

			for them in the inpatient settings as well.			
Ola			Okay. So being a care coordinator basically is the process of helping a person with mental health illness just for them to be able to access different services in a way that will help them to get better and that's part of their recovery as well. [...] Also you will be like the, the link person. So you'll do the interaction between the clinicians and the other care professionals [...]with the family and the other significant persons	Shortage of staff, shortage of staff so this is huge at the moment. Yes, Covid has done its own thing. People are really, really, really, really not you know like they burn out I would say. So people are leaving, people that have been, have retired they planning to come back but it's not as easy as before. Caseload is growing. It's really, really huge. Sometimes you see that you can't even remember how many people you've got on your caseload [...], I will say they find that the NHS team I know yes they're trying to do new things by creating maybe new services and [...]	Most of the services has been shut down and Government is now looking into reopening it. So that as well is lack of resources for them. We can't even refer them to places that can help them in their recovery process	We are left, we are left behind. People don't see how much you know like we carry in our head because sometimes you know people with mental health will pour their heart to you and you still carry what they've said, oh leave it at the door when you leave work, well no we don't normally leave it at the door, we still carry it with us

			in their life just to be sure that they are providing the right services for them and also my role and responsibilities is to improve the health and functioning of the people with mental health.	people are moving from one team to another so which is making the other team to be shortage in the staff.		
Susan			So at X we cover inpatients, outpatients, we cover Home Treatment Team. If there's no ward liaison consultant, we cover those. So basically the job is spread across the entire patient journey at X and its sort of treating patients with mental disorder, managing them in hospital and obviously discharge planning, getting them out into the	So I think a lot of the challenges you know can be about actual details. So things like if you're trying to get a patient on a Community Treatment Order and they are then on Section 17 leave in the community until that Treatment Order is in place, just trying to get the medication organised for that patient is really difficult because the GP won't pick up the prescribing until the patient is discharged [...]. There's no system for transport for the patient.	I think the two things I would say is to change the way the process for you know identifying the patient needs and finding the accommodation [...] So I think looking at making the discharge pathway for patients with complex needs more efficient would you know be better for patients and solve some of the bed crisis.	Well I think I mean some patients are fairly straightforward but for some patients discharge planning needs to be done quite carefully and you know you've got to get the process right or the patient will just bounce back into hospital. So it's kind of making sure that you have right support for the patient in that discharge process you know with Home Treatment Team and trying to get the care coordinators to in-reach in the hospital ideally you know so that there's good communication and things are smooth.

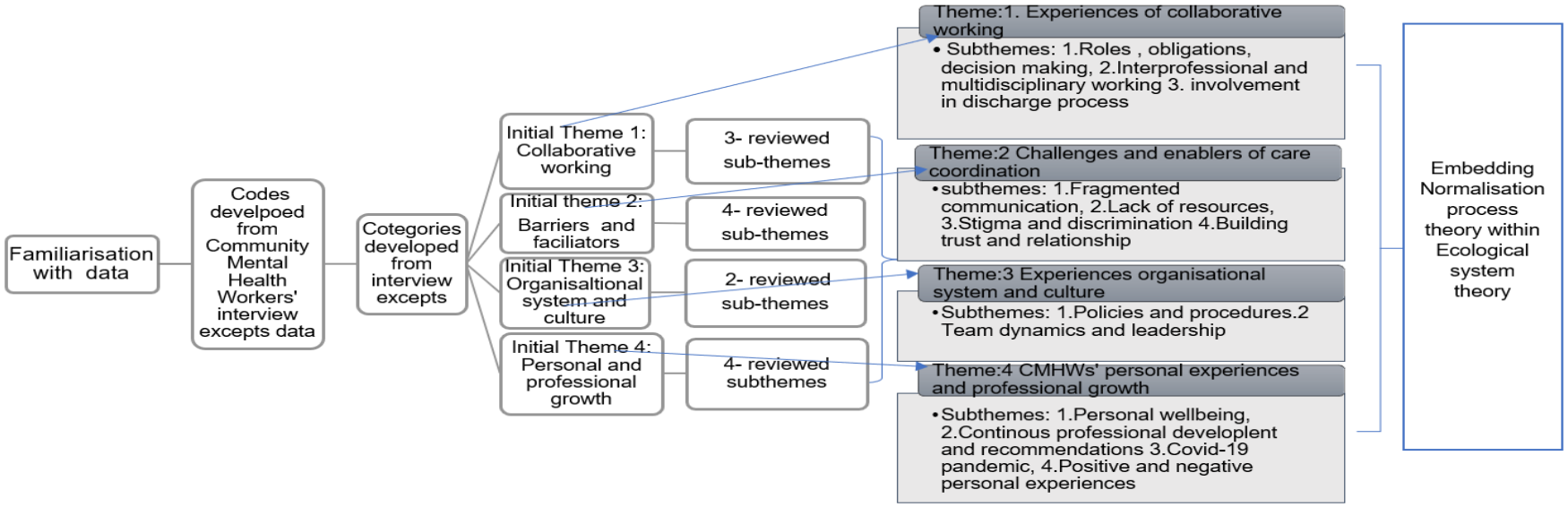
		community and looking after them in the community.				
Jessica		I will tend to try and have clinic more-so for diagnostic. People who are diagnostic queries, such as, have they got a severe mental illness? Have they got bipolar, or have they got EUPD or whatever, so some sort of diagnostic query [...] I will still give advice, and I will still advise about medications. I will give advice. They are still under secondary care, but I will not routinely see them in clinic. I don't know if that is particularly helpful for the patient.	It is something about communication between the ward and the outpatients. So the ward, if they are not care coordinated, the communication within the ward and Home Treatment Team usually goes pretty well. I think that tends to work quite well, but sometimes the ward then communicating with the, letting the care coordinator know that the patient has been discharged can go less well [...]	Well, if they are just pure autism or pure eating disorder, they shouldn't be under our care. We are not commissioned for them. But I do see people, so there is an autism team who do a diagnosis, but they don't then do much else. They are only two people or something, tiny, and they will sign post people, and there is an LD team but they only do moderate to severe LD and they do different things, but if someone has got dual diagnosis, that is a different matter. We will manage them.	Challenges. I don't know if I see anything as a challenge, really [laughs]. Challenges? I don't know about the word, challenge. I find the word, challenge, really- I don't find anything a personal challenge. Work is work. You have work to do. I don't find there is any particular personal challenge.	

Hannah			If it runs correctly, we'd be invited by the ward to become involved with a patient a couple of weeks before they were discharged [...] So we'd then work with the patient and when they came closer to discharge we'd then engage with the ward about medication. We'd make sure we knew what chemist they had, we'd make sure we knew did they have a key to get home, could they access their money, did they have food? We'd make, we'd support the patient especially if they didn't have family to have the home environment ready for home[...] And	Right, one of the biggest challenges is over the past 13 years, no 14 years I've been working in this job, is the loss of services. Housing Benefits, everything you used to be able to get and now you can't. So examples could be Housing whereas previously within my role I've been able to ring Housing and on the basis of me advocating for a client I've been able to get them re-housed from extremely inappropriate housing [...] Our clients are the same as every other client and they can be waiting years for re-housing. Clients, a lot of clients are losing their benefits[...]	With care packages, social services do care packages. If a client has established care needs, they go straight to a care package, and the care packages tend to again be a lot more restrictive than they used to be […]	We get supervision but we're supervised from the people who are higher who know exactly what's going on and yet have got to make the service work. So our managers know that we need more staff but they've clearly not got the money for it. Our managers know that services aren't working right but they're very interested in saying we'll make it work anyway and sometimes I just feel like I'm being a troublemaker by keeping on saying to my boss, "This isn't right, this isn't right, this isn't right." It feels like I should just shut up and make it work which is hard to do.	

			then upon discharge, if need be, we'd escort the				
Rudo			But above all involving the community staff, also thinking about the GP [...]And then the people, the community pharmacy then probably needs another 48 hrs to dispense the medication. So that information needs to be quite rapid. So that's what I would say really[...]	They have relapsed because they haven't been taking their medication. And the GP hasn't been aware that the patient had been in hospital and been discharged, because the information was also not communicated to the GP.	Yes, so again I think the other factor is, within X Care we don't have our own dispensaries, so we work on what we call a service level agreement. So, we are relying on the dispensing being done by an external Trust here at X General Hospital. So again, some of the barriers are, as much as I try to do my best to facilitate, it's more the discharge process. When it gets to pharmacy, the hospital pharmacy, staffing issues, at the moment we've been having shortages of pharmacy staff. So that can then also cause a bit	Yes. So I do have regular supervision with my line manager. So, I think it tends to probably be once every 8 weeks. And we also have regular team meeting because the nature of how we assess our plan, in X Care, with our five boroughs, the things that might happen in X might not necessarily be the things that are happening in Bury, down the road. So sometimes I do like to sense-check with my team members who are working in other boroughs, that are they encountering the same problems? Are they having the same feelings that I will be feeling?	

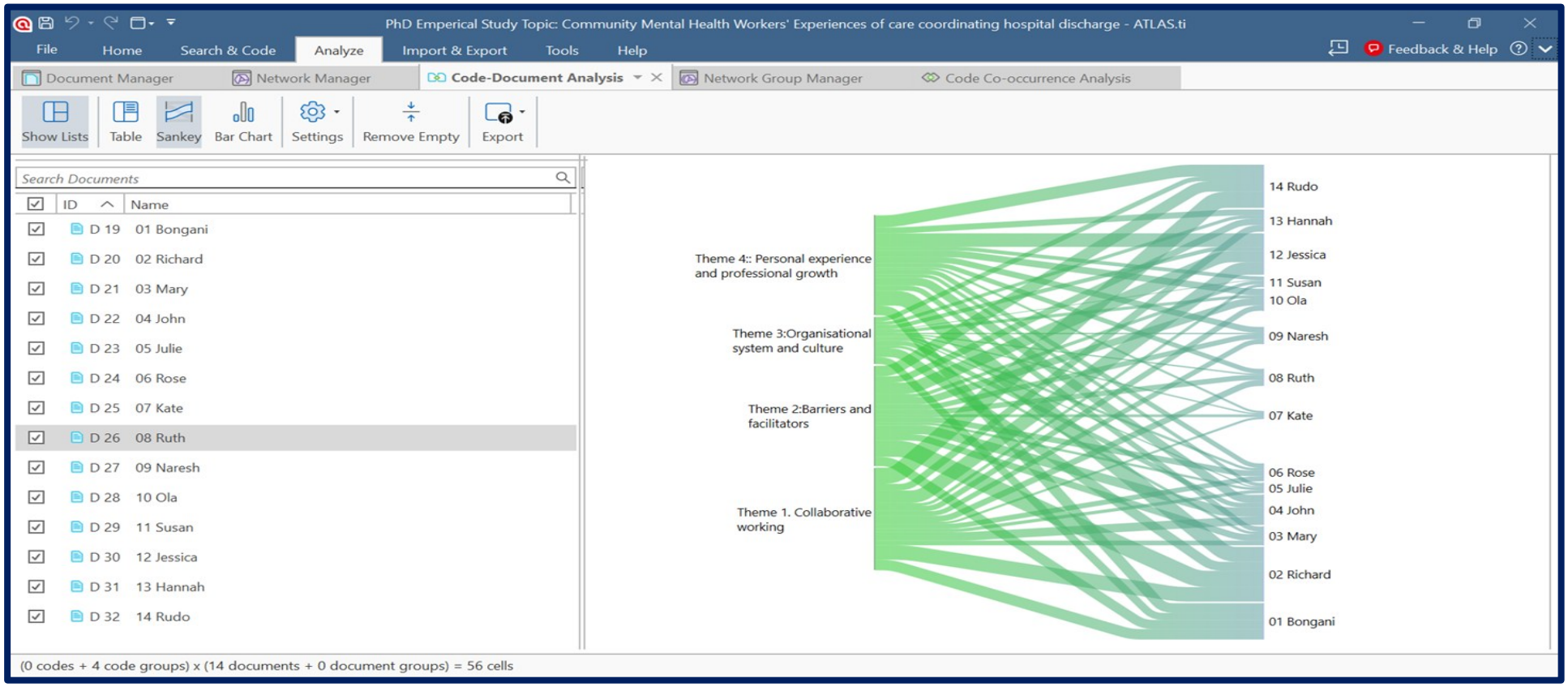
					of a delay in how the process is expedited [...]		

Appendix 22. Thematic map illustrating the process followed to develop codes, categories, 4 themes, and subthemes leading to embedding conceptual and theoretical framework.



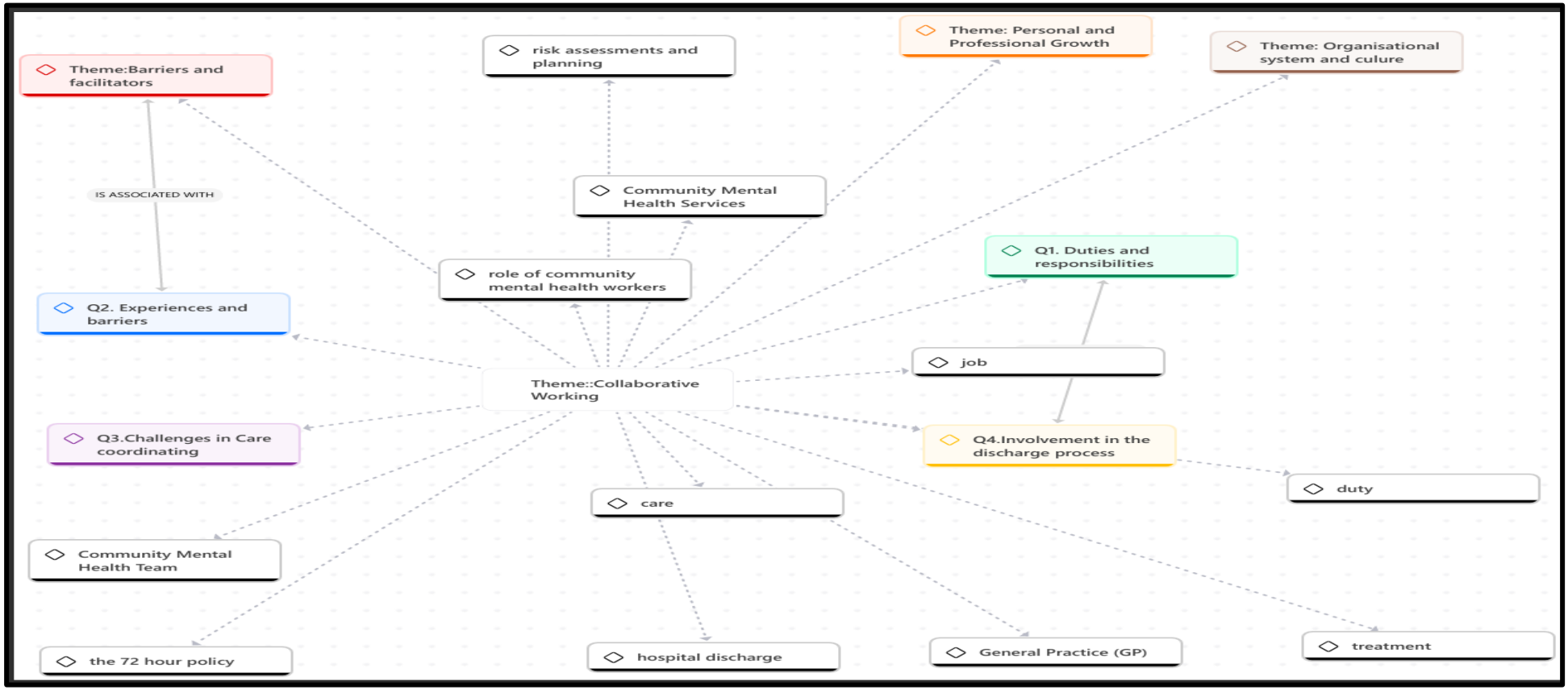
Adapted and modified from Saldana (2021p 115) NB: Upon reviewing the subthemes, it became evident that there existed a repetition of subthemes, which subsequently led to their consolidation into four themes.

Appendix 23. Example of Sankey Diagram developed using software illustrating the relationship of themes and distribution analysis of CMHWs' experiences



NB: Narrower lines represent fewer connections or relationships between codes or themes, while wider lines indicate stronger or more frequent connections

Appendix 24. Example of thematic map visualising empirical findings using thematic map to answer the research question with networks to develop a story across CMHWs' experiences of care coordinating patient hospital discharge.



Appendix 25. Poster presented at International Nursing Research Conference

Health & Medicine | Lancaster University

Experiences of community mental health workers in care coordinating hospital discharge of patients with a diagnosis of mental illness into community mental health integrated services in the Northwest of England

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Introduction

The role of community mental health workers (CMHWs) in the safe discharge of patients with a diagnosis of mental illness from hospital is increasingly important globally and there is a shift towards community-based mental health care (WHO,2022). Both previous and current studies have shown that there is a paucity of qualitative studies exploring the experiences of community mental health workers (BMA,2023).

Aim

The aim of this study was to explore the experiences of community mental health workers during the care coordination of patients with a mental health diagnoses when discharged from hospital into community mental health integrated services (CMHISs).

Methodology and study design

This qualitative methodology study employed a constructivist inquiry approach

Method

14 Community mental workers aged 18-65 years were recruited using purposive sampling from community mental health teams in one National Health Service (NHS) Foundation Partnership Trust in the Northwest of England . This method is aligned to the study's data collection and analysis procedure as illustrated in Figures 1 and 2.

Figure 1

Data Analysis

Figure 2

Study Findings

The findings of this study based on reflective thematic analysis revealed the following four key themes developed as illustrated in figure 2 :

- Collaborative Working,
- Barriers and Facilitators,
- Organisational System and Culture
- Personal Experience and Professional Growth.

Discussion

This study's findings on experiences of CMHWs in coordinating patient hospital discharge are intricately tied to their working environment highlighting barriers and facilitators that have become normalised as illustrated in Figure 3. These challenges persist within CMHTs and need addressing. This study's findings highlight persistent challenges in coordinating patient hospital discharge for individuals with mental illness within CMHISs, aligning with existing evidence, theory, and policies in this area. Despite the recognition of the importance of CMHWs' role in care coordination of patient discharge process continue to experience many challenges.

Figure 3

Implications

- These findings have several important and practical implications for clinical practice, policy, and education in community mental health.
- First, clinically, CMHWs' experiences highlight the need for developing and refining referral pathways for long-term monitoring to prevent relapse and readmission of patients with mental health conditions.
- Second, policy-wise, it underscores the necessity for integrating these pathways into standard care protocols, promoting a more cohesive and efficient care coordination of the patient discharge process.
- Thirdly, educationally, the study suggests incorporating these insights into training programs to better prepare CMHWs healthcare for effective care coordination and patient hospital discharge processes.
- There is a need for targeted interventions and policy development supporting seamless care coordination of patient hospital discharge to prepare CMHWs effectively.

Future Directions

- Future research is needed to compare considerable number of participants exploring CMHWs, patients and their care givers' experiences across wide and different geographical areas to further enrich our understanding and transferability of findings to various contexts.
- Future research should explore experiences that may affect CMHWs' from ethnic minority background in care coordinating patient hospital discharge.

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Braun, V., & Clarke, V. (2006). *Using thematic analysis in psychology*. Qualitative research in psychology, 3(2), 77-101.

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