Compassionate Care in a Crisis Resolution and Home Treatment Setting: A Thematic Analysis

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ABSTRACT

Background

Compassion has been positioned as an integral element of healthcare delivery (Care Quality Commission, 2011) and service users have highlighted the need for increased compassion in crisis resolution and home treatment team (CRT) settings. Despite this, it remains unclear how the term ‘compassionate care’ is understood by CRT stakeholders, and how it can be consistently actualised at individual and service levels.

Aims

This study aims to elucidate CRT staff conceptualisations of compassionate care, as well as the perceived barriers to, and facilitators of compassionate care within a CRT setting.

Methodology

This qualitative study used individual, semi-structured interviews to explore staff conceptualisations of compassionate crisis care, and the facilitators and barriers to this in a crisis team setting. Twelve CRT staff members took part in the study. The resultant data were analysed using reflexive thematic analysis.

Results

Four main themes and several related subthemes were generated from the study data. The main themes were: Going the Extra Mile; The Operation of Social Power; Centrality of Team Processes; and The Balancing Act.

Conclusions

The findings provide an insight into CRT staff members’ understanding and experience of compassionate care in crisis teams. Compassionate crisis care was characterised as involving an ethos of ‘going the extra mile’ in various ways, such as through efforts at creating consistency in CRT care. The findings also highlight the importance of attending to compassionate crisis care as a complex, relational phenomenon, involving dynamics of social power. Further, processes within the team, and the tension caused by several dilemmas, such as the risk of perpetuating CRT dependence, were highlighted as central to

understanding the generation and sustenance of compassionate crisis care. Overall, participants highlighted the need to understand and facilitate compassionate crisis care provision from organisational, service and policy levels, as well as at individual and relational levels.

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1. INTRODUCTION

1.1. Overview

In recent years, compassion has been positioned as a key concern in healthcare delivery (Care Quality Commission, 2011; Martinsen, 2006; Shields & Wilkins, 2006). However, it remains unclear how the term ‘compassionate care’ is understood by stakeholders, or how it can be consistently actualised at individual and service levels (Dewar et al., 2014).

This chapter provides an overview of the policy context and existing definitions of compassion. A critical analysis of the literature will highlight the need to explore unique conceptualisations of compassionate care across settings, and research around barriers to and facilitators of compassionate care will be explored to highlight the complex challenges of generating and sustaining compassionate care within healthcare contexts.

The chapter will conclude with an outline of the crisis resolution and home treatment team setting, the key relevance of compassionate care in this setting, and a summary of the study aims and research questions.

1.2. Definitions of Compassion

The word “compassion” stems from the Latin “compati”, meaning “to suffer with” (Strauss et al., 2016). Sinclair et al. (2018, pp. 2) offer a definition of compassion as “a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action”, whilst Lazarus (1991, pp. 289) defines compassion as “being moved by another’s suffering and wanting to help”.

Early religious conceptions (e.g. Dalai Lama, 1995) regard compassion as a sensitivity to suffering and a commitment to relieving it through action.

Expanding upon these ideas, Kanov et al. (2004) conceptualise compassion as consisting of three distinct, related sequelae: noticing, feeling, and responding. They describe ‘noticing’ as involving a cognitive, physical, or affective reaction to suffering. ‘Feeling’ is described as entailing an emotional response to the noticed suffering, generated through adopting the person’s perspective and imagining how they may be feeling. The third and final element, ‘responding’, involves desire to take action to assuage the other person’s suffering. Within this conceptualisation, affective, behavioural, and cognitive elements are highlighted as central to the definition of compassion (Kanov et al., 2004). Similarly, Gu et al. (2017) describe compassion as comprising five features: empathy; awareness of the ubiquity of suffering; being emotionally moved by another’s suffering; managing the difficult feelings aroused by this engagement; and experiencing a motivation to alleviate the other’s suffering. An evolutionary analysis and empirical review of compassion conducted by Goetz et al. (2010) concluded that compassion can be defined as attunement to undeserved suffering, associated with distinct signaling behaviours related to caregiving patterns around posture, touch and vocalisation, and a phenomenological and physiological experience that orients a person towards a social approach. Condon and Feldman-Barrett (2013) critique dominant conceptualisations of compassion as overly simplistic, and erroneously centred around positive/ pleasant affect. They describe compassion as a sometimes-distressing experience requiring a heightened sensitivity to the suffering of the self and others. Indeed, Roach (2007) posits that true compassion requires one to immerse oneself in the pain, brokenness, anguish, and fear of another, even when that other is a stranger to them.

Whilst Gilbert (2009) underlines that compassion should be regarded as a complex, multifaceted social and psychological process, dominant definitions have been critiqued as idealising compassion relations (Nolan et al., 2004). Simpson et al. (2014) argue that prevailing definitions centre around individualised perspectives, obscuring the relational nature of compassion and overlooking the nuances of power in compassion relations.

In the following subsections, distinctions between compassion and related constructs will be explored, with a view to contextualising the need to define compassion, and a prominent model of compassion within mental healthcare in the United Kingdom (UK), Compassionate Mind Theory (Gilbert, 2005) will be presented.

1.2.1. Distinctions Between Compassion and Related Constructs

The need to distinguish compassion from related constructs has been underlined by researchers, who note frequent conflation of compassion with related terms such as sympathy, empathy, kindness, dignity, and warmth (Sinclair et al., 2017; McMahon & White, 2017). Indeed, Dewar et al. (2014) and Soto-Rubio and Sinclair (2018) argue that the abundance of related terms and the overlap between descriptions of related constructs cause confusion for healthcare professionals (HCPs). They highlight the resultant need to distinguish compassion from related constructs to clarify its application within healthcare settings.

Cole-King and Gilbert (2011) describe compassion as distinct from other comparable constructs such as warmth, kindness, and gentleness. They state that while these factors may be present in a compassionate approach, compassion itself is distinct, in that it requires not only a sensitivity to suffering, but also the commitment, courage and wisdom required to address and alleviate it.

Exploring distinctions from a patient perspective, Sinclair et al. (2017) examined conceptualisations of and preferences between compassion, sympathy, and empathy amongst palliative care patients. Patients described the three terms as distinct, with sympathy constructed as a pity-based, unwanted response to distress. This was placed in contrast to empathy, which was constructed by patients as an attempt to acknowledge and understand another person’s suffering. Favoured by patients, compassion was described as involving facets of empathy, but also involving additional, resultant actions motivated by altruism and love, and small, supererogatory acts of kindness (Sinclair et al., 2017).

1.2.2. Compassionate Mind Theory

One prominent attempt at defining and operationalising compassion has been offered by Gilbert (2009) through Compassionate Mind Theory (CMT).

In contrast with many existing definitions which describe compassion as an emotion or motivation, CMT defines compassion as complex combination of attributes, qualities and learned skills (Cole-King & Gilbert, 2011).

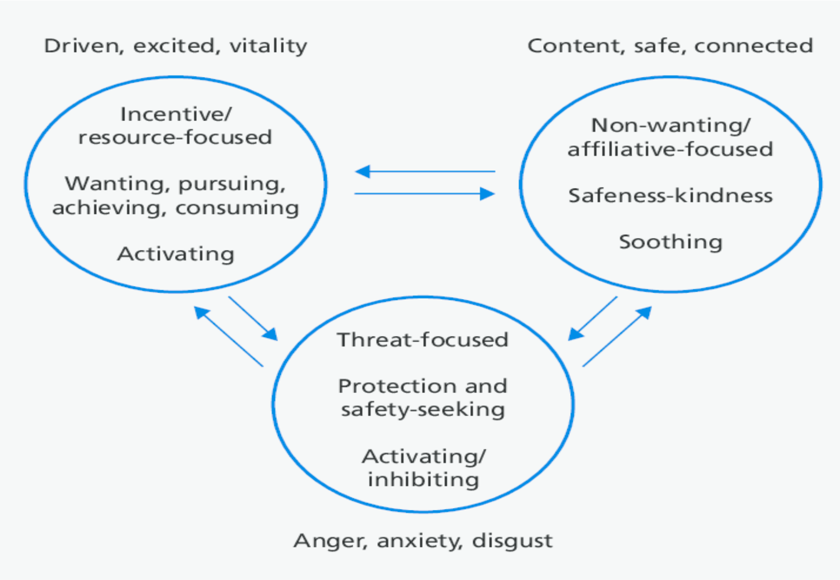
CMT provides an evolutionary perspective on human suffering, underlining it as the inevitable outcome of human brain development from basic mammalian responses to more complex, reflective, and self-monitoring functions. It discusses the resultant need for compassion for the self and others, as a means of addressing and managing this ubiquitous suffering (Gilbert, 2010).

Gilbert et al. (2011) underline the need for compassionate care, particularly in mental health settings, where service users may have experienced a great deal of suffering and societal stigma. CMT has been applied at both individual and service levels, and focuses on the generation of compassion, which is then theorised to flow from the self to others and from others (Gilbert, 2020).

CMT posits that emotional regulation systems, the “drive, threat and soothe” systems, can be seen to operate at both the individual and systems levels (Figure 1; Gilbert, 2005). A person or system operating under the threat system, without access to sufficient soothing activities, will experience greater unaddressed suffering and dysfunction. Further, a disproportionate tendency towards threat activation is hypothesised, owing to the evolutionary benefit of threat detection for survival. In order to balance this, Gilbert (2005) describes the need to foster the ‘soothe’ system at a service level, to enable and sustain compassionate care.

Figure 1

Emotional Regulation Systems



As a theory, CMT has been presented as useful in both conceptualising compassion and contextualising the operation of barriers to and facilitators of compassionate care at a systems level, with barriers often linked to the ‘threat’ system response, and facilitators linked to the operation of the ‘soothe’ and ‘drive’ systems (Gilbert, 2005). This theory has been utilised in the current study to support interview proforma design.

1.3. Background and Policy Context

Compassion has been positioned as central to human interactions across many contexts, including within religious traditions, the justice system, education, and medical codes of conduct. Indeed, compassion is highlighted as one of the six core values outlined within the National Health Service (NHS) constitution (Department of Health; 2013). Several reports and implemented strategies specifically focus on the delivery and measurement of compassionate care within the NHS (Royal College of Psychiatrists, 2015; Department of Health, 2016; West et al., 2017). These include the Compassion in Practice Strategy (Department of Health, 2012), focused on improving ‘compassionate leadership’ within the NHS, and on evidencing the impact of such improvements in terms of compassionate care at the clinical level.

This increased focus on compassion in the NHS has been driven, in part, by high profile reports highlighting serious failings in the delivery of compassionate care within some care homes and hospitals (Ballatt & Campling 2011; Francis Report, 2013; Bubb, 2014). These reports expose a ‘culture of fear’, implicated in triggering institutional failures (Francis, 2010; 2013), and cite an emphasis on quantitative targets as reducing compassionate focus in approaches to service provision (NHS England, 2014). Indeed, compassionate care researchers have argued that an increased emphasis on efficiency, through the introduction of target-based outcome monitoring, has led to caring values being compromised within the NHS (Fotaki, 2015; Pollock, 2005).

Despite the recent emphasis on compassionate care at a policy level, a lack of coherence has been noted in approaches to its clinical implementation (O’Driscoll et al., 2018). According to O’Driscoll et al. (2018), this resulting incoherence causes frustration for clinicians, tasked with the provision of ‘compassionate care’, whilst receiving little or no instruction in its implementation in practice. Indeed, the Compassion in Practice Strategy (Department of Health, 2012) has been critiqued as abstract and lacking in a clear vision on the sustainable delivery of compassionate practice (Dewar &

Christley, 2013). Pedersen and Obling (2019) argue that demands from healthcare leadership for compassion as a meta-virtue across services are unhelpful, and that they fail to provide tangible and tailored descriptions of what setting-specific compassionate care should look like in terms of specific tasks, behaviours, and skills across various settings.

1.4. Compassionate Care in Health Settings

Compassion has been described as “one of the most referenced yet poorly understood elements of quality care” (Sinclair et al., 2016, pp.194). Spandler and Stickley (2011) argue that whilst current policy is replete with demands for compassionate care across various physical and mental healthcare settings, there is a dearth of understanding regarding how these policies are to be realised across settings. Indeed, Strauss et al. (2016) cite a lack of consensus regarding the definition of compassion within healthcare. They, and others, have underlined the importance of establishing an agreed definition and adequate measurement, to promote a coherent understanding of the meaning and, consequently, the operationalisation of compassion in healthcare (Dewar, 2011; Durkin et al., 2018; Strauss et al., 2016).
The following sections will provide context regarding the perceived importance of compassionate care in physical and mental health settings.

1.4.1. Importance of Compassionate Care in Physical Health Settings

Despite identified challenges in the definition and measurement of compassionate care, its importance to service users and carers as a feature of physical healthcare settings has been demonstrated consistently across surveys (Attree, 2001; Lori et al., 2011) and empirical studies (Burroughs et al., 1999). Further, empirical research, based on prominent definitions of compassionate care as involving a virtuous response to suffering, has shown the benefits of compassionate care for patients in terms of a range of factors, including health outcomes (Maria-Napoles et al., 2009; Van der Cingel, 2014), health-related responsibility and control (Tehranineshat, 2018), quality of life (Kwan et al., 2013), physical healing (Post, 2011), anxiety levels (Fogarty et al., 1999), self-care (Arman & Hök, 2016), and adherence to suggested interventions (Hamilton, 2010).

Calong Calong and Soriano (2018) found that service users' ratings of perceived compassionate care were highly correlated with care satisfaction, indicating that compassionate care is seen by service users as more effective. Similarly, Lown et al. (2011) found that 85% of patients in a hospital setting believed compassionate care to be integral to positive health outcomes. Further, from a staff perspective, compassionate care has been identified as improving wellbeing (Post, 2011) and facilitating rapport-building with both colleagues and patients, enabling more effective interventions (Fry et al., 2013). Moreover, physical healthcare environments that were perceived by stakeholders as compassionate were also found to be associated with reduced complaints from service users and staff, and more adaptive team interactions (Post, 2011).

1.4.2. Importance of Compassionate Care in Mental Health Settings

Compassionate care has been positioned as a service priority in mental health settings, and particularly in acute mental health services, due to issues noted around standards of care across various reports (Department of Health, 2002; Goldberg, 1998; Muijen, 2002; Rethink, 2004).

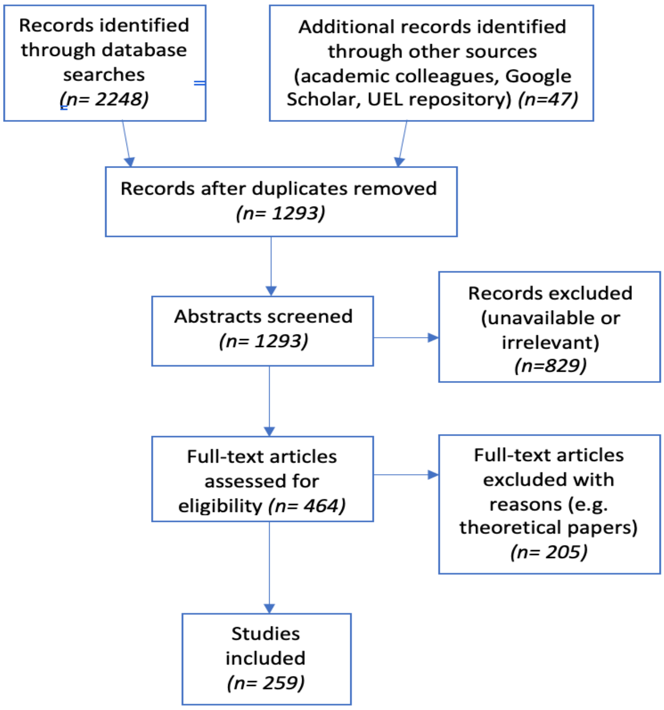
Aligning with findings from physical health services, compassion is one of the most regularly stated characteristics which service users report as important in mental health services (Clayton, 2013; Farrelly et al., 2014), citing this as a core feature of effective mental health care. This assertion has been substantiated through empirical research which has shown the benefits of compassionate care, as perceived and rated by service users, in terms of a variety of factors, including emotional wellbeing (Blomberg et al., 2016), healing from trauma (Strudwick et al, 2019), trust between service users and staff (Brodwin, 2013), engagement (Lloyd & Carson, 2011), physical wellbeing, and adherence to treatment (Hamilton, 2010). Moreover, Spandler and Stickley (2011) outlined that research evidence indicates a positive relationship between compassionate care and recovery from mental health difficulties. Indeed, Green et al. (2008) found that compassionate, trusting relationships between clinicians and service users with diagnoses of enduring mental health difficulties can enhance measures of both recovery and quality of life.

1.5. Literature Review

A thorough review of the literature was undertaken using systematic approaches, as recommended by Booth et al. (2016). The review was conducted to identify existing literature examining healthcare stakeholders' conceptualisations of compassionate care, and barriers to and facilitators of compassionate care across healthcare settings. The search terms used are listed in Appendix A, and were applied to searches of CINAHL Plus, PsycINFO, Scopus, and Academic Search Complete databases. References cited within relevant articles were reviewed to identify any further relevant publications missed during initial literature searches. As the compassionate care agenda has become particularly prominent in recent years (Department of Health, 2015), and crisis resolution and home treatment teams were founded within the NHS in 2000, searches of grey literature were also carried out for the period of 2000-2021. The search was restricted to publications written in English, owing to a lack of translation resources. The review results are presented in Figure 2.

Figure 2

Flowchart representing the results of the literature review



1.6. Research on Conceptualisations of Compassionate Care

Addressing the failure of policy documents to sufficiently conceptualise and operationalise compassionate care (Tierney et al., 2018), qualitative research across settings and stakeholder groups has contributed to our understanding of how compassionate care can be enacted across physical and mental health settings (Pauley & McPherson, 2010; Sinclair et al., 2018).

Following the literature review, identified studies were organised into the following categories: service user conceptualisations, collective conceptualisations, and staff conceptualisations.

1.6.1. Service User Conceptualisations of Compassionate Care

Sinclair et al. (2016) conducted a scoping review of the healthcare literature, noting a dearth of studies representing patient and carer voices in compassion research. Indeed, Bradshaw (2013) argued that service users' voices are often either absent, or censored, advertently or inadvertently, within research papers, resulting in a form of testimonial injustice (Fricker, 2007).

The following sections will present research representing patient, family, and carer conceptualisations of compassionate care in physical, followed by mental healthcare settings, to highlight the paucity of literature within mental healthcare settings.

1.6.1.1. In Physical Healthcare Settings: Bramley and Matiti (2014) explored service user conceptualisations of compassionate care in a hospital setting and found that participants viewed person-centred, tailored, individualised care as conveying compassion. Straughair et al. (2019) found that recipients of physical nursing care described being humanised by staff as a core component of a compassionate approach. Participants identified these humanising experiences of compassionate care taking varying forms depending on the setting and context, while having the same result of creating a sense of connection between staff and service users.

Halldorsdottir (2012) proposed a theory based on patients' perceptions of physical nursing care, which presented compassionate care as comprising competence, wisdom, attentiveness, empowering communication, and connection between nurse and patient. Similarly, Dewar and Nolan (2013) found that patients in an older people's care setting described compassionate care as involving appreciative, caring conversations, which enabled collaboration between staff and patients, and shaped the way that care was provided.

Sinclair et al. (2016) compiled the first empirically derived clinical model of compassionate care in health settings, using data from 53 semi-structured interviews with people receiving care in a palliative cancer service. They found that service users experienced compassionate care as grounded in a virtuous response that seeks to address suffering and the needs of a person, through a process of understanding and resultant action. Aligning with this model, Kret (2011) found that attentiveness and caring were core aspects of compassionate care from the perspective of surgical patients, and Schneider et al. (2015) found that service users presenting with complex regional pain regarded listening, believing, and taking the time to educate oneself about the condition as core components of compassionate care. Patel et al. (2019) conducted a systematic review exploring factors that improve service users' ratings of doctors' delivery of compassionate care. They found that physical and relational acts such as doctors sitting during conversations, taking time to detect non-verbal cues of emotion, expressing non-verbal communications of caring, and verbal statements of validation and acknowledgement, were viewed by service users as conveying compassionate care.

Whilst some consensus is evident across studies, variations are noted in terms of expressions of compassionate care across contexts. Further, much of the identified research exploring service user conceptualisations of compassionate care can be critiqued as restricting conceptualisations to the level of individual service user/ HCP interactions, arguably limiting the scope for broader or divergent conceptualisations (Lown et al., 2015).

1.6.1.2. In Mental Healthcare Settings: A dearth of research exists which explores service users' understandings of compassionate care in mental health services.

Alonso (2020) explored service users' conceptualisations of compassionate care within an Improving Access to Psychological Therapies (IAPT) service. She found that compassionate care was described as involving humanising responses to their distress and actions to empower them as service users.

Similarly, Pauley and McPherson (2010) found that service users who had experienced depression or anxiety conceptualised compassionate care as centred around a combination of kindness and action.

Gilburt et al. (2008) explored service users' experiences of psychiatric hospital admission. They found that compassionate, caring relationships with staff were integral to service users having a positive experience of admission. Participants described communication, cultural sensitivity, and the absence of coercion as integral components of these compassionate, staff-service user relationships, which they cited as resulting in trusting alliances with staff (Gilburt et al., 2008).

Recruiting through a mental health charity, Lloyd and Carson (2011) explored service users' perspectives on compassionate care in mental health services. They found that service users identified presence, collaboration, and persistence as key indicators of compassionate care within services. However, the setting may limit the generalisability of this finding within NHS contexts.

1.6.2. Collective Conceptualisations of Compassionate Care

A number of studies have explored collective conceptualisations of compassionate care across stakeholder groups, such as service users, carers, clinical staff, and service managers. In one such study, Kneafsey et al. (2016) explored both staff and service user conceptualisations of compassionate care across various environments, using focus groups. They found that establishing meaningful connections was viewed by both staff and service users as compassionate care. Within the focus groups, 'consistent compassion' across interactions was acknowledged generally as unrealistic, but it was nonetheless positioned as an important goal for healthcare staff to aspire to with a view to improving care (Kneafsey et al., 2016).

Babaei and Taleghani (2016) conducted an ethnographic study exploring compassionate behaviour amongst clinical nurses through interviews with nurses and patients on several medical and surgical wards. They found that participants described compassion as 'expressions of love' in the form of non-verbal emotional behaviours, showing empathy, and providing emotional support to patients at the bedside.

Comparing conceptualisations across groups, Smith-MacDonald et al. (2019) explored service users', carers', staffs', and managers' ideas of what constitutes compassionate care in a long-term physical health facility, using in-depth interviews and focus groups. They found that participants generally regarded compassionate care as comprising numerous actions and intentions, including seeking to understand, relational communication, virtuous responses and attending to needs. Further, they found that while staff and service users' conceptualisations were largely congruent at the level of individual interactions, staff participants built on these conceptualisations by highlighting the organisational and systemic influencers of compassionate care. Indeed, staff participants described compassionate care as something that is largely shaped by the extent to which the working environment enables it through adequate resource provision and a compassionate culture (Smith-MacDonald et al., 2019).

These findings indicate some congruence across conceptualisations offered by staff and service users, with staff contributing additional insights into wider, organisational factors influencing care.

1.6.3. Staff Conceptualisations of Compassionate Care

Whilst a larger literature base explores staff perceptions of compassionate care, most studies focus on nurse conceptualisations within physical health settings (e.g. Lundberg & Boonprasabhai, 2000; Nijboer & Van der Cingel, 2019). Further, studies frequently limit recruitment to within distinct professional groups rather than across teams; a distinct lack of research has focused on mental health settings generally, and on conceptualisations of compassionate care across multidisciplinary mental health teams.

The following sections will present research representing staff conceptualisations of compassionate care in physical, followed by mental healthcare settings, to highlight the paucity of literature within mental healthcare settings.

1.6.3.1. In Physical Healthcare Settings: Nijboer and Van der Cingel (2019) conducted a study exploring novice nurses' perceptions of compassionate care. They found that compassion was positioned as a core aspect of participants' professional identities. Indeed, participants described a journey in the development of professional competence in compassion as relating directly to nurses' ability to juggle the demands of environmental factors and their own perceptions, which, when navigated successfully, culminated in professional growth.

In a study conducted by Lundberg and Boonprasabhai (2000), student nurse participants identified compassion as a key component of effective nursing care and conceptualised this as involving: giving care from the heart; sharing own emotional experiences; and striving for honesty and helpfulness when supporting service users. Similarly, Christiansen et al.'s (2015) conceptualisation, based on understandings gleaned from a range of health professionals, centred around the undertaking of ‘small actions’ that help service users to feel cared for. This was echoed by Crowther et al. (2013), Goodrich (2016) and Perry (2009), who each found that staff described compassionate care as consisting of small, supererogatory actions, and attending to ‘the little things’. Similarly, Frank (2004) found compassionate care to involve interpersonal generosity, expressed by staff through giving more than required of them by their job description.

Gustin and Wagner (2012) found that staff participants described compassionate care as a way of “becoming and belonging together with another person, where both feel mutually engaged” (pp.1). They further described it as involving the caregiver being able to compassionately acknowledge “both self and other’s vulnerability and dignity” (Gustin & Wagner, 2012; pp.1). Similarly, Bray et al. (2014) found that HCPs across disciplines described a compassionate approach as involving individualised care, provided through warm and empathetic interactions, with the intention to treat others as you would want to be treated. This description was echoed by Day (2015), who also highlighted listening as integral to compassionate care.

Kvangarsnes et al. (2013) presented distinctive aspects of staff conceptualisations of compassionate care in a service providing care for exacerbated chronic obstructive pulmonary disease, highlighting the need for specificity when operationalising compassionate practice in various settings. Within this setting, staff placed an emphasis on compassionate care as expressed through preparing the patient for experiences of breathlessness. Similarly, Efstathious and Ives (2017) explored the specific actions associated with compassionate care at the end of life in acute physical healthcare settings. They found that nurses conceptualised this as involving expressions of care, the provision of support to the patient's family, and maintaining the patient's dignity by managing their symptoms and hygiene.

Overall, compassionate care was described as central to professional identities, and was often described as being expressed through supererogatory actions. Whilst some commonalities are observed across studies, divergences were also noted which highlight the need for tailored, practicable descriptions of compassionate care implementation across settings.

1.6.3.2. In Mental Healthcare Settings: Despite the emphasis placed on compassionate care in mental health policy, a scarcity has been noted in the literature in terms of what is understood by 'compassionate care' within mental health services (Crawford et al., 2013). Existing research exploring compassionate care in acute mental health settings focuses largely on inpatient settings (e.g. Brown et al, 2014), with a lack of research in acute community services, such as crisis resolution and home treatment teams.

Brown et al. (2014) explored staff conceptions of compassionate care in acute inpatient mental health wards, which they described as involving repertories of practice such as spending time with patients, playing games, and taking service users outside for cigarette breaks. These activities were described by staff as facilitating service users in sharing their concerns, enabling practical, compassionate mental health support. Vivino et al. (2009) found that therapists described compassion as deeper and broader than empathy, involving helping service users to feel understood and alleviating their symptoms. Barron et al. (2017) found that, whilst community mental health nurses conceptualised compassion as the key force underpinning the provision of quality mental healthcare, they noted complexity and difficulty associated with the provision of compassionate care in everyday practice, with several complex barriers to its actualisation.

In summation, variations shown across studies in terms of conceptualisations and enactments of compassionate care in various settings underline the need for tailored empirical research within each service context (Armstrong et al., 2000; Roze Des Ordons et al., 2019). Further, existing literature regarding conceptualisations of compassionate care has largely focused on nurse conceptualisations within physical health and long-term physical care settings.

This is in response, perhaps, to the aforementioned high-profile failures by this professional group to deliver compassionate care in these settings (e.g. Bubb, 2014; Francis, 2013). This disproportionate focus has resulted in the relative neglect of other professional groups, and of mental health settings.

1.7. Research on Barriers to Compassionate Care

Empirical research exploring barriers to, and facilitators of compassionate care has illuminated several areas and factors of perceived importance. Singh et al. (2018) proposed that barriers to compassionate care can be viewed as operating on three key levels: individual, relational, and systemic/ organisational. The research pertaining to barriers to compassionate care will be organised according to these levels, with a subsequent, corresponding section presenting research around facilitators of compassionate care.

1.7.1. Individual Level Barriers

Research indicates that individual-level staff demographic factors such as age, gender, sex, and ethnicity have a limited impact on compassionate care outcomes, accounting for only 3-5% of the variance in staff compassion fatigue scores (Dasan et al., 2015). Maladaptive staff coping strategies, however, such as alcohol use and social self-isolation were found to correlate with compassion fatigue (Chana et al., 2015; Dasan et al., 2015).

Much of the research focused on barriers to compassionate care at the individual level centres on the concept of compassion fatigue, which is described by Figley (1995) as a process which manifests in emotional exhaustion, low mood, anxiety, and feelings of failure, resulting from prolonged indirect exposure to trauma through clinical work. Joinson (1992) argues that the experience of compassion fatigue results in staff temporarily or more permanently losing their capacity to nurture and provide compassionate care. Kelly et al. (2015) explored predictors of compassion fatigue amongst acute care nurses, identifying a lack of meaningful recognition of staff effort by management, and longer periods of time in the role as predicting compassion fatigue. This aligned with the findings of Westwood et al. (2017), who conducted a study exploring factors associated with risk of staff ‘burnout’ in an IAPT service. They found that hours of overtime predicted a higher rate of burnout, whilst hours of clinical supervision were predictive of lower risk. Similarly, Rossi et al. (2012) explored predictors of compassion fatigue and burnout in community mental health services and found that staff with higher caseloads reported the highest rates of compassion fatigue, as well as those experiencing negative life events. Newman (2018) conducted a systematic review of compassion fatigue in the UK, considering findings in terms of CMT (Section 1.4.2.; Gilbert, 2009). He found that factors such as exposure to a high level of trauma, a lack of supportive relationships at work, perceived lack of autonomy, and excessive workload along with insufficient resources as contributing to compassion fatigue. Newman (2018) argued that this could be understood as the results of sustained activation of the CMT 'threat' system (Gilbert, 2009) at the service level. Whilst compassion fatigue has been predominantly studied at the individual level, Yu et al. (2016) argue that attention should be paid to the impact of macro-level, contextual factors. Indeed, Ledoux (2015) posits that compassion fatigue should not be viewed as an inevitable cost of caring, but rather as the result of external obstructions to the caring process.

In terms of differences across professional groups, Dev et al. (2019) found variations in barriers to compassionate care across healthcare disciplines, through a study exploring the experiences of doctors, nurses, and medical students. They found that medical students reported more barriers to compassionate care than doctors and nurses, related to expertise and experience, with doctors reporting more barriers than nurses. Additionally, they found that nurses reported greater work environment-related barriers than doctors and medical students, who were more likely to raise the need for increased mentorship and support in terms of professional and emotional development (Dev et al., 2019). Aligning with this finding, Vivino et al. (2009) found that less experience as a healthcare professional was generally predictive of greater barriers to compassion. They also identified factors such as feelings of incompetence and staff members' own personal issues as barriers to compassionate care. Also exploring the impact of juniority on compassionate practice, Curtis et al. (2012) identified that student nurses highlighted a dissonance between their professional idealism and the reality of practice and noted the negative impact that socialisation to a constraining, uncompassionate system had on their attempts at compassionate practice.

Within acute mental health settings, Doyle et al. (2007) explored factors affecting caring behaviour of emergency department nurses towards patients presenting with suicidal thoughts. They found that nurses' prior judgement around the perceived genuineness of the presentation could inhibit compassionate responses. This was echoed by Brener et al. (2010) and Bartlett et al. (2013), who found that staff bias and judgmental attitudes towards addiction can inhibit compassionate care for this group, resulting in reduced engagement and continuing difficulties for service users. Moreover, Cornelison (2001) posited that issues such as prejudicial views toward difference, and differing views in terms of autonomy and cultural responses to pain can act as barriers to compassionate care.

Overall, the literature highlights some barriers to compassionate care at the individual level, including workload, professional group, experience, and supervision, as well as staff biases and judgements (Lown et al., 2015). Critiques of the literature base around compassion fatigue highlight the need to attend to barriers operating at wider, organisational levels (Ledoux, 2015).

1.7.2. Relational Level Barriers

Several researchers have highlighted that compassionate care should be viewed relationally, underlining it as involving a process of interaction between clinicians and service users, rather than a simplistic receiving of care by the service user, from staff in a static, transactional way (McCormack & McCance, 2011; Nolan et al., 2004).

Tierney et al. (2017) explored staff views of relational barriers to compassionate care in a type 2 diabetes service. Staff reported experiencing difficulties in engaging compassionately with non-adherent patients. They further explained that the extent of reduction in compassionate care for non-adherent patients was partly determined by their own subjective appraisal of the interaction, as well as the resources that they have available to cope. Similarly, in a study conducted by Vivino et al. (2009) therapists identified relational factors that they felt hindered compassionate care, including the client being resistant, or the client being perceived as aggressive or violating boundaries. Singh et al. (2018) also found that staff identified a lack of gratitude from service users and a tendency to complain as relational barriers to compassionate care. Indeed, Greenfield et al. (2008) noted that staff found it more difficult to generate compassionate interactions with 'difficult' service users. Staff in the study defined ‘difficult’ service users as presenting with hostility or a critical stance towards staff, or a lack in motivation to adhere to suggested interventions.

In a study conducted by Hunter et al. (2018), nursing students’ perspectives on barriers to compassionate care in emergency departments were explored, with findings spanning relational and organisational levels. They found that presentations involving alcohol and drug misuse, regular/ repeat attendances, aggression from service users, staffing deficits, a lack of time, the imposition of government targets and the physical setting of the department itself presented barriers to compassionate care. Further, demonstrating the interaction between relational and organisational barriers, Rose et al. (2015) described a process by which stress for staff caused by organisational demands resulted in curt, uncaring interactions with service users, which in turn resulted in damaged alliances, insufficient and uncompassionate care.

Interestingly, despite staff participants across studies identifying several relational barriers to compassionate care, some also expressed a degree of discomfort or turmoil around the idea of compassion as something dependent on relational factors, given that this contrasted starkly with their own personal, moral conceptualisations of compassion as unconditional (Singh et al., 2018).

1.7.3. Organisational Level Barriers

An increasing emphasis in research is being placed on organisational barriers to compassionate care, and the need for systemic changes to enable compassion at the clinical level (Gilbert, 2014).

Bridges et al. (2012) cited organisational stressors within physical health settings as the main barrier to compassionate nursing care, arguing that service improvements were needed to enhance nurses’ ability to create compassionate relationships with patients. Similarly, Valizadeh et al. (2016) and Wright and McSherry (2013) identified unsupportive organisational cultures, including excessive workloads, inadequate staffing, and a lack of value placed on compassionate care as key barriers to compassionate nursing care. Horsburgh and Ross (2012) identified a lack of supervision and a sense of being ‘thrown in at the deep end’ as reducing compassionate practice amongst newly qualified staff. This lack of support, alongside experiences of teams as under pressure and resistant to change, resulted in what participants described as ‘institutionalised negativity’ within services, with compassionate care compromised as a result.

Jenkins and Elliot (2004) explored factors associated with burnout amongst nursing staff in acute mental health settings and found that inadequate staffing and high workloads were the main identified stressors. This finding aligned with that of Rose et al. (2015), who interviewed staff and service users in acute mental health settings. They found that feelings of powerlessness amongst staff in the face of administrative and workload demands gave rise to interactions with service users wherein they were perceived as inaccessible and uncaring.

In a rare study focusing on staff views regarding compassionate care in acute mental health inpatient wards, Crawford et al. (2013) highlighted a notable depletion in the use of terms related to a ‘’compassionate mentality’’ (pp. 719), amounting to what they describe as a ‘’production-line mentality’’ (pp. 721) amongst staff. Staff described stressors such as time pressures, organisational tensions, and the demands of complex care processes as compromising compassionate care in this setting. Moreover, Papadopoulous et al. (2016; 2017) found that only 20% of nurses surveyed internationally felt that they were provided with adequate training around compassionate care, and only 4.3% of nurse respondents felt that they had been treated compassionately by their managers.

Exploring the impact of marketisation and a business agenda within healthcare settings, Greenfield (2006) highlighted what he described as the conflicting demands placed on healthcare staff attempting to adhere to their own ethical/ moral orientations, whilst operating in a system that places an increasing emphasis on targets and cost control. Indeed, a perceived ‘business approach’ to care was identified by Christiansen et al. (2015) as a key barrier to compassionate care, alongside other organisational issues such as heavy workloads and staff shortages, reducing time available to spend with service users. Similarly, Hem and Heggen (2004), found that factors such as work-place hierarchies, the division of labour, and organisational governance structures can have a negative impact on compassionate nursing practice.

Exploring the barriers posed by ineffectual application of policy recommendations, Allan et al. (2017) examined awareness and involvement of staff members across various levels of seniority in the Compassion in Practice Vision and Strategy (Department of Health, 2012). They found that this policy, which promotes compassionate care, had not permeated to staff at the clinical level, and instead remained as a popular discourse amongst non-clinical, higher management staff. They also found that higher management lacked a clear plan in terms of its effective dissemination. The few clinical staff who were aware of the policy expressed feeling a lack of support and communication from senior leadership around delivering on its promises, with a sense of disconnect between the demands made by policy documents and their clinical realisation (Allan et al., 2017).

In summation, existing research suggests numerous, complex barriers to compassionate care, operating across levels of service provision. A particular emphasis in the literature is placed on organisational barriers and the need to ameliorate these to enact lasting improvements to compassionate care.

1.8. Research on Facilitators of Compassionate Care

Existing literature regarding facilitators of compassionate care also places an increasing focus on the organisational level, with individual and relational factors often positioned as being facilitated by wider organisational changes (Spandler & Stickley, 2011; Meyer, 2009).

1.8.1. Individual Level Facilitators

A subject of research interest regarding facilitators of compassionate care at the individual level is that of emotional labour (McQueen, 2004) on the part of healthcare staff. McQueen (2004) describes emotional labour as a process by which HCPs manage their emotions in order to signal their empathetic concern to service users. It is described as akin to emotional intelligence, defined as the capacity to be aware of, manage, and express one's emotions, and to handle interpersonal relationships empathetically (Rankin, 2013). Emotional labour has been positively linked with compassionate care outcomes in the literature (Larson & Yao, 2005; Rankin, 2013).

Msiska et al. (2014) explored the relationship between emotional labour and compassionate care through a qualitative study involving interviews with thirty undergraduate nurses. They found that participants felt that their capacity to deliver compassionate care depended on them engaging in a process of emotional labour, culminating in their ability to overcome their pre-existing assumptions and connect fully with service users. In team settings, this was facilitated by formal and informal discussions between staff members (Msiska et al., 2014). Similarly, Brown (2011) suggested that self-awareness and a knowledge and understanding of the barriers to compassionate care amongst staff are key in the development and maintenance of compassionate practice. Emotional intelligence has been thought to mediate this process, with research indicating that trait emotional intelligence enables staff to make better use of work-based opportunities for facilitated emotional labour (Karimi et al., 2013; Mikolajczak et al., 2007).

1.8.2. Relational Level Facilitators

At a relational level, Vivino et al. (2009) found that therapists identified factors such as understanding client dynamics, connecting with the client's suffering, identifying with and liking clients, and having a good therapeutic relationship as facilitating compassionate care. In a study by Singh et al. (2018), staff highlighted positive feedback from service users and their families, and expressions of gratitude as relational facilitators of compassionate care. These expressions of gratitude were described by some participants as the 'fuel to keep going' with compassionate practice. Further, staff identified that a feeling of connection with service users and their families also facilitated compassionate care. They argued that whilst pre-existing relationships with service users are not a prerequisite to compassionate care, an established relationship where trust has developed allowed for a more tailored, personalised intervention (Singh et al., 2018).

As mentioned, the process of emotional labour can operate relationally, through facilitated discussions at a team level. Msiska et al. (2014) suggest that collective emotional labour on the part of staff enables a gradual change from emotional detachment based on distress and fear of difference, to a sense of staff emotional engagement at the team level, built on experiential insights, knowledge, and emotional management. They suggest that this relational team process can enable staff to provide care driven by compassion as opposed to anxiety (Msiska et al., 2014). Indeed, emotional labour is posited by Curtis (2015) to facilitate improved care by enabling staff to understand and reflect together on the challenges associated with compassionate care.

1.8.3. Organisational Level Facilitators

As previously mentioned, an increasing body of research around facilitators of compassionate care highlights the need to enact changes at the organisational level. Indeed, Spandler and Stickley (2011) and Tierney et al. (2018) argue that compassion should be viewed not as an individual act or quality, but rather as something which can be facilitated or hindered within a healthcare context. They argue that relationships, cultures, and healing environments should, therefore, be emphasised in narratives around compassionate care. Indeed, Maben et al. (2012) state that a focus on systemically enhancing staff wellbeing is integral to improving the quality of care, and that factors such as a good local team climate and co-worker, organisational and supervisor support are central to facilitating staff to provide consistent compassionate care to patients. Factors such as compassionate, clear leadership (Christiansen et al., 2015; Crawford et al., 2009; Saab et al., 2019), informal support from colleagues (Jenkins & Elliot, 2004), regular team and individual supervision (Kurtz, 2005), positive cultures within teams (Beardsmore & McSherry, 2017; Jones et al., 2016), empowerment of staff (Laschinger et al., 2003; McConnell, 2016; Spreitzer, 1996) and regular reflective spaces (Donald et al., 2019) have also been highlighted as facilitative of compassionate care at the organisational level.

Zamanzadeh et al. (2017) conducted a study exploring nurses’ views regarding facilitators of compassionate care in their practice. They found that actions such as providing organisational support, professional education and recruiting nurses with a high pre-existing motivation to relieve suffering, were facilitative of compassionate care. Moreover, they found that compassionate care can be facilitated by encouraging staff to connect with their own values and belief systems, and by learning from each other as role models in compassionate practice. Similarly, the process of learning through role-modelling of compassionate practice by colleagues has been highlighted by Curtis (2015) and Sundus et al. (2020) as enabling the socialisation of staff to compassionate practice. Indeed, Hafferty (1998) describes organisational and team cultures as the “hidden curriculum” for trainee healthcare workers, with implicit messages conveyed to learners about what is valued in work settings.

Farr and Barker (2017) conducted a study exploring the use of Schwartz Rounds to improve compassionate care in community mental health services. Schwartz Rounds are evidence-based, interdisciplinary group discussions where healthcare staff are invited to share their experiences of the emotional and social aspects of providing care (Goodrich, 2016). Where Schwartz Rounds were properly implemented, they were found to improve confidence, communication, and trust amongst teams, which staff members reported as supporting them to deliver compassionate care (Farr & Barker, 2017; Goodrich, 2012; Shield et al., 2011). Further, when exploring staff perceptions of facilitators of compassionate care through Schwartz Round discussions, Goodrich (2016) found that participants emphasised the integrality of relationships with colleagues to sustaining compassionate practice.

In summary, the need to explore and highlight the unique factors associated with compassionate care across various settings is emphasised. Existing research around barriers to and facilitators of compassionate care highlights the complexity of attempts to generate and sustain compassionate care within healthcare contexts, with an emphasis placed on organisational changes as central to supporting compassionate practice.

1.9. Crisis Resolution and Home Treatment Teams

An area of service provision not yet fully explored regarding the delivery of compassionate care is that of crisis resolution and home treatment teams (CRTs). This may be owing to the dearth of research exploring compassionate care in acute mental health settings generally, and the relatively recent establishment of CRTs within the NHS.

1.9.1. Crisis Team Remit and Structure

CRTs were established in response to the NHS Plan (Department of Health, 2000), with the aim of providing an alternative to acute mental health hospital admissions and effective community care for those experiencing mental health crises (Johnson, 2013).

CRTs are typically composed of a multi-disciplinary team, including a team manager, clinical nurse specialists, social workers, assistant practitioners, support workers, psychiatrists, occupational therapists, and psychologists.

CRTs are intended to work with service users who are presenting in an acute mental health crisis, who pose a high risk to their own, or others’ safety. CRTs accept referrals from accident and emergency departments, community mental health teams, inpatient mental health settings, general practitioner surgeries, and other health and social care services (Johnson, 2013).

CRTs act as gatekeepers to hospital admissions, and support the facilitation of early discharge from admissions, aiming to enable timely integration back into the community following a mental health crisis (Garcia & Durcan, 2005). Barker et al. (2011) underline the utility of CRTs in terms of avoiding hospitalisations, providing mobile care to individuals in their homes, and in supporting the reduction of lengthy inpatient stays. Studies have shown CRT efficacy in supporting individuals with a wide range of presenting complaints (Brimblecombe & O'Sullivan, 1999; McCauley et al., 2003; Paton et al., 2016).

1.9.2. Crisis Teams and Compassionate Care

Compassionate care has been prioritised in acute mental healthcare owing to reported deficits in this area (Department of Health, 2002). Indeed, there have been repeated calls from service users for increased compassion within CRTs (CQC, 2015; Farrelly et al., 2014).

CRT work environments can pose unique challenges in terms of the delivery of compassionate care (Greener, 2015). These challenges may relate to varying shift patterns, the relatively short period of engagement (typically 2-4 weeks), the acute distress with which CRT service users typically present, the high level of risk, fluctuating caseloads, and dual agendas of paperwork and medication-monitoring alongside providing meaningful clinical support (Johnson, 2013). Greener (2015) highlighted what he described as a 'dismal picture' of crisis care in the NHS. Indeed, the Care Quality Commission (CQC) "right here right now" report (2015) outlined that whilst studies have highlighted compassion as a key feature of what CRT service users value in their crisis care (Farrelly et al., 2014), only 46% of people receiving care from CRTs felt that staff had treated them with compassion. Similarly, Hopkins and Niemec (2007) and Mind (2011) reported on service users' and carers' dissatisfaction regarding CRT input. At an organisational level, McNicoll (2015) underlined an 8% drop in funding for CRTs between 2011-2015, while Mind (2015) outlined a doubling in front-line workers' reported stress levels since 2010.

Morant et al. (2017) noted that misunderstandings of CRT remits are common amongst referrers, leading to stress and increased workloads for clinicians, and disappointment and frustration for service users. They also highlighted issues around excessive emphasis on medication provision over other, more person-centred and compassion-focused forms of support. Echoing these concerns, Wheeler at al. (2015) underlined the need for further research into components facilitating effective crisis mental health care.

In relation to compassion fatigue, the CRT environment can be considered a high-risk setting, owing to the levels of distress which service users are typically experiencing during acute mental health crises, as well as the frequent presence of trauma in acute mental health presentations (Figley, 1995; Sweeney et al., 2018).

Previous empirical research has shown compassionate care to result in better information sharing between patients and staff (Larson & Yao, 2005; Matthews et al., 1993; Sanghavi, 2006). This is particularly pertinent within CRT settings, where timely information-sharing around risk is imperative in facilitating effective clinical decision-making and safety-planning. Moreover, research has highlighted the protective role of compassionate care for staff and service users (Wright & Pendry, 2016), through its association with reduced staff burnout.

1.10. Rationale

1.10.1. Justification and Clinical Relevance

While it is recognised that compassionate care is an essential element in any healthcare setting, the current study will focus on CRTs owing to the scarcity of research in this area and calls by service users for increased compassion within CRTs (CQC, 2015; Farrelly et al., 2014). Given that perceptions and expressions of compassionate care vary across contexts (Armstrong et al., 2000; Roze Des Ordons et al., 2019), and considering the unique challenges present within CRT settings, there is a need to explore the distinctive features of compassionate crisis care.

As knowledge of relational constructs is best elicited through exploration of individual perceptions and experiences, conceptualisations of compassionate crisis care must incorporate CRT staff perspectives (Roberts et al., 2011). This study will contribute CRT staff perspectives to the conceptualisation of, and identification of barriers to and facilitators of compassionate care within CRT settings, with a view to improving compassionate crisis care.

1.10.2. Aims

This study aims to elucidate CRT staff conceptualisations of compassionate care, and perceived barriers to, and facilitators of compassionate care within a CRT setting.

1.10.3. Research Questions

This study seeks to address the following research questions:

- Research Question 1: How do CRT staff conceptualise compassionate care?
- Research Question 2: What do staff view as barriers to and facilitators of compassionate care within a crisis team setting?

2. METHODOLOGY

2.1. Overview

This chapter outlines the research design, procedure, and analytic strategy for the study. The epistemological context of the research and researcher reflexivity will also be discussed, concluding with an exploration of ethical considerations.

2.2. Epistemology and Ontology

This study was undertaken from a critical realist position. Within this ontological and epistemological stance, it is assumed that an external world exists, but that our observations of this world are influenced by culture and time (Bhaskar, 1979). It is described by Maxwell and Mittapalli (2010) as maintaining an ontological realism, whilst allowing for an epistemological relativism. As such, this position allows that entities such as ‘compassion’, ‘compassionate care’, ‘crisis resolution and home treatment team’ and ‘mental health’ exist, whilst acknowledging their existence as dependent on our understandings of them (Bhaskar, 1979).

A critical realist epistemology is suited to thematic analysis (TA; Braun & Clarke, 2006) and informed the method of TA adopted, as it advocates use of the literature base to explore social structures and ideologies that may shape and influence participants’ experiences. It acknowledges that participants may not be fully aware of the contextual factors influencing these experiences (McEvoy & Richards, 2006). Accordingly, both deductive and inductive elements were incorporated in the analysis.

As an epistemological position, critical realism acknowledges the existence of multiple realities. Therefore, a reflexive review will be provided in this chapter and expanded upon in the discussion chapter (Mingers, 2006).

2.3. Design

This is a qualitative study, where individual, semi-structured interviews were used to address the research questions. Individual interviews were selected over a focus group method to allow participants to freely express their views (Carruthers, 1990) and to reduce potential inhibition caused by the presence of colleagues. This methodological decision was endorsed by consultation feedback (Section 2.6.1.), which highlighted that a focus group format may activate a social desirability bias (Grimm, 2010) amongst participants. Indeed, Bergen and Labonte (2020) emphasise the need to limit the impact of social desirability bias in qualitative research.

2.4. Participants

2.4.1. Inclusion Criteria

Participants were recruited on the basis of being either currently employed in a paid, clinical role in an NHS Crisis Resolution and Home Treatment Team (CRT) setting in the UK or having held this role within the past 12 months. This timeframe was chosen to facilitate the inclusion of staff members who had recently left the role for various reasons, including work stress (Mind, 2015). Indeed, work stress has been linked to compassion fatigue in the literature (Berg et al., 2016). Twelve months was deemed to be a period within which staff were likely to retain and relay the salient aspects of working within the crisis role.

Participants were required to have at least 6 months of CRT experience at the time of recruitment, to ensure adequate clinical experience within the setting.

2.4.2. Recruitment and Sampling

Participants were recruited through the researcher’s personal and professional networks using criterion sampling (Patton, 2002). Research invitations were sent via text message (Appendix B), which were then shared with others in invited persons’ personal and professional networks. Potential participants provided their personal email addresses to receive the study Information Sheet (Appendices C & D) and Consent Form (Appendix E). Prospective participants were then given the opportunity to request further information about the research and to opt-in via a secure email address.

All invited participants were working within the same NHS Trust, across several separate but interacting teams. Some participants were known to the primary researcher, having previously worked in the same or connected teams.

Because of this and in keeping with the recommendations of McDermid et al. (2014), consideration was paid to ensuring that the interview approach was consistent across interviews (Section 4.7).

2.4.3. Sample Size

Guest et al. (2006) outline that twelve hour-long interviews can be considered to achieve data saturation. In line with this, twelve participants were recruited.

2.5. Materials

2.5.1. Interview Schedule

A semi-structured interview schedule was designed (Appendix F) to explore the views and experiences of participants regarding compassionate care, and its barriers and facilitators in a crisis team setting. Previous literature was consulted in the design process (Gilbert, 2005; Sinclair et al., 2018) and the semi-structured interview questions were designed to be open and broad with a view to avoiding constraint around topics for discussion (Singer & Couper, 2017). Prompt questions were included to elicit further information and elaboration when necessary (Willig, 2013).

2.6. Procedure

2.6.1. Consultations

An expert by experience was consulted regarding the design and relevancy of the research. Following this, in line with the recommendations of Lee and Renzetti (1993), a group of ex-crisis team staff were consulted regarding the acceptability of the method, interview schedule, dissemination, and ethical aspects of the research study.

2.6.2. Pilot Interviews

Three pilot interviews were undertaken with a convenience sample of ex-crisis team staff members who were ineligible due to having left the role more than twelve months prior. Adjustments were made to the semi-structured interview schedule in line with feedback received, to improve comprehensibility and flow, and to allow for more in-depth exploration of the topic by altering the structure of some questions (Appendix G).

2.6.3. Interviews

Eligible individuals who opted in as prospective participants were contacted by the researcher via email to provide them with the Information Sheet and Consent Form, and subsequently to arrange a time for online interview. Participants were asked to return the signed Consent Form by email before the interview, along with demographic information (Appendix H).

A Microsoft Teams video call invitation link was sent to participants 24 hours before their scheduled interview. A pre-interview briefing was read to participants prior to interviews, encouraging them to speak freely and acknowledging the challenging nature of NHS service, to help them to feel at ease (Potter & Hepburn, 2005). Interviews lasted between 65 minutes and 100 minutes (average of 83 minutes), following which participants were provided with a debriefing sheet (Appendix I). Interviews were recorded using a password-protected recording device and transcribed verbatim, including all verbal and some non-verbal utterances (Appendix J; Banister et al., 1994) as required by the chosen analysis method. Memos were written following each interview (Appendix K).

2.7. Data Analysis

The data were analysed using reflexive Thematic Analysis (TA; Braun & Clark, 2019). Reflexive TA was chosen for its utility across a range of epistemological approaches, including critical realism. It can be used to explore and describe the views and experiences of participants, whilst acknowledging social contexts (Braun & Clarke, 2006). TA identifies, analyses, and describes repeating themes across a body of data, and allows for interpretations to be made (Braun & Clarke, 2006). Further, reflexive TA acknowledges and foregrounds the impact of the researcher’s own position and relationship to the phenomena under study, underlining this as an integral area of awareness throughout the analysis process (Braun & Clark, 2019). It acknowledges the subjectivity of the process of data analysis, described by Braun and Clarke (2019) as an interactive and situated process, which reflects the data, the positionality of the researcher, and the research context.

An inductive, iterative approach to data analysis was adopted in initial stages of code generation, to identify themes from the data. Deductive strategies were used following this, to interpret themes in the context of existing literature (Braun & Clarke, 2012). An emphasis was placed on generating codes based on semantic meaning within the data, although some more latent codes were assigned where the latent meanings appeared salient (Braun & Clarke, 2019). A phase framework was used, which aligns with the reflexive approach to TA. This framework was chosen to “facilitate a rigorous process of data interrogation and engagement” (Braun & Clarke, 2006, pp.591), whilst acknowledging that the resultant analysis will differ reflexively between analysts.

2.7.1. Familiarisation with the Data

The process of familiarisation involved immersion in the data by listening back to each interview, transcribing the interviews by hand, and repeatedly reading the transcripts, while also logging initial coding ideas and memos.

2.7.2. Generating Codes

Codes were assigned to the data at sentence level (Appendix L), with codes selected which represented the language of participants.

2.7.3. Searching for Themes

Codes were sorted into potential organising themes related to the research questions using visual minds maps (Appendix M). Themes were selected based on prevalence, and with reference to how well they captured an element of the expressed perspectives of interviewees (Braun & Clarke, 2006).

2.7.4. Reviewing Themes

Potential themes were reviewed to ensure that they fit with the coded extracts and with the dataset as a whole. The transcripts were then re-read to ensure themes reflected the dataset, and to identify any missing themes.

2.7.5. Defining and Naming Themes

Themes were further refined through this iterative process, and were named, with subthemes identified and named also. It was ensured, through re-reading of the transcripts, that the themes and subthemes selected created a coherent narrative of the data and reflected the research questions (Braun & Clarke, 2006).

2.7.6. Producing the Report

The final themes and subthemes were presented as a coherent narrative. Example data excerpts (quotations) which illuminated themes and related the findings to the research questions were also presented. Consideration was paid as to whether to link data excerpts to participants' professional groups. It was decided, however, that doing so may risk compromising participant anonymity (Section 2.10.3).

2.8. Data Quality

The concept of trustworthiness of data (Lincoln & Guba, 1985) was drawn upon to assess the quality of the study. Trustworthiness is a conceptualisation of data quality specifically adapted for use in the context of thematic analysis (Nowell et al., 2017). The trustworthiness of the data reflects its value in relation to four criteria: credibility; dependability; transferability; and confirmability.

2.8.1. Credibility

This refers to the fit between the views of participants and the researcher's representations of them (Nowell et al., 2017). Credibility was attended to through triangulation; it was ensured that themes represented views expressed by more than one participant, data was collected from multiple participants, and prior research was used to support theme generation. In addition, peer debriefing was utilised to enhance credibility, interpretations of transcript data were checked with the research supervisor, and amendments were made regarding the structure of themes in line with feedback. A reflexive review was also carried out, to help the researcher to identify their own influence on the research (Sections 2.10. & 4.7.).

2.8.2. Dependability

The dependability of the study refers to the extent to which study findings are consistent and repeatable. Whilst acknowledging that within a reflexive TA frame, it would not be expected or considered desirable for findings to be repeatable per se (Braun & Clarke, 2019), a logbook was utilised throughout the process of data collection and analysis. This was intended to support dependability in the data by keeping track of decisions and rationales.

2.8.3. Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred or generalised to other settings or contexts (Nowell et al., 2017). The ability for readers to draw conclusions about the transferability of the research was facilitated by providing a detailed description of the study and its context.

2.8.4. Confirmability

The confirmability of the study refers to its ability to establish that findings are derived from the data (Nowell et al., 2017). This was ensured by meeting the above standards for credibility, dependability, and transferability, and by ensuring that quotes mapped onto identified themes.

A table is included in Appendix N which details the methods used to promote trustworthiness in the data.

2.9. Reflexive Review

Researcher reflexivity involves reflection on the part of a researcher around how their views, experiences, beliefs, values, interests, and identities shape the research (Willig, 2013). Reflexivity is an important aspect of TA and is particularly central to the process of reflexive TA (Braun & Clarke, 2019). Throughout the study, I endeavoured to remain aware of my own context in relation to the study topic, as a 28-year-old, white Irish, female, Trainee Psychologist, who has experience of working in a CRT setting.
Originating from a Catholic background, I was aware that elements of my identity may influence my own conscious and unconscious views and beliefs about compassion and compassionate care and what these should look like. For example, dominant narratives in my Catholic schooling were around compassion as depicted in biblical stories around the ‘Good Samaritan’, with

acts of selfless care shown to strangers as an expression of religious devotion. Conversely, scandals within the Catholic church (Murphy, 2009) during my adolescence highlighted to me a distinct lack of compassion at a systems level, leading me to reflect on how widespread and sustained acts of institutional abuse can exist within an institution steeped in narratives of compassion. Whilst I no longer identify with the Catholic faith, these narratives may have influenced my process in terms of data collection and analysis.
Researcher reflexivity will be explored in further detail in Section 4.8.

2.10. Ethical Considerations

The considerations below were addressed to ensure compliance with ethical practice, as stipulated in the British Psychological Society (BPS) Code of Research Ethics and Conduct (BPS, 2009).

2.10.1. Ethical Approval

Ethical approval was provided by the University of East London Ethics Committee (Appendices O, P, Q & R). As participants were recruited through personal and professional networks rather than through NHS services, no additional ethical approval was required.

2.10.2. Informed Consent

In line with the BPS (2014) Code of Human Research Ethics, informed consent was sought from participants prior to commencing the interviews, recorded either on a written Consent Form or verbally, depending on the participant's access to a printer/ scanner. It was made clear via the Information Sheet that participation was voluntary and that participants could choose to skip a question or stop the interview at any time without explanation. It was also stated that participants could withdraw consent to use their data within one week of completing their interview. Consent was also sought to publish the anonymised findings in the university repository, as well as through academic journals.

2.10.3. Anonymity and Confidentiality

The confidentiality of participant information was maintained throughout the study and beyond, in line with the BPS (2014) Code of Human Research Ethics.

Whilst risk issues were not assessed as likely, participants were informed via the Information Sheet that in the event of risk to themselves or others, their confidentiality may need to be compromised to access required support.
Any identifying information was removed from transcripts and samples in the thesis, to ensure anonymity (BPS, 2014). Transcripts were stored separately from participants' Consent Forms on secure university servers.

2.10.4. Further Support

The risk of distress to participants was assessed as being low. Despite this, information was provided in the debriefing sheet around support services. The debriefing sheet also provided contact details of the researcher, research supervisor and research lead at the University of East London, to facilitate any queries regarding the research.

2.10.5. Data Protection

Participants were directed to maintain the confidentiality of patient information during the interview. Following interviews, participants' data were stored on a password-protected audio recording device and were deleted once transcription had been completed. The data were anonymised at the point of transcription and transcripts were stored in password-protected files on a password-protected computer. Transcripts will be retained for five years following study completion, in keeping with data management procedures (UEL, 2019). All files were backed up on secure servers provided by the University of East London, under password protection.

3. RESULTS

3.1. Overview

This chapter presents the research findings; four discrete themes and relevant sub-themes which were generated through analysis of the interview data.

3.2. Participant Demographics

Twelve participants took part in the study. Participant demographics are presented in Table 1.

Table 1

Participant Demographics

Demographics	N	%
Age		
20-29	3	25%
30-39	3	25%
40-49	4	33.3%
50-59	1	8.3%
60-69	1	8.3%
Sex		
Male	4	33.3%
Female	8	66.6%
Gender		
Male	4	33.3%
Female	8	66.6%
Ethnicity		
White British	5	41.6%
White Other	2	16.6%
Asian	1	8.3%
Asian British	2	16.6%
Afro-Caribbean	1	8.3%
Latin American	1	8.3%
Professional Role*		
Assistant Practitioner	1	8.3%
Clinical Practitioner	2	16.6%
Clinical Nurse Specialist	6	50%
Social Worker	1	8.3%
Team Manager	3	25%
Psychiatrist	1	8.3%
Psychologist	1	8.3%

Duration of CRT Experience		
Less than 1 year	1	8.3%
1-2 years	3	25%
2-4 years	1	8.3%
5-10 years	5	41.6%
10-15 years	1	8.3%
15-20 years	1	8.3%
Working in CRT at time of interview?		
Yes	9	75%
No	3	25%

*Some overlap (e.g. Clinical Nurse Specialist and Team Manager)

3.3. Themes

The four major themes and seventeen related sub-themes generated from the data to address the research questions are displayed in Table 2.

Table 2

Thematic Map of Study Findings

Major Theme	Sub-themes
Theme 1: Going the Extra Mile	1. Making Time to Listen
	2. Humanising
	3. Creating Consistency
	4. Pragmatic Gestures
	5. Thoughtful Referring
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3.3.1. Theme 1: Going the Extra Mile

At the level of patient care, all participants described compassionate crisis care as involving *"going the extra mile"* P3[1], doing "*that little bit extra*" P12, and going beyond what is demanded by the job specification:

> *"Compassionate care is showing that you've got a heart of gold and going the extra mile." P7*

'Going the extra mile' was described as central to developing a rapport and trust within the confines of brief, transient crisis interventions:

> *"By doing something, going the extra mile for somebody, you know, I think those things are really important in building that relationship quite early on." P3*

The action of going above and beyond was described as a key marker of compassionate care in crisis teams:

> *"There is no one I haven't seen doing something further, going the extra mile. So that for me is an example that there must be some shared values regarding compassionate care." P10*

3.3.1.1. Sub-theme: Making time to listen: Participants described the crisis team environment as often *"intense"* P9 and *"pressured"* P6, with a resultant temptation to rush patient contacts in order to complete outstanding tasks. They described compassionate crisis care as overcoming these pressures in order to invest time in *"making people feel like they are actually being heard and listened to"* P8. Listening was described by participants as central to compassionate crisis care:

> *"Some people just need to talk, and we're not trained therapists or counsellors or anything like that, but to listen is such a skill." P1*

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[1] P1, P2, P3 etc. are used to denote participant numbers

They described listening as also tempering a tendency to jump in to *“fix”* P8 the patient. Instead listening was centred as a key intervention in itself:

> *“I think that sometimes just listening and understanding can be more compassionate than something to show that we think it's wrong, or, you know, kind of perpetuating that idea that something needs fixing in someone...” P6*

Indeed, listening was described as sometimes sufficient in and of itself in enabling the patient to feel heard and reducing their distress:

> *“I think a lot of people do appreciate that, because they don’t feel heard or listened to in their everyday lives.” P1*

> *“It could be anxiety, it could be anger, it could be frustration, it’s to take all that and contain it, and say “Alright, I hear you, I’m listening to you. I'm acknowledging you.” P10*

Listening was also described as enabling tailored, compassionate care for patients:

> *“Compassionate care is about showing that you've taken the time to thoughtfully listen to what they're saying and then offering something directly related.” P8*

3.3.1.2. Sub-theme: Humanising: Participants underlined the importance of humanising processes in compassionate crisis care.

> *“It’s (compassionate care) related to a sense of humanity, if you like, being humane and being caring for your fellow human being…” P5*

> *“Looking at people as human cases rather than just a task on paper, I think that, for me, is compassionate care.” P11*

Compassionate care through humanising was described as involving actions such as giving *"the sort of care that you would give to your own family"* P2 and finding common ground with the patient:

> *"It's really important to try to humanise them, and just try and find, like, some sort of common ground, you know, 'oh you've got a dog? I love dogs, where's your dog from?' [laughs]" P1*

This humanising process was described by participants as sometimes highlighting the 'light-hearted' aspect of care, where one connects human to human with the patient:

> *"Just trying to just go in, in a like light-hearted way (…) you need to try and find their humanness-" P1*
>
> *"It's all those human elements that come in during that short contact, that just manage to make it a bit more natural, a bit more fluid..."* P11

Humanising was described as a particularly necessary to reduce the negative effects of the *"tick-box"* P12 culture perceived as prevalent within CRTs:

> *"To view people on a humanistic level rather than just a tick box kind of exercise, I think would be a real way of looking at it (compassionate care), umm because I think we get desensitised, we can very quickly fall into that habit." P11*

This 'tick-box' culture was described as resulting in an excessive emphasis on risk, to the detriment of compassionate, humanising connections with CRT service users:

> *"It's very easy in a crisis team setting to go in with your priority being risk management and deliberate self-harm and suicidal thoughts, all of that, and I think sometimes that can impair the therapeutic relationship with someone who is in so much distress and they almost feel like they're being interviewed-" P8*

‘Going the extra mile’ to humanise and overcome the tick box culture was described as central to compassionate crisis care:

> *“It's not about ticking the boxes, it's about, you know, making sure this person knows that they are unique and individual and therefore treating them that way.” P12*

3.3.1.3. Sub-theme: Creating consistency: Participants raised the lack of continuity inherent to CRT input as a difficulty, with varying shift patterns resulting in service users reporting a sense of inconsistency and frustration. The 24-hour nature of crisis care was described as a *“double-edged sword”* P11 therein:

> ***“****On a team level, you know, because of the way the crisis team works, you have, you know, a patient has ended up being seen by 8 different clinicians…ummm, and I know it can become repetitive for them, and sometimes they complain about, you know, “I need to answer these questions every time”. So, I think that might hinder it a little bit, you know, the care.” P10*

> *“We have the capacity to see people every single day. I think that's something that's specific to our team that we can use to our advantage in compassionate care.... But unfortunately, because we don't have the same staff on shift every day, you could be starting from square one in terms of rapport on every occasion.” P11*

In response to this awareness of needs, ‘extra mile’ actions undertaken to create a greater sense of consistency, were described:

> *“I think consistency, trying to provide the service user with a level of consistency (…) if they can see the same person, or at least two people alone, within that period of time, that in itself is being compassionate.” P12*

These actions included the thoughtful allocation of visits, communicating to patients that CRTs work as a team, and ensuring an in-depth knowledge of patients’ histories before visits:

> *“The intervention is us working together as a team, and so it’s important, it’s one of the things that I try to convey to anyone I see.” P5*

> *“It's thinking about how we can have a unified approach, so that even if the patient can't see the same clinician, they can get similar approach.” P8*

These efforts to create consistency were described as enabling patients to have a smoother journey with the CRT:

> *“We all put ourselves in the patient’s shoes and would say “you know what, if I was in this position, I would probably prefer to see the person I saw last time again, rather than a complete stranger”. So even though it's not necessary to the role, it helps and it's just that little extra, that little bit more that could just make someone's journey a bit easier.” P11*

3.3.1.4. Sub-theme: Pragmatic gestures: Given the brief, transient nature of CRT interventions, and the resultant lack of time to develop in-depth relationships with CRT service users, participants described compassionate crisis care as often conveyed through pragmatic, role-surpassing gestures:

> *“In the crisis team it’s (compassionate care) more about the immediate stuff (…) so I mean we’ve all done it, where you would actually go and see if there’s a spare sandwich for the person; it’s an immediate response to a need that someone has.” P2*

These gestures were described as often involving practical actions conveying care, such as taking out the bins, taking care of someone’s pets, and packing someone a bag to bring to hospital:

> *"It's the extra part you might do, so for example taking someone's rubbish out, something like that (…) it's not part of your job." P3*

These gestures were described as often requiring CRT staff to surpass or *"transcend"* P8 their job description as a CRT staff member:

> *"Those little things that are not within, you know, it's not in your job description, it's not our responsibility, but still, we do those things." P10*

These pragmatic, supererogatory acts were described as distinguishing CRT staff members who are *"just doing the job"* P4, from those who are going above and beyond to provide compassionate crisis care:

> *"I don't think you can see working in a crisis team as just a job, it's so much more than that… you need to be a certain type of person to work in a field like this." P9*

Compassionate crisis care through pragmatic gestures was, however, acknowledged to be sometimes incompatible with the more complex needs of some CRT service users:

> *"For the crisis team to be pragmatic, to be compassionate but pragmatic, you can fall fowl of someone who is really troubled in the life that they've had, and sometimes I think that's where I would be too quick to find a solution, and that can sometimes be irritating..." P2*

3.3.1.5. Sub-theme: Thoughtful referring: Participants described that, given the limited timeframe and scope of CRT input, it can often feel *"superficial"* P4 and *"limited"* P2. They described that, in the context of these limitations, compassionate crisis care involves going the extra mile to make thoughtful onward referrals, helping to create a *"light at the end of the tunnel"* P12 for service users following their brief time with the CRT:

> *"That's compassion, it's making sure that the person sees some light at the end of the tunnel. If you can't provide it, at least, you know, you can*

> *say "I know somebody else or another service that will help you in your current situation" " P12*

> *"(It's important) knowing resources are available so, this almost intrinsic, um, need to help others, if it's not with the crisis team, at least you know where to send people… so having access straight away to a list of resources around, that makes a huge difference." P6*

Indeed, whilst triaging and onward referring were described as the *"bread and butter"* P11 of CRT work, participants described compassionate crisis care as going above and beyond to complete thoughtful, considered referrals that are tailored to patients' specific needs:

> *"It's making sure that the support we give them isn't just going to be temporary (…) it's something that's going to look into their specific needs going forward." P11*

Thoughtful referring was described as enabled by an in-depth knowledge of and contacts in available services:

> *"Making sure that you have contacts within other services, in terms of signposting as well. Having all that information is so vital; the more you know about other services the better you can signpost somebody." P12*

Further, participants described compassionate, thoughtful referring as guided by the patient's specific needs, rather than by one's own anxiety as a clinician:

> *"I think in the crisis team often you feel a lot of anxiety, like "I need to help this patient, I need to offer them referrals to whatever service it is", and it's less about bringing that anxiety of "I need to give them all of these things", when sometimes service overload isn't what they need, it's the quality of that service". P8*

Compassionate crisis care was described as avoiding this *"service overload"* P8 and instead 'going the extra mile' to connect service users with the right services:

> *"What patients really need is quality, they don't need a million referrals." P8*

3.3.2. Theme 2: The Operation of Social Power

Various forms of social power were described as impacting on compassionate crisis care. These included: hierarchical power within the healthcare organisation; processes of staff empowerment through support, training, and praise; and empowerment of CRT service users by offering choice and control. Other operations of social power discussed as relevant included assessments of the appropriate use of social power by CRT service users, and the power relations associated with the rejection of attempts at compassionate care.

3.3.2.1. Sub-theme: Trickling down through layers of hierarchy: Compassionate care was described as most readily generated through compassionate action from someone who has hierarchical power over a person:

> *"So it's (compassion) almost flowing down in a top down manner..." P5*

> *"I guess it's the same for patients and the same that my managers show it to me, it trickles down, doesn't it, from above, so I guess that in that way you can say that it is important to have those things from a director level to a service level." P3*

This was described as creating a "*trickle-down"* P3 or *"cascading"* P10 effect, where compassion from higher levels of seniority and power would be passed down through layers of the organisational hierarchy, eventually reaching CRT patients:

> *"I think it's very difficult for, you know, for a clinician to remain compassionate in a service when they feel that they are not receiving*

> *any compassion [laughs] from the people that manage them, or senior managers." P12*

> *"I think, reminding them (senior management) that this compassionate care has to be provided not only to the patients, but also to your staff, you know, that whatever approach you have with the patient, you should also have it for your staff (…) you need to be congruent." P10*

Conversely, the 'trickling down' of compassion through the organisational hierarchy was blocked at times, where that culture was not adopted at middle management level:

> *"Compassion has to be from top down, and if you've got some psychopath in the middle of that mixture, it becomes toxic." P7*

One key means of ensuring the successful 'trickling down' of compassion was through meaningful listening to, and empowerment of, clinical staff at lower levels of the organisational hierarchy:

> *"In a Trust they must make sure that, you know, they are compassionate towards the staff, and make sure that the staff are heard and listened to, and their work is recognised-" P1*

The 'trickling down' of compassion was described as rare, however, and participants described the negative effects of this on compassionate crisis care:

> *"You know, people talk about the lack of opportunities, they talk about not feeling a part of a team, you know. When it comes to management decisions, they feel like they're not included. I mean all of this trickles down and has an impact on you and your service user." P12*

> *"You can have all these consultations until you're sort of blue in the face, but there never seems to kind of genuinely… once they've (senior management) decided on a course of action it's my experience that they*

> *tend to kind of follow that, really… I mean we hold a lot of value in people being listened to, and that's kind of gotta include staff doesn't it?" P4*

> *"Our hospital feels very hierarchical, and they don't seem to care about the underlings… But we need, we need all these people (…) we all contribute to compassion." P7*

In addition to the passing down of compassionate actions of listening and empowerment, the 'trickling down' process was described as also requiring that stressors and pressures are prevented from filtering down through the organisational hierarchy:

> *"I think in my experience a lot of anxieties that were being passed down from my superior managers. I had to hold, hold onto, and make sure it wasn't passed down to my staff. Which was, which was a very difficult job, and it was extremely stressful." P12*

It was also recognised, however, that relative hierarchical social power does not mean omnipotence, and that it is, therefore, inevitable that some stressors will trickle down to lower levels of the hierarchy**:**

> *"I think for staff like heads of service and managers, often they are kind of… although they have power over the clinical staff, they are themselves quite powerless and are at the mercy of a more overarching government, um and I do feel for them because no amount of goodwill in the world can stop them implementing certain targets and having to cut budgets and staffing." P8*

3.3.2.2. Sub-theme: Compassionate care through empowerment: To promote consistent compassionate crisis care at the level of clinical practice, emphasis was placed on ensuring that staff are empowered so that they can, in turn, empower patients. This empowerment was generated through access to tailored staff training, consistent managerial support, and feeling respected with teams. Actions also described as empowering staff included flattening oppressive team hierarchies, valuing staff contributions, and ensuring that staff receive praise and support:

> *"You know, starting the job, I was asked "what do you think?", and that feels quite empowering… and I think, it's not being, you know, in a position of power, to be able to be compassionate, but feeling empowered to make decisions." P6*

> *"I think to sustain it (compassionate care) you need the kind of working environment where you're valued and, you know, where you're appreciated." P2*

These actions of empowerment resulted in a sense of security, support, and mastery among staff. Conversely, participants described a sense of *"powerlessness"* P8 and insecurity from a lack of the confidence necessary to fulfil their role as a barrier to compassionate care. Indeed, they stated that in the absence of a degree of empowerment as staff members, their own anxieties and insecurities could *"overshadow the patient's needs"* P8, inhibiting compassionate care:

> *"I think at the end of the day, being able to provide compassionate care comes from being confident in your abilities." P8*

> *"When you haven't got the skills then perhaps it makes you feel uncomfortable and a bit out of your depth (…) it then makes you feel very unconfident about really supporting that person, so perhaps then you're not giving them enough of compassionate care (…) and it all goes a bit downhill from there…" P3*

Participants described compassionate crisis care as involving actions of sharing this empowerment with patients, enabling the aforementioned 'trickling down' effect. They described compassionate care as distinct from commonly conflated constructs such as pity, owing to its emphasis on empowerment:

> *"It's not about feeling sorry for someone; it's not a pity thing." P2*

Actions described as empowering patients included genuine collaborative decision-making, skill-sharing, and providing choice:

> *“I would say “you know, I think these are the options, what do you think?” (…) you’re trying to make them feel empowered-” P10*

> *“Watching someone go through the empowerment process, I feel, is a really good example of compassionate care, because ultimately I think it goes back to that phrase, ‘give a man a fish he eats for a day, teach him how to fish and he can eat for life’.” P8*

3.3.2.3. Sub-theme: Transgressions blocking the flow: The operation of compassionate care through empowerment was described as impeded by perceived social transgressions or abuses of social power. Indeed, when people were perceived as having transgressed social rules, having misused, or abused their pre-existing social power, or attempted to gain access to social power to which they were perceived to be unentitled, compassionate care was inhibited:

> *“I was so angry because I just thought to myself, you know, that's not the way to be, that's not the way to communicate what you need-” P9*

In these instances, extra effort was required on the part of the clinician to practice acceptance and overcome judgement:

> *“Broadly compassion yeah is sort of all about like acceptance, um… even if you don’t necessarily agree with, kind of, some of the things that they kind of do, or have done, in some circumstances…so kind of a lack of hardness, if you can achieve that.” P4*

Transgressions such as a criminal or sexual offence history, violent or aggressive behaviour towards others, and substance misuse were mentioned:

> *"None of this, could kind of overcome which I think she'd actually done, which was, yeah, abused her child, so… I couldn't really work with her" P4*

> *"There is very little compassion for service users who are dependent on substances, who are addicted, because it's considered to be a choice. So if it's a choice, why don't people just stop?" P6*

Transgressions also included perceived manipulative behaviour and secondary gain-related engagement, where a service user was perceived as accessing the CRT service without a genuine mental health need:

> *"When someone's using your service for secondary gain, it's really frustrating (…) because that person is taking advantage of your service." P9*

These perceived transgressions and abuses of power resulted, at times, in negative assessments of the perceived 'worthiness' of service users to receive compassionate care:

> *"Your deepest, darkest thought might be, well I don't want to help you, you know, you've done something really horrible" P9*

Transgressions or abuses of social power were described as sometimes suppressing compassionate care as they cause clinicians to feel threatened themselves. As participant 7 said, *"Frightened staff lack compassion"*:

> *"Maybe you've read something in a note and you're anticipating somebody to be aggressive, and therefore you're kind of coming into their house already anticipating something, and therefore you're not showing compassion because you're a little bit scared, or a little bit intimidated…" P3*

Perception of transgression was described as varying from person to person, and being influenced by a person's upbringing, values, and culture:

> *"I feel like the professionals I've worked with who've had their own cultural beliefs or religious beliefs, those beliefs are really strong, and they have had them their entire life. And then they come into a field where they're faced with people who would go against those beliefs, and it's so hard to… I can understand where those people are coming from, it's really hard to kind of be neutral with those patients." P9*

3.3.2.4. Sub-theme: Power to reject compassionate approaches: Another expression of social power that was described as relevant to compassionate care was the social power which people hold to reject or refuse to engage with compassionate approaches. Indeed, staff described the personal, disempowering impact of instances when patients expressed dislike and disdain for them, rejecting their attempts at providing compassionate care. This resulted in them feeling like a *"burden"* P11, or a failure as a professional:

> *"You begin to recognise yourself as being like a burden, even if you know it's for the person's long-term wellbeing that they do need to see you…you still can't help but feel like a burden being there on the doorstep every, every night, you know, making them angry, making them upset, and they clearly don't want to speak with you." P11*

> "*She just hates us (the CRT), because we can't give her any continuity, hates us because it's always a different person, hates us because she finds us repetitive… so I always find it really hard to work with her." P1*

This rejection of attempted compassion was described as hurtful by staff, resulting in them employing various defences, such as avoiding the patient, or keeping visits brief.

> *"We give compassion to everyone, but you kind of want the same back, you don't want anyone shouting at you and you don't want anyone speaking to you in a disrespectful way."* P9

> *"When people are being quite rude and just, you know, offensive to me… it's not that I lack compassion for them, I want to offer compassion, but I*

> *think the other person's kind of feelings won't allow for a more compassionate sort of discussion..." P5*

This was described by participants as compounded when patients favour other team members:

> *"She doesn't like me, she doesn't talk to me, whereas someone else might go and they'd be like 'oh no she really opened up to me today and she told me all of this stuff', and 'I really find her charming'… it's hard." P1*

This rejection was described as sometimes cyclical, however, where a staff members' initial dislike for a service user may negatively influence future interactions:

> *"I found him very, very difficult to like. And I think probably one of the reasons that I found it so difficult to manage, was that he could pick that up in me, and then (…) he found it hard to accept anything that I might say." P2*

In contrast to the disempowerment of staff associated with rejection of care, participants described the potential for empowerment of staff by patients through expressions of liking:

> *"That's the other thing about compassion, I had a sense that she liked me, you know, and I got a sense even when I was approaching her that she was glad it was me." P2*

> *"I've had people come up to me in the supermarket and tell me how wonderful I am at my job." P7*

3.3.3. Theme 3: Centrality of Team Processes

Participants spoke about various ways in which CRT team processes are central to the generation and sustenance of compassionate crisis care. Owing to the varying shift patterns and 24-hour nature of the crisis team environment, staff described the team as the centre of compassionate clinical care in the CRT setting:

> *"What the crisis team does particularly well with compassionate care is that we do have that team environment that kind of absorbs each case. (…) it's almost like a weird crisis unity that handles the caseload." P11*

3.3.3.1. Sub-theme: Parallel care for colleagues: Participants described crisis teams within which staff are *"looking out for their colleagues as much as they're looking out for the patients"* P2 as promoting and sustaining compassionate crisis care. This care for colleagues was described as often conveyed through thoughtful gestures:

> *"One of the staff members cooked lunch for everybody and brought it in (…) and I thought, you know, that was something that they didn't have to do… I think food is always a way of showing compassion in our team [laughs]" P3*

It was also described as the informal support that was offered to colleagues, acknowledging the intensity of the role:

> *"It's about the idea of looking out for each other as a team, you know, this is incredibly difficult work that we're dealing with (…) so it is taking the time to actually ask about each other, not just wait for someone to tell you… actively asking 'how was that assessment, how was that visit?' " P5*

> "*It's looking out for each other and supporting each other with tasks that need to be done… sharing a space for someone to come in and unload a little bit, allowing that space to kind of breathe, if you like." P2*

> *"Talking to each other with kindness and care, it goes a long way. You know, if someone's come in, just asking them how they are (…) and noticing when someone's not themselves." P9*

This parallel care was described as creating cohesive teams with a *“strong team morale”* P9, and a sense of trust and support that can improve care for CRT patients:

> *“In order for the service to deliver the best compassionate care, you need a solid team. You need team that's working well together” P9*

> *“I think that it’s really important that you go out of your way to actually really be a team, and to understand the strength of that team, but also to just be nice to each other, you know, to go that extra step for each other.” P2*

Expressions of care were described as particularly beneficial when provided by managers; it was explained that this care can contribute to mitigating the potential harmful effects of job-related pressures and distress:

> *“What helped me to cultivate resilience was having a really supportive manager who would say, “let me know if you're feeling really uncomfortable with a patient, I’ll come to the visit with you…If you ever just need a few days off just take it, it's not a problem, if you don't feel like you can manage it”, and having that has made me feel so empowered, to the point that I haven't taken a sick day… so that resilience can be cultivated by a manager” P8*

3.3.3.2. Sub-theme: Digesting individual reactions: Participants described a team process whereby their own strong emotional reactions (e.g. frustration, dislike, hopelessness) towards particular service users were digested and *“evened out”* P11 within the wider team. They explained this process as enabled by there being *“other members of the team who don’t feel like that about a particular person”* P2. This digesting process at the team level was described as facilitating compassionate care by ensuring that staff members do not *“let our own personal biases overrule the next steps, and again, you know, interfere with good compassionate care”* P11. Participants described how this process facilitates the sustenance of compassionate crisis care:

> *"I think no matter what people's personal feelings are towards them, there's enough other people around involved to make sure it's always going to be quite objective…I guess any reaction could be sort of evened out by the people around at that time, you know." P11*

Participants described noticing and sharing individual emotional reactions as foundational to this 'digesting' process:

> *"I think as long as you recognise how you're feeling, and either you check yourself or someone else says to you, you know, "you need to pull yourself together or you need to watch that", I guess as long as you're mindful of that." P3*

> *"I've been in situations where I might say like "this person was really challenging. I found it quite frustrating, I'm probably quite biased in my opinion of what we should do next". Maybe I then sort of open up to the floor and let people tell me what they think the best route's going to be." P11*

> *"If we had any negative feelings, it's saying this is OK, why is that? And try to address those…" P10*

This was said to include an acknowledgement that as a staff member, you won't be compatible with every patient, and breaking the sense of shame that a clinician might feel about not connecting with every patient:

> *"It is a strange thing, isn't it, you know, but people are compatible? Nurses and patients, obviously that puts boundaries and all sorts of professional competencies and all sorts of things, but basically, you meet people in life where you have a rapport, or you don't…" P2*

> *"Staff might be scared to even have that thought, like "oh God they're really annoying…I saw them last week, it'll just be the same thing", like they might feel like that's a really horrible thing to say… but we are human [laughs], and we have feelings about everyone, not whether they*

> *have a mental health illness or not, just anyone, the people in society generally." P1*

They described this acknowledgment and normalisation as enabling staff to share how they are feeling with colleagues:

> *"I think just having more open discussions about it and allowing everyone to review how they're feeling. Because often, when you don't do that then you kind of feel like you're alone with your thoughts, and that makes you feel like a bit of a bad person, because you're like "oh God, I shouldn't be thinking like this, I shouldn't be having these views", so just having a few more open discussions (…) allowing people to air how they feel, and then, you know, coming together as a team." P9*

Indeed, this digesting process was facilitated by open, supportive relationships with colleagues, where staff members feel able to share their reactions and emotions, and regular reflective practice:

> *"It's this kind of informal support of, you know, "I feel really angry about this person" or "I feel really frustrated about this" and having the opportunity to talk openly about it, I think that really plays an integral part of keeping compassionate care." P6*

> *"I think when people are generally talking to each other about their experiences within the service, and service users that they've met and how it you know, perhaps how it's affected them, not in detail but perhaps they give a brief summary of "my God, this made me feel this way". I think that kind of encourages, you know, the compassionate care within the team, so there's that open dialogue amongst the staff members." P12*

3.3.3.3. Sub-theme: Difference enabling tailored care: Participants described difference and diversity within crisis teams as enabling a proliferation of ideas, solutions, and interventions for service users. These differences, in terms of profession, age, gender, ethnicity, sexuality, lived experience and so on, as well as in opinions, reactions and beliefs, were described as enabling CRTs to deliver tailored, compassionate care by connecting with, and generating solutions for a multitude of presenting patients:

> "*Going back to a very, very high functioning team, that would be a team that is able to build a rapport with a very different range of people-" P2*

> *"When you work in a really big team where people come from all walks of life, you can offer much more compassionate care." P8*

Indeed, these differences were described as contributing to holistic, compassionate care:

> *"We're quite lucky within the crisis team in that we have multi-disciplinary teams. So, on a team level we get insight from so many different professionals, from so many different angles, and it makes quite a holistic kind of plan moving forward. I think that's what I would view as compassionate care in a team environment, everyone gets to chip in and kind of indicate towards different aspects of that person's life, or different factors that might be bringing them into a crisis state…and start pitching in different solutions." P11*

> *"It's about having a sort of like broader range of intervention... then that in turn is going to be better care, isn't it? So I suppose then that is going to be more compassionate care, isn't it, because it's more holistic; maybe you'll be more able to meet the need of the client-" P4*

This was described as important owing to compassionate care being unique to, and therefore requiring tailoring to, each CRT patient:

> *"You can't be compassionate in the same way for one that you can for another… to everyone, to patients as well, compassionate care means something different." P9*

> *“The intervention, it has to be tailored (…) What one person needs may be different from another.” P12*

Within this sub-theme, participants described strict team hierarchies as inhibiting the benefits that could result from diversity within teams. Indeed, hierarchical team cultures were described as stifling some voices in the team, reducing the potential for idea-sharing:

> ***“**I wish it was more that kind flat hierarchy, just because, the job is difficult, uh, if there are difficulties in, you know, in being heard, in being able to follow up with your planning or being able to feel comfortable discussing things, then that does chip away… you stop caring” P6*

> *“Truly compassionate care looks like it's putting your ego aside (…) it's acknowledging that other people can sometimes know more than you, even if you're on a different banding to them.” P8*

3.3.3.4. Sub-theme: Socialisation through modelling: Compassionate crisis care was described as generated and sustained by a process of socialisation into the crisis team culture:

> *“So, we build up a team of people who all act in the similar way and have similar kind of values. Which means that when we have new staff starting, they’re immediately immersed in this environment of people who are very compassionate, people who are very caring and sincere, and you know like, are thinking above and beyond, and I think that they absorb a lot of that, which means that just kind of continues fuelling itself.” P11*

This socialisation process was described as particularly important given the lack of formal training offered to CRT staff around compassionate crisis care:

> *“When you join a crisis team, there's no real training in terms of how to deliver compassionate care (…) it's crazy really, because that's what we*

> *do, everything our job is about, and we're not really taught how to do that." P9*

The process of learning through socialisation was described as initiated through joint working during the induction period and continually built upon throughout the working life:

> *"I mean for me I always learn better by doing things alongside someone, so that coaching and mirroring by staff is really important… I mean I don't respond particularly well when somebody gives me a couple of lines about 'this is how we want you to behave', or 'this is what we expect', but I definitely will learn and replicate it if I see someone showing me how they do it." P3*

> *"The people and the nurses that I work with, alongside, have just been, like amazing (…) that's where you learn all the good stuff from…" P1*

Participants described the importance of compassionate leaders or role models within this process, who were described as setting the culture or overall tone in the team:

> *"I think certain people can be very influential, I think most of us are sheep really, followers, but I think you just need a few people who are kind of, who have got that solid kind of, you know, compassion and the right idea really, to have a very fundamental influence on how the rest of the team is." P4*

> *"I think when you have somebody positive in the team, and somebody that shows that compassion, you know, people start, you know, doing more, and wanting to go the extra mile, then you can end up having more people doing those things." P10*

This process of socialisation to compassionate crisis care was described as being fuelled by staff emulating what works well with patients, which was perceived as generally being actions conveying compassionate crisis care:

> *“If you see certain staff behave in a certain way and the client responds well, then you're going to try and do that too, because you want your contacts to go well.” P11*

> *“I think if there's a lack of compassion in interventions, the interventions aren’t as effective as they would be, or as they should be.” P12*

Participants explained that even after years of crisis team experience, joint-working could lead to learning new compassionate care-related skills from colleagues and new ways of conveying compassion:

> *“I always say that I like to see how other people see patients, because I try to learn, and I always learn, you know… I say “OK, you do the session”. And I always learn when I do that, you always learn, and can say “Ah, I like the way you did that, how that person asked this thing”, “Oh I like the way that…” ” P10*

> *“I'm still now having appointments with staff who I’ve not been on a shift with before, and I feel like I'm still learning new things every single time we go out together, because everyone handles things slightly differently.” P11*

3.3.4. Theme 4: The Balancing Act

Participants described some trade-offs, dilemmas and conflicts considered inherent to compassionate crisis care. Indeed, participants described the need to *“juggle multiple hats”* P8, continually engaging in a process of examining and evaluating these competing demands with a view to delivering the best possible compassionate crisis care. This was described as requiring an understanding of the knock-on effects of different decisions, with no one optimal solution to these dynamic dilemmas.

3.3.4.1. Sub-theme: Spreading compassion across a caseload: Participants described a constant need to spread finite care resources across an elastic caseload, with no upper limit placed by the service on the number or complexity of patients on a CRT caseload at any given time:

> *“There’s no limit on the patients under the team, so if there is not enough people to see all the patients that should be seen, it would be impossible to be as compassionate as you would like to be.” P10*

> *“There's no cut-off point as to how many people we can have, we can see within a particular time, so (…) I think that that in itself is quite distressing, and can affect the level of compassionate care that we provide to service users.” P12*

This results in periods when compassionate crisis care is compromised owing to CRTs becoming *“too focused on discharge planning”* P5 and lacking in time and capacity to provide care owing to complex patients *“taking up an awful lot of space in your mind”* P5. Accordingly, variations in compassionate crisis care can transpire, in keeping with the available resources:

> *“(In busier times) We’re having to be really harsh on referrals and who we will take on and who we won’t, and patients are getting really upset, because they’re not getting the care they used to have…” P7*

Participants also described a pressure to discharge, which was explained as balancing compassion for the patient in front of you with compassion for other, future patients who are about to go into crisis and will require CRT input:

> *“Sometimes to be kind to someone, or take someone on, we will need to decline someone else, and this is something we have to keep in mind... so as much as we feel sorry and empathise with someone's history, we have to keep in mind all the time that you know, “if we take this person on, someone that actually might need us more, we might not be able to care for them.”” P6*

> *“There is sometimes a pressure to get the caseloads down (…) you’re just thinking of the next person that’s coming in.”* P1

This balancing of compassion across the caseload of existing and hypothetical future patients was described as resulting in action and decisions that can seem "*harsh"* P7 or *"ruthless"* P6 from an outside perspective:

> *"It can look very ruthless I think, almost on an opposite continuum to compassion…and I think that's one of the things that the crisis team has to do more, when it comes to caseloads… in theory, we want to care for everyone that, um, seeks that care or that help (…) but we are all bound by, you know, limits to caseloads-" P6*

3.3.4.2. Sub-theme: Care in the moment versus tough love: Another dilemma to compassionate crisis care described by participants was around providing care in the moment versus the need for *"tough love"* P6 at times. Indeed, several participants reflected on the tension between alleviating a person's distress or suffering in the short-term and contributing to the continuation of their difficulties in the longer-term, by perpetuating a dependence on CRT input, reinforcing maladaptive patterns of help-seeking, or preventing the patient from developing resilience:

> *"Sometimes if you hold people in a bit of a bubble and hold on to them as long as they feel they need it, it's not sustainable for their growth, for their own development, you know… sometimes people need that little nudge to take responsibility to move forward-" P11*

This was described as requiring thoughtful planning at the team-level on a case-by-case basis, to reflect on whether CRT input in the short-term would further the patient's wellbeing in the longer-term:

> *"We as a team would say "actually, for your own wellbeing in the future and for your recovery going forwards, not working with us will probably be more beneficial, so we aren't going to get your hopes up, we aren't going to encourage certain types of behaviours, you know, that's going to be handled in a different place."" P11*

This related to boundaries, with some boundaries around crisis care aimed at reducing suffering, longer-term, despite causing some suffering for the service user in the short-term:

> *"I feel like compassionate care in that sense is actually not allowing him to perhaps behave in a certain way, and perhaps putting a boundary down, and that might sound odd, but actually in a way you're trying to help him to change behaviour uh, in order to function better in his life." P3*

> *"Sometimes rejection, or keeping very firm limits and boundaries is very compassionate, because it helps people develop within those restrictions, which we all are subject to-"* P6

> *"You have to maintain boundaries, and that on the outside can look like you're lacking compassion because that person is severely distressed (…) but if that person is distressed and they're saying they want to go into hospital, and you continue to say, "OK, I'll send you to hospital", you're not being compassionate, because that's not what's going to help that person, that's going to be worse for them, really-" P9*

While this could be viewed as uncompassionate care, participants described it as a necessary, brave, *"tough love"* P6 action, taken in order to break detrimental patterns and alleviate suffering in the longer term:

> *"That patient may not see it that way at all and might think that we're being negligent or something, that we're being uncaring, heartless, and horrible to them. And again, that's quite difficult when there's that incongruence between the sort of practical clinical decision, compared to how that person feels emotionally." P11*

> *"Sometimes a patient might not agree at all, um, with what the clinician views as compassionate care, but actually in a year's time they might look back and think, "yeah, they were definitely right, and they were caring for me and they were doing what's in my best interests, I just*

> *struggled to see at the time because I may not have been well enough."" P9*

Participants expressed some doubts about this dilemma, however, wondering whether it was truly a 'tough love' compassionate response, or whether it was also a means of managing staff feelings of hopelessness and frustration around frequent attendances:

> *"We say "it's very important to keep boundaries", "it's very important to, you know, establish limits", but are we establishing them for the patient, or is it for the service, and because the service can't deal with it or can't cope with the complexities of things?" P6*

3.3.4.3. Sub-theme: Balancing competing needs: Participants described compassionate crisis care as requiring a whole-organisation approach, with compassion shown for the needs of all stakeholders. It was described that some trade-offs were inherent to attempts to attend compassionately to these various and sometimes mutually exclusive needs:

> *"I do think that there's this balance between you know, the needs of the Trust, the needs of the patient, and your needs as clinicians as well, so it's finding that right balance." P10*

Participants noted perceived variations across CRTs in terms of the balance struck between the level of 'patient-focus' versus 'service-focus', with the former described as better representing compassionate crisis care for patients:

> *"It's still very much a service-focused, especially with, I think, within the NHS, um, it's very service-led, and, and a lot of the work that is done, it's not about what that specific person needs, it's about what the service needs..." P6*

This dilemma was noted across levels, and related to factors such as accessibility, thresholds, discharges, and targets. It was described as being approached differently across Trusts, with varying results in terms of compassionate crisis care for staff, patients, and the Trust:

> *"I'll call a particular crisis team and they don't take referrals, you know, they have all these limitations and all these restrictions, you know "oh we don't take referrals from the general public, it has to be a GP". It's absolutely ridiculous." P12*

> *"A lot of Trusts are quite restrictive, yeah, so you have to have your GP refer you, or your care coordinator, or you know, but we're quite open." P1*

Compassion for the needs of the Trust was perceived as meeting *"quantitative targets"* P6, reducing costs through avoided admissions, and reducing duration of care spells. Compassionate care for staff was described as using the threshold as a means of managing the workload, implementing rigid assessment processes to protect staff from individual blame, and the sharing of responsibilities via hierarchy:

> *"I think that the processes themselves, though a little tedious, are quite useful to protect our staff…it does mean that it's not down to one individual's decision, you know, there will be several clinicians involved in that journey, making sure the right screening's done, making sure the priorities are put into place-" P11*

Some of these processes were seen to clash with compassionate care for CRT service users, which was described as generally entailing flexibility, and increased accessibility of CRT care:

> *"I think accessibility of care, it is being compassionate, it means a lot. It means a lot to service users when they can be seen within a day or two-" P12*

> *"That's what crisis teams do really well, we get people seen within a few days by a doctor, when the system is working really well, and that makes a huge difference to a lot of people, and they feel really cared for*

> *because (…) we can get them input really fast to try to turn things around for them." P7*

Total accessibility was positioned as uncompassionate to staff, however:

> *"If we did get to a point where people could just sort of turn up at the door… I don't know how that would result, really, apart from it just being very overwhelming..." P11*

> *"If compassion was about offering your service to everyone, then that wouldn't work, you have a line to draw." P2*

Attempting to find this balance, participants understood that compassionate crisis care for CRT patients sometimes involves flexibility regarding the service remit, meeting the *"patient rather than the service needs"* P6 therein:

> *"It's about using that intuition and kind of sometimes… bypassing the processes… and being able to say actually in this situation, even though it's not our usual process, this is the most appropriate thing to do for that patient's welfare going forwards." P11*

3.3.4.4. *Sub-theme: Business versus Policy Demands:* Participants described the dilemma posed by the conflicting demands of policy documents around compassionate care and the prevailing business agenda within NHS services. Participants described that compassionate crisis service provision as presented in policy or *"paper-driven recommendations"* P11 often does not reach the day-to-day CRT work:

> *"There are all sorts of elements that I know are written in policies and NICE guidelines, you know, being person-centred or even evidence-based... that don't quite filter to the work..." P6*

> *"There are guidelines that say we need to work more compassionately (…) but in terms of the NHS I think that is just written down, a lot of the time, just written down with no meaning attached to it-" P6*

This was caused by an imbalance in favour of the priorities enforced by the wider business agenda prevalent within NHS services:

> *"We work in care, but often the care business is not that caring, and I think in that sense, not always very compassionate." P6*

Indeed, participants described business-oriented organisational priorities around targets as detracting from compassionate crisis care:

> *"I think the idea of targets and handling percentages and caseload numbers and all of that kind of implies that it's like a business or like a corporate job where you need to hit certain targets, whereas mental health isn't like that, it's not sales (…) I think introducing things that make it feel business-like in a setting that's meant to be so empathy and compassion-led just sits completely at odds" P8*

> *"Pressure from management to meet your targets and meet your response rates, that's hard, cause you think like I'm doing my best and I can only do so much…" P1*

This business-oriented, *"quantity over quality"* P8 agenda was described as resulting in staff having to compromise the compassionate care that is demanded by policy documents:

> *"Institutional requests and structures are some of the main things that keep me from delivering um or providing that care, umm… I wish things were not as outcome-measured, because I think we spend so much time ticking all the boxes, you know… that it takes away from compassionate care." P6*

4. DISCUSSION

4.1. Overview

This chapter will consider the results of the analysis in relation to the research questions. This will involve eliciting links with existing empirical research and theory and highlighting novel insights that have been generated from the data to inform compassionate care in CRT settings.

Researcher reflexivity and the strengths and limitations of the study will be discussed. The chapter will conclude with an exploration of future research directions and implications of the study findings.

4.2. Introduction to Findings

Four main themes and seventeen sub-themes were generated from the study data to address the research questions:

1. How do CRT staff conceptualise compassionate care?
2. What do staff view as barriers to and facilitators of compassionate care within a crisis team setting?

The main themes map onto the three levels proposed by Singh et al.'s (2018) model of compassionate care; Theme 1, 'Going the Extra Mile', maps onto the individual level, while Themes 2 and 3, 'The Operation of Social Power' and 'Centrality of Team Processes', map onto the relational and systemic levels, respectively. Theme 4, 'The Balancing Act' can be viewed as representing dilemmas to compassionate crisis care across levels, offering a valuable extension to Singh et al.'s (2018) model.

The contribution of the findings to addressing each of the two research questions will now be discussed.

4.3. Research Question 1: How do CRT Staff Conceptualise Compassionate Care?

Whilst compassionate care has been studied across many settings, this is the first empirical study to examine conceptualisations of compassionate care in a

CRT setting, offering original insights and a valuable contribution to the literature base.

Despite some variation amongst participants in terms of conceptualisations, which is consistent with previous empirical research findings (Dewar & Nolan, 2013), some commonalities were noted. Participants discussed compassionate crisis care as relating to the healthcare organisation as a whole, highlighting the need to understand and address compassionate crisis care provision at organisational, service and policy levels, as well as at individual and relational levels. This finding aligns with assertions made by previous empirical (Horsburgh & Ross, 2012) and theoretical accounts (Cole-King & Gilbert, 2011; Gilbert et al., 2014).

Four main themes were generated from the data to address Research Question 1. In Theme 1, participants described compassionate crisis care at the clinical level as involving ‘going the extra mile’ in various ways. Within Theme 2, they described compassionate crisis care as a relational process of empowerment, which is generated by compassion ‘trickling down’ from upper layers of the organisational hierarchy. Socialisation processes and an organisational orientation towards compassion for all stakeholders were highlighted as key features of compassionate crisis care in Theme 3. Finally, in Theme 4 compassionate crisis care was conceptualised as dynamic, involving constant engagement with and assessment of various dilemmas, conflicts, and trade-offs.

Each theme will now be discussed in terms of its contribution to addressing Research Question 1, whilst situating the findings in the context of existing literature.

4.3.1. Going the Extra Mile

At the level of clinical practice, all participants conceptualised compassionate care as involving ‘going the extra mile’ in various ways. Participants described going the extra mile as a general ethos and approach to providing compassionate crisis care, expressed through various supererogatory actions (Christiansen et al., 2015).

As a feature of this ‘extra mile’ ethos, participants described making time to listen as foundational to compassionate crisis care. Indeed, they described compassionate crisis care as requiring intentional, engaged listening, aligning with previous empirical (Christiansen et al., 2015; Day, 2015; Schneider et al., 2015; Straughair, 2012) and theoretical accounts (Bradley, 2016; Youngson, 2008). Further, previous research has found that compassionate care through listening enables information-sharing (Sanghavi, 2005), which is particularly pertinent within CRT settings owing to the need for risk-monitoring. Delivering compassionate crisis care by listening was described by participants as enabling CRT patients to feel heard while giving staff members the opportunity to enact tailored solutions to their specific difficulties (Brown et al., 2014; Hopkins et al., 2009).

Humanising was described by participants as central to compassionate crisis care. This was described as particularly important in terms of preventing crisis care from becoming exclusively risk-focused, resulting in detached, dehumanising interactions. This conceptualisation aligns with the findings of Straughair et al. (2019) and Alonso (2020), who presented service user conceptualisations of compassionate care as centring around humanising responses from staff. These humanising actions can be viewed as particularly important within CRT settings, to acknowledge and alleviate the distress and vulnerability associated with mental health crises.
Echoing previous findings, humanising was described as being enacted through various means, such as finding common ground (Sanghavi, 2006), going beyond a tick-box exercise (Meyer, 2009), and striving to treat service users with the same degree of care and thought that one would offer a loved one (Bray et al., 2014; Day, 2015).

Whilst CRHT service users have called for greater continuity in crisis care (Morant et al., 2017), compassionate care as expressed through concerted efforts at creating consistency is a novel finding. Indeed, it can be viewed as a unique, ‘extra mile’ feature of compassionate care in the context of the brief, transient, intensive, community interventions provided by crisis teams. This was described as a tailored adjustment to service provision in response to concerns raised by CRT service users. As such, it can be viewed as demonstrating an attentiveness to CRT service users' unique experiences and needs, aligning with previous findings (Bramley & Matiti, 2014; Dewar & Nolan, 2013).

The description of compassionate crisis care as expressed through pragmatic, supererogatory gestures aligns with the conceptualisation offered by Frank (2004), who describes compassionate care as involving a form of interpersonal generosity, with staff going above and beyond their job description in order to connect with service users. The pragmatic nature of these gestures was described as particularly pertinent in and unique to CRT settings, given the exceptionally short space of time within which to connect with service users, and lack of opportunity to follow-up on longer-term needs. This time pressure was described as resulting in compassionate crisis care centring on gestures which address a service user's most pressing, immediate need (Maslow, 1943). Supererogatory actions conveying care and attending to 'the little things' have been highlighted as central to compassionate care in previous empirical studies (Christiansen et al. 2015; Crowther et al., 2013; Goodrich, 2016; Perry, 2009).

The need for thoughtful referring, with a view to connecting CRT service users with meaningful longer-term support, was highlighted as central to compassionate crisis care. This conceptualisation aligns with Cole-King and Gilbert's (2010) definition of compassionate care as requiring, beyond a sensitivity to suffering, also the knowledge necessary to address that suffering. Whilst previous research has offered conceptualisations of compassionate care as intrinsically connected with resources available in the wider system (Zamanzadeh et al., 2017), the importance of thoughtful, considerate referring has not been previously highlighted as an aspect of compassionate care. This novel finding is significant in that it highlights compassionate crisis care as contingent on the functionality of the wider network of services.

4.3.2. The Operation of Social Power

The relationship between social power and compassionate crisis care was highlighted by participants in the current study. Whilst power has been referred to as the basic force motivating human behaviour (Cartwright, 1959), difficulties in defining power have been noted in the literature (Lukes, 1986). For the purposes of this discussion, power is referred to in terms of the 'power as influence' definition presented by Fiske and Berdahl (2007), which describes social power as the ability to cause or influence another to behave in a certain way. Empowerment is referred to as an interpersonal process whereby information, resources, support, and a conducive environment enable an individual to exercise a degree of control or influence over their situation (Coats, 1997; Hawks, 1992).

Although empirical studies and theoretical accounts in the domains of sociology, philosophy and business have explored the relationship between compassion and power (Dobbs, 1993; Poovey, 1995; Ryan, 2007), conceptualising compassionate crisis care within the context of social power is a novel finding. This conceptualisation addresses, to some extent, critiques levelled at existing compassionate healthcare theory and research on account of a failure to acknowledge compassion as a complex, contingent, and contested social phenomenon (McCormack & McCance, 2011; Nolan et al., 2004; Simpson et al., 2014).

Compassionate crisis care was described by participants as requiring a whole-organisation approach, where compassion is passed down through the organisational hierarchy through listening and empowerment. This echoes Kanov et al.'s (2004) description of compassionate organisational contexts, wherein compassion processes can be propagated within organisational settings through a top-down approach, and Gilbert's (2009) CMT, which posits that compassion, once generated, tends to flow from the self to others and from others. Aligning with this conceptualisation, Haugaard (2012a) argued that social power is inherent to all organisational relations, including those whose explicit aim is around compassionate care. Moreover, the idea conveyed by participants that compassionate care is most readily generated by those with relative hierarchical power aligns with Van Kleef et al.'s (2008) assertion that compassion signals that one ranks higher than 'the suffering other' in terms of social power relations.

Empowerment was highlighted by participants as a key feature of compassionate crisis care. This can be viewed as particularly important within CRT settings owing to the vulnerability associated with mental health crises, and the power imbalance inherent to assessments of capacity (Mental Capacity Act, 2005) and involuntary admissions (Cleary, 2003; Mental Health Act, 2007). Empowerment has been identified as a desired patient outcome within numerous health settings (Stevenson & Batts, 2016). Previous studies have highlighted the importance of empowering service users (Alonso, 2020; Halldorsdottir, 2012) and staff (Adam & Taylor, 2013; Day, 2014; McConnell, 2016; Rose et al., 2015) with a view to enhancing compassionate care. Indeed, Schantz (2007) underlines staff empowerment as central to compassionate care, in that it bolsters staff, enabling them to take necessary actions to alleviate suffering. The conceptualisation of empowerment described by participants as involving a sense of competence, security, and confidence, aligns with the assertions of Haugaard (2007) and Clegg et al. (2006). They argue that conceptualisations of compassion through the lens of social power must go beyond power as defined by hierarchical status and rather view processes of power as inherent to all social interactions. Indeed, compassionate care as enacted through instilling a sense of social security and ensuring quality in relationships aligns with previous conceptualisations (Knights and Roberts, 1982; Meyer, 2009).

Compassionate crisis care was described as blocked by perceived social transgressions and the perceived misuse or abuse of social power. This finding aligns with previous theoretical accounts which describe compassion as practiced on the basis of socially constructed values and norms (Clark, 1997; Schmitt & Clark, 2006). Indeed, Goetz et al. (2010) define compassion as contingent on assessments of the perceived ‘deservedness’ of a person’s suffering. Similarly, previous empirical studies have highlighted the risk of stigmatisation and ‘conditional compassion’ within healthcare settings, where compassionate care is delivered based on assessments of the perceived ‘worthiness’ of a recipient (Christiansen et al., 2015; Singh et al., 2018). Previous literature has discussed conceptualisations of compassionate care within Christian charity settings as enacting disciplinary techniques for the ‘correction’ and normalisation of the person receiving of the care, promoting adherence to social norms and rules (Mik-Meyer & Villadsen, 2013; Simpson et al., 2014). This finding illuminates a conceptualisation of compassionate crisis care as a complex and contingent political and social emotion (McCormack & McCance, 2011; Nolan et al., 2004).

Further, compassionate crisis care was described as a social relational process, where the intended recipient of care holds the social power to reject this. This conceptualisation aligns with previous commentaries (McCormack & McCance, 2011; Nolan et al., 2004; Simpson et al., 2013a, 2013b) which highlight the need to attend to the experiences, assessments, and appraisals of both the giver and the receiver of compassion. This finding offers an arguably more nuanced conceptualisation of compassionate care than that which is often presented in the research, one which acknowledges that both givers and receivers can experience many variations of negative as well as positive outcomes of compassionate care relations (Foucault, 1987; Nussbaum, 2001). Indeed, Whitehead et al. (2014) highlight that power imbalances are often inherent to the giving and receiving of compassion, with compassion described as having the potential to contribute to experiences of disempowerment. This finding gives rise to questions around whether compassionate care can be defined from one perspective, or whether it should always be identified through mutual discussions and evaluations between the giver and receiver (Simpson et al., 2014).

4.3.3. Centrality of Team Processes

The conceptualisation of compassionate crisis care as enacted through team culture and processes aligns with previous empirical findings (e.g. Smith-MacDonald et al., 2019).

Compassionate crisis care was described as enacted through a culture of compassion within crisis teams, echoing previous empirical findings (Wright & McSherry, 2013). Indeed, the conceptualisation of compassionate crisis care as being generated, expressed, and sustained through affiliative team interactions aligns with previous empirical (Christiansen et al., 2015; Jenkins & Elliot, 2004) and theoretical accounts (Gilbert, 2009). This can be interpreted in the context of CMT (Gilbert, 2009), with affiliative CRT culture activating the ‘soothe’ system at a systems levels. This culture of care can be viewed as particularly pertinent within CRTs, owing to the intensity of the setting, and the associated heightened risk of compassion fatigue.

Further, the conceptualisation of compassionate crisis care as a set of learned behaviours and actions echoes previous empirical studies which highlight the importance of role-modelling and immersion in compassionate work settings (Christiansen et al., 2016; Straughair, 2012). Participants explained that what they consider compassionate crisis care is what they have observed to be most effective in terms of connecting and making collaborative plans with CRT service users. This finding can be interpreted in relation to Bandura's (1977) social learning theory, with compassionate crisis care comprising learned behaviours and actions which are subsequently emulated.

4.3.4. The Balancing Act

Compassionate crisis care was conceptualised as requiring engagement with and making compassionate decisions in the context of several dilemmas, conflicts, and trade-offs. Indeed, it was described as requiring continuous 'juggling' of these various dilemmas and demands, with a view to providing the best possible care to the most stakeholders at any given time (Simpson et al., 2013a). This dynamic conceptualisation of compassionate care presents a novel finding within the literature base and represents some distinctive features of compassionate care within CRT settings.

For example, compassionate crisis care was described by participants as a finite resource, which must be spread across both the existing caseload and prospective high-need service users. This was particularly pertinent within the CRT setting, owing to the elasticity of the caseload and the need to maintain staffing capacity to respond swiftly to urgent, and often high-risk incoming referrals.

A further novel finding was that compassionate crisis care was described as requiring appraisals of shorter versus longer-term outcomes for the intended recipient. This related to the potential suffering caused to service users by the sudden withdrawal of CRT resources after a period of brief, intensive support, and the risk of perpetuating dependence on CRT input. Compassionate crisis care was therefore described as requiring conscious cost-benefit appraisals on a case-by-case basis. This conceptualisation could be interpreted using attachment theory (Bowlby, 1969). It could be posited that service users with less secure attachment patterns may be more likely to experience heightened distress and upset following the abrupt discharge which follows a brief, intensive CRT intervention.

Compassionate crisis care also involved balancing and attending to concurrent, and sometimes mutually exclusive needs of various stakeholders. This finding positioned compassionate crisis care as a wider systemic ethos and orientation (Post, 2011), rather than being intended solely for users of the CRT service. This aligns with previous research which highlights the need for compassionate care to be enacted across levels of an organisation (Tierney et al., 2018), and to be shown to all; patients, relatives, and staff alike (Meyer, 2009).

4.4. Research Question 2: What do Staff View as Barriers to and Facilitators of Providing Compassionate Care Within a Crisis Team Setting?

Participants identified a wide range of barriers to and facilitators of compassionate CRT care, spanning levels of service provision.

Barriers to compassionate crisis care were noted as particularly prominent and impacting on participants' desired practice, aligning with previous research findings (Barron et al., 2017). The emphasis placed on barriers aligns with Rynes et al.'s (2012) discussion of paradoxes in the expression of compassion, such that compassion is often absent or endangered in settings within which it is most assumed to be present, such as within mental healthcare settings. The findings highlight the need to attend to the organisational facilitation of compassionate crisis care, aligning with previous empirical (Spandler & Stickley, 2011), and theoretical accounts (Fernando & Consedine, 2014; Meyer, 2009).

Eight main barriers were highlighted by participants as inhibitors of compassionate care provision in CRT settings. These were: a risk-focused agenda; clinician's anxiety around risk; a lack of managerial support; perceived social transgression by service users; rejection of care by CRT patients; the need to apportion out resources across varying numbers of high-need patients; the mutual exclusivity of some needs of various CRT stakeholders; and a perceived dissonance between calls for compassionate crisis care within policy and the demands posed by the wider business agenda.

Seven main facilitators were highlighted by participants as promoting compassionate crisis care. These were: sufficient organisational resources to enable time spent with patients; knowledge of and access to services in the wider system; compassionate leadership; parallel care shown within teams; opportunities for sharing and digesting difficult reactions at the team level; diversity of perspectives within CRTs; and socialisation to compassionate practice through learning from colleagues.

Many of the barriers and facilitators highlighted can be viewed as having inverse relationships, with the presence of a certain process, resource or feature promoting compassionate crisis care, while its absence was seen to inhibit compassionate crisis care.

In the following sections, the above barriers and facilitators will be discussed in terms of their contribution to addressing Research Question 2, whilst situating the findings in the context of existing literature.

4.4.1. Going the Extra Mile

Much of the findings pertaining to the theme of ‘going the extra mile’ relate to Research Question 1 regarding CRT staff’s conceptualisations of compassionate care. However, some barriers and facilitators relevant to the theme of ‘going the extra mile’ in the context of compassionate crisis care provision, were identified.

For example, participants spoke about having time to spend with clients as being central to providing compassionate crisis care. This finding is echoed in previous studies, which highlight time as a key factor in enabling or preventing compassionate care (Crawford et al., 2013; Hunter et al., 2018; Valizadeh et al., 2016), and by Greenfield (2006) who found that sufficient staffing, a manageable workload, and a lessened preoccupation with quantitative demands can enable staff to make time to listen, facilitating compassionate care. Conversely, Wright and McSherry (2013) highlighted that distractions presented by organisational demands can act as a barrier to staff investing time in compassionate interactions.

They also described a risk-focused agenda as a barrier to connecting with service users in a human way, and that having to ‘tick the boxes’ regarding risks sometimes prevented them from meaningfully connecting with service users. This echoes previous empirical (Valizadeh et al., 2016) and theoretical (Meyer, 2009) accounts that have highlighted the negative impact of organisational cultures which prioritise risk management over and above compassionate care.

A novel finding from the current study was that knowledge of and access to services within the wider system was identified as a facilitator of compassionate crisis care. Indeed, thoughtful referring was viewed as an aspect of compassionate care in the CRT context, whilst clinicians’ anxiety around risk was highlighted as a potential block to tailoring referrals to patients’ unique needs. In this way, anxiety around risk was seen as a barrier to compassionate care as it undermined the process of thoughtful referring.

4.4.2. The Operation of Social Power

Within the theme of ‘the operation of social power’, an emphasis was placed on the contingent, relational nature of compassionate care (Parrott, 2001), with barriers and facilitators of compassionate crisis care associated with social power relations operating at relational, team, and organisational levels.

The need for compassionate care to be passed down through layers of hierarchy was described, with blocks to this process representing barriers to compassionate crisis care. This finding aligns with previous studies which highlight compassionate leadership as integral in facilitating compassionate care (Christiansen et al., 2015; Crawford et al., 2009; Saab et al., 2019).
The ‘trickling down’ of compassion can be viewed as particularly important in CRTs owing to the highly emotive and intense nature of the setting.
The need for organisational demands to be contained by managers was also described. Indeed, stressors and pressures passed down from higher management were described as inhibiting compassionate care at the clinical level, echoing the findings of Rose et al. (2015). This aligns with the assertion of

McMahon and White (2017) that individuals at each level of service provision need to engage in the modelling of compassionate behaviours, with a view to creating a culture of compassionate care.
Participants described this ‘trickling down’ of compassionate care as a relatively rare occurrence. This aligns with the findings of Papadopoulous et al. (2016) that HCPs tend to experience a lack of support from higher management. This can be interpreted in relation to previous empirical research exploring hierarchical power and compassion. Research in this area has found that those in power are less inclined to attend to and show compassion towards those at lower levels of an organisational hierarchy (Fiske, 1993; Van Kleef et al., 2008). This failure is described in the literature as resulting from a reduced motivation to notice and respond to suffering from a position of hierarchical power, owing to a lack of motivation to affiliate (De Dreu & Van Kleef, 2004; Hogeveen et al., 2014; Lim, 2017).

Some barriers to and facilitators of compassionate crisis care were described as involving decreased or increased empowerment of CRT staff members, respectively. This echoes previous studies which identify feelings of powerlessness amongst staff as inhibiting compassionate care (McConnell, 2016; Rose et al., 2015). Indeed, empirical research has highlighted the benefits of staff empowerment in terms of various outcomes, such as decreased job stress (Bartram et al., 2004), fewer burnout symptoms, improved staff mental health, and decreased sick leave (Hochwalder & Brucefors, 2005). Given that previous research has shown that positive staff wellbeing improves compassionate care (Spreitzer, 1996), empowering staff can be viewed as a facilitator of compassionate care, aligning with the current findings.

Perceived social transgressions were described by participants as a barrier to compassionate crisis care, aligning with previous research (Greenfield et al., 2008). Indeed, factors such as perceived manipulative behaviour, aggression, and drug and alcohol misuse have been previously identified as inhibiting compassionate care (Hunter et al., 2018). Similarly, Brener et al. (2010) highlighted that stigmatising perceptions of patients by staff can inhibit compassionate care responses. Further, the notion of social transgression as a barrier to compassionate care can be said to align with Doyle et al.’s (2007)

findings, which highlight compassionate care as contingent on staff assessments of the perceived genuineness of presentations, with compassionate responses inhibited where a patient was perceived to be lying. An interpretation of this finding could be that compassion may be withheld as a means of sanctioning individuals who are perceived to be socially transgressive (Simpson et al., 2014).
Further, participants described a sense of threat as a common mediator between the perception of social transgression and reduced compassionate crisis care. This finding can be interpreted in the context of Gilbert's (2009) Compassionate Mind Theory, wherein the activation of staff members' 'threat' system acts as a barrier to compassionate care.

The response of an intended recipient was also highlighted as an important facilitator of or barrier to compassionate crisis care, echoing previous empirical findings (Hunter et al., 2018). Indeed, previous studies have found that perceived hostility, a lack of gratitude, or criticalness on the part of patients can inhibit compassionate care responses (Greenfield et al., 2008; Singh et al., 2018; Vivino et al., 2009). This is particularly pertinent within CRT settings, where referrals are often contested by highly distressed service users, and where the threat of involuntary admission can increase the likelihood of relational challenges. Furthermore, rejection of care by service users warrants particular consideration within acute mental health services, given that previous research has highlighted a tendency toward fear of compassion and affiliative emotions generally amongst those who have experienced relational trauma or abuse (Gilbert et al., 2011).

4.4.3. Centrality of Team Processes

Several team processes were described as central to facilitating compassionate crisis care. Conversely, the absence of some of these team processes was highlighted as a barrier to compassionate care in CRT settings.

Participants described caring and compassionate CRT work environments as key facilitators of compassionate crisis care. This finding aligns with previous literature promoting 'compassionate contexts', which are characterised by informal and formal support provision, an emphasis on staff wellbeing, and a positive team climate (Christiansen et al., 2015; Jenkins & Elliot, 2004; Maben et al., 2012). It has been highlighted previously that compassionate team contexts generate and sustain compassionate care at the clinical level (Goodrich, 2016; Fry et al., 2013; Jones et al., 2016). Previous literature also highlights the benefits of compassionate cultures within wider organisations, stating that this can instill employees with hope and trust, whilst increasing their sense of commitment to and integration within the organisation (Dutton et al., 2007).

Care from management was described as central to compassionate CRT contexts. This echoes previous research which highlighted that compassion from management facilitates healing and growth amongst employees following traumatic events (Lilius et al., 2011). This can be viewed as particularly relevant to CRT settings owing to frequent engagement with high-risk and highly distressed service users.

The absence of this parallel team care was described as a barrier to compassionate crisis care. This is in line with previous literature, which states that organisational neglect and a lack of care for staff results in anger, resentment, and compassion fatigue, inhibiting compassionate care provision (Dutton et al., 2002; Newman, 2018). One interpretation of this finding is that organisational and team support fosters the ‘soothe’ system at individual and systems levels, whereas neglect activates the ‘threat’ system (Gilbert, 2009).

The description of the ‘digestion’ of difficult individual reactions at team level as a facilitator of compassionate crisis care, represents a novel finding, and will likely be a unique adaptation made within CRTs to manage the transient, acute, and intensive nature of the work.

According to participants’ descriptions, the team ‘digesting’ process involves identifying individual emotional reactions to CRT service users (Rankin, 2013), sharing these with the wider team, and committing to ensuring that these reactions do not negatively impact a service user’s CRT input. This description echoes previous theoretical and empirical accounts of emotional labour processes at team level as facilitating compassionate care (McQueen, 2004; Msiska et al., 2014). Similarly, Brown (2011) found that formal and informal team discussions support staff to examine their own assumptions and develop self-awareness, facilitating compassionate care. This process also emulates features of Schwartz Rounds (Goodrich, 2016), wherein HCPs are encouraged to share openly with colleagues about the emotional impact of caring. Unsurprisingly, Schwartz Rounds have been identified as a facilitator of compassionate care across healthcare settings (Farr & Barker, 2017; Goodrich, 2012; Shield et al., 2011).

Diversity within crisis multidisciplinary teams (MDT) in terms of experience, identity, and skillset was described as a facilitator of compassionate crisis care. Drawing from the diverse perspectives and skills of the crisis MDT was described as enabling connections with, and tailored, compassionate crisis care for a wide range of CRT service users. The benefits of diversity in team decision-making processes have been noted in previous studies (Gruenfeld et al., 1996; Watson et al., 1993). However, this is a novel finding regarding facilitators of compassionate care. Within this sub-theme, the description of oppressive hierarchies within teams which prevent the benefits of these diverse perspectives echoed previous empirical findings; Hem and Heggen (2004) highlighted that rigid workplace hierarchies can act as a barrier to compassionate nursing care.

Socialisation to compassionate crisis care, facilitated by shadowing and modelling by staff, was described by participants as a key facilitator of compassionate crisis care. Socialisation is described as a process which promotes mutual understanding, coordinated thoughts and actions, and interpersonal closeness within work settings (Hatfield et al., 1994).
Previous studies show that role-modelling amongst staff is a facilitator of compassionate care (Curtis, 2015; Sundus et al., 2020; Zamanzadeh et al., 2017). Participants stressed that socialisation processes are particularly pertinent to CRT settings owing to the absence of formal training in the delivery of compassionate crisis care, despite its perceived centrality to effective CRT interventions. Echoing previous research (Curtis et al., 2012), participants in the current study described compassionate crisis care as generally being what is observed to “work” with CRT service users; they described compassionate interactions as typically facilitating effective, collaborative crisis planning.

Socialisation has also been highlighted as a potential barrier to compassionate care, with negative socialisation reducing clinicians' ability to engage in compassionate practice (Curtis et al., 2012; Horsburgh & Ross, 2012).

4.4.4. The Balancing Act

Participants highlighted the dynamic nature of barriers to and facilitators of compassionate crisis care. The dilemmas, trade-offs, and tensions inherent in practitioners' attempts at providing compassionate crisis care were illuminated.

For example, the need to apportion finite resources across both current and prospective CRT service users was described as a barrier to consistent, compassionate crisis care. This barrier was described as resulting from the elasticity of CRT caseloads and the continuous need to reserve space for incoming, high-risk referrals. This novel finding represents a unique and dynamic barrier to compassionate care in CRT settings. The impact of inadequate resources and excessive workloads on compassionate care has, however, been documented in other settings as resulting in staff having to apportion care according to highest need, inhibiting compassionate care for those deemed to have less relative need (Valizadeh et al., 2016).

Discussion of the mutual exclusivity of some of the needs of CRT staff, service users, and the Trust yielded another novel empirical finding. This dilemma was understood to present dynamic, omnipresent barriers to compassionate crisis care, where compassionate care for one group could have negative knock-on effects for other stakeholders. Echoing this finding, Meyer (2009) discussed the complexity of meeting varying individual needs within organisational contexts.

Finally, the dissonance between calls for compassionate crisis care in policy documents and demands made by the wider business agenda was described as a prominent barrier to compassionate crisis care. This can be viewed as particularly pertinent within CRT settings, where pressures inherent to the CRT remit around reducing bed occupancy and demonstrating financial savings (National Health Service, 2014) are juxtaposed with the investment required to prioritise sustainable, consistent compassionate crisis care.

Previous studies have highlighted the negative impact of target-focused and cost-controlling agendas on compassionate care (Crawford et al., 2013; Greenfield, 2006; Pollock, 2005). Indeed, a focus on increased productivity rather than on a genuine sense of care, and the failure of policy recommendations to permeate to clinical practice, have been previously highlighted as barriers to compassionate care (Allan et al., 2017; Frost et al., 2006).

4.5. Evaluation of the Study

There are variations in opinion on whether, and if so how, qualitative research studies can be evaluated (Spencer & Ritchie, 2012). Yardley's (2000) evaluative criteria for qualitative research were consulted throughout the research process to attend to study quality. These consist of four factors, which are: sensitivity to context; commitment and rigour; coherence and transparency; and impact and importance.

4.5.1. Sensitivity to Context

Sensitivity to context is evaluated by examining the extent to which a study attends to its context, including the existing theory and empirical research in the area (Yardley, 2000). A comprehensive literature review was conducted to inform the generation of research questions (Section 1.6). This provided an orientation to past and present theoretical and empirical conceptualisations of compassionate care, deepening sensitivity to the study context and enabling the grounding of the study rationale in unexplored avenues within the literature. Further, the researcher's prior professional experience within a CRT setting can be viewed as contributing to an increased sensitivity to the research context (Section 4.8.).

4.5.2. Commitment and Rigour

Commitment is described by Yardley (2000) as involving prolonged engagement with the research subject and skill in the adopted methodology. In the current study, commitment to the methods of analysis was pursued through discussions with a senior supervisor proficient in Thematic Analysis (TA), and through immersion in the literature concerning TA generally and reflexive TA specifically. During the analysis process, practicing constant comparative analysis ensured that themes closely represented the data, and memo writing aided reflection around reflexive aspects.

Rigour is concerned with whether the data is detailed enough to support comprehensive qualitative analyses (Yardley, 2000). In the current study, this was pursued through in-depth interviewing methods, and through the recruitment of a wide cross-section of CRT staff, spanning professional groups, age groups, gender, ethnicities, levels of seniority and experience in the setting (Olsen, 2004).

4.5.3. Coherence and Transparency

Coherence refers to the clarity and cogency of the analysis (Yardley, 2000). In the current study, considerations around coherence were applied to the research aims, epistemological and ontological positioning, and method. For example, to ensure that research objectives and methods were congruent with a critical realist perspective, it was decided that a reflexive TA approach would be most suitable. The coherence of interpretations and themes was explored in supervision and through discussion with peers.

Transparency involves reflecting on the influence of one’s own personal assumptions, practices, and motivations on the research process (Yardley, 2000). Reflexive TA places an explicit emphasis on transparency of this kind, with conscious acknowledgment on the part of the researcher that their own subjectivity is inherent to the research process (Braun & Clarke, 2019). Supervision was used to explore any pre-existing ideas and assumptions, which were noted in a reflexive diary. Further, extracts are provided in the results chapter and excerpts from coding are provided in the Appendix L to promote transparency (Spencer & Ritchie, 2012).

4.5.4. Impact and Importance

Impact and importance reference a study’s contribution to the literature base and its academic and pragmatic utility (Cohen & Crabtree, 2006). This study was designed to address an identified gap in the literature around compassionate crisis care provision, with the aim of generating novel insights with practical implications. To the researcher’s knowledge, it is the first UK-based qualitative study to examine compassionate crisis care provision from the perspective of CRT staff. The findings are intended to aid in addressing the vague and unspecific nature of compassionate care policies in CRT settings. Novel insights were uncovered, including the conceptualisation of compassionate crisis care as dynamic and contingent on various forms of social power, providing a new lens through which to view and interpret discourses around compassionate care.

Regarding the utility and impact of this study, the findings indicate clear, actionable suggestions for clinical practice and training, as well as practical changes at service and organisational levels (Section 4.10.). Dissemination, a core component of research practice, will be pursued through publication in an open-access academic journal, and through presenting at relevant conferences across clinical and academic contexts (Holloway & Freshwater, 2009).

4.6. Strengths

4.6.1. Addresses a Gap in the Literature

The current study addresses a significant and long-standing gap in the literature around compassionate crisis care and responds to calls from service users for greater understanding of and emphasis on compassionate care in CRT settings (CQC, 2015; Farrelly et al., 2014). The conclusions drawn contribute novel insights to the compassionate care literature base and suggest directions for future research (see Section 4.9.).

4.6.2. Consultations and Pilot Interviews

Conducting two consultations, with an expert by experience and ex-crisis team staff members, enabled meaningful consideration of the acceptability and comprehensibility of aspects of the study during the design stage. Additionally, three pilot interviews contributed to ensuring that the interview schedule was accessible and appropriate to the intended participant group (Hazzi & Maldaon, 2015).

4.6.3. Heterogeneity of Sample

The heterogeneity of the sample in terms of professional background, age, sex, and gender provided a broad view of possible conceptualisations of compassionate crisis care. Moreover, the sample was diverse in terms of crisis team experience and seniority, which may have added to the depth of the data.

4.7. Limitations

4.7.1. Whiteness of the Sample

The heterogeneity in terms of some demographic factors was not as well reflected in terms of ethnicity; 58.2% of participants identified as either white British or white other. The findings may, therefore, be biased toward white-centric, Western-influenced conceptualisations of compassionate crisis care (Singh et al., 2020).

4.7.2. Context of COVID-19 Pandemic

On account of the COVID-19 pandemic, interviews took place via video-call rather than face-to-face. This may have reduced sensitivity to nuances of vocal tone and body language that are more apparent when interviewing participants in person (Seitz, 2015). Further, the pandemic changed participants' CRT working environments and practices (e.g. raised thresholds for crisis input and a reduction in home visits), which may have influenced the data. To minimise the impact of the pandemic on the data, however, both the information sheet and pre-interview briefing clearly explained to participants that the current study was aimed at exploring the context of CRT work prior to the pandemic.

4.7.3. Recruitment

The approach to recruitment, through personal and professional networks, may have introduced a potential for respondent bias (Williams & MacDonald, 1986). As such, participants may have inadvertently represented a certain, unidentified subgroup of CRT staff members. However, only half of the sample were previously acquainted with the researcher, limiting to some extent the risk of associated sampling bias. Further, views and experiences shared by participants appeared to be diverse and demographic variables also varied across participants.

Moreover, all participants were employed within the same NHS Trust, which may have limited the range of conceptualisations and barriers and facilitators to those most prominent within that setting. Many of the findings appeared to be broad and applicable across CRT contexts, however, and aligned with previous research findings.

4.8. Researcher Reflexivity

Reflexivity is described as the process by which a researcher engages in continual internal dialogue and critical evaluation of their own positionality, in explicit acknowledgement that this positionality can interact with and affect the process of data collection and analysis (Bradbury-Jones, 2007). In acknowledgment of how crucial researcher reflexivity is to the process of generating knowledge through qualitative research, this section reflects further on the bidirectional influences between the researcher and the research process (Ahmed Dunjya et al., 2011; Horsburgh, 2003). This approach aligns with the critical realist epistemology and the analysis method adopted in this study; reflexive TA involves full consideration and exploration of how researcher values and experiences may influence and shape the study design, data collection, analysis, and findings (Willig, 2013).

Throughout my time working within the NHS pre-doctoral training programme, I was aware of omnipresent discourses regarding compassion and compassionate care but felt lacking in a practicable understanding of what was being referred to by these terms. Working within the Compassion Focused Therapy model (Gilbert, 2009) during my first year of doctoral training provided me with an introduction to its conceptualisation of compassion, and to its complexity and divergence from simple kindness or “being nice”.

As mentioned in Section 2.9., my Catholic upbringing and the abuses unearthed within the Catholic church during my adolescence (e.g. Murphy, 2009) led me to reflect on the complexity of compassion, particularly at an organisational level. I had reflected on how compassion can be absent in organisations even when it appears foundational to organisational values. The operation of social power as a theme felt particularly illuminative to this context and may have been subconsciously influenced by my own search for meaning (Simpson et al., 2014). Moreover, through completing my doctoral training at the University of East London I have been immersed in much consideration of and discussion around power, which may also have influenced the lens through which I approached the study data.

As mentioned previously, my desire to study crisis teams was influenced by my own experience of working within a CRT setting. This experience granted me prior knowledge of and access to recruitment within the setting (Padgett, 2008). This familiarity may have also lent me an increased sensitivity to certain dimensions of the data, given my awareness of the complex processes and structures inherent to CRT settings (Berger, 2013).

I remained aware of my own positive feelings toward the setting and attended to fostering my curiosity regarding others' views (Berger, 2013). Further, I encouraged participants to expound upon ideas to avoid overlooking any topics or experiences assumed by participants to be known to me as an ex-crisis team staff member (Daly, 1992). I also remained aware of the risk of projecting my own biases and experiences onto participants' contributions. I attended to this by keeping process notes during interviews and analysis and continuously reflecting on any assumptions that I was tempted to make (Drake, 2010). These measures align with the recommendations of Corbin Dwyer and Buckle (2009), who argue that insider status in research can be managed by being insightful and open about one's own role in shaping research findings.

On a related note, my familiarity with some participants was important to consider throughout the recruitment, data collection and analysis processes (McDermid et al., 2014). I felt that the five years that had elapsed since I left the CRT setting aided me in taking a genuinely curious stance toward participants' views (Cecchin, 1987). Further, my implicit positioning as an in-group member appeared to contribute to putting participants at ease, enabling frank explorations of personal and professional struggles and vulnerabilities (De Tona, 2006).

4.9. Recommendations for Future Research

Further research that explores the ways in which compassionate care is conceptualised across mental health settings is warranted. Such research could elaborate on and contribute to the current findings. Indeed, given the relational conceptualisation of compassion offered by participants in the current study, it is important that experiences and views of CRT service users are captured and represented within the literature base. This is particularly pertinent given the dearth of research representing service users' voices within mental healthcare generally and in acute mental health settings particularly (Lloyd & Carson, 2011; Spandler & Stickley, 2011). This research could usefully examine whether service users' conceptualisations of compassionate crisis care align with the findings of the current study, which would have implications for clinical practice and organisational policy. Moreover, given the social relational conceptualisation offered in the current study, a joint study exploring compassionate crisis care as understood through mutual interpretation and agreement across stakeholders is warranted (Simpson et al., 2014).

Previous studies have highlighted that perceived barriers to and facilitators of compassionate care vary across professional groups (Dev et al., 2019). As such, future research could explore similarities and differences in terms of conceptualisations of, and barrier to and facilitators of compassionate care in CRT settings across professional groups.

Whilst the impact of compassionate care on outcomes has been explored in other contexts (Blomberg et al., 2016; Post 2011) and has been cited as important to service users in CRT settings (CQC, 2015; Farrelly et al., 2014), future empirical studies could explore whether the perceived degree of compassion in crisis care affects the efficacy of CRT interventions. This could involve explorations of the relationship between perceived compassionate crisis care and quantitative outcomes such as avoided hospital admissions and reduced recurrence of episodes of crisis, as well as qualitative outcomes such as staff and service user experience, satisfaction, and wellbeing.

4.10. Implications for Policy and Practice

The findings of the current study indicate a range of implications for CRT service provision, spanning clinical practice, training, service and organsational policy. Each area of suggested change can be viewed as interlinked with and mutually influencing changes at other levels of CRT service provision (Bronfenbrenner, 1979).

4.10.1. Clinical Practice

The findings of the current study describe compassionate crisis care as enacted through empowerment processes, with an emphasis on empowering CRT staff as well as patients to generate and sustain compassionate crisis care

(McConnell, 2016; Meyer, 2009). This was highlighted as particularly important given the often-pressured nature of CRT work environments (Greener, 2015). Having team discussions around empowerment and the forms of empowerment which staff members feel would be most helpful could be a useful starting point (McConnell, 2016). Further, team reflective places aimed at generating ideas around how best to empower CRT service users could raise awareness of and position empowerment as an explicit goal of crisis team interventions. Clinical psychologists could contribute to the creation and sustenance of these regular reflective spaces within crisis team settings.

Creating a culture of going the extra mile, with a shared team ethos around this, was highlighted as integral to compassionate crisis care. The findings indicate that, once established, this extra mile culture can then be perpetuated within CRT teams through socialisation processes, which were described as enabled by joint-working and shadowing periods for new staff members (Zamanzadeh et al., 2017). The findings also indicate the need for conscious fostering of compassionate CRT work contexts within which staff feel able to share any strong emotional reactions to service users, and where an explicit emphasis is placed on care and support for colleagues (Spandler & Stickley, 2011).

4.10.2. Training

This study indicates the need for training of staff across levels of the organisational hierarchy, including those in leadership and non-clinical roles, around what compassionate crisis care means in practice (Barron et al., 2017), and what structures, processes and resources need to be put in place to enable this (Horsburgh & Ross, 2012; Jones et al., 2016; Tierney et al., 2018).

For clinical staff, the findings highlight the need for CRT training which explicitly attends to fostering team processes such as: the sharing of individual emotional reactions; the flattening of team hierarchies with a view to benefitting from diverse perspectives and skills; ensuring sufficient shadowing to enable socialisation to compassionate practice; and a team culture of care for colleagues. Clinical psychologists could take a lead on delivering this training within crisis teams, with an explicit attention paid to the importance of fostering constructive team processes within CRT settings. The importance of these team processes could be underlined explicitly in training sessions for existing and incoming CRT staff members, ensuring that this is not lost in policy documents which are disconnected from day-to-day clinical practice (O’Driscoll et al., 2018).

Further, training aimed at de-stigmatising certain groups of patients who are sometimes labelled as transgressive or perceived to be less deserving of compassionate care is indicated (Parekh, 2016). This could include specific training aimed at deepening staff understanding of and compassion for people with substance misuse difficulties (Brezing & Marcovitz, 2016), the label of personality disorder (Aguirre, 2016), and those presenting with aggressive behaviour or a history of criminal offending.

Considering empowerment as a means of generating and conveying compassionate care amongst staff and service users, training could helpfully be positioned as a collaborative endeavour, with attention paid to empowering staff by highlighting and reinforcing positive, compassionate practice (Theo, 2007) and incorporating the ideas and experiences of clinical staff in resultant action points.

4.10.3. Service Level

The findings of the current study indicate the need to attend to the impact of hierarchical power on compassionate crisis care. Indeed, it is suggested that those at higher levels of the organisational hierarchy can improve compassionate care at the clinical level by ensuring meaningful listening to and empowerment of staff at lower levels of hierarchy (McConnell, 2016). This finding underlines the need to prioritise compassion-focused values when recruiting to positions across all levels of the organisational hierarchy.

At the clinical level, the findings also suggest that difference and diversity in terms of professional backgrounds and demographic factors contribute to compassionate, tailored crisis care, which has implications for crisis team recruitment processes.

The detrimental effects of the business agenda within crisis services are highlighted by findings. The business agenda was described as involving an excessive emphasis on quantitative and financial outcomes (Greenfield, 2006), to the neglect of compassionate crisis care elements. This was confounded by a perceived disconnect between policies which advocate for compassionate care at the clinical level and business demands which demonstrate devaluation of compassionate care (Fotaki, 2015). Creating spaces to discuss the impact of the business agenda on compassionate care at a service level could be a useful starting point, with a view to identifying practicable solutions and establishing a shared understanding and ethos. At a policy level, this would then need to be reflected in terms of an acknowledgement of the dissonance between demands for compassionate crisis care and the wider business context (O'Driscoll et al., 2018).

4.10.4. Organisational and Policy Level

The results of the current study highlight that it is overly simplistic to focus calls for compassionate care at the individual level (Meyer, 2009). Indeed, compassionate crisis care is described as a complex social phenomenon, requiring a cohesive organisational approach, with explicit attention paid to power as a potential barrier to and facilitator of compassionate crisis care.

By incorporating the perspectives of experienced crisis team staff, the current study can support a clearer and more practicable description of compassionate crisis care within CRT policies. For example, the current findings indicate that attention should be paid in policy to compassionate care for CRT staff as well as patients (Meyer, 2009).

Whilst current CRT audit and outcomes at the organisational level privilege avoided admissions, bed numbers, contacts, and financial savings as key outcomes (National Health Service, 2014), the current study suggests a need for greater focus on qualitative, experiential outcomes, with a view to reinforcing and showing explicit commitment to compassionate care values. Indeed, Simpson et al. (2013) argue that compassionate care within organisations must be upheld through the adoption of congruent, considered, and collaborative policies and practices, rather that imposing disconnected policies without any demonstration of care. This disconnect could arguably be ameliorated by what Lawrence and Maitlis (2012) describe as an organisational 'ethic of care', with compassion positioned as a core organisational value (Youngson, 2008).

4.11. Conclusion

This study illuminates a need to attend to the wider context of compassionate crisis care, ensuring sufficient empowerment across levels to enable consistent 'extra mile' actions at the clinical level. Higher-level, organisational changes appear necessary, as it is likely that a compassionate orientation will need to ‘trickle’ and permeate down through the levels to clinical practice. If factors impeding compassionate crisis care are not addressed at higher levels, and the complexity of compassion as a social and organisational emotion rather than an internal psychological state is not recognised, it seems unlikely that CRT staff will be able to continue to ‘go the extra mile’ in providing consistent, sustainable compassionate crisis care.

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Appendix A: Literature Review

An initial search, using combinations of the search terms “compassion” OR “compassionate care” AND “crisis resolution and home treatment team” OR “CRT” OR “crisis resolution team” OR “home treatment team” OR “CRHT”, did not yield any relevant articles.

Following this, several search terms (Table 3) were applied to searches of the CINAHL Plus, PsycINFO, Scopus, and Academic Search Complete databases. Search dates: 09/10/2020 and 16/10/2020.

The main aims of the literature search were to explore:

- How compassionate care has been conceptualised in the literature, and particularly by healthcare stakeholders, and
- What factors have been identified as barriers to and facilitators of compassionate care?

Table 3

Search terms used to identify literature, using various combinations with the Boolean operators ‘AND’ and ‘OR’

Compassion	**Client**	**Staff**
Compassionate care	Service user	Professional
Compassionate practice	Patient	Clinician
Compassionate relationship		Social worker
		Nurse
		Practitioner
		Support worker
		Healthcare staff
		Therapist
		Doctor
		Mental health professional
		HCP
		Psychologist

Inclusion criteria:

- English Language
- Human-based
- Full text available
- Abstract/ keyword only
- Published since 2000

Exclusion criteria:

- Theoretical/ non-empirical literature

Grey literature searches were carried out using Google Scholar and UEL repository, and references cited in identified articles were reviewed to identify additional literature.

Appendix B: Recruitment Text

Hi there, I hope you’re well.
Just getting in touch to invite you to take part in my thesis research study which is looking at compassionate care in crisis teams. Participation would involve a one-hour interview over Microsoft Teams videocall.
If you’re interested in taking part, please send me your personal email address and I will send you the research information sheet to read more about the study, and the consent form, in case you decide to take part.
Please forward this message on to any other crisis team staff members who you think might be interested in taking part.
Thanks a million,
Isobel

Appendix C: Email sent to Prospective Participants

Dear (insert name),

As a part of my doctoral thesis, I would like to invite crisis resolution and home treatment team staff members to take part in individual interviews. The title of my thesis is: “Compassionate Care in a Crisis Resolution and Home Treatment Setting.’’
Participation would involve taking part in an interview, which would take place over Microsoft Teams video call. The interview will involve a discussion of ideas about compassionate care in crisis teams and should last between an hour and an hour and a half. This study is not a review of the service or of individual practice. It is intended to get a sense of how compassionate care is seen by people working in crisis team settings. The interview will be voice-recorded in order to transcribe the data. The arising data will be anonymised and the recordings will be deleted after transcription. Participation will be anonymous.

Please find the participant information sheet attached for further information. I have also attached the consent form; if you would like to be involved then please fill this in and return it to me via email, along with your demographic information, and we can arrange a time for your interview.

Should you require any further information, please do not hesitate to email me. I hope to hear back from you soon.

Kind Regards,

Isobel O’Reilly, Trainee Clinical Psychologist, University of East London
Email: u1826623@uel.ac.uk

Supervised by Dr Katy Berg, Lecturer, University of East London
Email: k.l.berg@uel.ac.uk

Appendix D: Information Sheet

UNIVERSITY OF EAST LONDON

Information Sheet

Compassionate Care in a Crisis Resolution and Home Treatment Setting

You are being invited to participate in a research study. Before you agree to take part, it is important that you understand what this will involve. Please take some time to read this information sheet in detail.

Who am I?

I am a doctoral level student in the School of Psychology at the University of East London, on the clinical psychology training course. This research study forms an element of the course requirements.

What am I seeking to study?

I am conducting research into staff conceptualisations of compassionate care in Crisis Resolution and Home Treatment Teams. I became interested in this area as I noticed that while compassionate care is emphasised in policy documents, there does not appear to be a clear definition of what this would look like in service settings.

I am aware that the current COVID-19 pandemic is causing a lot of change and distress for many people. I sincerely appreciate that you are considering participating in the current study at such a difficult time. Whilst the pandemic is naturally at the forefront of all of our minds, I am interested in a general view of compassionate care in Crisis Resolution and Home Treatment Teams and would therefore be keen to hear of your views of how compassionate care operated in this setting before the current pandemic commenced.

My research has been approved by the University of East London ethics committee. This approval means that the panel has deemed my research to be ethical and worthwhile.

Why have you been asked to participate?

I have extended an invitation to anyone in my personal and professional network who is a clinical staff member working in the crisis resolution and home treatment team, or who has left the crisis team within the past year, and has worked within a crisis team role for longer than 6 months. I am particularly interested in speaking to crisis team staff as I feel that this is a unique working environment, and this setting has not yet been studied with regard to compassionate care.

You are free to decide whether or not you would like to participate.

What will participating involve?

If you agree to participate in this study, you will be asked to take part in an hour-hour and a half-long interview, conducted over ‘Microsoft Teams’ video calls, at a time that is convenient for you. Before the interview, I will verbally confirm with you what is involved, and you will be asked to sign a written consent form and provide some demographic information. If you do not have access to a printer/ scanner in order to sign and return the written consent form, you will be asked to provide audio-recorded verbal consent before the interview commences instead, where I read out the consent form to you to confirm the various points before we begin the interview. This consent form will confirm that you have read this information sheet and agree to take part in the study. The interview will involve some questions about your experiences of working in the crisis team and your ideas about compassionate care in this setting. I will record the interviews with a password-protected audio recorder, so that I can remember what you have told me with accuracy when writing up the research.

I will not be able to provide payment to compensate you for taking part in the research, but I would very much appreciate the time that you take to share your experiences with me, and I hope that this study will improve staff and service user experiences in the future by improving understanding in the area.

Taking part will be confidential

I will ensure that your privacy is protected throughout the study. I will do so by removing your name and any identifying details from the write-up after the interview. This includes the thesis itself, as well as any resulting publications, conference attendances or presentations.

The only instance in which I would need to break this confidentiality if I think that there is a risk to you, or to someone else. If this is the case, I will do my best try to discuss this with you before contacting anyone else.

You can choose to skip any question by saying ‘pass’, and you can end the conversation at any time, without having to provide me with a reason for this.

What will happen to the information that you provide?

Once I have recorded your interview on the password-protected device, I will transcribe the interview in a secure location, removing any potentially identifying information. I will not include your name or any other identifying details in any reports that I write up.

Your anonymised data will be seen by my supervisors and the people who grade my thesis. The analysed data and illustrative quotations may also be published in a journal after I have completed the doctorate. No one will be able to identify you from the data that is included in the write-up.

After the study has been completed, I will delete the recording of your interview and your details. I will keep the anonymised transcripts of the interviews for five years following completion, in keeping with data management procedures. The transcripts will be stored securely in a password-protected file, and I will have sole access to them.

What if you want to withdraw from the study?

You are free to withdraw from the interview while it is on-going without explanation, consequence, or any form of disadvantage. You can request to withdraw your data completely from the wider study within one week of the interview, after which you will no longer be able to withdraw as I will have begun to analyse the data.

Contact Details

If you would like any further information about my research, or if you have any questions or concerns, please do not hesitate to contact me.

Isobel O’Reilly, Trainee Clinical Psychologist,
University of East London
Email: u1826623@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor, Dr. Katy Berg, School of Psychology, University of East London, Water Lane, London E15 4LZ

Email: k.l.berg@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Glen Rooney, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email G.Rooney@uel.ac.uk)

Appendix E: Consent Form

UNIVERSITY OF EAST LONDON

Consent to Participate in a Research Study:

Compassionate Care in a Crisis Resolution and Home Treatment Setting

I have the read the information sheet relating to the above research study and have been provided with a copy.

YES ☐ NO ☐

The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about the study.

YES ☐ NO ☐

I understand what is being proposed and the procedures in which I will be involved have been explained to me.

YES ☐ NO ☐

I understand that my involvement in this study, and the data that arises from my involvement in this research, will remain strictly confidential.

YES ☐ NO ☐

Only the researcher(s) involved in the study will have access to my identifying data. It has been explained to me what will happen once the research study has been completed.

YES ☐ NO ☐

I hereby freely and fully consent to participate in the study, which has been fully explained to me.

YES ☐ NO ☐

Having given this consent I understand that I have the right to withdraw from the study at any time during the interview without disadvantage to myself and without being obliged to give any reason.

YES ☐ NO ☐

I also understand that should I withdraw longer than one week after the interview has been completed, the researcher reserves the right to use my anonymised data in the study, as the analysis will have already begun.

YES ☐ NO ☐

I understand that the final research paper will appear on the university website, and that the researcher may also seek to publish this finalised piece on an online journal. I am aware that this publication will not include any identifying information.

YES ☐ NO ☐

Participant's Name (BLOCK CAPITALS)

....

Participant's Signature

....

Researcher's Name (BLOCK CAPITALS)

....

Researcher's Signature

....

Date: ....

Appendix F: Semi-Structured Interview Schedule

Many thanks for taking the time to take part in this interview.
Have you read the information sheet and signed the consent form?
Just to remind you, the interview should take about one hour to 90 minutes, and we can take a break whenever you need. I've got some broad questions to be covered during that times, so please feel free to expand on your answers as much as you like as I'd like the interview to be led by you.
I will be asking questions in order to explore your views and experiences of compassionate care. I'm interested in compassionate care in crisis teams because of my own experience of working in the NHS and my awareness of the many demands that staff can face. There are no right or wrong answers, and as this is a confidential space, please feel free to share openly and honestly around your views and experiences.
I am interested in hearing your own personal as well professional views on the subject. I would like to assure you that I understand that the pressures and difficulties and I'm not assessing your practice but more wanting to hear about the realities of working in this setting.
If you don't feel comfortable in answering a question, just let me know and we will move on. I will be recording this interview using a recording device, so that I can concentrate fully on what you are saying and will be able to take some notes if I need to.
Are you still happy to take part in the interview?
Are you ready to begin?

1. Generally, what does the word compassion mean to you?

2. What does the term 'compassionate care' mean to you?

Prompts:

- On an individual level?
- On a relational level- In terms of the interaction?
- On an organisational level- In terms of the work environment?

3. What do you feel that compassionate care looks like in a crisis resolution and home treatment team service?

4. In your experience, are there are any differences between what compassionate care looks like in crisis teams versus other services?

5. Where do you think your ideas of compassion and compassionate care come from?

6. Can you give me a specific example of compassionate care in your service? Take your time and have a think about it.

Prompts:
  - What was it about that example that made it compassionate care?
  - Do any more specific examples of compassionate care come to mind?

7. What do you think influences compassionate care in your workplace?

Prompts:
  - On a personal level?
  - In terms of the work setting?
  - In terms of the interaction with the client?
  - In terms of management?
  - In terms of the healthcare system?

8. Do you think that your immediate team share a unified view of what compassionate care means, or do you feel that there are other perspectives in your team?

Prompts:
  - What might they be?

9. Is there a difference between the care that you would like to deliver in the crisis team, and that care that you do deliver in the crisis team? If so, what do you think causes this discrepancy?

Prompts:
  - At a personal level?
  - In terms of the relationship with the client?
  - In terms of the work environment?
  - At a policy level?

10. Can you tell me of a time when you found it difficult to provide compassionate care.

Prompts:
  - What do you think got in the way of this?

    - What do you think could have helped you to deliver more compassionate care?

11. Where and what should efforts be focused on in order to enhance compassion in crisis team settings?
12. If you could make improvements to training for new staff members at the various levels (clinical staff, managers, heads of service) in compassionate care in crisis teams, what would you want the key take home messages to be?
13. Is there anything related to compassionate care in crisis teams that we have not talked about today that you think is important or were hoping to talk about?

Many thanks for taking the time to speak with me today. It has been very useful hearing your views.

I will email you a debrief sheet that includes my details if you have any questions, or if you would like to withdraw your interview data from the study. This would need to be done within one week from now, as beyond then I will have begun analysis and won't be able to withdraw the data.

I have included some numbers of support organisations, and directions in terms of how to access occupational health services within your Trust in case you feel that you would benefit from support or a space to discuss anything that came up today further.

Thank you again for your time and effort in taking part in this study.

Appendix G: Changes Made to Interview Schedule Following Pilot Interviews

Key:
Underlined= Added following Pilot Interviews
~~Strike-through~~= Removed following Pilot Interviews
Bold= Reworded following Pilot Interviews
Italics= Moved following Pilot Interviews

Semi-Structured Interview Proforma

Many thanks for taking the time to take part in this interview.

Have you read the information sheet and signed the consent form?

Just to remind you, the interview should take about one hour- 90 minutes, and we can take a break whenever you need. There are only 13 broad questions to be covered during that time, so please feel free to expand on your answers as much as you like and I'll let you know if we need to move on.

I will be asking questions in order to explore your views and experiences of compassionate care. I'm interested in compassionate care in crisis teams because of my own experience of working in this setting and my awareness of the many demands that staff face in this setting. There are no right or wrong answers, and as this is a confidential space, please feel free to share openly and honestly around your views and experiences. I am interested in hearing your own personal as well professional views on the subject, and I invite you to answer openly and I would like to assure you that I understand that there are pressures and difficulties and I'm not assessing your practice but more wanting to hear about the realities of working in this setting.

If you don't feel comfortable in answering a question, just say 'pass' and we will move on. I will be recording this interview using a recording device, so that I can concentrate fully on what you are saying and will be able to take some notes if I need to.

Are you still happy to take part in the interview?

Are you ready to begin?

1. **Generally**, what does the word compassion mean to you~~/ how do you define compassion~~?
2. What does the term 'compassionate care' mean to you?

Prompts:

- On an individual level?

    - On a relational level- In terms of the interaction?
    - On an organizational level- In terms of the work environment?

3. What do you feel that compassionate care **looks like** in a crisis resolution and home treatment team service?
4. In your experience, are there are any differences between what compassionate care looks like in crisis teams versus other services?
5. ~~What aspects of your upbringing and life so far do you feel have informed your understanding of and practice in compassionate care?~~ *Where do you think your ideas of compassion and compassionate care come from?*
6. Can you give me a specific example ~~of when you felt you observed~~ of compassionate care in your service? Take your time and have a think about it.

Prompts:

- What was it about that example that made it compassionate care?
- Do any more specific examples of compassionate care come to mind?

7. What do you think influences compassionate care in your workplace?

Prompts:

- On a personal level?
- In terms of the ~~setting~~ **work environment**?
- In terms of the interaction with the client?
- In terms of the **healthcare system**?

8. Do you think that your immediate team share a unified view of what compassionate care means? Or do you feel that there are other perspectives in your team?

Prompt:

- What might they be?

9. Is there a difference between the care that you would like to deliver in the crisis team, and that care that you do deliver in the crisis team? If so, what do you think causes this discrepancy?

Prompts:

- At a personal level?
- In terms of the relationship with the client?
- In terms of the work environment?
- At a policy level?

10. Can you tell me of a time when you found it difficult to provide compassionate care.

Prompts:

- What do you think got in the way of this?
- What do you think could have helped you to deliver more compassionate care?

11. Where and what would you focus your efforts on in order to enhance compassion in crisis team settings?
12. ~~If you were responsible for training for students in compassionate care in crisis teams, how would you go about it?~~ If you could make improvements to training for new staff members at the various levels (clinical staff, managers, heads of service) in compassionate care in crisis teams, what would you want the key take home messages to be? Take your time in terms of thinking about this.
13. Is there anything related to compassionate care in crisis teams that we have not talked about today that you think is important or were hoping to talk about?

Many thanks for taking the time to speak with me today. It has been very useful hearing your views.

This debrief sheet includes my details if you have any questions, or if you would like to withdraw your interview data from the study. This would need to be done within one week from now, as beyond then I will have begun analysis and won't be able to withdraw the data.

I have included some numbers of support organisations, and directions in terms of how to access occupational health services within your Trust in case you feel that you would benefit from support or a space to discuss anything that came up today further.

Thank you again for your time and effort in taking part in this study.

Appendix H: Demographics Questionnaire Email

Hi ******,

Many thanks again for agreeing to take part in my thesis study.

Prior to your interview, please email me the following demographic details to my secure email address:

- Sex
- Gender
- Age
- Professional role/ title
- Ethnicity
- Months/ years working in the crisis team
- Are you currently working in the crisis team? – Yes/ No

Please don't hesitate to get in touch if you have any questions about the above.

Kind regards,

Isobel

Appendix I: Debriefing Sheet

UNIVERSITY OF EAST LONDON

Debriefing Sheet

Compassionate Care in a Crisis Resolution and Home Treatment Setting

Thank you for participating in this doctoral research study. Your contribution and time are greatly appreciated.

I would like to remind you that your data will be stored securely, and any information that you have given that will be included in my thesis, and any resultant publications, will be anonymised. This means that your name and any identifying information will be removed completely.

If for any reason you would like to withdraw from the study, you can do this within one week of the interview date. After this, it will not be possible to remove your data from the final write up, but all identifying information will be removed as explained above.

If you would like to speak to someone further about any of the issues that arose, or if you feel distressed by any of the topics discussed, I have provided some information about support services at the bottom of this page. I have also included directions regarding how to access occupational health services within your Trust, should you feel the need to access some support within your work environment.

Many thanks for taking part in this research; your contribution is highly valued.

Isobel O'Reilly, Trainee Clinical Psychologist, University of East London

Email: u1826623@uel.ac.uk

Dr. Katy Berg, Research Supervisor, University of East London

Email: k.l.berg@uel.ac.uk

Support Services:

Samaritans

Website: https://www.samaritans.org

Tel: 116 123 (freephone)

Email: jo@samaritans.org

Rethink Mental Illness Advice Line

Website: http://www.rethink.org/about-us/our-mental-health-advice

Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)

Email: online contact form

Mind

Website: www.mind.org.uk,

Tel: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463

Email: info@mind.org.uk

If any of the issues that we have discussed are having an impact on your ability to work, please speak to your manager, who will give you information regarding contacting the **occupational health** department in your Trust.

Appendix J: Transcription Conventions

Table 4

Transcription Conventions- Adapted from Banister et al. (1994)

Symbol	**Used to denote**
…	Pause
[inaudible]	Inaudible piece of transcript
[laughs] [sighs]	Notable non-verbal action by participant
(…)	Some speech removed (no more than 40 words)
<>	Brief interruption to conversation

Appendix K: Excerpt from Memo Following Initial Coding of Transcript 8

Memo following Interview with P8- Date: 26.07.20

The participant discussed CC as involving ‘breaking’ or reducing professional boundaries with CRT service users. He described this as involving a willingness to break from the comfort of the professional remove and to fully collaborate with a service user. This was described as transcending or going beyond the role given to you to show care and connect with service users.

The participant also spoke about CC within crisis teams as inhibited by hierarchical settings. He described this as informed by his own position as a lower-banded staff member, which was described as sometimes associated with a struggle in being heard or listened to within the team. Described a sense of powerlessness and lack of confidence as reducing ability to generate and sustain compassionate care (something here about power?).

The participant spoke about the need for variety in terms of professional groups, suggested included extra professions such as pharmacists and occupational therapist (ideas around tailored care?).

The participant discussed feeling constrained by issues with staffing/ lack of time and a general orientation towards *“quantitative over qualitative outcomes”.* This was described as stifling and/or inhibited his ability to pursue his own desired CC in the settings, as the feedback from management centres around other values. He described this wider orientation as at times inadvertently promoting a view of service users into *“obstacles to be jumped over”* rather than human beings. This chimes with previous literature explored, so need to ensure that this is grounded in the interview data.

The participant described CC as created and enhanced by support from colleagues and managers, with that care then being passed on to service users.

Appendix L: Sample of Coding (Interview 6)

Table 5

Sample of coding from Interview 6

I: Interviewer, P: Participant

Transcript	Initial Coding	Subtheme	Main theme
I: Is there anything else we kind of comes to mind for you in terms of the word compassion?			
P: Yeah, it's quite associated with care, and being caring, isn't it?	Being caring		
Uhm, and I think that's one of the elements where, we work in care, but often the care business is not that	Lack of care in the care business	Policy versus business demands	The balancing act
caring, and I think in that sense, not always very compassionate.	Lack of compassion in caring	Humanising	Going the extra mile
Um it's hard to, yeah, I think there is an element of actually caring for the person,	Genuine care for the person		
being able to, um accept who they are, what they do, their choices?	Accepting who a person is	Transgressions blocking the flow	The operation of social power
And allowing them to make those choices.	Accepting people's choices Allowing people to make choices	Compassionate care through empowerment	
I think that's quite a compassionate thing to do instead of just telling people what they need to do.	Not just telling people what they need to do		
I: Yeah, and ask that kind of links with the next question, which is what does the term			

compassionate care mean to you? P: So, for me there very it's very closely linked to, on one hand, the idea of, um, empathy and person-centred work, uh, where you know we follow the lead of the person, not uhm, the lead of the service, I guess um, and then there is this part of like the humanist aspect of it, uhm, that is thinking about the basic human rights and right to be safe, right to health, right to, I do put you know, helping or somehow contributing for people to have those basic human rights being held, I think that that is part of this compassionate care. Um yeah, and focus on, for me, I think, and it's kind of coming from non-nursing, or social work for that matter, perspective, there is a lot of trying to understand what's going on, instead of trying to fix what's going on, and I think that sometimes just listening and understanding can be more compassionate than something to show that we think it's	Empathy Person-centred work Following the lead of the SU Not just following the lead of the service Humanistic aspects Observing basic human rights Contributing to fulfillment of human rights Trying to understand, not just to fix Sometimes just listening & understanding	Compassionate care through empowerment Balancing competing needs Humanising Humanising Making time to listen Making time to listen	The operation of social power The balancing act Going the extra mile Going the extra mile

wrong, or, you know, kind of perpetuate that idea that something needs fixing in someone... Umm, so I think, for me, the idea of compassion, compassionate care it has to do with just actually taking the time to really listen to what people have to say and to bring.	Not perpetuating the idea that something is wrong Not jumping to intervene- reinforcing idea of deficit Taking the time to listen	Compassionate care through empowerment Making time to listen	The operation of social power Going the extra mile
I: Yeah, yeah, that that's really interesting			
P: But there's always a but to all of all of this because, as much is it's written that we should be person-centred, and you know we all use those sound bites in our CVs and so on... it's still very much a service-focused, especially with, I think, within the NHS, um, it's very service-led, and, and a lot of the work that is done, it's not about what that specific person needs, it's about what the service need… umm but yeah	Person v's service-focused Service-led decisions Not tailored to the specific needs Decisions made based on service needs	Policy versus business demands Balancing competing needs Balancing competing needs Policy versus business demands	The balancing act The balancing act The balancing act
I: Yeah, that's really interesting and this idea of, you mentioned the care being led by the person rather than the service, what			

relationship does that have to compassionate care, do you think? Do you think can be compassionate when it is led by the service? How do you think those two things kind of linked together?			
P: Umm, I think because and thinking about religion, often there is like, this kind of misguided compassion, I think, where people feel sorry for someone for their circumstances, for their lives, and they try to help… but by trying to help, sometimes they're reinforcing, uhm, what is wrong in the 1st place? Or what is, you know, what the issue or trauma might be. It's kind of misguided compassion if it's because you as a professional feel the need to help, rather than going with what the person actually needs and it is telling you they need. So I think that that's where it's so important to, the idea of person-centred for true compassionate care, and being led by a service user rather than the professional.	Risk of misguided compassion Shouldn't be pitying Not reinforcing idea of deficit Not causing further problems for the person Intervention not motivated by own agenda as clinician Tailored intervention to what SU needs True person-centred care Putting SU first rather than the professional's agenda	Making time to listen Compassionate care through empowerment Balancing competing needs Making time to listen Balancing competing needs	Going the extra mile The operation of social power The balancing act Going the extra mile

I: Yeah, yeah, that's really helpful, and what might care look like when it is led by the service when it's not led by the service user?			
P: Uhm, it's kind of one size fits all, ‘this is what we have to offer’, so it's kind of	Tailored care, not ‘one size fits all’		
‘take it or leave it’, um, tell um, and it's something with the crisis team, uhm,	Not a ‘take it or leave it’ offer	Balancing competing needs	
you know we talk about thresholds or lot, uh, we talk	Narratives around CRT threshold		The balancing act
about, you know, it's for people in crisis... what does that crisis look like? That's a whole new, a whole other	Lack of clarity around what constitutes a crisis	Balancing competing needs	
discussion. And so, I think we keep talking, for me one of the hardest things to do is to,	Staff having to explain threshold to SU	Policy versus business demands	The balancing act
um, is to explain, not taking someone on, and having to explain that it's just, it's not that they don't need something, or it's just that we are not the service for	Difficulty in validating SU when not taking SU on		
them… and, you know, for a lot of people this is just	Threshold causing SU to feel rejected		
one more rejection, they've been asking for help, um, and this is just one more, a rejection.	Requests for help rejected		
And, you know, well, that's just part of life, rejection and frustration is part of	Keeping SU’s possible experience in mind	Humanising	Going the extra mile

life, but I think for some people, uhm, it's not compassionate.			
Uhm, you know, we keep perpetuating those cycles of rejection, or that, you know, ‘there's nothing we can do	Perpetuating cycles of rejection due to thresholds		
for you’, or that, uh, you know ‘we're not the right service’, and a lot of the	Moral distress at causing SU to feel rejected	Care in the moment versus tough love	
times it comes across as ‘you don't fit our criteria’ and that's how it’s often phrased as well. So	Difficulty communicating thresholds		The balancing act
I mean it is a horrible thing to hear ‘you don't fit our service, so	Importance of language used	Spreading compassion across a caseload	
we're not taking you on’, so yeah it's the importance of	Communicating compassionately		The balancing act
language when phrasing things.	Remaining mindful of language	Humanising	
Saying that this service is not for you, is kind of different from saying ‘you don't fit our criteria’.	Using language to reduce sense of rejection		
I: Yeah			Going the extra mile
P: And sometimes rejection, or keeping very firm limits and	Firm boundaries sometimes compassionate	Humanising	
boundaries is very compassionate, because it helps people develop within those	Helping people to grow through boundaries		
restrictions, which we all are subject		Care in the moment versus tough love	
to, but at the same time, a lot of the time, I feel that those- and I'm	Need for specific thought around diagnosis of		

thinking specifically of working with personality disorders, but any patients really- there is the boundaries, so ‘it’s very important to keep boundaries’, ‘it's very important to, you know, establish limits’, but are we establishing them for the patient, or is it for the service, and because the service can't deal with it or can't cope with the complexities of things?	personality disorder		The balancing act
	Purpose of narratives around need for boundaries	Care in the moment versus tough love	
	Boundaries sometimes more for staff than SUs	Balancing competing needs	
	Lack of reflection around reason for boundaries		
	Staff defensive reaction to complexity at service level	Balancing competing needs	The balancing act

Appendix M: Theme Development

Figure 3

First draft: theme development process

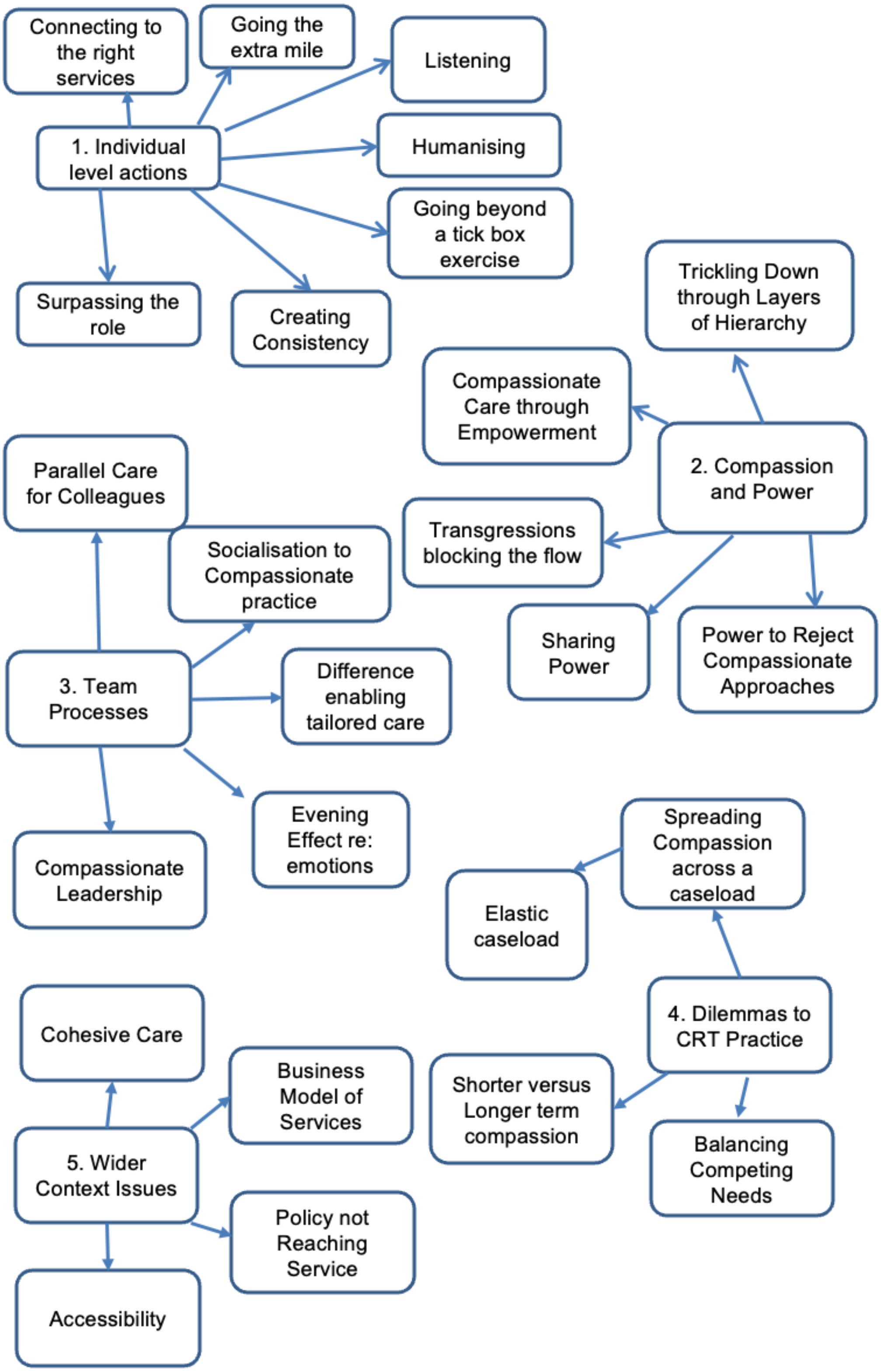


Figure 4

Second draft: themes development process

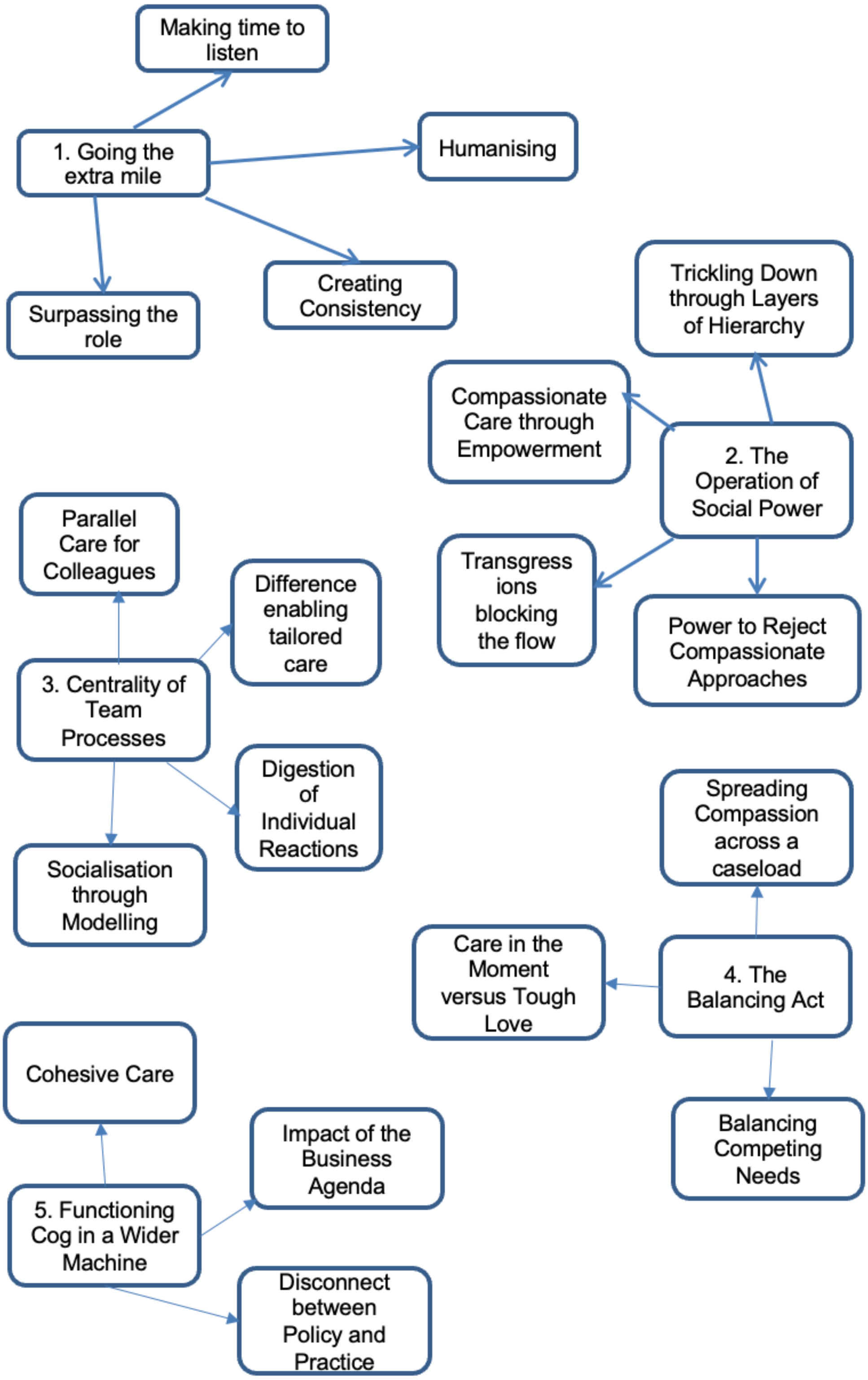
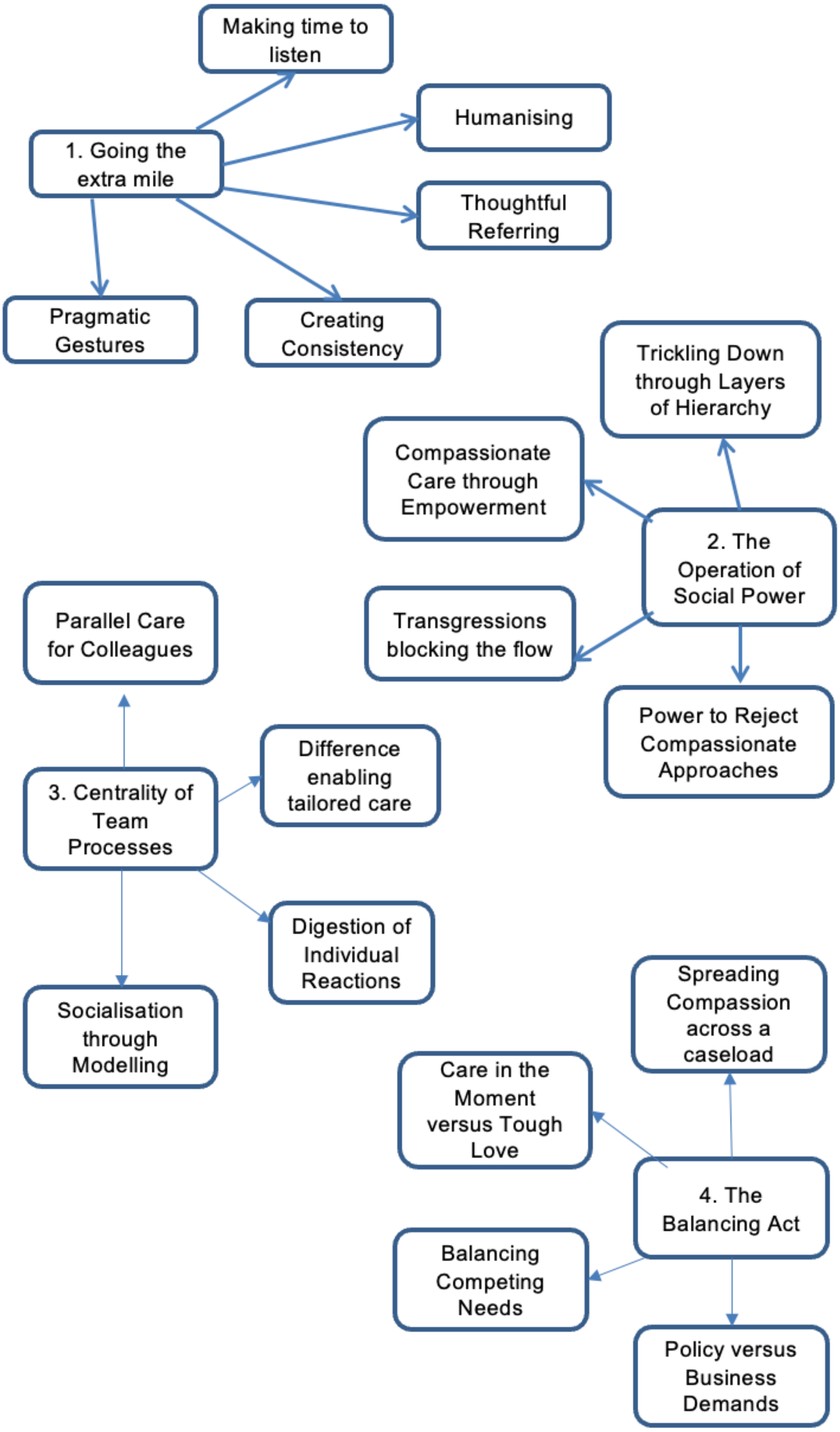


Figure 5

Third and final draft of themes



Appendix N: Table Detailing Methods Used to Promote Trustworthiness in the Data

Table 6

Establishing trustworthiness at each phase of thematic analysis based on Nowell et al., 2017

1.Familiarisation with the data	- Prolonged re-reading of the data - Thoughts, reflections and ideas about codes and relevant theory documented concurrently - Records of interviews, notes and transcripts maintained and revisited
2. Generating initial codes	- Record maintained of process of code generation - Writing in reflexive journal - Record maintained of decisions made and rationales
3. Searching for themes	- Keeping copies of mind maps used to organise themes - Completed triangulation of participant views - Record maintained of decisions made and rationales
4. Reviewing themes	- Peer debriefing- Discussing with director of studies (DoS) and thesis group - Reviewing potential themes in relation to codes and whole data set - Records maintained of decisions made and rationales
5. Defining and naming themes	- Peer debriefing- Discussing with DoS and thesis group - Themes and subthemes reviewed in relation to the data - Records maintained of decision-making processes
6. Producing the report	- Peer debriefing- Discussing with DoS and thesis group - Triangulation with the existing literature - Records maintained of the decision-making processes

Appendix O: Ethics Application Form

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2019)

FOR BSc RESEARCH
FOR MSc/MA RESEARCH
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

1. Completing the application

1.1 Before completing this application please familiarise yourself with the British Psychological Society's Code of Ethics and Conduct (2018) and the UEL Code of Practice for Research Ethics (2015-16). Please tick to confirm that you have read and understood these codes: ☒

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. By submitting the application, the supervisor is confirming that they have reviewed all parts of this application, and consider it of sufficient quality for submission to the SREC committee for review. It is the responsibility of students to check that the supervisor has checked the application and sent it for review.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter ☒

- The participant consent form ☒

- The participant debrief letter ☒

1.6 The following attachments should be included if appropriate. In each case, please tick to either confirm that you have included the relevant attachment, or confirm that it is not required for this application.

- A participant advert, i.e., any text (e.g., email) or document (e.g., poster) designed to recruit potential participants.

  Included ☒ or

  Not required (because no participation adverts will be used) ☐

- A general risk assessment form for research conducted off campus (see section 6).

  Included ☒ or

  Not required (because the research takes place solely on campus or online) ☐

- A country-specific risk assessment form for research conducted abroad (see section 6).

  Included ☐ or

  Not required (because the researcher will be based solely in the UK) ☒

- A Disclosure and Barring Service (DBS) certificate (see section 7).

  Included ☐ or

  Not required (because the research does not involve children aged 16 or under or vulnerable adults) ☒

- Ethical clearance or permission from an external organisation (see section 8).

  Included ☐ or

  Not required (because no external organisations are involved in the research) ☒

- Original and/or pre-existing questionnaire(s) and test(s) you intend to use.

  Included or

  Not required (because you are not using pre-existing questionnaires or tests) ☒

- Interview questions for qualitative studies.

  Included ☒ or

  Not required (because you are not conducting qualitative interviews) ☐

- Visual material(s) you intend showing participants.

  Included ☐ or

  Not required (because you are not using any visual materials) ☒

2. Your details

2.1 Your name: Ms Isobel O'Reilly

2.2 Your supervisor's name: Dr Katy Berg

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): Initial date: May 2021,
Resit date: May 2022

3. Your research

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.

3.1 The title of your study:
Compassionate Care in a Crisis Resolution and Home Treatment Setting

Your research question:
1) How do CRT staff conceptualise compassionate care?
2) What do staff view as barriers to and facilitators of compassionate care within a crisis team setting?

3.2 Design of the research:

This is a qualitative study, consisting of individual, semi-structured interviews, conducted via Microsoft Teams video calls. Individual, semi-structured interviews have been selected in order to allow participants to freely express their views (Carruthers, 1990). Individual interviews have been selected in preference over a focus group methodology in order to reduce the potential inhibition of views caused by the presence of colleagues. Furthermore, on a practical level, owing to varying shift patterns, it would be decidedly challenging, if not entirely unworkable, to gather a number of Crisis Resolution Team staff in one location at the same time. This is particularly relevant in the time of Covid-19 where face-to-face focus groups would not be possible and a focus group via Microsoft Teams would be extremely difficult if not unworkable.

3.3 Participants:

Inclusion Criteria

- Currently employed in a CRT (or left the role within the past year)*
- In a full-time, paid, clinical role
- Have occupied their role for at least 6 months**
- Able to provide written informed consent

* This timeframe has been chosen in order to allow the inclusion of staff members who have left the role owing to various reasons, potentially including work stress (Mind, 2015). The study wishes to ensure that these individuals can be included, as work stress and burnout have been linked to compassion fatigue in the literature. One year was deemed to be a period within which staff may still retain and relay the salient aspects of working within the crisis role, whilst beyond this it is considered that staff may, owing to immersion in a new work/ home context, struggle to answer the questions from a crisis team perspective.

** Six months was chosen as the requisite service in order to ensure that staff have settled into the crisis team context and have gained considerable experience of direct client work within the setting.

3.4 Recruitment:

Participants will be recruited through the researcher's personal and professional networks, with a text sent to acquaintances of the researcher with information about the research, and a request to forward this on to anyone that they know who would also be a suitable participant. This 'snowballing' method will be used, and a post will also be placed on the researcher's social media sites inviting those who would be eligible to take part to get in touch. A secure email address will be provided for potential participants to request further information about the research and to opt-in.

The participant information sheet (Appendix III) will be provided to participants via email, three weeks before their scheduled interview. Within this timeframe participants will have the opportunity to consider participation, and to withdraw if desired.

3.5 Measures, materials or equipment:

A semi-structured interview schedule will be compiled. Questions will be chosen with reference to previous research and with attention paid to allowing participants space within which to share their experiences. A password-protected audio recorder will be used to record interviews.

3.6 Data collection:

The interviews will take place via Microsoft Teams video calls, in observance of the current lockdown as a result of the Covid-19 pandemic. Microsoft Teams has been promoted by UEL as a secure platform to be used for all university-related communications and research. Prior to the interview, participants will be asked to fill and return a signed consent form. If the participant does not have access to a printer/ scanner due to Covid-19 restrictions, verbal consent will instead be recorded using a password-protected audio-recording device prior to the interview. Interviews will last approximately one hour, and will be recorded using a password-protected recording device. Recordings will be transcribed verbatim.

3.7 Data analysis:

Data will be analysed using a Thematic Analysis approach (Braun & Clark, 2006) combining inductive and deductive methods in order to both test pre-existing theory and generate new theory.

4. Confidentiality and security

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

4.1 Will participants data be gathered anonymously?

No, the audio-recordings of interviews would arguably not be anonymous as participants could be identified by their voice. The audio-recorded data will be anonymised at the point of transcription, with all identifying removed. Participant consent forms/ consent audio recordings will be stored separately to transcripts on the UEL H-drive.

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

Following interviews, participants' data will be stored on a password-protected audio recording device, and will be immediately uploaded onto the researcher's laptop after the interview, and will then be deleted from the password-protected audio-recording device. The data will be anonymised at the point of transcription, and transcripts will be stored in password-protected files on a password-protected laptop computer. The laptop is a personal, non-networked, laptop with a password known only to the researcher.

4.3 How will you ensure participants details will be kept confidential?

The audio-recorded data will be anonymised at the point of transcription, with all identifying removed. Participant consent forms/ consent audio recordings will be stored separately to transcripts on the UEL H-drive.

4.4 How will the data be securely stored?

Following interviews, participants' data will be stored on a password-protected audio recording device, and will be immediately uploaded onto the researcher's laptop after the interview, and will then be deleted from the password-protected audio-recording device. The data will be anonymised at the point of transcription, and transcripts will be stored in password-protected files on a password-protected laptop computer. Data will be transcribed verbatim, with any identifying information (names, locations etc.) removed. The laptop is a personal, non-networked, laptop with a password known only to the researcher.

Each participant will be attributed a participant number, in chronological interview order. Transcription files will be names e.g. ''Participant 1''.

4.5 Who will have access to the data?

In the event of researcher's absence, the data should not be accessed by others. If it needs to be shared with the research supervisor, only the anonymised transcripts labelled using the interview number, will be provided. Raw audio-data will not be shared beyond the primary researcher.

4.6 How long will data be retained for?

Until the thesis has been examined and passed, after which they will be deleted.

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ☒

5.2 Your research question ☒

5.3 The purpose of the research: ☒

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☒

5.5 That participation is strictly voluntar ☒

5.6 What are the potential risks to taking par ☒

5.7 What are the potential advantages to taking pa ☒

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ☒

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation): ☒

5.10 How long their data will be retained for: ☒

5.11 How their information will be kept confidential: ☒

5.12 How their data will be securely stored: ☒

5.13 What will happen to the results/analysis: ☒

5.14 Your UEL contact details: ☒

5.15 The UEL contact details of your supervisor: ☒

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature. No

5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

6. Risk Assessment

Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

The research itself is unlikely to cause distress directly, however any contact with others may involve distress depending on how the participant is feeling in their wider life at the time.
I will provide support numbers such as the Samaritans in the debriefing sheet (provided via email directly after the interview has taken place) and advice to speak to their manager if they have continuing concerns.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

No. Interviews will be conducted from the researcher's home via Microsoft Teams.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Yes, occupational health in the relevant NHS trust, and numbers of support services.

6.4 Does the research take place outside the UEL campus? If so, where?

At the researcher's home via Microsoft Teams video conferencing website. It is currently not possible to do face-to-face interviews owing to the on-going Covid-19 pandemic.

If so, a 'general risk assessment form' must be completed. This is included below as appendix D. Note: if the research is on campus, or is online only (e.g., a Qualtrix survey), then a risk assessment form is not needed, and this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed: ☒

6.5 Does the research take place outside the UK? If so, where?

No

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the Ethics folder in the Psychology Noticeboard), and included as an appendix. [Please note: a country-specific risk assessment form is not needed if the research is online only (e.g., a Qualtrix survey), regardless of the location of the researcher or the participants.] If a 'country-specific risk assessment form' *is* needed, please tick to confirm that this has been included: ☐

However, please also note:

- For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?

No

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this: ☐

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead: ☐

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead: ☐

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included these: ☐

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

No   If yes, please note: I will be not be recruiting through the NHS, but instead through my personal and professional networks.

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see further details here).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

9.1 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES

9.2 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

N/A

9.3 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

No

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix:

In addition, before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as ‘my’ or ‘I’ with ‘our organisation,’ or with the title of the organisation. This organisational consent form must be signed before the research can commence.

Finally, please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Ms Isobel M O’Reilly

Student's number: Date: 02/03/20

As a supervisor, by submitting this application, I confirm that I have reviewed all parts of this application, and I consider it of sufficient quality for submission to the SREC committee.

Appendix P: Letter Confirming Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Matteo Martini

SUPERVISOR: **Katy Berg**

STUDENT: Isobel O'Reilly

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Compassionate Care in a Crisis Resolution and Home Treatment Setting

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

1

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Matteo Martini

Date: 23/04/2020

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

Appendix Q: Ethics Amendment Approval Letter

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant: Isobel O'Reilly
Programme of study: Doctorate of Clinical Psychology (DClinPsych)

Title of research: Compassionate Care in a Crisis Resolution and Home Treatment Setting

Name of supervisor: Dr Katy Berg

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
To add, in addition to the option of submitting consent to take part in the study via a written word document, the option of participants providing their consent to take part verbally before their video call interview commences, as opposed to having to print, sign, scan and return a consent form.	Due to the Covid-19 pandemic and associated lockdown, some prospective participants will not have access to printer/ scanners due the data collection period. This would therefore prevent their participation in the study without the proposed amendment in place.

Please tick	**YES**	**NO**
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	

Student's signature (please type your name): Isobel O'Reilly

Date: 08.06.20

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: Tim Lomas

Date: 8.6.20

Appendix R: Change of Title of an Ethics Application Approval

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

7. Complete the request form electronically and accurately.
8. Type your name in the 'student's signature' section (page 2).
9. Using your UEL email address, email the completed request form along with associated documents to: Psychology.Ethics@uel.ac.uk
10. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

4. A copy of the approval of your initial ethics application.

Name of applicant: Isobel O'Reilly

Programme of study: Doctorate of Clinical Psychology

Name of supervisor: Dr Lorna Farquharson, Dr Katy Berg

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Compassionate Care in a Crisis Resolution and Home Treatment Setting	This addition was requested by the examiners following the viva voce examination, in order to make the project easier to find online for other researchers and clinicians.
New Title: Compassionate Care in a Crisis Resolution and Home Treatment Setting: A Thematic Analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	X	
Does your change of title impact the process of how you collected your data/conducted your research?		X

Student's signature (please type your name):

Date: 20.07.21

TO BE COMPLETED BY REVIEWER		
Title changes approved	YES	
Comments		

Reviewer:	Trishna Patel
Date:	20/07/2021