ORIGINAL ARTICLE

Compassion in Child & Adolescent Mental Health Services - A Qualitative Staff Study

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Abstract

Background: Most of the compassionate healthcare literature focuses more broadly on generic health care providers and, to a lesser extent, on mental health services. There appears to be a dearth of literature focusing on young people's experiences of compassionate health care, both generally and, more specifically, mental health care. Child & Adolescent Mental Health Services (CAMHS) are challenged with providing a service within the constraints of a high-pressure environment. It is therefore imperative in such settings to understand facilitators and barriers to compassion.

Objective: This qualitative study aims to understand community CAMHS staff's views on compassion in routine care.

Methods: A virtual focus group was held with ten members of CAMHS staff from various disciplines. Data were collected from a local team in the North of Scotland from January 2021 to March 2021. Staff were eligible to participate in the study if they worked in CAMHS at the time of data collection and had worked within the service for at least 6 months. Data was analysed using thematic analysis.

Results: From the focus group data, four main themes emerged from the thematic analysis: Ingredients of Compassion; Compassion in Action; Compassion experienced by young people & Families; and Compassion & Systems.

Conclusion: The continually increasing demands on CAMHS services from wait-time targets and increased referrals are negatively affecting the ability to provide quality, compassionate care. Restorative practices at the individual, team, and policy levels could enhance staff compassion.

Keywords: *Compassion, child and adolescent mental health services, thematic analysis, compassion fatigue.*

INTRODUCTION

The human experience is not without challenges; life across the planet can be difficult, and across all cultures, compassion is seen as a means to alleviate distress [1, 2]. Compassion is considered essential to healthcare globally [2]. The ability of a mental health service to provide compassionate care has been linked to positive patient outcomes. These include increased patient engagement in their care [3] and symptom reduction [4]. Compassionate care providers themselves can benefit from improvements in their own mental health and job satisfaction [5].

The National Health Service Scotland 2020 workforce vision states care and compassion as its first value, linked to the organisation's aim of being a world-class healthcare service. To deliver this vision, five key areas were identified: "healthy organisational culture"; "sustainable workforce"; "capable workforce"; "workforce to deliver integrated services"; and "effective leadership and management" [6]. Given that compassion is a value that underpins the NHS, understanding what promotes or inhibits compassion, and ensuring it is central to care, is a concern for everyone working within the NHS. De Vries and Timmins (2016) [7] use the term 'care erosion' to describe the quality of care decreasing slowly over time without it being noticed. When detailing the process of care erosion, declining standards of compassionate care are documented as a key facet.

Compassion is defined by Perez-Bret and colleagues [8] as "the sensitivity shown to understand another person's suffering, combined with a willingness to help and to promote the well-being of that person, to find a solution to their situation" [8]. Van der Cingel concluded that compassion in nursing consists of seven dimensions: "attentiveness", "active listening", "naming of suffering", "involvement", "helping", "being present", and "understanding of suffering" [9]. Papadopoulos and Ali [10] took the views of other healthcare professionals into account, uncovering additional themes, including the recognition and alleviation of distress, the ability to communicate with the patient, being highly skilled in one's role, and involving the patient in their care. It would appear from the literature that there is no universally recognised definition of compassion, and therefore it remains subjective [11, 12]. The translation of the word compassion itself is "to suffer together" [13]. Sinclair and colleagues [14] encourage further research to "establish

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conceptual specificity" of compassion, so that any related research will be more valid.

A scoping review of the literature on compassion in healthcare identified several future research directions and suggested that the validity and rigor of the literature thus far have been lacking due to compassion being conceptually poorly defined [12]. No studies in any paediatric setting were found in this review. The variance in the experience of compassion across different patient groups and clinical areas supports the direction of studying compassion in a Child and Adolescent setting.

There is very little in the literature exploring the compassion experienced by staff in health care settings. However, Maddox and colleagues explored compassion among adolescents in patient wards [15]. This mixed-methods approach with ward staff highlighted that this group, like patients, needed to feel 'compassionately held'. Emotional connection, a sense of being valued, and good communication were identified as essential elements in the delivery of compassionate care. This small sample study adds to the growing evidence base in this area. However, this sample was limited to clinical staff only.

The provision of compassionate care in CAMHS and beyond is not limited to trained professionals. The experience of the young person arriving at the service for an initial appointment, often anxious or distressed, requires frontline reception staff to be compassionate. Failing to provide compassion at this time could equate to the end of a young person's CAMHS experience. The waiting area of a CAMHS service is often an overwhelming place to be. A compassionate receptionist can support ongoing attendance at a CAMHS service. There is a paucity of research taking the views of non-clinical staff into account. The majority of the literature focuses on the nursing profession and the importance of compassionate care. In a multidisciplinary service, all staff who have contact with young people and therefore deliver care will have an important view on this topic.

Building on this small evidence base, our study explores compassion in a routine community Child and Adolescent Mental Health Service (CAMHS). This study, therefore, is unique in several aspects: the CAMHS service setting, the multidisciplinary approach, and, lastly, the inclusion of non-clinical staff.

Research Question

The primary research question is: What are staff views on compassion in routine care in a CAMHS service?

METHODS

A qualitative design using focus group methodology was implemented with NHS staff working in CAMHS in Northern Scotland. Data was collected in the first quarter of 2021. To our knowledge, no existing theory or model addressed this experience, so an inductive approach was adopted. Ethical approval was sought and obtained from both NHS Research and Development (as the study was conducted on NHS premises with NHS staff) and the University of Edinburgh's School of Health in Social Sciences.

The study used a purposive sample to identify clinicians who could answer the research question. The service comprised disciplines including medical, nursing, psychology, and allied health professionals, as well as management and administrative staff.

Staff were eligible to take part in the study if they worked in CAMHS at the time of data collection, had worked within the service for at least 6 months, and were over 18 years of age. Exclusion criteria were trainees in the service or staff who did not have direct contact with Children and young People. All staff who fulfilled the appropriate criteria were sent an email inviting them to participate and asked to express interest by email. Before data collection, verbal informed consent was obtained from each study participant. Potential participants were provided with an information sheet at least 24 hours before consent to participate was sought. Any questions the potential participants had were answered, and upon agreement, a consent form was signed electronically, and the details of the focus group arrangements were discussed.

The focus group consisted of 10 participants. They came from different professional groups: nursing (5), psychology (2), social work (1), allied health professionals (1), and reception staff (1). There were 10 females and no males. Age ranged from 24 to 54 years. Length of time working in CAMHS ranged from 1 to 17 years. All participants were white, British. Therapeutic approaches used by participants included cognitive behavioural therapy, acceptance and commitment therapy, developmental trauma models, systemic family therapy, eye movement desensitisation and reprocessing (EMDR), family-based treatment, and schema therapy.

Focus groups were chosen as the data collection method. Focus groups allow participants to discuss the study topic in depth, thus providing the rich data sought in a qualitative study [16]. The focus group lasted approximately two hours.

A schedule was created, listing five questions to prompt discussion in the focus group, as follows.

1. What does compassionate care mean to you?
2. How do you know you deliver compassion in routine CAMHS care?
3. What are examples of compassion in routine care?
4. Are there any barriers to compassion in routine care?
5. Are there any facilitators to compassion in routine care?

Careful consideration was given to the wording of the prompts to ensure they were neither leading nor suggestive, whilst remaining open-ended.

To improve accessibility, the focus groups were held on Microsoft Teams.

The researcher RT, who was collecting data, was a CAMHS female nurse working on the team being studied. To ensure rigor in the research, the researcher's reflexivity will be important throughout. Consideration was given to how the researcher's role as a researcher and also as a colleague of the participants may influence the research process. For reflection and transparency, the researcher documented this in a diary throughout the study. This process can aid the researcher in understanding their position and the impact this may have on the research or analysis of data [17].

Supervision from the Chief Investigator and Academic Supervisor, who is a Clinical Psychologist, also helped to promote reflexivity throughout.

Reflective thematic analysis was conducted in accordance with the guidelines of Braun and Clark [18]: 1) Familiarising: transcribing, reading, and re-reading and immersion in the data, documenting preliminary thoughts. 2) Initial Codes: coding all data systematically, classifying data into relevant codes. 3) Themes: collate codes into potential themes, gather data relevant to each theme. 4) Review: ensure themes relate to the extracts coded and from this form a thematic map. 5) Define themes: continue to analyse to refine specifics of themes, the story the analysis depicts, describe, and name the themes. 6) Report: concluding analysis, reporting of analysis, including the selected extracts, linking analysis to the research question and literature. The primary researcher, RT, kept a therapeutic journal and reflected on themes in supervision with CP. Themes were further analysed in a second round of data analysis with additional study authors. Data sufficiency was discussed in research supervision. A summary of the results was provided to the participants for comment.

RESULTS

Four themes emerged from the data: 1) Ingredients of Compassion, 2) Compassion in Action, 3) Compassion Experienced by Young People & Families, and 4) Families, Compassion & Systems. These key themes and the corresponding sub-themes are presented below in Table **1**.

Table 1: Table of themes.

Theme	Sub theme
Theme One: Ingredients of Compassion	Sensitive Communication
	Shared Understanding
Theme Two: Compassion in Action	Flexibility
	Facilitating Change
Theme Three: Compassion Experienced by Young People & Families	Being Liked?
	Non-Reciprocal Expectations of the Service
	Doing the right thing?
Theme Four: Families, Compassion & Systems.	Cumulative stressors: "Impacting on your ability to show compassion" Compassion Erosion?
	Stressed system and stressed staff

Theme One: Ingredients of Compassion

Sensitive Communication

Participants shared that their interpersonal skills allow them to communicate compassion, bringing them closer together with patients:

> It's about active listening, not just asking questions to get the information; proper active listening, and a bit of empathy and response, rather than just going through a list of questions. (Participant 9)

Participants highlighted validation, normalisation, empathy, patience, and warmth as key demonstrations of compassion. This interpersonal focus was thought to be characteristic of the CAMHS setting, which contrasts with how families may have experienced other health care settings:

> families are quite surprised by how welcoming it is and how much better the experience has been than they expected, compared to previous, sort of medicalised experiences. And that CAMHS is just a different environment, and maybe compassion is a part of that. (Participant 10)

Participant 3 expressed a similar sentiment and recalled patients sharing, "Oh, I was at the GP practice. Got a right dragon." These participants both draw a contrast between patient perceptions of CAMHS services and those of other medical providers. External healthcare services are characterized as cold, unfriendly, and aggressive, whereas CAMHS is "welcoming" and "much better". While these observations cannot be considered an unbiased reflection of the services, they do highlight the importance of sensitive communication. This style of communication invites patients to connect with staff, showing that their experiences are valued. This is at the heart of compassion as it builds the foundation for positive relationships.

Shared Understanding

When considering how compassion is received in CAMHS, staff recalled being told, "you just get it" (Participant 4). Staff felt that a shared understanding helps them experience compassion themselves and show compassion to patients. Participants also highlighted that developing a shared understanding can be an outward show of compassion, "at the very, very beginning, you need to set those expectations, and that's compassionate, […] because then you're both kind of working towards the same goals" (Participant 2). The repetition of "very" highlights the importance

of having these conversations with patients at the start of treatment. This is tied to the practical function of a shared understanding, as it informs the "direction" and "goals" toward which staff and families work. By developing a shared understanding, staff can manage patients' expectations, aligning their hopes for treatment with the support available. In doing this, staff help create a predictable experience and foster a sense of control for patients.

Despite the importance of a shared understanding, achieving it in CAMHS is often difficult. Participants expressed that they are often unaware of patients' perceptions and whether their behaviour is considered compassionate. This indicates an area where a shared understanding is absent: "You might feel like what you're doing is the most compassionate thing, but it might not be seen that way by the patient and family, […] Maybe that's not how they understand compassion at all" (Participant 1). While staff may feel they are doing the best thing for their patients, they often get no confirmation of how this is experienced. Participant 10 recalled crying after receiving positive feedback from a patient, which they found "just so abnormal." This lack of reinforcement fosters feelings of self-doubt, as staff are unsure whether patients understand their compassion. This indicates the importance of a shared understanding, as in the absence of patient voices, staff feel less confident in their care.

Theme Two: Compassion in Action

Flexibility

Participants expressed that compassionate behaviours are person-centred. These were identified by contrasting standard practice with demonstrations of flexibility. One example of this was offering school or home visits for patients with a learning disability. This was described as "thinking out of the box" (Participant 2) as it involved adapting standard practice. This can be viewed as compassionate, as it involved additional effort from staff to make care accessible, showing patients are the priority.

Participants raised the issue of non-attendance and how they can respond compassionately to this. CAMHS services have a Did Not Attend (DNA) policy that outlines how staff should respond to non-attendance. Participant 6 stated, "Understanding cancellations, I think, is an example as well! Not always discharging people after two DNA's, *etc.*" This was echoed by participant 8, "Absolutely agree 6, currently I send out a 2-week opt-in if people's DNA. Normally, when not so stretched, I might try more to engage a YP." Here we can see that participants felt driven to understand and engage with patients, even when non-attendance was a barrier. This issue may be particularly prevalent in CAMHS, as CYP may rely on adults to support their attendance or lack the means to communicate directly with staff. Rather than relying purely on policy to inform their actions, staff members desire to connect with service users before removing CAMHS support. This shows that compassion in CAMHS involves flexibility and patience in the face of non-attendance.

A final example of flexibility in CAMHS related to the service specification and going beyond the CAMHS remit. Participant 6 recalled their experience of this:

> I meet people in, at a time in their life where they've not wanted to be alive and they've taken paracetamol overdoses, and I think actually, the compassionate thing to do, even though I know that they don't fit into our service is to review them, because actually, it's not, I think it's completely invalidating otherwise (Participant 6)

Here we see that compassion is communicated by going above and beyond to support a young person. Participant 6 is mindful that further support is outwith the requirements of their role, but they choose to provide this as they know its importance for the young person. This shows a genuine care for the patient's well-being, as the practitioner is willing to be flexible with organisational procedure. Adopting this flexible approach allows staff to put patients' needs first and prioritise these above competing demands.

Facilitating Change

Participants emphasised that facilitating change is perceived as a core element of compassionate action in clinical practice. Children, Young People & Families seek support at CAMHS for various mental health challenges, and staff perceive that compassionate action involves helping these individuals make often difficult changes in their lives to begin feeling better and thriving in their everyday lives. This commitment to facilitating change is reflected in the following extracts;

> Bearing in mind how you can be supportive in helping on a different level, like keeping things moving forward, trying to get them to resolve some of the issues (Participant 5)

> I guess in a work-based situation, you are expecting change, and you're working towards a goal with someone, so it's about being compassionate to get alongside them to help them enable change (Participant 4)

The extracts above describe how staff perceived compassionate action as actively helping patients make necessary, often challenging, changes to address complex mental health challenges. Thus, the data suggest that a feature of compassion is facilitating change through compassionate actions. For practitioners, compassion is not just momentary empathy but a commitment to helping families achieve meaningful, lasting progress in their mental health journey.

Theme Three: Compassion Experienced by Young People & Families

Being Liked?

Early discussions within the focus group centred on whether providing compassionate care in CAMHS always means you are liked. The clinicians felt strongly that they were making decisions with compassion that might lead young people or family members to dislike them. "I often feel like we have to deliver unpopular news to families, which can mean we are not always liked, and I would guess that parents then would not view us as compassionate." (Participant 2). This is clearly at odds with the assumed traits of professionals who inherently have a drive to care for others. There was, however, an acceptance that being compassionate in professional decision-making and in the best interests of the young person and family means CAMHS professionals have to tolerate this. "I think being compassionate sometimes means that you're disliked, but you can hold that, and you can take it 'cause it's the best thing for the patient." (Participant 6).

Non-Reciprocal Expectations of the Service

This, in turn, is linked to the sub-theme of perceived non-reciprocal expectations of a CAMHS service from a professional's perspective *versus* that of a young person or family member. Participants noted that young people and families referred to CAMHS expect to be offered a service and supported. They have no prior understanding of the service criteria or its capacity. CAMHS professionals are all too aware of what can and cannot be offered and work hard to manage this mismatch in expectations. Participants were aware of the potential harm of offering a service, for example, "rescuing." This also links to the facet of empowerment within compassionate care.

> I think, often with a lot of my cases, the compassionate thing to do is not to be involved, and that's not necessarily about not giving understanding and reflection, or not trying to think about what the right supports are. (Participant 10)

In the management of young people who have been involved with the service, ending their episode of care with compassion was another example given, where young people and families may not agree that this has been compassionate care. Participants were compassionate in their reflections on how this must feel for the families, as well as acknowledging this as a challenging experience for themselves as professionals in managing these mismatched expectations.

> Children or parents with children with autism, who I think could probably be in CAMHS their entire life, because the journey keeps changing, and you have to let them go at some point. You build them up to that point and explain CAMHS's expectations and expertise along the journey. And it sometimes feels a bit counterintuitive because they are struggling, but it's still the right thing. Us continuing to be involved and continuing to provide support is not the long-term compassionate thing to do for those families. It's about providing them with systemic support at times and letting them go through that process. But it can feel a bit jarring and really quite difficult as you're doing it. (Participant 5)

Participants highlighted that to understand compassion in CAMHS care fully, the views of those receiving care need to be considered. They highlighted the delicate balance between managing expectations and the service's constraints, and being compassionate and accepting that this may mean you are seen as uncompassionate and not liked by those you strive so hard to support and care for. This could link to a lack of compassion satisfaction in the role.

Doing the Right Thing?

Participants spoke of how care and compassion for families often led to internal conflict over what was right for the family and the young person, describing it as "jarring" (Participant 5) at times. Staff acknowledged a need to remain firm in their conviction that they are doing the compassionate thing, which may not always be well received by families:

> Being compassionate sometimes means you're disliked, but you can hold that and take it, cause it's the best thing for the patient. (Participant 6)

> I've had experiences where families don't view that as compassionate, particularly when it's sometimes the worst period of their life, and they want someone to help them. (Participant 6)

Moreover, staff acknowledged that families themselves were not always aware of what was best for them, only later recognising the benefit. This leads to the clinician doubting themselves:

> …how do you know if you're delivering compassionate care? You might feel like what you're doing is the most compassionate thing, but it might not be seen that way by the patient and family, ever, or it might not be until later down the line that they recognise, actually, that was the best thing for us. (Participant 1)

Central to this discussion, participants reflected that whilst they might think that they are doing the right thing, it was difficult for them to really know without receiving direct feedback from the family and young person:

> You can think you're being compassionate…. But I don't know what their [the family's] experience is. You can feel that's what you are doing, but I don't know how you measure it…it's difficult to know what their experience actually is. (Participant 8)

> There's another bit of me thinking, am I the one to be judging, whether I'm…providing compassionate

> care, or not, I'm thinking, I don't know. I think I am, but am I? (Participant 5)

Theme Four: Families, Compassion & Systems

Cumulative stressors: "Impacting on your ability to show compassion." Compassion Erosion?

Working in a CAMHS setting involves frequent changes, challenges, and stress, compounded by long waitlists and limited resources. Participants felt their ability to provide compassionate care fluctuated due to stressors from both personal and work life. Key stressors included a lack of workplace compassion, high caseloads, difficulty meeting personal needs, and the emotional toll of working with vulnerable populations. The accumulation of these stressors across both personal and professional domains was seen as negatively impacting participants' ability to show compassion, as evidenced in these extracts.

> Can we always say we're always compassionate? And there'll be times when you do think back and think, oh, maybe, you know, I didn't handle that the right way, because you're feeling busy, stressed, whatever it is. That kind of pressure we sometimes feel within the service, going from one person to the next. You can see that impacting your ability, sometimes, to be responsive and compassionate. (Participant 8)

> It is when you feel that pressure and you feel that stretched. I think it's probably then you lose your curiosity and interest in the family, and then you're just doing, you're just doing an assessment, and you've lost the depth and breadth of that, really, in terms of compassion. (Participant 5)

These extracts show the cumulative negative impact of the stressors on CAMHS staff's capacity to offer compassionate care. This suggests that CAMHS-specific stressors, alongside the existing demands of providing healthcare within the NHS, were exhausting for participants. For participants, their realities were changed by their individual perceptions that the ongoing demands and increased stress, takes an emotional toll, which negatively impacts their compassionate capacity.

Staff perceived a lack of compassionate leadership as a barrier to their own compassionate capacity. For participants, a lack of compassionate leadership from senior levels down to direct management hindered participants' ability to practice compassion in their roles.

> If there isn't a culture of compassion in the workplace, that would be a barrier to individual people being able to show compassion (Participant 1)

Participant 1 clearly illustrates that compassionate care was perceived to be influenced by the broader organisational culture. A lack of a compassionate workplace culture impedes staff members' ability to demonstrate compassion toward patients. This suggests that if compassion is not experienced in the workplace, it becomes increasingly difficult for staff to sustain their own compassionate engagement with patients.

Stressed System and Stressed Staff

Participants consistently identified rigid institutional structures as a significant stressor to delivering compassionate care in a CAMHS setting. Strict appointment schedules and the pressure to meet operational targets created a high-stress environment. For example, from the personal perspective of participant 8, described 'when not so stressed I might try more to engage YP'. Thus, being a stressed system and stressed staff were perceived as cumulative stressors that impact your ability to show compassion, as evidenced by the following extract;

> I think there are lots of systemic or institutional barriers that impact compassion, so having to see patients within a certain time frame puts a lot of pressure on the staff, which can then impact compassion…In my experience, when I feel stressed, I become more focused on appointments that people may have missed or don't think about critically. (Participant 6)

This extract highlights how rigid institutional structures, such as time pressures, act as barriers to staff's ability to show compassion. For participants, the expectation to see patients within strict time frames was perceived as fostering a sense of urgency and increasing the stress of working in CAMHS, thereby negatively impacting their ability to show compassion in routine care.

Working in CAMHS exposes clinicians to emotionally demanding and complex cases, which participants understand to contribute to the accumulation of stressors that hinder their capacity for compassion. The combination of high caseloads and the complexity of individual cases often left clinicians feeling overwhelmed, making it difficult to maintain the emotional space needed to provide compassionate care. The following extracts describe participants' experience of emotional overwhelm.

> You know if your caseload is really high or really complex, and you feel really. When overwhelmed, it can be difficult to maintain the emotional space to be compassionate. (Participant 1)

> I've got a lot of child protection cases, and I sometimes feel very compassionate toward the child, but not always toward the family. I need to be more compassionate to the families, but sometimes you don't have space in your head to be compassionate to both. (Participant 2)

These extracts highlight how the volume and complexity of cases can create an environment where compassion becomes challenging to sustain. The pressure to manage numerous high-need cases can detract from the compassionate capacity clinicians need to engage

with patients and families. Thus, suggests a disconnect between participants' ideals of compassionate care and the reality they face in practice, particularly under pressure.

While work pressures in healthcare settings are already high, individual clinicians also face personal challenges and needs that are perceived as negatively affecting their ability to deliver compassionate care. These personal factors—such as fatigue, hunger, stress, or even individual mental health were perceived to diminish their emotional capacity to consistently provide the level of compassionate care required, as evidenced in these extracts;

> Our own personal circumstances can influence our ability to be compassionate. (Participant 4)

> We might want to be compassionate all the time, but it might not always be doable to the extent we want because of other things that're going on or how we feel. To be compassionate, we can only manage it if we're, I guess, looking after ourselves… I don't know how much sleep we've had, or if we've had lunch, well, actually, that's, yeah. Cause for me, if I'm hungry, then I'm like, I need to get this appointment finished because I'm starving. So maybe I'm not always compassionate. (Participant 5)

Together, these quotes highlight how clinicians' personal needs and well-being, coupled with the demands of CAMHS, negatively affect participants' ability to offer compassionate care. This suggests that, while clinicians aim to be compassionate, individual well-being was central to the negative understanding and experience of their compassionate capacity. As such, staff perceived their personal well-being as contributing to cumulative stress, which reduced their compassionate capacity.

Overall, the cumulative toll of both institutional and individual stressors was perceived to reduce participants' capacity for compassion significantly. The demands of working in CAMHS increased staff's stress, often leaving them feeling overwhelmed and pressured, while also having to manage their own personal stressors and needs. Although some positive aspects were mentioned, they diminished over time and were outweighed by the negative impacts. As a result, the ongoing stress and emotional burden of working in CAMHS is likely to impact clinicians' compassionate capacity and how this, in turn, is experienced by the families.

DISCUSSION

Our study sought to explore the staff's views on compassion in routine CAMHS. A narrative of compassion emerged from the data. As cited in the introduction, there is no agreed-upon universal definition of compassion. However, the participants in our study concede that the ingredients of compassion are 1) sensitive communication that fosters connection and 2) shared understanding that helps staff to manage families' expectations. This was also viewed as a central tenet of CAMHS service delivery. Perez-Brett and colleagues [8] described compassion as "a willingness to help and to promote the well-being of that person, to find a solution to their situation [8]. The aim of compassionate care in CAMHS remains to provide what Perez-Bret and colleagues [8] imply, with the responsibility for promoting well-being shared between clinician and family, rather than lying firmly with the clinician. This may be extended further by considering opportunities for intervention in the wider system, for example, supporting schools and other educator providers delivering compassion-focused education intervention. As many young people have reported fearing compassion [2], wider systemic interventions can help normalise compassion, promote future help-seeking, and support engagement with CAMHS care that is compassionately bounded.

Compassion in action involved flexibility, which is often at odds with the NHS DNA policy. In CAMHS, it also involved a commitment to facilitate change during difficult periods in the lives of children, young people, and families. A striking facet of this active compassion is that it can be experienced differently by families. Interviewees discussed not being liked and how doing the right thing can be difficult and may not be well-received by families. Specific examples include sharing 'unpopular news, for example, CAMHS workers will often use the phrase 'normalising'. This form of care involves reassurance that there is no mental health difficulty and, therefore, no problem for a clinician to solve. This form of compassionate care understandably can be challenging for clients. Nonetheless, contemporary definitions of self-compassion do reference the need to understand one's own negative feelings as a normal human response to adversity [19]. Our participants also described compassionate care as resisting the urge to step into 'rescuer roles' for families. In models of compassion-focused therapy, compassion can involve clear limits, boundaries, and difficult tasks [20, 21].

The participants in this study report that organisational culture and the complexity of the work impact compassion capacity. This is in keeping with the literature review conclusion of Sinclair and colleagues [14]. The nature of CAMHS work and the scarcity of economic resources in health care generally mean clinicians are working in threat-driven mode. Competing motivations to achieve (drive) and avoid failure (threat) reduce compassion capacity [22]. Protective factors, such as Schwartz Rounds, have been shown to improve staff well-being and compassion between colleagues and service users [23]. Within teams, it is recognized that the combination of structured mindfulness and compassion training is associated with alleviating compassion fatigue, increasing self-compassion, and increasing compassion satisfaction [24]. Multi-level approaches targeted at influencing at the individual and organizational level may be delivered through compassionate leadership [15].

STRENGTHS AND LIMITATIONS

As no other studies of compassion in a CAMHS service have been found in the literature, the results serve as a starting point for understanding compassion in this area and therefore constitute a strength of the study. The study encompasses views from multiple disciplines, both clinical and non-clinical, allowing consideration of compassion across a CAMHS service.

The results, however, reflect the perspective of only 10 participants in one CAMHS service and can therefore only be understood in this context. Regarding the study cohort, no medical staff and no male members of staff participated. Theme saturation was reached within the focus group. With a longer time frame for the study and less clinical pressure, more participants may have been willing to give their time, thus allowing other potential themes to arise from the data. Of note, this study focuses exclusively on practitioners' views; future directions should include those of young people and families.

Earlier in this paper, the conceptual variation of compassion across studies was documented. Notably, our paper employed a single qualitative approach. However, future research may seek to use mixed-methods approaches, as in Maddox and colleagues [15]. In an attempt to move towards conceptual specificity, quantitative methodologies could use short-form psychometric measures of self-compassion [25].

As a member of the team being studied, RT, who collected the data, was a mother and nurse; reflexivity was crucial to ensure the results were not influenced by the researchers' position, background knowledge, and experience, given the subject area of compassion. Testimonial validity and the credibility of the data were ensured by asking participants in the research to read the results and verifying that the themes were a true reflection of the focus group discussion. To ensure confidentiality, the results were shared with other team members who were experienced in research and did not participate in the study. Results were also given to clinicians from the wider service. They operate from a site in a different locality and were not invited to participate due to subtle differences in service setup and delivery, which add to conformity and, in addition, dependability. All those questioned fed back that the results were a fair reflection of the focus group and agreed with the research findings.

CONCLUSION

Understanding what promotes compassionate healthcare will remain an NHS priority, given the robust literature highlighting its benefits for both staff and service users. Fostering a culture of compassion at every level, with appropriate supportive staff initiatives, is both the key to protecting the CAMHS workforce and to ensuring CAMHS service users receive compassionate, high-quality care.

FUTURE DIRECTIONS

The primary research question has been answered with several key themes emerging. To our knowledge, there have been no other documented studies of compassion within a CAMHS service to date. This stand-alone study of one outpatient service can therefore be taken only as a preliminary glimpse into the subject area. A follow-up study in the CAMHS setting, with a representative sample of CAMHS professionals, would be required to build on these initial findings. This study was carried out within a locality team in a Northern European country, which limits the transferability of the findings. Future research would explore compassion in CAMHS in different cultures.

This study explored staff views, and the evidence base recognizes that patients' perceptions of compassion are pivotal in understanding and promoting compassionate care [12]. Future research questions should capture the voices of young people and families.

ETHICS APPROVAL

This study has Research and Development Permission from the relevant NHS board in Scotland (IRAS No: 276128). The study also has ethical approval from Clinical Psychology Research Ethics at the University of Edinburgh. All procedures performed in studies involving human participants were conducted in accordance with the ethical standards of the institutional and/or national research committee and the Helsinki Declaration.

CONSENT FOR PUBLICATION

Before data collection, verbal informed consent was obtained from each study participant.

AVAILABILITY OF DATA

Due to the sensitive nature of the topic, the data cannot be shared on a public forum. The data is the intellectual property of the University of Edinburgh.

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CONFLICT OF INTEREST

The authors declare no conflict of interest

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AUTHORS' CONTRIBUTION

RT conceptualized the study. RT and CP prepared the study protocol. RT collected the data and prepared transcriptions. RT CL, SD & KS contributed to data analysis. RT CL, SD & KS prepared initial draft of the study. CP critically reviewed and revised the study draft. All authors have read and approved the manuscript.

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