Us and Them? Exploring Organisational and Personal Factors in Patient Dehumanisation Perceptions Among Inpatient Mental Health Professionals

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Thesis Declaration Form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Research on inpatient mental health wards often reveals complex experiences, both for staff working in these settings, and for service users being supported.

Part 1 is a systematic review using thematic synthesis to explore qualitative studies focusing on mental health professionals' (MHPs') experiences of working within Crisis Resolution Home Treatment Teams (CRHTTs). Themes from nine included studies demonstrated how MHPs perceive the CRHTT mission and the nature of the work. These closely aligned with original CRHTT values and national guidance. Although staff reported fulfilment, significant challenges such as high workload, limited resources and high responsibility were raised. Recommendations for implications and future research were made.

Part 2 is an empirical paper exploring how organisational and personal factors shape dehumanisation of service users among inpatient MHPs. A battery of quantitative self-report measures was completed by 69 NHS MHPs working on acute or rehabilitation inpatient wards. Organisational factors (feeling dehumanised or unsupported by their organisation and burnout) and personal factors (years working within inpatient settings, personal experience of mental health difficulties, individual propensity to dehumanise) were explored in relation to four dehumanisation measures. This found MHPs tended to perceive service users as less human than colleagues on three dehumanisation measures. Higher perceived organisational support and lower burnout correlated with more humanising service user views. Personal factors showed complex and surprising associations with dehumanisation, warranting further research.

Part 3 presents a critical appraisal of the research, including reflections on topic selection, difficulties with ethical approval and recruitment and consideration of the researcher's positionality and related dilemmas.

Impact Statement

Part 1 provides a systematic review exploring mental health professionals'
(MHPs') experiences of working within Crisis Resolution Home Treatment Teams
(CRHTTs). This review identified themes related to work satisfaction, particularly in
taking pride in offering an alternative to hospitalisation and the alignment of CRHTT
values with MHPs' own ethos. MHPs also emphasised the value of strong team
working and noted barriers in collaboration with other services, especially
inappropriate referrals and other challenges such as high workload and limited
resources.

To date, no systematic review focuses specifically on CRHTT staff
experiences. Existing reviews explore effectiveness (usually from a cost-effective
and admission rate reduction perspective) and service user satisfaction. However,
staff-related issues frequently emerged in these reviews as a contributor for reduced
effectiveness and service user dissatisfaction. This highlights the importance of
prioritising staff wellbeing due to the impacts this could have. This review revealed
limited research exploring CRHTT MHPs' experiences. Notably, no qualitative
studies focused explicitly on staff wellbeing or burnout. The importance of offering
service users a different experience and approach to hospitalisation, a home-based
flexible service prioritising human connection, was emphasised. Nonetheless,
challenges were reported, particularly interaction with other services and difficult
working conditions. Inappropriate referrals were often raised, stressing the need for
interventions to mitigate these such as inter-team training and CRHTTs having clear
roles, thresholds and referral criteria which should be clearly communicated to
collaborating services. Further stressors included high workload, high pressure and
responsibility alongside limited resources. This suggested a need for supervision,

protected time for reflection, debriefs and training as well as services being appropriately funded and staffed. Future research should focus on MHPs' voices to better understand their experiences and inform practical interventions, which could improve staff and service user experience.

Part 2 includes an empirical paper exploring how organisational and personal factors influence dehumanising views of service users among inpatient MHPs. The study found that MHPs tend to hold more dehumanising views of service users compared to colleagues. Greater perceived organisational support and lower levels of burnout were associated with more humanising views. Unexpectedly, personal experience of mental health difficulties and fewer years of inpatient working were both linked to more dehumanising attitudes.

To our knowledge, no previous research has explored these factors in an NHS inpatient context. Understanding what can shape dehumanising views of service users is critical, as such attitudes can negatively impact care and could contribute to toxic working cultures. The findings indicated the key roles played by organisational factors, especially how these can affect MHPs and trickle down to how they view service users. Therefore, addressing and preventing burnout and ensuring MHPs feel supported by their organisation are priority areas. The surprising associations regarding personal experience of mental difficulties and years in inpatient settings warrant further research to fully understand these processes. However, this could be related to the link between increased burnout and increased dehumanising views of service users. This research showed key differences from existing literature in physical health settings, showing the importance of specifically mental health research.

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PART 1: SYSTEMATIC LITERATURE REVIEW

A Systematic Review of Qualitative Studies Exploring Mental Health Professionals' Experiences Working in Crisis Resolution Home Treatment Teams (CRHTTs)

Word count (excluding tables, references and appendices): 11,504 words

Abstract

Aims: There has been a significant shift towards home-based services for people experiencing a mental health crisis, due to concerns and service user dissatisfaction with inpatient care. Previous reviews have shown Crisis Resolution Home Treatment Teams (CRHTTs) are generally effective in reducing hospital admissions and cost-effective, and positively viewed by service users. However, staffing related issues emerged in both reviews with no systematic review specifically on staff experience. Therefore, this review explores qualitative research into CRHTT staff experience.

Method: A systematic search of the literature was conducted to identify qualitative studies exploring staff experiences of working within a CRHTT. Five databases and citations of included studies were searched to find studies meeting the criteria. The Critical Appraisal Skills Programme (CASP) tool was used to assess the methodology quality of studies included in the review.

Results: Of the 3795 studies identified, nine studies met the inclusion criteria and were generally rated high quality with the CASP tool. Using a reflexive approach to thematic synthesis, five analytical themes were found: '*CRHTT mission and ethos*', '*Nature of CRHTT work*', '*Interface with other services*', '*Work-related fulfilment*' and '*Work-related challenges*'.

Conclusions: These themes closely aligned with the ethos and values of CRHTTs, national guidance and echoed themes from CRHTT service user and family/carer experiences. These emphasised the importance of home-based approaches, alternatives to hospital admission, flexibility and human connection. Challenges concerning interface with other services, limited resources and high pressure and responsibility were reported by staff. Recommendations for implications and future research were made.

Keywords: mental health, crisis resolution home treatment, mental health professionals' experiences, qualitative

Introduction

Historical context and theoretical framework

Over the past three decades, a significant transformation has been made across Western acute/crisis mental health services, moving away from long-stay psychiatric hospitals to community-based alternatives, often referred to as 'deinstitutionalisation' (Bachrach, 1978). This movement prioritises providing care in the person's own environment in a way to reduce hospital admissions and improve quality of life (Bachrach, 1996). These approaches also aim to address institutionalisation, a term coined by Goffman (1961). This refers to people losing parts of their identity and independence and internalising the 'patient' role often due to social isolation, stigma and the restrictions typical in settings such as psychiatric hospitals (Chow & Priebe, 2013). The emerging need for community-based services was also influenced by early accounts of service user dissatisfaction with inpatient care. Concerns were raised around power, coercion, safety and a lack of involvement and information about their care (Lovell, 1995).

Although, home-based psychiatric care approaches to purposefully divert admissions from psychiatric hospitals date back to the 1930s (Querido, 1935), the broader shift towards these community-based services became more established in the USA and Europe several decades later (Rissmiller & Rissmiller, 2006). In 2000, the UK, through the National Health Service (NHS), was the first country to mandate the introduction of Crisis Resolution Home Treatment Teams (CRHTTs) nationwide (Department of Health, 2000). By 2005, there were already 343 UK CRHTTs in place (National Audit Office, 2007) and many European countries followed suit (such as Norway; Hasselberg et al., 2011 and Germany; Gühne et al., 2011).

While there is not one main theoretical framework followed by CRHTTs (Johnson & Needle, 2008), the teams were initially influenced by Caplan's (1964) crisis intervention theory. In this theory, crisis is conceptualised as a temporary period of transition in which an individual's usual coping abilities do not suffice and thus a rapid intervention is needed. Linking with deinstitutionalisation, initial approaches tended to divert from the traditional psychiatry medical model (Bracken & Thomas, 2001) and instead took a more contextual and systemic lens to crisis. Rather than seeing a set of symptoms, this approach enabled teams to address social and environmental factors relating to crisis. These factors were actually shown in many cases to determine hospital admission, even more so than the mental health difficulty itself (Polak, 1967). Other important initial principles were addressing power imbalances between service users and professionals when crises are managed within the home (Mezzina & Vidoni, 1995) and an appreciation that coping skills are most effectively applied in the context they are learnt in therefore may equip people to better manage future crises (Stein & Test, 1980).

Terminology

In the UK and Norway, teams are most commonly referred to as CRHTTs but terms such as crisis resolution teams (CRTs), home treatment teams (HTTs) and intensive home treatment (IHT) can also be used (Johnson, 2013; Sjølie, Karlsson and Kim, 2010). As the teams essentially serve the same functions independent of the label used, the term CRHTT will be used throughout this review. People who have current or previous experience with mental health services will be referred to as 'service users' based on mental health literature (Slade, 2009) and the most frequently used term in well established guidelines such as National Institute for

Health and Care Excellence (n.d.) guidelines. People who work in CRHTTs will be referred to as mental health professionals (MHPs) throughout.

Overview of CRHTTs currently

According to UK guidance (Department of Health, 2001; Home Treatment Accreditation Scheme, 2020; Hoult, 2006), in their current format CRHTTs ideally consist of a multi-disciplinary team offering 24/7 home-based care. Usually, this is open to any working age adult (16 to 65 years) experiencing an acute psychiatric crisis, who traditionally may have been admitted to a psychiatric hospital. Interventions tend to be short-term until the crisis is resolved and the person may then be offered ongoing care by another service. Given this, an aim and often a challenge of CRHTTs is integration with other parts of the mental health system especially Community Mental Health Teams (CMHTs) and inpatient services to ensure smooth and thoughtful transitions for service users (Johnson, 2013). 'Gatekeeping' is seen as a pivotal role of CRHTTs (National Audit Office, 2007), both at the point of potential admission and discharge from hospital. CRHTTs ideally assess all people at risk of hospital admission to determine which service can best meet their needs whilst attempting to prevent hospital admission. CRHTTs also have a role in facilitating early discharge for those people in hospital (Hoult, 2006). Due to the multi-disciplinary nature of the teams, biopsychosocial interventions are typically offered. Biological needs are addressed through medication reviews and management for example. Ways of targeting psychological needs include crisis-focused talking therapy, safety planning or psychoeducation. While family/carer involvement, liaising with social services regarding housing or employment support and facilitating community connection are designed to meet social needs (Royal College of Psychiatrists, 2022).

Research on CRHTT effectiveness

Initially, research focused mainly on CRHTT effectiveness from an admission reduction and cost-effectiveness perspective, given these were key governmental aims. The evidence base is fairly mixed and contentious regarding effectiveness. Various criticisms have been outlined such as generalisability to other areas, inconsistencies in service implementation and low fidelity to the model, timing of reductions in availability of inpatient beds in general, and robustness of studies comparing time periods before and after CRHTT implementation (Jacobs & Barrenho, 2011; Onyett et al., 2008). Prior to the UK rollout, a home treatment approach showed hopeful results, as it was feasible for two thirds of people who would have otherwise been hospitalised (Dean & Gadd, 1990). Similar findings followed; the opening of CRHTTs throughout the UK were associated with reductions in admission rates (Johnson et al., 2005a) especially for teams always on call (Glover, Arts & Babu, 2006). An RCT comparing people with or without access to a 24-hour CRHTT also showed the association between CRHTTs and reduced admission rates (Johnson et al., 2005b). However, other studies found a general fall in hospital admissions in areas with or without CRHTTs (Glover, Arts & Babu, 2006) and no significant difference in admissions when aforementioned concerns regarding robustness were addressed (Jacobs & Barrenho, 2011). A much-needed systematic review (Carpenter et al., 2013) on CRHTT effectiveness concluded that eight out of 12 'pre- and post-CRT comparison' studies showed significant reductions in admission rates once CRHTTs were introduced and were more cost-effective than inpatient care. Interestingly, two out of the four studies with no significant reduction in admission rates reported experiencing staff shortages.

Research on service user and family/carer experiences of CRHTTs

As already noted, early research demonstrated service user dissatisfaction with inpatient care (Lovell, 1995). Although subsequent findings have been mixed (Woodward, Berry & Bucci, 2017), often qualitative accounts of inpatient care feature themes related to coercion, difficulties with staff and isolation from relatives (Mind, 2011; Staniszewska et al., 2019). As CRHTTs can offer an alternative to inpatient care, similar research was needed to explore service user experience of CRHTTs. Initial quantitative studies revealed higher scores on Client Satisfaction Questionnaires after CRHTT introduction (Johnson et al., 2005a), even when compared to a control group (no CRHTT input) in an RCT (Johnson et al., 2005b) suggesting a preference for CRHTT care. However, subsequent survey data revealed only 14% of UK service users felt the care they received was the right response and helped resolve the crisis (Care Quality Commission, 2015). As quantitative approaches can fall short in capturing the reasons for these ratings, exploring subjective experiences through qualitative methods was needed.

In an initial survey, service users and carers shared positive aspects of CRHTTs, such as being offered an alternative to hospital, remaining in a familiar environment, 24/7 support, and areas of concern which included long waiting times due to high demands on staff, inter-agency miscommunication and seeing several MHPs (National Audit Office, 2007). A systematic review of 13 mixed methods studies outlined three major sources of service user satisfaction for CRHTTs; i) access and availability, ii) being understood as "normal" human beings, and iii) dealing with crises in an everyday life context (Winness, Borg & Kim, 2010). They highlighted positive aspects of the service such as being seen at home, flexible MHPs respecting personal choice and the inclusion of family members. More

unhelpful issues included service discontinuity, short follow-up care, staff shortage and long waiting times for care. A more recent systematic review of 10 qualitative studies on service user experience of CRHTTs showed similar themes; i) accessibility of care, ii) the importance of therapeutic relationships, iii) user empowerment in involvement of care and iv) consistency and continuity of care (Yang, Glover & Wood, 2025). Again, service users appreciated being seen at home, traits of CRHTT MHPs, being seen as a "normal human being" and shared decision making. Some less helpful aspects revolved around staff such as poor timekeeping, impersonal and generic care and staff discontinuity.

Neither systematic review included themes relating to the experiences of service users' support networks, although two papers in Yang, Glover and Wood (2025) included a sample of carers or relatives. In these, relatives/carers were relatively satisfied with CRHTT treatment with similar themes to service users including nurses' professionalism, communication and therapeutic relationships (Giménez-Díez et al., 2020), and accessibility, reliability, flexibility and home-based treatment (Morant et al., 2017). However, family/carers voiced feeling excluded or not listened to and struggled with staff discontinuity (Morant et al., 2017).

Research on staff experiences of CRHTTs

Interestingly, while staff related issues were referred to in both research on CRHTT effectiveness and service user and family/carer satisfaction, research into CRHTT MHPs' experiences is relatively underexplored. In physical health settings, research has found a link between staff experience and service user satisfaction, showing that staff burnout, teamwork and communication directly impacted service user satisfaction and adverse events (Bragge et al., 2025). It seems reasonable to hypothesise this may be applicable to mental health settings. Additionally, general

employee burnout has been linked to increased mental health difficulties, absenteeism and high staff turnover (Morse et al., 2012). Therefore, if CRHTT MHPs experience work-related dissatisfaction and burnout, this could impact their personal wellbeing and the quality of care given to service users emphasising the importance of research within this area.

Staffing capacity issues, lack of resources and inter-team problems have been reported in 88% of UK CRHTTs (Onyett et al., 2006) suggesting a difficult working environment. This is in addition to the nature of the role, which revolves around managing high levels of risk in an urgent manner whilst a person is actively experiencing a crisis (Ford & McGlynn, 2006). Themes of suicide and violence and making difficult clinical decisions were most associated with stress in MHPs working in a UK CRHTT (Menon et al., 2015). That being said, UK CRHTT MHPs reported being moderately satisfied with their jobs with a greater sense of personal accomplishment compared to other mental health teams (Nelson, Johnson & Bebbington, 2009). Additionally, MHPs reported less emotional strain, fewer demands and higher levels of autonomy compared to acute inpatient wards and CMHTs (Johnson et al., 2012). This suggests despite the challenging work environment, CRHTT MHPs perceive the work to be rewarding with greater flexibility and independence and thus greater satisfaction in their roles. However, it is important to acknowledge the changing landscape of mental health settings at least in the UK NHS since this research (2009 and 2012) and thus CRHTT MHPs' experiences may be different now.

Between 2010/11 and 2011/12, CRHTT investment fell for the first time in a decade by £29 million (Docherty & Thornicroft, 2015). At this time, referrals rose by 16% (Buchanan, 2013) suggesting demand grew whilst funding fell. This trend

continued between 2015 and 2016 with CRHTT referrals rising by up to 61% in some NHS trusts whilst CRHTT expenditure was cut by up to 21% (Bulman, 2017). Urgent CRHTT referrals in England more than doubled between 2023 and 2024 (Murray & Mohdin, 2025). Additional concerns regarding acute inpatient bed availability and reduced staffing have been raised (BMA Board of Science, 2014; Trades Union Congress, 2018). In addition to the impacts of austerity, the COVID-19 pandemic affected workforces across the NHS in general with increased stress, burnout and pressure (House of Commons, 2021). Service users, carers and frontline MHPs voiced concerns about a UK CRHTT being understaffed and overwhelmed by demand especially during and after the pandemic with one participant stating "*crisis care is always in crisis*" (Healthwatch York, 2023, p. 57). Therefore, not only is there evidence of the direct clinical work within CRHTTs being challenging, but also additional systemic pressures and demands which may further increase the difficulties of working within a CRHTT.

Aims of the current review

Given the discussion around challenges of CRHTT working and despite existing systematic reviews on CRHTT effectiveness and service user experience, no systematic review on CRHTT MHPs' experiences exists to our knowledge. Therefore, this current review primarily aims to fill this gap by exploring the current evidence base investigating MHPs' experiences of working within a CRHTT. The review hopes to increase understanding of how CRHTT MHPs experience their role and working life given the significant impact staff experience can have on service delivery and service user experience. The review will consider practical implications and recommendations from the findings.

<center>**Method**</center>

Search strategy and study identification

      To develop the search strategy, scoping searches were conducted on Google Scholar to explore existing literature within this area. This also enabled gaps in the literature to be identified and to gain a familiarity with the most current terminology and internationally used terms for CRHTTs. The SPIDER strategy tool (Cooke, Smith & Booth, 2012) was used to develop the search strategy and derive appropriate search terms by breaking down the research question into key concepts (see Table 1 for completed SPIDER tool). Qualitative research was chosen as it closely aligns with the research question allowing for in-depth exploration into subjective experiences and views. The key concepts taken forward for the systematic search based on the SPIDER tool were: i) any MHP, ii) service type being a community crisis mental healthcare setting and iii) exploring experiences, views or perspectives. Although the review is focused on qualitative research (including mixed methods with a substantial qualitative component), a term stipulating the specific approach of qualitative or a specific methodology was not included in the search strategy due to the limited pool of research in this area and the risk of limiting the studies found or excluding studies utilising mixed methods.

Table 1

Compiled SPIDER Tool

SPIDER	Current review
S - Sample	Any staff member working within a community mental health crisis setting.
PI – Phenomenon of Interest	Working within a community mental health crisis setting for an adult population.
D - Design	Any qualitative design (structured or unstructured interviews, either individually or in a focus group).
E - Evaluation	Experiences, perceptions and views of staff members regarding the phenomenon of interest.
R – Research type	Qualitative research, or mixed methods if there was sufficient qualitative data which was distinct from quantitative

Five electronic databases, PsycINFO, EMBASE, Medline, Web of Science and CINAHL Plus, were searched on the 12th of December 2024 for articles since the year 2000 that contained the search items listed in Table 2 within the title, abstract or key words (see full searches by database in Appendix A). Although the crisis resolution approach existed prior to 2000 in various forms, given the major transformation since the year 2000 and the national mandating of CRHTTs across the UK (Department of Health, 2001), a decision was made to include publications from 2000 onwards (similar to other reviews in this area such as Sjølie, Karlsson and Kim, 2010).

The search terms were based on above key concepts, previous reviews, discussions with thesis supervisor and with a specialist librarian in psychology. As demonstrated in Table 2, search terms related to the three aforementioned main concepts, focused on staff, experience and crisis setting.

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Table 2

Final Search Terms Categorised by Key Concept

Key concept 1: Staff terms		Key concept 2: Experience terms		Key concept 3: Community crisis home treatment teams
(staff* OR worker* OR professional* OR clinician* OR practitioner* OR psycholog* OR psychiatr* OR therapist* OR nurs* OR "social worker*" OR "occupational therapist*" OR "healthcare assistant*" OR "support worker*" OR doctor*)	**AND**	(experience* OR perception* OR view* OR perspective*)	**AND**	("crisis resolution*" OR "crisis intervention*" OR "crisis team*" OR "home treatment*" OR "crisis house*" OR "mobile cris*") **OR** ((("mental health" or psych* or suicid* or "self-harm*" or "self-injur*") adj3 (cris* or emergenc* or acute)) AND ((home or community) adj3 (treatment* or team* or service*))

Note. Boolean operator "AND" combined concepts and "OR" in concept 3 enabled studies with CRHTT equivalent without it being named as such to be found. Truncation symbol "*" allowed variations of a root word with different endings. Proximity operator "adj3" allowed for terms within three words of another to also be found.

All references found from the searches were imported into EndNote and duplications were removed. Following de-duplication, all references were imported to Rayyan, a web-based platform designed to streamline initial screening processes in systematic reviews (Ouzzani et al., 2016). Each paper's title, abstract and keywords were screened against the review criteria (see next section). These were screened by the first author (ST). 10% (400) of studies were also screened for inclusion by a

second, independent reviewer (HB) and agreement was considerable (99%) with five

conflicts which were resolved via further discussion.

To ensure all relevant studies were included in the search results, a thorough

hand search was completed in addition to database searching (Haddaway et al.,

2015). This was done by reading the title, and abstract where relevant, against the

review criteria. This was done for: i) all references included in previous scoping or

systematic reviews within this area cited in the introduction, ii) all references included

in the final nine studies and iii) all 217 results from a Google Scholar advanced

search (("staff*" AND "crisis resolution home treatment team*" AND ("experience*"

OR "perspective*" OR "perception*" OR "view*")).

Review eligibility criteria

The inclusion criteria for the current review were: i) any MHP (regardless of

professional role, length of time in team) working within any community crisis team

for people experiencing a mental health crisis (excluding crisis houses as they use a

significantly different model of delivery to CRHTTs) for an adult population (18+), ii)

studies which explicitly named staff's "experiences", "perspectives", "perceptions",

"views" or "discourses" in at least one of their aims (excluding any study exploring a

specific diagnosis or intervention), iii) qualitative or mixed methods with a substantial

qualitative component to the research, distinct from the quantitative findings, iii) peer

reviewed articles and iv) title and abstract available in English. See Table 3 for

detailed inclusion and exclusion criteria.

In terms of population, studies including experiences of MHPs alongside other

sample groups such as service users, family members or carers, CRHTT

collaborators or developers were only included if the findings from each separate

group were reported distinctly and clearly enough to extract data specific to MHPs.

Studies reporting findings in an amalgamated or general manner across sample findings were excluded. Regarding setting, the CRHTT model was considered internationally and services with an equivalent or very similar model outside of the UK were included and those with a slightly different remit or role were excluded. If the service included emergency services (for example police or emergency department staff) or was another crisis related service such as charity run crisis telephone helplines or crisis house, the study was excluded as neither operate the same as CRHTTs and thus staff experience could vary significantly. The focus of the study was considered carefully in relation to the research question, and thus only studies including an aim explicitly naming MHP experiences (or synonym for experience) were included. This led to studies focusing on a specific intervention, such as reflective practice or new implementation model, or a specific diagnosis, such as 'borderline personality disorder' or dementia to be excluded due to not aligning with the research question.

Table 3

Inclusion and Exclusion Criteria

Area	Inclusion Criteria	Exclusion Criteria
Population	Staff members, regardless of their professional role or time within the team.	Service user or family/carer only samples, collaborators with crisis teams.
Setting	Working within any community mental health crisis service including CRHTT, crisis cafes.	Working in an inpatient setting, crisis houses, or crisis telephone helplines for example Samaritans.
	For an adult population (18+).	For children and adolescents (below 18), or older adults services (typically 65+).
Focus	Study explicitly names staff's "experiences", "perspectives", "perceptions", "views" or "discourses" in at least one of their aims	Any specific diagnosis or intervention
Papers	Qualitative or mixed methods with a substantial qualitative component distinct to the quantitative findings.	Quantitative data only.
	Peer-reviewed papers.	Non-peer reviewed papers including theses, conference abstracts/presentations, systematic or literature reviews.
Language	English	Any other language than English

Quality appraisal

The Critical Appraisal Skills Program (CASP) qualitative checklist (CASP, 2025) was used to measure the quality of the final studies included in the review. The tool, consisting of 10 questions, assesses the rigour and validity of qualitative studies in various areas such as research aims, methodology and findings. There is no particular guidance on scoring or allocating a specific rating however for the

purpose of this review, each item was assigned a number so a score could be displayed. Each question was scored as 'Yes' (1 point), 'Can't Tell' (0.5 point) or 'No' (0 point). Therefore, the overall score ranged from 0 (lowest quality rating) to 10 (highest quality rating). Both the first author (ST) and independent reviewer (HB) assessed all final studies.

Data extraction and synthesis

The following data were extracted from all included studies into an Excel spreadsheet; i) author(s), ii) year of publication, iii) study title, iv) country, v) study aim(s), vi) sample including size, professional role and any demographic information provided, vii) data collection method, viii) data approach and analysis, ix) main themes, subthemes or discourses and x) all staff participant quotations.

A thematic synthesis was conducted for this review, as outlined in Thomas and Harden (2008). Thematic synthesis can describe and summarise qualitative data and generate themes across different papers. This is mostly used across literature to synthesise people's experience of a phenomenon, therefore it felt closely aligned with this review's research question. Thematic synthesis involves three main stages; i) line by line coding, ii) developing descriptive themes and iii) generating analytical themes.

Firstly, an in-depth reading of all final papers was completed on multiple occasions to familiarise the author. The main themes and sub-themes were extracted from each paper and an initial consideration of similarities across papers was made, both via post-it notes and on a Microsoft Excel spreadsheet (see Appendix B). Anything underneath the 'results' or 'findings' section of each paper was inserted into a Microsoft Word document. A search for supplementary information or additional files was done for each paper, which was included if they

reported further 'results', 'findings' or quotes. This was only the case for one paper (Morant et al., 2017) in which an additional file including further participant quotations was inserted into the Microsoft Word document.

Line by line coding was completed; this was done by assigning a meaning/'code' to each sentence, with each sentence having at least one of these codes but some having multiple. For example, in the line *'You're empowering the client and including them in the decision-making process a lot of the time'* (from Freeman, Vidgen and Davies-Edwards, 2011, p. 5), the two codes assigned were; 1) Empowering service user and 2) Collaborative decision-making. Sections referring to other parts of the sample (such as non-CRHTT MHPs or service users) were 'crossed out' using strikethrough to ensure they were not included in synthesis but were included in the document for context (see Appendix C for an example of coded results process). All 138 initial codes were extracted onto an Excel spreadsheet, organised by paper then by number of times featured across the final papers (see Appendix D). Codes were read through, and those referring to similar concepts were grouped together into one code resulting in a total of 98 codes. From these codes, 14 descriptive themes were generated which were then used to develop higher level analytical themes which are presented in the results section.

To ensure the analytical themes reflected, rather than replaced or duplicated, the original themes identified in the nine included studies, the primary papers were revisited after the initial analysis. This process confirmed that the thematic synthesis both incorporated key information and extended the original themes to generate higher-level insights across the nine included studies.

Reflexivity statement

The first author is a white, female, trainee clinical psychologist with an interest in acute care including CRHTTs and inpatient care. She has experience working within inpatient mental health settings as a support worker and as part of an assertive outreach team for young people experiencing a mental health crisis as a trainee clinical psychologist. She does not have experience working within a CRHTT nor personal experience of being a recipient of care from acute mental health services. The second author (main supervisor) is a clinical psychologist with extensive experience working within rehabilitation but not acute inpatient settings, and in community teams interacting with CRHTTs; and the third author (second supervisor) is a professor in clinical psychology specialising in stigma research. The first author recorded reflections throughout the review process and discussed these with the research team to reflect on potential influence of her own background and experiences and where possible to minimise bias when interpreting the literature.

Results

Study selection

The current review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines and was registered on the Prospective Register of Systematic Reviews (PROSPERO; registration number: CRD42024626760). The PRISMA flow diagram is presented in Figure 1 showing the inclusion of papers throughout each stage. A total of 7541 papers were identified in the initial database search. After removing the duplicates (n = 2557) and papers prior to the year 2000 (n = 1189), 3795 papers remained. Of these 3795 papers, 3737 did not meet the initial inclusion/exclusion criteria at the title and abstract stage and were excluded. The seven articles identified via citation and

reference searching and one article from the Google Scholar search were then included. The remaining 66 papers (58 from databases, 8 from other methods) were read in full and a total of nine papers were decided as eligible for the current review. The 66 papers eligible for full text screening were screened by the first author (ST). Approximately 20% (14) of studies were also screened for inclusion by the second independent reviewer (HB) and agreement was 86% due to two disagreements. These disagreements were resolved through discussion and consulting thesis supervisor.

Figure 1

PRISMA Diagram
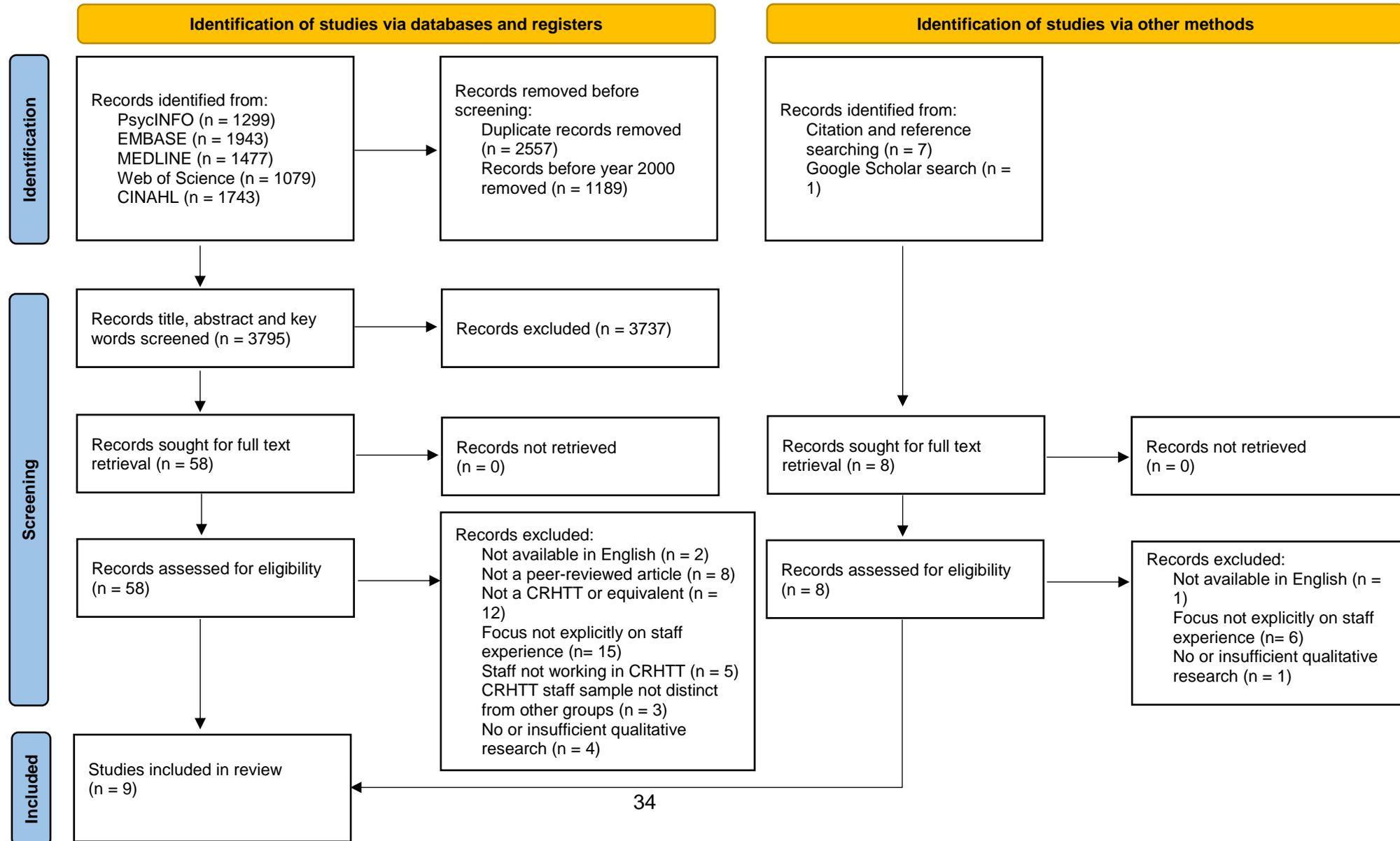
Study characteristics

The key characteristics from the nine studies included are summarised in Table 4. The studies were published between 2011 and 2024. Two thirds of the studies were based in the United Kingdom (n = 6) with others conducted in Norway (n = 2) and Spain (n = 1). Most studies referred to CRHTT or CRT with one study referring to HTT (Home Treatment Team) and another study referring to IHT. All of these teams appeared to share similar approaches closely aligning with the CRHTT model. Studies varied in terms of recruiting participants from a single site or across different sites and localities. Overall, the studies covered both rural and urban areas.

The aims and objectives were relatively closely aligned in terms of exploring a part of CRHTT professionals' experiences however some had more specific focuses than others. Two studies looked at gatekeeping and risk responsibilities, one study explored psychosocial care and one study was interested in the relation between personal history and professional role. Most studies recruited a profession mix within their samples, although two studies focused specifically on nurses' perspectives and one study on clinical psychologists as they were interested in experiences specific to that professional role.

Sample sizes ranged significantly from five CRHTT MHPs to 88. There was a total of 166 CRHTT MHPs across eight of the studies, with an additional estimated 48 CRHTT MHPs from Klevan et al. (2018) as their sample size was not reported but an average number of six MHPs in each of the eight focus group interviews was provided. Most studies presented the job role split in the sample size; with nurses being the most represented, but across the nine studies at least one study included each of the core CRHTT disciplines (nursing, psychiatry, psychology, social work). Two studies also included a sample of service users and carers exploring their

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views, and one of these studies included CRHTT referrers, collaborators and developers. These parts were excluded from the analysis as aforementioned. Limited demographic information was provided and the two studies with additional non-CRHTT MHP samples only provided their overall demographic information which is cannot be used. The majority of studies (n = 6) included the sample's gender split which showed a skew towards females, and four studies reported an average age (most commonly in their thirties) or age range. Only one study reported the sample's ethnicity breakdown which was an all-White British sample (Freeman, Vidgen and Davies-Edwards, 2011). Of the studies reporting years of experience in crisis community care, this ranged from 1-3 years to an average of 11.5 years and was most commonly around 2-3 years.

The qualitative data collected was mainly through semi-structured interviews (n = 6), although focus groups were also used (n = 3). A variety of qualitative approaches and analysis methods were used including thematic analysis (n = 3), Interpretative Phenomenological Analysis (IPA) (n = 2), Hermeneutic-Phenomenological Approach (HPA) (n = 1), grounded theory (n = 1), discourse analysis (n = 1) and case study (n = 1).

Table 4

Study Characteristics/Data Extraction Table with Studies Presented in Date Order

Author(s) and Year	Title	Country	Study aim(s)	Sample	Data collection method, approach and analysis	Main themes
Freeman, Vidgen and Davies-Edwards (2011)	Staff experiences of working in crisis resolution and home treatment.	South Wales, UK	To investigate the experiences of individuals working in a CRHT service, to provide an in-depth understanding of their subjective accounts	N = 5: 4 mental health nurses, 1 community worker (3 female, 2 male. All White British. Average age: 38. Average time in CRHT 2 years 5 months).	Semi-structured interviews. IPA.	1) Motivating factors 2) Stressors 3) Coping
Sjølie, Karlsson, and Binder (2013)	Professionals' experiences of the relations between personal history and professional role.	Norway	To explore how CRHT team members experience possible relations between their personal histories and professional roles	N = 13; 8 nurses, 3 social workers, 2 psychologists (11 female, 2 male. Aged between 27 and 59).	Semi-structured interviews. Hermeneutic-phenomenological approach.	1) Experiences related to the participant as an individual 2) Work related experiences 3) Family related experiences
Murphy, Vidgen, Sandford and Onyett (2013)	Clinical psychologists working in crisis resolution and home treatment teams: a grounded theory exploration.	England and Wales, UK	To explore clinical psychologists' experiences of working in CRHTTs including their relationships with other professionals and perceptions of working with service users in "crisis"	N = 11; 11 clinical psychologists (9 female, 2 male. Average time in CRHT 2.8 years).	Semi-structured interviews. Grounded theory exploration.	1) Psychological and clinical work 2) Team work
Begum and Riordan (2016)	Nurses experiences of working in Crisis Resolution Home Treatment Teams with its additional gatekeeping responsibilities.	Midlands England, UK	1) How do nurses experience the gatekeeping role in addition to their responsibilities as nurses working within CRHTT? 2) What factors influence their ability to gatekeep effectively?	N = 6; 6 community psychiatric nurses working across 2 CRHTTs (3 female, 3 male).	Semi-structured interviews. Thematic analysis.	1) Gatekeeping as a specialist role 2) Core principles of gatekeeping role 3) Redefining risk management for gatekeepers in CRHT 4) Future of gatekeeping
Morant, Lloyd-Evans, Lamb, Fullarton, Brown, Paterson and Johnson (2017)	Crisis resolution and home treatment: stakeholders' views on critical ingredients and implementation in England.	England, UK	To investigate stakeholders' experiences and views of CRTs and what is important in good quality home-based crisis care	N = 88*; 61 CRT clinical staff, 14 CRT senior managers, 13 CRT senior staff.	Focus groups. Thematic analysis.	1) Organisation of CRT care 2) Content of CRT work 3) Role of CRTs within acute and continuing care systems

Authors	Title	Location	Aim	Sample	Method	Themes
Sacks and Iliopoulou (2017)	The impact of professional role on working with risk in a home treatment team.	London, England, UK	To explore how the staff of a well-established HTT experience risk.	N = 24; team manager, psychologist, nurses, social workers, occupational therapists, 2 support workers, 2 psychiatrists, junior doctors.	Focus groups. IPA.	1) Managing risk in the context of caring for the client 2) Managing the impact on ourselves
Klevan, Karlsson, Ness, Grant and Ruud (2018)	Between a rock and a softer place—A discourse analysis of helping cultures in crisis resolution teams	Norway	To identify and explore how clinicians in CRTs construct discourses of helpful help	No reported N. Clinicians from 8 CRHTTs with an average of 6 participants in each group. Nurses, psychologists, social workers, medical doctor/psychiatrist (two thirds female, age 26 to 48, average length in mental health services 11.5 years).	Semi-structured focus groups. Discourse analysis.	Discourse 1: "The creators of something new and different" – help as made Discourse 2: "the representatives of the expert system" – help as given
Giménez-Díez, Maldonado-Alía, Torrent-Solà, Granel and Bernabeu-Tamayo (2022)	Nurses' Experiences of Care at Crisis Resolution Home Treatment Teams: A case study research.	Barcelona, Spain	To explore nurses' perceptions and constructions about care in CRHTT services	N = 10; 10 registered nurses (7 female, 3 male. Average age of 34. Experience of CRHT 1-3 years).	Semi-structured interviews. Case study, conceptual framework under constructivism theory.	1) Nurses' perspectives of the care provided 2) Nursing setting of care at home 3) Nursing care plan at home
Clibbens, Close, Poxton, Davies, Geary and Dickens (2024)	Psychosocial Care Delivery in Intensive Home Treatment During a Mental Health Crisis: A Qualitative Thematic Analysis.	North England, UK	To explore staff, service user and carer experiences of receiving and delivering psychosocial care in the context of IHT.	N = 9; 8 registered nurses and 1 psychiatrist (at least 2 years of experience in IHT).	Focus groups. Thematic analysis from critical realist epistemology.	1) Staffing model and effective care provision 2) Organisation of work and effective care provision 3) Fit between skills and training and service user need 4) Service user and carer involvement and personal choice 5) Centrality of effective communication

Note: *The sampling in Morant et al. (2017) involved multiple different groups. In the staff sample, there is a total of 147 participants including CRT clinical staff, CRT managers, senior managers and CRT referrers. In the breakdown, it is reported there were 61 CRT staff, 39 senior staff, 14 senior managers. Then they report final number of participants working in CRT as 88. It is assumed that the 61 CRT staff is included and 14 senior managers, then an additional 13 from the 'senior staff' sample which must work in a CRT setting included also. For results, only results explicitly naming 'CRT staff' were used.

Quality appraisal results

Table 5 contains the quality appraisal results and Appendix E details the quality ratings given by both the first author and independent reviewer. Overall, the nine final papers had high quality ratings with no paper scoring under an eight and the majority (n = 6) scoring 9 or above. There were some discrepancies in the ratings given between the author and independent reviewer which may be due to the tool being fairly subjective and difficulties differentiating between 'can't tell' and 'no' ratings. Despite the differences, the papers were still rated highly taking into consideration the independent review's ratings with no study scoring lower than 7.5 out of 10.

All studies had clear aims, an appropriate qualitative methodology which also addressed the aims, appropriate means of data collection and analysis with clear statement of findings which add value to the evidence base. However, there were three particular areas where papers were of lesser strength. Three studies were not clear enough about whether ethical issues had been adequately considered or whether ethical approval had been sought and granted. It was difficult to ascertain in four of the studies whether the recruitment strategy was appropriate to the aims of the research, as factors such as participant selection, the pool they were selected from and why a specific sample were chosen were slightly vague. Finally and perhaps most surprisingly, only one study was rated to clearly consider the relationship between themselves (the researcher) and participants. This seems surprising as self-reflexivity is a key component of qualitative research in acknowledging the researcher's assumptions and potential biases at each stage of the research (Finlay, 2002). Despite these issues, all studies were included in the analysis given the overall high quality of the papers and limited pool of papers.

Table 5

Quality Appraisal of the Included Studies Using the CASP Qualitative Checklist Tool

	Author(s) and Year	1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	10. How valuable is the research?	**Total score***
1.	Freeman, Vidgen & Davies-Edwards (2011)	Y	Y	Y	?	Y	N	?	Y	Y	Y	8
2.	Sjølie, Karlsson & Binder (2013)	Y	Y	Y	?	Y	?	N	Y	Y	Y	8
3.	Murphy et al. (2013)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	9.5
4.	Begum & Riordan (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
5.	Morant et al. (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9
6.	Sacks & Iliopoulou (2017)	Y	Y	Y	Y	Y	?	?	Y	Y	Y	9
7.	Klevan et al. (2018)	Y	Y	Y	?	Y	N	Y	Y	Y	Y	8.5
8.	Giménez-Díez et al. (2022)	Y	Y	Y	?	Y	Y	Y	Y	Y	Y	9.5
9.	Clibbens et al. (2024)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	9.5
	Percentage of studies rated Y:	100%	100%	100%	56%	100%	11%	67%	100%	100%	100%	

Note. Scoring key: Y (Yes) = 1, ? (Can't Tell) = 0.5 and N (No) = 0 and thus in the final column, each paper was given a score out of 10 (0 lowest quality rating, 10 highest quality rating).

Thematic synthesis

Five analytical themes were developed; 'CRHTT mission and ethos', 'Nature of CRHTT work', 'Interface with other services', 'Work-related fulfilment' and 'Work-related challenges'. Within these themes were 14 descriptive themes in relation to staff's experiences of working within a CRHTT. The analytical and descriptive themes are presented in Table 6 with the occurrence of each theme by study.

Table 6

The Analytical and Descriptive Themes by Study

	Freeman et al. (2011)	Sjølie et al. (2013)	Murphy et al. (2013)	Begum et al. (2016)	Morant et al. (2017)	Sacks et al. (2017)	Klevan et al. (2018)	Giménez-Díez et al. (2022)	Clibbens et al. (2024)
Theme 1: CRHTT Mission and Ethos	✔	✔	✔	✔	✔		✔	✔	✔
1.1. Offering an alternative to hospital	✔	✔	✔	✔	✔		✔	✔	
1.2. Working with the whole person	✔	✔	✔	✔	✔		✔	✔	✔
1.3. Dominance of the medical model		✔	✔		✔		✔		✔
Theme 2: Nature of CRHTT Work	✔	✔	✔	✔	✔	✔	✔	✔	✔
2.1. Connection is key	✔	✔	✔	✔	✔	✔	✔	✔	✔
2.2. Decision making				✔			✔	✔	
2.3. Roles and responsibilities			✔	✔	✔	✔		✔	✔
Theme 3: Interface with Other Services	✔			✔	✔				
3.1. Challenges with other services	✔			✔	✔				
3.2. Connecting with other services					✔				
Theme 4: Work-related fulfilment	✔	✔					✔	✔	
4.1. Making a difference	✔						✔	✔	
4.2. Enjoying the work		✔						✔	
Theme 5: Work-related challenges	✔	✔	✔	✔	✔	✔			✔
5.1. High workload, limited resources	✔		✔	✔	✔				✔
5.2. Just part of the job	✔					✔			
5.3. Personal coping with emotional impact	✔		✔						
5.4. Team coping with emotional impact	✔	✔	✔		✔	✔	✔		

Analytical theme 1: CRHTT Mission and Ethos

This theme outlined staff's views on the mission and ethos of the introduction of CRHTTs. Three descriptive themes were encompassed in this analytical theme; '*offering an alternative to hospital*', '*working with the whole person*' and '*dominance of the medical model*'.

Descriptive theme 1.1: Offering an alternative to hospital. Many MHPs referred to the value of being able to offer people an alternative provision to the traditional inpatient hospital stay when experiencing a mental health crisis. MHPs acknowledged difficulties associated with hospital settings such as restriction, stigma and it being perceived as "the solution for everything" (Klevan et al., 2018, p. 259). MHPs suggested how CRHTTs can offer a different experience to this. Additionally, MHPs spoke to the unique benefits of having a home-based model in seeing and treating people in their own environment in the least restrictive manner. This appeared to be a pivotal part of the work, assisting in rapport building, balancing out the power dynamics between MHPs and service user, and maintaining more normality for the person.

> *Before the home treatment teams where created a lot*
> *of people that we are nursing in the community would*
> *have gone straight into hospital you know and services*
> *of that kind, it was damaging and stigmatising. (P4,*
> *Female) (Begum & Riordan, 2016, p. 48)*

When I go into a patient's home, something happens

regarding symbolism. I am a guest, I take my shoes off,

and I sit nicely on the couch. There is something

different going on from what happens in in-patient care.

(Sjølie et al., 2013, p. 6)

Being creative and flexible were also noted to be key ingredients in offering a different experience compared to more traditional and sometimes perceived as rigid ways of offering support within a hospital setting.

P3: At its best, a CRT can be something more,

something more fruitful, so that one can ascribe another

dimension to it, where you can ensure that more

formalized requirements regarding treatment are

safeguarded, but you also have more flexibility and

scope for creativity. (Klevan et al., 2018, p. 258)

> *Being creative was presented as an important personal*
>
> *quality by a few of the participants. It was described as*
>
> *using an artistic variable, being safe enough in one's*
>
> *own knowledge and experience to be able to do things*
>
> *that might be seen as unprofessional. Stepping out of*
>
> *the box that represents traditional treatment, doing*
>
> *those small things that were not traditional treatment*
>
> *but which had a therapeutic effect. (Sjølie et al., 2013,*
>
> *p. 5)*

Descriptive theme 1.2: Working with the whole person. MHPs also referred to the importance of empowering service users and ensuring that decisions were collaboratively made with the service user which perhaps feels more achievable in a community home-based team compared to inpatient settings where restrictions are higher and traditionally fewer choices are available. MHPs appeared hopeful for service users "to give people the belief that they can manage" (Klevan et al., 2018, p. 259) and saw their role as helping people regain some control in their life and working towards recovery. MHPs also voiced the need to see the person as a whole person in their work, "as a mental, physical and social individual" (Sjølie et al., 2013, p. 6) which again perhaps feels more prominent when seeing the service user in their own environment.

You're empowering the client and including them in the

decision-making process a lot of the time […] I guess

that's what it's all about, isn't it, it's about empowering

(Pat). (Freeman et al., 2011, p. 80)

I think a lot of the crisis work that we do is about

empowering the individuals to take control of their own

lives, rather than going into hospital where it's all sorted

out for them. (Practitioner group 20; senior staff)

(Morant et al., 2017, p. 9)

MHPs also spoke of involving the service user's network (such as family,

carers, friends) as a part of seeing the whole person that exists in a community. In

some papers, this was seen as a "pivotal role" and "integral" (Begum & Riordan,

2016, p. 49) however two papers identified barriers to involving a person's network

such as the nature of CRHTT work, lack of skills/training and limited time and

resources (Clibbens et al., 2024; Morant et al., 2017).

Descriptive theme 1.3: Dominance of the medical model. One of the main

risks to achieving some of the CRHTT mission/aims appeared to centre around the

overreliance on medication and the prominence of the medical model in the CRHTT.

MHPs often emphasised how relationship building is key to their work, however

viewed the reliance on medication management to go against this aim.

> *CRTs are often too narrowly focussed on medication, at*
>
> *the expense of other interventions, or time talking to*
>
> *service users. (Morant et al., 2017, p. 9)*

Related to this, there was a discourse in some papers that staff being action-oriented and reactive can be opposing to a more reflective and thoughtful approach. This was especially relevant in a sample of clinical psychologists (Murphy et al., 2013) however a clinical psychologist in another paper with a predominantly nursing professional sample (Sjølie et al., 2013) viewed being action oriented as an important aspect of their professional role.

> *Natalie: There is a bit of a conflict there because I think,*
>
> *Crisis Team, are very reactive, they go out. Whereas I*
>
> *think I'm a lot more reflective, and I want people to stop*
>
> *and think. It almost doesn't fit really, trying to be a*
>
> *psychologist in a team that doesn't want to think.*
>
> *(Murphy et al., 2013, p. 188)*

MHPs in Murphy et al. (2013) saw the need to work alongside the medical model in a pragmatic way and weave in more psychological principles. There was less of this discussion in the other papers with more of a mixed profession sample.

Analytical theme 2: Nature of CRHTT Work

Encompassed in this theme were MHPs' experiences of the nature of working in a CRHTT and more of an insight into their daily role. This comprises of three descriptive themes; 'connection is key', 'decision making' and 'roles and responsibilities'.

Descriptive theme 2.1: Connection is key. MHPs highlighted various personal qualities that feel essential in the work they do. In almost every paper, MHPs described being able to build a relationship with a service user as a crucial and non-negotiable aspect of their day-to-day role. MHPs spoke of building the therapeutic rapport as a part of their role they enjoy and find deep meaning in, as well as it being the "vehicle for helping them [service users] recover" (Freeman et al., 2011, p. 80).

> *There is something important about the sense of*
> *belonging and attachment. To be seen by someone and*
> *that somebody is looking out for you. Someone asks if*
> *you are ok, and maybe even sees that you are feeling*
> *bad without the need to ask. Sometimes that is all that*
> *is needed to see a patient blossom. (Sjølie et al., 2013,*
> *p. 6)*

> *Staff also stated that developing good rapport could*
> *relax the client and avoid provoking paranoia. (Sacks &*
> *Iliopoulou, 2017, p. 68)*

Qualities named to facilitate this relationship building included trust, respect and empathy. MHPs also recognised the importance of excellent communication skills, being able to stay composed in difficult situations and offering a place of containment and safety to others. Staying composed was often described as staying "calm and unflappable" (Murphy et al., 2013, p. 186), "being able to stand back and

not rush into a situation" (Sjølie et al., 2013, p. 5) and "representing a tranquil place in the midst of chaos" (Klevan et al., 2018, p. 258).

> *A combination of skills similar to those identified by*
> *service users and carers was identified [by CRT staff]:*
> *being caring, friendly, supportive, a good listener,*
> *respectful, non-judgemental and courteous (Morant et*
> *al., 2017, p. 8)*

> *Nurses provide care, empathy and compassion, based*
> *on empirical data, with a non-judgmental and equal*
> *approach. (Giménez-Díez et al., 2022, p. 51)*

These qualities were also referenced to when acknowledging service users' experiences of seeing multiple MHPs due to differing shifts and emergencies, and that these personal qualities can help mitigate any staff discontinuity.

> *Ensuring staff communicate well, (...), in addition to*
> *being friendly and caring can ensure emotional support*
> *even when there are different individuals visiting.*
> *(Morant et al., 2017, additional file 2, p. 7)*

Descriptive theme 2.2: Decision making. Decision making and gatekeeping responsibilities were discussed by MHPs as areas they have specialist expertise in, which allow them to do their job effectively. There was an appreciation that because MHPs have expertise within the field and are skilled decision makers, this enables

them to decide who can be supported at home in the community and who cannot.

There was also reflection on their gatekeeping role and preventing people from going

into hospital, whilst also occasionally enabling hospital admissions for some people

and being involved in this. A further reflection was around being involved in

discharge planning for those already in hospital.

> *I don't think anyone can do it, I think you have to have a*
>
> *level of expertise in this field otherwise everyone would*
>
> *end up in hospital. (P6, Male) (Begum & Riordan, 2016,*
>
> *p. 48)*

> *P3: I think one of the most important tasks is to avoid*
>
> *unnecessary hospital admissions. But also the*
>
> *opposite! To ensure swift and smooth admissions,*
>
> *when required. (Klevan et al., 2018, p. 260)*

> *Home treatment is pretty good; we partake in early*
>
> *discharge planning. So should somebody be admitted*
>
> *then home treatment can get the patient discharged*
>
> *from hospital sooner than perhaps they would have*
>
> *been in the past. (P2, Female) (Begum & Riordan,*
>
> *2016, p. 49)*

Descriptive theme 2.3: Roles and responsibilities. In numerous papers, MHPs also briefly mentioned other roles and responsibilities they have. This was especially prominent in the sample of clinical psychologists in Murphy et al. (2013) possibly due to psychologists being a newer role within CRHTT and in some teams still being established. Psychologists talked about responsibilities such as formulation, service evaluation and improvement and supervision (Murphy et al., 2013). Staff in other papers discussed a range of roles and responsibilities including medication, monitoring mental health, providing psychoeducation, liaising with other services, establishing daily behaviours and routines and promoting relaxation techniques (Begum & Riordan, 2016; Clibbens et al., 2022; Giménez-Díez et al., 2022). Another major role and responsibility raised was around risk management and one paper especially focused on the concept of positive risk taking (Begum & Riordan, 2016). One paper also presented differing views on the role of signposting which was advocated by some MHPs and criticised by others (Morant et al., 2017).

Analytical theme 3: Interface with other services.

This analytical theme comprises of two descriptive themes 'challenges with other services' and 'connecting with other services'. Staff experiences related to how the CRHTT is positioned in the wider system and the interface with other services is included in this theme.

Descriptive theme 3.1: Challenges with other services. One of the main challenges raised by MHPs in three papers was around receiving inappropriate referrals (Begum & Riordan, 2016; Freeman et al., 2011; Morant et al., 2017). MHPs spoke about how other services may have a different threshold and understanding of what constitutes as a 'crisis' and may also refer based on their own anxieties rather than the service user's presentation especially colleagues in primary care and

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accident and emergency (A&E) departments. This can lead to issues such as other services wrongfully promising CRHTT input to service users which can then be disappointing for staff and service users when service users are not accepted by CRHTTs. Some MHPs also felt they had to justify their decisions which can create conflict between teams, defensiveness and exhaustion as some staff can feel "we are justifying ourselves all the time" (Freeman et al., 2011, p. 80). One paper highlighted that these issues can be associated with service gaps, delays in receiving support and confusion (Morant et al., 2017).

> *We have some inappropriate referrals. If people know*
> *really what criteria is required or what is needed for you*
> *to refer to the home treatment team, your job would be*
> *much easier and you know enjoyable. (P5, Female)*
> *(Begum & Riordan, 2016, p. 49)*

> *We get referrals that are in the best interests of the*
> *referrer, and they're the difficult ones […] it's about their*
> *anxieties, not the needs of the client. And we see that*
> *quite often with primary care and out of hours referrals*
> *(Pat). (Freeman et al., 2011, p. 80)*

Descriptive theme 3.2: Connecting with other services. Whilst discussing the challenges, MHPs in one paper made some suggestions to mitigate these. These included joint working especially around the time of CRHTT discharge to prioritise continuity of care, considering referral route into the CRHTT and

communicating with other services to increase their understanding (Morant et al.,

2017).

> *Professional respondents offered examples of*
>
> *strategies that had successfully facilitated easy and*
>
> *rapid access to CRTs: clear dissemination to referrers*
>
> *of CRT contact details and referral criteria; accepting*
>
> *and acting on phone referrals rather than waiting for a*
>
> *written form; including details of how to access crisis*
>
> *help in routine mental health service appointment*
>
> *letters; and a "no wrong door policy", where CRTs take*
>
> *responsibility for referring people on to other services if*
>
> *they decline to take them on for treatment. (Morant et*
>
> *al., 2017, additional file 2, p. 1)*

Analytical theme 4: Work-related fulfilment.

Within this theme, MHPs speak to their motivations for working within CRHTT

and the sense of fulfilment it brings to them. It comprises of two descriptive themes;

'making a difference' and 'enjoying the work'.

Descriptive theme 4.1: Making a difference. Across three papers, a

common motivating factor for working in CRHTTs was making a difference to

another person's life and being part of this change process. Part of this seemed

related to the earlier theme of offering an alternative to hospital and feeling a sense

of pride and innovation in offering this.

It's nice to be able to help people and to see results (...)

you see people get better. You see people function

again, get back to normality (Kim). (Freeman et al.,

2011, p. 80)

P1: A kind of additional prize is that you get to be part

of a change of attitude when you succeed in stabilizing

someone at home and the carers have been involved.

(Klevan et al., 2018, p. 259)

Conversely, one MHP talked about their experience of feeling frustrated and downhearted due to feeling like they are unable to make a difference despite their high levels of commitment which can cause stress and frustration.

You've given them 100 per cent but it hasn't made any

difference, that's quite stressful […]. You know within a

couple of weeks they're going to come back to you, and

you know it's going to be the same problem (Sam).

(Freeman et al., 2011, P. 81)

Descriptive theme 4.2: Enjoying the work. There were limited responses regarding other forms of job satisfaction and enjoying the work. However, some staff voiced feeling a sense of enjoyment from the work, especially the fast-paced nature of the work and excitement related to this. Additionally, some MHPs talked about the value and enjoyment felt when creating relationships with service users.

Four participants describe how they were attracted by

the unpredictability and excitement of their everyday

work life. Each case was different and exciting; there

were changes all the time. The participants liked the

feeling of daily new experiences and challenges which

the job brought. (Sjølie et al., 2013, p. 5)

Nurses believed that providing home care facilitates an

intimate perspective, which creates a special bond with

patients and instils personal satisfaction with their work.

(Giménez-Díez et al., 2022, p. 51)

Analytical theme 5: Work-related challenges.

This theme outlines the challenges faced by MHPs working in CRHTTs which unfortunately were more prominent and frequent than work-related fulfilment. It comprises of five descriptive themes; 'high workload, limited resources', 'just part of the job', 'emotional impact of the work', 'personal coping with emotional impact' and 'team coping with emotional work'. The final two descriptive themes tapped into MHPs' need to find ways to cope with the emotional demands and challenges of CRHTT work.

Descriptive theme 5.1: High workload, limited resources. MHPs consistently spoke of the pressures of working in a setting which often was characterised by a high workload and limited resources. Examples of limited resources were commonly a lack of supervision time and space (Clibbens et al.,

2024; Freeman et al., 2011) and an overall lack of training but also limited relevance to CRHTT working (Clibbens et al., 2024; Freeman et al., 2011). MHPs also raised concerns with limited bed availability which increases pressure to ensure people are treated at home even when a hospital admission may be clinically indicated (Begum & Riordan, 2016).

> *The level of work has increased; the resources haven't.*
> *(Morant et al., 2017, additional file 2, p. 10)*

Three papers acknowledged limitations in staffing capacities which can make the team feel more stretched or inadequate to fulfil the service's aims (Begum & Riordan, 2016; Clibbens et al., 2024; Morant et al., 2017). One paper reflected on the value of a multi-disciplinary team but cuts leading to positions not being funded and thus a loss was experienced by the team, as outlined in Morant et al. (2017, p. 7):

> *We used to have a psychologist who did a lot of family*
> *work and also supported the rest of the team in doing*
> *that. That post was cut unfortunately a few years ago,*
> *and as a result a lot of the family work we used to do*
> *has just disappeared because people don't feel… they*
> *lost their skill and it just fell by the wayside. (Senior*
> *CRT clinicians focus group 35)*

Some papers went beyond these observations/experiences to consider the outcomes and consequences of limited resources alongside increased workload. Morant et al. (2017) highlighted that these constraints can lead CRHTTs to only

provide brief interventions whilst Clibbens et al. (2024) also acknowledged that staff did not have enough time to deliver psychosocial interventions, to reflect and think about the work they are doing and to actually effectively co-ordinate care.

Descriptive theme 5.2: Just part of the job. Some of the downsides of the job were reported by MHPs, but alongside a sense of acceptance and resignation that this is "part of the job" (Freeman et al., 2011, p. 82) which "you have to deal with it" (Sacks & Iliopoulou, 2017, pg. 68). Part of this was the unpredictable nature of working within a CRHTT in which it was felt no amount of planning can prepare staff for the day ahead due to the emergency setting they work within and it can be difficult when things feel out of their control (Freeman et al., 2011).

Furthermore, there appeared to be more than one MHP talking about having to tolerate abuse due to their professional role. For example, a staff member was racially abused and felt they could not ask for an apology due to having to act in a professional way (Sacks & Iliopoulou, 2017). Although this may not be unique to CRHTT working specifically, this highlights a level of tolerance of unacceptable behaviour because of the work setting. Related to this, there also seemed to be an expectation that MHPs put up with various situations and even ignore signs of danger in some of these. For example, ignoring "misgivings because the patient was begging them" to then be confronted by a machete in the house and another situation in which staff entered the house of someone raising their voice despite potential risks (both examples from Sacks & Iliopoulou, 2017, p. 68). There were also brief mentions of the emotional impact of the job, but again an expectation this is just part of the job and something to be tolerated and accepted, as stated in Sacks and Iliopoulou, 2017:

There was a sense that it was not acceptable to

complain about or experience difficult emotions about

stressful events that occurred in the course of the job

(p. 68)

A participant felt that she should not be upset by difficult

events: 'It does not make me feel anything because I

know it is – it is actually expected when we are working

in this kind of client group' (Gp 2) (p. 68)

Descriptive theme 5.3: Personal coping with emotional impact. In a

minority of papers, there were brief mentions of how MHPs address the challenge of

coping at a personal level with some of the emotional impacts of the work. MHPs in

Freeman et al. (2011, p. 82) referred to the importance of "regulating their emotions

when coping with stressors, including remaining "calm", "moving on" emotionally and

"self-reassurance"". There was also an acknowledgement of staff having to protect

themselves when dealing with risk everyday, with one of the strategies being

emotionally detaching themselves from work but also ensuring they are not

becoming too desensitised to risk related issues (Murphy et al., 2013).

Lauren: There have been plenty of times when I walk

away and I'm thinking, "I hope I don't come in tomorrow

and find out they've killed themselves". And that's very

real, but I think you possibly become desensitised to it

as well. I think there's a certain level of becoming

automatically detached from it, emotionally at least.

(Murphy et al., 2013, p. 188)

Descriptive theme 5.4: Team coping with emotional impact. Although still

limited, there seemed to be more comments related to the challenge of coping with

emotional impacts of the role via team support and leaning on the resource of being

in a strong, connected team which was referred to in four papers. MHPs talked about

the value of the team, from a perspective of being able to support each other

emotionally and having trust in team members and team managers (Freeman et al.,

2011), as well as leaning on the competence and expertise of the team (Sjølie et al.,

2013) and appreciating multiple perspectives (Murphy et al., 2013). Additionally, staff

reported that holding risk in the team feels containing. Conversely, one MHP spoke

of a difficult experience which stayed with them due to a lack of debriefing which

validates above, that if MHPs are able to share the experiences with the team, this

can feel containing with a shared feeling of responsibility (Sacks & Iliopoulou, 2017).

Louisa: I also love the fact that you are within a team,

so all the risk is within the team, the whole team takes

responsibility for that client which is fantastic compared

to the CMHT [Community Mental Health Team], where

you can guarantee Friday afternoon, you are going to

go home with the most worrying client in the world. You

don't have that as well, which is great. (Murphy et al.,

2013, p. 188)

I like the team spirit. I like the way that the majority of

us watch each other's backs. We kind of support each

other. You can speak freely. You can say how you feel

about things and you feel safe doing that the majority of

the time (Kim). (Freeman et al., 2011, p. 82)

Discussion

The current review of nine qualitative studies explored mental health

professionals' (MHPs') experiences of working within CRHTTs. Five analytical

themes were found; *CRHTT mission and ethos, Nature of CRHTT work, Interface*

with other services, Work-related fulfilment and Work-related challenges, with a

number of descriptive themes identified for each*.*

The analytical theme '*CRHTT mission and ethos'* captured staff's reflections

on the core values, mission and ethos behind CRHTTs, aligning with the historical

context and theoretical framework outlined in the introduction. MHPs frequently

emphasised being able to offer people an alternative to inpatient admission, not only

in relation to the physical environment (hospital versus home) but also allowing for a different approach to be taken, consistent with deinstitutionalisation aims (Bachrach, 1978; 1996). Supporting someone at home was viewed as more flexible and aligned with least restrictive approaches, and allowed MHPs to acknowledge power imbalances and engage with people more equally and humanely. This is pertinent given service user accounts of distressing experiences around power imbalances across mental health settings (Gale, 2020) and inpatient care being overly rule-bound, controlling and dehumanising at times (Hallett et al., 2023; Jina-Pettersen, 2022; Shojaei et al., 2023). This illustrates how CRHTT MHPs' reported values and aims are closely connected and possibly informed by service user experience.

Within this theme, MHPs also reflected on the prominence of the medical model, noting that overreliance on this approach could threaten a more flexible, humanising and person-centred approach. The medical model can represent a culture of privileging medical power driven not specifically by medical staff but by broader systems and organisational structures (Barnes, Haghiran & Tracy, 2022). This dominance has been documented across mental health settings in general (Huda, 2021). Specifically in CRHTTs, it has shown to be a barrier to alternative models such as effective psychological implementation (Ahmed et al., 2024). Inpatient research and the 'antipsychiatry' movement suggest the medical model perpetuates power imbalances, underestimates the importance of relationships and hinders positive risk taking (Rissmiller & Rissmiller, 2006; Verbeke et al., 2019). In this review, these observations were mainly raised by psychology staff and may not represent the views of CRHTT staff more generally.

The analytical theme '*Nature of CRHTT work*' captured MHPs' insights into their day to day role in which building therapeutic rapport was identified as crucial.

Across almost all of the reviewed papers, MHPs recognised the importance of this, facilitated by personal qualities such as trust, respect, empathy, communication skills and a calm and containing presence. This mirrors themes from CRHTT service user systematic reviews: "being understood as a normal human being" (Winness, Borg & Kim, 2010, p. 80) and "the importance of therapeutic relationships" (Yang, Glover & Wood, 2025, p. 8) which both describe the value of feeling listened to, understood and involved in their care. These are also compatible with two current NHS priorities, person-centered care and trauma informed care (NHS England, 2019). Both prioritise collaboration, choice, empowerment and building connection (Reeves, 2015; Santana et al., 2018; Skills for Health, 2017).

Staff's reflections on their daily roles mapped fairly well onto existing guidance for effective CRHTTs (Hoult, 2006; National Audit Office, 2007) with interventions covering the biopsychosocial model matching prior guidance (Royal College of Psychiatrists, 2022). Opinions towards signposting varied, with some MHPs seeing its value whilst others felt they should be providing the support themselves rather than signposting. Limited research exists on service user perspectives of these roles and responsibilities.

The third analytical theme 'Interface with other services' outlines how CRHTTs are positioned within the broader healthcare system, highlighting challenges and proposed opportunities to improve collaboration with other agencies. MHPs frequently reported inappropriate referrals, particularly from primary care and A&E colleagues. They linked this to differing thresholds of crisis, misunderstanding referral criteria, and the referrer's anxiety rather than service user presentation. This coincides with previous accounts from CRHTT staff suggesting CMHT care coordinators have a lower tolerance for risk, leading to inappropriate referrals

(Rhodes & Giles, 2014). A similar theme '*referrer in* crisis' appeared in a paper exploring how CRHTT staff understand the concept of crisis, reflecting how inappropriate referrals often indicate the referrer feels stuck or anxious rather than service user need (Tobitt & Kamboj, 2011). Additionally, inter-team problems, particularly limited support from CMHTs for CRHTT gatekeeping, were identified as threats to CRHTT effectiveness (Onyett et al., 2006). National Audit Office (2007) survey data confirmed collaborating services' knowledge of CRHTT referral criteria with only 39% of 597 referring clinicians to CRHTTs fully understanding these services. This percentage lowered in general practice (26%) and emergency medicine (11%) colleagues which mirrored CRHTT MHPs' perspectives in this review. This can lead to CRHTT staff feeling they have to justify their decisions to referrers, causing inter-team conflict and personal exhaustion. This process may be symptomatic of the wider mental healthcare system, in the UK at least, where service gaps and long waiting lists can leave GPs supporting people with complex mental health needs without specialist training (Naylor et al., 2020).

This highlights the importance of interventions to mitigate these challenges however only one paper made suggestions to do so such as joint working, communicating referral criteria to referrers and a "no wrong door policy" which will be discussed in the implications section. Although there are recommendations when setting up CRHTTs (Flowers & Hoults, 2008), many UK CRHTTs predate these recommendations and variation in fidelity across CRHTT services (Onyett et al., 2008) could add to confusion for other professionals.

'*Work-related fulfilment'* captured motivating factors for working within a CRHTT such as positively impacting other people's lives, enjoying the fast-paced environment and valuing relationship-building. These coincide with quantitative

research highlighting CRHTT staff's sense of personal accomplishment, particularly in preventing hospital admissions (Nelson, Johnson & Bebbington 2009) and engaging in direct work with service users (Menon et al., 2015). This sense of purpose also resonates with the pride taken in offering alternatives to hospitalisation in '*CRHTT mission and ethos*' reflecting a congruence between personal values and service aims. Such value alignment has been associated with increased wellbeing and reduced burnout amongst MHPs (Veage et al., 2014). However, fewer papers contributed to this theme suggesting that for MHPs, work-related challenges may be more prominent.

Finally, within the analytical theme of '*Work-related challenges',* MHPs in over half of the papers described a challenging work environment characterised by high workload, high pressure and responsibility alongside limited resources such as staffing issues, limited training and infrequent supervision. These affirm quantitative data demonstrating resource constraints and staffing issues in CRHTTs (Onyett, 2006), and links to funding reductions alongside demand increases (Bulman, 2017; Murray & Mohdin, 2025). Increased workload can contribute to burnout in MHPs (O'Connor, Neff & Pitman, 2018) and there is an association in the general workforce between burnout, job dissatisfaction and intention to leave a job (Schaufeli & Enzmann, 2020). This emphasises the importance of hearing MHPs' experiences and implementing changes. Limited resources can also result in staff feeling unable to provide quality care, leading to moral injury which could impact their wellbeing (Chew, Lee & Sim, 2023) as well as affecting service user and family/carer experience. For example, carers often feel excluded in crisis care (Morant et al., 2017) and MHPs in two papers in this review identified limited time, resources and training as barriers to involving family/carers.

Worryingly, some MHPs seemed resigned that unacceptable, abusive or dangerous behaviour/situations is 'just part of the job'. This suggests a lack of agency of control within their job, which has been found in other mental health settings to lead to fear and frustration (Whittington & Burns, 2010) and underreporting of abusive behaviour (Scott et al., 2011). This may lead to acceptance of the status quo and prevent future change and progression in the service. This could also be indicative staff's relationships with management if they feel these experiences are something they have to just accept. These views are well documented across general healthcare settings in relation to violence and abuse and could apply to CRHTTs also (Jones & Lyneham, 2001; Rosenthal et al., 2018; Wales Audit Office, 2005). Such resignation may reflect an under-resourced and stretched system, which may lead to the system defaulting to a more structured, medically-oriented model rather than a more resource-intensive holistic approach (Huda, 2019). This relates to earlier links to the prominence and risk of overreliance on the medical model in CRHTTs.

Furthermore, in this theme, MHPs also reflected on the emotional impact of their role in the CRHTT and the need to find ways of coping. Some mentioned drawing on the resource and emotional containment of the team. Previous research mirrors these findings with company of colleagues being a significant contributor to job satisfaction in CRHTT nurses (Nelson, Johnson & Bebbington, 2009) and talking to colleagues as a major coping strategy in 90% of CRHTT staff (Menon et al., 2015). Across MHPs more generally, informal contact with colleagues helped staff cope with difficult and demanding aspects of work (Reid et al., 1999). Social support within the team predicted reduced emotional exhaustion (Tummers et al., 2001) and burnout (O'Connor, Neff & Pitman, 2018). Therefore, this theme demonstrates that

alongside significant demands and challenges of working within CRHTTs, the team can be a significant source of support.

Strengths and limitations

This review is the first to synthesise qualitative reports of CRHTT MHPs' experiences, which is a relatively under-researched area but one that can greatly contribute to staff and service user experience as well as service delivery. The systematic search looked at a large breadth of qualitative literature without limiting to one country or specific qualitative methodology and although only a small number of papers were included in the analysis, those papers had relatively strong quality ratings. As discussed, the review findings aligned with; i) broader CRHTT mission and ethos, ii) quantitative research into CRHTTs, iii) previous CRHTT service user experiences, and iv) general MHPs' experience.

Due to the small number of papers and sparse research area, the research question was intentionally broad and the inclusion criteria relatively open. This however led to heterogeneity across the studies, with some having a narrower focus. For example, Sacks and Iliopoulou (2017) had multiple themes in their analysis including difficult emotions and team culture however they only presented their sub-theme 'professional role and responsibility' given this was their primary interest. This potentially limits the depth and breadth of the overall research, and leads to difficulties in developing consistent and robust themes. Whilst some themes had strong representation throughout most of the included studies, some descriptive themes were based on fewer studies therefore affecting the generalisability and meaningfulness of proposed implications.

Despite the review looking at global research, only English-language papers were retrieved and all studies included in the review are from Western countries. This limits the generalisability and misses insights from other countries and non-English papers. However, it is somewhat unsurprising given CRHTTs are a Western model and approach to mental health crisis and services differ greatly internationally. Although the included studies often provided demographics such as gender, profession and years working, only one out of the nine studies included an ethnicity breakdown of the sample which was exclusively White British. The lack of reporting on ethnicity is disappointing as this review may not be representative of ethnically diverse workforces, and may miss important intersectional dynamics. Particularly given the well-documented racism experienced by NHS professionals (Kilne, Warmington & Somra, 2024) and research suggesting poorer job satisfaction and greater burnout amongst Black and mixed-race NHS MHPs (Nelson, Johnson & Bebbington, 2009).

Future research

Future research could explore several areas highlighted by this review. Firstly, researching power dynamics and the medical model specifically in CRHTTs could be interesting, given differences between the papers regarding the expert position which is often an important factor when considering power dynamics. Some MHPs emphasised the importance of particular expertise (Begum & Riordan, 2016) whilst others felt taking a non-expert position aligned more with the CRHTT approach (Klevan, 2018). Additionally, as aforementioned the narratives around the medical model in this review came from psychology staff therefore exploring these with a range of CRHTT disciplines could be beneficial. Exploring which CRHTT

interventions felt most beneficial for service users and their family/carers could

further contribute to views and practice for areas raised by MHPs such as

signposting, and the friction between brief medication-oriented visits and longer more

therapeutic input.

Inter-agency working challenges including inappropriate referrals were

frequent, thus future research could explore the impact of implementing clinical

recommendations (see next section) on referral appropriateness and inter-agency

working. Surprisingly, burnout and wellbeing were not explicitly discussed in the

primary papers. Given the significant challenges reported, future studies should

examine burnout, wellbeing and coping strategies more directly in CRHTTs MHPs.

Finally, all research should always report the sample's ethnicity breakdown and

prioritise ethnically diverse samples to ensure representativeness.

Implications

Several implications for practice arise from this review. One being the

importance and value of being able to offer this home-based and flexible model to

people in crisis that align with both staff and service user values. Discussions around

the medical model and other approaches could be had in CRHTT, to explore the

benefits and costs of relying on this model for both staff and service users. Ways to

pragmatically work in this way, whilst also considering other approaches could be

interesting team discussions. Inter-agency collaboration could be strengthened by

implementing existing research/guidance suggesting close connections with local

services, joint working, CRHTTs clearly communicating their referral criteria and

considering a 'no wrong door policy' (Flowers & Hoult; Johnson, 2013; Morant et al.,

2017; Rhodes & Giles, 2014).

The significant challenges reported by MHPs highlight the great need, at least within the UK, for well-funded services to meet the needs of both staff and service users. Adequate staffing, protected time for reflection, debriefing and supervision and relevant training should be prioritised to support staff wellbeing and reduce risks of burnout. Finally, CRHTT supervisors and managers should always take any abusive or dangerous experiences towards MHPs seriously by reporting to appropriate channels and considering service-level evaluations to ensure learning and progress is made.

Conclusion

This review drew together qualitative research on mental health professionals' (MHPs') experiences of working within Crisis Resolution Home Treatment Teams (CRHTTs). The themes found aligned closely with the historical context and theoretical framework of CRHTTs, national guidance and echoed service user and family/carer experiences highlighting the importance of home-based support, flexibility and human connection in crisis care. Alongside these values, MHPs reported significant challenges such as interface with other services, limited resources and high levels of pressure and responsibility. Future research and service development projects should continue to prioritise staff voices to better understand their experiences to ensure they are cared for at work as this will most likely impact service user experience and quality of the service provided.

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PART 2: EMPIRICAL PAPER

Us and Them? Exploring Organisational and Personal Factors in Patient Dehumanisation Perceptions Among Inpatient Mental Health Professionals.

Word count (excluding tables, references and appendices): 10,362 words

Abstract

Aims: This study explored how mental health professionals (MHPs) working in inpatient mental health settings perceive patients in their care. Specifically, the roles of organisational factors (feeling dehumanised, unsupported and burnt out by their organisation and work) and personal factors (years working in inpatient settings, personal experience of a mental health difficulty and individual propensity to (de)humanise others) were investigated according to MHPs' scores on three dehumanisation measures and an infrahumanisation measure. Furthermore, based on intergroup bias and infrahumanisation theories, comparisons were made between MHPs' perceptions of fellow colleagues and patients.

Method: The cross-sectional study (N=69) employed self-report measures assessing organisational and personal factors, and infrahumanisation and subtle and blatant dehumanisation in NHS inpatient MHPs.

Results: As expected, MHPs significantly attributed more human traits to colleagues than patients on the three dehumanisation measures, although this was not found for the specific infrahumanisation measure. Higher perceived organisational support and lower burnout were correlated with more humanising views towards patients. Feeling dehumanised by their organisation did not correlate with perceptions towards patients but did correlate with the other organisational factors. Unexpectedly, fewer years in inpatient settings and having personal experience of a mental health difficulty were related to more dehumanising views of patients. Individual propensity to dehumanise was correlated with blatant measures of dehumanisation. The regression models were mixed depending on the measure, although demonstrated that organisational factors accounted for significant variance in infrahumanisation and blatant mechanistic dehumanisation scores.

Conclusions: These findings highlight the significant influence of organisational and

personal factors on MHPs' perceptions of patients, which could significantly impact

both staff wellbeing and quality of care. Enhancing staff support, addressing

intergroup dynamics and further research are considered.

Introduction

The concept of dehumanisation

Dehumanisation, broadly defined as the denial of a distinctively human mind (Haslam, 2006), has long been recognised as a powerful psychological process. It plays a central role in enabling acts of discrimination, violence and inhumanity by reducing empathy and moral concern for the 'other' (Bandura, 1999; Bandura, Underwood & Fromson, 1975). Historically, it has been evidenced in contexts of extreme atrocities such as genocide and war (such as Nazi Germany: Kelman, 1973; Staub, 1989) and slavery and systemic oppression (Jardina & Piston, 2023). However more recently, research has recognised that dehumanisation not only contributes to extreme violence, but is also an everyday cognitive process operating in everyday interpersonal and intergroup interactions and can be subtle and implicit (Haslam, 2006; Haslam & Loughnan, 2014). One of these processes has been labelled infrahumanisation. This is based on intergroup relations theories and intergroup bias demonstrating social categorisation, into an 'ingroup' (a group you belong to/share some similarities) and an 'outgroup' (outside of your group) (Allport, Clark & Pettigrew, 1954; Tajfel et al., 1979). Infrahumanisation specifically refers to attributing more humanity via secondary emotions to people in your ingroup relative to those outside of your group (Leyens et al., 2001). Measures of these subtler forms of dehumanisation have revealed dehumanising attitudes towards people seeking asylum (Greenhalgh & Watt, 2015), people with obesity (Bernard, Nathalie & Klein, 2014), people with intellectual disabilities (Capozza et al., 2016) and autistic people (Cage, Monaco & Newell, 2019).

Generally, dehumanisation has been suggested to occur along two dimensions; agency and experience (Haslam, 2006). Agency refers to qualities that

are viewed as unique to humans, such as civility, rationality and morality. Denial of these *uniquely human* (UH) qualities is coined as animalistic dehumanisation, viewing someone as a nonhuman animal. This is common in the extreme atrocities outlined above, in which marginalised or oppressed groups are explicitly and blatantly likened to animals (Kteily et al., 2015). Alternatively, experience refers to a person's capacity to feel pleasure, pain and human emotions. Denying someone these *human nature* (HN) attributes is referred to as mechanistic dehumanisation, seeing someone as a machine or an inanimate object. This has been documented in for example, perceiving women as sexual objects (Heflick & Goldenberg, 2009; Vaes, Paladino & Puvia, 2011). Both dimensions are then used as a rationale for treating groups in ways that would otherwise be unacceptable.

In addition to previously mentioned atrocities and violence, research has shown dehumanisation can have detrimental consequences and pervasive impacts on groups facing more subtle forms of dehumanisation. For example, viewing individuals from lower socioeconomic backgrounds as animalistic predicts decreased support for public policies aiming to reduce income inequality (Sainz et al., 2020). Similarly, increasing levels of disgust and dehumanisation towards a historically marginalised ethnic group then increases support for deportation (Dalsklev & Kunst, 2015). Therefore, viewing others as less human can impact social attitudes, political decisions and may perpetuate social exclusion and discrimination against already marginalised and stigmatised groups.

Dehumanisation and mental health

People experiencing mental health difficulties are often highly stigmatised (Angermeyer & Dietrich, 2006; Schomerus et al., 2012). Given documented links between stigma and dehumanisation (Fontesse, Rimez & Maurage, 2021), it is

therefore perhaps unsurprising that research consistently reveals dehumanising attitudes towards this group (Boysen, Chicosky & Delamore, 2023). For example, individuals with a "chronic mental illness" label are ascribed less humanity than those with a "chronic physical illness", a perception also linked with increased beliefs about dangerousness (Martinez et al., 2011). Furthermore, people with a "mental disability" are attributed both less UH (animalistic) and HN (mechanistic) traits compared to those with a physical disability (Rasset et al., 2022). People with a "mental health illness" were seen as less human than groups commonly identified in the literature as experiencing dehumanisation (religious and ethnic minorities) (Boysen et al., 2020).

However, it is worth noting the nuance in the literature, with levels of dehumanisation varying depending on certain factors. For instance, studies have found dehumanisation by the general population varies by diagnosis, with higher levels reported for intellectual disability, drug addiction and schizophrenia (Boysen et al., 2020). Similarly, perceived severity of the mental health difficulty impacted these attitudes with individuals more likely to assign dehumanising characteristics towards a "psychotic" target, followed by a "neurotic" target in relation to a "healthy" target (Svoli, Sakalaki & Richardson, 2018). A person with a "chronic mental illness" label who was reported to be in remission engaging in "normative behaviour" was assigned more human traits, even more so than the "chronic physical illness" condition (Martinez et al., 2011). Additionally, individuals with a mental "disorder" and low status were dehumanised more than those with high status suggesting a crucial role of intersectionality in shaping these cognitive processes (Sakalaki, Richardson & Fousiani, 2017). This growing body of literature highlights that dehumanisation towards people with mental health difficulties is prominent and widespread amongst

the general population and is further shaped by within group differences in variables such as diagnosis, behaviours and class/status.

Research has also shown the implications of dehumanisation, influencing both a person's coping strategies and their relationship to help/treatment and outcomes. Fontesse et al. (2020) found levels of metadehumanisation (the perceptions of being perceived by others as less human) was linked to less functional coping strategies and poorer outcome for people with "substance and alcohol use disorder". Importantly, self-dehumanisation (the perception of oneself as less than human) mediated these relationships showing the importance of not only perceptions of how one is perceived by others, but how this is internalised and believed to be true. Similarly, Martinez et al. (2014) showed that when people with "mental illness" are ascribed more humanity, others held more compassion towards them which resulted in higher willingness to seek treatment.

Dehumanisation in physical healthcare

Given the evidence showing people with mental health difficulties face dehumanisation from the general population, it is crucial to explore whether this permeates into health settings in which people are often at their most vulnerable and requiring of support. Research into physical health settings show subtle unconscious and unintentional dehumanisation from health professionals towards patients (Haque & Waytz, 2012). This has been explained as a coping strategy and something that helps when making incredibly difficult decisions and problem solving (Lammers & Stapel, 2011; Schulman-Green, 2003). For example, a surgeon may distance themselves from their patient and view them as a set of malfunctioning parts rather than a human to make it easier to perform risky life-saving surgeries. Some research suggests this "defensive dehumanisation" among physical health professionals can

reduce/protect from burnout and stress (Di Bernardo et al., 2011 as cited in Haque &
Waytz, 2012; Trifiletti et al., 2014; Vaes & Muratore, 2013). However, the protective
function of dehumanisation has been called into question by more recent research,
as dehumanisation was associated with higher levels of burnout, post-traumatic
stress disorder and depression symptoms in medical staff post-COVID-19 (Testoni et
al., 2022).

From a patient perspective, less satisfaction and compliance to treatment was
associated with a vignette involving a "dehumanising" general practitioner than a
"humanising" one (Adams, 2014). This shows that although this may act as a
protective mechanism for staff, it may harm the relationship and have consequences
for treatment. As a result, suggestions of how to "humanise" physical health settings
to improve interactions, treatment and quality of life have been proposed (Borbasi et
al., 2013; Haque & Waytz, 2012).

Dehumanisation in mental healthcare

It could be hypothesised that mental health contexts differ significantly from
physical health settings. The relational nature of the work and importance of
therapeutic rapport (for example, Gilburt, Rose & Slade, 2008) may positively impact
on how human mental health professionals (MHPs) perceive the people they support
to be. However, themes of dehumanisation frequently emerge in mental health
service user satisfaction studies, particularly in acute inpatient care (Jina-Pettersen,
2022; Shojaei et al., 2023). Research from a mental health charity found that not
only do 35% of British adults feel confident that a loved one would be safe in a
mental health hospital, but also 32% and 34% lacked confidence they would be
treated with respect or compassion respectively (Mind, 2013), potential indicators of
dehumanisation. Numerous high-profile incidents in the UK have revealed horrific

physical and psychological harm towards service users from MHPs, especially within inpatient mental health or learning disability settings in the UK (BMJ, 2024; Department of Health, 2012). Highlighted behaviours in these reports include referring to people in derogatory terms, denying dignity and human rights and normalising abuse. While such incidents are extreme and not reflective of standard practice across mental health settings, this raises important questions about underlying psychological mechanisms such as dehumanisation, as perceiving someone as less human can lead to justification of harm (Bandura, 1999). Whilst individual accountability is necessary, focusing on this solely may overlook broader systemic and institutional factors, factors that have been raised in physical health settings (Haque & Waytz, 2012). Further exploring these psychological processes specifically within mental health settings could provide valuable insights. Particular attention to inpatient settings may be most beneficial given power dynamics can often feel particularly amplified in inpatient settings, an environment described as "overshadowed by an atmosphere of control" with an "unacceptable imbalance in power between patients and staff" in Johansson, Skärsäter and Danielson (2006, p. 242), which may increase the distances between "us" the ingroup (MHPs) and "them" the outgroup (patients). This "us" and "them" dynamic has been well documented across mental health settings (Helmus et al., 2019; King et al., 2020; Richards, 2010; Villatoro et al., 2022).

Evidence suggests dehumanisation towards someone with a mental health difficulty is present among MHPs. Mental health and physical health professionals in Greece showed similar levels of mechanistic dehumanisation to a "hospitalised patient", more so than the general population (Lekka et al., 2021). Nurses in Belgium had higher levels of dehumanisation towards someone with a psychiatric disorder

("severe alcohol use disorder" or schizophrenia) compared to someone with cardiovascular disease despite most of the nurses working or having contact with the psychiatric disorders (Fontesse, Rimez & Maurage, 2021). Notably, nurses in this study who felt dehumanised by their superiors were more likely to perceive patients as less than human, suggesting a potential 'trickle-down' effect.

Organisational dehumanisation

This 'trickle-down' effect aligns with the concept of perceived organisational dehumanisation (POD), which is typically defined as feeling objectified by the organisation a person works for and has been linked to mechanistic dehumanisation (Bell & Khoury, 2011). Increased POD has been linked with negative work-related outcomes in various workforces such as reduced psychological wellbeing in hotel frontline employees (Gip et al., 2023), reduced trust in ICT employees (Väyrynen & Laari-Salmela, 2015) and job stress and even increased scores on a deviant work behaviours questionnaire among nurses (Sarwar et al., 2021). Research with a mixed sample of employees found POD mediated the relationship between perceived organisational support (POS), how much staff feel valued and cared for by their organisation (Eisenberger et al., 1986), and wellbeing measures such job satisfaction and emotional exhaustion (Caesens et al., 2017). Whilst the concept of POD has not been applied directly to NHS settings, a lack of a voice in the wider organisation (Totman et al., 2011) has been documented by inpatient MHPs, alongside accounts of feeling like "just a number" and a "servant to the system" from NHS staff more generally (Spence, 2023). These could be indicators of high POD. A further example of the 'trickle-down' effect was evidenced in prison officers, with higher POD predicting higher levels of depersonalisation towards incarcerated individuals (Stinglhamber et al., 2022). Depersonalisation,

often used in the context of burnout, refers to emotionally detaching self from the work and was chosen as a measure of a "(milder) form" of dehumanisation in Stinglhamber et al. (2022).

Given the aforementioned nuanced link between burnout and dehumanisation in physical health settings, and the well-evidenced high levels of burnout amongst NHS MHPs (O'Connor, Neff & Pitman, 2018), there is a surprising lack of research into this relationship and how it may differ from physical health settings.

Personal factors and dehumanisation

Additionally, other potentially related personal factors such as years in profession, lived experience of mental health difficulties and individual differences in the general tendency to see others as more or less human have not been widely researched in the mental health field related to dehumanisation. In mental health nurses, increased years in profession has been shown to correlate with both a lower and higher prevalence of mental health difficulties (Oates, Drey & Jones, 2017). MHPs with less than five years' experience reported the highest levels of stress and burnout (Yang, Meredith & Khan, 2015), and mental health nurses with more years' experience had higher emotional competency and less personal self-doubt (Humpel & Caputi, 2001). Interestingly, a systematic review evidenced a fairly consistent relationship between increasing age and increased risk of depersonalisation towards patients in MHPs (O'Connor, Neff & Pitman, 2018). Although this research looked at age specifically, rather than years in profession or organisation, it is hypothesised there may be a link between increased age and increased years working for the organisation. Some research suggests that the longer a person works in mental health settings, the more desensitised and detached they may become and therefore perhaps are at risk of dehumanising patients. This may be linked to the

aforementioned 'defensive dehumanisation', to cope with the daily emotional demands of the work.

Furthermore, having personal experience of a mental health difficulty has been associated with more prosocial reactions and less likelihood of distancing themselves from a person with a "mental health illness" (Angermeyer & Matschinger, 1996). Specifically in MHPs, personal experience of a mental health difficulty was also linked with more positive attitudes about people with "mental health problems" (Stuber et al., 2014). Therefore, although research is lacking regarding dehumanisation specifically, it may be reasonable to expect MHPs with lived experience of mental health difficulties to perceive patients as more human. This is especially so given the research linking empathy and dehumanisation (Halpern & Weinstein, 2004; Scatolon et al., 2023), as well as lived experience and links with increased empathy (Gilbert & Stickley, 2012).

Finally, a validated measure of a person's individual propensity to (de)humanise in general has been constructed, the Humanity Inventory (HumIn; Lantos & Harris, 2021), supporting the existence of an individual difference variable underlying a person's general propensity to dehumanise. Therefore, including a measure such as this may control for individual differences in the tendency to generally dehumanise others, and also provide evidence supporting the measure. No research exists exploring these personal factors in relation to dehumanisation in a UK NHS mental health context to our knowledge.

Aims and hypotheses

The present study aims to investigate the extent to which MHPs perceive patients as human and the factors that impact on this perception. Specifically, the roles of POD, POS, burnout, years of inpatient experience, personal mental health

experience (themselves or a close family member or friend), trait level dehumanisation and group membership (colleagues vs patients) are explored in regards to shaping attitudes towards humanity perceptions of patients. Given intergroup bias and infrahumanisation research suggesting people tend to ascribe more human traits to ingroup members than outgroups members, this may lead to greater humanisation of fellow staff compared to patients, reinforcing a psychological 'us vs them' dynamic. Although previous research tends to compare people with mental health and physical health or no mental health difficulty, the comparison between patients and colleagues can provide insight into whether dehumanising attitudes differ between the groups or not. The hypotheses are as follows:

Infrahumanisation

H1: MHPs will perceive the ingroup (colleagues) as more human than the outgroup (patients).

Organisational factors

H2: Negative relation between POD and dehumanisation levels towards patients. The more dehumanised MHPs feel, the less human patients are perceived to be.

H3: Positive relation between POS and dehumanisation levels towards patients. The more supported MHPs feel, the more human they perceive patients to be.

H4: Negative relation between burnout and dehumanisation levels towards patients. The higher MHPs score on the emotional exhaustion (EE) and depersonalization (DP) subscale and the lower they score on the personal achievement (PA) subscale, the less human they perceive patients to be.

Personal factors

H5: Negative relation between years in profession and dehumanisation levels towards patients. The longer MHPs have worked in inpatient settings, the less human they perceive patients to be.

H6: Positive relation between personal experience of mental health difficulties and dehumanisation levels towards patients. Having personal experience of a mental health difficulty will be associated with more humanising views towards patients.

H7: Negative relation between a person's trait-level propensity to dehumanise and dehumanisation levels towards patients. The higher the tendency to humanise others in general, the lower the dehumanisation levels towards patients.

Combination/model

H8: To explore to what extent the above factors can predict levels of dehumanisation of patients.

Method

Ethical considerations

Participants were provided with a participant information sheet (Appendix G) explaining ethical considerations including voluntary participation and the right to withdraw at any time. To avoid potential priming effects, some details of the study's aims were withheld until a debrief. The study was approved by University College London Ethics Committee (reference: 26881/001) and NHS Health Research Authority (reference: 24/HRA/3323), see appendix J for UCL approval letter and appendix K for NHS approval letter. Data were handled and stored in accordance with data protection regulations.

Design

This study employed a cross-sectional, within-participants quantitative design. All participants completed the same battery of questionnaires at a single time point. The within-participants variable was the comparison between humanity ascribed to colleagues (ingroup) and patients (outgroup) on each of the four measures.

Participants

Eligibility criteria: Participants were eligible to take part if they met the following criteria (outlined in all recruitment materials): i) currently employed as an MHP in a patient-facing role, ii) employed in their current role and ward for a minimum of three months, iii) had at least six months of experience working in acute inpatient settings, iv) given the NHS setting, participants were over 18 years of age and v) likewise due to the setting, it was assumed all participants had sufficient English language proficiency to complete the questionnaires.

Power calculation: As the regression is the most demanding analysis, a power analysis was conducted using G*Power 3 (Faul et al., 2007) to determine the required sample size for multiple regression analysis, with eight predictor variables. Assuming an alpha level of .05, desired power of .80, and a medium effect size (f^2 = .15), the required sample size was 109 participants. This is relatively in line with general recommendations regarding participant per predictor variable ratio, although it does vary greatly from 10 to 50 participants per predictor variable (Riley et al., 2020).

Recruitment: Recruitment took place across 14 acute (including three Psychiatric Intensive Care Units (PICUs) and one acute older adult ward) and five rehabilitation wards across two sites within a London-based NHS Foundation Trust. Ward managers, medical directors, psychologists, and/or lead occupational

therapists were contacted and asked to disseminate the study to staff via internal NHS emails. In-person visits were also offered and arranged to facilitate engagement. Participants were recruited between 29 January and 24 April 2025 through internal email circulation, and in-person visits were conducted across 10 wards between 20 March and 17 April 2025.

Procedure

All staff on participating wards received the recruitment email (see Appendix F), which included a link to the online Qualtrics survey. Staff were emailed between one to five times depending on communication with ward manager. The email contained the participant information sheet (appendix G), research poster (appendix H) and consent form within survey link (see appendix I for consent form embedded into the survey). Participants were required to read a brief information sheet and provide consent before accessing the survey. Upon completion, participants were shown a debrief form which included signposting to staff wellbeing services.

During in-person visits, the researcher introduced themselves to staff and provided study details. Participants could complete the survey immediately or receive study details via email. Each participating ward received a £20 supermarket voucher handed to the ward manager, psychologist or nurse in charge at the end of data collection.

Measures

All measures were self-report questionnaires (see appendix I for full measures presented in the survey). The questionnaires were chosen from previous research, and either the most widely used in previous research or the most appropriate for this particular study were decided upon.

Demographic information

Participants reported age range, gender identity and ethnicity.

Perceived Organisational Dehumanisation (POD; Caesens et al., 2017)

To measure POD, an 11-item organisational dehumanisation scale was used from Caesens et al. (2017) which is a widely used measure within this field. It uses a 7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*) and good internal consistency (α = 0.86) in this study. This was similar to the original study (α = 0.89) and previous research with prison officers (α = 0.93; Stinglhamber et al., 2022) and nurses (α = 0.84; Sarwar et al., 2021). One item was adapted for NHS applicability, "to make more profit" was replaced by "to be more efficient and meet targets". Higher scores indicated greater POD.

Perceived Organisational Support (POS) (SPOS; Eisenberger et al., 1997)

POS was measured using the eight-item version of the Survey of Perceived Organisational Support (SPOS; Eisenberger et al., 1997). Participants responded to items such as "My organisation cares about my opinions" on a 7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*). Higher scores indicated greater POS. Internal consistency was acceptable (α = 0.71). This is slightly lower than the original study (α = 0.90; Eisenberger et al., 1997) and previous research (α = 0.85; Caesens et al., 2017).

Burnout (MBI-HSS MP; Maslach & Jackson, 2016)

Burnout was assessed using the Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP; Maslach & Jackson, 2016). This includes three subscales: Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment (PA). These were kept as three separate variables as per

author guidelines (Maslach & Leiter, 2021). Each item was rated on a 7-point Likert scale regarding frequency (0 = *Never* to 6 = *Everyday*).

EE. A nine-item subscale assessing feelings of being emotionally overextended and exhausted by their work, for example "I feel emotionally drained from my work". Higher scores indicate greater EE. Internal consistency was good (α = 0.94).

DP. A five-item subscale measuring mental distance/detachment and unfeeling/impersonal responses towards patients, for example "I don't really care what happens to some patients". Higher scores indicate higher levels of DP. Internal consistency was acceptable (α = 0.77).

PA. An eight-item subscale measuring competence and achievement in work. An example item is "I have accomplished many worthwhile things in this job" with higher scores indicating higher PA. Internal consistency was acceptable (α = 0.75).

Years working in inpatient settings

Participants were asked how many years they have worked in their current role, in inpatient settings and in the NHS. For analysis, only years of inpatient experience was used.

Experience of mental health difficulties

Participants reported whether they or a close friend/family member had experienced mental health difficulties. Responses were coded as "yes" or "no" for analysis. Details on service use were collected but only analysed descriptively.

Individual propensity to dehumanise (HumIn; Lantos & Harris, 2021)

The eight-item Humanity Inventory (HumIn; Lantos & Harris, 2021) was used as an individual difference and trait-level measure in the propensity to engage in dehumanisation. Items were rated on a 7-point Likert scale (1 = *strongly disagree* to

7 = *strongly agree*). Higher scores indicated a lower general propensity to dehumanise others. In the present study, internal consistency (α = 0.62) was lower than reported in the original validation study (Cronbach's α = 0.76; Lantos & Harris, 2021).

Outcome variables

Three separate measures (as blatant animalistic and mechanistic dehumanisation is from one measure) were used which are all explicit in nature. Infrahumanisation and subtle indirect animalistic dehumanisation have been described as 'subtle' in the literature, whilst indirect animalistic and mechanistic dehumanisation has been described as 'blatant' (Rasset et al., 2022). Each measure was also given in respect to views towards 'typical patients on the ward' and then separately regarding views towards 'typical colleagues on the ward'. This was a necessity for the infrahumanisation measure given that an ingroup/outgroup comparison is required to calculate the overall infrahumanisation composite score. It was decided to compare patients to colleagues on the other three measures, to explore more generally intergroup bias and whether this affects humanity ascribed to each group as per one of the hypotheses.

Infrahumanisation (Leyens et al., 2001; Tam et al., 2007). Based on Leyens et al. (2001) and Tam et al. (2007), participants indicated which of 28 emotions (14 primary, 14 secondary, equal numbers of positive and negative emotions) described "typical patients" and separately "typical colleagues". Some words were given additional synonyms such as "melancholy (sadness)" to enhance comprehension. As per previous research, participants were advised to select as many words as they thought were relevant in describing the group in general. To control for the number of emotions selected in general, proportion scores were computed by averaging how

many secondary emotions were selected for each group then divided by the total number of all emotions selected across both groups to control for this. This produced a separate patient secondary emotions composite score, and a colleague secondary emotions composite score. The infrahumanisation composite score was then calculated by subtracting the secondary colleague (ingroup) composite score from the patient (outgroup) composite score, therefore higher scores reflect less infrahumanisation towards patients when compared to colleagues.

Subtle animalistic dehumanisation (Capozza et al., 2013). As outlined in Capozza et al. (2013), four UH traits (reasoning, rationality, impetus, morality) and four non-UH traits (drive, intellectual abilities, impulsiveness, instinct) were presented to participants with a definition of each term. Participants indicated the extent they agree 'patients' and separately 'colleagues' are characterised by these on a 5-point Likert scale (1 = *definitely false to* 5 = *definitely true*). Ratings on the non-UH traits were reverse score so an overall score was generated, with higher scores indicating less animalistic dehumanisation.

Blatant animalistic and mechanistic dehumanisation (Bastian & Haslam, 2010). As used in Bastian and Haslam (2010), six UH traits ('refined and cultured', 'adults, not children', 'self-restraint', 'rational and logical', 'less than human, an animal' and 'unsophisticated', latter two reverse scored) and seven HN traits ('interpersonal warmth', 'open minded', 'emotional, responsive and warm', 'superficial with no depth', 'like objects, not human' 'mechanical and cold, like robots', latter three reverse scored) were presented to participants with a scale to rate agreement on a 7-point Likert scale (1 = *not at all to* 7 = *very much so*), once for 'patients' and once for 'colleagues'. UH and HN scores were analysed separately representing

animalistic and mechanistic dehumanisation. Higher scores indicate less

dehumanisation for both sections.

Data analysis

Data were analysed using JASP (version 0.18.3). Data were screened for

missing values and assumptions of normality, linearity, multicollinearity and

homoscedasticity were assessed for each test. Descriptive statistics were calculated

and explored for demographics, each predictor variable and outcome variable to

characterise the sample. Significance was determined at $p < .05$.

To test Hypotheses 1, a paired samples t-test compared ascribed humanity

scores between ingroup (colleagues) and outgroup (patients) for each

dehumanisation measure. For the infrahumanisation measure, the separate patient

secondary emotions composite score and colleague secondary emotions composite

score were used for the paired samples t-test. Further paired samples t-tests were

conducted for the infrahumanisation measure; for primary emotions, positive

emotions and negative emotions for supplementary analysis. A repeated-measures

ANOVA was also conducted to explore the interactions of group type, emotion type

and emotion valence for the infrahumanisation measure.

To test Hypotheses 2-7, a correlation matrix was produced to examine

relations between key variables. Following this, to test Hypothesis 8 four separate

linear multiple regressions were planned; one for each dehumanisation measure. For

these analyses, the infrahumanisation composite score was used (which was the

secondary colleague (ingroup) composite score subtracted from the patient

(outgroup) composite score).

Results

Sample

  Participants were recruited from 16 of the 18 wards that were approached. In-person recruitment was conducted on 10 of the wards. A total of 104 responses were collected. Of these, 34 (33%) were incomplete and were thus excluded. No participants requested withdrawal after submitting their response via email although there were a number of unfinished responses suggesting a relatively high withdrawal rate. One response was excluded for not meeting length of service eligibility criterion. The final sample therefore comprised of 69 participants.

  Completion times were positively skewed due to a number of unusually long durations (13 responses over one hour with five of those responses over three hours). The median completion time was 18.63 minutes. Longer durations likely reflect interruptions during working hours.

Participant demographics

  Overall, the demographics (gender, age and ethnicity) were mixed, see Table 1 for detailed participant demographic information. The sample comprised of 64% identifying as female, 33% aged between 18 and 29 and 39% identifying as Black, Black British, Caribbean or African. Most participants (67%) worked on an acute ward (including PICU). In terms of professional discipline split, nursing represented 52% of the sample, see Table 2. The mean number of years in their current role was four (ranging from one month to 31 years), seven years working in inpatient settings (ranging from five months to 31 years) and eight years working within the NHS (ranging from six months to 40 years), see Table 3 for further details.

Table 1

Participant Demographics

Demographic	Category	N	%
Age	18 – 29 years	23	33
	30 – 39 years	14	20
	40 – 49 years	15	22
	50 – 59 years	12	17
	60+ years	4	6
	Prefer not to say	1	1
Gender identity	Female	44	64
	Male	25	36
	Non-binary	0	0
	Prefer not to say	0	0
Ethnicity	Black, Black British, Caribbean or African	27	39
	White British	22	32
	White Other*	7	10
	Asian or Asian British	6	9
	Mixed or Multiple ethnic groups	6	9
	Prefer not to say	1	1
Ward	Acute (including PICU)	46	67
	Rehabilitation	22	32
	Prefer not to say	1	1

Note. *The 'White Other' category combines respondents who identified as 1) White Irish, 2) White Gypsy or Irish Traveller, Roma or Other White or 3) White European.

Table 2

Participant Discipline and Profession Split

Discipline and profession	N	%
Nursing staff	**36**	**52**
Registered mental health nurse*	18	26
Support worker**	9	13
Charge nurse	5	7
Assistant practitioner	1	1
Matron	1	1
Nursing associate	1	1
Trainee nursing associate	1	1
Psychology staff	**16**	**23**
Clinical psychologist	6	9
Trainee clinical psychologist	4	6
Clinical associate psychologist	2	3
Assistant psychologist	4	6
Allied health professionals	**5**	**7**
Occupational therapist	4	6
Art therapist	1	1
Medical staff	**3**	**4**
Consultant psychiatrist	1	1
Psychiatrist	1	1
Resident doctor	1	1
Management	**3**	**4**
Ward manager	2	3
Deputy ward manager	1	1
Other	**6**	**9**
Activity worker	4	6
Network navigator	1	1
Prefer not to say	1	1

Note. *Registered mental health nurse included synonyms such as nurse and mental health nurse. **Support worker included terms such as care support worker, clinical support worker and healthcare assistant.

Table 3

Participant Years in Profession

	Mean	SD	Range
Years working in current role	4.05	5.97	0.08 – 31.00
Years working in inpatient settings	6.96	7.75	0.42 – 31.00
Years working in NHS	7.70	8.90	0.50 – 40.00

Regarding personal experience of mental health difficulties, two thirds of participants either had their own experience of a mental health difficulty (13%), a close family member or friend (28%) or both (26%) with the remaining 33% of the sample having no personal experience, see Table 4. When exploring what services those people have accessed, six participants' data were removed as they initially ticked they had not experienced a mental health difficulty but then ticked a different option (n=5 'I have experienced a mental health difficulty but not accessed support' and n=1 'I have accessed primary care services'). Around two thirds of the 27 participants who had experienced a mental health difficulty had accessed primary care services (n=17) with fewer experiences of other services, see Table 5 for detailed breakdown. Regarding experiences of a close family member or friend, eight responses were removed due to conflicting answers (not ticked a close family member or friend had experienced a mental health difficulty then ticking they had accessed services). Out of 37 participants with a close family member or friend having experience of a mental health difficulty, almost two thirds (n=22) had accessed primary care services and around a third had accessed secondary care services (n=11) and more than a third having been supported in an inpatient setting or by a home treatment team (n=14), see full breakdown in Table 5.

Table 4

Participant Experience of a Mental Health Difficulty

Experience of mental health difficulty	N	%
Neither myself nor a close family or friend have experience	9	13
I myself have experience	19	28
A close family member or friend has experience	18	26
Both myself and a close family member or friend has experience	23	33

Table 5

Services Accessed for Themselves (N=27) or for a Close Family Member or Friend (N=37)

Services accessed for self	N	%
Primary care services e.g. GP, Talking Therapies	17	63
Secondary care services e.g. Community Mental Health Team	3	11
Home treatment team or inpatient setting	1	4
Other: private therapy	5	19
No professional support accessed	6	22
Services accessed for a close family member or friend	**N**	**%**
Primary care services e.g. GP, Talking Therapies	22	59
Secondary care services e.g. Community Mental Health Team	11	30
Home treatment team or inpatient setting	14	38
Other: private therapy	2	5
Other: school counselling	1	3
Other: undisclosed	1	3
No professional support accessed	3	8
Unspecified	4	11

Note. Participants were asked to tick all options that apply which is why the total responses does not equal sample size. For services accessed for themselves (N=27), five participants ticked more than one option. For services accessed by a close family member or friend (N=37), 13 participants ticked more than one option. Percentages calculated with the number of participants rather than number of responses.

Descriptive statistics

The mean and other descriptive statistics were calculated for all Likert-scale variables, as data was treated as interval data, and for the continuous data of years working in inpatient settings, see Table 6. For the binary variable of experience of mental health difficulties, data was coded as no experience (0) or experience (either myself, close friend/family member or both) (1). The mean and other descriptive statistics were also calculated for all four dehumanisation measures for patient ratings with all data being interval data, see Table 7.

Table 6

Descriptive Statistics for Interval and Continuous Predictor Variables

Predictor Variable	Mean	SD	Range
POD (out of 7)	3.67	1.21	1.18 – 6.46
POS (out of 7)	3.94	1.01	1 – 6.50
EE (out of 7)	2.67	1.52	0 – 5.89
DP (out of 7)	1.04	1.12	0 – 4.60
PA (out of 7)	4.42	0.87	2.13 – 6.00
HumIn (out of 7)	5.52	0.74	3.63 – 7.00
Years in inpatient settings (years)	6.96	7.75	0.42 – 31.00

Note. POD: Perceived Organisational Dehumanised. POS: Perceived Organisational Support. EE: Emotional Exhaustion. DP: Deperonalisation. PA: Personal Achievement. HumIn: Humanity Inventory.

Table 7

Descriptive Statistics for Outcome Variables

Outcome Variable	Mean	SD	Range
Infrahumanisation	0.08	0.09	-0.11 – 0.32
Subtle animalistic dehumanisation (patients) (out of 5)	2.79	0.38	1.88 – 4.00
Blatant animalistic dehumanisation (patients) (out of 7)	5.24	0.79	2.50 – 6.83
Blatant mechanistic dehumanisation (patients) (out of 7)	5.65	0.60	3.83 – 7.00

Within-participants factor: Ingroup vs. Outgroup

Prior to the paired-samples t-tests, the assumptions were assessed. Normality was evaluated using the Shapiro-Wilk test. Results indicated the assumption of normality was met for infrahumanisation ($W = 0.97$, $p = 0.11$), subtle animalistic dehumanisation ($W = 0.97$, $p = 0.14$) and blatant mechanistic dehumanisation ($W = 0.98$, $p = 0.26$). Inspection of the Q-Q plots supported these findings. However, scores for blatant animalistic dehumanisation significantly deviated from normality ($W = 0.94$, $p = 0.003$). The Q-Q plot suggested the presence of four outliers, though none were more than 3 standard deviations from the mean. Given the relatively large sample size (n=69), the paired-samples t-test is considered robust to mild violations

of normality thus the analysis proceeded (Field, 2013). A series of paired-samples t-tests were conducted to compare ratings of patients (outgroup) and colleagues (ingroup) on each of the four dehumanisation measures.

Infrahumanisation

There was a significant difference in secondary emotion attribution between patients (M = 0.29, SD = 0.05) and colleagues (M = 0.21, SD = 0.05), t(68) = 7.42, p < .001, d = 0.89. Participants attributed significantly more secondary emotions to patients than to colleagues, with a large effect size. The same was found for primary emotion composite scores, which significantly differed between patients (M = 0.29, SD = 0.05) and colleagues (M = 0.21, SD = 0.05), t(68) = 7.54, p < .001, d = 0.91 with more primary emotions attributed to patients compared to colleagues, with a large effect size.

Regarding emotion valence, there was not a significant difference between the number of positive emotions attributed to patients (M = 0.23, SD = 0.09) and colleagues (M = 0.26, SD = 0.09), t(68) = -1.84, p = .07, d = -0.22. There was however a significant difference between the number of negative emotions attributed to patients (M = 0.35, SD = 0.10) and colleagues (M = 0.16, SD = 0.10), t(68) = 10.71, p < .001, d = 1.29. Participants attributed significantly more negative emotions to patients compared to colleagues. See Figure 1 for each composite score comparison.

Figure 1

Each Infrahumanisation Composite Score for Colleagues (Ingroup) and Patients
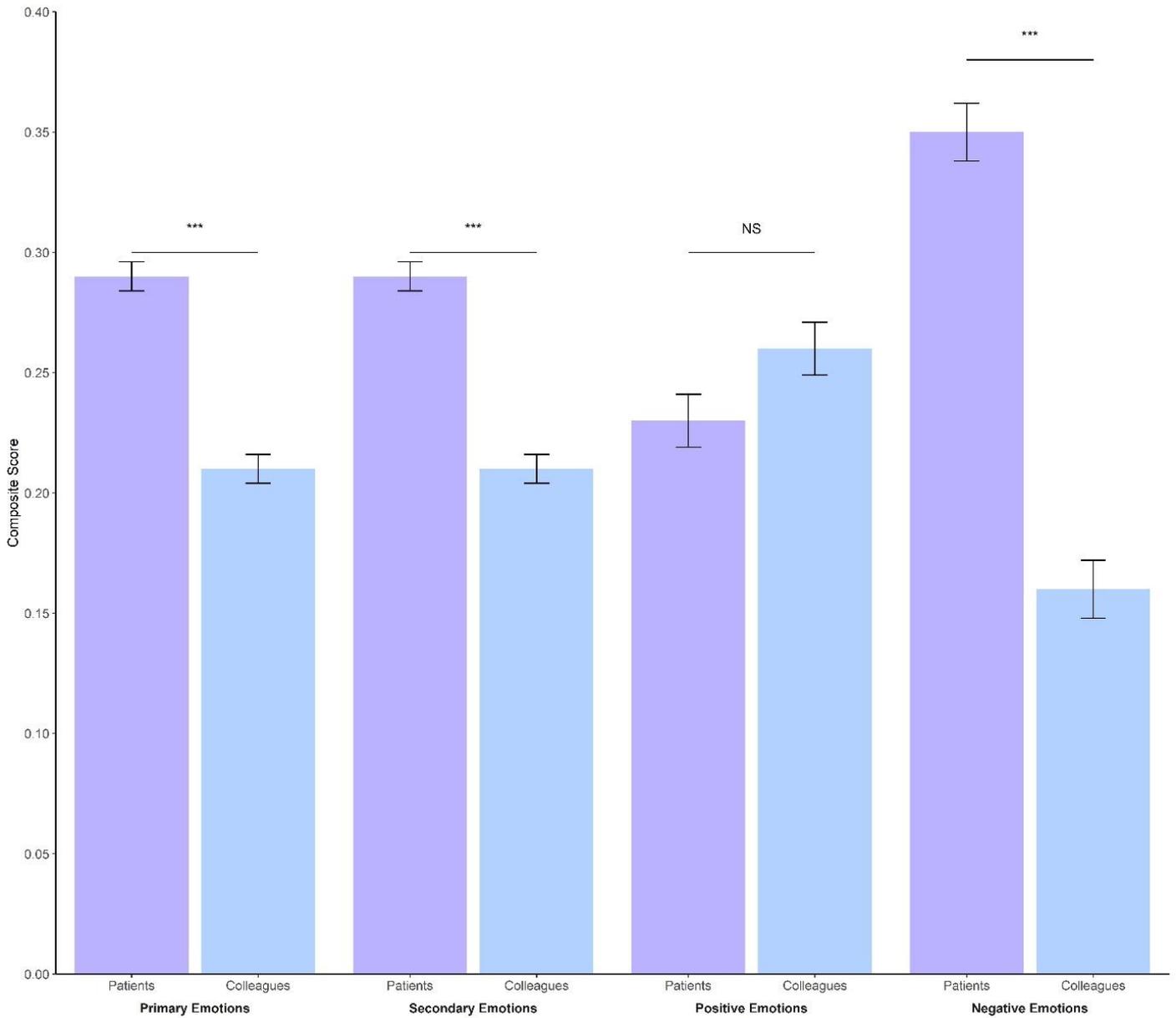
(Outgroup)

Note. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$). Error bars represent standard error of the mean (SEM).

Given these findings, a 2(group type)x2(emotion type)x2(emotion valence) repeated-measures ANOVA to further examine potential interactions. Group type

levels were: outgroup (patients) and ingroup (colleagues); emotion type levels were

primary emotions and secondary emotions; and emotion valence levels were positive

emotions and negative emotions. See Table 8 for descriptive statistics and Table 9

for full statistics.

This revealed a significant main effect of group type, $F(1, 68) = 64.55$, $p <$

.001, $\eta^2 = .12$, indicating that participants attributed more emotions in general to

patients than to colleagues, see Figure 2a. There were no significant main effects of

emotion type or valence. However, there was a significant interaction between group

type and valence, $F(1, 68) = 84.19$, $p < .001$, $\eta^2 = .20$, suggesting that the pattern of

positive vs negative emotion valence differed by group type. Specifically, more

negative emotions were associated with patients, and more positive emotions were

associated with colleagues (see Figure 2b). Additionally, a significant interaction was

found between emotion type and valence, $F(1, 68) = 23.10$, $p < .001$, $\eta^2 = .01$,

indicating that the attribution of positive vs negative emotions differed between

primary and secondary emotions. As shown in Figure 2c, primary emotions were

more strongly associated with negative valence, whereas secondary emotions were

more strongly associated with positive valence. The three-way interaction between

group type, emotion type and valence was not significant.

Table 8

Descriptive Statistics for Each Grouping

Group Type	Emotion Type	*Emotion Valence*	Mean	*SD*
Patient	Primary	Positive	0.11	0.05
		Negative	0.18	0.06
	Secondary	Positive	0.12	0.05
		Negative	0.17	0.05
Colleague	Primary	Positive	0.12	0.05
		Negative	0.09	0.06
	Secondary	Positive	0.13	0.05
		Negative	0.08	0.05

Table 9

Repeated Measures ANOVA Statistics for Infrahumanisation

Predictor	Sum of Squares	*df*	*F*	*p*	*Partial η²*
Group type	0.24	1(68)	64.55	<.001***	0.12
Emotion type	0.00	1(68)	0.62	0.43	0.00
Emotion valence	0.00	1(68)	0.28	0.60	0.00
Group type * Emotion type	0.00	1(68)	0.37	0.54	0.00
Group type * Emotion valence	0.39	1(68)	84.19	<.001***	0.20
Emotion type * Emotion valence	0.02	1(68)	23.10	<.001***	0.01
Group type * Emotion Type * Emotion valence	0.00	1(68)	2.30	0.134	0.00

Note. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$).

Figure 2

Statistically significant ANOVA effects for infrahumanisation
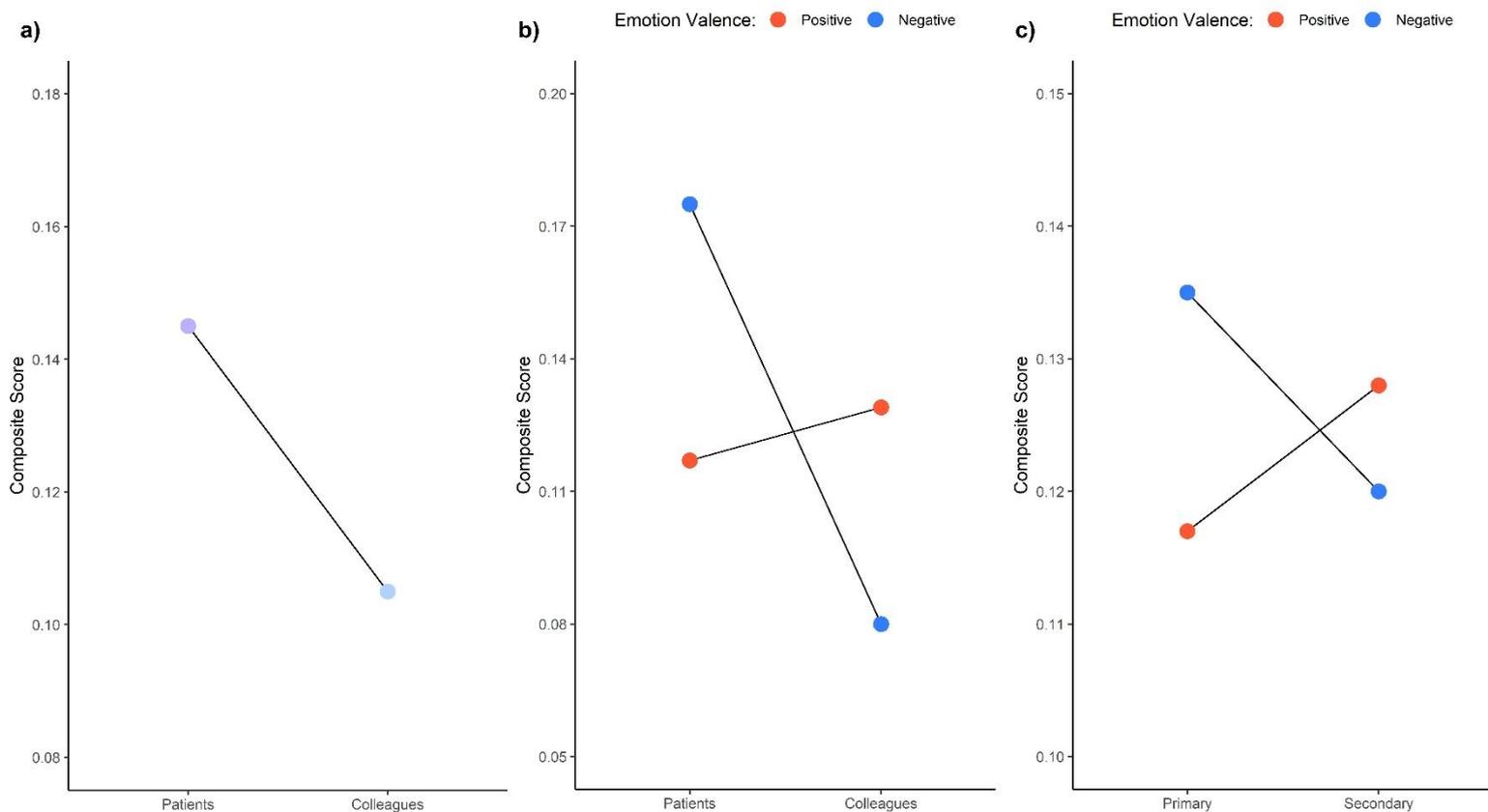
Subtle animalistic dehumanisation

There was a significant difference in ratings of UH traits given to patients ($M = 2.79$, $SD = 0.38$) compared to colleagues ($M = 3.38$, $SD = 0.05$), $t(68) = -9.53$, $p < .001$, $d = -1.15$), see Figure 3. Participants attributed significantly more UH traits to colleagues compared to patients, with a very large effect size.

Figure 3

Scores on Subtle Animalistic Dehumanisation Measure for Patients (Outgroup) and

Colleagues (Ingroup)
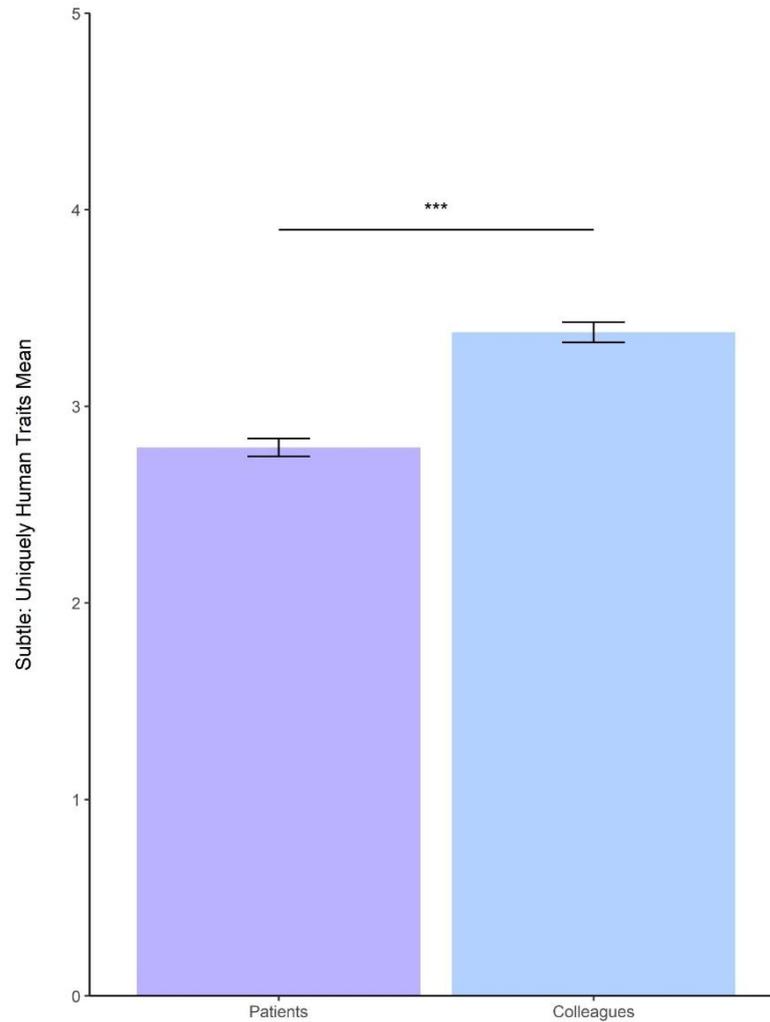
Note. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$). Error bars represent standard error of the mean (SEM).

Blatant animalistic dehumanisation

Participants again attributed significantly more UH traits to colleagues ($M =$

5.83, $SD = 0.83$) compared to patients ($M = 5.24$, $SD = 0.79$), $t(68) = -6.09$, $p < .001$,

$d = -0.73$), see Figure 4a, reflecting a medium to large effect.

Blatant mechanistic dehumanisation

There was a smaller but still significant difference in HN trait ratings, with colleagues ($M = 5.88$, $SD = 0.92$) rated higher than patients ($M = 5.65$, $SD = 0.60$), $t(68) = -2.29$, $p = 0.03$, $d = -0.28$, see Figure 4b. This indicates a small effect size.

Figure 4

Scores on Blatant Animalistic and Mechanistic Dehumanisation Measure for Patients (Outgroup) and Colleagues (Ingroup)
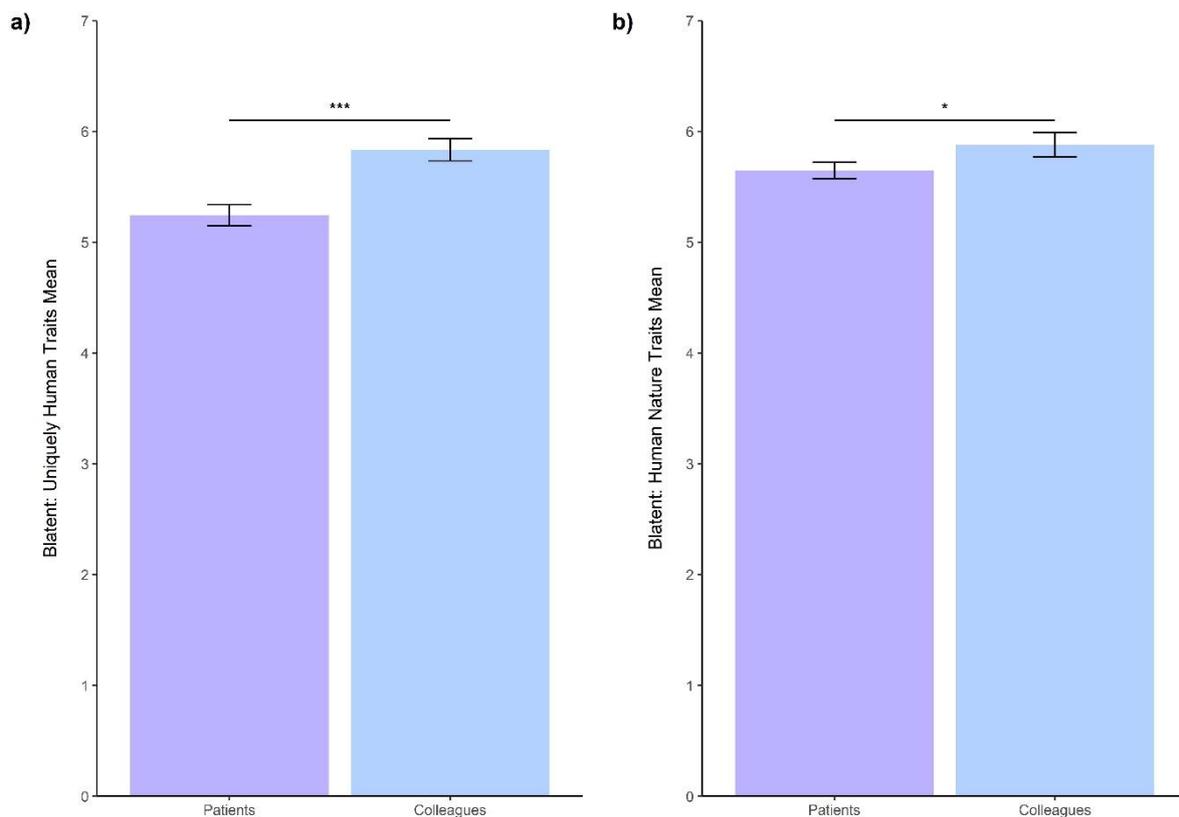
Note. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$). Error bars represent standard error of the mean (SEM).

Correlation matrix

Prior to conducting correlation analyses, the assumption of normality was assessed for each variable individually. Most interval/continuous variables met the assumption of normality based on Shapiro-Wilk tests. However, two predictor variables, DP ($W = .80$, $p < .001$) and years in inpatient settings ($W = 0.79$, $p < .001$),

deviated significantly from normality. Given the relatively large sample size (n=69), the analyses proceeded using Pearson's correlation, which is robust to small violations of normality in larger samples (Field, 2013). Scatterplots between predictor and outcome variables demonstrated approximately linear relations, further supporting the use of Pearson's r.

A Pearson correlation matrix was used to examine relations between all continuous, interval and nominal predictor and outcome variables, see Table 10. Several predictor variables were significantly correlated with a measure of dehumanisation.

POS was positively correlated with subtle animalistic dehumanisation (r = 0.28, p = .02) and blatant mechanistic dehumanisation (r = 0.29, p = .02). This suggests greater perceived support from the organisation was associated with more humanising perceptions towards patients. EE was negatively correlated with blatant mechanistic dehumanisation (r = -0.28, p = .02) indicating greater burnout, specifically emotional exhaustion, was associated with increased dehumanising perceptions of patients. DP also showed negative correlations with blatant animalistic (r = -0.33, p = .006) and blatant mechanistic dehumanisation (r = -0.35, p = .006). This again suggests greater levels of depersonalisation is related to more dehumanisation of patients. PA was positively related to blatant mechanistic dehumanisation (r = .29, p = .02) showing participants who feel more accomplished in their work have more humanising perceptions of patients. HumIn scores were positively associated with both blatant animalistic (r = 0.31, p = .011) and blatant mechanistic dehumanisation (r = 32, p = .007). This indicates individuals who tend to humanise others more generally also have more humanising perceptions of patients. Years in inpatient settings were positively correlated with subtle animalistic

dehumanisation (r = 0.27, p = .02) suggesting more years working in inpatient settings was associated with more humanising perceptions of patients. There was a significant negative point-biserial correlation between personal experience of mental health difficulties (coded as 1) and subtle animalistic dehumanisation (r = -0.39, p = .001). This suggests participants with personal experience of mental health difficulties tended to report higher levels of dehumanisation towards patients.

Although POD was not significantly correlated with any of the outcome variables, it was significantly correlated with other predictor variables; POS (r = -0.26, p = .031), EE (r = 0.49, p < .001), DP (r = 0.32, p = .007) and years in inpatient settings (r = -0.24, p = .049). This suggests that individuals who feel dehumanised by their organisation also tended to feel less organisational support, more burnout in terms of EE and DP and tended to have worked more years in inpatient settings.

Table 10

Correlations between Predictor Variables and Outcome Variables

Variable	POD	POS	EE	DP	PA	HumIn	Years in inpatient settings	Mental health experience	Infrahumanisation	Subtle animalistic	Blatant animalistic	Blatant mechanistic
POD	-											
POS	**-0.26***	-										
EE	**0.49***	**-0.45***	-									
DP	**0.32**	-0.19	**0.59***	-								
PA	-0.20	**0.44***	**-0.36**	**-0.24***	-							
HumIn	-0.12	**0.32**	**-0.25***	**-0.33**	**0.41***	-						
Years in inpatient settings	**-0.24***	0.11	**-0.34**	-0.20	0.11	0.08	-					
Mental health experience	0.19	-0.18	**0.33***	0.20	**-0.24***	-0.10	**-0.26***	-				
Infrahumanisation	0.13	0.01	-0.22	-0.20	0.03	0.07	-0.07	-0.03	-			
Subtle animalistic	-0.01	**0.28***	-0.23	-0.22	0.19	0.17	**0.27***	**-0.39**	0.10	-		
Blatant animalistic	-0.02	0.19	-0.13	**-0.33**	0.19	**0.31***	0.04	-0.06	0.12	0.21	-	
Blatant mechanistic	-0.12	**0.29***	**-0.28***	**-0.35**	**0.29***	**0.32**	0.17	0.00	-0.07	0.01	**0.64***	-

Note. This table presents Pearson's *r* correlations among predictor variables (displayed in the upper half) and outcome variables (presented below the horizontal line). POD: Perceived Organisational Dehumanised. POS: Perceived Organisational Support. EE: Emotional Exhaustion. DP: Deperonalisation. PA: Personal Achievement. HumIn: Humanity Inventory.

Asterisks denote significance, for positive relation: *p<.05   **p<.01   ***p<.001
for negative relation: *p<.05   **p<.01   ***p<.001

Multiple linear regression

Given the number of incomplete data reducing the overall participant number (n=69) which was below the desired sample size to meet sufficient power (n=109) it was decided not to include the planned eight predictor variables in the regression analysis as it would be underpowered. The G*Power 3 (Faul et al., 2007) calculation for three tested predictor variables (with total number of eight predictors) assuming an alpha level of .05, desired power of .80, and a medium effect size ($f^2 = .15$) indicated a required sample size of 77 which was closer to the acquired sample size. As organisational factors, POD, POS and burnout have already been researched in other populations, these were chosen to be entered into the regression. EE was selected to represent the concept of burnout as it is often considered the primary element of burnout (Mind Garden, n.d.).

Prior to running the regression, assumptions were checked. Visual inspection of the Q-Q residual plots for each four outcome variables suggested that residuals were approximately normally distributed with no clear evidence of heteroscedasticity. One significant outlier (more than 3 standard deviations from the mean) was identified for subtle animalistic and blatant animalistic dehumanisation measures. These were different participants, and due to the small sample size, all cases were retained in the analyses. Multicollinearity was not violated as no intercorrelations among predictors exceeded a Pearson's *r* of .60 and all Variance Inflation Factor (VIF) were below 3.

Although some predictor variables (such as POD) did not show significant bivariate correlations with outcome variables, they were retained in the regression models due to theoretical relevance and previous literature suggesting potential predictive value. Three predictors were included for the final regressions; POD, POS

and EE due to sample size. Four separate multiple linear regressions were run, one for each dehumanisation measure. A 'forced entry' approach was utilised as there was not sufficient research and evidence to suggest an order into a hierarchical model, and there are significant limitations noted for a stepwise approach (Field, 2013).

Infrahumanisation

The regression model predicting infrahumanisation scores from the three organisational variables was statistically significant, $F(3, 65) = 3.19$, $p = .03$, $R^2 = 0.13$, adjusted $R^2 = 0.09$. Two predictor variables were individually significant: POD ($t = 2.33$, $p = .02$) and EE ($t = -2.84$, $p = 0.006$) whilst POS was not an individually significant predictor ($t = -0.71$, $p = 0.48$). See Table 11 for full statistics. Participants who felt more dehumanised by their organisation scored higher on infrahumanisation indicating lower levels of infrahumanisation of patients. Participants who felt more emotionally exhausted scored lower on the infrahumanisation scale meaning higher levels of infrahumanisation of patients.

Table 11

Regression Statistics for Infrahumanisation

| Predictor | Unstandardised Coefficients | | Standardised Coefficients | *t* | *p* |
	B	SE	β		
(Constant)	0.09	0.07	–	1.43	0.16
POD	0.02	0.01	0.31	2.33	0.02*
POS	-0.01	0.01	-0.09	-0.71	0.48
EE	-0.02	0.01	-0.41	-2.84	0.006**

Note. POD: Perceived Organisational Dehumanisation. POS: Perceived Organisational Support. EE: Emotional Exhaustion. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$).

Subtle animalistic dehumanisation

The model predicting subtle animalistic dehumanisation was not significant, $F(3, 65) = 2.66$, $p = .06$, $R^2 = 0.11$, adjusted $R^2 = 0.07$. See Table 12 for regression statistics. None of the individual predictors reached statistical significance.

Table 12

Regression Statistics for Subtle Animalistic Dehumanisation

Predictor	Unstandardised Coefficients		Standardised Coefficients		
	B	SE	β	*t*	*p*
(Constant)	2.42	0.28	–	8.75	<.001***
POD	0.05	0.04	0.15	1.10	0.28
POS	0.09	0.05	0.23	1.73	0.09
EE	-0.05	0.04	-0.20	-1.40	0.65

Note. POD: Perceived Organisational Dehumanisation. POS: Perceived Organisational Support. EE: Emotional Exhaustion. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$).

Blatant animalistic dehumanisation

The regression model for blatant animalistic dehumanisation was not significant, $F(3, 65) = 0.92$, $p = .44$, $R^2 = 0.04$, adjusted $R^2 = -0.004$. See Table 13 for regression statistics. No individual predictor was shown to be significant.

Table 13

Regression Statistics for Blatant Animalistic Dehumanisation

Predictor	Unstandardised Coefficients		Standardised Coefficients		
	B	SE	β	*t*	*p*
(Constant)	4.69	0.60	–	87.82	<.001***
POD	0.04	0.09	0.06	0.42	0.68
POS	0.13	0.11	0.17	1.25	0.22
EE	-0.04	0.08	-0.08	-0.52	0.60

Note. POD: Perceived Organisational Dehumanisation. POS: Perceived Organisational Support. EE: Emotional Exhaustion. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$).

Blatant mechanistic dehumanisation

For blatant mechanistic dehumanisation, the overall model was significant $F_{(3, 65)} = 2.78$, $p = .048$, $R^2 = 0.11$, adjusted $R^2 = 0.07$. See Table 14 for regression statistics. No individual predictor was significant.

Table 14

Regression Statistics for Blatant Mechanistic Dehumanisation

	Unstandardised Coefficients		Standardised Coefficients		
Predictor	B	SE	β	t	p
(Constant)	5.31	0.44	–	12.17	<.001***
POD	0.02	0.07	0.04	0.26	0.79
POS	0.13	0.08	0.21	1.61	0.11
EE	-0.08	0.06	-0.20	-1.40	0.17

Note. POD: Perceived Organisational Dehumanisation. POS: Perceived Organisational Support. EE: Emotional Exhaustion. Asterisks denote significant levels (* $p < .05$, ** $p < .01$, *** $p < .001$).

Discussion

The main aims of this study were to investigate whether mental health professionals (MHPs) working in NHS inpatient mental health settings perceive 'typical' patients on the wards as more or less human compared to colleagues, and whether organisational and personal factors influence dehumanisation of patients. Across three out of four measures, MHPs attributed significantly more UH (animalistic) and HN (mechanistic) traits to colleagues (ingroup) than to patients (outgroup). In relation to organisational factors, perceived organisational support (POS) and all three burnout components correlated with at least one dehumanisation measure showing higher perceived support from the organisation and lower levels of perceived burnout were associated with more humanising views towards patients. Interestingly, perceived organisational dehumanisation (POD) was not correlated with dehumanisation scores. Among personal factors, fewer years in these settings

and having lived experience of a mental health difficulty were unexpectedly related to higher dehumanising views towards patients. Unfortunately due to low sample size, regression analysis was limited to the three organisational measures. Models were significant for two of the measures; infrahumanisation and blatant mechanistic dehumanisation. POD and EE significantly predicted infrahumanisation whilst no individual predictor reached significance for blatant mechanistic dehumanisation.

H1: MHPs will perceive the ingroup (colleagues) as more human than the outgroup (patients).

This hypothesis was supported by the three dehumanisation measures overall, showing that MHPs significantly attributed more animalistic and mechanistic traits to colleagues compared to patients, both subtle and blatant. This supports the theory that people tend to view ingroup members as more fully human, whilst members of the perceived outgroup are denied aspects of humanness (Haslam, 2006; Leyens et al., 2000). This finding aligns with documented narratives of an 'us' and 'them' dynamic in mental health settings (Helmus et al., 2019; King et al., 2020; Richards, 2010; Villatoro et al., 2022). Addressing such dynamics is crucial given well-documented consequences such as discrimination, exclusion and inequality (Helmus et al., 2019). Mitigating these issues may come from interventions aiming to reduce stigma (for example, Helmus et al., 2019), blurring intergroup boundaries through collaboration and co-production (Mulvale et al., 2021) and valuing lived mental health experience and peer support (such as Gray, Sisto & Conley, 2024).

Unexpectedly, the specific infrahumanisation measure, comparing attribution of secondary emotions (unique to humans) to each group showed the opposite pattern; MHPs attributed more secondary emotions to patients than colleagues. Further analysis revealed that MHPs also attributed more primary emotions to

patients than to colleagues, contrary to infrahumanisaiton theory in which attribution of primary emotions (not unique to humans) should be equal in both groups (Leyens et al., 2000; Leyens et al., 2001). This suggests a general tendency to attribute more emotions to patients, reinforced by MHPs also attributing more negative emotions to patients than colleagues. Reasons for this may include MHPs having a greater exposure to patients' emotional expressions in periods of crisis and distress than colleagues. Associating negative emotions more strongly with the outgroup contradicts infrahumanisation theory, which predicts ingroup association with secondary emotions regardless of valence (Enock, Tipper & Over, 2021). Therefore, this may reflect ingroup favouritism rather than infrahumanisation (Demoulin et al, 2009) but does indicate these group memberships do occur in these settings.

Infrahumanisation depends on relevant and meaningful distinctions (Demoulin et al., 2009) and strong identification with the ingroup (Paladino et al., 2004). These findings on infrahumanisation could suggest that, within MHPs working on inpatient wards, this identification is not sufficiently strong to elicit intergroup biases such as infrahumanisation. There is very limited research looking at infrahumanisation processes within MHPs thus future research examining the validity of the patient/colleague distinction is warranted, additionally the influence of MHPs' lived experience on their ingroup identification. Research suggests when MHPs perceive people with mental health difficulties as members of their own group, they tend to stigmatise less (Helmus et al., 2019). This may similarly affect dehumanisation. However, significance on the other three dehumanisation measures suggests the distinction between colleagues and patients was strong enough for significant differences in ascribed humanity and thus MHPs do identify with colleagues more than patients.

H2: Negative relation between POD and dehumanisation levels towards patients.

Contrary to the hypothesised "trickle-down" effect based on previous research (Fontesse, Rimez and Maurage, 2021), POD was not correlated with dehumanisation measures. However POD was correlated with depersonalisation (DP), mirroring the trickle-down effect in Stinglhamber et al. (2022), who used DP as their dehumanisation measure. POD may therefore influence 'milder' forms of dehumanisation such as depersonalisation. Future research could explore the relation between POD, DP and dehumanisation, and investigate whether DP could serve as a mediator between POD and dehumanisation. High levels of organisational pride can buffer against feeling dehumanised (Bell & Khoury, 2011), and given the general high levels of pride in their work in NHS employees (Integrated Care Journal, 2024; NHS England, 2019), this may have complicated the relationship between POD and dehumanisation.

H3: Positive relation between POS and dehumanisation levels towards patients.

Higher POS correlated with lower subtle animalistic and blatant mechanistic forms of dehumanisation as expected. If 'defensive dehumanisation' proposes that seeing patients as more human is more effortful and can result in negative work-related outcomes (Vaes & Muratore, 2013), perhaps organisational support means utilising dehumanisation as a way of coping or managing with difficult work environments is less necessary. POS also related to lower EE and higher PA, reinforcing the importance of organisational support. These findings echoed studies related to burnout, wellbeing and even affective commitment in other settings

(agricultural employees: Ladebo, 2009; mixed employee sample: Caesens et al., 2017).

H4: Negative relation between higher representations of burnout and dehumanisation levels towards patients.

All burnout subscales (EE, DP and PA) correlated with blatant mechanistic dehumanisation, and DP additionally with blatant animalistic dehumanisation. These findings suggest emotional exhaustion, detachment and reduced professional accomplishment are associated with perceiving patients as less human. Unlike earlier physical healthcare research proposing a potential 'defensive dehumanisation' suggesting dehumanisation protects against burnout (Di Bernardo et al., 2011 as cited in Haque & Waytz, 2012; Trifiletti et al., 2014; Vaes & Muratore, 2013), our findings align with more recent studies linking higher burnout and higher dehumanisation (Testoni et al., 2022). These preliminary findings indicate differences between physical and mental healthcare and may reflect the more relational nature of mental healthcare work, warranting further and distinct research in both settings.

H5: Negative relation between years in profession and dehumanisation levels towards patients.

Personal factors were also hypothesised to affect MHPs' perceptions of patients, although previous research has not explored these specific variables in relation to dehumanisation or MHPs. Surprisingly, more years in inpatient settings were associated with lower subtle animalistic dehumanisation. This finding contrasts with literature linking increased risk of depersonalisation and increasing MHP age (O'Connor, Neff & Pittman, 2018) although they looked at age rather than time in service. Research in a very different context (hotel frontline workers) suggests longer

tenure moderated the impact between POD and wellbeing (Gip et al., 2023), proposing employees with longer tenure may have resources to protect against POD. This is similar to previous findings across various workplace settings (Ng & Feldman, 2013). Newer staff to inpatient settings may therefore be more vulnerable to both burnout and feeling dehumanised, which may increase dehumanising perceptions of patients.

H6: Positive relation between personal experience of mental health difficulties and dehumanisation levels towards patients.

Contrary to predictions and previous research linking personal experience with decreased mental health stigma (Stuber et al., 2014), increased empathy (Gilbert & Stickley, 2012) and more prosocial reactions towards people with mental health difficulties (Angermeyer & Matschinger, 1996), participants with personal or family/friend mental health experience reported slightly higher subtle animalistic dehumanisation scores. Intergroup contact theory suggests that direct contact with a group of people reduced prejudice and improved intergroup relations (Pettigrew, 1998; Pettigrew et al., 2011), as well as improving humanity attributions to outgroup (Capozza et al., 2014) therefore the opposite to the findings was hypothesised. However, it can depend on the nature of the contact, for example Lin et al. (2022) showed lower social distance, positive attitudes and less prejudice towards people diagnosed with schizophrenia only in health professionals who had positive prior contacts, whereas this was not the case with prior negative contacts. Additionally, general contact may not be sufficient in changing perceptions held towards people, as contact with people presenting with substance and alcohol related difficulties did not impact the level of stigmatisation or dehumanisation nurses held towards them (Fontesse, Rimez and Maurage, 2021).

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Furthermore, the link between mental health experience and higher EE and lower PA suggests burnout could have mediated the effect on dehumanisation. In relation to loved ones, family members of someone experiencing a severe and enduring mental health difficulty can experience significant stress, high levels of burden and issues with mental health services (Saunders, 2009). As a relatively high number of participants in this study reported a close family member or friend having accessed secondary or crisis mental health services, these findings may be applicable to this sample. This may suggest a higher need for coping strategies such as 'defensive dehumanisation' and may help to explain increased dehumanising views towards patients.

A further possible explanation for this finding could be related to self-stigma and self-dehumanisation. Self-stigma refers to people experiencing stigmatisation internalising the stigma, shown in people with mental health difficulties (Watson et al., 2007). Self-stigma reduces self-esteem in people with mental health difficulties (Corrigan & Watson, 2002) and can even persist when psychological wellbeing improves following intervention (Link et al., 1997). Strategies outlined in Thoits (2011) could explain why possibly MHPs with mental health experience may distance themselves from patients such as cognitive separation from the stigmatised group, resisting to apply the stereotype to themselves and ways of defining the problem which do not impact identity. This distancing which can be a way to protect identity may then reduce identifying with the outgroup (patients), leading to more distance between the two and could lead to increased dehumanisation. Reinforcing this, qualitative accounts from MHPs with lived experiences of mental health services showed a switch between two different and largely unintegrated identities, "professional" and "patient" (Richards, Holttum & Spingham, 2016), emphasising

how professional role and splitting parts of their identity may play a role in these intergroup dynamics. Self-dehumanisation (perceiving oneself as less than human) has been linked with poorer wellbeing (Sakalaki, Richardson & Fousiani, 2017) and greater levels of stigma and prejudice contribute towards self-dehumanisation in voice hearers (O'Brien-Venus, Jenkins & Chadwick, 2023). However less is known about self-dehumanisation regarding lived experience in MHPs and how this may affect dehumanisation towards others. Additionally, given the small sample size and uniqueness of this finding, this requires replication and further consideration.

H7: Negative relation between a person's trait-level propensity to dehumanise and dehumanisation levels towards patients.

As expected, higher trait-level humanisation was associated with lower blatant dehumanisation, supporting its validity (Lantos & Harris, 2021). The lack of correlation with subtle dehumanisation may reflect social desirability bias; MHPs who self-report egalitarian values and less likely to dehumanise others may answer blatant questionnaires in a more socially desirable way (Gawronski & De Houwer, 2014). This suggests subtle measures of dehumanisation may be less susceptible to social desirability biases and may be preferable in future research with MHPs.

H8: To explore to what extent the above factors can predict levels of dehumanisation of patients.

Unfortunately, due to limited sample size the regression was not conducted as planned with the full eight predictors. Instead, the organisational factors (POD, POS and EE for burnout) were entered into a 'forced entry' regression. The model predicted variance in infrahumanisation and blatant mechanistic dehumanisation.

For infrahumanisation, higher POD surprisingly predicted allocating more secondary emotions to patients rather than colleagues. This could be due

measurement limitations (as outlined in the limitations section), but also the intergroup differentiation between colleagues and patients with potentially complicating findings related to POD. For example, MHPs having higher POD could mean they feel more dehumanised by the organisation but also by their seniors who may be close colleagues on the ward (such as nurse and nurse in charge). In turn this may mean they do not feel as strongly identified with the ingroup of colleagues if they feel dehumanised by some of them, which can affect infrahumanisation (Paladino et al., 2004). Higher EE predicted allocating more emotions to colleagues than patients coinciding with the correlational findings. Although due to the cross-sectional nature of this study, it is unknown whether higher EE leads to increased dehumanisation, or if increased dehumanising views towards patients can cause staff to feel more emotionally exhausted. This could be an interesting avenue for future research. Interestingly, POS was not a significant predictor although it was correlated with infrahumanisation. This may suggest that POS may suppress POD's relation with infrahumanisation in the correlation, whereas when it is controlled for in the regression, POD's relation with infrahumanisation becomes clear. This seems possible based on previous research showing POD to mediate POS and other work-related outcomes (Caesens et al., 2017; Eisenberger et al., 1986).

Strengths and limitations

This study explored a range of novel variables, exploring how organisational and personal factors can influence how MHPs perceive patients in regards to humanity, within the context of accounts of patients feeling dehumanised in the literature (Jina-Pettersen, 2022; Shojaei et al., 2023). Recruiting directly within the NHS improved the representativeness of the sample compared to online recruitment. Additionally, the sample was fairly diverse regarding gender, age, ethnicity and years

in profession. However, representation from medical staff particularly, such as psychiatrists, was limited which is unfortunate given prior research suggesting medical training can reduce empathy and shape dehumanising perceptions of patients (Haque & Waytz, 2012). Additionally, this study was conducted in one London-based NHS Trust across two sites which may limit generalisability to other areas.

The relatively small sample limited regression analyses due to insufficient power and may have increased the risk of Type II error (Faber & Fonseca, 2014). High rates of incomplete responses (33%) impacted this which introduces attrition bias; MHPs experiencing the greatest workload, burnout or least interest in the research subject may have not completed the study which potentially limits the representativeness of the findings. Social desirability may have also influenced results given the self-report measures were fairly obviously tapping into dehumanisation, especially blatant measures. This is particularly pertinent in nursing and allied healthcare research (Van de Mortel, 2008). Additionally, reported burnout levels were relatively low, despite documented high NHS MHP burnout rates (O'Connor, Neff & Pittman, 2018). This may reflect underreporting, sampling bias or MHPs worrying that management would be aware of their reporting (which was informally reported to researchers despite recruitment resources stating clearly it was anonymous). Using objective markers such as sickness absence and staff turnover, which were informally reported as being high, could complement self-report measures in the future.

Additionally, although all of the measures were used in previous research and had relatively good or acceptable internal consistency reliability in this study, most were non-standardised and not specific or thoroughly validated in the

study's context (healthcare). For example, the POD scale may not have mapped neatly onto NHS structures and participants may have answered based on ward or division level experiences (support from their senior managers), rather than at trust or wider NHS level. This may explain the lack of correlations between POD and dehumanisation measures, although POD did correlate with other organisaitonal factors as expected and coinciding with previous research (Caesens et al., 2017; Fontesse, Rimez & Maurage, 2021; Stinglhamber et al., 2022). The forced-choice yes/no format for the infrahumanisation measure differed from other studies where participants were free to select as many emotions from a list (Rasset et al., 2022; Tam et al., 2007; see Appendix I for measure). Forced choice may have disrupted the implicit process necessary for infrahumanisation effects which could have contributed to the unexpected results and lack of correlations with other variables, and was reported as difficult to complete by some participants.

Finally, causality cannot be inferred and impacts or consequences of dehumanisation on the quality of patient care or staff wellbeing qualitatively were not examined in this study. Future research could address this, and a larger sample size could allow for the planned regression or more sophisticated path analysis could explore mediation and moderation effects. Additionally, variables such as differences across wards (acute vs rehab), age and gender could have been further explored with sufficient sample size.

Implications

These findings suggest key differences between physical health settings and mental health settings, possibly due to the relational nature of mental health work, as burnout is associated with more dehumanising perceptions of patients suggesting it may be a consequence or symptom of, or a contributor to high levels of emotional

exhaustion. There appears to be a role of organisational factors in shaping MHPs' views of patients, stressing the importance of prioritising staff wellbeing and ensuring MHPs feel supported and viewed as human by their organisation, as well as addressing burnout in this setting. Future research could examine the impacts certain interventions have on dehumanisation of patients among MHPs. Interventions may include adapting those in physical health settings aiming to address burnout (West et al., 2016) or humanising patient care in physical health settings (Haque & Waytz, 2012). Protected spaces such as reflective practice have been shown to impact on reflective capacity, team cohesion and readdressing hierarchies in inpatient health settings (Yiu et al., 2025) therefore it may be reasonable to hypothesise these spaces may shape views and perceptions MHPs hold towards patients. The unexpected findings regarding lived experience and years in inpatient settings highlight potential nuances in this group regarding identity and how personal and professional experiences can interact, and warrants further research.

Conclusion

Overall, this study provides evidence that MHPs in acute and rehabilitation mental health inpatient settings tend to perceive patients as less human than colleagues, as reflected across three dehumanisation measures. Lower perceived organisational support and higher emotional exhaustion were linked to higher dehumanising perceptions of patients. This highlights the potential role of organisational and systemic factors in shaping these perceptions, although causation cannot be established. Personal factors showed complex and surprising associations, highlighting the need for further research to expand our understanding of these processes. These findings suggest a need for intervention, whether this is enhancing

organisational support, addressing burnout, or tackling intergroup dynamics and prioritising humanising approaches in mental health inpatient care. Future research should focus on clarifying causal pathways and examining how dehumanisation may impact both staff wellbeing and the quality of care provided to patients.

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Part 3: CRITICAL APPRAISAL

Word count (excluding references): 4152 words

Overview

This critical appraisal will first reflect upon choosing a systematic review topic and the process of conducting a qualitative synthesis for the review as someone with little experience in this area. Then, the focus will move onto the empirical paper; providing insight into why I was particularly motivated to conduct research in this area, choosing dehumanisation measures, difficulties with ethical approval processes and recruitment, conducting research in inpatient mental health settings and finally reflecting upon researcher reflexivity and dilemmas.

Choosing a systematic review topic

Having no prior experience of conducting a systematic review, I had not anticipated how challenging it would be to select a viable topic for review. Choosing an area with enough research to meaningfully synthesise, but not one so broad or saturated that synthesis would become incredibly complex and outside the remit of a DClinPsy thesis was quite a difficult balance. I had hoped for an area similar to my empirical paper on factors shaping dehumanisation of service users by mental health professionals (MHPs). Unfortunately, there were already fairly recent reviews on mental health difficulties and dehumanisation (Lekka et al., 2022), more specifically within health contexts (Diniz, Bernardes & Castro, 2019) and even on 'humanisation of care' looking at key elements in healthcare (Busch et al., 2019). More specific searches, such as organisational dehumanisation in healthcare contexts, resulted in too few papers to consider a systematic review.

As the empirical paper was focused on inpatient MHPs, I next considered reviewing literature either associated with service user experience of inpatient settings, or staff experiences of these settings as I felt this would complement the empirical paper. I was also interested in gaining experience in qualitative research

methods, as up to this point the only experience I had of qualitative research was my service-related research project in which I interviewed a very small sample of service users (n=5) and used rapid thematic analysis to analyse. However, this avenue also proved difficult as reviews were published on both service user experiences (Hopkins et al., 2009; Staniszewska et al., 2019; Wood & Alsawy, 2016) and staff experiences (Thompson et al., 2024; Wyder et al., 2017).

Given my interest in the deinstitutionalisation movement (Bachrach, 2014) and a personal preference for working in alternative community-based settings to inpatient wards (after having experience in both), I started to explore experiences associated with services typically offered as an alternative or step before inpatient settings. At the time, I was on placement at an adolescent assertive outreach team and was really interested in the rationale behind the fairly recently developed model of care of assertive outreach teams. I was curious about service user perspectives on such crisis services and alternatives to hospitalisation, especially given service user accounts of feeling dehumanised in inpatient settings (Jina-Pettersen, 2022; Shojaei et al., 2023) and wondering whether community alternatives are more positively viewed by those who access them. There was something about seeing young people and their families at home, and the discussions happening in our team at the time that felt more aligned to trauma-informed and person-centred care, compared to my previous experience in inpatient settings. Although I appreciate this may not be the case in all settings, and is based on my own subjective experiences.

A systematic review on service user experiences of crisis resolution home treatment teams (CRHTTs) had been published (Winness et al., 2010) however with 15 years having passed, and additional papers exploring service user experiences of these teams having been published, this appeared to be enough to consider

updating this systematic review. However, upon searching the Prospero database, a previous DClinPsy thesis from 2023 had conducted a systematic review in this exact area (Goodier, 2023), although this has not been published to date. Whilst writing up this systematic review, a systematic review on service user experiences of CRHTTs was published (Yang, Glover & Wood, 2025) with similar findings to Winness et al. (2010) and Goodier (2023).

During the time searching and re-evaluating, I noticed how a systematic review on CRHTT effectiveness mentioned staff shortage as a possible reason for reduced effectiveness (Carpenter et al., 2013) and that staff related factors were mentioned in both systematic reviews on service user experiences (Goodier, 2023; Winness et al., 2010). However, this seemed to be a relatively unexplored area with no systematic review published to my knowledge suggesting a gap worth exploring.

Finding a topic was quite a lengthy process, and I often found it difficult to tolerate the uncertainty and frustration surrounding finding a potential topic, researching the area then realising it is not viable. I feel this made me more hesitant when exploring other options and less confident in the direction I was going in. This was especially pertinent as after I committed to staff experiences of CRHTTs, there was some uncertainty as to whether there was enough relevant literature for an appropriate systematic review. At one point, I considered a scoping review instead as I thought the eligibility criteria of the systematic review (such as qualitative research only) was limiting the papers too much.

In hindsight, I am pleased I persisted with the systematic review format. I believe the small pool of papers allowed a more in-depth and thoughtful synthesis and wondered whether this would have been possible if I had a much larger pool of final papers.

Conducting qualitative research

As mentioned previously, I had little prior experience with conducting qualitative research but I have always been drawn to the rich, in-depth insights it can offer. A qualitative approach aligned with the aim of my systematic review; to synthesise research which gave MHPs a voice and spoke to the nuances of their experiences working within CRHTTs. I found reading through their subjective experiences really engaging, however it felt overwhelming at times with so much data. Also, because some of the papers varied in terms of aim and sample (for example, mixed sample compared to sample of psychologists), I found the data complex to navigate in parts. I also felt a sense of responsibility and pressure to accurately capture the essence of what the research participants had passed onto the separate research papers, and not to lose any of the depth or nuance. However this made it difficult to determine what to include, as I soon realised I needed to be selective and prioritise certain themes in order to construct a meaningful and coherent synthesis.

To manage this, I followed Thomas and Harden's (2008) method and appreciated having a structured framework to follow. This involved coding, identifying recurring patterns across studies and collapsing codes, and I also found it helpful to see these visually on post-it notes and colour-coded spreadsheets. Throughout the process, I reflected on my own assumptions or how my experience impacted the way I interpreted the data. Given my previously mentioned preference for inpatient alternative services, I was aware that emerging themes around pride in offering an alternative to hospitalisation could have been influenced by my lens. However, ongoing discussions with my supervisor and peers and compiling the table showing which papers contributed to each theme helped to support reflexivity.

I am glad I chose to challenge myself with choosing qualitative methods for one part of my thesis, as I feel this significantly developed skills in this area and increased my understanding of the value of qualitative research. If I had more time, I would have been interested in seeing how a second coder would have rated the data, which would have enhanced reliability and reduced potential bias. Perhaps I could have considered giving a second person a section of the data and asked for them to code it, although this may have been difficult without the full context and richness of the data.

Choosing an empirical paper topic

'Us and them' dynamics have been at the forefront of my mind since I started working in mental health settings. My first role after my undergraduate degree was in an inpatient forensic medium secure psychiatric setting as a healthcare assistant where I witnessed these strong dynamics enhanced by the working environment, culture and management. I struggled with what I felt were dehumanising attitudes of the people on the ward and how that often justified highly restrictive practices. My interest in this area was further developed when I worked in a community team for people with learning disabilities, and became aware of the horrific abuse that took place at Winterbourne View. Our team took a very humanising approach to the work, always keeping the person and their loved ones at the centre. Even small acts such as making sure a service user's name (and not initials) was used at meetings, and taking a genuine interest in their lives and not just a list of symptoms made the dynamics of 'us and them' seem less prominent. I valued thinking about dehumanisation and its relation with stigma, empathy and oppression in this sector, and felt it aligned with my passions around healthcare being compassionate, fair and respectful at all times. For me, the thought of researching dehumanisation was never

to be critical or blaming but to understand these processes more and to consider how to enhance more humanising approaches, so both staff and service users can feel treated with respect and dignity which we all deserve. Working with peer support workers in drug and alcohol services and an advanced lived experience practitioner in a community mental health team further grew my passion and interest in this area.

Designing the study

Another reason I chose this project was that it was not fully defined from the outset, which offered flexibility and allowed me to adapt to my specific interests. Although this came with challenges, I am grateful for this experience as I found the initial literature searching engaging and I enjoyed the process of developing and refining ideas. As soon as I read about organisational dehumanisation, I saw the links to NHS mental health settings especially the 'trickle-down' effect evidenced in previous research (Fontesse, Rimez & Maurage, 2021).

A challenge associated with this field is there is no 'gold standard' or established way of measuring dehumanisation. One of the most widely used measures is the Ascent of Man scale, in which participants are asked to rate a group of people on the evolution scale (Kteily et al., 2015). However, a choice was made not to include this measure, as it felt inappropriate and with it being such a blatant measure, we suspected high levels of social desirability especially in a sample of MHPs. Adapting the Implicit Association Test (Karpinski & Hilton, 2001) to tap into implicit attitudes was considered, however would likely have exceeded the practical scope of a DClinPsy thesis especially as I hoped to explore multiple variables. Reading more about infrahumanisation theory and measurement (Leyens et al., 2001) and how it captures a subtler form of intergroup differences led us to include this as a measure. Based on Haslam's (2006) conceptualisation of animalistic and

mechanistic forms of dehumanisation, it felt appropriate to include a measure of both. The final dehumanisation measures were influenced by Rasset et al.'s (2022) choice of measures. With there being different elements of dehumanisation and not one agreed 'right' way to measure, a variety of measures were hoped to address this and allow the findings to be compared on each measure. Additionally, I was conscious of how little time MHPs may have to complete the survey so did not want to add any additional measures that may have increased the demand too much. Although I wanted to include additional constructs such as empathy (for example, Jefferson Scale of Physician Empathy; Hojat et al., 2001), I prioritised variables most directly relevant to my research questions given time and resource constraints.

The organisational factors were more prescribed in terms of the measures that tend to be used in research, and due to the close relations between perceived organised dehumanisation, perceived organisational support and burnout, these three seemed important to include. A choice was made to ask MHPs if they have personal experience (themselves or a close family member or friend) of a mental health difficulty for various reasons. One reason being that dehumanisation often refers to intergroup dynamics and being a MHP with experience of being a 'patient' may blur these intergroup boundaries and influence dehumanising views of patients. Additionally, as someone with lived experience of mental health difficulties, this is something I feel passionately about understanding more in research and noticed limited research within this area.

In hindsight, I wonder if I may have overcomplicated the research or was possibly overly ambitious by including a range of variables, possibly as a way to meet perceived expectations of 'doctoral-level' work.

Difficulties with ethical approval

I found the process of obtaining ethical approval and navigating the processes associated with recruiting MHPs directly from NHS workplaces possibly one of the most challenging and time-consuming parts of doctoral training.

When planning the project, there was two options; 1) to recruit MHPs directly from NHS acute inpatient wards, via circulating emails around NHS email addresses, displaying recruitment advertisement in communal areas and attending the workplaces to disseminate, or 2) to recruit MHPs from spreading the information via social media and word of mouth. At the time, my supervisor and I favoured the first option, direct recruitment of MHPs from NHS workplaces, for several reasons. One of the main reasons being concerns about the representativeness and self-selection sampling bias in social media samples (Oudat & Bakas, 2023). In a variety of different samples, social media samples have shown a skew towards younger, female and white samples, and can exclude people from lower socioeconomic backgrounds (Benedict et al., 2019; Sanchez et al., 2020). In the context of MHPs, it was anticipated only certain professions may be represented in a social media recruited sample who belong to certain online groups. For example, a brief Facebook search revealed multiple groups for "UK Clinical Psychologists" and "UK Occupational Therapists", a few for "UK Mental Health Nurses" and none according to my search for "UK Psychiatrists" or specifically for "UK Mental Health Support Workers" or "UK Mental Healthcare Workers". Given these are the groups that I would have likely posted the study in, perhaps an overrepresentation of Psychologists and Occupational Therapists would have been observed.

An associated issue is self-selection bias (Bethlehem, 2010), particularly if recruitment occurred via my professional networks in which trainee or qualified

psychologists and nurses may have been overrepresented. As aforementioned, recruiting on social media may have also led to responses from MHPs with a specific interest in this area. Although recruiting NHS staff directly does not eliminate self-selection bias, it was considered a way to mitigate this by reaching professionals less likely to engage in research via social media. This was somewhat true as some participants informally told me they had not participated in research before.

Importantly, this recruitment strategy did not need full NHS ethics as I was recruiting staff (rather than service users) so NHS Health Research Authority (HRA) approval sufficed. At the time, a pilot streamlining the process of obtaining approval specifically for recruiting NHS staff was being offered. Based on this, we decided on recruiting NHS MHPs.

I started liaising with the NHS trust's research and development (R&D) team in late 2023. However, we were informed early 2024 that unfortunately the pilot streamlining the process for recruiting NHS staff had been paused due to high demand. I submitted UCL ethics and NHS HRA approval documents in February 2024. UCL ethical approval was granted three months later, however HRA approval did not come through until nine months later in November. Capacity and Capability approval for recruitment to begin took a further three months, until the end of the January.

During this time, I liaised extensively with the UCL Joint Research Office (JRO) and the NHS R&D team, completed a 32-page Integrated Research Application System (IRAS) form, completed a 21-page protocol and submitted 1) 4 documents for UCL ethics, 2) 22 documents for HRA approval, and 3) 3 documents for Capacity and Capability.

Whilst I recognise and appreciate the significant importance of thorough governance, I found the process fairly overwhelming and at times frustrating. The relevance of certain requirements (such as forms relating to physical health studies, or high-risk research, or research associated with a substantial cost element) were unclear, but were still necessary for me to obtain the approval. Whilst I remain very grateful to everyone at the UCL JRO, NHS HRA and R&D team who helped me navigate these processes and for all of their input, frequent delays in communication (possibly reflecting the high levels of demands on these systems) were beyond my control and added to the feelings of frustration and powerlessness.

Nonetheless, this experience gave me insight into setting up healthcare research, and the challenges that can exist alongside this. I now have a clearer sense of how to navigate future research in NHS settings, especially regarding potential timelines. However, the length and complexities of the process raised questions about whether such barriers might discourage research activity within NHS settings. While I was able to remain committed due to the requirements of my doctoral thesis and working towards a strict deadline, I am conscious in previous roles as a full-time clinician doing research projects in very limited amounts of time, I am unsure I could have remained as committed. I suspect this may be a common challenge faced by other clinician-researchers in the NHS. This aligns with wider concerns in the literature. Snooks et al. (2023) showed those involved in UK health research report challenges such as risk adverse systems, disproportionate requirements for low-risk studies, overly bureaucratic processes and delays. Encouragingly, the HRA is actively considering ways to improve the process (NHS HRA, 2022) and perhaps the paused pilot for recruiting NHS staff will have positive outcomes.

With hindsight and considering the limited time and capacity of a DClinPsy thesis project, perhaps recruiting from social media would have been more appropriate for this project. Especially given my UCL ethical approval came through in February 2024, hypothetically if I started social media recruitment then I would have had a whole year extra to reach the required sample size and most likely could have exceeded this. This would have led to sufficient power for all planned analyses including the regression with all eight predictors.

Recruitment issues

Once approval was granted, unanticipated challenges also arose with recruitment. When recruitment could start, the wards involved were preparing for an upcoming Care Quality Commission (CQC) inspection. Mindful of not overburdening already stretched MHPs, I took a more passive approach to recruitment initially. This involved emailing 12 ward managers with study information, requesting they forward the recruitment email to staff and suggest if there were times I could attend a team meeting or the ward to ask MHPs to participate.

Unfortunately, only one ward manager responded and agreed to forward the recruitment email to their ward. Fortunately, my thesis supervisor works on one of the wards so was able to help recruiting MHPs on that ward. After the CQC inspections concluded in March, I followed up with all ward managers. No responses were received. At this point, I only had 12 completed and eligible responses. Although I anticipated managers would be extremely busy, forwarding an email seemed a relatively reasonable and quick task, so I was somewhat surprised by the lack of responses. I wonder if this reflects ward managers' high workloads, other projects ongoing or a desire to protect staff from additional tasks.

Subsequently, with support from my thesis supervisor and the head of psychology, I joined some of the wards' allocated psychologists for on-site visits to introduce myself to the ward manager, ask permission to share and to speak to MHPs. This more active strategy proved more effective, but was labour intensive. In hindsight, I massively underestimated the time commitment and complexities required to recruit MHPs in this way. I initially believed that reaching out via email, with the support of ward managers, would suffice to recruit 109 participants especially as one ward's mailbox has around 30-40 staff.

In a 4-week period, I conducted 7 separate day on-site visits across 10 wards and the return was variable, one day 10 MHPs completed the survey and another only two completed. I attended team meetings to speak about the research, emailed further sites and the leads of each discipline, put up the research poster in communal staff areas and sent numerous emails sent to staff members I had spoken with who did not have time to complete the questionnaires at the time. This slow and labour intensive recruitment process was disheartening and I missed the data collection deadline my supervisor and I had set (as we only had 32 responses at this point). However, I was incredibly grateful for the support I received from my thesis supervisor, psychologists, occupational therapists, nurses and ward managers during this time who helped me gain access to the wards, circulated the research project and encouraged others to participate. Their contributions highlighted the importance of cultivating on-the-ground support within clinical teams when conducting research in NHS environments. With hindsight, cultivating this support from the very beginning would have been advantageous.

Research in inpatient mental health settings

Challenges associated with conducting research in acute inpatient mental health settings were also observed and reflected upon throughout the recruitment period. The wards support people in significant distress, and on several occasions, I was advised not to access wards due to incidents of harm to themselves or others. However on other occasions, I only became aware of the situation after arriving. Having worked in inpatient settings before (but nearly 8 years ago), I was reminded just how unpredictable working in this setting can be.

Midway through the questionnaires, an MHP had to leave urgently to intervene in a physical altercation resulting in a visit to A&E. Upon returning to the office, they offered to continue with the questionnaires which I felt highlighted just how desensitised MHPs can be in this setting and that these incidents are part of their day-to-day working lives.

Witnessing close physical aggression from service users to MHPs, clearly seeing fear amongst MHPs and hearing their personal experiences with recent assaults and feelings at work prompted personal reflections, on previous experiences and difficult memories, and the current research project and aims. I kept a reflective journal during this time to help make sense of some of these experiences and as a continual reminder of why I was interested in this research project; how working environments and organisational factors can influence our perceptions and thought processes at work. I was also mindful I was only present on the wards for brief periods, whereas these pressures are a constant reality for staff.

Researcher reflexivity and research dilemmas

This prompted me to also reflect on the research and dilemmas that arose, particularly around my positioning in the research, as a researcher, a clinician and a

person with experience of mental health difficulties, and how these roles can sometimes feel conflicting. I became increasingly aware of the 'us and them' dynamics in these settings in relation to 'patients' and 'professionals' but also in research as 'participants' and 'researcher', and the responsibility that comes with the power differences. These binary constructs can unintentionally reinforce power hierarchies. Whilst writing up, I felt a strong responsibility to present and communicate the findings in a non-blaming and non-judgmental way. While this was always my intention, spending time on the wards and engaging with MHPs reinforced this further. I hope my efforts to frame the dynamics carefully, by highlighting how implicit and unconscious dehumanisation can be and something that can be shaped by systemic pressures and emotional fatigue, rather than a vindictive choice made by MHPs to deliberately inflict harm comes through in the empirical paper. However, I also did not want to shy away from the reality that these dynamics can be harmful and deeply impactful, both for MHPs and for people they support who tend to be at their most vulnerable. Having read qualitative experiences from people with a diagnosis of psychosis feeling dehumanised by healthcare professionals in a recent DClinPsy thesis (Pendlebury, 2024) further reinforced the importance of research within this field.

The systemic and social constructionist notion of 'both-and' (for example, Burnham, 1992), rather than seeking what is 'right' and 'true', helped me organise my thinking and manage this tension. It helped me to hold multiple truths at once; MHPs can be deeply compassionate and caring, and work incredibly hard in such a challenging workplace, whilst also engaging in practices that are dehumanising to those they are giving care to which can cause harm to service users and their support networks. This study hoped to explore how systemic organisational factors

and personal factors can shape these perceptions in order to advance our understandings of such phenomena to then inform future interventions in these settings. I hope this can be a small piece of the jigsaw.

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APPENDICES

Appendix A: Database Searches for the Systematic Review

These were the database search terms and results according to the database searched. PsychInfo, Embase, MEDLINE, Wed of Science and CINAHL Plus were searched.

Database 1: APA PsycInfo

1   (Staff* or worker* or professional* or clinician* or practitioner* or psycholog* or psychiatr* or therapist* or nurs* or social worker* or occupational therapist* or healthcare assistant* or support worker* or doctor*).ab,id,ti.   1597107
2   (Experience* or perception* or view* or perspective*).ab,id,ti. 1596129
3   (Crisis resolution* or crisis intervention* or crisis team* or home treatment* or crisis house* or mobile cris*).ab,id,ti.   5592
4   ((mental health or psych* or suicid* or self-harm* or self-injur*) adj3 (cris* or emergenc* or acute)).ab,id,ti.   21390
5   ((home or community) adj3 (treatment* or team* or service*)).ab,id,ti.
        31376
6   4 and 5   673
7   1 and 2 and 3   1191
8   1 and 2 and 6   164
9   7 or 8 1299

Database 2: Embase

1   (Staff* or worker* or professional* or clinician* or practitioner* or psycholog* or psychiatr* or therapist* or nurs* or social worker* or occupational therapist* or healthcare assistant* or support worker* or doctor*).ab,sh,ti. 3948376
2   (Experience* or perception* or view* or perspective*).ab,sh,ti.   3601167
3   (Crisis resolution* or crisis intervention* or crisis team* or home treatment* or crisis house* or mobile cris*).ab,sh,ti.   11355
4   ((mental health or psych* or suicid* or self-harm* or self-injur*) adj3 (cris* or emergenc* or acute)).ab,sh,ti.   60757
5   ((home or community) adj3 (treatment* or team* or service*)).ab,sh,ti.
        68558
6   4 and 5   1289
7   1 and 2 and 3   1714
8   1 and 2 and 6   327
9   7 or 8 1943

Database 3: Ovid MEDLINE

1   (Staff* or worker* or professional* or clinician* or practitioner* or psycholog* or psychiatr* or therapist* or nurs* or social worker* or occupational therapist* or healthcare assistant* or support worker* or doctor*).ab,hw,ti. 3137599
2   (Experience* or perception* or view* or perspective*).ab,hw,ti.   2860116
3   (Crisis resolution* or crisis intervention* or crisis team* or home treatment* or crisis house* or mobile cris*).ab,hw,ti.   9578
4   ((mental health or psych* or suicid* or self-harm* or self-injur*) adj3 (cris* or emergenc* or acute)).ab,hw,ti.   22489
5   ((home or community) adj3 (treatment* or team* or service*)).ab,hw,ti.
         130733
6   4 and 5   1011
7   1 and 2 and 3   1345
8   1 and 2 and 6   203
9   7 or 8   1477

Database 4: Web of Science

1: TS=(Staff* or worker* or professional* or clinician* or practitioner* or psycholog* or psychiatr* or therapist* or nurs* or "social worker*" or "occupational therapist*" or "healthcare assistant*" or "support worker*" or doctor*)   Date Run: Thu Dec 12 2024 11:01:22 (Greenwich Mean Time) Results: 3509806
2: TS=(Experience* or perception* or view* or perspective*) Date Run: Thu Dec 12 2024 11:02:16 GMT+0000 (Greenwich Mean Time) Results: 6321428
3: TS=("Crisis resolution*" or "crisis intervention*" or "crisis team*" or "home treatment*" or "crisis house*" or "mobile cris*") Date Run: Thu Dec 12 2024 11:03:31 GMT+0000 (Greenwich Mean Time) Results: 6110
4: TS=(("mental health" or psych* or suicid* or "self-harm*" or "self-injur*") NEAR/3 (cris* or emergenc* or acute)) Date Run: Thu Dec 12 2024 11:04:19 GMT+0000 (Greenwich Mean Time) Results: 29949
5: TS=((home or community) NEAR/3 (treatment* or team* or service*))   Date Run: Thu Dec 12 2024 11:04:47 GMT+0000 (Greenwich Mean Time) Results: 87786
6: #4 AND #5 Date Run: Thu Dec 12 2024 11:05:17 GMT+0000 (Greenwich Mean Time) Results: 862
7: #1 AND #2 AND #3 Date Run: Thu Dec 12 2024 11:05:26 GMT+0000 (Greenwich Mean Time) Results: 916
8: #1 AND #2 AND #6 Date Run: Thu Dec 12 2024 11:05:33 GMT+0000 (Greenwich Mean Time) Results: 246
9: #7 OR #8 Date Run: Thu Dec 12 2024 11:05:39 GMT+0000 (Greenwich Mean Time) Results: 1079

Database 5: CINAHL

|			
S 1	Staff* or worker* or professional* or clinician* or practitioner* or psycholog* or psychiatr* or therapist* or nurs* or social worker* or occupational therapist* or healthcare assistant* or support worker* or doctor*	Expanders - Apply equivalent subjects Search modes - Proximity	2,144,623
S 2	Experience* or perception* or view* or perspective*	Expanders - Apply equivalent subjects Search modes - Proximity	956,075
S 3	Crisis resolution* or crisis intervention* or crisis team* or home treatment* or crisis house* or mobile cris*	Expanders - Apply equivalent subjects Search modes - Proximity	10,308
S 4	(mental health or psych* or suicid* or self-harm* or self-injur*) W3 (cris* or emergenc* or acute)	Expanders - Apply equivalent subjects Search modes - Proximity	6,198
S 5	(home or community) W3 (treatment* or team* or service*)	Expanders - Apply equivalent subjects Search modes - Proximity	60,280
S 6	S4 AND S5	Expanders - Apply equivalent subjects Search modes - Proximity	431
S 7	S1 AND S2 AND S3	Expanders - Apply equivalent subjects Search modes - Proximity	1,685
S 8	S1 AND S2 AND S6	Expanders - Apply equivalent subjects Search modes - Proximity	103
S 9	S7 OR S8	Expanders - Apply equivalent subjects Search modes - Proximity	1,743

Appendix B: Grouping of Existing Literature Themes for the Systematic Review

All themes and sub-themes in the nine final papers identified were written onto a post-it note then grouped by similarity.
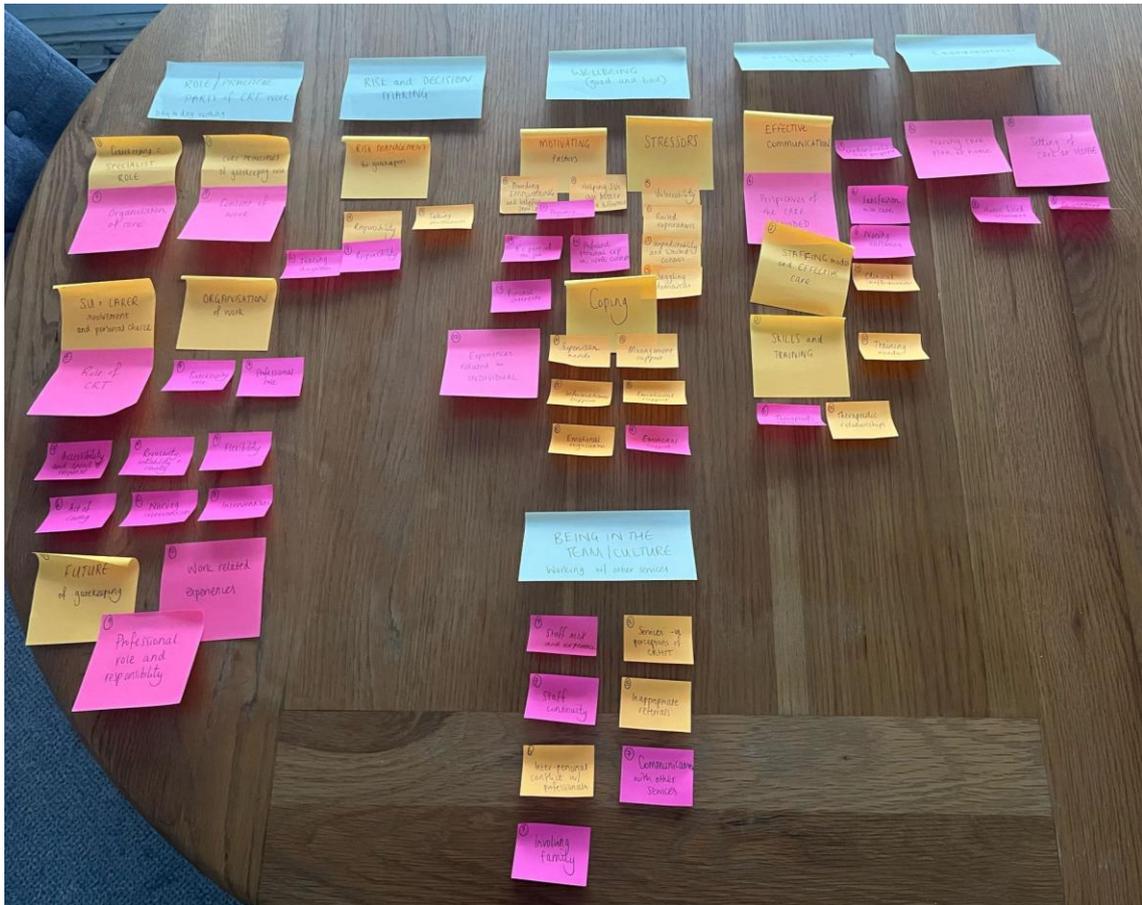
Appendix C: Line by Line Coding for the Systematic Review

This includes an example of the line by line coding via track changes on Microsoft word and an example of section that was excluded (due to referring to other parts of sample) which was done via strikethrough.

"Stress" was also located internally, in aspects of the team functioning (shift co-ordinating) and in the allocation of work to team members.

> **Thomas, Sioned**
> Within team conflict

I felt that I allocated appropriately and the fact that that person was challenging my capabilities to effectively manage the shift […]. Initially I felt quite frustrated and annoyed because I thought I had given rational reasons to why I felt it was appropriate for a member of staff to visit […] throughout the shift, I think it was kind of niggling at the back of my mind (Joan).

> **Thomas, Sioned**
> Within team conflicts
>
> **Thomas, Sioned**
> Justifying self

Participants related the sense of trying to adjust to the unpredictability of the role as well as feeling that they lacked control in attempting to meet the demands placed on the team, from managing current caseloads and demands arising out of referrals.

> **Thomas, Sioned**
> Unpredictability

I am still getting to grips with the fact that no matter how well you plan the day out, you plan your visits with the clients that are already on our caseload, things crop up and you are having to sort of move visits around and maybe put pressure on other members of staff. It's not having that control, things are out of your control on occasions, but it is just the nature of the work […] at any moment you could get referrals coming through (Joan).

> **Thomas, Sioned**
> Unpredictability; not in control

An emergency referral comes in and then the pack of cards goes up in the air. The allocations boards have been changed twice today because of referrals, but that's the nature of the work […] (Pat).

> **Thomas, Sioned**
> Unpredictability; lack of control

As can be seen from above, there is also a sense of acceptance that the unpredictability and reduced sense of control are "part of the job", something to put up with as expected in this service context. However, there was also a clear sense that at times the demands on the team were outweighing the resources available especially in terms of referral volume:

> **Thomas, Sioned**
> Part of the job
>
> **Thomas, Sioned**
> Lack of resources

It's stressful for the staff because there might be other assessments, we got others lined up then and we might be doing three or four assessments in a day which is too much really, you know, as they are coming through, they are piling up then (Charlie).

> **Thomas, Sioned**
> High workload; lack of resources

Not surprisingly, participants discussed their work in the CRHT entailing considerable degree of responsibility and vulnerability.

> **Thomas, Sioned**
> Responsibility; vulnerability

stakeholders that hospital Accident and Emergency (A&E) departments were the least satisfactory referral pathway. ~~Some service users and carers had experienced long waits in stressful and uncomfortable A&E environments.~~ CRT staff criticised the quality of assessments and appropriateness of referrals from A&E and psychiatric liaison colleagues. However, their value in providing emergency assessments was recognised, especially at night, when other sources of help are unavailable. ~~"I know it's a bit of a broad brush statement, but there's lot of referrals that take place in A&E where people have maybe had a bit too much to drink and have taken an overdose, the hospital are reluctant to discharge them without a psychiatric assessment, so the team go out or this one person goes to A&E, does an assessment, ends up saying actually you don't need any follow up from psychiatric services." (Practitioner group 32, CRT referrers)~~For both new referrals and existing clients, there was also agreement across all groups about the need for a 24/7 service offering at least rapid telephone access to clinical advice. Around a third of service users and carers described experiencing this as reassuring, although a small minority of both groups described negative impacts of being unable to successfully make phone contact, or feeling let down by a phone only overnight service. Staff and CRT developers acknowledged that providing a more substantial 24/7 service has significant resource implications.

> **Thomas, Sioned**
> Inappropriate referrals
>
> **Thomas, Sioned**
> Appreciation of other service
>
> **Thomas, Sioned**
> Appreciation of other services

Regularity, reliability and clarity

~~Regular contact with CRT staff was extremely important for service users and carers, many of whom felt that visits daily or more frequently facilitated trust and emotional support (see section 2.2 below). Regular visits were cited as the most helpful aspect of treatment by a third of service users and a quarter of carers.~~ ~~I: What would you say was the most helpful thing about the crisis team? SU07: It was the daily support, definitely; knowing that, when I got up each morning, if I was frightened or upset, I knew that someone was coming to see me.For the most part, services appeared to be successfully providing regular contact, although a few service users said that infrequent contact had been the least helpful aspect of their care.~~ While practitioners also viewed regularity as important, this was more because it enabled them to monitor risk and clinical changes. ~~Service users and carers also described reliability and clear communication as helpful to forming trusting therapeutic relationships, and a small minority of both groups described large negative impacts when staff were not reliable (e.g. they did not visit at agreed times, or failed or were slow to do things they had agreed to). "They were supposed to come here one day, and it was the first time he felt comfortable enough to be on his own with them, and I went to work, and I rang him, just to make sure he was up out of bed, and I think I~~

> **Thomas, Sioned**
> Risk management

Appendix D: Initial Codes for the Systematic Review

These were the initial 138 codes inserted onto an Excel spreadsheet, organised initially by each paper in a column, then by number of times featured.

Initial codes by paper

Freeman et al.	Sjøle, Karlsson and Binder	Murphy et al.	Begum and Riordan	Morant et al.	Sacks and Iliopoulou	Klevan et al.	Giménez-Díez et al.	Clibbens et al.
Composure I	Composure III	Composure I				Composure II		
Dedication I	Dedication I				Dedication I			
Emotional support from team II								
Empowering SU I		Empowering SU II		Empowering SU I		Empowering SU IV	Empowering SU II	Empowering SU
Frustration I		Frustration II						
Gaps in knowledge				Gaps in knowledge I				
High workload I		High workload I		High workload I				High workload
Home environment I	Home environment V	Home environment I	Home environment I	Home environment I		Home environment I	Home environment XI	
Inappropriate referrals I			Inappropriate referrals II	Inappropriate referrals III				
Involving SU in decision making III						Involving SU in decision making I	Involving SU in decision making III	Involving SU in de...
Justifying decision making II								
Justifying self I								
Knowledge within team III	Knowledge within team III			Knowledge within team II				
Lack of supervision II		Lack of supervision I						Lack of supervision
Lack of training I								Lack of training
Limited resources II			Limited resources IV	Limited resources viii				Limited resources
Management support I								
Not in control II					Not in control/agency II			
Not making a difference II								
Openness within team III								
Other team anxiety I								
Other team conflict I				Other team conflict IV				
Other team lack of knowledge I			Other team lack of knowledge I	Other team lack of knowledge IV				
Part of the job I					Part of the job III			
Planning ahead II				Planning ahead I				Plannign ahead
Providing an alternative to hospital I	Alternative to hospital II		Alternative to hospital IV	Alternative to hospital I		Alternative to hospital III	Alternative to hospital IV	
Reassurance from team I								
Referrers views II								
Regulating emotions I								
Relationship with SU VI	Relationship building IV			Relationship V	Relationship II	Relationship I	Relationship XII	Relationship
Responsibility I		Responsibility III	Responsibility IV		Responsibility II		Responsibility I	
SU choice I				SU choice II			SU choice I	
SU improvement							SU improvement I	
Team work I		Team work III		Team work I		Team work I		
Trust within team I		Trust within team II						

Tabs: Initial themes before coding | **Initial codes by paper** | Combined codes by paper | Combined codes by number | Combined codes

Combined codes by number

Code	How many papers?	How many times in total?
Relationship	7	32
Home environment	7	21
Flexibility	7	15
Alternative to hospital	6	15
Involving SU's network	6	13
Empowering SU	6	11
Responsibility	5	12
Work satisfaction	5	11
Pressure	5	9
Limited resources	4	21
Fast paced	4	14
Risk related issues	4	12
Communcation	4	11
Creativity	4	8
Involving SU in decision making	4	8
Working with whole person	4	8
Composure	4	7
Team work	4	6
High workload	4	4
Least restrictive option	4	4
Medical/other models	3	11
Decision making	3	9
Unpredictability	3	9
Knowledge within team	3	8
Duties	3	6
Inappropriate referrals	3	6
Other team lack of knowledge	3	6
Respect	3	5

Tabs: Initial themes before coding | Initial codes by paper | Combined codes by paper | **Combined codes by number**

Appendix E: Quality Appraisal Ratings for the Systematic Review

This is the quality appraisal rating table using the CASP qualitative checklist, and rated by the first author (ST) and independent reviewer (HB). An overall score was given from 0 (lowest quality score) to 10 (highest quality score).

Author(s) and Year	1. Was there a clear statement of the aims of the research?		2. Is a qualitative methodology appropriate?		3. Was the research design appropriate to address the aims of the research?		4. Was the recruitment strategy appropriate to the aims of the research?		5. Was the data collected in a way that addressed the research issue?		6. Has the relationship between researcher and participants been adequately considered?		7. Have ethical issues been taken into consideration?		8. Was the data analysis sufficiently rigorous?		9. Is there a clear statement of findings?		10. How valuable is the research?		Overall score	
	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB	ST	HB
Freeman, Vidgen & Davies-Edwards (2011)	Y	Y	Y	Y	Y	?	?	?	Y	Y	N	N	?	?	Y	Y	Y	Y	Y	Y	8	7.5
Sjølie, Karlsson & Binder (2013)	Y	Y	Y	Y	Y	Y	?	?	Y	Y	?	Y	N	N	Y	Y	Y	Y	Y	Y	8	8.5
Murphy et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	?	?	Y	Y	Y	Y	Y	Y	Y	Y	9.5	9.5
Begum & Riordan (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	?	Y	Y	Y	Y	9	8.5
Morant et al. (2017)	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	N	?	Y	Y	Y	Y	Y	Y	Y	Y	9	9
Sacks & Iliopoulou (2017)	Y	Y	Y	Y	Y	Y	Y	?	Y	Y	?	Y	?	?	Y	?	Y	Y	Y	Y	9	8.5
Klevan et al. (2018)	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	8.5	9
Giménez-Díez et al. (2022)	Y	Y	Y	Y	Y	Y	?	?	Y	?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	9.5	9
Clibbens et al. (2024)	Y	Y	Y	Y	Y	Y	Y	?	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	9	8.5
% of studies rated Y:	100%	100%	100%	100%	100%	78%	56%	44%	100%	89%	11%	33%	67%	67%	100%	78%	100%	100%	100%	100%		

Appendix F: Recruitment Email for the Empirical Paper

This is the recruitment email which was circulated to all participating

wards/mental health professionals.

Dear all,

📢 Research participants needed for a quick anonymous online survey please.

I'm Sioned, a Trainee Clinical Psychologist from University College London (UCL). I'm conducting my doctoral research exploring different factors that influence how staff feel about the organisation they work for and the patients they support.

📋 What's Involved?

A quick, anonymous online survey (around **10 to 20 minutes**).
Please read the Participant Information Sheet attached before you decide whether to take part.

📝 Who can take part?

Anyone in a **patient facing role** e.g. healthcare assistant, nurse, psychiatrist, allied health professionals. You should have worked on an **acute (including PICU) or rehabilitation inpatient ward** for at least <u>6 months</u> and on the **ward you currently work on** for <u>3 months</u>.

💡 Why participate?

We would like to better understand how mental healthcare professionals feel at work, especially in busy inpatient settings, and what factors may affect how staff feel towards their organisation and the patients they care for. Each participating ward will receive a £20 Sainsbury's voucher as a thank you for your time.
Participating is voluntary and you can withdraw at any time.

💬 Ready to start the survey?

Please scan the QR code with a smartphone, or click the link on a laptop or computer to take part in the study:

[Redacted link]

❓ Questions?

If you have any questions about the research, please don't hesitate to email me on [redacted email address]

This study has been granted ethical approval by UCL Research Ethics Committee (ID number: 26881/001) and granted HRA approval (IRAS number: 339949).

🤝Thank you so much for your time, I really appreciate it.

Kind regards,
Sioned Thomas (she/her)
Trainee Clinical Psychologist (Third Year)
Doctorate in Clinical Psychology
University College London, 1-19 Torrington Place, London WC1E 6BT
Email: [redacted email]

Exploring factors affecting staff's perceptions of patients, EDGE (Sponsor) number 167933, IRAS number 339949, Recruitment Email, Version 2.0, 13/09/2024

This is the participant information sheet which was circulated to all

participating wards/mental health professionals.

**RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL
AND HEALTH PSYCHOLOGY**

UCL

Participant Information Sheet
UCL Research Ethics Committee Approval ID Number: 26881/001

Exploring the impact of organisational and personal factors on the perception of patients by mental healthcare professionals in the NHS.

We would like to invite you to take part in this research study. Before you decide, it is important you understand why the research is being done and what it will involve. Please take time to read the information. Please feel free to reach out to the research team by email if anything is unclear or if you have any questions.

What is the purpose of this project?
We are interested in how mental healthcare professionals feel at work and how they are treated by their organisation. Research shows if people do not feel supported at work, they experience higher levels of burnout. We are also interested in the links between organisational support and how staff feel about the patients they work with. For example, if someone feels supported at work, they may perceive and feel differently towards patients compared to someone who feels very unsupported.

Why have I been chosen?
You have been chosen because you are a mental healthcare professional in a patient facing role in [NHS Trust]. If you have been working in acute inpatient wards for at least 6 months and on the ward you are currently working on for at least 3 months, you are eligible to participate. It does not matter if you are part-time or bank staff. If you are unsure you meet this criteria or have any questions, please email the research team.

Do I have to take part?

It is up to you to decide whether or not to take part. You can withdraw at any time without giving a reason and without it affecting your employment in any way. If you want to withdraw once you have completed the questionnaires, please email the approximate time/date you completed the questionnaires to the researcher ([redacted email]). If we cannot locate the data from this, we may have to ask for other details such as your age range and gender.

What will happen to me if I take part?
Everyone who takes part will be asked to complete a tick-box consent form and complete some questionnaires asking you for your demographic information, your profession, your experience of mental health difficulties, how supported you feel at work and how your organisation makes you feel, and how you feel towards the patients typically supported on your ward. This should take around 10-20 minutes to complete.

Research designs often require that the full details of the study are not explained before participating. Although we have described the general nature of the research and tasks you will be asked to complete, the full intent of the study will not be explained to you until after you have completed the questionnaires (you can withdraw your data from the study within 4 weeks of completing the study). All of your answers will be anonymous and we will not be able to identify who has completed the questionnaires.

Will my taking part in this project be kept confidential?
You will not be asked to give your name, contact details or disclose the current ward you work on therefore your answers are anonymous. You will be asked for some personal information such as age, gender identity and ethnicity but all data will be kept strictly confidential and only be accessed by the two researchers. You will not be identified in any reports or publications that arise from this research.

What are the possible disadvantages and risks of taking part?
We do not anticipate any risks from taking part. During the study, you may think more about how you are feeling at work and how work is impacting on your wellbeing, this may lead to a slight chance of you finding some of the questions distressing. At the end of the questionnaire, there will be a list of services/resources which may be helpful if you would like additional support.

What are the possible benefits of taking part?
Whilst there are no immediate benefits for those participating in the project, it is hoped that this research will help us understand more about how mental healthcare professionals feel at work and what factors may affect how patients are viewed. This may lead to recommendations being made to [NHS Trust].

What will happen to the results of the research project?
The results of the study will form part of the researcher's thesis for the doctorate in clinical psychology and will be written up into a scientific research report which will be put forward to be published, in which no individual can be identified. If you would like a copy of the report or a summary of the findings, please contact the research team within 1 year of completing the survey. This summary is likely to be available to be shared with you by January 2026.

What will happen to my data?

The data controller for this project is University College London (UCL) and will determine how special category personal data (health and ethnicity) are used in the study. The UCL Data Protection Officer can be contacted at data-protection@ucl.ac.uk. Further information on h ow UCL uses personal information can be found here: UCL General Privacy Notice for Participants and Researchers in Health and Care Research Studies | Legal Services - UCL – University College London. The lawful basis used to process special category data will be for scientific research and statistical purposes.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact The UCL Data Protection Officer in the first instance.

Data will be stored securely in a password protected file on a UCL desktop and on the OneDrive only accessible by the two researchers. Consent forms and data will be held securely by UCL for 10 years after the end of the study, as per the guidance in the UCL Research Data Policy. This data will not be shared or stored for future use. We will ensure that all the requirements of the Data Protection Action 2018 and General Data Protection Regulation are complied with.

What if something goes wrong or I have a complaint?

If you have a concern about anything in this study, in the first instance please contact the Primary Researcher Dr Janice Williams ([redacted email address]). If you feel your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee (ethics@ucl.ac.uk).

Contact details

Dr Janice Williams (Principal Researcher) [redacted email address]
Room 439, 4th Floor, 1-19 Torrington Place, London WC1E 7HB
Sioned Thomas (Trainee Clinical Psychologist) [redacted email address]

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix H: Recruitment Poster for the Empirical Paper

This is the recruitment poster which was circulated around to mental health professionals and posted in communal areas.

Appendix I: Survey with the Consent Form and Measures for the Empirical Paper

This is the questionnaires embedded into the Qualtrics survey which begins

with a summary of the participant information sheet and a consent form participants

must have completed before continuing with the questionnaires.

Header Exploring factors affecting staff's perceptions of patients, EDGE (Sponsor) number 167933, IRAS number 339949, Survey, Version 2.0, 08/09/2024

Hello!   Thank you for considering to take part in our research study. My name is Sioned Thomas, and I am studying for my Doctorate in Clinical Psychology at University College London (UCL). This means I am a Trainee Clinical Psychologist, conducting research under the supervision of Dr Janice Williams who works at UCL. Here is some information about the study: As a mental health professional working on an acute or rehabilitation inpatient ward, we are interested in how you feel at work and how you feel you are treated by your organisation. We are also interested in the links between organisational support and how you feel about the patients you work with. For example, if someone feels supported at work, they may perceive and feel differently towards patients compared to someone who feels very unsupported. We are asking you to kindly complete a survey which should take around 10-20 minutes. The survey compiles of different questions asking you about your profession and experience of mental health difficulties, how supported you feel at work and how you perceive the patients that are typically being supported on the ward you work on.   If you are happy and understand this information, please proceed to our consent form which has further details about how your data will be stored and used. In this research study, we will use information from you. We will only use information that we need for the research study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. If you have any further questions about the study, or do not understand the above information please do not hesitate to contact the researcher via email on [redacted email address]

Header Exploring factors affecting staff's perceptions of patients, EDGE (Sponsor) number 167933, IRAS number 339949, Consent Form, Version 2.0, 08/09/2024

Thank you for proceeding and confirming that you have understood the information thus far. I confirm that I understand that by ticking each box below I am consenting to this element of the study. The survey will not let you proceed if you leave any box unticked. If you are unsure and would like more information before giving your consent, please contact the

researcher on [redacted email address]. The chief investigator for this project is Dr Janice Williams, based at University College London Room 439 4th Floor 1-19 Torrington Place London WC1E 7HB.

I confirm that I have read and understood the information sheet via earlier email contact for the above study. (1)

I have had the opportunity to ask questions if I have any and they have been answered. (16)

I understand that my participation is voluntary and I am free to withdraw at any time, within 4 weeks of completing the study, without giving a reason. To withdraw during the survey, I can simply exit the survey and my answers will not be saved. To withdraw after completing the survey, I will email the researcher on sioned.thomas.22@ucl.ac.uk and provide an approximate date/time that I completed the survey. If my data cannot be located from that, I understand the researcher may ask me for my age range (then if that is not successful, you will be asked gender and job title). (2)

I understand that if I choose to withdraw, this will in no way affect my employment and no one will be informed if you choose to withdraw. (25)

I agree that data gathered in this study will be stored anonymously and securely. (5)

I understand that all answers are anonymous and that my responses will in no way have an impact on my employment. (22)

I understand that all personal information will be kept confidential, therefore all data will be anonymous in reports or presentations following on from the study. (3)

I understand the benefits and potential risks of participating and I am aware of the support available to me should I become distressed during this study. (18)

I am aware of who I should contact if I would like to raise a complaint. (21)

I confirm I have been working on an acute (including PICU) or rehabilitation inpatient mental health ward in [NHS Trust] for at least 3 months and in an inpatient setting for 6 months. If not, please exit this survey or enquire with the researcher on [redacted email address] (26)

I voluntarily agree to take part in this study. (15)

Page Break ─────────────────────────────────

End of Block: Consent form

Start of Block: Demographics

Q1 Which age bracket are you in?
18 to 24 (1)
25 to 29 (2)
30 to 34 (3)
35 to 39 (4)
40 to 44 (5)
45 to 49 (6)
50 to 54 (7)
55 to 59 (8)
60 to 64 (9)
65+ (10)
Prefer not to say (11)

Q2 Which term best describes your gender identity?
Male (1)
Female (2)
Non-binary (3)
Prefer not to say (4)
Other: please specify (5) _____

Q3 Which term best describes your ethnicity?
Asian, Asian British or Asian Welsh (1)
Black, Black British, Black Welsh, Caribbean or African (2)
Mixed or Multiple ethnic groups (3)
White: English, Welsh, Scottish, Northern Irish or British (4)
White: Irish (5)
White: Gypsy or Irish Traveller, Roma or Other White (6)
Other ethnic group: please specify (7)
_____
Prefer not to say (8)

End of Block: Demographics

Start of Block: Profession

Q4a Do you work on an acute (including PICU) or rehabilitation inpatient ward currently?
Acute (including PICU) (1)
Rehabilitation (2)
Prefer not to say (3)

Q4b Please provide your job title, for example healthcare assistant, nurse, psychologist, psychiatrist.

_____

Q5 How long have you been in your current job role?

_____

Q6 How long have you worked on inpatient mental health wards?

_____

Q7 How long have you been working in the NHS?

_____

Q8 Have you or a close family member or friend experienced a mental health difficulty? Please feel free to self-define what this means to you, you do not need a diagnosis or to have sought support from any services in order to answer yes. Please tick all that apply.
Yes - I myself have experienced a mental health difficulty (1)
Yes - A close family member or friend of mine has experienced a mental health difficulty (2)
No - neither myself or a close family member or friend of mine has experienced a mental health difficulty (3)

Q9 If you have experienced a mental health difficulty, have you accessed any of the following mental health services? Tick as many as apply.
Yes, I have accessed 'primary care services' e.g. GP, Talking Therapies, IAPT (1)
Yes, I have accessed 'secondary care services' e.g. Community Mental Health Team (2)
Yes, I have been supported in an inpatient setting or by a home treatment team (3)
Yes, I have accessed support from a mental health service which is not listed above. Please specify: (6) _____
No, I have experienced a mental health difficulty but have not accessed any professional support (4)
Does not apply, I have never experienced a mental health difficulty (5)

Q10 If you have a close family member or friend who has experienced a mental health difficulty, have they accessed any of the following mental health services? Tick as many as apply.
Yes, they have accessed 'primary care services' e.g. GP, Talking Therapies, IAPT (1)
Yes, they have accessed 'secondary care services' e.g. Community Mental Health Team (2)
Yes, they have been supported in an inpatient setting or by a home treatment team (3)
Yes, they have accessed support from a mental health service which is not listed above. Please specify: (6) _____
No, they have experienced a mental health difficulty but have not accessed any professional support (4)
I do not know (7)
Does not apply, none of my close family members or friends have experienced a mental health difficulty (5)

Q11 From the following list, select which words that you consider to be typical of the **patients** you usually see on the ward you work on. You can select as many words as you wish, but please make sure you feel the item is relevant in describing this group of patients.

	Does NOT describe patients I see on the ward (1)	Does describe patients I see on the ward (2)
Melancholy (sadness) (1)		
Surprise (2)		
Elation (happiness) (3)		
Anger (4)		
Humiliation (5)		
Pain (6)		
Pleasure (7)		
Suffering (8)		
Hope (9)		
Fear (10)		
Optimism (11)		
Excitement (12)		
Caring (13)		
Love (14)		
Disenchantment (disappointment) (15)		
Fury (rage) (16)		
Disgust (17)		
Guilt (18)		
Panic (19)		
Calmness (20)		
Disconsolate (fed up) (22)		
Shame (23)		
Fright (24)		
Nostalgia (25)		
Passion (26)		
Attraction (27)		
Enjoyment (28)		
Admiration (29)		

Q12 Here are a list of statements. 'Patients' refer to the **patients** you usually see on the ward you work on. Please rate how much you agree with the statement on the scale below.

	1 "definitely false" (1)	2 (2)	3 "neither false, nor true" (3)	4 (4)	5 "definitely true (5)
Patients are characterised by reasoning (thinking about something in a logical, sensible way) (1)					
Patients are characterised by rationality (quality of being based on or according to reason or logic) (2)					
Patients are characterised by impetus (makes things happen quicker, similar to momentum) (3)					
Patients are characterised by morality (distinction between right and wrong/good and bad) (4)					
Patients are characterised by drive (determined and ambitious) (5)					

Patients are characterised by intellectual abilities (to think and understand information) (6)	
Patients are characterised by impulsiveness (acting without thinking carefully first) (7)	
Patients are characterised by instinct (way we naturally react or behave without thinking about it) (8)	

Q13 For each statement, please indicate how much you feel the statement describes the **patients** that are typically being supported on the ward you work on.

	1 "not at all" (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 "very much so" (7)
They have self-restraint (1)							
They are less than human, like an animal (2)							

They are open minded and can think clearly (3)	
They are adults, not children (4)	
They have interpersonal warmth (5)	
They are superficial and have no depth (6)	
They are emotional, responsive and warm (7)	
They are like objects, not human (8)	
They are mechanical and cold, like robots (9)	
They are unsophisticated (10)	
They are refined and cultured (11)	
They are rational and logical, like they are intelligent (12)	

Q14 From the following list, select which words that you consider to be typical of your **colleagues** who you work with on the ward you work on. You can select as many words as you wish, but please make sure you feel the item is relevant in describing this group of staff.

	Does NOT describe the people I work with (1)	Does describe the people I work with (2)
Melancholy (sadness) (1)		
Surprise (2)		
Elation (happiness) (3)		
Anger (4)		
Humiliation (5)		
Pain (6)		
Pleasure (7)		
Suffering (8)		
Hope (9)		
Fear (10)		
Optimism (11)		
Excitement (12)		
Caring (13)		
Love (14)		
Disenchantment (disappointment) (15)		
Fury (rage) (16)		
Disgust (17)		
Guilt (18)		
Panic (19)		
Calmness (20)		
Disconsolate (fed up) (22)		
Shame (23)		
Fright (24)		
Nostalgia (25)		
Passion (26)		
Attraction (27)		
Enjoyment (28)		
Admiration (29)		

Q15 Here are a list of statements. '**Colleagues**' refers to the people you typically work with on the ward you work on. Please rate how much you agree with the statement on the scale below.

	1 "definitely false" (1)	2 (2)	3 "neither false, nor true" (3)	4 (4)	5 "definitely true (5)
Colleagues are characterised by reasoning (thinking about something in a logical, sensible way) (1)					
Colleagues are characterised by rationality (quality of being based on or according to reason or logic) (2)					
Colleagues are characterised by impetus (makes things happen quicker, similar to momentum) (3)					
Colleagues are characterised by morality (distinction between right and wrong/good and bad) (4)					

Colleagues are characterised by drive (determined and ambitious) (5)	
Colleagues are characterised by intellectual abilities (to think and understand information) (6)	
Colleagues are characterised by impulsiveness (acting without thinking carefully first) (7)	
Colleagues are characterised by instinct (way we naturally react or behave without thinking about it) (8)	

Q16 For each statement, please indicate how much you feel the statement describes the **colleagues** that you typically work with on the ward you work on.

	1 "not at all" (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 "very much so" (7)
They have self-restraint (1)							
They are less than human, like an animal (2)							
They are open minded and can think clearly (3)							
They are adults, not children (4)							
They have interpersonal warmth (5)							
They are superficial and have no depth (6)							
They are emotional, responsive and warm (7)							
They are like objects, not human (8)							
They are mechanical and cold, like robots (9)							
They are unsophisticated (10)							
They are refined and cultured (11)							
They are rational and logical, like they are intelligent (12)							

Q17 Below there are a series of statements that represent possible feelings that you might have about the organisation you work for. With respect to your own feelings about the particular organisation you are working for ([NHS Trust] including the ward you work on), please indicate how much you agree with each statement on the scale below.

	1 (Strongly disagree) (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (Strongly Agree) (7)
My organisation cares about my opinions (1)							
My organisation really cares about my wellbeing (2)							
My organisation strongly considers my goals and values (3)							
Help is available from my organisation when I have a problem (4)							
My organisation would forgive an honest mistake on my part (5)							

	1 (Strongly disagree) (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (Strongly agree) (7)
If given the opportunity, my organisation would take advantage of me (6)							
My organisation shows very little concern for me (7)							
My organisation is willing to help me if I need a special favour (8)							

Q18 These are more statements in relation to your organisation ([NHS Trust] and the ward you work on). Please rate how much you agree with the following statements.

	1 (Strongly disagree) (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (Strongly agree) (7)
My organisation makes me feel that one worker is easily as good as any other (1)							

My organisation would not hesitate to replace me if it allowed the organisation to be more efficient and meet targets (2)	
If my job could be done by new technology, my organisation would not hesitate to replace me by this new technology (3)	
My organisation considers me as a tool to use for its own ends (4)	
My organisation considers me as a tool devoted to its own success (5)	
My organisation makes me feel that my only importance is my performance at work (6)	

My organisation is only interested in me when it needs me (7)	
The only thing that counts for my organisation is what I can contribute to it (8)	
My organisation treats me as if I were a robot (9)	
My organisation considers me as a number (10)	
My organisation treats me as if I were an object (11)	

Q31 MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP): Copyright ©1981, 2016 Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

[Redacted measure due to copyright]

Q20 Please rate how much you agree with the following statements.

	1 (Strongly disagree) (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (Strongly agree) (7)
I am easily upset by seeing other people in distress (1)							
I feel deeply upset when I see others suffering and I am often motivated to help them (2)							
I am not a prejudiced person (3)							
I am a very social person (4)							
I usually do morally good things (5)							
I am a nice person (6)							
Most people are very smart or morally good (7)							

To me, an ideal society is one with complete equality (8)

Q26 Thank you so much for participating in our research study. We really appreciate the time you spent answering the questionnaires. Our research hopes to understand how several factors can impact on how mental healthcare professionals can perceive the patients they support on the wards they work on. The factors we are looking at are; perceived organisational support (how supported you feel at work), perceived organisational dehumanisation (how human you feel you are being treated by your work), burnout at work, the profession you are in and how many years you have been in post and own lived experienced of mental health difficulties. We are then going to see the relationships between these variables, as well as how these may impact on how human you perceive the patients on the ward to be.   If you would like to find out more about the study, or would like to request a copy of the written up report, please email the researcher (sioned.thomas.22@ucl.ac.uk). If you have any questions or concerns, please do email either the researcher or supervisor of the project ([redacted email address]). If you wish to withdraw your data, please email [redacted email address] with the approximate time/date of completing the survey and your demographic data so the data can be destroyed immediately. If any of the areas in the survey made you more aware of how you are feeling at work, and you are feeling distressed, please reach out for support from your organisation; [NHS trust intranet support page]. Please ensure you click the arrow to submit your answers.

Appendix J: UCL Ethical Approval for the Empirical Paper

This is the UCL ethical approval letter received in May 2024.

RESEARCH AND INNOVATION SERVICES

UCL

16ᵗʰ May 2024
Dr Janice Williams
Research Department of Clinical, Educational and Health Psychology UCL

Cc: Sioned Thomas

Dear Dr Williams

Notification of Ethical Approval
Ethics ID and Title: 26881/001: Exploring the impact of organisational and personal factors on the perception of patients by mental health professionals in the NHS

Further to your satisfactory responses to reviewer comments, I am now very pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your high-risk application has been ethically approved by the UCL REC until **1st June 2025.**

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research
Please seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the REC any unanticipated problems or adverse events involving risks to participants or others. The REC should be notified of all serious adverse events via the Research Ethics Service (ethics@ucl.ac.uk) immediately after the incident occurs. Where the adverse incident is unexpected and serious, the Chair will decide whether the study should be terminated pending the opinion of an independent expert.

For non-serious adverse events, the Chair should again be notified via the Research Ethics Service within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair will confirm that the

Research Ethics Service
Research and Innovation Services
University College London
ethics@ucl.ac.uk
www.ucl.ac.uk/research-ethics/

incident is non-serious and report to the REC at the next meeting. The final view of the REC will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1- 2 paragraphs will suffice) which includes issues relating to the ethical implications of the research i.e., any issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research;
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

[redacted signature]

Professor Sarah Edwards
Chair, UCL Research Ethics Committee

Appendix K: NHS HRA approval letter including list of final documents for the Empirical Paper

This is the NHS HRA approval letter granted in September 2024.

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Janice Williams
Room 439, 4th Floor
1-19 Torrington Place
London
WC1E 7HBN/A

13 September 2024

Dear Dr Williams

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

Study title:	**Exploring the impact of organisational and personal factors on the perception of patients by mental health professionals in the NHS.**
IRAS project ID:	**339949**
Protocol number:	**1.0**
REC reference:	**24/HRA/3323**
Sponsor	**University College London**

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

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

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

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

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

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **339949**. Please quote this on all correspondence

Yours sincerely,
Sharon Northey
Approvals Manager
Email: [redacted email address]
Copy to: Pushpsen Joshi

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor insurance]	1.0	10 July 2024
IRAS Application Form [IRAS_Form_02082024]		02 August 2024
Letter from funder [Funding declaration letter]	1.0	10 July 2024
Organisation Information Document [Organisation information document]	2.0	08 September 2024
Participant consent form [Consent form within survey]	2.0	08 September 2024
Participant information sheet (PIS) [Participant information sheet]	2.0	13 September 2024
Participant information sheet (PIS) [Recruitment email]	2.0	13 September 2024
Participant information sheet (PIS) [Research poster]	2.0	11 September 2024
Research protocol or project proposal [Research protocol]	2.0	08 September 2024
Schedule of Events or SoECAT [SOE]	1.0	10 July 2024
Summary CV for Chief Investigator (CI) [CI CV]	1.0	28 August 2024
Summary CV for student [Student CV]	1.0	10 July 2024
Summary CV for supervisor (student research) [CI/supervisor CV]	1.0	10 July 2024
Validated questionnaire [Survey with questionnaires]	2.0	08 September 2024

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Research activities and procedures as per the protocol and other study documents will take place at participating NHS organisations.	NHS Organisations will not be required to formally confirm capacity and capability, and research procedures may begin 35 days after provision of the local information pack, provided the following conditions are met. HRA and HCRW Approval has been issued. The NHS organisation has not provided a reason as to why they cannot participate. The sponsor may start the research prior to the above deadline if the participating NHS organisation positively confirms that the research may proceed. The sponsor should now provide the local information pack to	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	Study funding arrangements are detailed in the Organisation Information Document.	The Chief Investigator may be responsible for all research activities performed at participating NHS organisations.	Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). Where these activities will not take place in NHS facilities then no arrangements under the HR Good Practice Pack are required.

	participating NHS organisations in England and/or Wales. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.
- Please note that the study uses a mix of validated and non-validated questionnaires.

Appendix L: List of Abbreviations Used Throughout

This is a list of the abbreviations which were used throughout the thesis.

A&E	Accident and Emergency
ANOVA	Analysis of variance
CASP	Critical Appraisal Skills Programme
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CRHTTs	Crisis resolution and home treatment teams
CRTs	Crisis resolution teams
DP	Depersonalisation
EE	Emotional exhaustion
GP	General Practitioner
HN	Human nature (indicative of mechanistic dehumanisation)
HRA	Health Research Authority
HTT	Home treatment team
HTTs	Home treatment teams
HumIn	Humanity Inventory
IHT	Intensive home treatment
JRO	Joint Research Office
MBI-HSS MP	Maslach Burnout Inventory Human Services Survey for Medical Personnel
MHPs	Mental health professionals
NHS	National Health Service
PA	Personal achievement
PICU	Psychiatric Intensive Care Unit

POD	Perceived organisational dehumanisation
POS	Perceived organisational support
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
RCT	Randomised controlled trial
UCL	University College London
UH	Uniquely human (indicative of animalistic dehumanisation)