Tackling the erosion of compassion in acute mental health services

Elisa Liberati and colleagues argue that understanding the systemic and institutional forces behind lack of compassion in mental health services is key to solutions to this problem

A series of undercover investigations in 2022 exposed instances of serious abuse in UK mental health facilities. Service users were observed being verbally humiliated, subjected to unnecessary seclusion and excessive restraint, and dragged down corridors by members of staff.[1] Although extreme, these incidents reflect a broader pattern of failures in compassion in acute mental health services across the UK. Even before the extra pressures of the covid-19 pandemic, a 2018 ombudsman report, based on more than 200 sources, identified persistent shortcomings in the ability of mental health services to treat service users with kindness, dignity, and respect.[2] Prominent service user organisations have highlighted low levels of compassion,[3-5] and similar issues have been identified by mental health staff, academics, and the psychiatric survivor movement.[6-8]

Compassion is a complex concept spanning several areas of thought, such as psychology, philosophy, and Buddhist practice. British clinical psychologist and the founder of compassion focused therapy, Paul Gilbert, describes it as "a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with a wish and effort to relieve it."[9] Compassion is an essential component of resilient health systems and high quality care,[10] and is a precondition for positive therapeutic relationships[9 11]; some evidence suggests it is associated with better outcomes.[12 13] In mental healthcare, this association is likely to be amplified: for people in extreme distress, human connection and meaningful relationships are key components of recovery.[4 14 15]

Hanna Pickard, a philosopher and therapist based in the United States, notes that compassion requires one to consider why service users behave in a particular way, given their life experiences.[11] For instance, rejecting or non-trusting behaviour may be the result of trauma, abuse, neglect, and social stressors, which are often racially and socioeconomically patterned.[11] The ability to contextualise another person's distress is central to compassion.[9]

Developing such a compassionate stance requires time, capacity for reflection, and an environment that values emotional as much as physical safety.[8 11 16] But these preconditions for compassion are becoming harder to achieve in mental healthcare in many countries,[17-19] particularly in inpatient services. Although failures to act with compassion happen at the interpersonal level, systemic and structural factors are eroding the capacity of mental health staff to provide compassionate care. We examine these pressures and propose ways to counter them.

KEY MESSAGES

- Failings of compassion occur at the interpersonal level, but they are underpinned by high level, systemic, and institutional forces
- Disillusionment, burnout, moral injury, and a risk centric culture can compromise the compassion of mental healthcare staff
- Power differences between service users and staff in inpatient settings can give rise to institutional oppression
- Compassion requires a reflexive ethos, an environment that prioritises therapeutic relationships, and challenging of policies and cultures that normalise oppression

Working conditions in mental healthcare

Rising demand, resource shortages, and weak organisational support are causing burnout and disillusionment among mental health staff, compromising their ability to act compassionately. Staffing levels in the UK National Health System (NHS) are insufficient,[20 21] with declines in numbers of essential staff groups since 2009—a problem that has been exacerbated by sickness and covid related self-isolation. At the same time, demand for services is increasing.[21] According to the Care Quality Commission, "workforce and staffing shortages remain the greatest challenge for the [mental health] sector," with staff saying that they have insufficient time to develop relationships with patients.[20] Bed shortages are also severe, which means not only that patients in crisis may be left vulnerable, but that thresholds for admission to hospital have increased, so that patients who are admitted are often acutely unwell.[22]

Pressured and under-resourced environments contribute to staff burnout.[20] In the 2021 NHS staff survey, 44% of mental health nurses and 50% of clinical psychologists reported feeling emotionally exhausted always or often,[23] which is in line with the prevalence across mental health staff across the world.[24] These problems are especially acute in inpatient settings, where staff are often exposed to intense negative emotions[17 18] and may experience vicarious trauma.[25]

Insufficient organisational support can further contribute to staff exhaustion, particularly for support staff, such as healthcare assistants, who spend the most time in direct contact with distressed patients but receive the least training and supervision.[26 27] Training for healthcare assistants does not cover how to de-escalate conflicts and how severe mental health difficulties may manifest themselves,[28] both of which are vital to foster compassionate responses. Support staff also experience more abuse, poorer working conditions, and fewer opportunities for progression than other staff.[27]

These poor working conditions and the resulting burnout are associated with more negative feelings about service users and poorer quality of care.[29] When burnt out staff become psychologically distanced from their work and service users, neglectful workplace cultures can arise.[30]

Mental healthcare policies and priorities

Trends in mental healthcare policies and priorities—namely an increased focus on the biogenetic causes of mental illness[31] and a growing tendency to practise with an eye on prioritisation and legal

consequences[14 32]—also make it harder to cultivate compassion.

Although intended to decrease stigma, the framing of mental distress as a disease like any other has not helped advance compassion.[31 33] Receiving a psychiatric diagnosis is, for some, a welcome validation of their experience and an avenue for seeking care.[34] However, attributing mental health difficulties solely to brain disorders or genetic factors can create negative attitudes towards service users—casting them as potentially dangerous and physiologically different from the rest of the population—and hinder humane and compassionate responses.[31 33] Biogenetic understanding of mental illness can also increase prognostic pessimism[34] and overshadow the social determinants of mental distress, thus de-emphasising the importance of comprehensive case formulations and therapeutic relationships, both of which are fundamental to compassion.[31 33]

Greater focus on meeting targets and legal ramifications also hinder compassion. In a climate of chronic resource shortages, mental health staff can be prone to a production line mentality, where beds need to be "protected" from service users.[8 14] This "us versus them" mindset is incompatible with compassion. Reducing the risk of service users harming themselves or others is vital in acute mental healthcare. But safeguarding assessments, intended to assess and mitigate for such risk, can be influenced by the need to exonerate staff from responsibility, rather than acting as a prompt for meaningful conversations about the distress of service users.[14 16 35] An Australian survey in 2013–14 found that 72% of 164 mental health staff agreed that they often reflected on the potential medicolegal consequences for themselves with the decisions they make about an individual's level of risk.[19] Risk stratification and prioritisation also mean that service users can be rejected from services with contradictory arguments, such as being too sick or not sick enough.[14 36]

If staff cannot provide good quality care in these circumstances, occupational moral injury may follow—that is, the "perceived violation of one's own professional integrity and concurrent feeling of being constrained from taking the ethically appropriate action."[37] As with burnout, moral injury can erode compassion. To cope with seeing individuals in deep distress denied much needed care, staff may become emotionally neutral, disconnecting from the pain experienced by service users.[14]

Institutional oppression

As in other high pressure, under-resourced environments, mental health staff may struggle not only to cultivate compassion but also to challenge ways of working that conflict with their values. Sometimes, they may even comply with behaviours that outsiders might see as unacceptable,[30 38] thus furthering oppressive environments. Such "normalisation of deviance"[38] demands particular attention in inpatient mental health, where power imbalances are pronounced and the restriction of the rights of service users is legally permitted.

The Mental Health Act of England and Wales establishes that, under specific circumstances, people can be detained and treated without consent. It is intended to protect individuals (and those around them) at a time when they may be too distressed or confused to make informed decisions, and can be important in preserving life.[39] However service users' experiences of detention are often negative. While views of the appropriateness of detention vary, fear and distress during detention are common, particularly in relation to the use of force.[40] Failure to involve service users in decisions about their own care, sometimes because staff assume that service users are incapable of understanding information, can also contribute to such distress.[40 41]

Worryingly, patterns in detention reflect broader structural injustices. In England and Wales, in 2021, black people were more than four times as likely as white people to be detained under the Mental Health Act[42] and 10 times more likely to be subjected to community treatment orders—compulsory treatment provided in the community.[42] In addition, there is the potential for serious harm in detention. Between April 2021 and March 2022, 325 people died under detention or while subject to community treatment orders. Of these deaths, 66 were of an unnatural cause and 53 were confirmed suicides.[43]

The 2021 independent inquiry into the Mental Health Act concluded that "the current legislation goes too far in removing people's autonomy" and that sometimes people "are excluded from decisions [and] treated with neither dignity nor respect."[39] Concerted efforts from service user organisations[44] and within some areas of psychiatry[45] have sought to reduce restrictive practices, such as physical restraint and seclusion, and reform of the Mental Health Act is under way.[39] These are positive signs, but tackling institutional oppression and promoting compassion require cultural change and effort to challenge policies and practices that frame distress as requiring containment ahead of compassionate understanding.

Opportunities to promote compassion in healthcare

Compassion is central to the provision of healthcare. It is enshrined in the NHS Constitution, where it is linked with patient safety, experience, and outcomes.[13] Mental health staff serve people at times of basic human need, when they need compassion most. Yet, in the UK and worldwide, the preconditions for compassion have been severely eroded.

Little research exists on how to improve compassion in mental healthcare—a gap that needs addressing. Evidence from organisational learning and healthcare improvement offers starting points in countering the decline in compassion and fostering resilience in individuals and systems.

A necessary first step is material improvement of the environments of care. Under-resourced environments that breed burnout and moral injury are not conducive to compassion. Despite recent investments, UK mental healthcare services are not meeting required standards of quality, especially compared with physical healthcare.[46] It is a familiar refrain, but greater investment in mental healthcare, in partnership with the voluntary sector and primary and social care, is vital.

High levels of exhaustion, low morale, and disillusionment among staff must be taken seriously and tackled through improved organisational support. Assistant staff, who spend the most time with service users, need training in how to de-escalate conflict and how severe mental health difficulties may manifest themselves. This will help to contextualise behaviours, which is crucial for compassionate responses.

Fostering reflexivity among mental health staff more broadly is important for enhancing compassion and countering disillusionment and burnout. Reflexive practice involves revisiting an experience to develop new understanding, with a view to informing the response to similar situations in the future.[47] When meaningfully done, reflexive practice can expand staff's capacity to recognise unconscious stigma and behaviours that are contradictory to compassion. A reflexive ethos can be nurtured both through informal mentoring and peer support and more formal spaces, such as Schwartz rounds—

where staff come together to reflect on the emotionally demanding aspects of their work. Evaluations of Schwartz rounds in UK healthcare organisations, including mental health services, suggest they are effective in reducing psychological distress[48] and may foster compassion.[49] This kind of space may be particularly useful for understanding the roots of negative incidents in inpatient settings and for exploring alternative approaches, particularly where detention is concerned.

Conceptualisations of mental distress focused narrowly on biological functioning have proved unhelpful in fostering compassion towards service users. At the level of clinical teams, these conceptions can be countered through supervision and training that emphasise alternative thinking—including through case studies presented by service users and their families. These interventions can also shed light on the dangers of risk centric practices, namely narrow approaches to risk assessment focused on the legal ramifications of incidents.

Promoting therapeutic approaches that empower service users, focus on collaborative therapeutic relationships, and encourage attention to the social determinants of distress may help mitigate the erosion of compassion caused by reductionist and risk centric approaches. Trauma informed,[50] recovery based,[51] peer led,[53] and compassion focused[52] therapeutic approaches all constitute attempts to embed compassion firmly in clinical interactions. Although more evidence for some of these approaches is needed, some service users and healthcare staff endorse their benefits.[50] A good example is Open Dialogue, a model of care provision that ensures the consistent inclusion of the families of service users and wider social networks in the treatment, with a view to exploring the meanings behind mental health symptoms. This approach originated in Lapland, Finland, and is now being piloted in other countries,[54] including in a controlled trial in England.[55]

Finally, more must be done to tackle institutionally oppressive aspects of the mental healthcare system. Despite global calls for an approach to mental healthcare grounded in human rights,[56] much of the campaigning in these areas has been spearheaded by service user groups. Initiatives such as the World Health Organization's QualityRights, which supports countries to improve the quality of mental health services and promote human rights within them,[46 57] are important to ensuring that the principles of human rights are applied in daily practice. Such initiatives are the work of many hands, and mental health staff and leaders have a vital responsibility to ensure that efforts of this kind have positive outcomes.

Breaking down the barriers

The barriers to compassion in mental healthcare, particularly in inpatient settings, are wide ranging. Policy and legal impediments to compassion require long term solutions that go beyond what mental healthcare professionals can do on their own. Yet (to paraphrase Margaret Mead), social change often starts with small groups of thoughtful, committed citizens: healthcare leaders, frontline staff, researchers, and educators have pivotal roles to play.

Improved training and organisational support, reflexive practices, recentring of the therapeutic relationship, and endorsement of collaborative therapeutic approaches are all important to empower service users and foster the resilience staff need to practise compassion in difficult working conditions. Importantly, compassion breeds compassion: it must be modelled through kind and intelligent leadership and placed at the heart of supervision, training, and professional development.

Complex problems demand nuanced and comprehensive interventions, especially in healthcare systems recovering from the covid-19 pandemic. But improving compassion is too important—for service users and mental health staff alike—to indulge in despair or to wait indefinitely for policy change. Intervening to change what we can, at the interpersonal, therapeutic, and organisational levels, will at least soften the worst effects of the barriers to compassion we face. And it might even form a foundation for broader change.

Contributors and sources: EL is a social scientist, qualitative researcher, and trainee psychotherapist. NR is an assistant psychologist and qualitative researcher. SR is a philosopher of psychiatry and medicine specialising in talking therapy. JG is a senior service user researcher with personal experience to inform research and clinical trials. GM is a social scientist with research interests in healthcare organisation and delivery.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare SR is employed by the UK Council for Psychotherapy. The views expressed in this article are her personal views and not necessarily those of her employer.

Provenance and peer review: Commissioned; externally peer reviewed.

This article is part of a collection proposed by the Health Foundation, which provided funding for the collection, including open access fees. *The BMJ* commissioned, peer reviewed, edited, and made the decision to publish these articles. Rachael Hinton and Paul Simpson were the lead editors for *The BMJ*.

Elisa Liberati, researcher associate[1]

Natalie Richards, research assistant[1]

Sahanika Ratnayake, independent researcher[2]

John Gibson, senior service user researcher[3]

Graham Martin, director of research[1]

[1]The Healthcare Improvement Studies (THIS) Institute, University of Cambridge, Cambridge, UK

[2]Cambridge, UK

[3]McPin Foundation, London, UK

Correspondence to: E Liberati
elisa.liberati@thisinstitute.cam.ac.uk

1 Watts J. England's mental healthcare lacks money, yes—but it also lacks compassion. *The Guardian* 2022 Nov 10. https://www.theguardian.com/commentisfree/2022/nov/10/england-mental-health-services-compassion-scandals-patients#:~:text=England's%20mental%20health%20care%20lacks,compassion%20|%20Jay%20Watts%20|%20The%20Guardian.
2 Parliamentary Health Services Ombudsman. Maintaining momentum: driving improvements in mental healthcare. 2018. https://www.ombudsman.org.uk/sites/default/files/page/Maintaining%20momentum-driving%20improvements%20in%20mental%20health%20care-%20Report-Final-Web-Accessible.pdf
3 Rethink. Behind closed doors: acute mental health care in the UK: the current state and future vision of acute mental health care in the UK. 2004. https://www.rethink.org/media/2682/behind_closed_doors.pdf
4 Mind. Listening to experience: an independent inquiry into acute and crisis mental healthcare. 2011. https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf
5 Mind. Mental Health Act overlooks the dignity and human rights of people with mental health problems, finds report. 2017. https://www.mind.org.uk/news-campaigns/news/mental-health-act-overlooks-the-dignity-and-human-rights-of-people-with-mental-health-problems-finds-report/
6 Morrison LJ. *Talking back to psychiatry: the psychiatric consumer/survivor/ex-patient movement.* Routledge;2013. doi:10.4324/9780203958704.
7 Wells A. Who gets believed: abuse in mental health services. NSUN (National Survivor User Network); 2022. https://www.nsun.org.uk/who-gets-believed-abuse-in-mental-health-services/2022
8 Crawford P, Gilbert P, Gilbert J, Gale C, Harvey K. The language of compassion in acute mental health care. *Qual Health Res* 2013;23:719-27. doi:10.1177/1049732313482190
9 Gilbert P. The compassionate mind. Robinson; 2009.
10 Sokol-Hessner L, Folcarelli PH, Annas CL, et al, Practice of Respect Delphi Study Group. A road map for advancing the practice of respect in

health care: the results of an interdisciplinary modified Delphi consensus study. *Jt Comm J Qual Patient Saf* 2018;44:463-76. doi:10.1016/j.jcjq.2018.02.003
11 Pickard H. Responsibility without blame: empathy and the effective treatment of personality disorder. *Philos Psychiatr Psychol* 2011;18:209-24. doi:10.1353/ppp.2011.0032
12 Roter D. The enduring and evolving nature of the patient-physician relationship. *Patient Educ Couns* 2000;39:5-15. doi:10.1016/S0738-3991(99)00086-5
13 Department of Health and Social Care. The NHS Constitution for England. https://www.gov.uk/government/publications/the-nhs-constitution-for-england
14 Beale C. Magical thinking and moral injury: exclusion culture in psychiatry. *BJPsych Bull* 2022;46:16-9. doi:10.1192/bjb.2021.86
15 Priebe S, Mccabe R. Therapeutic relationships in psychiatry: the basis of therapy or therapy in itself?*Int Rev Psychiatry* 2008;20:521-6. doi:10.1080/09540260802565257
16 Veale D, Robins E, Thomson AB, Gilbert P. No safety without emotional safety. *Lancet Psychiatry* 2023;10:65-70. doi:10.1016/S2215-0366(22)00373-X
17 Hammarström L, Devik SA, Hellzén O, Häggström M. The path of compassion in forensic psychiatry. *Arch Psychiatr Nurs* 2020;34:435-41. doi:10.1016/j.apnu.2020.07.027
18 Maslach C, Leiter MP. Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry* 2016;15:103-11. doi:10.1002/wps.20311
19 Wand T, Isobel S, Derrick K. Surveying clinician perceptions of risk assessment and management practices in mental health service provision. *Australas Psychiatry*. 2015;23(2):147-53. doi:10.1177/1039856214568227
20 Care Quality Commission. The state of health care and adult social care in England 2021/22. 2022; https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf.
21 British Medical Association. Mental health pressures in England. 2023. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis
22 Annual number of psychiatric care beds in the United Kingdom (UK) from 2000 to 2021. Statista, 2022.
23 NHS England. NHS staff survey 2021. 2022. https://www.nhsstaffsurveys.com/results/national-results/
24 O'Connor K, Muller Neff D, Pitman S. Burnout in mental health professionals: a systematic review and meta-analysis of prevalence and determinants. *Eur Psychiatry* 2018;53:74-99. doi:10.1016/j.eurpsy.2018.06.003
25 Croft A, Lascelles K, Brand F, et al. Effects of patient deaths by suicide on clinicians working in mental health: a survey. *Int J Ment Health Nurs* 2023;32:245-76. doi:10.1111/inm.13080
26 Kantaris X, Radcliffe M, Acott K, Hughes P, Chambers M. Training healthcare assistants working in adult acute inpatient wards in psychological first aid: an implementation and evaluation study. *J Psychiatr Ment Health Nurs* 2020;27:742-51. doi:10.1111/jpm.12633
27 Palmer B, Rolewicz L, Hemmings N, Appleby J, Trust N. Untapped? Understanding the mental health clinical support workforce. Nuffield Trust; 2021. https://www.nuffieldtrust.org.uk/research/untapped-understanding-the-mental-health-clinical-support
28 McAndrew S, Chambers M, Nolan F, Thomas B, Watts P. Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *Int J Ment Health Nurs* 2014;23:212-20. doi:10.1111/inm.12044
29 Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA* 2002;288:1987-93. doi:10.1001/jama.288.16.1987
30 Ballatt J, Campling P. Intelligent kindness: reforming the culture of healthcare. RCPsych; 2011.
31 Larkings JS, Brown PM. Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *Int J Ment Health Nurs* 2018;27:928-41. doi:10.1111/inm.12390
32 Bifarin O, Felton A, Prince Z. Defensive practices in mental health nursing: professionalism and poignant tensions. *Int J Ment Health Nurs* 2022;31:743-51. doi:10.1111/inm.12936
33 Lebowitz MS, Ahn WK. Effects of biological explanations for mental disorders on clinicians' empathy. *Proc Natl Acad Sci U S A* 2014;111:17786-90. doi:10.1073/pnas.1414058111
34 Baek CH, Kim HJ, Park HY, Seo HY, Yoo H, Park JE. Influence of biogenetic explanations of mental disorders on stigma and help-seeking behavior: a systematic review and meta-analysis. *J Korean Med Sci* 2023;38:e25. doi:10.3346/jkms.2023.38.e25
35 Felton A, Repper J, Avis M. The construction of people with mental health problems as risk objects: findings of a case study inquiry. *J Psychiatr Ment Health Nurs* 2018;25:558-68. doi:10.1111/jpm.12501
36 Liberati E, Richards N, Parker J, et al. Qualitative study of candidacy and access to secondary mental health services during the COVID-19 pandemic. *Soc Sci Med* 2022;296:114711. doi:10.1016/j.socscimed.2022.114711
37 Lamiani G, Borghi L, Argentero P. When healthcare professionals cannot do the right thing: a systematic review of moral distress and its correlates. *J Health Psychol* 2017;22:51-67. doi:10.1177/1359105315595120
38 Jones A, Kelly D. Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. *Sociol Health Illn* 2014;36:986-1002. doi:10.1111/1467-9566.12137
39 Department of Health & Social Care. Consultation outcome: reforming the Mental Health Act. 2021 https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act.
40 Sugiura K, Pertega E, Holmberg C. Experiences of involuntary psychiatric admission decision-making: a systematic review and meta-synthesis of the perspectives of service users, informal carers, and professionals. *Int J Law Psychiatry* 2020;73:101645. doi:10.1016/j.ijlp.2020.101645
41 Chambers M, Gallagher A, Borschmann R, Gillard S, Turner K, Kantaris X. The experiences of detained mental health service users: issues of dignity in care. *BMC Med Ethics* 2014;15:50. doi:10.1186/1472-6939-15-50
42 GOV.UK. Ethnicity facts and figures: detentions under the Mental Health Act. 2023. https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest#download-the-data
43 Care Quality Commission. CQC reports serious concerns monitoring the Mental Health Act. 2022. https://www.cqc.org.uk/press-release/cqc-reports-serious-concerns-monitoring-mental-health-act
44 World Network of Users and Survivors of Psychiatry. Implementation manual for the United Nations convention on the right of persons with disabilities. 2008. www.un.org/disabilities/documents/COP/WNUSP%20CRPD%20Manual.doc
45 Royal College of Psychiatrists. MH-SIP – Reducing restrictive practice (RRP). 2021. https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice
46 Eaton J. Human rights-based approaches to mental health legislation and global mental health. *BJPsych Int* 2019;16:37-40. doi:10.1192/bji.2018.5
47 Iedema R. Creating safety by strengthening clinicians' capacity for reflexivity. *BMJ Qual Saf* 2011;20(Suppl 1):i83-6. doi:10.1136/bmjqs.2010.046714
48 Dawson J, McCarthy I, Taylor C, et al. Effectiveness of a group intervention to reduce the psychological distress of healthcare staff: a pre-post quasi-experimental evaluation. *BMC Health Serv Res* 2021;21:392. doi:10.1186/s12913-021-06413-4
49 Farr M, Barker R. Can staff be supported to deliver compassionate care through implementing Schwartz rounds in community and mental health services?*Qual Health Res* 2017;27:1652-63. doi:10.1177/1049732317702101
50 Sweeney A, Clement S, Filson B, Kennedy A. Trauma-informed mental healthcare in the UK: what is it and how can we further its development?*Ment Health Rev (Brighton)* 2016;21:174-92 . doi:10.1108/MHRJ-01-2015-0006.
51 Spandler H, Stickley T. No hope without compassion: the importance of compassion in recovery-focused mental health services. *J Ment Health* 2011;20:555-66. doi:10.3109/09638237.2011.583949
52 Wilson AC, Mackintosh K, Power K, Chan SWY. Effectiveness of self-compassion related therapies: a systematic review and meta-analysis. *Mindfulness* 2019;10:979-95. doi:10.1007/s12671-018-1037-6.
53 King AJ, Simmons MB. A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions. *Psychiatr Serv* 2018;69:961-77. doi:10.1176/appi.ps.201700564
54 Freeman AM, Tribe RH, Stott JCH, Pilling S. Open dialogue: a review of the evidence. *Psychiatr Serv* 2019;70:46-59. doi:10.1176/appi.ps.201800236
55 Pilling S, Clarke K, Parker G, et al. Open dialogue compared to treatment as usual for adults experiencing a mental health crisis: protocol for the ODDESSI multi-site cluster randomised controlled trial. *Contemp Clin Trials* 2022;113:106664. doi:10.1016/j.cct.2021.106664
56 United Nations. Convention on the Rights of Persons with Disabilities. 2008. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities
57 Moro MF, Pathare S, Zinkler M, et al. The WHO QualityRights initiative: building partnerships among psychiatrists, people with lived experience and other key stakeholders to improve the quality of mental healthcare. *Br J Psychiatry* 2021;220:1-3.

Cite this as: *BMJ* 2023;381:e073055
http://dx.doi.org/10.1136/bmj-2022-073055