Exploring community mental health clinicians lived experiences of reflective practice during a pandemic using an interpretative phenomenological analysis.

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Introduction to the thesis

I have been studying for my Professional Doctorate in Health Psychology at the University of the West of England since 2017. The doctorate involves the successful completion of five competencies:

1. **Professional Skills in Health Psychology:** in this competency I learnt all the relevant codes of professional practice and how to apply them in my own professional practice.
2. **Health Behaviour Change Interventions:** where I learnt to design, assess, formulate, provide, and evaluate health behaviour change interventions.
3. **Consultancy Skills in Health Psychology:** I developed skills to successfully negotiate, carry out, evaluate, and report consultancy work in health psychology setting.
4. **Teaching and training in Health Psychology:** in which I learnt to assess the training needs of teaching groups, designed teaching sessions and content, delivering the sessions, and evaluating the effectiveness of the teaching and training.
5. **Research:** where I learnt to conceptualise, design, and implement a research study in health psychology. This included data collection, data analysis, evaluation of methods, discussion of implications of the data in contributing to the development of new ideas and techniques and the relationship of data to previously published research.

The research competency is divided into two parts. Part 1 involved conducting a systematic review and part 2, a thesis. I successfully completed part 1, the systematic review, which you will find in Appendix 1. The systematic review has been submitted, passed and marks verified by the University of the West of England's examination board. The review titled: A Systematic Review of the evidence of the effectiveness of psychosocial interventions to improve the outcomes for parents of preterm infants. I focused on this initially due my experience in 2016 of having had my own preterm baby and noticing how I and other parents struggled during this stressful time. It was for this reason I conducted my systematic review.

When I started the Professional doctorate, I had only just returned to my role as a CAMHS practitioner in the Midlands Child and Adolescent Mental Health Service (CAMHS), the focus of my work was running parenting groups, carrying out therapeutic interventions, review of children and young people's mental health, crisis assessments and teaching and training sessions. Initially my research was going to evaluate the effectiveness of the newly implemented parenting workshops

and long-term attachment group running to understand if the two interventions were effective in improving parent/carer health, stress, and the relationship with their child. However due to service changes this was no longer a viable research project.

Through consultation in 2020 with my work, the Midlands CAMHS service and local trust it was affiliated with it was agreed that I would focus and carry out research looking at what could be done to improve the health and wellbeing of the clinicians working for the service. Through consultation and management backing reflective practice groups were put in place and evaluated to prevent staff burn out and reduce sickness rates. Therefore, this would form the basis for my research. Consequently, my thesis does not stem from my systematic review but is looking at improving the health and wellbeing of clinical staff not parents. This thesis has therefore been submitted for the award of Professional Doctorate in Health Psychology, for the completion of the research competence.

Abstract

Background and aims

Reflective practice is a core competency for clinicians in their clinical practice, it allows a space for clinicians to develop their in-depth thinking about work activity with the aim of developing as a practitioner.

The key aim of the research was to understand the lived experience of community clinicians attending reflective practice through a pandemic. The literature previously had focused on understanding reflective practice more generally rather than specifically what it meant to clinicians to have this space to build awareness and explore how clinical work was affecting them.

Methods

To address this gap in the literature, a mixed methods design was implemented to gain insight into clinicians experience of reflective practice groups. Firstly, quantitatively to determine if there is a causal link between attending reflective practice groups and clinicians general health, wellbeing, and burnout. Then qualitatively to explore the lived experience of clinicians through using Interpretative Phenomenological analysis (IPA).

Results

A total of 22 participants took part in the quantitative phase of data collection, with only 3 participants completing at all three time points, baseline, 3 months post and 6 months post. As a result, only descriptives statistics were reported, the observation made of the data over time was that there was a stabilisation of scores on both the General Health Questionnaire, observed on all 4 constructs, somatic symptoms, anxiety, social dysfunction and depression, and Maslach Burnout Inventory, observed on all three constructs, personal accomplishment, depersonalisation, emotional exhaustion.

To explore the results further, in depth semi structured interviews were carried out with 6 participants, all female clinicians. Using IPA, five themes were generated, 1) Grounding and perspective through the creation of a different space for clinicians, 2) Clinicians confidence and competence develops, 3) Clinicians feel contained through the structure of a model, 4) Clinicians recognising the impact of the pandemic on personal and professional life and 5) Feeling the priority of the clinical tasks above your own need for reflection – where does the pressure come from?

Conclusions

The consideration of these findings suggest that reflective practice plays a key part in clinicians wellbeing at work and impact on their clinical work by allowing them to enter a forum that they feel safe and contained in. Reflective practice was shown to be particularly effective when there was good facilitation and there was a good frame around the session impacting on clinicians feeling more motivated and ready for the next challenge but also in creating safety for the clinician. Overall, the research enabled the voice of the clinician to be heard about what they need to support them as a clinician working in a community setting. Further research on reflective practice should focus on the intricacies of being reflective and how this can influence clinicians ongoing professional development and wellbeing at work.

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Covid 19 Statement:

During the completion of this doctoral thesis, data collection for both phases occurred during and as sanctions were being lifted from the Covid 19 global pandemic. Whilst the engagement with this research was sustained and remained within the predicted time frames, several unpredictable and unique challenges were faced. These will be discussed in more detail within this thesis.

Chapter 1: Literature review

1.1 Reflective Practice

Reflective practice facilitates the integration of theory and practice and fosters person-centered approaches to care by providing a safe space to discuss cases and reflect on personal and professional responses (Ghaye & Lillyman, 2010), put simply it is a form of in-depth thinking about work activity with the aim of developing as a practitioner (Kurtz, 2020). It is acknowledged to be a vital element of clinical practice (Caley, Pittordou, Adams, Gee, Pitkahoo, Matthews, Cruse and Muls, 2017) providing opportunities for learning, equipping clinicians with the knowledge, skills, and attitude to perform in their job role to provide quality care (Contreras, Edwards-Maddox, Hall, and Lee, 2020) and sustain practice-based learning (Stedmon and Dallos, 2009).

Reflective practice is about developing as a practitioner, equipping clinicians with the skills they need to perform in their job role and increasing their confidence, leading to better patient care and outcomes for patients accessing the service (Alcantara, Reed, Willis, Lee, Brennan, and Lewis 2014). Increasing confidence in knowledge and decision making suggests that professionals may feel empowered by reflective practice (Sim and Randloff 2008), giving them the tools, they need to effect change in the workplace by feeling more proactive in their role and adopting more evidence-based approaches to their work (Alcantara et al, 2014). Therefore, suggesting that there is something that clinicians value about the process of reflective practice, O'Neill, Johnson, and Mandela (2019) found that a group of psychiatric nurses, working within an Emergency Department, valued reflective practice groups in 4 main ways: 1. Sharing and learning, 2. Grounding and perspective, 3. Space and 4. Relationships. Research, has highlighted key themes of reflective practice like O'Neill et al (2019) found through their research.

1.1.1 Grounding and Perspective

O'Neill et al (2019) identified that there were several areas of value added for the nurses in the study to attend reflective practice due to the importance they placed on reflective practice improving areas of their work. One area is grounding (technique to bring the mind back to the present moment) and perspective (different ways of thinking about and explaining incidences, situations, behaviour etc.). Reflective practice can be argued to bring a different platform for discussion that allows reflection on the impact of clinical work on the individual and the team.

One of the areas of influence is the impact on clinicians' psychological wellbeing, especially the emotional impact of clinical work, there has been extensive research documenting the impact of clinical work has on clinicians, which can lead to stress and burnout (Miller, 2021; Leung, Schmidt, Mushquash, 2022; Acker and Lawrence, 2009; Rossler, 2012; Doyle, Kelly, Clarke and Braynion, 2007). Lutz, Scheffer, Edelhaeuser and Tauschel (2013) found using clinical reflection training, they were provided with a way of addressing the professional challenges faced by medical students during their clinical phase of their study to enable them to strengthen their intra and inter personal attitudes and skills to deal with stressful and complex clinical situations, to provide a reflective practice template for self-directed learning, almost all participants reported a reduction in stress and some even mentioned a prevention of burnout. A factor in stress and burnout is a loss of empowerment and self-efficacy, therefore leading to reducing staffing levels and effecting work-life balance (Boamah, Read and Spence-Laschinger, 2016). The loss of belief in yourself as a clinician and ability to act on their own, to have a sense of autonomy, will reduce your capacity in achieving success and satisfaction with work. Sim and Randloff (2008) suggested through research that the implementation of online learning to enhance reflective practice allowed their research group of radiographers to develop their sense of empowerment and reflection. These factors were seen through a change in their behaviour to how they approached their work being more enthusiastic, confident, adopting a positive attitude towards work and learning, further noted was that new challenges were actively sought out (Sim and Randloff, 2008). Ultimately giving the sense that reflective practice plays an active part in how clinicians cope with their work by gaining new perspectives. Vachon, Durand and LeBlanc (2010) found that a factor that influenced how reflective practice was received was providing a way of coping with negative emotions and perceived self-efficacy.

The function of reflective practice is to think more deeply and critically, therefore allowing clinicians time to think about their about stressors and therefore develop coping strategies, it was noted after the development of reflective practice clinicians were enabled to do this coming up with solutions and making changes on an individual level (personal stressors), relational level (relationships with colleagues, supervisors, friends and family) and the organizational level (guidelines, procedures, processes and systems) (Frosch, Mitchell, Hardgraves and Funk, 2019). Individually it enabled clinicians to think about working less (not doing extra hours), permitting themselves to have that separation between work and home (not taking it home), which allowed a balance between family life and work life to be achieved, also noted was an active effort to engage in self-care (Frosch et al, 2019). At the

relationship level it allowed clinicians to reflect on how they used socializing with friends and family. At the work level being able to discuss with colleagues, which would also open avenues to talk about cases, exploration of ideas and talk issues through by using supervision and consultation (Frosch et al, 2019). It could be assumed that these activities would allow working relationships to improve and improve communication. The theme of fostering relationships was further supported by Willis and Baines (2018) as the participants in the study valued the camaraderie between colleagues and addressed the issues of stress through the offloading, sharing, and validating of emotions and experiences. At the organizational level coping was discussed less, perhaps due to clinicians feeling powerless to effect change, what was noted in reflective practice was that they appreciated some of the changes in terms of meetings happening on line, allowing for more time to be spent with patients. There were also reflections about how information was communicated and checking that it was understood (Frosch et al, 2019). This brings up the importance of communication and how it is key in clinicians being able to cope, which may lead to better outcomes for clinician's and their patients.

A key factor in the role of a clinician is communication to other colleagues, patients, their families, and other professional agencies, therefore being able to communicate effectively in any given clinical situation should only improve outcomes. Lutz, Roling, Berger, Edelhauser and Scheffer (2016) stated that good communication is a major factor in delivering high quality care and that communication skills training skills in isolation would not be sufficient. They surmised that reflective practice allows exploration of the communication situations in clinical practice, by being able to reflect on what is difficult, the emotions that are involved and creating solutions in clinical communication (Lutz et al, 2016). The process of reflective practice allows the identification of the issue, being able to work through the needs of the clinician and the person hearing the information, almost like a process of critical thought to develop a new skills and tool to be developed in communication (Lutz et al, 2016). As well as providing a process to think more critically, there is thought that it is the reflection on real challenges that were essential (Lutz et al, 2016). By allowing clinicians to explore clinical situations that were personal to them provided them with something that is more meaningful and create a real learning opportunity that may otherwise get missed. One of the first steps of reflection is to become aware of the dilemma and notice what is going on from this further reflection into the process can be explored and more creative solutions developed, Lutz et al (2016) concluded from the research that reflective practice groups may enhance the creative and idiographic competency to apply knowledge

and skills in difficult professional or communication situations so that they can be resolved in a new and useful way.

The value of reflective practice explored by the research discussed above talks fundamentally about the contribution of benefits of reflective practice on a personal level and professional level, however is unable to explore the specific experiences grounded in clinical work that capture the different levels of reflection (Carmichael, Rushworth and Fisher, 2020). Taking an idiographic approach acknowledges clinicians real experience of reflective practice producing a depth of knowledge that shows how reflective practice is being used in clinical practice. Carmichael et al (2020) using an interpretative phenomenological analysis (IPA), identified three main themes exploratory questioning, containment of own thought and feelings in practice and human survival. This research demonstrated how clinicians used the reflective practice experience to notice more about what led to positive outcomes of; gaining a deeper level of understanding of themselves and the experience, more opportunities, and possibilities by being comfortable with uncertainty, slowing clinical work down and being more aware, noticing the impact of their thoughts and feelings and developing reflection as a form of self-care. But also, the negative outcomes of clinical work, particularly the negative feelings that are evoked like hopelessness, feeling stuck and the how the relationship with work is affected when it is challenging (Carmichael et al, 2020). This critical examination of their clinical work allowed the clinicians in the research to look at the origins of their assumptions and gain new perspectives and interpretations, which impacted on how they then approached and reacted to patients in therapeutic sessions (Carmichael, et al 2020). By taking this approach more can be understood about reflection that is grounded in clinical practice allowing a development of a coherent understanding of reflective practice and its application (Carmichael et al, 2020). But through taking this approach it can expose clinicians practice moving from a freeing experience to a stance of examination of clinicians therapeutic practice (Stedmon and Dallos, 2009).

1.1.2 Learning and development

Reflective practice is a tool to develop clinician's skills and therefore is seen as a space to learn and develop. Reflective practice gives clinicians the experiences of not feeling on their own (O'Neill et al 2019) and reduces work place isolation through sharing experiences (Alcantra et al, 2014). Referring to the experience as a cathartic experience, being able to unload how they are thinking and feeling (O'Neill et al 2019). The sharing of experiences with other clinicians about a case or a clinical incident

that they may have previously felt quite isolated with, reflective practice gives a forum for this to happen in a supportive and containing way allowing confidence in clinician's ability to build and develop. This happens through a process of listening and sharing these experiences and getting feedback, which can generate ideas, deeper thinking and noticing of things that previously may have been missed. Thus, allowing clinician to develop their reflective thinking and being able to learn from both those positive and negative experiences, developing into a more rounded practitioner.

Through this process clinicians are encouraged to engage in critical thinking through reflective practice allowing a deeper thought process and evaluation of their practice, which can lead to better patient outcomes. Kashiwagi, Burton, Hakim, Manning, Klocke, Caine, Hembre and Varkey (2015) conducted a study into the effect of reflective practice in reducing readmission rates to hospital, they found that readmission was due to patient characteristics, operational factors, and care transitions, but after reflection around these factors, thinking more deeply about what was needed, physicians would schedule earlier follow ups and other members of the team had improved discharge instructions to patients. This led to a decrease of readmissions during the review and this was sustained for a year following the intervention being implemented (Kashiwagi et al, 2015). Reflective practice allowed these clinicians space to think about a process that may have become automatic, to stop and think more critically about their practice and what the patients needed to prevent readmission. The slowing down and being able to be thoughtful facilitated change, which for clinicians to learn and develop is key. This was further evidenced by Vachon et al (2010) finding that thinking about a critical incident through reflective practice there was a change in their perspective that effected their decision-making process, it always started with questioning the decisions and actions in a previous client encounter. The findings broke down the clinical decision-making process further through identifying six key steps, 1. Recognition of a challenging practice situation, 2. Description of the work problem, 3. Definition of the clinical role, 4. Identification of the therapeutic sense of self, 5. Creation of an appropriate context and 6. Evaluation of outcomes (Vachon et al, 2010). Reflective practice is a skill that must be learnt and developed, allowing change to happen at every stage of the decision-making process. Allowing this questioning at every stage of the decision-making process is a learning process in its self as it means questioning your understanding of the clinical incident and may require a change in perspective and the emotions attached to the incident.

An important factor in learning and development is that it happens differently for everyone, and this could be dependent on previous experience if any of reflective practice, clinical background, engagement of others in the group etc. Vachon et al (2010) stated that this development of reflective thinking happened at a different pace for every participant, participants being influenced by personal and contextual factors, there was also a realization that their own feelings and thoughts were key in this process. The question of how reflective thinking develops could be through instruction and feedback, when a real understanding of what reflective thinking is and what it is not, it seems to impact on responses from clinicians becoming more reflective (Teply, Spangler, Klug, Tilleman and Coover, 2016). It may be that more directed teaching on how to analyze a situation and how to utilize this learning from experience to improve clinicians practice (Teply et al, 2016). Therefore, being able to look inwards, recognizing how your own thoughts and feelings influence decision making process, how you analyze and learn from that incident are important to allow change to happen. For development of reflective thinking over time this would assume that there is a sustained attendance and consolidation of the skill. Alcantara et al (2014) suggested that confidence only seems to be maintained through continued participation, to benefit educationally from the group and aid in improving their knowledge base and decision-making process. Reflective thinking seems to be a mediating factor for frequency of engagement in personal learning and development and continued teamwork and performance (Welp, Johnson, Nguyen, and Perry, 2018). Being able to think purposefully about clinical work to improve core skills and attitudes only happens when it is perceived as being useful to do so and the clinician involved has developed this reflective thinking (Welp et al, 2018). Therefore, having this self-awareness in clinical scenarios helps to define how clinical work is approached, to aid in effective team functioning and the processes involved (Welp et al, 2018). However, the reverse cannot be shown, that just participating in personal development activities to improve core skills does not improve reflective thinking (Welp, 2018). This would suggest that one of the core skills that clinicians need to develop and grow in their role is to develop reflective thinking to then learn from experience and engage in activities that continue their professional development.

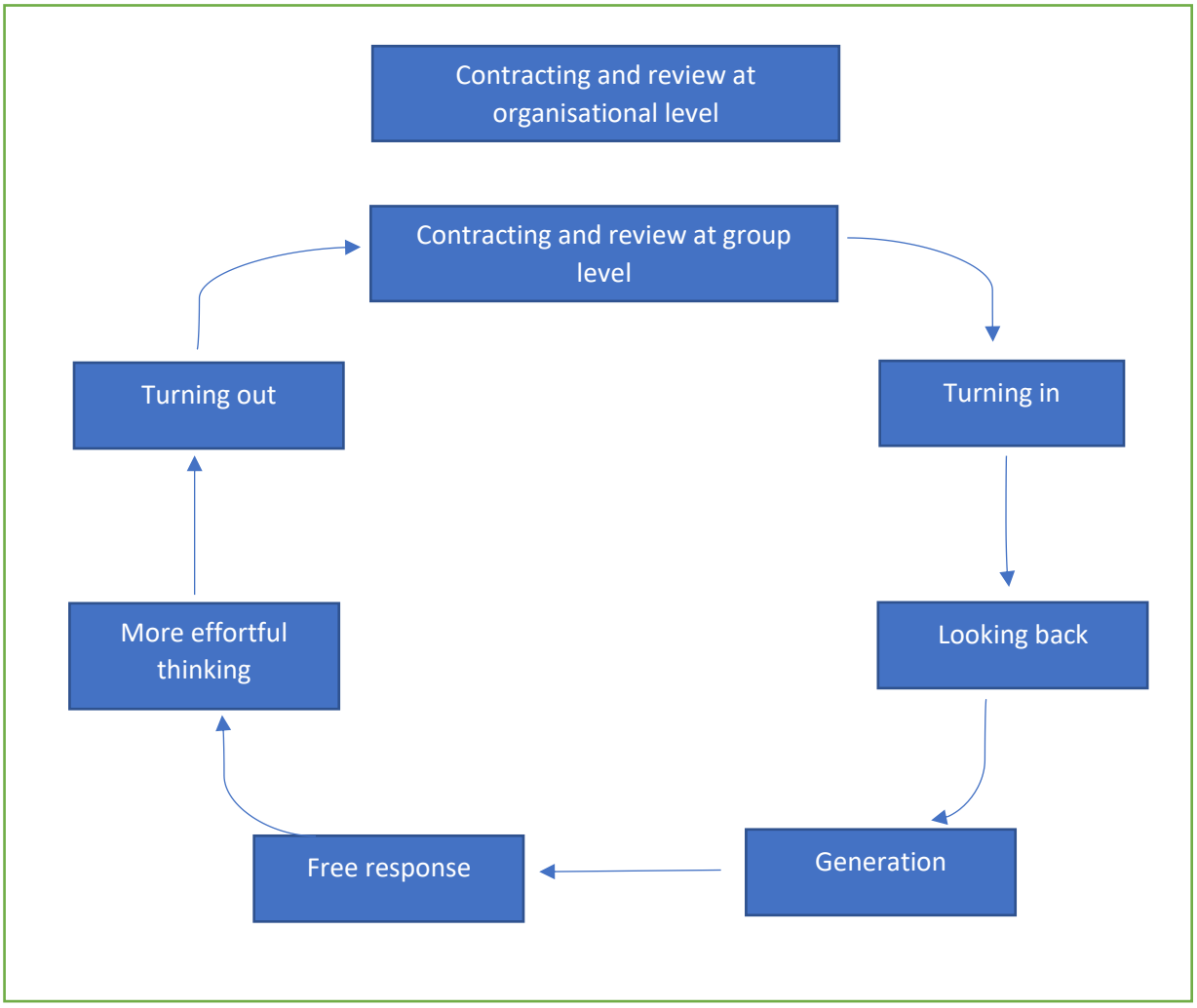
1.1.3 Structure of the space

Research has suggested that having a structure allows for the space created by reflective practice to feel safe. O'Neill et al (2019) reported that the reflective practice space provides a structure, which encouraged openness, therefore suggesting that a structure to reflective practice maybe a key factor in influencing how clinicians use and experience the space. A structure to the session could also

provide a forum for a more meaningful discussions, which can impact positively on personal development and ongoing learning (Caley, Pittordou, Adams, Gee, Pitkahoo, Matthews, Cruse and Muls, 2017). Vachon et al (2010) found that a structure developed through examining critical incidences, as already detailed previously a six-stage process. Therefore, the structure seems to be dependent on the group attendees, the facilitator and how the group evolves.

The theory is that a model allows the clinician to reflect critically on an incident, positives or negatives identified, to enable learning and to be able to move forward (Ashby, 2006). By using a model, the incident can be seen from different perspectives rather than just focusing on the individual's response to it. The model will also allow for the maintenance of reflection rather than it becoming a case discussion or problem-solving exercise. Ashby (2006) talks about a model leading to empowerment, as clinicians learn from their experiences, and transformation, as models require clinicians to look at the emotional aspect of an incident or case, which can lead to a deeper understanding of themselves. There are many models of reflective practice that are used in supervision practices, group forums, a lot of research focuses on creating a new model, Cartwright, Hayes, Yang and Shires (2021) used a counter transference model based on 5 component model of countertransference (origins, triggers, manifestations, effects, and management), it was concluded that it could be used to enhance trainees' reflective practice. Therefore, it is about thinking with theory rather than having no structure (Wimpenny, Forsyth, Jones, Evans, and Colley, 2006). There are many examples of models that shape reflective practice including the Heads and Hearts model, illustrated below in figure 1.

Figure 1: Heads and Hearts model.



The Head and Hearts model is an Intersubjective model of Reflective Practice, this model is reported to be a way of describing a series of stages which, are key components of this way of thinking about clinical work (Kurtz, 2020). The model is designed to represent the structure of a reflective practice session. Further models like the solution focused model used principles of solution focused group work; focusing on change and possibilities, creating goals, building strengths, skills, and resources, looking for "what's right" and "what's working," being respectfully curious, creating co-operation and collaboration and the last principle was using humour and creativity (Sharry, 2007). This model relies on moving forward rather than looking back to what has gone wrong, searching for solutions with co-operation and collaboration between group members asking searching questions to enable a solution to be sought. In contrast the 5 P's formulation model does look back, using a holistic approach to look at the whole picture. The formulation model utilises the five p's which are: Presenting problem (identified difficulties and how it affects the person); predisposing factors (comprises of possible biological, genetic vulnerabilities, environmental factors and psychological or personality factors);

precipitating factors (what preceded the current difficulty); perpetuating factors (maintenance of the current difficulty); protective/positive factors (identifying strengths and supports that mitigate the impact of the disorder) (Macneil, Hasty, Concus and Berk, 2012). The 5 P's formulation model will guide the case presentation and allow the reflective team to focus but would not necessarily provide a structure for the reflective practice group.

Although a structure to the space is highlighted as being important, it is also having the physical environment to enable a reflective space to be created that is important also, having a space to go and sit to have the group that is fit for purpose and staff free to attend (Heneghan, Wright, Watson, 2014). This would suggest that at times there are barriers to attending and making use of reflective practice.

1.1.4 Barriers to reflective practice

Reflective practice groups have been recommended for improving staff wellbeing and team functioning, as previous research has shown in the value that is gained from reflective practice (Heneghan, Wright and Watson, 2014). Heneghan et al (2014) identified that engagement, group dynamics and lack of management support were common challenges. A further challenge identified by Plant, Li, Blankenburg, Bogetz, Long and Butani (2017) was a lack of understanding of reflective practice.

Investment in attending the group is important as Alcantara et al (2014) proposed that continued and sustained attendance is key in keeping up the skills developed through reflective practice. However, due to the nature of reflective practice it can cause distress to clinicians, some clinicians have indicated that while they found reflective practice groups of high value they found them highly distressing, this may be due to clinician being exposed to the distress of other people through their clinical work, there is a need to confront and work with the distress in themselves and therefore reflective practice may provide an opportunity to do this (Knight, Sperlinger and Maltby, 2010). But may be a factor in influencing why clinicians would not attend reflective practice groups, however there are also other factors that come into it, as due to the nature of the clinical role, there are practical tasks that need doing, another patient needed to be squeezed in, paper work and other meetings, being used as an excuse to not attend groups (Heneghan et al, 2014).

Group dynamics are an important factor in attendance at a group, for change to take place and development of reflective thinking, the whole groups thinking style must change to continue to reinforce and stabilize the change in its members (Levi and Askay, 2021). Heneghan et al (2014) highlighted how it was the psychological contributions of participants to the group aided in a change of thinking, further it was the open and honesty of group members that facilitated shared aims to be developed. Therefore, demonstrating that having a shared goal and understanding of the group is key. Also demonstrating how their own reflexivity about how the group is running and the influence this has within the group is equally important as it can be those values held by groups members that can cause groups to become polarized. Consequently, being able to recognize your own assumptions and being realistic in the context of working relationships is important (Heneghan et al, 2014). This can not only be seen in the group members but also the facilitators themselves when they have made assumptions about how the group is going to run and the topics (they are using to guide the group), feeling is true reflection taking place (Thomas and Isobel, 2019). Within the group setting there can be a notion towards venting or moving towards a different purpose leading away from the true nature of reflective practice (Thomas and Isobel, 2019). Thus, leading to a non-reflective space and leading group members to opting out of the group. This could mean there was not true understanding on the process of reflection, with many not having a true understanding due to not being taught during their training or practice (Plant et al, 2017). While it has been discussed previously that learning and development happens because of reflective practice in their clinical role, this assumes that there is a genuine understanding of what reflective practice is and the purpose of it, therefore suggesting that there must be a conscious effort put in when asking clinicians to attend these groups that they truly understand what it is that they are attending and the purpose of the group.

An important principle is the support from the organization and the management within that organization. Heneghan et al (2014) identified that the service context was important in how the reflective practice groups were run, also changes in management structure and how staff perceived themselves within that structure. The influence felt by clinicians to attend to clinical tasks immediately and attend to the risk being managed must be prioritized but this culture of thought comes from the organization itself, not prioritizing the needs of its clinical staff (Heneghan et al, 2014). Therefore, leadership support becomes vital in ensuring that groups like reflective practice are prioritized and clinicians feel able to prioritize with few barriers being created. Allowing for time and space to be created and not having the practical barriers to prevent attendance, however it must be acknowledged

that this does not just come from a service or management context but from the clinician themselves being hesitant to take time out from clinical duties (Thomas and Isobel, 2019).

The evidence presented makes a powerful case for why reflective practice is critical to the clinical role, however much of the research was carried out pre pandemic and all clinicians, where focused on the everyday normal routines of work and incidences that occur during their working day. But when working practices need to change rapidly and new ways of working, reflection becomes more important providing an effective mechanism for practice change (Walpola and Lucas, 2020).

1.1.5 Covid and its impact on Clinicians

During early 2020 a global pandemic hit and this rapidly a changed how people lived and worked. Within the healthcare system it meant having to adapt to an immediate change to working practices and provide several learning opportunities for the development of resilient health care systems (Walpola and Lucas, 2020). The uncertainty, fears, mass lockdowns, financial worries, and the virus itself were predicted to increase suicide and mental health disorders in the general population (Xiong, Lipsitz, Nasri, Lui, Gill, Phan, Chen-Li, Iacobucci, Ho, Majeed and McIntyre, 2020). The World Health Organisation (2020) recommended that measure be put in place to protect mental health of health workers in the work place, they recommended that mechanisms should be implemented for early and confidential identification and management of anxiety, depression and other mental health conditions and promote a mental health prevention culture among health workers and health managers.

Research has shown increase in psychological distress not only in the general population with pre-existing mental health disorders but also in healthcare workers (Xiong et al, 2020). The pandemic placed a great amount of pressure on the NHS as whole and healthcare workers on the frontline. Much of the media started reporting front line workers burnout, stress, and struggle to cope with the increasing demand. The World Health Organisation (WHO) in response published guidelines to promote general psychological well-being of staff, stressing the importance of managing wellbeing and the usage of coping strategies (World Health Organisation, 2020). Research has looked at healthcare workers personal resource throughout the pandemic, finding that it is influenced by the perceived organisational support, in a study of Nurses working in the United Arab Emirates (UAE) throughout the global pandemic, they found that perceived organisational support was associated with higher levels of personal resilience, compassion and decreased intention to leave and also social support, particularly

being married and having children, may also have a role in improving the perception of support received from their organisations (Ahmed, Bani-Issa, Timmins, Dias, Al-Yateem, Subu, Alzahmi, Saqan, Rahman and AbuzRuz, 2022). Ollis and Shanahan (2021) research looked at health and wellbeing initiatives and the associated use of these initiatives on stress and wellbeing during the Covid 19 pandemic. Significantly more stress and psychological distress were reported by those that were accessing the health and wellbeing initiatives and reported a negative rating of the organisation. They felt less supported in the organisation and not listened to. The key factor for both studies (Ahmed et al, 2022 and Ollis et al, 2021) is the support from the organisation. Ollis et al (2021) suggested stress levels would be expected to remain heightened during a global pandemic and that it is the ongoing support of HCW's during long term health emergencies that is of importance. Ahmed et al (2022) made a similar suggestion that organisational support is key in HCW's level of personal resource increasing, therefore placing the emphasis on management to look at the support given.

The interventions that were put in place in the research detailed by Ollis et al (2021) of counselling, general wellbeing advice, online resources, workshops, online yoga classes, PPE guidance, were reported to not reduce stress and psychological distress. Cipolotti, Chan, Murphy, Van Harskamp and Foley (2021) implemented a support service for all staff working in a neuroscience hospital, consisting of daily telephone calls and twice weekly walk-in clinics offering one to one support. All staff underwent a psychological assessment and depending on outcome tailored psychological support was put in place (Cipolotti et al, 2021). The research did report a high amount of psychological distress among staff caused by the risk of infection, work challenges and social change, which was shown in Ollis et al (2021) but the survey evaluation revealed that the staff considered psychological support as being particularly useful (Cipolotti et al, 2021). It was concluded that the findings highlighted the importance of providing stratified, one to one support interventions tailored according to professional group rather than applying generic approaches. Cipolotti et al (2021) promoted the importance of tailored one to one support however, Baker, Savage, Pendleton and Bate (2021) researched how the implementation of group reflective rounds within a children's hospital before and during the Covid-19 pandemic provided support for participants, the last round of reflective practice was done as a virtual round, this was reported to have worked just as well as the face to face rounds with participants evaluating the virtual round favourably, with none rating the rounds as poor. The majority agreed that they had gained insight that will help them meet the needs of their patients. Comments were made in the free text response of the evaluation that participants found rounds, thought provoking,

informative, powerful, and engaging (Baker et al, 2021). They valued the panellists sharing their experience and patient stories, showing their vulnerability, giving a sense that they were not alone, also commenting on the powerful role modelling. The participants also made comments of being encouraged to speak in a safe environment and non-judgemental environment (Baker et al, 2021). This research would suggest that the shift from face to face to virtual still provided participants with a platform to gain support in their job role and with their clinical role. Also, that a group format can provide support that is deemed as beneficial as the one-to-one support that Cipolotti et al (2021) recommended in their research.

Baker et al (2021) reported that virtual reflective practice during the pandemic was beneficial and evaluated favourably, however this was one session. In other research where participants were receiving regular reflective supervision/practice during the pandemic, it was found they would still engage in self-care practices and maintain them despite the negative impact Covid-19 had on reducing self-care practices (Morelen, Najm, Wolff and Daniel, 2022). It was also noted that those that engaged in reflective supervision/practice also had fewer internalising symptoms of anxiety and depression (Morelen et al, 2022).

In line with the WHO recommendations reflective practice could be seen as a support intervention for maintaining and supporting health care staff. However, there is little research other than that detailed above about how effective as an intervention it was for clinicians working through the COVID-19 pandemic, although the research shows encouraging results for its effectiveness.

1.2 Conclusion and summary

The literature on reflective practice has described many benefits of reflective thinking, describing the value of reflective practice and how it aids in supporting with learning and development, exploring how structure provides a framework for reflective practice to happen and what barriers exist to prevent attendance. More recent research, although limited has provided support for reflective practice offering some support to clinicians through the pandemic.

However, many of the studies use thematic analysis and quantitative approaches to build a general perspective of reflective practice, that addresses the benefits of reflective practice on personal and

professional growth as a clinician, mainly in medical fields and social care settings. There was one study that used Interpretative Phenomenological Analysis (IPA) to understand the lived experience of participants and deeper levels of reflection rather than generalised themes across the data (Carmichael, Rushworth, and Fisher, 2020). There is limited research in the effect of the pandemic and how clinicians coped during this stressful world event using reflective practice as an intervention and the impact of a structured reflective practice group has for clinicians, it is implied in a lot of research that mention they used a framework but is limited in if there is a significance of this in clinicians attending and if this structure provided containment.

Chapter 2: RESEARCH RATIONALE

Initially in August 2019, trainees' from a Midlands Trust delivered a presentation on reflective practice to introduce the idea of the benefits of this approach in reducing staff sickness rates and providing a forum for reflection (Appendix 10). Research and the staff survey have supported the need for reflective practice, to be included in clinicians job plans, to allow for open discussion and validate and normalise conflicts of emotions clinicians experience (Leddie, 2019). It was agreed that reflective practice groups would be set up in the Midlands CAMHS service for all teams with in the service to attend. After the agreement, the Covid 19 pandemic hit the UK in March 2020 and the way the service was run changed, moving all meeting and patient contact on line. This also meant a change to how the reflective practice groups would run, moving to the Microsoft Teams platform.

2.1 Aims and Objectives

It was agreed that the reflective practice groups as an intervention be evaluated as being fit for purpose and if the model was working as a structure. After doing a literature search, as detailed in chapter 1, there was scope to create and interpret new knowledge through the generation of original research not just focusing on the psychological wellbeing of community clinicians but also the physical wellbeing, the pandemic also allowed for a further generation of original research through looking at the impact of this worldwide phenomena on a group of clinicians that would be part of the study.

The aim of the research was to evaluate the lived experience of clinicians attending one of the reflective practice groups, through gaining an understanding of the impact of the groups on clinicians overall wellbeing during a global pandemic.

The objectives of this research were:

- To explore clinicians response to attending reflective practice groups.
- To explore the impact of the reflective practice groups on clinicians physical and psychological wellbeing.
- To explore and understand if the reflective practice groups affected how clinicians coped physically and psychologically during a global pandemic.

Chapter 3: Method and Methodology

3:1 Sampling and Selection

Non-probability convenience sampling was used due to the specific population that was being targeted; mental health clinicians working in a community setting who had experience of reflective practice. It is understood that using this type of sampling method reduces the ability to generalise the results to the population lowering the external validity of the research. However, as the research is exploring a particular group with the aim of understanding their experiences of the intervention being studied it was this population that had the characteristics needed for the research.

Convenience sampling techniques were used as the population required was readily available to the researcher. The research was open to all mental health clinicians working in the Midlands CAMHS service. All clinical backgrounds could take part as the focus of the study was not to compare each profession and if their experience differed depending on their clinical training but to understand if reflective practice had any impact on the clinicians wellbeing during a global pandemic with the conditions they were working under.

3.1.1 Recruitment process for Quantitative data collection

The research recruitment took place across the Midlands CAMHS service, which covers a large area of the Midlands. Across the service there are approximately 210 employees, from management to clinicians working face to face with patients. Employees are from varying different clinical backgrounds, including Clinical Psychology, Counselling Psychology, other psychological backgrounds, Nursing both paediatric and mental health, Psychotherapy, Art therapy, Occupational therapy, Social Work, Drama therapy and CBT therapy.

Three standardised emails (Appendix 2,3, 4) were sent to all employees using their NHS email address from the researchers NHS email, at baseline, 3-month time point and 6-month time point, as this would allow for it to remain secure and enable all potential participants to access the Qualtrics link. Participation in the research was completely voluntary and anonymous.

3.1.2 Recruitment process for the Qualitative data collection

Recruitment for this part of the research was open to all clinicians working in the Midlands CAMHS service. An email was sent out to all clinicians to ask for volunteers to take part in a semi-structured interview. This was done via email (Appendix 5) from the researchers NHS email address to the clinicians within the service, allowing for all correspondence between the researcher and potential interview participants to remain secure. Participants responded to the email invite and a date and time was negotiated for the interview to take place via the Microsoft Teams platform. Once 6 participants had been recruited no further participants were invited to attend an interview.

3.1.3 Inclusion and exclusion criteria

The inclusion criteria were clinicians that were employed by the service within the Midlands CAMHS service. All participants must hold a clinical role trained in any clinical background (psychology, psychotherapy, nursing, occupational therapy etc) and can be full or part time employed. They can hold any role in the reflective practice group, either that of an attendee or a facilitator. Their attendance can be either current or past attendance.

Participants that do not hold a clinical role or students on placement due to short term nature of placements were excluded from the research.

3.1.4 The Participants

In total 22 participants took part in the research with no one being excluded from the research as they all indicated that they held a clinical role in the service. Demographic data was only collected on 14 participants as others took part at different time points during the research. Of the 14 participants that data was collected on 13 were female and 1 was male. The age range varied from 25 years to 59 years (mean age of 38 years). 11 identified as white British; 2 as white other background and 1 identified as Indian. There was mix of different clinical backgrounds, 5 from psychology, 6 from nursing, 2 from occupational therapy and 1 from a clinical background not categorised. Participants had between 0

years and 20 plus years NHS experience (mean experience was 10 years). Years since training varied from 0 years to 20 plus years (mean years since training was 9 years).

3.2 Mixed methods

3.2.1 Rationale for Mixed Methods

A mixed methods approach, explanatory sequential design (Creswell and Creswell, 2018) was implemented for this research project. Creswell and Creswell (2018) suggested that more insight into a problem is to be gained from integrating the quantitative and qualitative data, providing a stronger understanding of the topic being researched than one approach on its own.

Sequence of methods

The first part of this research involved the collection of quantitative data via the Qualtrics platform using the General Health Questionnaire – 28 (GHQ-28) and Maslach Burnout Inventory – 9 (MBI-9). Following collecting this data, the results will be used to inform the qualitative data collection stage, influencing the areas covered in the semi structured interview. The semi structured interviews will allow for expansion and exploration of the quantitative results, investigating further the impact of the reflective practice groups on clinicians overall wellbeing.

Due to the nature of explanatory sequential mixed methods design the qualitative data is to explain the quantitative data, with two distinct phases with quantitative sampling in the first phase and more purposeful sampling in the second phase (Creswell and Creswell, 2018). The same sample of participants was approached for the second phase of data collection, although impossible to know if they had taken part in the first phase of the research, as all responses were anonymous.
In terms of sample size, a power analysis was completed using a G power software for ANOVA repeated measures within factors analysis, 34 participants were needed for a medium effect size.

22 participants took part in the research at different time points and only 3 completed at all time points. 6 participants from the original sample group emailed, volunteered for the interview phase of the research. Smith, Flowers, and Larkin (2009) suggest a sample size between 3 and 6 as being an optimum number, therefore all 6 were taken forward to the interview phase.

Quantitative or qualitative driving the method?

The research was driven by the qualitative data, due to this being an exploratory study. Evidence from previous research on reflective practice has suggested that a qualitative approach is more appropriate as it leads to a quality for the study and more reasonable findings, leading to a better understanding of the theoretical models and perspective (Mann, Gordon, and MacLeod, 2009).

The qualitative data will allow for insight into the "lived experience" of the clinicians working in a mental health setting during a pandemic and provide evidence for reflective practice being an essential part of the clinical role, where the clinician is moving from the ways that they have always done it to one that has to be more dynamic and move with the situation (Walpola and Lucas, 2020). The quantitative data was not intended to be over shadowed by the qualitative data but due to lack of response from participants there was not enough power in the data, however it aided in driving the semi-structured interview script.

3.3 Quantitative approach

3.3.1 Analysis

Data would have been analysed using an ANOVA repeated measure within factors, however due to not gaining a sufficient sample size, the descriptive statistics will be used to inform the qualitative phase of the research.

3.4 Qualitative approach

3.4.1 Rationale for Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) was used as the most appropriate method of qualitative analysis as it is providing a study of individuals, therefore being idiographic allows a unique perspective to be taken on personal experience. IPA has been informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, study of experience, hermeneutics, theory of interpretation, and ideography, concerned with the particular of what it means to that individual (Smith, Flowers, and Larkin, 2022). To understand and access these experiences, is made more difficult by the researchers own pre conceived ideas about the subject being studied, however this is essential in making sense of that personal world through a process of interpretative study, described as a double hermeneutic process, in which the participant is making sense of their world and the researcher is trying make sense of the participant trying to make sense of their world (Breakwell, 2012). Within this process is the way in which it combines both empathic and critical hermeneutics,

therefore studying what it is like for the person, their emotional state, and trying to stand back from the experience to see what the participants motivation or underlying meaning is being communicated (Breakwell, 2012).

Phenomenological is concerned with seeking to explore the way things appear to us in our experience, the reality that we live is an experiential one and it is experienced through practical engagement with things and others in the world and it is inherently meaningful (Willig and Stainton-Rogers, 2012). However, it is impossible to gain a complete understanding of the other person's perspective as the whole process is contingent on the interpretation of the researcher.

For this research IPA allows the key researcher to explore the perspectives and meanings for the participants taking part in reflective practice. Reflective practice in its approach has its origins in phenomenological philosophy, with the common interest being human thought and reasoning and the view that a full engagement with experience, i.e., the complex nature of living rather than abstract ideas about living, is intrinsic in learning (Kurtz, 2020). Therefore, it was felt that IPA would be the most appropriate method to gain the insight needed to gain the in-depth interpretations to allow for effective implementation of reflective practice in community settings not just in the Midlands CAMHS service but other services and trusts within the NHS.

IPA has the purpose of focusing on the individual characteristics of the participant but also the purpose of being able to look across individual data sets to identify patterns of similarity and differences across the personal data sets. In contrast thematic analysis (TA) is a method for developing, analysing, and interpreting patterns across a qualitative data set involving a systematic process of data coding to develop themes about the subject/phenomena being researched (Braun, 2021). This method was considered as a method of analysis for this research. IPA generates two data sets, the personal experiential themes pertaining to the individual (idiographic) and the group experiential themes across the data set (nomothetic). However, TA applies a nomothetic approach but cannot create themes that are individual to one or two participants. The nomothetic approach applied by TA has its strength in contrast to IPA, as a method of analysis it has the potential for wide ranging application and like IPA can highlight similarities and differences across the whole data set (Braun, 2021). Therefore, it could produce meaningful results from the participants relevant to this research, the sample for this research is attending a group that uses an approach that is based on a phenomenological philosophy. Therefore,

the individual experience of those attending the reflective practice group could be missed or over looked, needing the more in-depth analysis. It was therefore felt that key evidence of participants individual perceptions could be analysed in more detail using IPA.

Other qualitative approaches such as grounded theory, discourse analysis and narrative analysis were not considered as appropriate methods for this specific piece of research.

3.4.2 Semi – Structured Interviews

The semi-structured interview was selected, as most IPA studies use a semi structured interview approach as it can be used flexibly and the participant has an important investment in what is being covered (Smith, Flowers, and Larkin, 2022). One of the features of a semi-structured interview is that it is sufficiently structured enough to guide the interview but leaves space for the participant/interviewee to offer new meanings to the topic under investigation (Galletta,2013). The arrangement of the questions can be structured and open-ended to illicit extensive and often multi-dimensional streams of data. (Galletta, 2013). The structure provided allows the key researcher to gain insight to explore the participants understanding and views on the subject under investigation.

This method of interview also allows for reciprocity between the key researcher and participant and creates a space for challenging of beliefs and exploration of the topic together. This give and take allows for the participant to explain and give detail to their experiences.

The topic of reflexivity, that assumes that a rapport has been established between the researcher and the participant prior to data collection, will be discussed later in chapter 5. The assumption is therefore made that a semi-structured interview would be the most effective method to gain the depth of data needed for the topic under investigation.

3.5 Research Approval

The study was approved by the Research Ethics Committee of the Faculty of Health and Life Sciences (HAS) at The University of the West of England (UWE), Bristol. A letter of collaboration was also obtained from the Midlands CAMHS service that the key researcher was working, to allow for the research to be completed (Appendix 6)

3.6 Ethical considerations

All participants were asked to complete a consent form prior to participation (Appendix 7). Also detailed on the participants information sheet pertaining to the research was the number for the staff counselling service, which provides staff with counselling and support (Appendix 8).

3.7 Data management plan

All data was collected within the study remained anonymised and confidential, participant were asked to assign themselves with a unique participant number made up of the day they were born, first two letter of the street they grew up on and first two letters of their mother's maiden name. All participant data was collected via the Qualtrics platform, which was password protected and results from the data were only accessible by the key researcher. The Qualtrics platform is a simple to use web-based survey tool to conduct survey research, evaluations, and other data collection activities.

The semi-structured interviews were recorded via Microsoft teams and downloaded to the key researchers personal work drive, which only the key researcher can access and access is password protected. The interviews were transcribed solely by the key researcher, in compliance with General Data Protection Regulations (GDPR). All interviews and transcription of interviews were completed in private rooms.

Chapter 4 – Quantitative Data collection Phase

4.1 – Procedure

Participants were recruited via e-mail distribution to their NHS work-based email's, this took the form of a group email to all clinicians working within the Midlands CAMHS service. The email took the form of an invitation to take part, explaining that the research was aiming to evaluate and audit the reflective practice groups that were being attended by clinicians and would form part of the researchers doctoral thesis and the mental health services audit evaluation. The email provided a link to the Qualtrics platform that provided them with the participant information sheet (appendix 8) to provide further information and allow participants to make an informed decision of whether they want to take part. A consent form was attached after the participant information sheet for them to give their consent to take part (appendix 7).

The procedure was repeated at the 3-month time interval and again at the 6-month time interval, providing a different link at each time period to the Qualtrics platform. Each time participants were provided with the participant information sheet, to remind them of the purpose of the research. Email reminders were also sent out during the data collection phase to prompt participants.

4.1.1 Experimental design

Due to the conditions of this research all clinicians were able to attend the reflective practice groups and therefore to implement a control group would have been unethical meaning that staying with a true experimental design would not be possible. The lack of a control group will not enable a certainty that the outcome of the results is due to the reflective practice group and not some other variable. Without the control group there is no baseline of what would be normal outcomes for this group of clinicians in terms of their general health and burnout.

To counter act the lack of a control group a quasi-experimental time series design using one sample was implemented. It is recommended that there are multiple data collection points but being aware of fatigue, boredom, and irritation this was limited to three timepoints (Breakwell, Wright and Barnett, 2020). Although this creates problems as there is the threat of testing effects as participants become familiar with the measures meaning they perform better and start to understand what is being asked for (Breakwell et al, 2020). There is also the issue of participant withdrawal, with this research being carried out during the COVID pandemic, participants may become ill and miss a time point or may withdraw from the reflective practice intervention.

4.1.2 – The measures

All measures used in the research were used with the proper permissions and approvals from the authors of the psychometric measures. There were two standardised questionnaires measuring the clinicians psychological wellbeing and level of burnout. By measuring these factors, it would allow the researcher to evaluate the effectiveness of attending the reflective practice group. The following standardised questionnaires were chosen for differing reasons. The General Health Questionnaire (GHQ-28) was chosen because it is a self-report measure and allowed focus on the clinicians psychological wellbeing understanding various distress for workers, as well as predisposing factors (Jackson, 2007). Jackson (2007) stated that the GHQ – 28 cannot be used in isolation therefore due to thinking about a further measure of psychological wellbeing Maslach Burnout Inventory - 9 (Maslach,

Jackson and Leiter, 1996) was also used. MBI-9 was used as this is the most widely used measure of burnout and has been used in several studies.

General Health Questionnaire (GHQ-28)

The GHQ-28 (Goldberg, 1978) is a self-report questionnaire that is used to screen for psychological wellbeing. The GHQ – 28 identifies two main areas of concern:

1. The inability to carry out normal functions
2. The appearance of new and distressing phenomena (Goldberg and Hillier, 1979)

There are 28 items split into four scales; Somatic symptoms (items 1-7), measuring physical symptoms asking about overall wellbeing, anxiety/insomnia (items 8-14), measuring symptoms of anxiety and sleep difficulties, social dysfunction (items 15-21), measuring how respondents are functioning in normal day to day activities and depression (items 22-28), measuring respondents symptoms of feeling low and suicidal ideation. Each of the areas can be taken in isolation or form a total score. Each item on the GHQ-28 is measured by respondents circling not at all (0), no more than usual (1), rather more than usual (2) and much more usual (3). Scores are applied after the GHQ-28 is completed, marked by giving a score to each response.

Many studies have investigated the reliability and validity of the GHQ-28 in different populations. Test – retest reliability has been reported to be high (0.78 to 0.9) and interrater and intrarater reliability have both been shown to be good (Cronbach a 0.9 – 0.95). High internal consistency has also been reported (Sterling, 2011).

Maslach Burnout Inventory (MBI-9)

The MBI-9 assesses three components of burnout syndrome; emotional exhaustion, depersonalization and reduced personal accomplishment. There are 9 items divided into 3 subscales. The term recipients is used to refer to the people for whom the respondent provides a service, care, or treatment to. The items are in the form of statements about personal feelings or attitudes. The items are scored by the respondent in terms of the frequency with which the respondent experiences these feelings on a 7-point scale ranging from 0 (never) to 6 (every day).

The emotional exhaustion subscale assesses feelings of being emotionally overstretched and exhausted by work. The depersonalisation subscale measures an unfeeling and impersonal response toward those accessing the respondents service, care, or treatment. The personal accomplishment subscale assesses feelings of competence and successful achievement in the respondents work with people. The personal accomplishment scale is independent of the emotional exhaustion and depersonalisation subscales. The scores of each subscale are considered separately and not combined into a single total score.

The test-retest reliability has been tested with different populations finding a range from low to moderately high. The test-retest reliability coefficients from the subscales have found to be between 0.6 to 0.82 for emotional exhaustion, 0.54 to 0.60 for depersonalisation and 0.57-0.80 for personal accomplishment. Studies have found that the MBI subscales are stable over time, with correlations in the range of 0.50 to 0.82, for time spans of three months to a year.

4.2 Data analysis

Descriptive statistics were collated and interpreted looking for features in the data set that allow a summary to be generated.

4.3 Results

The final sample consisted of 22 participants that took part at different time points from baseline to 6 months, 14 participants provided data to allow their demographic data to be collected and this consisted of 93% females and 7% males. Only 3 participants completed at all 3 time points.

Table 1: Breakdown of Completion:

	N	**%**
All three time points	3	14
2 time points	5	23
1 time point	14	64
Total	22	100

From the power analysis 34 participants were needed for a medium affect, therefore due to having only 3 sets of complete data there would not be enough power to detect an effect of the reflective practice groups on this group of clinicians through the measures used, GHQ-28 and MBI-9.

The mean age of the group of participants was 38 years old with an age range between 18 to 60 years old. 79% of the sample identified as White British, 14% as other white background and 7% as being Indian ethnicity. The majority of the sample were psychologists (36%) and nurses (43%), with varying experience of working in the NHS, 36% having only worked for 4 years or less, 29% working for 20 plus years, the average years worked for the NHS within the sample was 10 years 3 months. Most participants had been 0-4 years post training (43%), the average years post training from the sample was 9 years 4 months.

Table 2: Participant Demographics

Gender	Number	%
Male	1	7
Female	13	93
Age Group		
18-24	0	0
25-29	4	29
30-34	4	29
35-39	1	7
40-44	0	0
45-49	2	14
50-54	1	7
55-59	2	14
60+	0	0
Ethnicity		
White		
British	11	79

Irish	0	0
Gypsy/Traveller	0	0
Any other background	2	14
Mixed/Multiple ethnic		
White and Black Caribbean	0	0
White and Black African	0	0
White and Asian	0	0
Any other background	0	0
Asian/Asian British		
Indian	1	7
Pakistani	0	0
Bangladeshi	0	0
Chinese	0	0
Any other background	0	0
Other Ethnic group		
Arab	0	0
Any other background	0	0
Profession	Number	%
Psychology/Clinical/Counselling	5	36
Nursing	6	43
Social Worker	0	0
Occupational Therapist	2	14
Psychotherapy/Art Therapist	0	0
Other not stated	1	7
NHS Experience		
0-4 yrs	5	36
5-9yrs	2	14
10-14yrs	2	14

15-19yrs	1	7
20+	4	29
Years since training		
0-4yrs	6	43
5-9yrs	2	14
10-14yrs	1	7
15-19yrs	2	14
20+	3	21
Team Worked for		
Navigation Hub	1	7
Access and Engagement Team	0	0
Eating Disorders	0	0
Family therapy	0	0
Core specialist mental health team	9	64
Intensive Support Team	2	14
Learning Difficulties	0	0
Looked After Children's Team	1	7
Refugee Team	0	0
Mental health in schools team	0	0
Crisis Team	1	7
Other	0	0

Participants were from different teams working across the Midlands CAMHS service, 64% were from the core specialist mental health team.

4.4 Summary of Quantitative findings:

Three complete sets of data were collected and 22 participants took part at different time points, therefore there was not a large enough sample to show the likelihood of an effect of reflective practice over time on participants wellbeing. Therefore, only the descriptive statistics from both the GHQ-28 and MBI- 9 are reported.

The descriptive statistics could not show a significant impact of the reflective practice groups on clinicians psychological wellbeing and improvement in lowering the risk of burnout as they are unable to demonstrate a causal link between the data and the reflective practice groups. Therefore, the main features of the data will be described and used to guide phase 2 of the data collection process.

4.4.1– General Health Questionnaire – GHQ-28

The psychological wellbeing of participants was measured using the GHQ-28, split into Somatic scale, anxiety scale, social dysfunction scale, depression scale and total score. Somatic scale asks about the general physical wellbeing of the respondent. Over the time period from July 2021 to May 2022 while attending the reflective practice groups, participants mean score seemed to be maintained over time, suggesting that for this sample their physical wellbeing did not get worse or better over the time period, this could have been due to many factors and not as a direct result of attending the reflective practice groups.

Table 3: GHQ-28: Somatic scale

	N	Minimum	Maximum	Mean	Std. Deviation
Baseline – Somatic	14	3	15	8.79	3.332
3 month- somatic	10	1	18	8.60	5.232
6 month- somatic	8	2	15	8.50	3.928

A similar trend was observed in the anxiety scale scores, the scale asked about struggling with sleep, feeling under strain, getting panicky, feeling overwhelmed and bad tempered. There was only a little variance between the three time points suggesting that again there was a maintenance over the time period. However, it cannot be concluded that this was as a result of the reflective practice groups.

Table 4: GHQ-28: Anxiety scale

	N	Minimum	Maximum	Mean	Std. Deviation

Baseline- anxiety	14	0	18	10.14	4.605
3 month – anxiety	10	1	16	7.70	4.644
6 month-anxiety	8	0	13	8.00	4.071

The social dysfunction scale examined the participants ability to function in their daily lives, being mindful that it was not just the everyday things that were being battled with but also the impact of the pandemic, it would be expected that this may create some struggle and adapting to their daily functioning. However, the scores again did show some consistency over time, with a small improvement in scores at the 3-month time point and 6-month time point compared to the mean score at the baseline time period.

Table 5: Table 6: GHQ – 28: Social Dysfunction scale

	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Baseline – Social Dysfunction	14	3	17	10.29	3.911
3 months- Social Dysfunction	10	2	14	8.70	3.466
6 months Social Dysfunction	8	6	12	8.63	1.996

The depression scale was the lowest scoring scale in the sample of participants that responded, indicating that those that responded would not meet the clinical score for possible depression. Much like the other scales there is consistency over the three time points of data collection.

Table 6: GHQ – 28: Depression Scale

	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**

Baseline – Depression	14	0	10	1.86	2.742
3 months – Depression	10	0	6	1.80	1.814
6 months – Depression	8	0	10	2.75	3.694

The total score of the sample, showed consistency at the 3-month time period and 6-month time period. The score at baseline was higher, which may suggest that the sample of participants were struggling with their overall psychological wellbeing. However, the assumption cannot be made that the scores reducing at the 2nd and 3rd data collection points was as a result of attendance at the reflective practice groups.

Table 7: GHQ – 28: Total score

	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Baseline – Total	14	10	55	31.07	10.908
3 months – Total	10	9	50	26.80	13.742
6 months – Total	8	9	37	27.88	8.610

4.4.2– Maslach's Burnout Inventory 9 – MBI-9

The MBI-9 average scores for each scale are to be considered separately for each scale.

Personal accomplishment:

A score of 12 or lower would be suggestive of burnout within the sample, the mean scores move from the high burnout score to the moderate burnout range. The scores do not vary considerably from baseline, 3-month post and 6-month post and are maintained over time. This cannot be assumed to be due to the reflective practice group impacting on the participants in the sample and could be that other variables were impacting to support clinicians.

Table 8: Descriptive statistics – MBI-9

	N	Minimum	Maximum	Mean	Std. Deviation
Baseline Personal Accomplishment	**14**	**6**	**15**	**11.21**	**2.455**
3 months post Personal Accomplishment	**10**	**8**	**16**	**12.60**	**2.591**
6 months post Personal Accomplishment	**8**	**7**	**18**	**13.38**	**3.249**
Baseline Depersonalisation	**14**	**0**	**6**	**1.36**	**1.906**
3 months post Depersonalisation	**10**	**0**	**12**	**1.60**	**3.748**
6 months post Depersonalisation	**8**	**0**	**2**	**0.75**	**1.035**
Baseline Emotional Exhaustion	**14**	**1**	**18**	**10.07**	**4.565**
3 months post Emotional Exhaustion	**10**	**0**	**17**	**9.90**	**5.405**
6 months post Emotional Exhaustion	**8**	**1**	**15**	**10.50**	**4.781**

Depersonalisation:

The scores across the three time points indicate low burnout in the participants that responded, however it cannot be assumed that this is as a direct result of the reflective practice groups. The mean scores would also suggest that participants are not being unfeeling or impersonal towards those recipients in their care accessing treatment from them.

Emotional exhaustion:

The average mean scores from the sample of participants show a moderate burnout and the mean scores are consistent across the three time periods measured, however it may be suggesting that participants in this sample are feeling overstretched and emotionally exhausted. The maintenance of the scores cannot be attributed to the attendance at the reflective practice groups as the data is descriptive.

4.5 Discussion

Interpretation

The features of the data show that there is a maintenance of the scores over time, the assumption cannot be made that the reflective practice groups may have been a factor in supporting clinicians over the pandemic period in creating a forum for containment. This due to only the descriptive statistics being presented and this data can only describe the characteristics of the sample and does not allow predictions and enable the key researcher to reach a conclusion about the population being studied, which inferential statistics would allow for.

Implications

Reflective practice is implemented to provide a space for clinicians to have a space to reflect on clinical issues affecting their work and them personally and case discussion to allow deeper thinking about the issues being raised in the case they are working with. Due to the nature of the work that the participants in the sample carry out, this can be very emotive and create a deterioration in their psychological wellbeing or produce burnout. Therefore, it was expected that through attending reflective practice groups that the discussion in reflective practice groups, would allow processing of the feelings and emotions attached to their work to support with the clinicians psychological wellbeing and prevention of burnout. The measures used screened for psychological wellbeing and burnout and have been tested with a number of different populations, with good test re-test scores. However due to not collecting sufficient data sets, no significant result could be found and only inferences could be made from the data, with a pattern of maintenance being observed. Therefore, this would be used to inform phase two of data collection.

The descriptive data showed mean scores over 3 time periods, baseline, 3 months post and 6 months post baseline, due to the maintenance in scores suggesting that a factor or number of factors were containing the participants in the sample, this would be furthered explored in the interview stage of data collection. The key researcher was able to focus the questions to aid in the exploration of factors that help to stabilise participants through the pandemic, which may have been the reflective practice groups or other interventions that were offered or other sources of support. Reflective practice may have been a factor but a relationship or correlation between maintenance of psychological wellbeing and attendance at the reflective practice groups could not be established, there is a similar assumption with the burnout reported, this will also be explored further in phase 2 of data collection.

Limitations

Three sets of complete data were collected from baseline to 6 months' post baseline time period, with 22 participants taking part at different time points, with the number of participants reducing over the time period. Descriptives statistics can only describe features of the data and 34 full sets of data where needed to achieve a medium affect therefore, no significant result could have been achieved. This would suggest that it was the method of data collection that was undertaken could be influential in the lack of data. But also, it could have been due to possible clinician burnout, as data was collected during the Covid-19 pandemic when demand on services was high and restrictive measures were still being employed in the clinical areas.

The method of data collection was via email and therefore was reliant on participants to read and complete. There was no preparation prior to the email being sent out and would have been at time when the department was carrying out many audits of other parts of the service, some examples were working with children with autism, time frames for Education Health Care Plans (EHCP) and support needed to complete these. Therefore, it maybe that clinicians felt overwhelmed by having another form to complete. On reflection of using this method to collect data, it may have been more beneficial to have attended each reflective practice group in each team or whole service meeting to talk about the research and send out an email following attendance at these meeting. Then repeating this at each time point measurement.

One clinician approached the key researcher and said that she had decided to withdraw from the study after completing 2 time points due to no longer attending the reflective practice groups. Therefore, it maybe that this was a factor in gaining the requisite number of participants, so there may have been barriers for clinicians in attending the reflective practice groups, causing them to then drop out of the research data collection phase. The barriers that maybe perceived by clinicians to attend reflective practice maybe an important factor to explore further in phase 2 of the research.

Already noted, is the volume of audits being carried out in the service and the time of data collection was during the Covid-19 pandemic, it is wondered if there was an element of clinicians feeling overwhelmed and highly stressed, Ollis et al (2021) suggested stress levels would be expected to remain heightened during a global pandemic. The data produced from MBI-9 suggested in one of the scales, emotional exhaustion, that burnout was at a moderate level. It may have been that during the

pandemic participants may have felt overwhelmed by work load and the pandemic itself. Therefore, this may have been an influence for other clinicians in taking part in the research.

Future recommendations

Overall, the main feature of the descriptive statistics was that there was a maintenance to the scores over time, which could indicate that there is some factor that supported the participants to remain stable over the time period measured. However, to enable investigating the quality of the reflective practice group as an intervention, there would need to be more participants included to enable a link between the reflective practice groups being effective in managing clinicians psychological wellbeing and burnout. Therefore, the measures could be used again and participants approached at each of the reflective practice groups to collect the data needed for a medium effect to allow inferences from the data to be made to the effectiveness of reflective practice in improving or maintaining clinicians psychological wellbeing and feelings of burnout.

The MBI-9 mean descriptive scores were suggestive of burnout on two scales, emotional exhaustion, and personal accomplishment during a high stress period. Depersonalisation showed low burnout consistently, this scale measures how clinicians view their patients, suggesting that the sample of participants kept the patients at the heart of their work during the pandemic, future research could explore these 3 factors in why when there is burnout through emotional exhaustion and personal accomplishment, depersonalisation remains low.

Chapter 5: Qualitative data collection phase

5.1 Procedure

Participants for the qualitative data collection stage were invited via email, participants were required to have attended reflective practice groups but it was impossible to know if they had taken part in the first stage of the research, as this was anonymous through the Qualtrics platform. Participants were not asked at interview if they had completed the questionnaires and it was assumed that they had not due to having only three complete sets of data and six participants took part in the semi structured interviews.

Six participants expressed an interest in taking part in second part of the data collection phase of the research, consent was obtained verbally and in writing at the virtual face to face interview and they

were sent a copy of the participant information sheet (appendix 8) and consent form via email to send back to the researcher (appendix 9). The interviews commenced 3 months after the completion of the 6-month data collection phase, interviews took place over an 8-week period due to researcher and participant availability. Participants were briefed prior to starting the interview, informing them that the interviews would be recorded and would be confidential, with the recording being held solely by the researcher on the secure drive of the researchers NHS user area. They were also reminded that the interview was about their lived experience of reflective practice and that the researcher was interested in their views and opinions.

The semi structured interview took approximately 30 minutes to complete. A pilot interview was conducted to test if the questions being asked captured the essence of the participants lived experience of reflective practice, the interview schedule was altered slightly to include a focus on the structure of reflective practice groups. The interviews were conducted by the key researcher who is experienced in the area and was aware of the issues that may arise for the participant. The interview took place via Microsoft teams with both participant and the key researcher being in a confidential and quiet area, either in an office on their own or in their own home. Following the interview, participants were debriefed and checked that they were ok, with time for questions to the researcher to be asked.

5.1.1. Conducting the interviews

To start the process, an interview schedule was produced to structure the format of the interview, with suggested questions to ask the participants. The purpose of the interview was explained through the email sent to recruit the participants and again at the start of the interview process.

Semi-structured interview process

A semi-structured interview format was used, which included a few interview questions to allow issues brought forward by the participant to be explored (McGrath, Palmgren, Liljedahl, 2019). The researcher had developed a knowledge of reflective practice and experienced the reflective practice group being run in the service. The questions were determined prior to the interview and formulated using the researcher questions.

It was identified by Kallio, Pietila, Johnson and Kangasniemi (2016) that the development process of semi structured interview guide development were: 1. Identifying the prerequisites for using semi-

structured interviews; 2. Retrieving and using previous knowledge; 3. Formulating the preliminary semi structure interview guide; 4. Pilot testing the interview guide and 5. Presenting the complete semi-structured interview guide. Each of the phases are interrelated as each contribute to the success of the next. The pre-requisites were met for using a semi structured interview approach as this was recommended for using IPA (Smith, Flowers, and Larkin, 2022). The literature review offered a basis for retrieving and using previous knowledge to understand the subject area to guide what the researcher is hoping to find by critically understanding the current state of knowledge in the field of reflective practice. Through this knowledge and critical understanding guiding the aims for the research allowed the researcher to formulate the preliminary semi structure interview guide. A pilot interview was carried out and included in the final data set, this experience allowed the researcher to understand the main themes being generated and identified that the structure was important in the experience of reflective practice for the participant, therefore this led to the restructuring of the interview guide. Table 9, presents the complete interview guide.

Table 9: Researcher and Interviewer questions

Researcher Questions	Interviewer questions
How does understanding the clinicians experience of reflective practice lead to what is the value added to the clinicians role?	1. There is a lot of research into the effects of attending RPG, in terms of clinical practice, changing patient outcomes, changing level of support, impact on stress and staff sickness. After joining the RPG group what impact have the sessions had for you? 2. Depending on the answer to 1 – think about changes to the following: i. Resilience ii. Confidence iii. Clinical experience iv. Personal development v. Health status
What was the impact of the pandemic on clinicians and did the reflective practice groups support with this impact?	1. The RPG were set up while working through a global pandemic, with the aim of

	supporting staff through this difficult time. What are your thoughts around this? 2. Reflecting on working through the pandemic, has the RPG had any impact on you in your work or your own health and have you been able to explore this through RP?
Does the reflective practice group support clinicians with their psychological and physical wellbeing – keeping it stable as the quantitative data suggests?	1. Did the RPG help to stabilise your mental and physical health rather than it deteriorating? 2. If the groups did not support in stabilisation what would have kept things stable? 3. What needs did RPG meet and what did not meet, wonder what would have helped further? 4. How do you feel once you come out of the reflective practice groups?
What impact does having a structure have for the clinician attending the group?	1. The RPG used the heads and hearts model of RPG, where you aware of this and if so, what did you think of this as a model for you as a practitioner in the group?

Table 9 shows the translation of the researcher questions into the interview questions to provide the researcher with a way of gaining the knowledge needed to answer the research question and create a natural flow to the conversation.

Interviewer questions

The interview questions were kept open and simple, worded in a way to try and illicit as much reflection on their experiences of the reflective practice groups.

The following questions were incorporated into the semi structured interview:

- Introductory questions to encourage rich descriptions of participants lived experiences
- Follow up and clarifying questions or implicit communication such as nodding and pausing to encourage further description from the participants.
- Direct questions to move the conversation forward and introduce each area of the research.
- Indirect questions
- Structuring questions to maintain the flow of the conversation to allow focus on the key topics of the interview.
- Time for reflection to allow participants to expand further on the conversation.

There was a sequence to the questions to cover all areas being researched, however there was an openness to change the sequence and adaptation of the questions to ensure the conversations flowed and ensure the participants were able to share their experiences of reflective practice by creating their own narrative. There was also awareness of the rapport between the researcher and the participant, as this is crucial to allow the participant to provide a rich and detailed account of their experience, many participants were known to the researcher due to working in the same service, therefore rapport was quickly built.

5.1.2 Risk and Risk Management

The risk element of this data collection point was assessed as being low and on the participant information sheet information was given to where they could access support. Participants were also reminded of the following:

- Participants were asked at the beginning of the interview if they still consented to take part and after an overview of the form the interview would take, it was checked that they were still happy to take part.
- They were reminded that they only had to share what they wanted to share and all content of the interview would be kept confidential.
- Participants were also reminded that they could withdraw during and after the interview, a full debrief would be offered if this occurred, no participants did withdraw.

- At the end of the interview participants were encouraged to ask questions.

5.1.3 Data protection and transcribing

The participants were informed that the interviews would take place via Microsoft teams and be recorded via this platform. They were assured that only the researcher would have access to the recording and a copy of the recording would be kept on the researchers secure NHS drive. Participants were given the right to withdraw and could do at any point during, after and until the data was anonymised, 6 weeks after the interviews had taken place. At the point of data analysis and after transcription, all data obtained and Microsoft teams recordings would be destroyed. At the point of transcription, data would be anonymised with participants being given a participant number. Data would be analysed separately from each participant and with the other anonymised participant data. All transcripts of the interview were produced by the key researcher.

All interviews were transcribed word for word and analysis of data commenced as soon as possible to maintain accuracy and recall by the key researcher. Transcribed interviews were kept on the key researchers personal computer and the content of the key researchers computer is protected by a complex pin number, considered to be secure.

5.2 Data analysis (IPA)

IPA was used to develop the data collected into something more meaningful to understand the participants voice and lived experience of reflective practice. IPA can be characterised by a set of common processes and principles which are applied flexibly to the analysis, meaning that the analysis can be described as being an iterative process and an inductive cycle (Smith, Flowers, and Larkin, 2022) The following protocol was followed, which was proposed by Smith, Flowers, and Larkin (2022) and were followed by the key researcher:

1. The researcher immerses themselves in each of the interview transcripts, reading and re-reading the data, becoming familiar with the data.
2. The researcher begins the process of noting anything of interest within the transcript while maintaining an open mind, referred to as exploratory noting. This is done in separate column alongside the original interview script.

3. Constructing experiential statements, which articulates the most important features of the exploratory notes and relate directly to the participant's experiences.
4. The next stage involves the development of mapping of how the experiential statements fit together looking for connections and themes across the data.
5. Naming the Personal Experiential Themes (PETs) to describe the characteristics of the experiential statements.
6. A table is produced of each participants PETs, which are the highest-level organisation and sub themes of the PETs.
7. PETs are worked with to develop Group Experiential Themes (GET's) aiming to look for patterns of similarity and differences across the PETs. Allowing a highlighting of the shared and unique experience across the participants.
8. Finalise the GET's and the sub level GET theme table, ensuring that this has been reviewed.
9. A full narrative of the evidence is produced through a detailed commentary, which takes the reader through the interpretation theme by theme, ensuring clarity is presented between the researchers interpretations and the participants statements.

Through adopting this process regular breaks were taken to allow the researcher time to process and reflect on the data. This gave time for the researcher to consider how their own influences and emotions would influence the data.

5.3 Reflexivity

IPA examines the lived experiences of the participants and as such cannot be separated from the researchers own lived experiences and views of the research area. Therefore, it is important to be aware of the multi-level reflection, looking both inward (researchers own understanding of the impact of the research) and outwards (to look at the wider social and intellectual framework around the topic) (Flick, 2022). The key researcher will take this knowledge and highlight the influence of past and present life experiences that led to this research and how these experiences were considered through the research process.

The key researcher is a trainee health psychologist working as a CAMHS Practitioner post within the Midlands CAMHS service. All participants were from the trust and working within the same service, some within the same team as the key researcher and some within other teams, therefore a

professional rapport had already been established. The key researcher accepts that there is a need to be aware of one's own attitudes, values, and beliefs and how this will influence translation of the information provided by the participants (Alley, Jackson and Shakya, 2015). The key researcher is aware that this could create a bias upon data collection, although preventative measures were implemented. Therefore, by making this information unambiguous, readers of the research can make their own decisions as to the quality of the research. However, having experienced the reflective practice groups can give an element of the understanding of what the participants may have experienced and being able to utilise the skills and knowledge that have been developed over time of reflective practice could be seen as a strength giving a further element to building a rapport. The key researcher also accepts that her own experience could bias her views on the participants experience. The key researcher has attended the reflective practice groups and has had positive experiences of reflective practice finding them a useful and purposeful space for her to use for her own clinical work. Therefore, this could impact how the key researcher approaches the discussions with other clinicians believing her experience to be the right experience and therefore the key research may expect that other clinicians would have the same positive experiences as her. Also the key researcher is a colleague to some of the participants and therefore this could influence the researcher/participant relationship possibly leading to a response bias from the participant.

With this in mind, the key researcher is aware that during the interview process that her own experience could be used to unduly influence the participants account of their experiences and make inferences from their communication. Therefore, the interviews were approached with an aim to stay objective and to not ask leading questions or share their own experiences of reflective practice. The intention of the interviews was to allow the participants time, space, and the opportunity to share their thoughts, feelings, and experiences openly. Having the role of being a researcher, participants were assured that all interviews were confidential, private, and non-judgemental.

5.4 Analysis of qualitative findings

5.4.1 Summary of the Qualitative findings

This summary provides an overview of each Group Experiential Themes (GET's), followed by a critical analysis and interpretation of meaning resulting from the interview transcripts.

The aim of this phase of research was to study the lived experiences of clinicians attending reflective practice groups. There were 5 GET's and 12 group level sub themes that emerged from the data set following the application of IPA that appeared to illustrate these experiences.

The following table details these themes;

Table 9 – IPA Group Experiential Themes

Group Experiential theme 1: **GROUNDING AND PERSPECTIVE THROUGH THE CREATION OF A DIFFERENT SPACE FOR CLINICIANS**	Group level sub-theme 1a: **Clinicians feel safe in the space to open up.** Group level sub-theme 1b: **Clinicians are enabled to stop, process, and realise how they are feeling** Group level sub-theme 1c: **Clinicians can be more thoughtful towards their clinical work.**
Group Experiential Theme 2: **CLINICIANS CONFIDENCE AND COMPETENCE DEVELOPS**	Group level sub-theme 2a**: Clinicians can learn through their peers in the group** Group level sub-theme 2b**: Clinicians build their confidence to carry out their role**
Group Experiential Theme 3: **CLINICIANS FEEL CONTAINED THROUGH THE STRUCTURE OF A MODEL.**	Group level sub-them 3a**: Structure provides safety and containment** Group level sub-theme 3b**: Allows clinicians to make sense of their experiences in clinical work**
Group Experiential Theme 4: **CLINICIANS RECOGNISING THE IMPACT OF THE PANDEMIC ON PERSONAL AND PROFESSIONAL LIFE**	Group level sub-theme 4a**: Clinicians having to get use to change quickly** Group level sub-theme 4b**: Clinicians being given the space to consider their wellbeing** Group level sub-theme 4c**: Clinicians recognising the support that they need**
Group Experiential Theme 5:	

FEELING THE PRIORITY OF THE CLINICAL TASKS ABOVE YOUR OWN NEED FOR REFLECTION – WHERE DOES THE PRESSURE COME FROM?	

Table 10 – Participant Demographics

Participant Number	Age	Gender	Ethnic Origin	Professional Background	Years worked for the NHS	Years post qualifying
Participant 1	35-44	Female	Asian	Psychology	5-9	5-9
Participant 2	25-34	Female	White British	Occupational Therapy	0-4	0-4
Participant 3	25-34	Female	Asian	Psychology	0-4	0-4
Participant 4	35-44	Female	White British	Nursing	15-19	10-14
Participant 5	25-34	Female	White British	Psychology	0-4	0-4
Participant 6	45-54	Female	White British	Psychotherapy	5-9	0-4

5.4.2 Grounding and Perspective is created through a different space for clinicians

Group Experiential Theme 1: Grounding and Perspective is created through a different space for clinicians.

The GET theme contains three sub- themes, clinicians feel safe in the space to open up; clinicians are able to stop, process and realise how they are feeling and clinicians can be more thoughtful towards their clinical work. This theme showed how participants needed containment through grounding, allowing the mind to be brought back to the present moment. Being able to create new perspectives through exploring different ways of thinking. This allowed them to discover new ways of working and expand upon their clinical knowledge.

"I think they can offer clarity of thinking that you can't get just by your own circular thoughts, been able to share things and hear other people's thoughts on what you have shared. I think can be invaluable, be that about a case but also I found in terms of organisational difficulties or wider team difficulties, a safe place to put something." (Participant 6).

For participant 6 it is about not getting stuck with their own thoughts, a forum like reflective practice allowed her to share those thoughts and hear reflections back to gain new insight. But it was identified that this is not just at the individual case level but the wider context of the team and organisation, providing a space to explore the wider issues that affect clinicians as well as the individual issues. The element of safety is highlighted, feeling that reflective practice is place to share these thoughts and feelings.

Group level sub-theme 1a: Clinicians feel safe in the space to open up

This theme emerged from the transcripts through participants sharing their experience of feeling safe to be able to speak openly about feelings, and being able to connect to colleagues through these feelings, but for this to happen and achieve a containment in a group setting, the participants have to feel safe. Achieving this can be difficult as attending a reflective practice group can come with some hesitancy. There can be a fear of being open, illustrated through the comment from participant 1 about experiencing a reticence of going into the reflective practice groups when it had not been managed well previously.

"it felt that it was going to be a negative space to be picked on a little bit, feel a bit exposed, I think historically the space hadn't been managed very well." (Participant 1).

Participant 1 highlights the fear of engaging in a group that has previously been experienced as being negative, using the word "exposed" highlights how vulnerable the participant must have felt in the group and possibly felt targeted further showing how vulnerable being a participant in the group can be as she may have felt that by attending you are opening yourself up to others opinions and judgements that may have been interpreted as being personal. The second part to pick up on in this extract is the use of the space not being managed well, suggesting that the facilitation of the space was not effective and left the participant feeling more vulnerable and unsafe. However, this was an anticipation of what the space would be rather than what it was as participant 1 said after experiencing a whole reflective practice session:

"Then there would be like a physical closing, the paper would be ripped, scrunched up and put on the table and somebody would peel open the fruit. There was a natural transition from this focused

reflective mode and because it all finished on compliments if you like or people saying what you did really well." (Participant 1).

This contrast described a more containing and validating experience, the vulnerable feelings were able to dissipate. They talk of a "natural transition" out of something that was very intensive to something more free flowing and enabled general discussion, a coming out of reflective practice. As though the containment of the space allows a relaxing effect to be achieved;

"I do often feel at the end of them sessions I probably feel a bit more relaxed than when I entered them because I think it's just been a space for discussion and you know letting things out and talking can often be very therapeutic, certainly been beneficial in that respect." (Participant 5)

Participant 5 refers to the process of the group allowing space to be more open and honest, treating it like a form of therapy for them to let go of emotions that may be impacting on their clinical work or caused by the clinical work, allowing the participants to achieve a sense of relief or healing from the clinical work. There is sense of feeling safe within the group to show the vulnerability, to talk openly about cases.

There is a feeling throughout the transcripts that there is a real emotional element to reflective practice for some of the participants, due to the case discussions and clinical incidences raised;

"So those situations where we have had to deal in terms of unhappy parents particular when there has been delays and we have had to focus on young people in crisis. Which has again caused delays, changed to the normal ways of working, which has caused lots of frustration and I think we have kind of bore the brunt of that at times, which has been a challenge, so having that safe space to come together." (Participant 4).

Participant 4 highlights how being on the front line that they have to deal with a lot of emotion from parents and young people, stirring up strong feelings, frustrations for the participant and patients families. To deal with this the participant was able to use the reflective practice space to come in and be honest about how they were feeling about these difficult situations;

"I think it's really important to have really open and transparent space for staff to be able to share how things are going and certainly for me when I have been in reflective practice spaces the most honest you tend to experience staff being." (Participant 5)

Participant 5 shares that there is a definite freedom for group member to be honest, she talks about the importance of having a space without any agenda to allow staff to feel free enough to talk. This is shown through other participants mentioning that there had been difficult conversations in the groups;

"But yeah absolutely come out of that after having that difficult case discussion just kind of reassured that the reflective practice team that really acknowledged and validated my feelings and gave me that space to be really open and honest about the impact it had." (Participant 4)

"I have also been part of reflective practice groups where there has been like inter team challenges and its been facilitated in way that is the kind of place you can go, ok I don't what is going on here but this is what I feel and that has to be facilitated really, really well in order for it to be a safe space but it can be really, really useful." (Participant 6).

In these two extracts both participants communicate a difficult situation, case discussion and inter-team challenges, however both communicate that it was handled well, both the case discussion through the reflective group and the inter team challenge by the facilitator. This would indicate that it is about the group dynamic and how well it is managed by the facilitator that impacts on the safety of the group, highlighting the need for good facilitation.

Group level sub-theme 1b: Clinicians are enabled to stop, process, and realise how they are feeling

The theme addresses the need to stop and have the time to reflect on what is going on for them as clinicians. There is a culture of keep going, due to the need to complete work, see the next patient, waiting lists, the next meeting etc and this environment can increase the stress and burnout clinicians feel. The creation of a space like reflective practice gives the opportunity to slow down, stop and gain a sense of containment of your own thoughts and feeling in practice;

"The not always having that opportunity or allowing ourselves the opportunity to stop and reflect, I think it's given us that, whereas before it might be go to work, come back, it's just a continuation." (Participant 4).

The internal pressure felt by this participant to keep going and noticing that it is you as a clinician that does not give yourself permission to stop. It is the not allowing herself time to be able to think about that case or the difficultly being experienced. The same participant recognised that it is often increasing demands that stop this from happening;

"It very much like this (gesture with hands), to go into reflective practice, we probably go into it at 100mph with all sorts still ticking over, so to start with the mindfulness exercise really good starting point to go breath, mindfulness, it kind of just yeah, brings everything down and then the check in with each other." (Participant 4).

There is a recognition that the participant had so many things happening at once that she probably entered the sessions with a million things in her head that need doing. But recognising that ability to stop, by doing something practical that allowed her to ground herself and back into the moment. The same was experienced for participant 5, that the mindfulness exercise at the beginning of the reflective practice allowed her to feel grounded;

"not so much my physical health certainly in terms of psychological wellbeing its certainly been nice, I've been to reflective practice spaces where there has been a mindfulness exercise at the start of the space and that been really helpful in terms of bringing anxiety levels down and pressing pause." (Participant 5).

For this participant the calm beginning allowed for an improvement in her psychological wellbeing and to focus elsewhere rather than on the day-to-day clinical work being completed. The experience of reflective practice in being able to consider the emotional impact of the work they were doing;

"reflective practice was helpful for us to talk about how we are managing and coping in a service that was forever changing and adapting to the need of the clients" (Participant 3).

Due to lots of change in the service, caused by the pandemic, the participant appreciated the time given by reflective practice to stop and consider how it was impacting on them. A period of change can feel disruptive and unsettling therefore being able to process and talk openly about this change can be beneficial, this participant communicated that it was "much needed" showing that she felt the benefit of the space created.

Group level sub-theme 1c: Clinicians can be more thoughtful towards their clinical work.
Participants shared an experience through reflective practice that they were able to be more thoughtful due to being able to offload and process their feelings, allowing more clarity of thought to be achieved. This sub-theme addresses the participants being able gain perspective so that work can stay at work;

"I've noticed when it's been particularly stressful having a reflective practice space that you know is a reflective practice space as well can alleviate the stress that you take away with you at the end of the working day, stop you waking up in the middle of the night going oh what, you know wondering about something." (Participant 6)

This extract illustrates how for this participant, having that space to process and being enabled to contain their own thoughts and feelings stopped them from carrying it with them, in particular disturbing their sleep, which could impact her ability the next day. It is having the opportunity to talk it through and communicate to someone why it is hard or why it is stressful, sharing those thoughts and feelings to enable her to move forward. It also could create a forum to challenge those beliefs and open up new perspectives;

"I think certainly I generally found them to be an eye opening enlightening place to be and helped me I suppose understand the challenges and perceptions that other staff have about other things." (Participant 5)

For this participant being allowed to gain clarity allowed them to feel clearer about where others were at. Achieving clarity allows the confusion to no longer cloud the judgement of the participant, she used "eye opening" and "enlightening" to explain the acquiring of greater knowledge about the subject

being discussed. By having this space to achieve clarity of thinking enabled another participant to be think and reflect on how others might be thinking;

"I think when you are particularly working like a multiagency way and again I am thinking particular about the role I had in youth justice, where we would be working with the police, social care and education, very differing perspectives in a way but you have a shared, a perceived shared view to a degree about protecting the public but how you go about that can be really, really stressful when you are the only person in that group that is trying to think in a different way." (Participant 6).

There is an acceptance that others will think in a different way due to differing professional backgrounds despite the same shared goal. However, although this may be stressful, it allows you to be more thoughtful about how others are trying to reach that shared goal.

Discussion

This GET has so much overlap between the sub-themes of clinicians feels safe in the space to open up; clinicians are able to stop, process and realise how they are feeling and clinicians can be more thoughtful towards their clinical work, as all require some level of containment. Containment being the action of keeping something potentially harmful under control or within limits, which could follow the boundaries of reflective practice but in order for this to happen the participants had to feel a level of grounding and being open to different perspectives. This would require a level of confidence in their ability to be able to access the depth of thought and challenge their perspectives through others reflections.

5.4.3 Clinicians confidence and competence develops

Group Experiential Theme 2: Clinicians confidence and competence develops

This theme was about the participants noticing that they were able to grow as a clinician both in confidence and competence, describing that they were able to explore and think deeply about clinical work, this theme has two subthemes clinicians can learn through their peers and clinicians build their confidence to carry out their role. Participant 1 talked about a problem-solving approach as a way of learning from clinical work;

"there was a monthly team get together that was reflecting over things that were good, things that hadn't worked out so well, problem solving and things like that." (Participant 1).

In this short extract there was a recognition that learning is created through critical thinking about clinical work that had gone well and not so well. The use of "problem solving" suggests for this participant that they need a solution to the issues being experienced through work. There is an assumption that this solution would be the solving of the clinical issue or the situation being dealt with, therefore gaining competence in the issue being experienced. There is an expansion of knowledge being described, as participant 1 went on to say:

"I would always know or somebody said something, I didn't even think about that, I would always note it so I would know there is different ways to problem solve and stuff" (Participant 1).

The participant talks about taking a physical record of the different ways of thinking about an incident, allowing for further learning to happen but also that there was a discovery for this participant "I didn't even think about that." Reflective practice allowed this participant time to stop and think about a case/incident differently to how they would have normally done, therefore creating a consideration of doing or approaching their clinical work differently, expanding their knowledge through their colleagues in the group.

Group level sub-theme 2a: Clinicians can learn through their peers in the group

Within this sub theme it was noticed that through sharing experiences from the facilitators, themselves and other group members and reflecting on how they were feeling about cases and clinical aspects of work, it opened them up to new ideas and ways of thinking. Through the sharing of their own reflections on clinical work it allowed others to be open to this and bring their own view points, allowing for learning to occur.

"We all learnt the value of picking up on strengths and areas of improvement and stuff." (Participant 1).

Using "learnt" as gaining knowledge and skills through reflective practice by sharing experience of clinical practice. The participant seemed to embrace looking at how they could improve in their

practice and how they could build on their strengths in a none threatening learning platform that reflective practice provided them with. This was supported by participant 2:

"I was able to problem solve and use that space to clarify and express my views on what was going on." (Participant 2).

Feeling that they were able to make use of the space to gain real insight and test how they were thinking and feeling about the case being discussed. There is also a sense that the participant did not feel judged, that they could express freely to gain the information needed to understand and work better therapeutically with the patient.

This may be due to the group membership, having a varied experience was important to participant 2:

"The group that we had varied in experience, their job role and their outlook, there was completely different people in there and I think that added to how supportive, supported I felt in that group." (Participant 2).

There is an expression of feeling contained within the group having group members that had so much experience and different clinical backgrounds, this added to the participants sense of getting a lot from the group, it was through this support that learning from experience could occur. It speaks to the usefulness of the group and finding something useful allows for learning to occur:

"Someone outside the team would be running the session, having their sort of input, understanding of our team and our experiences, giving us some advice and guidance was really helpful." (Participant 3).

The growth for this participant came from the facilitator, although they were outside the team, it was their objectivity that allowed them to provide something useful to the participant. The key in this extract seems to come from the participant feeling that the facilitator really understood the team and the things that they had experienced clinically. They added later in the interview that reflective practice gave them "a great start for me at the early point of my career."

Group level sub-theme 2b: Clinicians build their confidence to carry out their role

The sub theme focuses on finding the confidence within themselves from others affirmations and using the learning they had gained in the group to take forward into their clinical work. For one participant the power of having positive affirmation was key in their thought of I am doing a good job.

"That affirmation for me was really valuable, maybe that goes back to my own schema's and how I am as an individual but very much of the opinion that if somebody has done well at work then you should be able to say, do you know what you did a really great job and I take the feeling into my work now." (Participant 1).

Being able to take that feeling of doing a good job, doing well at something, really allowed this participant to embrace that positive affirmation and allow it into her work with patients and other work colleagues. There is also a sense that she wants to share this feeling with others and use her own positive experience to give someone else that confidence that they are doing well. But this feeling of confidence and self-esteem in their work, went further for this participant and impacted on their wellbeing at work;

"Positive affirmation definitely helps my wellbeing and wanting to be in work." (Participant 1)

It seems that it is a sense of feeling valued and having that sense of being appreciated that added to the participants confidence and "wanting" to be in work. In contrast the lack of positive affirmation could have a negative impact;

"I think I'd worked long enough in the team to be literally questioning myself, I am doing the right bloody thing here and because no one was saying that was really good, the thing is I still need affirmation at the end of the day." (Participant 1)

For this participant having the experience to ask questions of themselves but not being able to receive feedback on these thoughts and wonderings left them examining their practice. Therefore, the confidence has to come from elsewhere, needing someone else to tell them that they are doing a good job. This ability to explore thoughts and question their own practice and feel confident in doing this for another participant was again through the validation of others;

"this is what I am thinking and feeling and can we just talk it through, where as if I had moved and we hadn't done reflective practice I don't think I would have been able to do that." (Participant 2)

From this extract it seems that there is permission needed to explore their practice and ask the questions of themselves, but once they experienced this, they were able to take this permission that it was ok, into other clinical work with them. There is sense when it comes to new learning or exploration of ideas that there is confidence that needs to grow and reflective practice provides this space;

"a lot of learning and a lot of new terminology and new way of working but it was very helpful to have a space like reflective practice." (Participant 3)

Having to get use to new ways of working and when there is a lot of information to take in again being useful to have a safe space to explore these issues when feeling unsure. Reflective practice gave a space for experimentation of thought and exploration of clinical work to allow for confidence to grow.

Discussion

Within this theme learning through reflective practice comes from the exploration of thought. Participants gave a feeling that they were able through the space created by reflective practice to share thoughts and reflect on the thoughts of others, allowing for expansion in thinking from others perspectives to allow their clinical work to develop. But also, through this learning from others their confidence developed, however this confidence came from others in the group through positive affirmations being shared and permission being given to explore their clinical practice.

5.4.4 Clinicians feel contained through the structure of a model

Group Experiential Theme 3: Clinicians feel contained through the structure of a model

GET three is made up of two sub themes, structure provides safety and containment and allows clinicians to make sense of their experiences in clinical work. It is important to note that different approaches were used in each of the reflective practice groups, each team set up the group using different models, the majority of teams used the Heads and Hearts model (Kurtz, 2020) to shape the format of the group, previously discussed in the introduction.

Participant 6 talked positively about the Heads and hearts model, but questioned if it was the way it was delivered or the model itself;

"I don't know if I really like the model or whether I really like the way it was delivered by the facilitator. Just really worked for me, she had the confidence to deliver it in a really helpful way. So she used the model, but it was a frame that held the space rather than, moving on to. It felt really reflective." (Participant 6)

There was a lot of wondering from the participant about if it was the model as it held the structure of the session, allowing the participant to be reflective in the space and not feel that they were following a model. But also, the facilitator delivered it in a way for the participant to find it useful to gain the most out of the session. Therefore, it was important to have a facilitator that could deliver the model in a useful way to gain the most from reflective practice. The usefulness of the model was supported by participant 2;

"It was a bit challenging at first to get my head round it because you were very much told it was the Gibbs cycle of reflection and that sort of stuff and this was a lot more gentle and I like the process, I like the fact that we did the mindfulness at the start to bring you in and then it was done more gently, it wasn't just going off load and then there was a process to it, I really liked it once I got my head around it." (Participant 2).

The model provided an alternative way of being able to process clinical work, for this participant it felt calmer, the transition from work to the reflective practice group. The reference to "it wasn't just off load" suggests that there was something different about the model, that the structure gave purpose to the conversations. There was a lot of positivity about the Heads and Hearts model and it was something that was really valued by the participant.

There were also other models used and this will be considered as to the impact on how participants made sense of their experience of reflective practice, participant 1 attended a group that used a solution focused approach.

"I think if it's a model that has a good structure to it, it doesn't sound like it would be better than solution focused because both of them are routed in focusing on the positives." (Participant 1).

Participant 1 was contrasting the heads and hearts model to the solution focused model she had experienced. The sense that was made that neither model seemed to be more superior as both allowed to focus on positive outcomes of the clinical case being discussed. It was the focus on the model having a good structure to it that was more important not the model itself to provide a framework for discussion.

One participant mentioned the 5 P's model explaining that she had been part of a reflective group that used this to start the group off;

"I am really useless with model remembering, is it 4 p's one that was part of it." (Participant 6).

It was clarified that she meant the 5 p's model, but it was that this only formed part of the group discussion, it was mentioned as only being a starting point for discussion. Other participants had experienced an unstructured approach to reflective practice, which seemed to focus on reflecting on clinical practice rather than case discussion.

"No, I don't think there was mentioned about like there was a mention of what model we were using or if we were following a model, it was very unstructured and we just took turns to reflect on our experience on our role, it was an open floor I guess." (Participant 3).

This created uncertainty for this participant, as there was a lot of unknowns of what structure was being created for the group members. In saying "we just took turns" feels dismissive and perhaps not feeling very containing as everyone was able to speak and not reflective as the participant explained after;

"I don't think team members felt that they had enough time to speak, it was one person after another and if one person too space to talk about a lot things then person after didn't have space to talk if they want to." (Participant 3).

This approach led to tension building as there was a lack of space to talk about their experiences and feels that there was frustration for the participant. Therefore, a structure created through a model of reflective practice is important for creating a flow to the conversation and being able to process, as mentioned by participant 6 it can create a frame to hold the space.

Group level sub-them 3a: Structure provides safety and containment

This sub-theme explores the safety that a structure provides participants, what was noticed within this sub-theme was the different perspectives participants took and what they needed to feel safe within the structure of the reflective practice groups. It was felt by one participant that due to the unstructured nature of the group it felt that there was lack of appreciation of others roles and this led to feeling quite awkward;

"to be mindful that everyone has different experiences despite doing similar things, so that would have really helped to contain the team rather than it turn into that tension and feeling like we had to be careful and tread on egg shells." (Participant 3).

The participant focuses on being mindful, using it in the context of thinking about everyone's experiences and showing an appreciation that this will influence how they see their job roles from their perspective. The participant when saying "so that would have really helped to contain the team" was referring to having a structure/model, feeling that this would have prevented the space from becoming full of tension and created a flow for the discussion to happen, illustrated by participant 1;

"When she was there it was a lot more structured because she able to say like, that's great, it's been really good hearing from you, how's everyone else getting on" (Participant 1)

There was a movement that allowed for positive affirmation to be given and lead to hearing other's voices in the group. The context to this is that the participant appreciated not only the structure but having someone who led on that structure, providing boundaries for the group. The structure helped to contain the group members but it was also talked about in the context that it allowed the participant as a clinician to be pushed out of their comfort zone but not feel threatened by this;

"I think that pushed you into a position where you could get a bit defensive and yeah well, I could have done that, but whatever. But because you could not speak it really did push me into a frame of mind of what you are saying has really good value." (Participant 1)

Due to the model being used the participant was not able to speak while the reflective team was reflecting on the case brought and the participant recognises that sometimes she can become defensive about how she has worked with a case, but due to that "push" she was able to consider an alternative way, what she could have done differently and this was really useful to the participant, as it allowed a different perspective to be gained.

The movement in and out of the reflective practice groups that the structure provided the group with was also valued by the participant, the movement into the group allowed for the containment to begin;

"I think start coming together as a group, starting off with some mindfulness, checking in with each other, it just really gives you that time to come together, take the time, stop what you are doing focus on the reflective practice, I found that really helpful." (Participant 4)

Participant 4 shares about the setting up of the group session and finding it containing through a self-permission to stop and focus by engaging in something practical like mindfulness. By maintaining a focus away from the clinical world it allowed reflective practice to become useful. But it was the movement out that aided in providing the safety for one participant;

"Then the safety I guess of the moving you back out to what every you got next. It just felt really containing quite luxurious in a world of madness, but again I think it was the facilitator we had that was really good at." (Participant 6)

The extract portrays the participants appreciation of how they were moved out of the reflective space to the clinical work they had come from, but feeling contained by this movement so that the stress of the whatever was to come next was manageable. The participant talked about it being "luxurious" as though it was a comfort and it had been recognised that they had gone from a space of reflection, which can be exposing, to a work environment that could be stressful and un-containing.

Group level sub-theme 3b: Allows clinicians to make sense of their experiences in clinical work

Reflective practice is a form of in depth thinking about clinical practice in order to develop as a practitioner (Kurtz, 2020). But for this development to happen there has to be time to process and make sense of the clinical practice, this sub-theme demonstrates how participants have used the structure the model provided to make sense of their clinical experiences. A lot of time clinicians keep going from one session to another without thinking about what they are doing therapeutically. Through reflecting on the use of the model in reflective practice participants talked about recognising, being more aware and how "It became really enabling." (Participant 1).

There was a recognition that it is about seeing and noticing the impact of the work for the patient rather than just thinking about it.

"Recognising the benefit of your work more than just thinking about it." (Participant 6).

It is using that deeper level processing to not only think about the what you did that aided in supporting that patient but also what other may have done, allowing for deeper level of processing to happen about clinical practice.

"So, I think when you keep in whether it's the heads and heart model or the solution focused model, it focuses on things that went well with some space over what someone else might have done differently." (Participant 1).

The model created a space for other group members to open up a conversation about what they may have done and the person listening, has time to really hear what is being said, which for participant 1 was a positive experience as there was recognition of what went well as well as someone reflecting on what they may have done differently. Being open to this level of deep critical thinking allows the managing of emotions that may have been evoked by a particular case as it was for participant 4.

"I know one of the cases I reflected upon in one of the reflective practice sessions, was a particularly challenging case, was a case that I had been holding for a considerably amount of time, a case that was really quite complex, there had been lots of challenges, lots of barriers that I had come across, it had caused a huge amount of frustration for me, maybe hadn't realised how much frustration until I

brought it to reflective practice and then probably off loaded to everybody there. But yeah, absolutely come out of that after having that difficult case discussion just kind of reassured that the reflective practice team that really acknowledged and validated my feelings and gave me that space to be really open and honest about the impact it had, whereas I had not had that elsewhere." (Participant 4)

The space that was created for this participant really allowed them to stop and think about what was happening for them, process the frustrations of the case and be validated by the reflective team. The section that is created by the model for the participant to "off load" about the case gave them something that they had not been able to achieve elsewhere. There is a real sense for her of being able to think through the complexity and how this had caused those feelings she was experiencing in relation to the case. There was a time to share through the space being created however in some participants experience this did not happen;

"no one felt that like people had equal time to speak. So that un-structuredness didn't really help." (Participant 3)

The positive experiences of having a space created came from having a structured model, in the extract from participant 3, it was communicated that this could be cut short with no equity between group members to speak about clinical work. It was clearly communicated that the lack of structure was not useful. Therefore, suggesting little time to try and understand and think more deeply about the issues being brought. In the below extract, participant 5, shared that it was not having enough group members that may have reduced the usefulness of the group;

"It felt good as long as there was a decent amount of people in the reflecting team, it was really tough when we had a low attendance as it almost felt someone put a lot of effort into bringing their reflection, spoke about it at length and they would get 1,2,3 very similar reflections back, which we never had negative feedback, we always had feedback that it was helpful." (Participant 5).

Although they reported that the session was experienced as useful by the group members, it is communicated that having a number of people in the reflecting team would allow them to process more about the reflection being presented, allowing for more discussion to happen. The usefulness

came from the discussion created and for this participant this was by having an optimum number of group members.

Discussion

Having a structured model is suggested to be more beneficial in creating a space that feels safe and containing, although there is no consensus of opinion on what or if any model is more useful. The models that were focused on for participants in this research were heads and hearts model (Kurtz, 2020), solution focused approach (Sharry, 2007) and 5 P's formulation (Macneil et al, 2012), there was no clear preferred model, as all were described as being positive. It was the presence of a model that gave the most meaning for participants rather than having no structure, which presented participants with a negative experience. It was this structure that was created that allowed them to gain the most from the space created by reflective practice, in terms of feeling safe and the processing of their thoughts.

5.4.5 Clinicians recognising the impact of the pandemic on personal and professional life

Group Experiential Theme 4: Clinicians recognising the impact of the pandemic on personal and professional life.

In March 2020 the UK was hit by the Covid-19 global pandemic, this impacted how the whole population lived and worked. The NHS remained operational and a great demand was placed on all departments and services offered, but it caused a change to the way some departments in the NHS worked, the CAMHS service taking part in this research had to make a sudden change to how the service was run moving to online appointments and meetings, telephone appointments and only the most at risk patients being seen face to face with personal protective equipment (PPE) being worn. The extra pressure and demand on the service impacted on the staff working with in the CAMHS service. It was felt to be an important aspect of the research and was focus of part of the semi-structured interview.

"I don't know it allowed us as mental health practitioners to come to the fore in facilitating that space, the isolation, the difficulties that people personally were going through, in fact those spaces were possibly more valuable than the work content over that time." (Participant 6).

Participants were able to reflect on the impact of the pandemic highlighting the unknown and uncertainties that had been created from the restrictions placed on the population due to the pandemic, in the extract from participant 6, they saw that the reflective practice group as being more valuable, as it offered an opportunity to explore the impact of this global pandemic on individuals. An extract from participant 5 evidences how they were feeling:

"I think it came with its positives and negatives, I think it felt like a very chaotic time in terms of lots of unknowns, we weren't sure how long this was going to go on for, a lot of stress on people, work changed a lot, ways of working changed." (Participant 5).

Here, the participant is looking at the initial stages of going into the pandemic and how the unknown was impacting on how others felt and the series of changes that this meant, that initially had a negative impact on reflective practice mentioning that "it turned into a space for unproductive moaning." Possibly for this participant it felt that the impact was more of a negative space being created, with thoughts being chaotic, fear of the unknown and changes, which can be unsettling for many people. In contrast to this participant 6 felt that the impact of the pandemic for their professional life was positive as they spoke about;

"I don't think I had the need of that kind of support think it was more of an opportunity for me to even have a reflective space because actually the reflective practice space I had was set up during, remotely entirely, so it was, it afforded me an opportunity I hadn't had, when we were face to face, which would have been more difficult my work was out and about, I was in schools, in homes and everything." (Participant 6).

Participant 6 presented with more a resilient attitude not feeling that sense of negativity around the pandemic, mentioning that the reflective practice did not provide that support but the pandemic enabled a positive shift in her work to enable her to attend the reflective practice group and therefore the impact for this participant was that it enabled a positive change in their professional life. These two extracts show the contrast in how the views and feelings could be different in approaching the impact of the pandemic. This was supported by participant 4, who also spoke about the opportunity of reflective practice giving rise to feelings that they were not isolated once they were able to see beyond themselves and reflect with the group;

"To have it as there, to have that space there ongoing we would be beneficial at any time, but I think it's been particular because of the timing, because of when it was set up at time when we all needed it the most absolutely, think it's been crucial, really because during the time of the pandemic, we were remote working predominately and kind in a lot of ways very isolated and alone in working, remote working from home, not necessarily having that informal supervision that we would get in the office, not getting the opportunities to kind of reflect with others particularly about cases, so yeah I think it gave that space when it was most needed." (Participant 4).

Participant 4 speaks about the timing being "crucial" in the context of the change of working practices, changing from the being in the office together to remote working, but still being provided with a space to come together. The participant refers to reflective practice being a replacement for the informal supervision and corridor conversation about cases that would be achieved out of pandemic times. Which, leads to the feelings of isolation brought about by lone working impacting on the professional role, however this isolation was also felt personally.

"having that check in time, there has been times where we've not everyone has been ok, struggled in lots of different ways and I think feeling connected to your team and having the opportunity to reassure each other has been really helpful that you are not entirely on your own, I think we have had very similar experiences in terms of challenges we have faced through the pandemic." (Participant 4).

This extract speaks to importance of the space to create a way to remain connected to others, alleviating some of the isolation previously spoken about. The connection is not only just from everyone coming together but also the shared experiences of having to cope with the demands of family life, working and adapting to changes quickly through the pandemic.

Group level sub-theme 4a: Clinicians having to get use to change quickly

A recurrent theme for participants was the suddenness of change from working in one way to the movement of working completely differently, from working every day in the clinic to working from home, working face to face to working virtually, which, highlight the major shift for the CAMHS team. Participant 1 picked up on the suddenness of the change;

"The online functions came quite quickly didn't it and once we figured out how to use it." (Participant 1)

There was a period of adjustment of trying to "figure out" how to use the online functions and how this would change working practices. There was uncertainty in these changes and how was this going to impact. One particular change was going from working in a clinical environment to home working;

"The concept of working from home felt like logistically felt, how am I going to do that? Then when it happened, I haven't got to worry about what I'm wearing, how my hair washed." (Participant 1)

There was an uncertainty communicated from the participant about the practicality of how it was going to work, the assumption can be made that as a clinician much of the day-to-day work is face to face seeing patients, having meetings etc. So, the uncertainty of "how am I going to do that?" may have come from this. But they were able to see some of the benefit of not having to worry so much about their appearance. Working from home afforded a relaxation around dress codes and appearances, reducing some of the stress of having to be ready on time to leave the house.

With everything moving online, this meant an adjustment not only to change to working practices of seeing patient but also to groups attended by clinicians and as noted above in the introduction to the impact of the pandemic, online working and home working afforded the opportunity to clinicians to attend the reflective practice groups but this came with some negatives:

"Although you do lose something of the being in the room, which can be a bit more protected at times because you know I was in a space that you could see in their backgrounds that they are in an office, no, you can't, they would say I'm limited to what I can say, no just find a room." (Participant 6)

There is an annoyance communicated by this participant in those attending the group and not being able to take part fully in the space that is being created. It follows with the adjustment having to be made to virtual working, an issue created by the pandemic and possibly others not treating the confidentiality needed with the group like they would patient work. This extract also suggests that virtual working takes something away from the experience that being together face to face would provide. Possibly, making a difference in how others engaged in the group.

Group level sub-theme 4b: Clinicians being given the space to consider their wellbeing

The World Health Organisation (2020) recommended that measure be put in place to protect the mental health of health workers in the work place, they recommended that mechanisms should be implemented for early and confidential identification and management of anxiety, depression and other mental health conditions and promote a mental health prevention culture among health workers and health managers. Reflective practice would have been considered to be an intervention that would provide support with clinical working, improving clinicians mental health (Lutz et al, 2013). This sub-theme explores how the participants made use of the space to explore how they were feeling and coping with working through the pandemic. Initially the feeling was that the reflective practice space was used as a forum for venting;

"The more recent experiences rather than those initial experiences, which probably did feel repetitive, lets reflect on covid when we were in the height of it and no one really knew, it definitely felt negative, definitely pros and cons I would say." (Participant 5).

The comparison between the height of the pandemic and after the initial panic of what it would mean, was different for this participant. They highlight how the initial sessions of reflective practice could feel the same with discussing COVID-19 and the uncertainty of this subject. Despite it feeling like a mainly negative experience the participant was able to look at both sides and appreciate the positives of being able to discuss the subject. For another participant the impact for her was more positive;

"I think that's one of the biggest benefits is being, is having that space to be open and honest, actually this has been really tough, we have not been able to do that elsewhere because we have to very much maintain that professionalism." (Participant 4)

There was an appreciation of the unique space that was created to explore how if had been a difficult time. There was also an opportunity created for being able to be real and say how they were really feeling, almost being able to drop the mask and say it how it was for them.

To explore the impact of reflective practice on participants wellbeing, they were asked how they felt coming out of the groups. Most of the participants reported a positive feeling coming out of the group, suggesting the impact of the reflective practice group was beneficial to their wellbeing at work. But

conversely it was found that when the session did not go so well it had the impact of participants struggling to get back into work, affecting their motivation to carry on their day.

"The ones that online, when they were good and there were effective, I suppose I would feel like I could come out of reflective practice and have a bit of a stretch and get myself a fresh drink and get myself sat back down to work. But the day it didn't go so well it was difficult to get focused into work, I use to think urgh, good that's over now, I would try to get back into work and wouldn't be able to do it." (Participant 1).

"In general it felt like we were able to get things off our chest and put it out there, allow other people to jump in and add their experiences and knowledge, support each other, so I definitely like before that incident we all felt contained, we all felt good after reflective practice maybe once or twice we felt we didn't have enough time to talk about this or that but most of the time it was quite nice and erm quite helpful for a remote team." (Participant 3).

"When it worked well you came out of it feeling refreshed and ready for work. But when it is not utilised very well no one turns up or its poor attendance you can come out of it feel quite deflated" (Participant 5).

The three extracts from participant 1,3 and 5 show a very mixed reaction to how it impacted on them. Both participant 1 and 5 give a very clear message that when it went well there was feeling that they could carry on with their day. Participant 5 expressed that the group could provide her with a freshness as though reinvigorated to go to the next task. Participant 1 talked more about using physical attributes to get ready to go back into the working day and moving away from the screen, however conversely it seems that when it was negative, they did not mention the movement away from the screen possibly due to feeling a lack of energy. Participant 3 was more positive about the impact of reflective practice, highlighting feeling contained, with only a couple of times due to lack of time to share communicating some frustration.

Participant 4 viewed coming out of reflective practice as very positive, giving no mixed messages;

"I found that really beneficial, so absolutely it kinds reassured, validated, relieved would be the best words coming out of that." (Participant 4)

The extract would suggest that participant felt that reflective practice gave her a lot of confidence and would boost her wellbeing at work as she uses the adjective "relieved" describing how the group gave her reassurance that she was doing a good job, helping to remove her doubt, and being offered support from the group members. This positive impact of reflective practice on clinical work was echoed by participant 6;

"Really good experience of reflective practice I would come out of those sessions feeling cool I can do this, I can do my job, I can do it well, I can go to that meeting and not feel like I' going to be crushed or whatever, I can be." (Participant 6)

Again, this extract would suggest for this participant that reflective practice led to them feeling motivated to carry forward, showing confidence in their job role and how to perform more effectively in their clinical work (Sim and Randloff, 2008).

Group level sub-theme 4c: Clinicians recognising the support that they need

Reflective practice allows clinicians to reflect on what is working well and what needs to change, this clarity can aid in helping them identify what they need to support them, during the pandemic this became particularly important, the sub-theme identifies how clinicians through reflective practice were able to recognise what they needed to support them, both personally and professionally. One of the main issues was the sense of isolation, having to hold clinical issues, cases, and day to day experiences on your own, isolation being a factor in affecting mental health.

"Suppose when I think on a personal level for me, just having that kind of opportunity to check in and feel connected, people feels that because you know we know for those that have worked throughout a pandemic and kind of worked from home not have had very much interaction and engagement" (Participant 4).

It was a sense of connection that was still needed to work colleagues, needing the interactions that was previously experienced in the clinic situation, as working from home could be experienced as

feeling isolated with a clinical issue or after an online session. There was not the same structures and coping mechanisms in place that there had been previously before the pandemic of the impromptu conversations about clinical work.

"I was thinking mental health has always been an issue for us it's just becoming loud now, you're thinking everyone's working from home, you don't have that social structure in the office and stuff." (Participant 1).

This short extract from participant 1 explains that there have always been mental health issues for clinicians but the pandemic amplified it, which was supported by the World Health Organisation (2020). The participant picked up on for them the absence of having that support in the office as everyone is in their own home. From this participant's started to reflect on how reflective practice provided them with the support they needed to communicate the issues that were occurring for them realising that this was a shared experience.

"The fact that we would having to do sessions online or have to go home after that was quite isolating at times so being able to have that space of an hour, hour and half of getting to see people virtually it helped quite a lot." (Participant 2)

Participant 2 demonstrates this theme of finding support in the reflective practice seeing people virtually after doing therapeutic interventions in isolation, recognising the usefulness of having that slot that was available for them to attend. The conversation about clinical work was becoming lost as there was no separation between work and home, having to perform clinical duties at home, shown through an extract from participant 4;

"during the pandemic we lost that to a certain extent, you know there was no separation between work and home sometimes which had its challenges. It's highlighted in the reflective practice group, it highlighted the need for reflection, self-care, that it's ok to not be ok, it reinforces that really" (Participant 4)

The challenges were that the separation between home and work were lost, as previously you would have had the drive home to reflect and quite the mind. The challenge of looking after yourself and

admitting how you are really feeling, reflective practice highlighted this for this participant and how much the reflective space was needed;

"Right this is reflective practice and kind of put it in there rather than like everything we put off, but protecting that time has ensured we do come together to reflect and then definitely benefits of doing that." (Participant 4).

There is a real sense of this time being protected and prioritised as it was this that offered some support through the pandemic.

Discussion

This GET highlights reflective practice created a space to not feel isolated and keep a connection both professionally and personally throughout the pandemic, which supported with participants wellbeing. Within this theme there is a communicated struggle to get use to a different way of working that the pandemic created. But also, there is the positives highlighted of homeworking through the creation of online platforms and the negative working in the office environment, which could feel quite isolating as others were working from home. Participants highlighted that reflective practice gave them the much-needed support through the pandemic, as it offered the permanent slot of time that could be protected by the participants.

5.4.6 Feeling the priority of the clinical tasks above your own need for reflection – where does the pressure come from?

Group Experiential Theme 5: Feeling the priority of the clinical tasks above your own need for reflection – where does the pressure come from?

This theme was recurring for the majority of participants, feeling that due to the clinical role that the pressure they felt for seeing patients and attending meetings was greater than prioritising attending reflective practice. In contrast to the other themes this theme could be made sense of without having a supporting subtheme. Reflective practice allowed them to explore what prevented reflective practice from happening for them but also wondering what could be used to support others in attending. Participant 6 spoke about it being a "luxury" and an "indulgence" to attend the group, as it was a time for them as clinicians focusing on what they needed rather than the everyday of what the patient and the service needed. Therefore, questioning is the pressure internal (i.e., from the individual clinician)

or external (i.e., management, the service or organisation as a whole). The extracts from the interviews explores this conflict with particular focus on the internal conflict.

"So historically wouldn't have prioritised it, I probably would have thought I can see a young person at that time but I think having now engaged in the reflective practice groups I would be more inclined to prioritise that because I know it's kind of beneficial to have that, to have that time to reflect." (Participant 4)

For this participant the conflict came internally, that thought of needing to put another therapeutic session in for a patient, but through actually attending the reflective practice session it allowed them to remove this barrier and place the priority on their own time for reflection. The investment in the participant's own time for reflection was further demonstrated by participant 6;

"But yeah I think it could be, that's what I mean by investing a reflective space, can just make you more productive and so it's a false economy trying to squeeze another appointment in instead of reflective practice type thing." (Participant 6)

Again, this permission had to come internally from the participant, realising that trying to cram as much as possible into one day was not actually allowing time for stopping to think purposefully about cases or the therapy that was being carried out. But what about the external factors, participant 3, illustrated this through the lack of a facilitator due to them being needed elsewhere;

"I think the reason it didn't happen for a while was because of availability of the organiser and I think it kind of got forgotten in the mix, because there was a lot going on, case load increasing, dealing with a lot of patients in crisis." (Participant 3)

From the perspective of this participant, it was service demand that prevented reflective practice from happening, the increasing need of patients taking the facilitator away, as more clinical time was needed to reduce demand on the service. The external pressure can also come from the job role itself, when it is very much community based having to visit different venues and it is not until there is a shift in service provision due to external influences, like the pandemic that if can afford the opportunity for attendance at reflective practice;

"I don't think I had the need of that kind of support think it was more of an opportunity for me to even have a reflective space because actually the reflective practice space I had was set up during, remotely entirely, so it was, it afforded me an opportunity I hadn't had, when we were face to face, which would have been more difficult my work was out and about, I was in schools, in homes and everything." (Participant 6)

The participant felt that they did not need the support personally for reflective practice but it was more being given that opportunity when things were removed to remote online working. This service change worked in the favour of the participant to attend reflective practice by removing the barriers of the travelling community work they had to perform in their job role.

But this internal and more overt external factors still did not explain fully the barriers to attending reflective practice. Participant 5 through the interview reflected on it maybe not being so much of a priority like other meetings that are made mandatory;

"We have really good attendance at MDT's, people will very regularly attend if not always their clinical supervision space so it about understanding why reflective practice doesn't feel like such a priority to people and I wonder if its because to a lay man is it just a little get together and we will just share our thoughts and won't get much out of it." (Participant 5)

The participant is suggesting that it is perhaps that it is not understood what reflective practice is and what it involves, whereas multidisciplinary meetings are understood to be important and that clinical supervision is a priority for ongoing safe practice, being part of a professional registration.

Further understanding of the barriers may come from an extract from the interview with participant 6, who talked about managers being involved in reflective practice;

"I think that innately that a lot of managers don't like to be vulnerable so they shy away from that kind of thing, but I think they are kind of missing a trick because I think they should be having their own reflective practice, there is usefulness not having all different managers and workers in the same reflective practice to give the freedom and safety." (Participant 6).

There is clear thought that it should be separate to clinicians reflective practice, but they highlight an important consideration is it the vulnerability that is created in reflective practice having to open up and have that deeper thought process in thinking about service provision and new ways of working. I wonder if participant 6 reflected on this through the interview thinking that if managers understood the process more intimately then this would lend their support to encouraging clinical staff to attend the reflective practice session, removing some of the barriers. There is also an empathy being shown to managers that they may find this experience difficult and acknowledging that they need a separate space.

Discussion

It is arguable that the question of where the pressure comes from is from many avenues, it shows that participants very much felt the pressure of fitting another patient in, attending a meeting, or getting clinical admin tasks completed as a barrier to attending, but through reflection there was some thought that it also comes from the managerial and organisational level. However, it could be seen that if the support comes from the managerial and organisational level that these groups should be prioritised would this have an effect on changing clinicians points of view to prioritise their own need for reflection. There was no clarity of thought about this from participants and none of the participants occupied a managerial role.

5.5 Discussion

GET Theme 1: Grounding and perspective through the creation of a different space for clinicians.

Interpretations

Grounding through reflective practice was talked about in the context of moving into the group and using mindfulness to focus. This sense of being able to come into the group and slow down after maybe being in clinical sessions, was important as it was spoken about in the context of wellbeing, allowing them to bring down some of the more stressful emotions associated with clinical work. Therefore, suggesting it was the mindfulness exercise itself that is important but also giving time to focus away from the clinical context of the day-to-day activities, as reflective practice was talked about in the context of creating a safe place.

Participants very much felt they benefitted from have a space to feel safe in their thoughts and feelings. There was a context to where and how is this safety created, participants spoke about it being

created through the facilitator and the validation of feelings from others in the group. The sense that the facilitator needs to manage the space well, allowing conflict, emotive subjects, and clinical issues to be discussed, as participants can feel exposed bringing their experience of clinical work into this space. Participants gave feedback that when the space was managed well it allowed them to feel safe to discuss these issues. But alongside this there was a need for validation, that they were doing a good job and that they managed the situation well, to give them the confidence in their clinical role.

Reflective practice gave a space for freedom of expression of their thoughts and feelings, which allowed them to gain differing perspectives on their clinical work. The discussion was centred around the perspective of others, coming from the reflective team, and their own perspectives, presenting the case/clinical issue, through their own perspectives they talked about a freedom to let things out and be honest and open. But also, it was hearing others perspectives and appreciating the honesty and openness from colleagues. Through this process, it was expressed that it allowed them to gain a clarity about how they and others were feeling. This increased understanding led to being able to separate work and home, have a deeper understanding of the challenges faced and working together.

GET Theme 2: Clinicians Confidence and competence develops.

Interpretations

The concepts of competence and confidence are inextricably linked, as competence develops, a sense of knowing how to successfully, so does confidence in their ability to act. Through the discussions it became clear that it was the openness to hearing others perspectives and others hearing their perspective that was important to them. Creating this forum of being able to test their own thinking and off load what was happening in their clinical work allowed for the possibility of further exploration of thoughts of what was happening in the case more deeply. It was noted by two of the participants that it was the problem solving together through sharing knowledge, which led to positive results for them, allowing them to work out what to do next. It was through this process that participants felt their competence, knowing how to, increased. Learning was able to occur as the environment created, was described as being one of openness and not feeling judged. The reflective practice groups were portrayed as being a place where professionals with varying different experience came together to be supportive of one another, this aided in others being able to respond to reflections without feeling judged and enabled a place where they could learn from each other.

The development of confidence was described as coming from external sources, hearing it from others and needing a permission to be enable to ask questions of themselves. The external voice of others giving positive affirmations and saying you did a good job or there is not anything I would not have done differently was key in many of the transcripts. It was this sense of feeling good that participants could take forward into their clinical role and used to enable their wellbeing to improve. It would be hoped that this would be internalised into their self-esteem and confidence, which was communicated through needing permission, in that once it was given it allowed them to use this to ask more questions of themselves and to others to allow reflection to carry on beyond the group.

GET Theme 3: Clinicians feel contained through the structure of a model

Interpretations

There was a real appreciation of having a structure in reflective practice, the structure provided a frame for the session which, was described as giving purpose to the conversations as there was clear agenda, case discussion/clinical incident discussion by one person and then a reflective team that would reflect on what had been said. It was having a time to talk in contrast to having no structure, which was reported to be frustrating. This also highlighted that having a model was better than having no model, but there was no model that was described as better than the other, therefore this was inconclusive to which model would be favoured, as all the models that participants had experienced where described favourable.

Previously discussed in the sub theme of GET theme 1 (Grounding and Perspective through the creation of a different space for clinicians) was clinicians feeling safe. The theme of safety was highlighted again through having a structure in reflective practice. For this there was a feeling that it was the facilitator leading the session adhering to the model and the delivery of the model that maintained the structure allowing clinicians to experience a containment to the discussions, as it was described as feeling that they had time to talk and be heard. It was this safety that also provided clinicians with learning opportunities as they spoke about being aware of the boundaries that the model provided but that they could be pushed out of their comfort zone. This was described as being able to hear others perspectives from the reflective team and being able to see them as a way of progressing rather than criticism of what they should have done. It was that this that allowed the development of the clinician through the safety of a structure and this being managed by a competent facilitator.

The safety was also maintained through the movement into the group and out of the group. The structure had supported them to come into the group, calm and focus into being reflective. The main element was the mindfulness or check in that was highlighted by participants as this allowed them to press pause, this was also found in one of the sub themes of GET theme 1, clinicians are enabled to stop, process, and realise how they are feeling. It could be that this practical start points to the clinician leaving the clinical world as you enter the reflective practice group, providing the containment needed for clinicians to come back to the present and focus. It was not only the movement into the group but also the movement out of the group that gave clinicians a lasting sense of containment, as they spoke about having definite end and a closing of the group, although this was done in differing ways, it was discussed how they were left feeling contained. This would suggest that how the group opens and closes is an important aspect to the reflective practice groups.

The models used in the differing groups provided an opportunity for a space to be created that could not be achieved elsewhere, there was a difference that was felt about reflective practice to other meetings they attended. There was a space created by the model for discussing a case or clinical issue, the participants spoke about this opportunity as being allowed to off load and talk through the complexity of the case. It was the discussions that were generated by this and others reflecting on what they had presented that was felt important. For most it allowed them to think more deeply and critically about how they and others were responding to the issues raised by the case.

GET Theme 4: Clinicians recognising the impact of the pandemic on personal and professional life.

Interpretations

The impact of the global pandemic created a feeling of uncertainty initially and priorities changed for how services were targeted. There was two parts to this theme, what affect personally it had for them and what it meant professionally, with changes to working practices and recognising what they needed to be able to get through the pandemic.

There was a real sense of how reflective practice provided a space to think about the issues that were affecting them and how they were being affected. Isolation was emphasized by participants either for themselves or others, this seemed to depend on the resilience of the individual and the existing support in place prior to the pandemic. To support with the feelings of isolation it was discussed how the space they had in reflective practice gave time for reassurance to be offered and connection to

others, as others would reflect on the what the pandemic meant for them and a realisation that others shared their concerns. Through this process the image of reflective practice allowing them to drop the mask was given and say no I am not ok, felt powerful and gave a real understanding of how much personally this space meant to this participant. Also, it highlighted for participants that there was a sense of there being no separation between work and home, as prior to pandemic they would leave the clinic and drive home, giving time for individual reflection but this was not happening there was no separation between home and work. This made some really want to protect the reflective practice space.

For work the pandemic allowed an initial slow down until they got use to the new ways of working, with this the opportunity was created to attend reflective practice that had not been present before, however this seemed to be described as replacing the informal corridor conversations that were missing due to home working, highlighting the issue of isolation in the clinical role. The power of the impromptu conversation or the support of just being in the clinic with others seems to have been under estimated but supports with the feeling of needing to connect with others.

The global pandemic allowed many the opportunity to attend the reflective practice group and there was a recognition of how much this was needed by clinicians. The impact of reflective practice on the individual session by session was very much dependent on how the group went. There was a difference highlighted between participants on how it impacted their day. For the majority of participants, they had good experience of reflective practice that left them feeling reinvigorated and motivated, impacting positively on their clinical work by helping them face the next meeting, session, or task. Conversely when the session did not go well, they were left with feelings of being deflated and frustrated leaving them struggling to get back into work mode.

GET Theme 5: Feeling the priority of the clinical tasks above your own need for reflection – where does the pressure come from?

Interpretations

There was a conflict between if it was the internal pressure participants placed upon themselves to complete clinical work or the barrier was created by external pressures from management and the organisation. Through the discussions it was inconclusive as participants talked about both the internal

and external, therefore suggesting it could be both play an equal factor as without the pressure of external influences there would be no internal pressures placed upon themselves as clinicians.

The internal pressures came from thoughts of clinical work needing to take precedence over their own needs as clinicians for their continuing professional development (CPD). However, there was a recognition that once experienced or once reflected upon that reflective practice the benefit it provides in making clinicians more productive and motivated to engage in their clinical work alleviated the internal pressures they felt. However, the drive to attend the group needs to come from a knowledge of what reflective practice is, it was felt that this may have been a barrier to attendance. Therefore, there needs to be a focus on how it is communicated to clinicians about what reflective practice is allowing them to make an informed decision about whether they attend or not.

A fundamental issue is that the support for attendance also needs to come externally from management and the organisation, to allow clinicians to give themselves permission to attend. But equally there was thoughts that management also needed to experience reflective practice away from clinicians, so as not to create another barrier for clinicians but also showing an empathy towards managers that they need their own time to reflect.

Implications

The common theme throughout the GETs was the creation of safety and containment created through the facilitation of the group and structure of the group. The facilitation of the group was highlighted through the discussions. The group being facilitated well through managing the group dynamics and discussion created a sense of containment and safety, therefore it highlights the need for those facilitating the group to really understand reflective practice. The understanding of what is needed for a successful reflective practice group is essential and for objectivity to be maintained by the facilitator. The facilitator being able to hold the structure of the group is powerful, as the structure was agreed to be something that was important.

The structure was also important and needs to be kept in mind when creating reflective space, it was described as a frame to hold the space. It was valued as it enabled discussion to occur to open experimentation of thoughts and think purposefully about the impact of clinical work on the clinician and the patient. Without the structure and it feeling purposeful to those attending there would not be

this sense of containment and safety that is important to clinicians in having a forum to discuss clinical work especially when it is personal to them.

There is a common understanding that reflective practice creates a feeling of exposure, as it is a deeper level of thinking. There was a recognition on a fundamental human level, that the different levels of work force need separate spaces for reflective practice, that the need for clinicians and management will be different. For clinicians it was the need for appreciation and validation, that was gained through reflective practice, therefore it is important to acknowledge that this is needed in different forums as well as reflective practice. However, it is unknown what management would need as there was no member of management that took part in the interviews, but it would be understood that things they would want to reflect on would be away from clinicians.

A further implication of the research shows the impact of the pandemic and how clinicians cope and what they need when facing adverse situations. What was clear was there was an amplification of feelings and thoughts about isolation and things being different, therefore this may be getting missed in pre and post COVID-19 times around what clinicians need. The needs and wants that clinician highlighted like, time to reflect with colleagues even out of reflective practice, time to stop and process are still valid needs out of COVID pandemic times.

Limitations

The study produced a diversity of valuable and detailed material exploring the experiences of clinicians attending reflective practice groups, acknowledgement is required in regards to the limitations of the study.

First limitation that should be addressed is that all interviews were carried out via video call during a COVID-19 pandemic. While clinicians were use to this way of having meetings, supervision and therapeutic sessions, this method of interviewing is less personal and therefore some of the rapport building could have been difficult, also non-verbal cues could have been missed during the interview using this method. Participants were in their own homes or an office in the clinic, therefore this may have affected how they responded, as in a busy office environment it may have been more difficult for them to give full and honest answers.

Secondly the key researcher has knowledge and experience of the reflective practice groups and has worked with some of the participants through her job role. This bias must be acknowledged and recognise that this may have caused some response bias. The effects of this need to be recognised in the findings.

Thirdly, the sample used in this phase of the research was an all-female sample and all occupied none senior positions in the organisation. The workforce within the Midlands CAMHS service is predominately female with a small percentage of males occupying clinical positions, therefore it was likely that the sample would be predominately female. All participants had attended the reflective practice groups for differing amounts of time and this may have impacted the results also in terms of how prolonged and consistent attendance influences how the participants responded to the questions. There is also the bias to none management within the sample and as there was consideration of how management would respond to reflective practice, this was not captured in this research.

Future recommendations

This phase of the research endeavoured to explore the lived experience of community mental health clinicians experience of reflective practice during a pandemic, there is little research on this phenomenon due to the uniqueness of the time period that the research was carried out in. Further there are limited IPA studies looking at clinician's experience of reflective practice, therefore similar studies using this approach may be required to look at if similar finding would be achieved out of pandemic conditions and face to face rather than the virtual forum.

This research highlighted the importance of having a structure around the reflective practice sessions showing how the frame that was enabled to be held around the session helped support clinicians to feel safe and contained. There were limited models explored in this research, Heads and Hearts (Kurtz, 2020), Solutions Focused model for groups (Sharry, 2007) and the 5 P's formulation model (MacNeil et al, 2012), as having been experienced by clinicians, therefore future research may want to focus on the usefulness of each reflective practice model in producing a frame around the session and how this influence clinicians experience of the session.

A further consideration is the barriers to reflective practice, this was a factor that emerged unintentionally, but was an important factor for all participants, it was highlighted that the barriers that were felt were external (management and organisational) and internal (personal barriers), however it was not clear which factor was the influencing factor. Participants discussed more internal barriers but as this was not a focus of the research it maybe if this was explored more that they would emerge and would give more insight to whether it was the pressure clinicians put on themselves or the pressures felt from the organisation.

Previous research has been limited in showing positive patient outcomes after clinicians have attended reflective practice (Kashiwagi et al, 2016 and Vachon et al, 2010). The research discussed here, was limited in participants talking in detail about the outcomes for patients, although indirectly, showing how processing of their thoughts and feelings left them feeling more clarity to enable them to think about patient cases differently. Therefore, research that focuses exclusively on the outcomes for patients in terms of better outcomes, which may include sooner discharge, more appropriate interventions, changing of therapeutic modality etc, after clinicians have experienced reflective practice.

Chapter 6: Overall Discussion

This chapter draws on the results from the two phases of data collection undertaken to complete the research to understand the impact reflective practice had for clinicians working through the Covid 19 pandemic working in an NHS community setting. The chapter will start with a summary of findings from both phases of the research, which will include the impact of the Covid-19 pandemic, as this was a key element of the research. Followed by reflections on the methodology and then clinical implications from the research, which will highlight the implications of this research for ongoing and setting up of future reflective practice groups. To end the chapter the strengths and limitations of the current research and suggestions for future research will be considered.

6.1 Summary of findings

The finding from the quantitative research phase suggested that there was a stabilisation of general health, measured through somatic symptoms, anxiety/insomnia, social dysfunction, and depression. The same stabilisation over time was observed for burnout, measured through emotional exhaustion,

depersonalisation, and reduced accomplishment. However, due to not collecting enough data sets this could not be tested using inferential statistics to gain a cause-and-effect result. Therefore, due to not obtaining a significant result, the observation of stabilisation of the mean scores was explored further through data collection in phase 2 of this study by asking a direct question about stability of wellbeing, along with investigating the impact of the pandemic on community clinicians after attending reflective practice groups.

During the second phase, it was evident that reflective practice was valued. The research used an IPA approach to explore the lived experiences of clinicians attending reflective practice groups through a pandemic and the impact this had on them. Initially it was to look at how this impacted on their wellbeing but through hearing the participants experience, it became clear that lots of elements, feeling safe, the structure, impact on personal life and barriers, were of key importance for reflective practice to be useful. A key part of the research examined the effects of the COVID-19 pandemic on how clinicians coped and how reflective practice supported clinicians through this difficult time of change. Clinicians started attending reflective practice in May 2020 and there were sessions running in the service until approximately December 2022, which would have covered the major period of the COVID-19 pandemic. The interviews were carried out in September 2022 and therefore participants would have been able to reflect on the impact of the pandemic, however as the participants were no longer under the restrictions of the pandemic at work, this may have influenced how they responded to the questions about the impact of the pandemic. If the interviews had taken place through the height of the pandemic the discussions may have been more heavily influenced by the pandemic and stress levels heightened. However, clinicians may not have been able to attend as many reflective practice sessions, with less experience it may have influenced how they described their experiences.

The question of stabilisation over time was addressed through the interviews and this did not come through as a theme, however it would have been argued to have been addressed through the initial GET 1, grounding and perspective is created through a different space for clinicians, and the sub themes (clinicians feel safe in the space to open up, clinicians are enabled to stop, process, and realise how they are feeling, clinicians can be more thoughtful towards their clinical work). Through this theme it gave meaning to what caused the stabilisation over time, which may have been the containment that was experienced by clinicians by experiencing safety, pausing and being more thoughtful.

6.2 Reflections on methodology

To display a critical understanding of the methodology of enquiry with in this research, and to critically reflect on this approach, a reflection on the methodological approach used in the research is essential.

A pragmatic, mixed methods approach was used for this research to achieve the aims and objectives of the study, as it was an exploratory study to understand the lived experiences of clinicians attending a reflective practice group during a pandemic. Adopting this approach embraces two different analytical logics; an exploratory/hypotheses generating one and confirmatory/hypotheses confirmation one (Creamer and Reeping, 2020). It is argued that this approach is not simply the combination of methods but provides a different way of knowing and making sense of the world (Greene, 2007). However, there has been a lot of criticism aimed at this approach, mainly the lack of compatibility between quantitative and qualitative approaches. This is due to the approaches differing considerably with quantitative approaches being associated with positivism and qualitative approaches being associated with constructivism, these two differing worldviews it creates a conflict (Creswell and Plano Clark, 2018). Pragmatism is associated with mixed methods and therefore would fall between positivism and constructivism. The primary concern being the question being asked rather than the method of enquiry (Creswell and Plano Clark, 2018).

The quantitative approach (positivism) to research is predicted as being objective and unbiased, allowing there to be a single reality and therefore seeks to find a cause-and-effect relationship through objective measurement and quantitative analysis (Doyle, Brady, and Byrne, 2009). Using this method there may be an acceptance of this causal relationship without understanding why, this research aims to understand what reflective practice means to participants and by adopting a quantitative approach in isolation would not allow for the true meaning of the data to be understood, therefore by adopting a qualitative approach, the researcher is subjective with the focus directed at deeper understanding of what is happening with a smaller sample (Doyle et al, 2009).

Adopting a mixed methods approach is challenging and can be time consuming requiring careful planning and time management skills of the researcher. Using a pragmatic approach is described as a "question-driven philosophy" where the research question or questions is central to the research process impacting decisions about methodology and methods (Archibald, Grant, Tuot, Sewell, Price,

Grad, Shipman, Campbell, Guglani, Wood and Keely, 2023). During this research it was necessary to make decisions about the data collection phases, as the first phase took place over a 6-month period and failed to collect enough data sets to produce a cause-and-effect relationship. It therefore meant adopting more an explanatory sequential design, which meant that the quantitative informed some of the qualitative data collection to try and explain the observation in the data that was collected at the quantitative phase. There was some agreement that was able to be established between the observation of the data in phase 1 and the data collected in phase 2, however the focus of the being able to answer the research questions was based on the analysis of the qualitative data phase.

Therefore, to increase the validity and credibility of the qualitative finding other validation procedures were also considered. To make thematic connections across the transcripts, a rigorous process of coding and recoding took place with the transcripts, with the researcher taking breaks in between to take time for the analysis to occur. Recurring supervision also allowed opportunities to discuss the research reasoning.

Although the quantitative phase of data collection did not yield the results hoped for, overall, the methods adopted in this research worked well to explore and understand the experience of the participants in the research. It would be recommended that mixed methods approach be employed again to address this research paradigm but with employing different methods to collect the quantitative data.

6.3 Clinical Implications

The research has implications on how we support clinicians in clinical practice, the focus of reflective practice is to facilitate the integration of theory and practice and fosters person-centered approaches to care by providing a safe space to discuss cases and reflect on personal and professional responses (Ghaye & Lillyman, 2010). This was certainly achieved by the Midlands CAMHS service; however, the research was able to go into a greater depth finding that fundamentally this was about containment and opening up to new perspectives, which in turn should lead to better outcomes for their clinical work. It would suggest that reflective practice is something that is useful and has meaning for clinicians, therefore it should continue. But it is also about looking at those elements that were highlighted that were important to the participants.

The structure of the group was particularly highlighted to be important, it is this dimension that would suggest that the use of structure not just in this forum but other clinical forums where in-depth discussion takes place, for example multidisciplinary meetings, complex case discussion, safeguarding case discussion etc., would be beneficial. Consequently, through creating a structure it leads to more benefits as it gives scope for discussions to happen and the voice of the clinician to be heard, which is significant to build upon as this increases self-esteem and confidence (Alcantara et al, 2014 and Sim et al, 2008). But also hearing the voice of the clinician in this research stressed the importance of hearing positive affirmations and feeling appreciation in their clinical roles. Therefore, it is thinking about how this can be done more regularly within other forums.

A key aim of the research is to expand the scope of practice for health psychologists, through supporting with staff wellbeing and advising on interventions for staff. One of the roles of a Health Psychologist is to find ways to improve people's health and wellbeing, by using their skills and knowledge to synthesize evidence, develop tools and guidance and provide support. Through developing and understanding the functions of reflective practice and what it means to clinicians, this knowledge can be used to improve outcomes for clinicians and the working environment.

6.4 Strengths, limitations, and future recommendations

6.4.1 Strengths

This is the first study to look at the experience of community clinicians attending reflective practice through a pandemic going beyond the reporting of general views of reflective practice. The research produced insights that can be used to shape future research. A mixed methods approach was adopted and although the quantitative data did not produce a causal relationship it aided in informing the qualitative phase of the data collection, providing support for the aims and objectives of the study to increase understanding of the clinician's experience in reflective practice. By adopting this approach, it gave the participants the chance to discuss their lived experiences, giving the clinician a voice to hear their insights and try to truly understand their perspective.

Key points have already been discussed within this research that can inform clinical practice around the importance of reflective practice and future research should build upon this.

6.4.2 Limitations

The most notable limitation of this research is that the quantitative data could not gain cause and effect between the measures used and the impact of reflective practice on those clinicians attending the groups. The fundamental issue could have been due to the how data collection was carried out, it had to be done in a remote way due to COVID-19. Previously the key researcher would have been able to visit the reflective practice groups to gain more participants and talk about the reflective practice study.

It also must be noted that due to the nature of IPA it is focused on the detailed analysis of the phenomena under investigation, moving from the individual nuances of each transcript to the convergence and divergence between participants experiences (Tuffour, 2017). However, there is a question over the standardisation and generalisability of findings. The research is specific to this cross section of clinicians working in a CAMHS setting and thus understanding if similar findings would be found in different settings and different professional groups would still have to be investigated. Although it is a limitation there is legitimacy to the study of individual thought and thought that exists in that time and space to inform clinical practice.

The sample consisted of clinicians occupying a clinical role, there was a cross section of clinicians from differing professional background, however there was no management perspective, which may have changed the perspective of some of the themes. But also, there was no specific questions about how their professional backgrounds may influence their experience of reflective practice.

6.4.3 Future recommendations

Future research needs to go beyond the general views on reflective practice and while this study and the study by Carmichael, Rushworth, and Fisher (2020), has started building this evidence base by understanding how reflective practice is being used in practice, there is still scope to expand on this. This research has identified the need to look at other specific aspects of the clinical role, for example does the banding and professional background influence how reflective practice is used in clinical practice. By understanding the intricacies of what influences clinical practice it will have an effect of being able to shape the support and professional development that clinicians need, reflective practice builds clinicians ability to reflect and by doing this enables clinicians to access the depth of thought needed to answer what is needed.

It would also be recommended that possibly repeating the research with getting enough quantitative data sets to understand if there is a causal relationship between burnout and general health and the implementation of reflective practice does accurately predict stabilisation of clinician's wellbeing. But also, if this is related to and supports the qualitative data that was achieved. However, repeating the study would be missing a fundamental element of the research and that was the response of clinicians working through a global pandemic, but it may act as an interesting comparison study, to allow understanding if this subjective view of reflective practice was similar in none pandemic times.

Highlighted through previous research (Ahmed et al, 2022 and Ollis, 2021) and mentioned briefly in this research is the need for support from the organisation to attend reflective practice and provide this investment in clinicians. Therefore, it would be suggested that there needs to a focus on this subject and understand from both clinicians and management, what factors maybe influencing this taking an IPA approach, to gain the depth of understanding that would be needed.

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Appendix index:

Appendices 1

Systematic review

A Systematic Review of the evidence of the effectiveness of psychosocial interventions to improve the outcomes for parents of preterm infants.

Abstract:

Background: Having a premature baby can have detrimental affects on parents. Psychosocial interventions to support parents to improve psychological and physiological factors should lead to better outcomes for parents allowing them to parent their premature infant. The aim of the review is to examine different psychosocial interventions that have been put in place for parents in neonatal units and their effectiveness in improving outcomes for parents in terms of their coping and emotional wellbeing

Methods: UWE library database, Cochrane Library, Medline, Psych info and Google Scholar were searched from November 2017 to January 2018 and updated in April 2018. A total of 5436 titles were identified and 5 from other sources were also identified through a grey literature search. A total of 2633 titles and abstracts were screened, and 25 full papers were evaluated, and eight studies were identified as meeting the inclusion criteria.

Results: Interventions varied across studies categorised as a) education interventions, b) interpersonal interventions and c) Group intervention. The reporting quality of the studies varied from Strong to weak, with the majority rating as weak as measured by the EPHPP. The 8 included studies varied in interventions, 2 education interventions, 2 infant-parent interactions, 2 based on reflection, 1 relaxation and 1 empowerment support group. There was no conclusive evidence that any of the interventions would provide an effective improvement in outcomes for parents.

Conclusion: The evidence would suggest that there is no one intervention that provides a definite improvement in parental outcomes. In more than one of the studies there was more than one component to the intervention therefore it was not known which factor accounted for the outcome of the study.

1. Introduction:

Having a premature baby is a very stressful event and can increase the risk of parents experiencing a trauma reaction, (1) found it increased by 23% compared to Mother's in the well-baby nursery. This was also found in a study reporting that 30% of the sample met the criteria for PTSD one-month post follow up (2). The symptoms of PTSD are also associated with feelings of anxiety, depression and psychosomatic symptoms. Therefore with the evidence of increasing psychological and physiology symptoms being reported by mothers with a preterm infant a robust and effective intervention needs to be implemented to help this clinical population cope.

1.1 Types of interventions

There is a wealth of research that evidences the use of interventions with parents with preterm infants that are admitted to Neonatal intensive care units, however there is little agreement in the literature to suggest what intervention improves outcomes for parents. The psychosocial

interventions that have been implemented are split into three types, education interventions, Interpersonal interventions and group interventions.

1.1.1 Education interventions

Studies have that have focused on Education interventions have reported mixed results. Lee, Wang, Lin, Kao (3) found that giving fathers an information booklet with guidance from nurse practitioners found that it did increase fathers confidence in their ability to parent and in turn reduced their stress. Whereas Glazebrook, Marlow, Israel, Croudace, Johnson, White and Whitelaw (4) showed no effect of a parenting support educational intervention on parental stress.

1.1.2 Interpersonal interventions

Alternative to education interventions is the more personal interventions, psychosocial parental support programs delivered one to one have been found to reduce the stay of preterm infants (5). One to one intervention based around six sessions of cognitive behavioural therapy did not reduce the prevalence of depression and anxiety of mothers with preterm infants (6). Conversely Bernard, Williams, Storfer-Isser, Rhine, Horwitz, Koopman and Shaw (7) found that brief cognitive – behavioural intervention did reduce symptoms of depression but not trauma related symptoms. Therefore, it may be a more intensive support program is needed one to one to provide any consistent change. Jotzo and Poets (8) were able to demonstrate a positive effect of introducing a structured psychological intervention that combined crisis intervention, psychological counselling throughout the stay of the premature infant and intensive support at critical times in the NICU, the study reported that the intervention group showed lower levels of symptomatic response to traumatic stressors.

1.1.3 Group interventions

Studies have shown the usefulness of groups in providing support not only providing knowledge but emotional support to parents. Mothers do report that having a support group can help manage the experience of being on the NICU and can meet their emotional needs (9). The use of social networking sites is also a consideration when looking at providing support to parents, however Gabbert, Metze, Buhrer and Garten found that in a sample of 278 families, 64% stated that social networking sites did not meet their needs to exchange information and get support (10). This led Gabbert et al to conclude that there needed to an expert controlled social networking site provided to parents of preterm infants while on the NICU and after discharge, allowing up to date and aiding facilitation between parents (10).

There appears to be a mix of interventions that have been implemented and their effectiveness studied but producing no conclusive evidence that one intervention type is more effective than another. Interventions have focused on different samples, some including just mother, just fathers and then both parents together, again producing no conclusive evidence that a particular intervention is more beneficial for one or both parents. Considering the importance of mothers and fathers in this stressful time in an important factor.

1.2 Mothers and Fathers

Historically there has been a bias in focusing on mothers and the effect of preterm birth on mothers (11). However the importance of fathers in this highly stressful time needs to be studied for the effects this has on their own psychological well being (11). King et al (11) found that for fathers it was the story of the pregnancy in terms of the effect on their partner and after baby was born their role as father, initially being afraid to touch and hold their infant and not

experiencing the joy like fathers of full term infants do. The effect on mothers seems to be more acute in that they experience more post traumatic symptoms (1). However Gangi, Dente, Bacchio, Giampietro, Terrin and Decurtis, (12) found that including parents in the care and familiarising them with the neonatal unit in the first few weeks of their infant's life improved parental role perception and focusing on anxiety could reduce the risk of PTSD. Therefore it is important to include both parents in interventions in the NICU, especially in the first few weeks of their infant's life. But the interventions may have to be tailored to separate intervention for Mothers and fathers due to the differing perceptions as highlighted by King et al (11) and Vanderbilt et al (1).

1.3 Conclusions and aim of the systematic review

The evidence illustrated shows that there is no consistent evidence of an effective intervention that can reduce the psychological impact of having a premature infant and also the importance of having this impact measured on both parents, not mother above fathers and vice versa. Previous systematic reviews, Benzies et al (13), and Schappin et al (14) for example have focused not only on parental outcomes but also outcomes for the infants. While the positive outcomes for infants cannot be ignored it is can be said to be addressed in focusing just on parents and improving outcomes for them. Research has already shown in other fields that improving outcomes for parents has the bonus of improving child behaviour and perception of the child, this was shown in a study by Huber, McMahon and Sweller (15), through parents accessing a parent programme there was an improvement not only in parental psychological outcomes but also improved child behaviour and positive parent perceptions of their child, this was further supported by a review done by Barlow and Coren (16). The review summarized findings of systematic review and found that parenting programmes improve the psychosocial outcomes for parents but also are effective in improving emotional and behavioural outcomes for children. Therefore, the **aim of the review is to examine different psychosocial interventions that have been put in place for parents in neonatal units and their effectiveness in improving outcomes for parents in terms of their coping and emotional wellbeing** and the objectives identified are to a) to identify key components of an intervention that improve outcomes for parents b) what interventions are measuring in terms of psychological factors and c) to look at the timing of measures in terms of measuring the effectiveness of the intervention d) assess the quality of the studies and e) provide evidence for future research and clinical practice to identify an effective intervention for parents in NICU's.

2. Method:

2.1 Protocol and Registration

The PRISMA checklist for reporting systematic reviews guided the review (17). No research protocol exists.

2.2 Eligibility criteria

To identify eligible studies that focused on outcomes for parents using a psychosocial intervention a strict inclusion and exclusion criteria was used. The inclusion criteria used met the following:

1. Studies published in English in a peer reviewed journal from 2008 to 2018.
2. The gestational age of the infant had to less than 37 weeks gestation, as after the start of the 37th week is considered full term.

3. Studies should include outcomes for parents and should be the main focus for the study, studies that included both mothers and father, mothers only or fathers only were included in the review.
4. Studies had to demonstrate that a psychosocial intervention was used for parents in the intervention group that was over and above the standard care that parents normally receive within the Neonatal Intensive Care Unit (NICU).
5. All studies had to include a control/comparison group.
6. Studies had to demonstrate a clear outcome for parents, i.e. decrease in stress symptoms or improved health outcomes etc.

The exclusion criteria used met the following criteria:

1. Studies that included full term infants alongside preterm infants.
2. Qualitative studies were not included.
3. Studies that primarily focused on outcomes for infants in terms of their development, health, follow ups appointments, hospital readmission after discharge from the NICU.
4. Pilot studies as the results are preliminary, which could bias the conclusion being made.
5. Historical data being used with participants not being seen by researchers and medical files being reviewed only.
6. Systematic reviews and meta analysis

2.3 Information Sources

Systematic literature searches using the databases were conducted from November 2017 to January 2018 and updated in April 2018. The UWE library database, Cochrane Library, Medline, Psych info and Google Scholar were used limiting the search to English language only. Parameters around date, published between 2008 and 2018, were used only in the updated search in April 2018. A grey literature search was also done by searching reference lists of articles already identified and a similar systematic review (13). Also contact was made to the BLISS charity that does research with Warwick University and the lead Consultant from a local NICU unit, but no feedback was received.

2.4 Search

The following search terms were used to search the UWE library database and Google Scholar, psychosocial interventions, parents, preterm infants and outcomes. When the search terms were used with Cochrane Library, Medline and Psychinfo there were no results therefore the search terms were reduced to parents and prematurity, this allowed the articles to be screened using the exclusion and inclusion criteria.

2.5 Study selection

One reviewer screened abstracts against the inclusion and exclusion criteria and the decision to include was based on this criteria. Figure 1 illustrates the process.

2.6 Data collection Process and Data Items

One reviewer extracted the data from the articles using a data extraction sheet designed for the review. The extracted data included; participants, gestational age of infant, model, setting of intervention, design, control/comparison group, measures used and timing, results and effect size. Data extraction was then presented in Table 1.

2.7 Risk of bias in individual studies

Studies were evaluated using the Effective Public Health Practice Project (EPHPP) (18); two reviewers independently assessed the risk of bias un-blinded. The results of the global rating

of each included study are included in Table 1. Table 2 shows the results for selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop outs and global rating.

2.8 Summary Measures

The summary measures examined were the significance differences between the mean scores for the intervention/experimental group and the control/comparison group. Also within groups the significant difference between the means was also analysed, where this was reported by the author/s. Pre and post intervention p values and effect sizes were recorded, where the author/s had reported the results or calculated were there was the relevant data to do so.

2.9 Synthesis of results

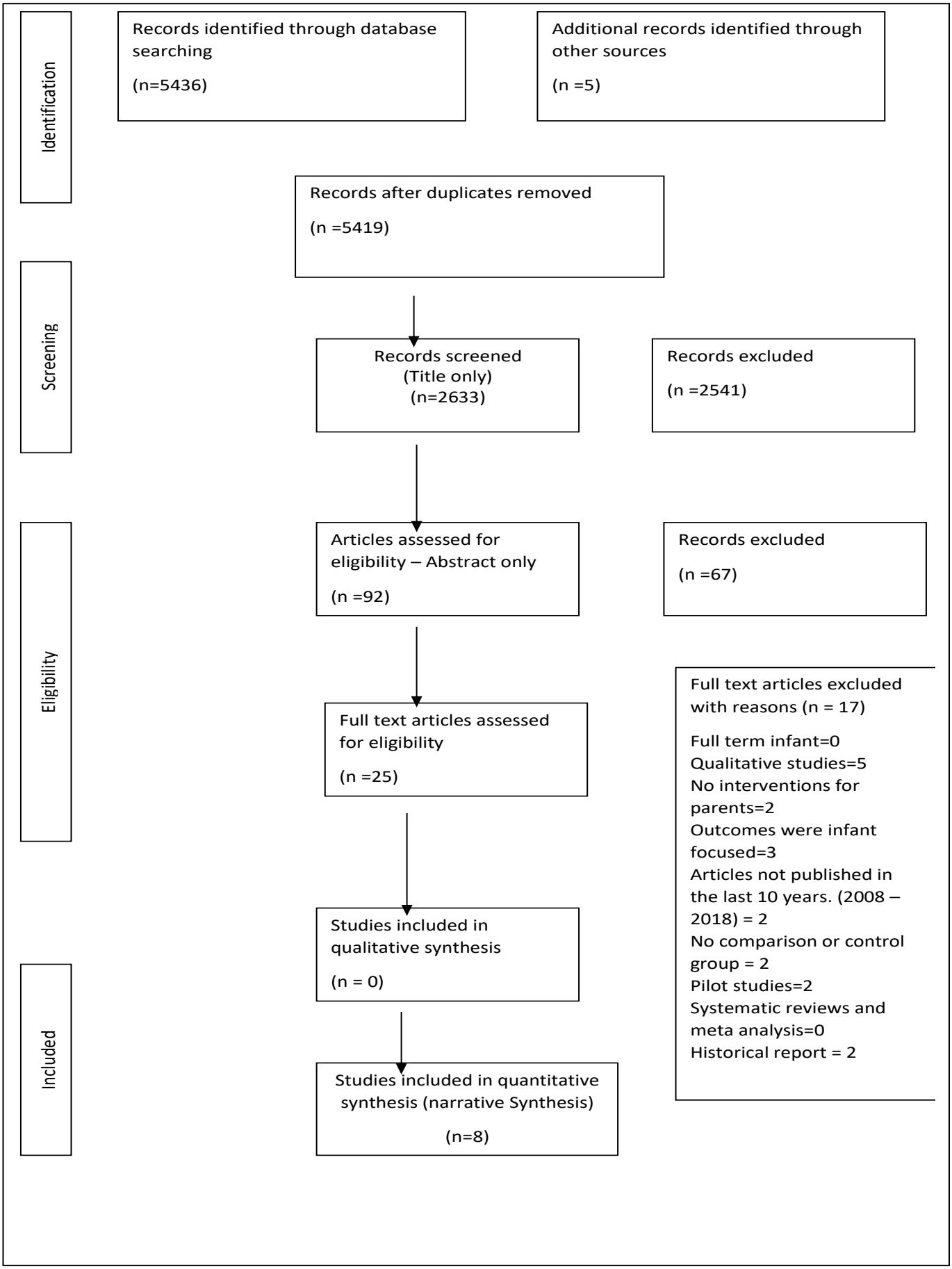
The studies used were assessed for methodological quality and diversity of intervention. While all included studies have an intervention and control/comparison group there were differences in the gestational ages of infants included in the studies, the types of interventions and although the majority of studies used a variation of the same measure, the other measures varied greatly. Therefore, given the variability in the identified studies it was deemed inappropriate to perform a Meta analysis on the data.

3. Results:

3.1 Study Selection

The initial search of UWE library database, Cochrane Library, Medline, Psych info and Google Scholar provided a total of 5436 titles and 5 from other sources were also identified through a grey literature search. Duplicates were removed and provided 5419 titles. Using the UWE library database returned the majority of titles, therefore this was further reduced by selecting only journal/e-journal, journal articles, reports and thesis and by adjusting the subject terms (families and family life, family, mother, mothers-psychology, parents and parenting, paediatric, premature birth, preterm birth and preterm infants). This yielded 2633 titles that were screened from the search of the databases, 2541 titles were excluded at this stage and 92 abstracts were reviewed. Twenty five full papers were evaluated and eight studies were identified as meeting the inclusion criteria. Reasons for exclusion are documented in the PRISMA flow chart illustrated in figure 1.

Figure 1: Prisma 2009 flow diagram


Identification
Records identified through database searching
(n=5436)
Additional records identified through other sources
(n =5)
Records after duplicates removed
(n =5419)
Screening
Records screened
(Title only)
(n=2633)
Records excluded
(n =2541)
Eligibility
Articles assessed for eligibility – Abstract only
(n =92)
Records excluded
(n =67)
Full text articles assessed for eligibility
(n =25)
Full text articles excluded with reasons (n = 17)
Full term infant=0
Qualitative studies=5
No interventions for parents=2
Outcomes were infant focused=3
Articles not published in the last 10 years. (2008 – 2018) = 2
No comparison or control group = 2
Pilot studies=2
Systematic reviews and meta analysis=0
Historical report = 2
Included
Studies included in qualitative synthesis
(n = 0)
Studies included in quantitative synthesis (narrative Synthesis)
(n=8)

3.2 Study characteristics

Five of the studies included both parents (19,20,21,22,23), three of the studies just focused on Mothers (23,24,25) There was a total of 582 participants included in the studies, 352 of the sample were mothers and fathers (19–22,26), the remaining 230 were mothers only, (23–25). There were a range of interventions used across studies, those that centred on the parent-child relationship (21,24), two studies that focused on the mothers and fathers reflection(19,23). Both Turan et al, (26) and Carvalho et al, (25) had an education element to their interventions. Lui et al (22) employed a support group delivering Empowerment strategies and Fotiou et al (20) focused on the effect of relaxation on mothers and fathers. All studies used a control/comparison group to compare to the intervention group(19–26). The outcomes for parents/mothers focused on improving their emotional wellbeing, in particular stress(19–22,24,26), anxiety both state and trait (25,26), PTSD (23), Depression (22–25), Health utilisation of and physical health of participants,(23) and self-efficacy(22).

3.3 Participants

Five studies included both mothers and fathers (19–22,26). Weis et al (19) was the only study to compare scores on all measures used between Mothers and fathers, finding that there was significant difference between mothers and fathers stress total score, on the subscales measured, parental role and infant behaviour but not for sights and sounds in the NICU and experience of nursing support. Matricardi et al (21), did compare results between mothers and fathers, however only reported that there was a significant difference for the subscale of parental role, suggesting that the total stress score, sights and sounds and infant behaviour were not significant. The three studies (20,22,26) that did not compare mothers and fathers focused their results on the comparison between the intervention and control group.

3.4 Intervention Characteristics and effectiveness

The aim of all the studies was to implement an intervention to improve the emotional and psychological health of parents involved in the studies, by measuring the effect of the intervention on one or more of the following outcomes stress, anxiety, PTSD symptoms, self efficacy, depression, reduce use of health services and improve physical health. There was a diversity of interventions used in the eight included studies. All results of the eight included studies are presented in Appendix A, with statistics reported to a least two decimal points, a summary of the results are present in Table 1.

3.4.1 Education

Two studies used an education-based intervention; this would involve educating the parents about the NICU environment, their babies care, possible treatment etc, either through audio visual and print materials (25) or one to one education session (26). Turan et al (26) was able to demonstrate a reduction in parental stress compared to the control group, ($p = 0.000$, $d = 2.11$). Both studies looked at the effect of the intervention on trait anxiety, Carvalho et al (25) did not find that the intervention had an affect ($p = 0.97$, $d = 0.0001$), where as Turan et al (26) was able to demonstrate using the intervention there was a significant reduction in trait anxiety in both mothers ($p = >0.05$, $d = 0.07$) and fathers ($p=>0.05$, $d = 0.23$). Carvalho et al (25) also included state anxiety and depression again there was no significant effect of the intervention between groups, however there was a significant difference in terms of the measurement between admission of their infant and discharge in the intervention group. Turan et al (26) only measured at one time period, 10 days after admission.

Author	Participants	Model and setting of intervention	Intervention delivery	Design	Control or comparison group	Measures and timing	Results	Effect size	Bias measured by EHCPP
Carvalho, Beatriz, Linhares, Padovani and Martinez (2009)	59 mothers	Psychological support and education Hospital of Clinics at the school of Medicine – Brazil	Psychological intervention centred in the hospital part of standard care and supported with audio visual and print materials offered in the first two care sessions intended for intake of mothers (G1)	Comparison study	23 mothers – received psychological intervention centred in the hospital by a psychologist as routinely until the time of the study beginning. (G2)	State-Trait Anxiety inventory (STAI), Beck Depression inventory (BDI), questionnaire for characterisation of mother, video of the Intervention Program for Mothers of Preterm Babies, Support book for psychological guidance for mothers of preterm newborns, Clinical risk Index for Babies and medical chart of the infants. At admission and after discharge at their first follow up appointment.	Maternal state anxiety prior to psychological intervention (T1) and discharge (T2) in G1 and G2. Moment (evaluation and re-evaluation) – p = 0.0001 Moment x Type of intervention – p = 0.42 Comparison between G1 and G2 – p = 0.53 Trait anxiety: Moment – p = 0.001 Moment x Type of intervention – p = 0.76 Comparison between G1 and G2 – p = 0.97 Depression: Comparison between type of intervention and time of evaluation: Moment – p = 0.04 Moment x type of intervention – p = 0.75 Comparison between G1 and G2 – p = 0.47	d = 0.24 (small) d = 0.01 (small) d = 0.007 (small) d = 0.16 (small) d = 0.002 (small) d = 0.0001 (small) d = 0.07 (small) d = 0.002 (small) d = 0.009 (small)	Strong
Fotiou, Vlastarakos, Bakoula, Papagroufa	66 parents	Relaxation NICU of a tertiary maternity	Group delivery: Control group: accessed 5	RCT	28 Parents	Perceived stress Scale (PSS:14), State-trait anxiety inventory	Within groups: Intervention group: PSS:14 – p=0.056, STAI (1)– p=**0.026**,	Effect sizes not recorded due to not having means for each group,	Weak

lis, Bakoyannis, Darviri and Chrousos (2015)		hospital, Greece	interactive sessions lasting 90 minutes. Intervention group: 5 interactive sessions plus relaxation (Progressive muscle relaxation, guided imagery and diaphragmatic breathing)			(STAI) and Salivary cortisol levels Psychometric tests: 10-15 days after infants delivery and 3 months after discharge from NICU. Salivary Cortisol levels measured 3 times daily.	STAI (2 – p=0.071, Salivary Cortisol: AM – p =0.114, 30 mins after waking – **p=0.012**, PM – p=0.659 Control Group: PSS:14- p= 0.113, STAI (1) – p= 0.069, STAI (2) – p= 0.190, Salivary cortisol: AM – p= 0.292, 30 mins after waking = 0.749, PM – p=0.342 Between Groups: PSS:14- p= 0.699, STAI (1) – p= 0.515, STAI (2) – p= 0.020, Salivary cortisol: AM – p= 0.940, after waking = 0.263, PM – p=0.636	only given difference between the mean.	
Horsh, Tolsa, Gilbert, du Chene, Muller-Nix and Graz (2016)	65 Participants (mothers only in study)	Expressive writing NICU in university hospital – Switzerland	Workbook with written instructions. Participants has to write 3 narratives about their deepest thoughts and feelings about the most traumatic experience relating to the birth and hospitalisation of your	RCT	32 Mothers received treatment as usual and sent same questionnaire pack.	Primary Outcomes: Perinatal PTSD questionnnaire (PPQ) Edinburgh Postnatal depression Scale (EPDS) Seconday Outcomes: SF36 Health Survey and use of healthcare services. Measured at 3, 4 and 6 months post discharge,	Post traumatic stress: PPQ – comparison of expressive writing group (EWG) to Control group (CG): 3-4months – p = NS 3-6 months – p = NS Depression: EPDS comparison of EWG to CG: 3-4 months – p = NS 3-6 months – p = <0.05 Mental health: SF – 36 comparison of EWG to CG 3 – 4 months – p = NS 3 – 6 months – p = NS	 d = 0.37 (small) d = 0.42 (small) d = 0.22 (small) d = 0.67 (med) d = 0.12 (small) d = 0.21 (small)	Moderate

			premature baby.				Health care utilisation: Number of health care professionals seen comparison of EWG to CG 3-4 months – p = NS 3-6 months – p = <0.05 Number of non-medical specialists seen comparison of EWG to CG 3-4 months – p = <0.05 3-6 months – p = NS		
Liu, Chao, Huang, Wei and Chien (2010)	70 parents (15 fathers and 55 mothers)	Empowerment strategies support group. NICU at a medical centre in Northern Taiwan	Received 6 sessions of empowerment strategies in a support group format – elements included partnership, participation and collaboration, self awareness and self help.	Quasi experimental design	35 parents who did not attend the initial support group.	Modified Maternal Confidence Questionnaire (MFQ) measuring self efficacy in the maternal role. Resource-utilisation confidence questionnaire (RUCQ) measuring self efficacy when using resources to solve child rearing issues. Perceived Stress Scale (PSS) measuring stress and Beck Depression Inventory (BDI) measuring parental stress. Collected at the times of recruitment - infants discharge from the NICU and 3	Comparison of scores on self efficacy-parental roles: Pre intervention between intervention group and control group: All (70) – p = 0.29 < 1500g (24) – p = 0.58 ≥1500g (46) – p = 0.07 Post intervention between intervention group and control group: All (70) – p = 0.05 < 1500g (24) – p = 0.89 ≥1500g (46) – p = 0.03 Difference between pre and post measurements between groups: All (70) – p = 0.56 < 1500g (24) – p = 0.52 ≥1500g (46) – p = 0.71	No effect sizes were reported.	Weak

						months post discharge.	Self Efficacy-utilising resources: Pre intervention between intervention group and control group: All (70) – p = 0.13 < 1500g (24) – p = 0.93 ≥1500g (46) – p = 0.05 Post intervention between intervention group and control group: All (70) – p = <0.001 < 1500g (24) – p = 0.005 ≥1500g (46) – p = <0.001 Difference between pre and post measurements between groups: All (70) – p = 0.007 < 1500g (24) – p = 0.04 ≥1500g (46) – p = 0.11 Perceived stress: Pre intervention - intervention group and control group: All (70) – p = 0.94 < 1500g (24) – p = 0.01 ≥1500g (46) – p = 0.04 Post intervention-intervention group and control group: All (70) – p = 0.10 < 1500g (24) – p = 0.53		

							≥1500g (46) – p = 0.10 Difference between pre and post measurements between groups: All (70) – p = 0.16 < 1500g (24) – p = 0.006 ≥1500g (46) – p = 0.66 Depression: Pre intervention- intervention group and control group: All (70) – p = 0.45 < 1500g (24) – p = 0.27 ≥1500g (46) – p = 0.85 Post intervention between intervention group and control group: All (70) – p = 0.001 < 1500g (24) – p = 0.52 ≥1500g (46) – p = 0.001 Difference between pre and post measurements between groups: All (70) – p = 0.004 < 1500g (24) – p = 0.12 ≥1500g (46) – p = 0.03		
Matricardi, Agostini, Fedeli, Montirosso (2012)	42 participants (mothers and fathers)	Pre and post intervention at a hospital in Rome	Joint observation method and infant massage	RCT	Standard support group – n=21	Socio-demographic questionnaire, Neonatal Acute Physiology Perinatal Extension II, PSS:NICU	ANOVA yielded significant parent affects in each sub scale of the PSS:NICU: Sights and Sounds – p = <0.05 Infant appearance and behaviour – p = <0.01	d = 0.06 (small) d = 0.10 (small)	Weak

						First week of admission and upon discharge of infant.	Parental Role Alteration – p = <0.001 Time of Assessment Factor: Higher related stress at admission compared to discharge: Sights and Sounds – p = Not significant Infant appearance and behaviour – p = Not significant Parental Role Alteration – p = <0.01 There was a significant 2 way interaction between group and time: Sights and Sounds – p = <0.05 Infant appearance and behaviour – p = <0.001 Parental Role Alteration – p = <0.001	d = 0.15 (small) d = 0.00 (none) d = 0.00 (none) d = 0.14 (small) d = 0.05 (small) d = 0.15 (small) d = 0.22 (small)	
Ravn, Smith, Smeby, Kynoe, Sandvik, Bunch and Lindemann (2011)	106 participants (mothers)	Mother – Infant Transaction Program (MITP) Urban level 3 Hospital, Norway	MITP- 11 sessions one hour standardised intervention program. Aim is to get parents to appreciate their infant's characteristics,	RCT	50 mothers and infants received standard care	The centre for Epidemiological Studies Depression Scale (CES-D) measured at one month after discharge, 6 and 12 months, Breastfeeding self report – 6, 9 and 12 months, Parenting Stress Index – PSI short version at 6	Maternal depression: 1 month after discharge mothers in intervention group reported less somatic symptoms on CES-D than the control group – p = 0.05 Same observed for depression scores – p = 0.04 Significant decrease of depression scores for IG and	d = 0.44 (small) d = 0.43 (small)	Strong

			temperament and developmental potential to assist parents in being more responsive to physiological and social cues, stimulus overload and establish a good pattern of interacting.			months and PSI long version at 12 months, Infant behaviour questionnaire – 6 and 12 months, Questionnaire about infant communication skills – 12 months.	CG from 1 to 12 months – p = <0.001 Parenting Stress: compared IG and CG at different time periods. At 6 months – p = 0.08 At 12 months – p = 0.46	 d = 0.41 (small) d = 0.16 (small)	
Turan, Basbakkal and Ozbek (2008)	20 mothers and fathers – control group 20 mothers and fathers in experimental group	Nursing intervention in a 15 bed unit of a Turkish university hospital	Intervention group received a one to one face to face education information sessions and shown round the unit, introduced to staff, the machinery and infants condition and treatments that may be used.	Randomised interventio n	20 mothers and fathers	Trait Anxiety inventory (TAI) and the Perceived stress scale: Neonatal Intensive Care Unit (PSS:NICU) 10 days after admission.	Between groups: TAI mothers = p >0.05 TAI fathers = p >0.05 PSS:NICU: Sights and sounds = p- 0.008, Infants appearance and behaviour = p- 0.157 Parental role alteration = p-0.000, Total = p-0.000. Comparisons of Fathers mean scores- PSS:NICU control group compared to intervention were not significant: Sights and Sounds-p = 0.053 Infant appearance and behaviour – p= 0.628 Parental Role Alteration – p = 0.793	 d =0.07 (small) d = 0.23 (small) d = 0.74 (med) d = 0.5 (med) d = 2.11 (large) d = 0.43 (med) d = 0.68 (med) d = 0.16 (small) d = 0.22 (small)	Weak

							Total score – p = 0.256	d = 0.38 (small)	
Weiss, Zoffman, Greisen, Egerod (2013)	134 Parents (78 families)	Guided Family-Centred Care Intervention (GFCC) Level 3 NICU at a Danish University referral hospital.	Parent – nurse delivery GFCC and Standard Care (SC)	RCT	60 parents (33 families)	Demographic information taken. Intervention group had reflection sheets to prepare for dialogues – during time in the NICU, Perceived stress scale: Neonatal Intensive Care unit (PSS:NICU) and Nurse Parent Support Tool (NPST)- completed on discharge (45 families), 70% had 3+ planned GFCC dialogues, 18% - 2 dialogues and 1% had one dialogue. 50% of the SC group had 3+ unplanned parent-nurse meetings.	Intervention group – Primary outcome measure PSS:NICU did not vary significantly between control group (CG) and intervention group (IG)(p=0.28). PSS:NICU subscales: Sights and Sounds = p = 0.07 Infant behaviour = p= 0.127 Parental role = p = 0.69 NSPT – no significant difference between the two groups (p=0.86) Difference between Mothers and Fathers reported: PSS:NICU total stress score p= 0.0006 Subscales: Sights and sounds p = 0.08 Infant behaviour p = 0.04 Parental role p = 0.00004 NPST p = 0.83	d= 0.14 (small) d=0.28 (small). d = 0.22 (small) d = 0.07 (small) d = 0.02 (small) d = 0.33 (small) d= 0.16 (small) d = 0.26 (small) d= 0.58 (med) d = 0.02 (small)	Moderate

Table 1: Characteristics and Results of studies

Carvalho et al (25) presents strong methodological quality, however the results of the intervention suggest that the intervention implemented, audio visuals and print materials, was not effective in reducing anxiety and depression when compared to the control group. However there was a significant reduction in anxiety and depression when just focusing on the intervention group. It is important to note in this study both groups received psychological interventions as part of the standard care. Turan et al (26) intervention group just received the one to one education session alongside the normal standard care that the control group received. The methodological quality of this study was weak, therefore suggesting the results are biased.

Both studies do show that an education intervention can have some affect on improving psychological outcomes for parents, Carvalho et al (25) in terms of change over time and Turan et al (26) demonstrated a significant difference between the intervention group and the control group; however this needs to be approached with caution as it could be that it is the combination of the standard care and education that ultimately yielded the outcome observed. Further to this the study that demonstrated a strong methodological quality showed no significant effect of the intervention compared to the standard care group. The time period that was used in both studies was different therefore had Turan et al (26) measured over the same time period the results may have been different. Therefore, this would provide inconclusive evidence for an education intervention effecting outcomes for parents with a preterm infant.

3.4.2 Individual focused interventions

Infant – Parent Interaction

There were similarities in the interventions used by Matricardi et al (21) and Ravn et al (24) as they both focused on how the interaction between parent and infant could improve emotional health, this took the form of guided interactions, however Matricardi et al (21) also included baby massage. Both studies focused on reducing stress in parents; however Ravn et al (24) only included mothers in the study and also looked at reducing depressive symptoms.

The infant – parent interaction interventions had conflicting results in reducing parental stress. Matricardi et al (21) reported a significant effect of group and time (admission and upon discharge) on reducing stress in terms of the different aspects of the NICU environment, sights and sounds ($p = <0.05$, $d = 0.05$), infant behaviour ($p = <0.001$, $d = 0.15$) and Parental role alteration ($p = <0.001$, $d = 0.22$). All the effect sizes are small suggesting a trivial difference between the 2 way interaction of group and time, also the quality of the study was weak, suggesting bias within the study. Ravn et al (24) reported that the intervention did not reduce the stress of parents at two follow up periods, 6 months post discharge ($p = 0.08$, $d = 0.41$) and 12 months post discharge ($p = 0.46$, $d = 0.16$). Both studies used different time periods therefore had Ravn et al (24) measured at the same time periods as Matricardi et al (2012) this may have shown that infant parent interaction interventions were effective in reducing parental stress. However, Ravn et al (24) did report that the intervention was effective in reducing somatic symptoms and depression ($p = 0.04$, $d = 0.44$). The methodological quality Ravn et al (24) was assessed as being strong therefore this would suggest a lack of bias and thus the

results reported could be assessed as being more representative of the target population and outcomes measured.

It may be that the difference between the infant – parent interaction intervention used by both studies may only have an effect on reducing one aspect of psychological outcomes for parents, however Matricardi et al (21) did not include depression as one of the studies outcomes. Both studies had stress as an outcome, although used different measures and there was no consistency in the results of the studies.

Interpersonal communication – reflection
Interventions that included reflection as the main focus of the intervention was included in two studies, Guided family care that relied on reflection sheets to guide dialogues between parents and nursing staff (19) and the second asked parents to complete three expressive narratives that focused on the trauma related to the birth and hospitalisation of their premature baby (23). Both studies looked at different outcomes for parents and Horsh et al (23) only included mothers in the study.

Both studies methodological quality was assessed as being moderate, which would indicate a moderate risk of bias. Weis et al (19) implemented intervention demonstrated no significant effect of the intervention on reducing parents stress, ($p = 0.28$, $d = 0.14$). However between mothers and fathers total stress score there was a significant effect ($p = 0.0006$, $d = 0.33$). This would indicate that there is a difference in how parents cope with stress within the NICU environment. Although Horsh et al (23) did not consider the outcome of stress, the study demonstrated a positive effect of the intervention on reducing depression, from 3 to 6 months post discharge, ($p = <0.05$, $d = 0.67$). The study further demonstrated that the intervention reduced mothers use of health care services over the same time period ($p = <0.05$), however the reduction of none medical professionals was only observed from 3 to 4 months post discharge ($p = <0.05$) and not 3 to 6 months post discharge. The intervention had no effect between groups on Post Traumatic Stress reduction, however within groups was reported as having an effect on the intervention group at both time periods (3 to 4 months – $p = 0.013$) and (3 to 6 months – $p = 0.029$). This effect was observed for the intervention group in all outcomes (Depression, health care utilisation, physical health and mental health) suggesting that there was a positive outcome for those mothers in the intervention group.

This would suggest that utilising reflection as part of an intervention may be beneficial when considering the trauma related with having a premature infant to improve symptoms of depression, physical and mental health, rather than just focusing on stress reduction as Weis et al (19) demonstrated.

There is no conclusive evidence that would favour one individual focused intervention in improving outcomes for parents.

3.4.4 Group interventions

Support Group
One of the studies utilised empowerment strategies to increase parent's self-efficacy, (22). The intervention measured the outcomes of self-efficacy in the maternal role and in using resources, depression and stress to assess its effectiveness at

admission, discharge and 3 months post discharge. The empowerment strategies had a significant effect on self-efficacy when using resources ($p = 0.007$) and depression ($p = 0.004$). For all other measures there was no difference between the intervention group and the control group.

The power of the results is affected by the weak methodological quality of the intervention increasing the risk of bias. Therefore, any significant effect of the intervention should be considered with caution, the results suggest that empowerment strategies have a positive effect on self-efficacy using resources and depression. However, the intervention was a group intervention therefore you cannot rule out the possibility of the effect of group support and shared experience.

Relaxation

A relaxation intervention was implement, which included progressive muscle relaxation, guided imagery and diaphragmatic breathing, (20). The intervention showed a positive effect on reducing trait anxiety ($p = 0.020$), this was not supported by the comparison between the baseline measure (10-15 days after delivery) and 3 months post discharge. The intervention did not have an effect on the other outcomes of state anxiety and stress, however state anxiety was found to reduce when time periods were compared in the intervention group ($p = 0.026$). The inconsistency in results could be explained by the weak methodological quality of the study.

The results suggest that trait anxiety is reduced by relaxation techniques at 3 months post discharge, however the immediate effect while parents were in the NICU was not assessed or longer term affects

3.5 Risk of bias within studies

Table 2 shows the risk of bias for each individual study included in the review. Relaxation, Empowerment strategies, joint observation method and infant massage and Nursing education intervention were deemed to be at high risk of bias.

Risk of bias across studies

In all the studies there was no true control group as all participants received standard care, which takes the form of daily updates about their infants condition, informal discussions with the nursing staff and doctors. In one of the studies psychological support comes as part of the standard care that parents receive when their infant is admitted (Carvalho et al, 2009).

	Selection Bias	Study design	Confounders	Blinding	Data Collection	Withdrawals and Dropouts	Global rating
Carvalho et al (2009)	Moderate	Moderate	Strong	Moderate	Strong	Strong	Strong
Fotiou et al (2015)	Weak	Strong	Strong	Weak	Strong	Moderate	Weak
Horsch et al (2016)	Moderate	Strong	Strong	Weak	Strong	Strong	Moderate
Liu et al (2010)	Moderate	Weak	Strong	Weak	Strong	Weak	Weak
Matricardi et al (2012)	Moderate	Strong	Strong	Weak	Strong	Weak	Weak
Ravn et al (2011)	Moderate	Strong	Strong	Moderate	Strong	Strong	Strong
Turan etal (2008)	Moderate	Strong	Strong	Weak	Strong	Weak	Weak
Weis et al (2013)	Moderate	Strong	Strong	Weak	Strong	Strong	Moderate

Table 2: Risk of Bias for studies utilised using the EPHPP

Discussion

Having a premature infant admitted to the NICU can result in parents experiencing adverse psychological and physiological outcomes and therefore receiving a psychosocial intervention can be advantageous. The aim of this systematic review was to examine different psychosocial interventions that have been put in place for parents in neonatal units and their effectiveness in improving outcomes for parents in terms of their coping and emotional wellbeing. An additional aim was to identify any implications for policy, practice and development of any future research.

Education interventions were shown to have inconclusive evidence to their effect on outcome for parents, while one study showed that there was change over time in the intervention group and demonstrated a strong methodological quality, it did not show a significant effect of the intervention when compared to the control group (25), the second study demonstrated a significant effect of the intervention (26).

The period that was used in both studies was different and this was the only factor in demonstrating the effectiveness of an intervention, as the sample utilised was a convenience sample. The sample size of both studies was small (59 and 40) and therefore a response bias could have been measured, as both studies did not blind the participants to which group they were in. Turan et al (26) had low retention rates of participants and therefore this reduced the samples size, also the effect size was small suggesting a trivial difference between the samples.

Carvalho et al (25) produced audio visuals and print materials given to parents in one off session and this was the only difference from the control, both groups received psychological intervention, therefore the intervention given did not have a strong enough affect to change parents' outcomes significantly. Turan provided one

to one education sessions, which could explain the difference and therefore it maybe that a one to one approach or face to face is an important component in the delivery of an intervention.

Interpersonal interventions did provide the face to face component and the two studies utilized gave inconclusive evidence for the use of Infant – parent interaction. In both studies there was only a change in one or two of the outcomes identified not all that were measured. It maybe that the this type of intervention targets specific psychological outcomes for parents. Both studies included stress, Matricardi et al (21) demonstrated a change, however Ravn et al (24) did not. However, Ravn et al (24) demonstrated a strong methodology and therefore it could be concluded that this provided the most meaningful results suggesting that their infant – parent interaction was more effective. However, this was based on one study, therefore it would be important to look to other studies that used the same infant-parent interaction. Newnham, Milgrom and Skouteris (27), showed a positive effect on mother's being less stressed by their infant post discharge using the infant-parent interaction program.

The time period that the studies used differed greatly, Matricardi et al (21) using focused on the time period in the NICU, whereas Ravn et al (24) focused on the time period after discharge. This demonstrates further evidence that the time period that the effectiveness of interventions is measured over may be key in producing meaningful results. Matricardi et al (21) also importantly picked up on the component of the interventions, bringing up the issue of researching needing to ascertain which part of an intervention brought about a change.

Using a reflection intervention also yielded similar results to the previous two intervention outcomes, that there is a conflict in demonstrating effectiveness of the intervention. The results from these studies (19,23) suggested that considering the trauma of having a premature infant and looking at the most frequent psychological and physiological symptoms reported by mothers and fathers would be beneficial. Both studies produced positive improvements in the outcomes measured, Weis et al (19) reported the difference between mothers and fathers stress score, demonstrating the difference between how they cope in the NICU environment, this was also reported by (11) to be an important factor.

The timing of the intervention in both studies was different, one was carried out while still in the NICU (19) and the second was after discharge (23), this would suggest timing is a key factor in implementing an intervention. Although a lot research suggests that early intervention is recommended (13). Horsh et al (23) provides a cost-effective intervention, as it is parent led.

The group interventions used differed from those already described, relaxation (20) and empowerment strategies (22). Both interventions only demonstrated an effect on one or two of the outcomes identified. This would highlight the possibility that certain intervention has the effect of changing specific outcomes for parents and therefore a combination of interventions needs to be developed. However, the results of the two studies do need to be approached with caution as the overall methodological quality was weak in more than one criterion.

The relaxation intervention provided group sessions for parents around differing techniques and then relied on parents to carry this on after discharge, therefore there will be a danger of extinction and thus the follow up after 3 months would not be measuring the effectiveness of the intervention. The intervention group were also exposed to an education session prior to having the relaxation, therefore like one of the parent-infant interaction interventions it is not known which component had the effect of the improvement in anxiety.
Empowerment strategies provided little impact on improving outcomes for parents. They did not employ random assignment of the group participants, as participants that turned up to the first session were included in the intervention group and the conditions were not blinded, therefore this could have produced a placebo effect, as participants may have been motivated to attend. Attendance at a support group can also lead to change without any other factors been employed. Empowerment could also be seen to be a factor in the infant-parent interactions as both interventions supported parents to care for their infant and the encouragement to do so. Therefore, it could be argued that empowerment is a powerful component in any intervention.

All studies had a control group; however, the group was often referred to as the Standard Care group as it would be unethical not to provide parents with no support. Furthermore, all studies had relatively small samples, therefore this may account for those studies that did not demonstrate a effect or the experimental design was not powerful enough to detect a meaningful change in parents when they were exposed to the intervention. There were a few studies that had more than one component to their study, therefore it was difficult to assess if one of more elements of the intervention was having an effect.

The review focused on articles published in English only, therefore articles published in different languages with the same clinical sample may have yielded other results. The studies were restricted by date and with the inclusion and exclusion criteria yielded a small assortment of studies to be analysed. The review focused on studies that produced quantitative results and it could be that including studies that had a qualitative data could have produced more rich data in terms of what intervention work best with this clinical population.

Conclusion

The evidence would suggest that there is no one intervention that provides a definite improvement in parental outcomes, also there were studies that included more than one component to their intervention and the results reported did not measure each individual component therefore it was not known which factor accounted for the outcome of the study. The studies all have a control group but this group all received standard care, which always provides a form of support for parents, thus it could be that all parents improved in the outcomes measured due to the support they received on the unit therefore not producing a big enough effect for the standard questionnaires to identify. Each of the studies used different time points to measure the effectiveness of the studies, therefore it is difficult to compare the results. Furthermore, all eight studies had a relatively small sample, average sample size was 73, therefore this may account for the results reported as it will reduce the confidence level and the power of the study.

Recommendations for future research

Leading on from the conclusions drawn it may be that a combination of outcomes is needed to demonstrate a meaningful improvement in parents psychological and physiological health or each individual component is studied to understand the effect that it has on the outcome for parents. The conclusion of this systematic review is similar to that provided by Benzies et al (13) systematic review that focused on key components of early intervention programs for preterm infants and their parents suggesting that components of interventions that proved to be successful should be combined in a large-scale randomised control trial (RCT) to understand better the outcomes for parents and their preterm infants.

It may be beneficial to study the effect of interventions at different time points to understand when the most optimal time would be to measure the effectiveness of the intervention. The intervention could also be implemented at different time points to comprehend when the best time is for an intervention. Alternatively, it could be that qualitative study that includes interviews or a focus group of ex NICU parents is used to gain insight into what they would have found useful and when.

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parents of very low birth weight infants: Experiences and the potential of a dedicated site. European Journal of Pediatrics. 2013;172(12):1671–7.
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Behavioural Development; 2012;35(1):36–47.
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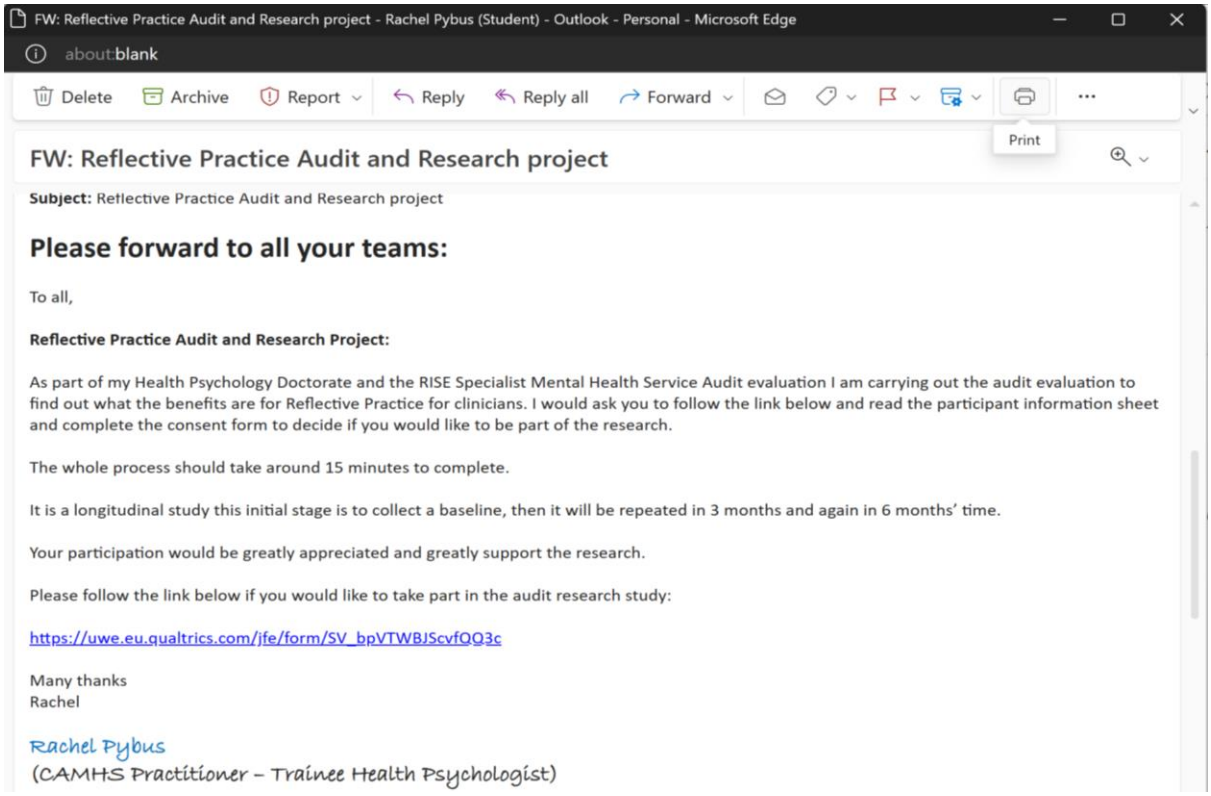
Appendix 2 – Baseline email



FW: Reflective Practice Audit and Research project - Rachel Pybus (Student) - Outlook - Personal - Microsoft Edge

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FW: Reflective Practice Audit and Research project

Subject: Reflective Practice Audit and Research project

Please forward to all your teams:

To all,

Reflective Practice Audit and Research Project:

As part of my Health Psychology Doctorate and the RISE Specialist Mental Health Service Audit evaluation I am carrying out the audit evaluation to find out what the benefits are for Reflective Practice for clinicians. I would ask you to follow the link below and read the participant information sheet and complete the consent form to decide if you would like to be part of the research.

The whole process should take around 15 minutes to complete.

It is a longitudinal study this initial stage is to collect a baseline, then it will be repeated in 3 months and again in 6 months' time.

Your participation would be greatly appreciated and greatly support the research.

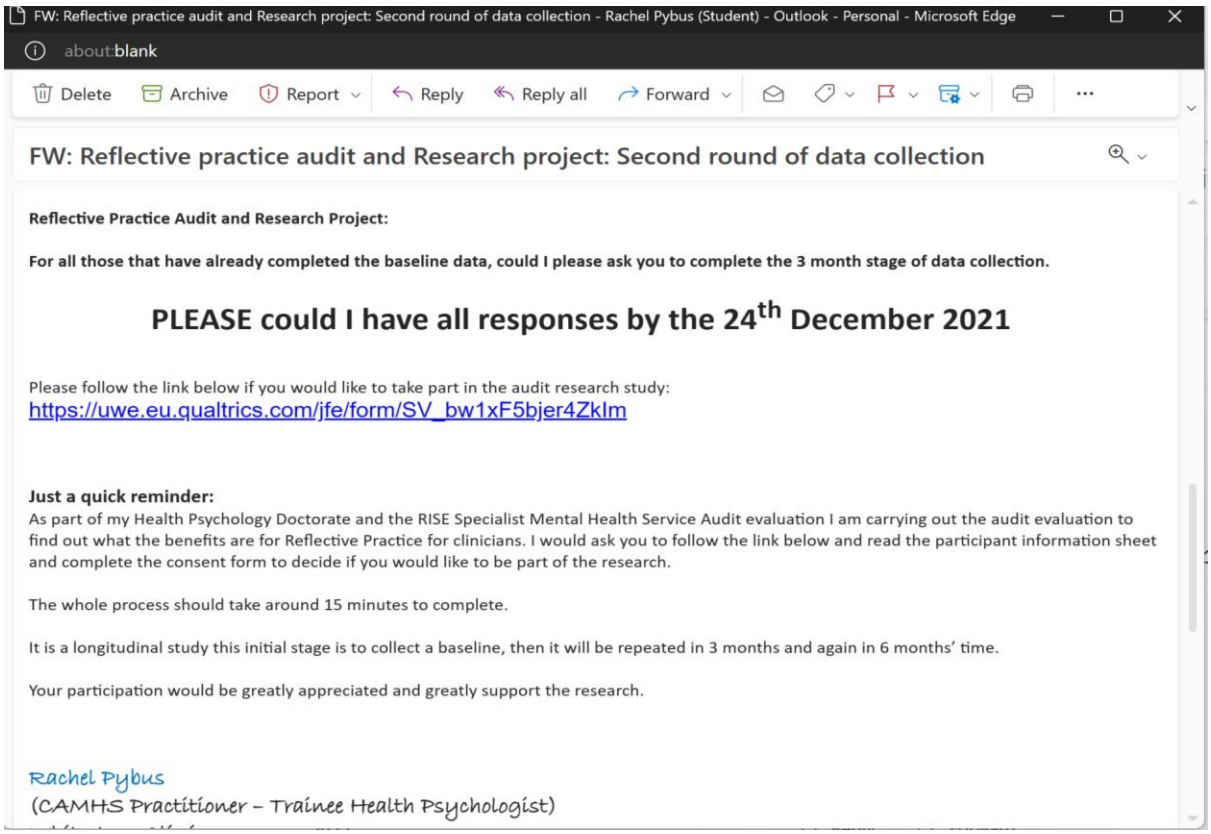
Please follow the link below if you would like to take part in the audit research study:

https://uwe.eu.qualtrics.com/jfe/form/SV_bpVTWBJScvfQQ3c

Many thanks
Rachel

Rachel Pybus
(CAMHS Practitioner – Trainee Health Psychologist)

Appendix 3 – 3 month email



FW: Reflective practice audit and Research project: Second round of data collection - Rachel Pybus (Student) - Outlook - Personal - Microsoft Edge

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FW: Reflective practice audit and Research project: Second round of data collection

Reflective Practice Audit and Research Project:

For all those that have already completed the baseline data, could I please ask you to complete the 3 month stage of data collection.

PLEASE could I have all responses by the 24th December 2021

Please follow the link below if you would like to take part in the audit research study:
https://uwe.eu.qualtrics.com/jfe/form/SV_bw1xF5bjer4ZkIm

Just a quick reminder:
As part of my Health Psychology Doctorate and the RISE Specialist Mental Health Service Audit evaluation I am carrying out the audit evaluation to find out what the benefits are for Reflective Practice for clinicians. I would ask you to follow the link below and read the participant information sheet and complete the consent form to decide if you would like to be part of the research.

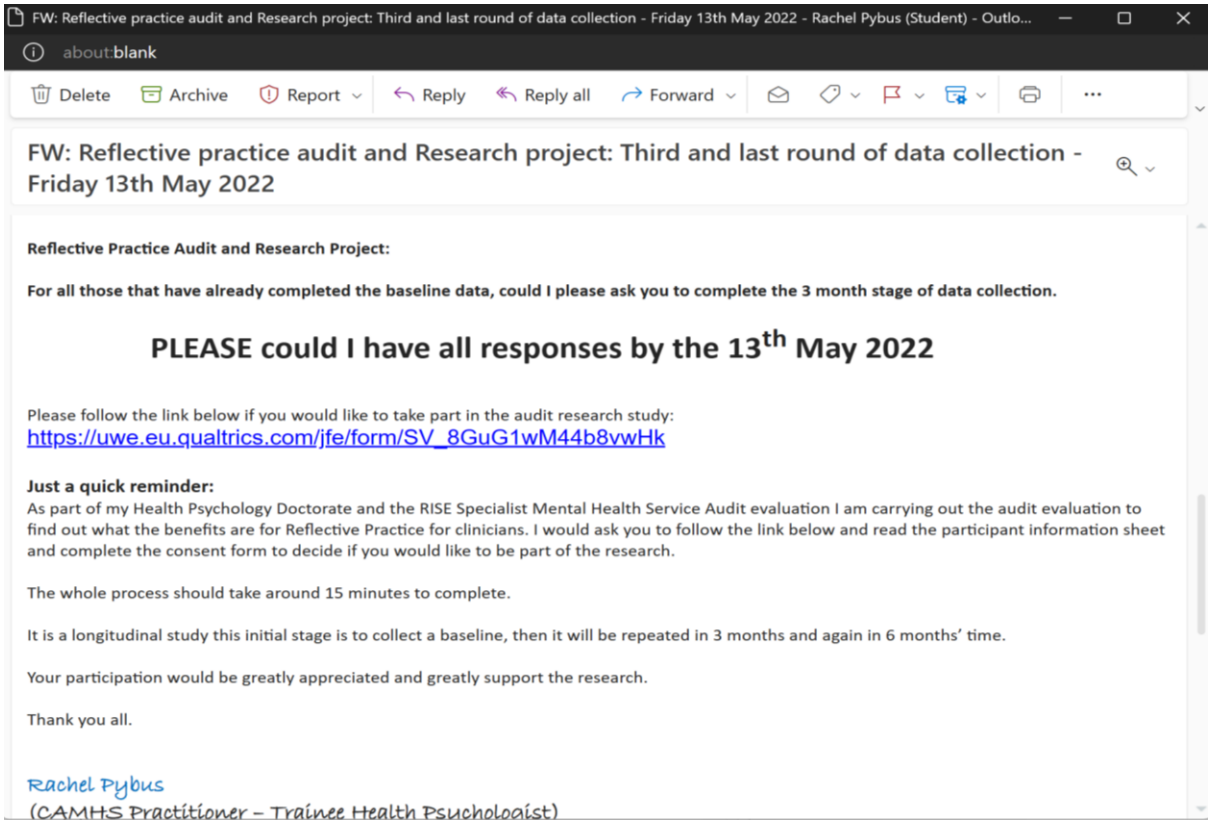
The whole process should take around 15 minutes to complete.

It is a longitudinal study this initial stage is to collect a baseline, then it will be repeated in 3 months and again in 6 months' time.

Your participation would be greatly appreciated and greatly support the research.

Rachel Pybus
(CAMHS Practitioner – Trainee Health Psychologist)

Appendix 4 – 6 month email



FW: Reflective practice audit and Research project: Third and last round of data collection - Friday 13th May 2022 - Rachel Pybus (Student) - Outlo...

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FW: Reflective practice audit and Research project: Third and last round of data collection - Friday 13th May 2022

Reflective Practice Audit and Research Project:

For all those that have already completed the baseline data, could I please ask you to complete the 3 month stage of data collection.

PLEASE could I have all responses by the 13th May 2022

Please follow the link below if you would like to take part in the audit research study:
https://uwe.eu.qualtrics.com/jfe/form/SV_8GuG1wM44b8vwHk

Just a quick reminder:
As part of my Health Psychology Doctorate and the RISE Specialist Mental Health Service Audit evaluation I am carrying out the audit evaluation to find out what the benefits are for Reflective Practice for clinicians. I would ask you to follow the link below and read the participant information sheet and complete the consent form to decide if you would like to be part of the research.

The whole process should take around 15 minutes to complete.

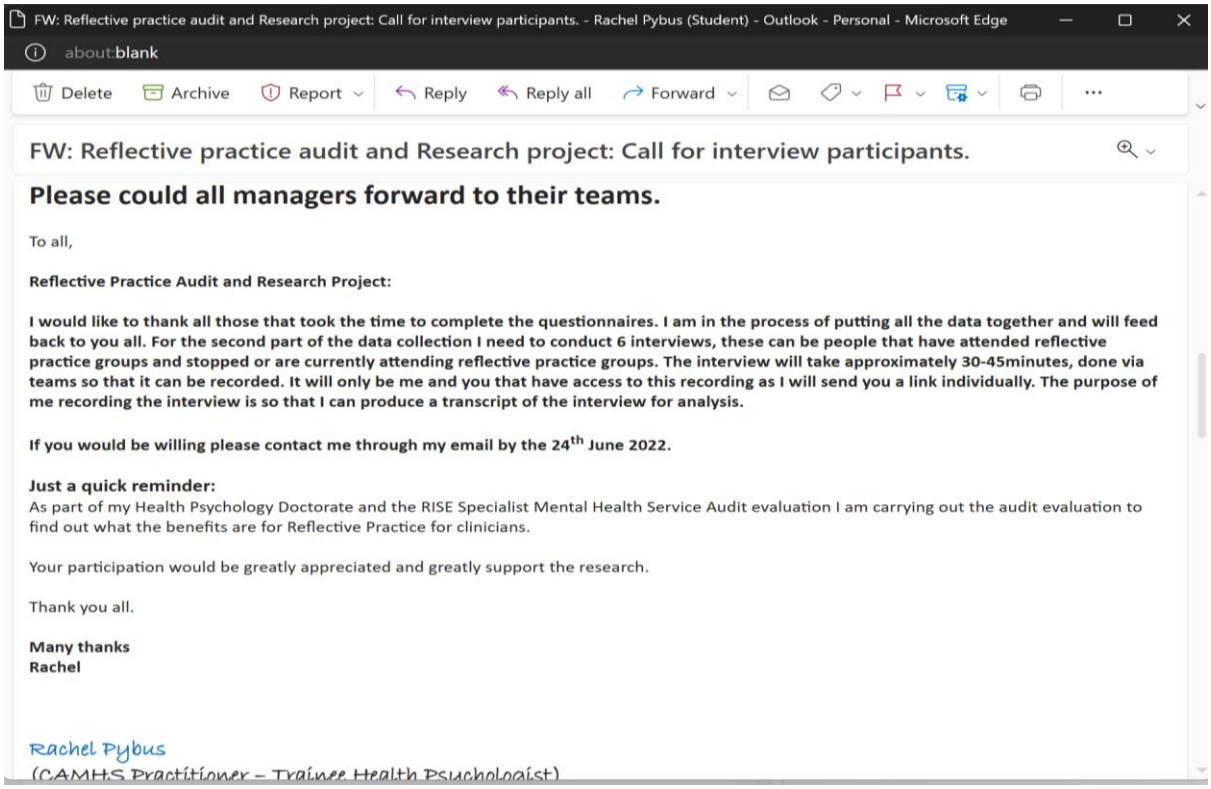
It is a longitudinal study this initial stage is to collect a baseline, then it will be repeated in 3 months and again in 6 months' time.

Your participation would be greatly appreciated and greatly support the research.

Thank you all.

Rachel Pybus
(CAMHS Practitioner – Trainee Health Psychologist)

Appendix 5 – Email to recruit interview participants



FW: Reflective practice audit and Research project: Call for interview participants. - Rachel Pybus (Student) - Outlook - Personal - Microsoft Edge

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FW: Reflective practice audit and Research project: Call for interview participants.

Please could all managers forward to their teams.

To all,

Reflective Practice Audit and Research Project:

I would like to thank all those that took the time to complete the questionnaires. I am in the process of putting all the data together and will feed back to you all. For the second part of the data collection I need to conduct 6 interviews, these can be people that have attended reflective practice groups and stopped or are currently attending reflective practice groups. The interview will take approximately 30-45minutes, done via teams so that it can be recorded. It will only be me and you that have access to this recording as I will send you a link individually. The purpose of me recording the interview is so that I can produce a transcript of the interview for analysis.

If you would be willing please contact me through my email by the 24th June 2022.

Just a quick reminder:
As part of my Health Psychology Doctorate and the RISE Specialist Mental Health Service Audit evaluation I am carrying out the audit evaluation to find out what the benefits are for Reflective Practice for clinicians.

Your participation would be greatly appreciated and greatly support the research.

Thank you all.

Many thanks
Rachel

Rachel Pybus
(CAMHS Practitioner – Trainee Health Psychologist)

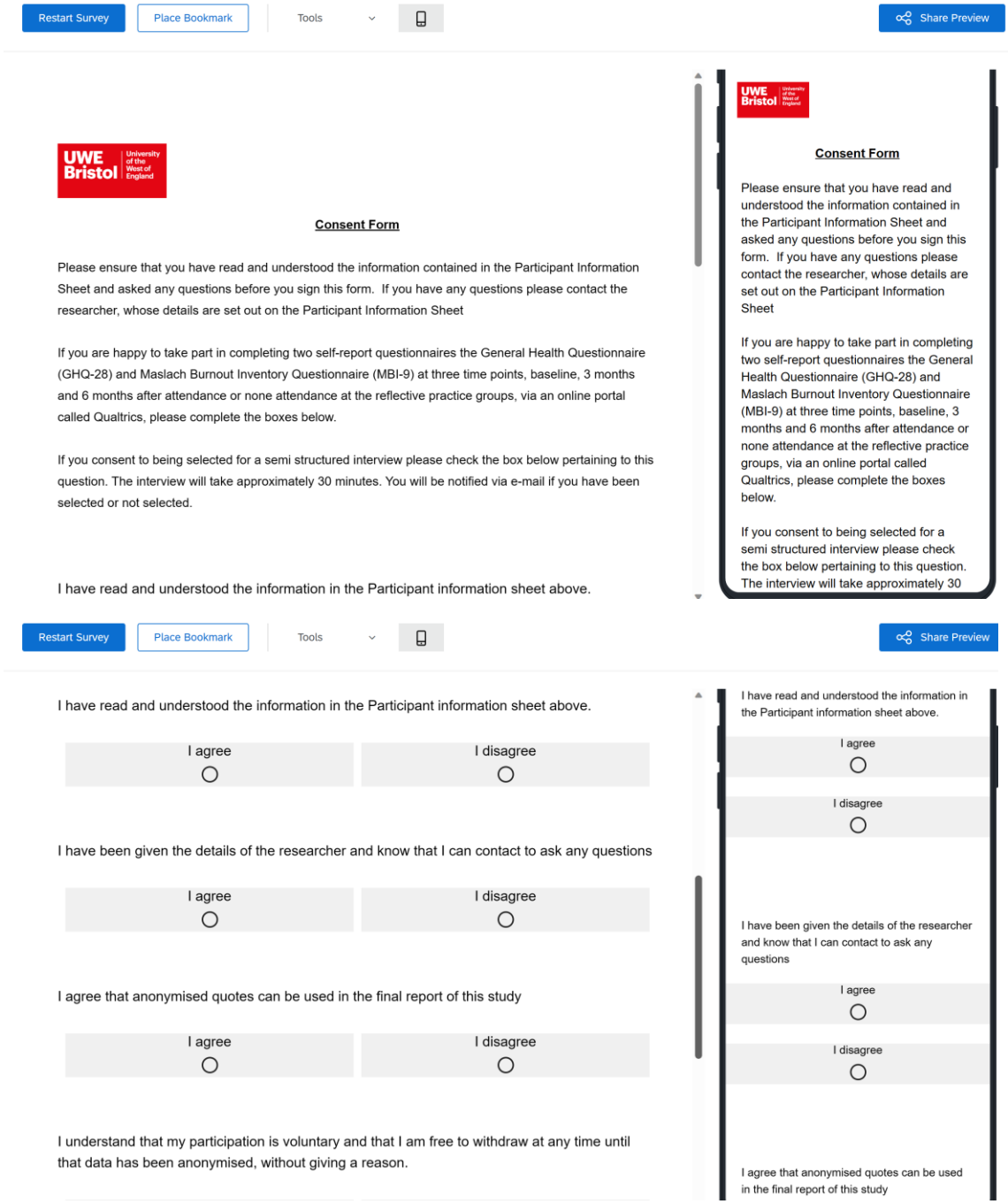
Appendix 6 – Letter of collaboration

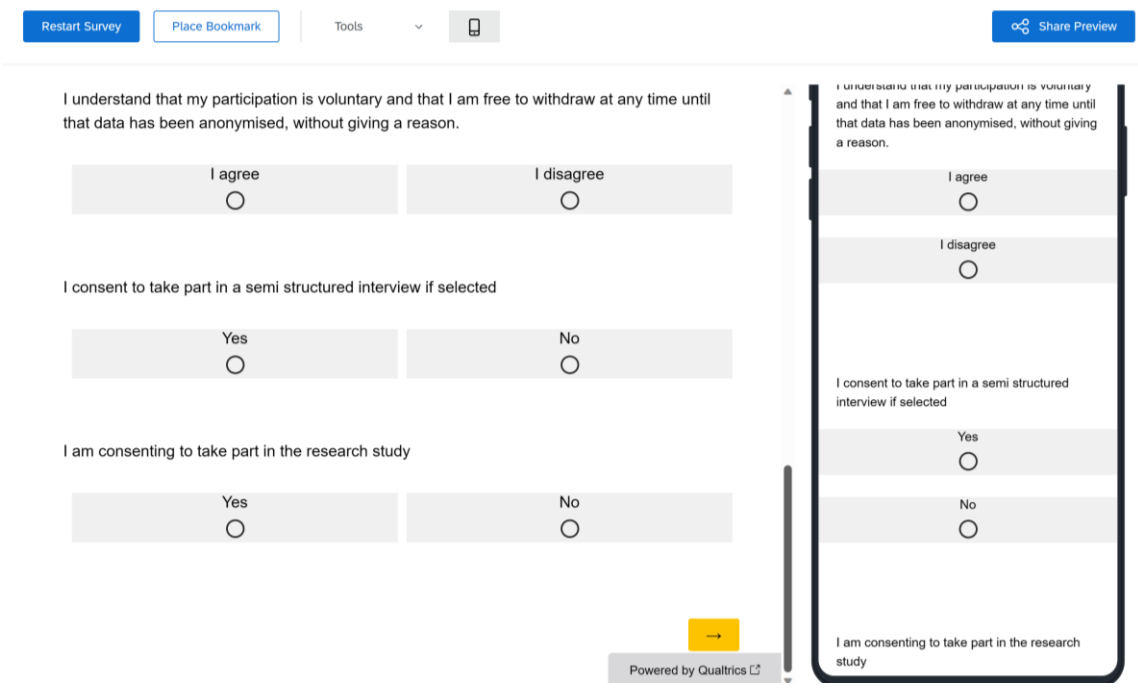
From: Hill Victoria (RYG) [redacted]
Sent: 24 May 2021 15:25
To: 'Tim.moss@uwe.ac.uk' <Tim.moss@uwe.ac.uk>
Cc: Pybus Rachel (RYG[redacted]
Subject: research confirmation

Dear Tim,
I can confirm that Rachel Pybus is currently undertaking some research into the use of Reflective Practice and the impact of this on the wellbeing of staff in the Specialist Mental Health services in RISE, Coventry and Warwickshire Partnership Trust. This research forms part of a collaborative venture between the Trust and The University of the West of England, Bristol and is the subject of Rachel's thesis for her doctorate . This is also a valued contribution towards staff support and research activity within the service. Please do not hesitate to contact me if you have any queries about this study.
Best wishes,
Vicki

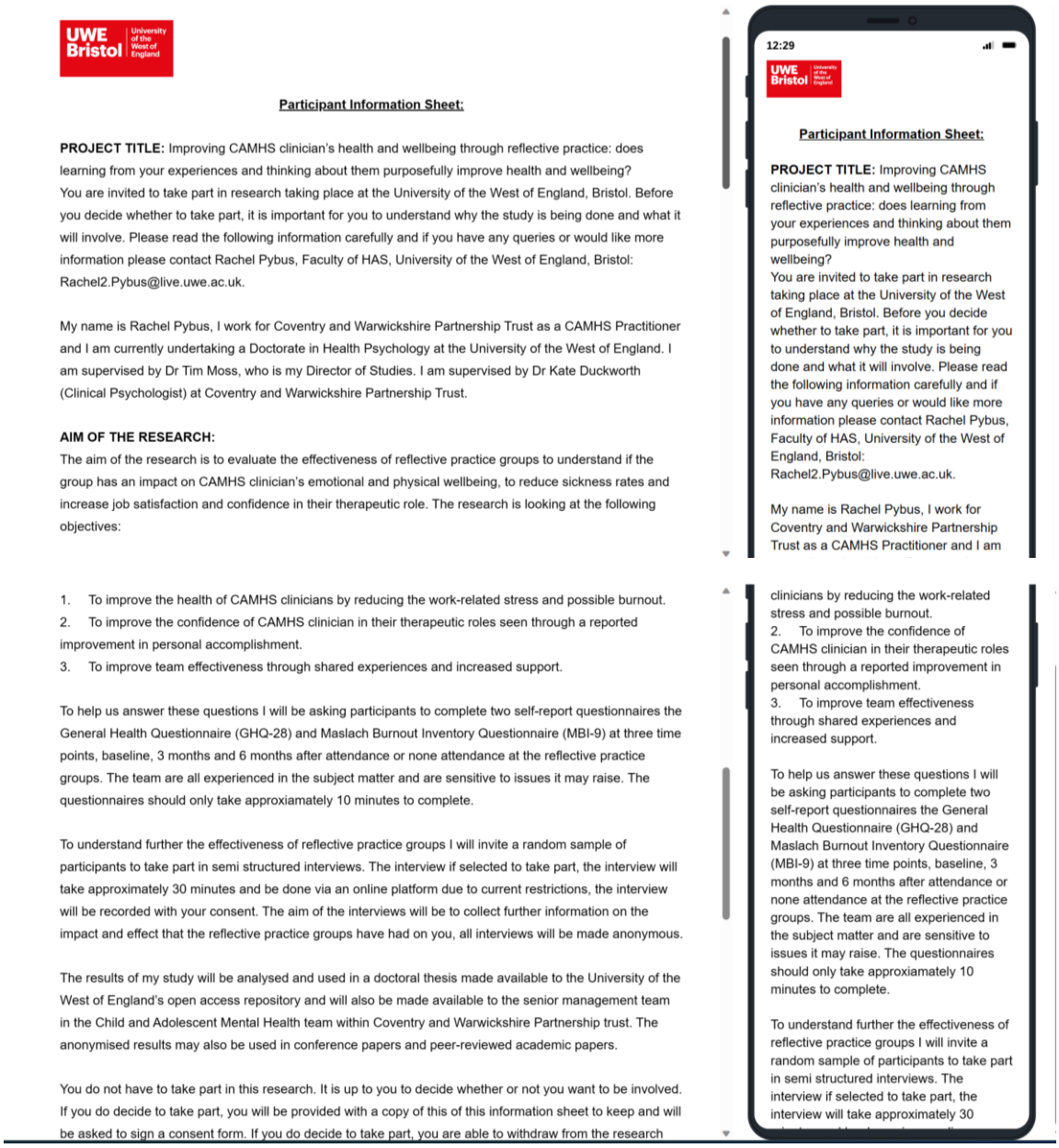
Victoria Hill
Consultant Clinical Psychologist
[redacted]

Appendix 7 – Qualtrics consent form




Restart Survey
Place Bookmark
Tools
Share Preview
I understand that my participation is voluntary and that I am free to withdraw at any time until that data has been anonymised, without giving a reason.
I agree
I disagree
I consent to take part in a semi structured interview if selected
Yes
No
I am consenting to take part in the research study
Yes
No
Powered by Qualtrics
I understand that my participation is voluntary and that I am free to withdraw at any time until that data has been anonymised, without giving a reason.
I agree
I disagree
I consent to take part in a semi structured interview if selected
Yes
No
I am consenting to take part in the research study

Appendix 8 – Participant information sheet from Qualtrics



Participant Information Sheet:

PROJECT TITLE: Improving CAMHS clinician's health and wellbeing through reflective practice: does learning from your experiences and thinking about them purposefully improve health and wellbeing?
You are invited to take part in research taking place at the University of the West of England, Bristol. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Rachel Pybus, Faculty of HAS, University of the West of England, Bristol: Rachel2.Pybus@live.uwe.ac.uk.

My name is Rachel Pybus, I work for Coventry and Warwickshire Partnership Trust as a CAMHS Practitioner and I am currently undertaking a Doctorate in Health Psychology at the University of the West of England. I am supervised by Dr Tim Moss, who is my Director of Studies. I am supervised by Dr Kate Duckworth (Clinical Psychologist) at Coventry and Warwickshire Partnership Trust.

AIM OF THE RESEARCH:
The aim of the research is to evaluate the effectiveness of reflective practice groups to understand if the group has an impact on CAMHS clinician's emotional and physical wellbeing, to reduce sickness rates and increase job satisfaction and confidence in their therapeutic role. The research is looking at the following objectives:

1. To improve the health of CAMHS clinicians by reducing the work-related stress and possible burnout.
2. To improve the confidence of CAMHS clinician in their therapeutic roles seen through a reported improvement in personal accomplishment.
3. To improve team effectiveness through shared experiences and increased support.

To help us answer these questions I will be asking participants to complete two self-report questionnaires the General Health Questionnaire (GHQ-28) and Maslach Burnout Inventory Questionnaire (MBI-9) at three time points, baseline, 3 months and 6 months after attendance or none attendance at the reflective practice groups. The team are all experienced in the subject matter and are sensitive to issues it may raise. The questionnaires should only take approxiamately 10 minutes to complete.

To understand further the effectiveness of reflective practice groups I will invite a random sample of participants to take part in semi structured interviews. The interview if selected to take part, the interview will take approximately 30 minutes and be done via an online platform due to current restrictions, the interview will be recorded with your consent. The aim of the interviews will be to collect further information on the impact and effect that the reflective practice groups have had on you, all interviews will be made anonymous.

The results of my study will be analysed and used in a doctoral thesis made available to the University of the West of England's open access repository and will also be made available to the senior management team in the Child and Adolescent Mental Health team within Coventry and Warwickshire Partnership trust. The anonymised results may also be used in conference papers and peer-reviewed academic papers.

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you do decide to take part, you will be provided with a copy of this of this information sheet to keep and will be asked to sign a consent form. If you do decide to take part, you are able to withdraw from the research

12:29

Participant Information Sheet:

PROJECT TITLE: Improving CAMHS clinician's health and wellbeing through reflective practice: does learning from your experiences and thinking about them purposefully improve health and wellbeing?
You are invited to take part in research taking place at the University of the West of England, Bristol. Before you decide whether to take part, it is important for you to understand why the study is being done and what it will involve. Please read the following information carefully and if you have any queries or would like more information please contact Rachel Pybus, Faculty of HAS, University of the West of England, Bristol: Rachel2.Pybus@live.uwe.ac.uk.

My name is Rachel Pybus, I work for Coventry and Warwickshire Partnership Trust as a CAMHS Practitioner and I am

clinicians by reducing the work-related stress and possible burnout.
2. To improve the confidence of CAMHS clinician in their therapeutic roles seen through a reported improvement in personal accomplishment.
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To understand further the effectiveness of reflective practice groups I will invite a random sample of participants to take part in semi structured interviews. The interview if selected to take part, the interview will take approximately 30

without giving a reason, until the data is anonymised and therefore cannot be traced back to you. This point will take place 3 months from when the last data collection point. If you want to withdraw from the study within this period, please write to Rachel Pybus using the details provided above. Deciding not to take part or to withdraw from the study does not have any penalty.

We do not foresee or anticipate any significant risk to you in taking part in this study. If, however, you feel uncomfortable at any time you can ask for your participation in the study to stop. If you need any support during or after the research then the researchers will be able to provide you with contact details for COPE, the support service for all NHS workers or an appropriate service. The COPE Service can be contacted, contact details are:

Email: Cope@covwarkpt.nhs.uk

Contact number: 07920 581 981

The project has been reviewed and approved by University of the West of England University Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at:

Researchethics@uwe.ac.uk

If you would like any further information about the research please contact in the first instance:

You do not have to take part in this research. It is up to you to decide whether or not you want to be involved. If you do decide to take part, you will be provided with a copy of this of this information sheet to keep and will be asked to sign a consent form. If you do decide to take part, you are able to withdraw from the research without giving a reason, until the data is anonymised and therefore cannot be traced back to you. This point will take place 3 months from when the last data collection point. If you want to withdraw from the study within this period, please write to Rachel Pybus using the details provided above. Deciding not to take part or to withdraw from the study does not have any penalty.

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Researchethics@uwe.ac.uk

If you would like any further information about the research please contact in the first instance:

Rachel Pybus: Rachel2.pybus@live.uwe.ac.uk

Thank you for taking part in the study. If you would like a copy of this participant information sheet then please e-mail me and I will forward a copy to you for your records.

→

Powered by Qualtrics

We do not foresee or anticipate any significant risk to you in taking part in this study. If, however, you feel uncomfortable at any time you can ask for your participation in the study to stop. If you need any support during or after the research then the researchers will be able to provide you with contact details for COPE, the support service for all NHS workers or an appropriate service. The COPE Service can be contacted, contact details are:

Email: Cope@covwarkpt.nhs.uk

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The project has been reviewed and approved by University of the West of England University Research Ethics Committee. Any comments, questions or complaints about the ethical conduct of this study can be addressed to the Research Ethics Committee at the University of the West of England at:

Researchethics@uwe.ac.uk

If you would like any further information about the research please contact in the first instance:

Appendix 9 – Consent form for interview participants.

Consent Form

PROJECT TITLE: Improving CAMHS clinician's health and wellbeing through reflective practice: does learning from your experiences and thinking about them purposefully improve health and wellbeing?

This consent form will have been given to you with the Participant Information Sheet. Please ensure that you have read and understood the information contained in the Participant Information Sheet and asked any questions before you sign this form. If you have any questions please contact the researcher, whose details are set out on the Participant Information Sheet

Thank you for agreeing to take part in the semi structured interviews. The interview will take approximately 30 minutes. If you are happy to proceed please sign and date the form. You will be given a copy to keep for your records.

- I have read and understood the information in the Participant Information Sheet which I have been given to read before asked to sign this form;
- I have been given the opportunity to ask questions about the study;
- I have had my questions answered satisfactorily by the researcher;
- I agree that anonymised quotes may be used in the final Report of this study;
- I understand that my participation is voluntary and that I am free to withdraw at any time until the data has been anonymised, without giving a reason;
- I agree to take part in the research

Name (Printed)…….

Signature……. Date…….

Researcher (Printed)……..

Signature……. Date…….

Appendix 10 – Presentation from clinical trainee's.

Reflective Practice Groups

- What are they?
- Why are they important?
- Do they work?
- Does the team want it?
- How could we introduce it?
- How would we know if it works?

The wider context

The pressure mental health clinicians are under, and the subsequent need to find ways to cope, is well recognised

(Kravits, McAllister-Black, Grant & Kirk, 2010; Lambert & Lambert, 2008).

Generic Child and Adolescent Mental Health Services (CAMHS) teams are currently stretched- between 2013/14 and 2014/15, referral rates increased **five times faster** than the CAMHS workforce

(The Mental Health Taskforce, 2016).

Staffing levels in CWPT CAMHS Services

In [redacted] services, there are high levels of staff sickness and many posts that are unfilled.

As an example, the staffing in June in the [redacted] is as follows:

- 7 out of the total of 15 staff members on sick leave (since 13th May 2019).
- 4 members of staff on maternity leave (1 returning in October 19, 2 have only recently left and the return for the fourth is not yet known).
- There are no full time clinicians; the 8 staff in work all work part-time.
- A number of posts are out to advert or are waiting to be filled.

The cost of sickness and burnout

Research has demonstrated that high rates of sickness and burnout are a big cost to individual clinicians, and the NHS as a whole:

- Work-related stress is related to poorer wellbeing, burnout and subsequent mental and physical health difficulties (Mental Health Foundation, 2010; Mindfulness All - Party Parliamentary Group [MAPPG], 2015).
- NHS has particularly high rates of work-related stress, burnout and compassion fatigue (Dall'ora , Griffiths, Ball, Simon & Aiken, 2015).
- These high rates of stress and burnout cost the NHS between £300m to £400m a year (NHS Employers Organisation, 2014).
- The current high rates of stress and burnout have been linked to the current high rates of staff turnover in the NHS (Davies, 2014).
- Ten million working days are lost each year to sickness absence in the NHS (The Mental Health Taskforce, 2016)
- 43 per cent of mental health staff cite work-related stress as the cause of sickness absence.
- Findings from the British Psychological Society and New Savoy staff wellbeing survey for 2015 show that around 50% of psychological professionals surveyed report depression, and 70% say they are finding their job stressful (The Mental Health Taskforce, 2016).

Nurses' experiences in [redacted] services

- Recent research in the trust explored CAMHS nurses experiences of working with adolescent's who self-harm (Leddie, 2019)
- The Generic CAMHS nurses described how challenging work in Generic CAMHS can be, and described experiences of shame and personal and professional conflicts due to difficulties balancing the needs of young people and service pressures, such as large caseloads.
- They expressed the benefits of peer support and reflection in coping with the emotional impacts of this work.
- However, many nurses described not being able to manage or address the difficult emotions they experience, due to not having the time to access support, feeling that their colleagues were too busy, or prioritising the adolescents over their own self-care.

Reflective practice sessions, included in clinician's job plans, were therefore recommended to facilitate open discussions, and validate and normalise the conflicts and emotions nurses experience.

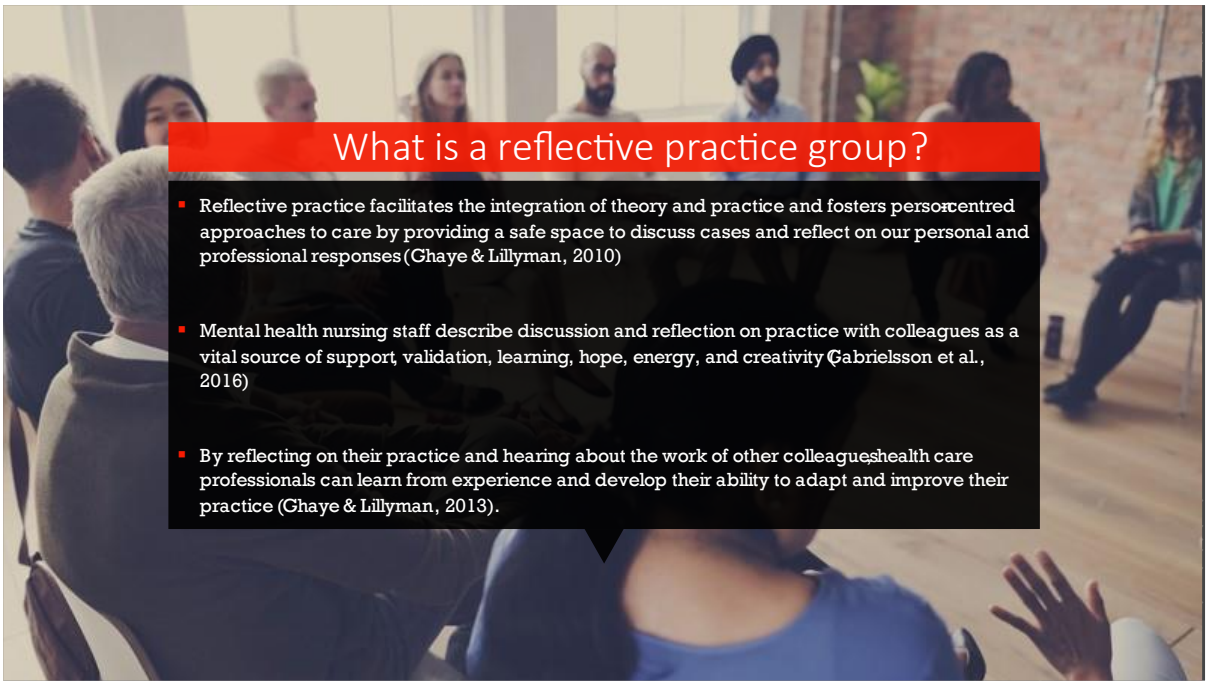
This recommendation is in line with NICE guidelines, which state that all professionals working in mental health services should receive appropriate supervision and training.

What is reflection?

Reflection is an *"activity in which people recapture their experience, think about it, mull it over and evaluate it"*

Reflection requires *"a combination of thinking, emotion and commitment to action"*.

Put simply, reflection is a **powerful learning tool** that can improve practice and enhance job satisfaction and resilience.



Do reflective practice groups work?

Reflective practice groups in mental health settings have been found to:

- Promote self-awareness
- Improve clinical insight
- Improve quality of care
- Facilitate stress management
- Improve team building
- Moves professionals from indecision to action

(Dawber, 2013)

Nurses who feel unsupported are more burdened by feelings of guilt (Wilkstrand et al., 2007) whereas professionals who receive compassionate responses feel better able to recover (Abedini et al., 2018).

The Primary Mental Health Team's experience of a Case Discussion Group

The Primary Mental Health Team runs a monthly case discussion meeting that uses a solution-focused format to facilitate case discussions.

- 7 clinicians provided anonymous feedback on their experiences.
- 71% attend 'usually', 29% attend 'always'
- 100% felt it helped their wellbeing, 29% felt it helped their wellbeing 'a great deal', 43% felt it helped 'a lot' and 27% felt it helped 'a moderate amount'
- 86% felt monthly sessions were the right frequency, the rest felt more frequent sessions would be helpful

The Primary Mental Health Team's experience of a Case Discussion Group

- **Things that help them to attend:**
  - Blocking the time in their diaries
  - Lots of advance warning
  - The room being booked
  - Taking place after team meeting
  - Case discussionrota
  - Compulsory attendance
  - Prioritised as a team
- **What they like about the case discussions:**
  - A reflective space for people to discuss interesting cases in a formatted way
  - Exposure to new ideas and to be challenged in my thinking
  - When a case is presented I feel it strengthens the team as we spend time discussing the practitioners strengths
  - Learning from colleagues.
  - The different view points.
  - Often through these meetings I have discovered a new service or charity that may be of use to the family. I also like the structure of the solution focused format all team members know the structure and generally follow it well with help from our allocated chair.
- **What they would change:**
  - Everyone coming prepared and having sufficient material to discuss
  - Meeting more frequently than once a month
  - Discussing one case in depth in the time allocated, rather than two
  - Being able to acknowledge that there isn't always a solution

National Case Example: NHS Employers

- An IAPT service in Hammersmith and Fulham implemented changes to improve wellbeing including:
- **A weekly reflective practice group**
- A review of risk management procedures
- Thank you emails when team members had helped someone else
- Wellbeing information was shared
- Better workstations
- Team led mindfulness exercises
- Monthly team socials
- These changes helped to significantly improve staff wellbeing. The number of staff rating themselves as having good mental health rose from **57% to 84%** and the number of staff who were comfortable in meeting the demands of their role rose from **58% to 86%.**

How do [redacted] clinicians feel about introducing a reflective practice group?

- We recently surveyed Generic CAMHS clinicians to get their views on introducing a reflective practice group.
- 17 clinicians responded.

"Do you think yo would find reflective practic sessions helpful

- **16/17 clinicians said 'Yes', they thought it would be helpful**
  (one did not respond, saying they would need more information regarding what it would involve)

- Comments included:
  - opportunity to explore cases in more detail with other professionals opportunity to think about my own practice increase self awareness
  - …having reflective practice sessions would allow me to process and think psychologically about a whole host of things, if it was ring fenced time!
  - It will also allow a time and space to think about the effects of the job on our emotional wellbeing and enable us to think psychologically about our clients.
  - Peer support and having time to talk about the difficulties in the workplace is always helpful and a way to build better relationships. Allow time and manage stress that come with the job
  - Chance to connect with and share experiences with and learn from other clinicians, helps to feel less isolated. Would give permission to take time for reflective practice which we ideally would be doing anyway, also therefore helping staff to feel valued and looked after by the organization

"If reflective practice sessions were introduced, what would you like them to include?"

Suggestions included:

- Complex case discussions
- Refection's on managing situations clinically and how this impacts on the individual clinician
- Sharing research
- Reflection on themes that are coming up in clinical work and/or organisationally
- Peer support - a safe space
- Discussing what went well
- Reflecting on lessons learnt
- Personal development

"What would be the barriers to attending reflective practice sessions?"

Responses included:

- Time
- Clinical pressures
- Others not being able to attend or facilitate sessions
- Not being in the job plan
- Managerial approval
- Everyone valuing the session
- Not having a safe environment
- Venues and travel
- Being on non-working days

"What would help you to attend?"

Suggestions included:

- Protected time in the job plan
- An accessible venue
- Rotating the venue around the Trust
- Managerial approval
- Plenty of notice
- Consistent date and time
- Others prioritising the sessions and attending

Summary

- 94% of CAMHS staff surveyed thought Reflective Practice Sessions would be helpful
- 100% of PMHS staff surveyed said that Case Discussion Sessions helped their Wellbeing
- Clinicians felt they needed protected time in their job plans and Managerial approval to attend. NHS Workforce Health and Wellbeing Framework (Strategy Group, 2019) states that the essential building blocks of good staff health and wellbeing start with structural and cultural support from leadership

Research and the staff survey supports the need for Reflective Practice sessions, included in clinician's job plans, to facilitate open discussions, and validate and normalise the conflicts and emotions Clinicians (nurses) experience (Leddie, 2019).

What Is Needed?

- Given the research evidence, we would like to introduce weekly reflective practice sessions for the generic CAMHS teams. The Psychology team would be happy to facilitate these.
- We propose initially introducing trial reflective practice sessions withinCAMHS, evaluating theimpact on staff health, wellbeing, attendance and retention
- Given the barriers identified, we require support from leadership to enable CAMHS clinicians to be given space in their jobs plans to enable them to attend these sessions.

How will we know if the group is are helping?

- Monitoring levels of staff sickness and retention
- Ask for anonymous feedback from attendees after the group has been running for a few months
- Ask group members to complete validated measures on their experience of the group (e.g. the Clinical Supervision Evaluation Questionnaire, Horton et al., 2008)
- Ask group members to complete validated measures of their wellbeing e.g. NHS Employers Today I feel… , CWPT Wellbeing toolkit questionnaire or HSE Indicator Tool

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Appendix 11

Reflective practice interview 1 – Participant 1

Experiential Statements	Original Transcript	Exploratory Comments
	Researcher: Its just a series of questions that I will ask but however during the conversation the questions get covered anyway. Just going to launch straight into it. There is a lot of research into the affects of attending RPG, in terms of clinical practice, changing patient outcomes, changing level of support, impact on stress and staff sickness, there are some of the thing that the research has shown. After joining the RPG group what impact have the sessions had for you?	Space to think/consider answer
Reflective practice is about a space to feel safe and validated. Reflective practice is not about feeling exposed or put on the spot. Awareness of needing affirmation from the space.	Participant: So I think when it was first coming into practice, it was introduced by one of the seniors in PMHT, it felt that it was going to be a negative space to be picked on a little bit, feel a bit exposed, I think historically the space hadn't been managed very well. But actually it was invaluable, the validation, so we used a solution focused approach for reflective practice and it was really positive. Confidential, the space was and there was a real boundary around it. Like we had sections where only the presenter was talking and then only the people were listening were talking and that kind of helped because you didn't enter any like debate or didn't feel like you were put on the spot, it was all very constructive. Like after the first experience of it feeling a little bit daunting. It was space I really looked forward to and we all looked forward to. We had it about	The use of language is quite negative, there is some reticence about being a target? The use of "feel a bit exposed." Management of the space Relief in the end and being validated. Mention of the model and this being positive – is this something creates a better space? Element of safety about the space – confidential, boundary, structure, vulnerability (not wanting to be put on the spot). Terms of constructive, validation – is there something about getting something from it. Which leads to a positive affirmation of the space. Time (frequency)

Building relationships with team members. Relationships being managed within the space which led to feeling more safe within the team. Value added of the reflective space being managed for some team members and not others. Structure being lost due to change in working practices. Reflective practice creating learning opportunities to grow within the role of clinician.	once a month, I do think it made the staff members come together a little bit more. You know when you have that thing, that someone else knows something way better than you, when you get into a space you realise that actually they don't always know everything and they also need help. There was a particular person at PMH, that I always struggled to get along with and in reflective practice I always use to like to be mindful that I might take his comments negatively, but genuinely, because the space was safe I like could learn a lot from him and realise that there was space for learning for him as well, I think that kind of helped build team moral as well. It's interesting because I use to find myself getting annoyed at people when it was their turn and they'd say I don't have anything to bring because I was getting so much out of it, how can you even not bring one case to not even reflect over, its so easy to do. We had sort of rotations. When it came it came to the pandemic, everything shifted online, I suppose what we didn't do was follow any structure as such, as before we had a whiteboard and then we had reflective practice agenda to look for, but maybe it was because we were so use to engaging in it or maybe it's because we knew the value of it, there was a monthly team get together that was reflecting over things that were good, things that hadn't worked out so well, problem solving and things like that. We all learnt the value of picking up on strengths and areas of improvement and stuff.	Team dynamics – bring the team together, changing perspectives on team members. Safety mentioned again as offering protection from other team members that allowed learning and maybe exploration? Team Dynamics – building moral within the team, but also there is others not valuing it as much as the participant, "how can you not bring one case to not even reflect over." Reflecting on change, shifting to online working and no longer having the same structure as before. Repetition of the value of reflective practice – "we knew the value of it" and "value of picking up on strengths and areas of improvement." Learning opportunities, recognitions of strengths and improvements being made.

Change in working practices and the implications of this for clinicians. New ways of working reducing stress. New ways of working allowing insight into colleagues homes, sharing parts of their lives. Awareness of the change due to the pandemic and the impact this had on routine. Moving away from structure.	Researcher: It's interesting there that you mentioned pandemic moving, online, that was a massive change, do you think having that reflective practice space during the pandemic was useful, did it help, where you able to explore the impact on your own health, psychological wellbeing during that time? Participant: I would say definitely, so I was sent home quite abruptly because I was pregnant. Amongst all the what is going on, are we going to manage this. The online functions came quite quickly didn't it and once we figured out how to use it. The team lead at the time set up the group, everything was done very quickly, so when we all came into the meeting we all saw it as a bit of a novelty as you got to see each other's house and where you were sitting. The first thing people said was how nice it was they didn't have to stress about parking and things like that. So actually I could see the benefit to it. What was the other part to your question? Researcher: So talking about your own health and sort of psychological impact for you to think about that within the reflective practice space? Participant: It was really helpful to be able to continue that, because the concept of working from home felt like logistically felt, how am I going to do that? Then when it happened I haven't got to worry about what I'm wearing,	Mention of physical state right at the beginning of the pandemic and the implications that being pregnant had. Reflection on change in terms of different working practices and how this shift was quick, time being important. Reference to the new ways of working, highlighting some of the positives as it removed the stress. But also the differences and some excitement (seeing colleagues homes, not stressing about parking). Acknowledging this benefit. New ways of working – the impact on routine/isolation, having time to process all the changes. Some worries and concerns about logistics of working from home. Changing to way that RP was run due to the pandemic – moving from structured diary appointment to an everyday occurrence. Some questioning about what the changes meant and how it impacted on the participant. Acknowledgement in the shift of purpose of the RP group and willingness to engage.

Reflecting on the process of change and the impact on physical and emotional wellbeing. Acknowledgment of the increasing stress and pressure to prove they were working. Increasing knowledge of what made the reflective space helpful.	how my hair washed. But very quickly the isolation set in as well. So having that, initially Jane set up those half an hour mornings every day, everyday they were set up at the same time and when we had reflective practice as a team before the pandemic it was structured diary appointment, as when the pandemic happened it was more of an option but I found people were more willing to come to it, it did give them a chance to talk about their wellbeing and stuff. But we didn't always get a chance to talk about how we were feeling, it was space to process some of these new things, because I'd never worked from home online in my life, so maybe at the time I couldn't reflect on the positives or the negatives of it but would still be able to process it in that time as being quite valuable. I think because I was pregnant, my manager was conscious of my health as well. So for example, she kept saying don't sit for long periods of time, make sure you get up, she remined me to look after my physical health as well. But definitely supported emotional wellbeing at work to be able to see everybody and talk to everybody. Researcher: So do you feel like it helped to stop it from deteriorating then? Participant: Not all the time, what was impacting on the reflective space was that people wanted to see you more often. It wasn't the reflective practice that was becoming the problem, it was the fact that people were putting in meetings	Questioning their ability to process the positives and negatives, almost reflecting on the process that they had been through, through the interview. Made reference to her physical wellbeing, being made more aware of how she should look after herself? Contrast to emotional wellbeing, maintaining contact with others. Picking out elements that were impacting on them, referring to a inferred expectation. Heightening stress - again to do with expectations of attendance at meetings. Reference to what was being unsaid at this time, using the word "need." The impact on them being felt. Feeling of the purpose getting lost with different factors Frustrations expressed by knowing, recognising what would make the space better.

	back to back to back. So overtime it started to feel like they need to see me at 9 but we have got that reflective team talk, so I won't go to it today, do you know what I mean? But I think, on times when somebody would take over it would feel like. Like sometimes, we had one particular staff member. I was in the old team, the previous team when I was doing reflective practice, there was one particular staff member that was having difficulties and towards later parts when everybody couldn't attend together it did sort of use to start feeling taken over by one particular person's difficulties, so it didn't feel helpful in that respect. When it was structured and it was scheduled that it was this weeks its [redacted] turn, next week its someone else's, that was a lot more helpful than having unstructured reflective practice. Researcher: I can imagine did it feel safer having a structure around it? Participant: 100% having a structure around it, because there weren't like any notes being taken it was literally that one whiteboard, because you would physically see it being wiped clean, or physically scrunched up and popped into the confidential waste bin. It felt like you have got the conversation but it's gone sort of thing. Where as online, it use to feel dismissive, cause like I would, if the background was a bit darker, you could see other people, they have glasses on and you can see they are looking though their emails or	There is knowledge of knowing what is helpful and what feels better. There is an essence of safety/protection being expressed around a structure, feeling heard. Contrasted with online where you did not feel listened to – others being distracted. Value of the space not being appreciated – "dismissive." Questioning of other behaviour, frustrations being expressed and feeling the space wasn't valued in the same way it was by the participant.
Contrast of face to face to online knowing that you are being heard not dismissed. Structure provides safety. Essence of frustration in the value of the space being missed.		

Acknowledgement of the space being valued and that being recognised by others. Context of structure is important.	something. That felt a bit hard as well, as you would think why are you in this space if you are just looking at, if I had something to do I wouldn't come into that session. Because it is there for reflection, I wouldn't have come into it and thought I'll just scroll through that. Does that make sense? Researcher: Absolutely yeah Participant: So things that started to feel a bit difficult as well. Researcher: So it kind of felt weren't valuing it the same way you were? Participant: Yeah definitely. Researcher: Must have been so frustrating? Participant: It was frustrating, especially when like, if you were addressing someone directly and they weren't responding and then you might call them by name, what you would see is the light of their face change, because you've just minimised a document that you have just been reading. You can see when someone has minimised something on a screen, I just think that's so disrespectful of that space. I know for me, I have always been into reflective practice, remember when we use with Alex in 2009, I think that working so closely with Alex kind of instilled the real benefit of reflective practice and what that looks like and that's what gave me insight into what bad reflective space	There is anger and frustration being expressed especially through the use of the word disrespectful, goes to valuing the space that reflective practise brought. Participant reflective about why this space is so important to them but keeping the contrast between what's good and what's bad. They are expressing again about value of the space I'm being quite angry towards others and not valuing the space. Expression of value especially in the context of structure, this has been mentioned before and therefore seems to be important to the value of the space for the participant.

Feeling safe within a space that creates vulnerability. Structure being important Maintenance of a structure with in the clinical framework in times of uncertainty. Prioritisation of other factors over the reflective practice groups.	looks like as well. So I know I do value it quite a lot and I know it annoyed me when others where just like what ever. Researcher: It sounds like, from that reflective practice you sort of built up some resilience around, what it should look like, how you valued it and how you should use it? Participant: I think so yeah. Researcher: And adding to that clinical experience for you. Participant: That was really invaluable, especially in the structured one, as in the solution focused reflective practice you get a chance to hear what other team members would have done differently, questions they would have asked and in that space you don't talk back you just listen. I think that pushed you into a position where you could get a bit defensive and yeah well I could have done that, but what ever. But because you couldn't speak it really did push me into a frame of mind of what you are saying has really good value. I would always know or somebody said something, I didn't even think about that, I would always note it so I would know there is different ways to problem solve and stuff. So that was really valuable from structured reflective practice, 100%. Researcher: Is there anything that would have helped further during the pandemic or when it	Participant expressing vulnerability in terms of having that introspective view of their own work and being accepting offer the criticism because it felt safe. Structure highlighted as being important. Participant almost laughing when highlighting the sense of irony a big push towards mental health during the pandemic, the trust trying to give structure in uncertain times, the pandemic highlighting the need for structure and routine through the offering of sessions. Feeling that the extra sessions that were being implemented were adding to the stress, feelings of time pressure. Pressure to attend meetings and be there at the same time seemed more important than attending reflective practise.

	became unstructured, what would have helped further to get back into that reflective practice space?	
	Participant: I reckon having that, putting the agenda back in would have been helpful, but also, it was ironic what happened because mental health became a big thing for staff members during the pandemic, which was annoying because I was thinking mental health has always been an issue for us its just becoming loud now, your thinking everyone's working from home, you don't have that social structure in the office and stuff. But then you started getting bombarded with pause sessions and joining meditation, it felt, then people putting in meetings back to back to back to back, you literally would come out of one meeting at 10.30 say team meeting and then someone else was booked in at 10.30, you didn't need to account for travel space and stuff. I think if reflective practice had been given that same like no you need to be there, I think if it wasn't every day, because like initially the every day thing sounded good but it lost its value then. Like having it once a month for an hour and half was good because you knew it was coming up only once a month, it felt more valuable, I think having it every day turned it into a bit of a coffee morning after 3 or 4 months because everybody was use to it, you could still use the space to reflect over how your weeks been difficult. When the new manager came in she changed it to once a week there wasn't any like you should really be	The frequency of meetings especially meeting around reflective practise lacking that value to session.
Time pressure being highlighted.		There is a narrative being built around losing the value of reflective practice, Being held back from attending due to being checked.
Building of stress		I can hear the build-up of stress in the participant's voice as they are talking about this experience.
Stress playing a major factor in management of time and attendance at Reflective practice.		Reference to physical state. Highlighting other stresses that impact

Understanding the value of the sessions. Safety and containment provided by a leader.	there, what they did was replace the reflective practice daily sessions or reflective session into a check in, could you just log in on teams and say morning so we know, started to feel like a checking if you are logged in or not. I think that had a knock on in the reflective session as on the Wednesday when we would have it, it use to feel like also, oh you are just checking to see if you have logged in at 9 o clock. Does that make sense? It just lost its value as what it stood for initially, changed. Researcher: I can almost hear the stress in your voice there, talking about the whole and that seems to counterbalance what reflective practice is about. Participant: Absolutely, because what use to grind me, I have really found this difficult, so you know I was heavily pregnant, I also had Sam (younger child) at home most days. So I would log in and have my computer ready say at 8-8.30am. I would check my emails, make sure my diary was for that day. Say at 8.50 I might have like gone to toaster and tea and what ever so I would miss the 9 o clock log in. I would always get picked up about that but if I didn't attend the Wednesday reflective session, no one ever said I didn't see you in session today? I use to think you are so bothered about me logging in a 9 and saying good morning at 9 to prove that I am on teams but you don't give two hoots that, your not asking why is no one in the reflective session today. Sometimes	Being a target – stressor Questioning the value placed on RP. Questioning the purpose of the session and the value being placed on it by others. Safety being in place and impact of having someone leading the session. Containment of the session Struggle and regret. Losing the purpose of the session.

Structure providing meaning and a sense of validation.	only one staff member would be in there and I think it became something it really shouldn't have become. It felt it was more of checking in session than a helpful space and then the new manager didn't use to come into those sessions whereas the old manager did. When the old manager was transitioning to her new role she couldn't then come all the time, which was fine, but it was still valuable, she would still make time to be there once a week. When she was there it was a lot more structured because she able to say like, that's great, its been really good hearing from you, how's everyone else getting on, Rups you mentioned this last week how's that gone this week? She was a bit more, she was able to say things that perhaps maybe we would not have said to each other. But later on it just became a hassle, which is such a shame. Researcher: Yeah especially for what it is meant for. It feels like it really moved away from that? Participant: Yeah it genuinely did, I would go as far as saying that it just became a coffee morning check in thing, it completely lost its value 100%. Researcher: I think what I'm picking up is that the structure of it is of key importance, I know you said you used the solution focused model and other reflective practice groups within the trust have used, within the CAMHS team, have used different models. I'm getting the impression the model important to you?	Acknowledgement that this is important. Purpose of the model to give it structure and draw on the positives.

Confidence needs to build to allow growth in clinical abilities. Contrast of expectations versus reality based on passed experiences.	Participant: Yeah definitely, definitely. Researcher: I don't know if you are aware the other model that was used in the trust was something called the heads and hearts model? Participant: Oh ok, I haven't heard of that. Researcher: So that model, looks at, it does look at management structures above that helps or hinders, its whole structure looks at, you kind of check in process, so at the beginning you have a check in, how is everybody, turning into the reflective practice space, then there is mindfulness exercise, then somebody brings a case or something want to reflect upon, so that is what ever it is, then the person speaks, like you were saying in solution focused, then the reflective team listening, then the reflective team then speaks, then the person that presented doesn't and you listen like you say and then you have that turning out process. So that you go back into work but you have turned out of reflective practice so its kind of quite structured. Do you feel like something like that would have helped or do you think solution focused was better? Participant: No I think if it's a model that has a good structure to it, it doesn't sound like it would be better than solution focused because both of them are routed in focusing on the positives and thinking about how things could have been done	Reflecting on what's important to the participant, sense of validation. Taking the criticism. Doubting their own abilities, being able to have confidence in their abilities, needing validation. Fear of the RP and being criticised, possible fear of it not being what it said to be. Maybe based on passed experience.

Positive affirmation – needing this to carry on and take forward into clinical work for themselves and others. Recognition of what others can bring or may need for their clinical role.	differently but not necessarily better. I think for me that's what is really important about reflective space that, cause we don't often hear someone say, you know what you did a really good job there. So I think when you keep in whether it's the heads and hearts model or a solution focused model, it focuses on things that went well with some space over what someone else might have done differently. I think know one is saying you could have done this, people are saying I would have thought about that or I would have actually liaised with that person. It takes the personal part of it away and I'm sure there might be more unhelpful reflective practices. I don't really know what those models are. Researcher: It sounds like for you having that reflective team, kind of coming back and saying these were the positives really helped your whole mindset, is that fair to say? Participant: 100% yes, I think I'd worked long enough in the team to be literally questioning myself, I am doing the right bloody thing here and because no one was saying that was really good, the thing is I still need affirmation at the end of the day. When [redacted] introduced the reflective practice, my genuine initial thought was, oh god no because I've seen things before being coined as, no we are just going to get together and talk about things and you end up being criticised and picked upon. When we went in there and she did the first case presentation to sort of show us	Positive space and validation of their own work. Affirmation is something used by the participant a lot – needing that validation, maybe having doubts in their ability. Using that positive feeling to take forward into work. Application of this experience and replicating it for others. Appreciation of what someone else can bring. Assumption of what others need – to feel good and take forward with their role.

Anticipation of stress within the clinical role. The power given to what affirmation means to job performance. Context of being a space to explore learning opportunities leading to the sense of validation.	what it would sort of look like, it became a really enabling space, it was really nice to have your turn and hear somebody say, I think you did a really good job, there's nothing I would have done differently. That affirmation for me was really valuable, maybe that goes back to my own schema's and how I am as an individual but very much of the opinion that if somebody has done well at work then you should be able to say, do you know what you did a really great job and I take feeling into my work now. I don't, we don't currently have reflective space in my team but I meet with them once every month on a Tuesday morning, team of band4's, I meet with them to give them that affirmation, to say you know when you picked that up you did a great job. Right the others are you aware you can go through this pathway or I pose a question to them and say, lets say a parent called up and they say their child has been self harming, brainstorm about things and think about, you know what sort of solutions you could use, what signposting would you use, when would you call the crisis team. I always end on that with a real positive for everybody and make sure I specifically say, like [redacted], one of my NP's, she's really got my back, if I miss something she will always pick it up, make a point of saying I missed that email from Jo last week, thank you so much for picking that up, it was really helpful, I think you dealt with that in a really good way. Because that's what gave me that good positive for my role, so I assume it will be beneficial for other people as well.	Work stress/anticipation of stress Not being able to share the anticipation of the stress. Positive affirmation/feel good factor Validation/Affirmation being able to keep them in work- feeling appreciated and valued. Losing something of value (said in a jokey way) Positive validation, confidence, feeling valued.

	Researcher: Sounds like a positive affirmation is really important isn't it? Does that kind of help keep you in work, kind of help with your mental health in work, feel more positive?	Learning opportunities highlighted. An essence of getting something from the space – validation?
Awareness of what is needed from reflective practice to create a positive and containing space.	Participant: Yes it does, it does. Kind of like sometimes, I have this family, you know one of these families everybody knows them, talked to everybody. The mum had been quite abusive to admin staff 2 weeks before. When I was asked to call her back, I instantly felt really anxious about it, because I thought if she's abusive to me, I will have to deal with it, it's fine. Its not going to feel very nice that I can't say to somebody oh my god I had a really bad call with a parent but by the time I called her, she was in a completely different frame of mind and she said to me afterwards "do you know what I really feel like you listened to me, thank you so much." That changed the entire experience for me, her saying I really feel that you listened to me, I feel I've been listened to really, really well. Obviously I'm aware she has a pattern of behaviour and that it might not be there the next time I speak to her, but it gave me confidence boost for that day I guess. Positive affirmation definitely helps my wellbeing and wanting to be in work. That's one of the things in the old, previous team got lost, you know you just treading along, even supervision became a thing of the past. Like in the old team, supervision, what supervision, I haven't had supervision for a year. I was having supervision with [redacted]	Structure creating a positive experience. Discussing the process of RP, (smiling whilst talking), seemed like a containing process.
Positive affirmation leading to motivation after containment.		Positive affirmation A real note of motivation and positivity after the structured session.
Awareness of what was not helpful leading to a lack of motivation.		Not talked as so warmly, but there was a recognition of this space being useful. However contrasting with the negative using "draining" as a way to describe the experience – negative thoughts.

Transformation of what is expected to the reality based on prior experience. Management of expectations and what is possible to achieve with in the specific clinical roles. Structure and containment being important – bringing clarity.	[redacted], so like the value we placed on supervision, learning and positive affirmation, so if I take away, like with mark every time I met with him I would always take away something new, that's something I've learnt, that's something come across that's brand new. But also the fact that [redacted] use to say you have done a great job or that was really tricky to deal with and you dealt with it in a really good way. That's really important. Researcher: Just bringing it back to the reflective practice group or space, how did you feel coming out of those groups, did you feel, well how did you feel? Participant: When it was the structured ones it was really positive, when we had the morning ones, somebody would bring fruit or pastries or something and we naturally fell into the pattern of having those at the end. So what would happen is we would have the reflective session and it would take an hour, an hour and 15 -20 minutes. Then there would be like a physical closing, the paper would be ripped, scrunched up and put on the table and somebody would peel open the fruit. There was a natural transition from this focused reflective mode and because it all finished on compliments if you like or people saying what you did really well. It felt like there was a physical transition, those particular sessions I would come out feeling like motivated, quite light, quite happy. The ones that online, when	Real feel of negativity towards the space, frustration that the space wasn't being used how it could be. Last two answers – Transformation from what is expected to the experience of what has happened – both positive and negative. Confusion over the role, making reference to their banding and struggling with what expectations were of themselves and others. Not feeling contained with their role – questioning how to support others. Having had space to reflect and time being given to you as a practitioner/clinician providing that containment and clarity for others. Acknowledgment of what the structure can bring to others.

Recognition of the benefit of reflective practice from experience. Evolving through learning opportunities.	they were good and they were effective I suppose then I would feel like I could come out of reflective practice and have a bit of a stretch and get myself a fresh drink and get myself sat back down to work. But the day it didn't use to go so well was difficult to get focused into work, I use to think aurgh, good that's over now, I would try to get into work and wouldn't be able to do it. So I definitely felt that the better sessions had a better ending for me and I can could transition into work more easily because I didn't feel frustration but the sessions when I use to feel oh my god shut up or this isn't reflective practice or I use to think this is draining, like if somebody use to moan and moan, that doesn't feel very reflective for me. So that use to feel quite draining and that would impact the session finished. Researcher: Sounds like you have had a really mixed experience of it really. Participant: Yeah, yeah definitely, but do you know what that's been helpful, I am still a six but I have more responsibility in my new team role at Neuro, its made me a better six looking after the NP's. You know before I could quite hung up on, we had an assistant PMHT practitioner, whatever that's supposed to be and that obviously our role was to support her but I use to find myself getting hung up about that stuff, because I didn't feel very well looked after. But now, experiencing bad practice has made me really mindful that I want	Reflecting on what RP can bring Individually and professionally with a varied experience of RP, moving from the not realising the benefit to what it can bring, almost a journey for them and to take this forward for others. Self-discovery and learning opportunities being recognised. Expanding knowledge base to include other coping strategies, bring focus for them. Self-discovery – looking inward to yourself.

Acknowledging that clinicians need to stop and allowing you to reflect and take notice to then move forward more thoughtfully.	others to walk away from me having a good experience. So that when I do give them that space , I always remember that when they come out of this I want them to come out of this ready to work. It is a very stressful team the neuro team is, nobody has got time for anything, supervision is like once every 3 months something like that. I have clinical supervision once every 6 weeks and that's a good reflective space, erm but some of the staff don't get that structure that I get, so I try to put in place for them. Because of it's value but I definitely have a varied experience of it. I'm glad that I appreciate the value it brings because I lacked that awareness before, as before 2019, I lacked any awareness of the benefit that reflective practice can bring to yourself as an individual and as a professional. I really wasn't aware of it at all, like you mentioned mindfulness, in head and heart, like I have never engaged in mindfulness and until, [redacted] brought in, I don't know where these people are from or where she got them from, but she got in a team of people to come in and teach us mindfulness and like I was the only one in the room that didn't know much about it, which was so embarrassing almost. But like now when I am feeling stressed or overwhelmed, I literally force myself to come back into the moment, so, you know like head and heart having a mindful space we didn't have that in solution focused so that would probably be a really valuable thing to have as part of it. It encourages yourself to look after yourself doesn't it?	Stopping to take care of yourself, relearning to stop is ok, almost giving permission. Stopping, taking stock and allowing you to notice. Encouragement of others to learn the benefit of stopping and taking a break. Self-care, permission to stop.

	Researcher: It's about bringing all the elements together and trying to work out, that's part of it, we are looking at trying to what is going to benefit you guys community clinicians. Well that comes to the end of the interview, so thank you very much. Participant: You are welcome. Researcher: Is there anything else you would like to say or anything else you want noted? Participant: It is right what you are saying, community practitioners sometimes just expected to carry on and get on with it. And we need to relearn that stopping is completely acceptable. Because when you are at work, you feel obliged to just carry on and just think oh I'll just do this and then I'll get up. Yesterday I was with my NP's, we had been online for 2 and half hours and at 11.30, all of you need to exit the meeting, get up, get a drink because the next task that they had to do was really draining. So we have like an ADHD tracker and it has got every child on the waiting list on there and it can be messy and chaotic, it can be quite anxiety provoking when you find a child that has been waiting for 2 years, think shit how have I not seen them before, so I knew that task was going to be one that was going to really give them a lot of work, so that was why I was like right stop, get out of the meeting, get up, have yourself a little	

	5-10 minute refresher before you sit down again. Some of the staff members were like no I'll be alright but because some of my staff members that know me really well, are like yep [redacted] we are going to log off now, we will speak to you in a bit. It encourages the others to do it as well, as self-care can be a little embarrassing for some people. Ah no I'll be fine, I'll just carry on, so I do think the other staff members who know me well say listen it's important that you do this, they encourage the other staff members. I think everyone in community needs to be told, it alright, its ok to stop.	

Personal Experiential Themes (PETs) for Participant 1

PET A: PERSONAL VALUE OF CLINICIANS NEED IN THE REFLECTIVE SPACE

Awareness of what I need from the space

Awareness of what is needed from reflective practice to create a positive and containing space. P.12

"Then there would be like a physical closing, the paper would be ripped, scrunched up and put on the table and somebody would peel open the fruit. There was a natural transition from this focused reflective mode and because it all finished on compliments if you like or people saying what you did really well."

Awareness of needing affirmation from the space. P.1

"It was space I really looked forward to and we all looked forward to."

Reflective practice is about a space to feel safe and validated. P.1

"But actually it was invaluable, the validation, so we used a solution focused approach for reflective practice and it was really positive."

Understanding what was not helpful

Understanding the value of the sessions. P.8

"Sometimes only one staff member would be in there and I think it became something it really shouldn't have become."

Reflective practice is not about feeling exposed or put on the spot. P.1

"it felt that it was going to be a negative space to be picked on a little bit, feel a bit exposed, I think historically the space hadn't been managed very well."

Awareness of what was not helpful leading to a lack of motivation. P.12

"but the sessions when I use to feel oh my god shut up or this isn't reflective practice or I use to think this is draining, like if somebody use to moan and moan, that doesn't feel very reflective for me."

Essence of frustration in the value of the space being missed P.4
"That felt a bit hard as well, as you would think why are you in this space if you are just looking at, if I had something to do I wouldn't come into that session."

Increasing knowledge of what made the reflective space helpful. P.4
"It did sort of use to start feeling taken over by one particular person's difficulties, so it didn't feel helpful in that respect."

Past experience influences

Recognition of the benefit of reflective practice from experience. P.13
"Because of it's value but I definitely have a varied experience of it. I'm glad that I appreciate the value it brings because I lacked that awareness before."

Contrast of expectations versus reality based on past experiences. P.10
"When we went in there and she did the first case presentation to sort of show us what it would sort of look like, it became a really enabling space."

What gets in the way

Prioritisation of other factors over the reflective practice groups. P.6
"I think if reflective practice had been given that same like no you need to be there, I think if it wasn't every day, because like initially the every day thing sounded good but it lost its value then."

A. Impact of the pandemic

The impact of change on working practices

Awareness of the change due to the pandemic and the impact this had on routine. P.3

"The concept of working from home felt like logistically felt, how am I going to do that? Then when it happened I haven't got to worry about what I'm wearing, how my hair washed."

Structure being lost due to change in working practices. P.2

"When it came it came to the pandemic, everything shifted online, I suppose what we didn't do was follow any structure as such."

Change in working practices and the implications of this for clinicians. P.2

"The online functions came quite quickly didn't it and once we figured out how to use it."

Reflecting on the process of change and the impact on physical and emotional wellbeing. P.3

"I'd never worked from home online in my life, so maybe at the time I couldn't reflect on the positives or the negatives of it but would still be able to process it in that time as being quite valuable."

The need for maintenance

Maintenance of a structure within the clinical framework in times of uncertainty. P.6
"I was thinking mental health has always been an issue for us its just becoming loud now, your thinking everyone's working from home, you don't have that social structure in the office and stuff."

B. Value of structure in Reflective Practice

Management of structure

Value added of the reflective space being managed for some team members and not others. P.2
"It's interesting because I use to find myself getting annoyed at people when it was their turn and they'd say I don't have anything to bring."

Feeling safe within a space that creates vulnerability. P.6
"I think that pushed you into a position where you could get a bit defensive and yeah well I could have done that, but what ever. But because you couldn't speak it really did push me into a frame of mind of what you are saying has really good value."

Safety and containment provided by a leader. P.8
"When she was there it was a lot more structured because she able to say like, that's great, its been really good hearing from you, how's everyone else getting on"

Intuitive understanding of what structure provides

Moving away from structure. P. 3
"when we had reflective practice as a team before the pandemic it was structured diary appointment, as when the pandemic happened it was more of an option but I found people were more willing to come to it, it did give them a chance to talk about their wellbeing and stuff."

Structure provides safety. P.4
"100% having a structure around it, because there weren't like any notes being taken it was literally that one whiteboard, because you would physically see it being wiped clean, or physically scrunched up and popped into the confidential waste bin."

Structure providing meaning and a sense of validation. P.9
"I think if it's a model that has a good structure to it, it doesn't sound like it would be better than solution focused because both of them are routed in focusing on the positives."

Positive affirmation leading to motivation after containment. P.12
"There was a natural transition from this focused reflective mode and because it all finished on compliments if you like or people saying what you did really well. It felt like there was a physical transition, those particular sessions I would come out feeling like motivated, quite light, quite happy."

Structure and Containment being important – bring clarity. P.13
"So that when I do give them that space , I always remember that when they come out of this I want them to come out of this ready to work."

C. Growth and learning in your clinical role

Increasing learning opportunities
Reflective practice creating learning opportunities to grow with the role of clinician. P.2

“We all learnt the value of picking up on strengths and areas of improvement and stuff.”

Context of being a space to explore learning opportunities leading the sense of validation. P.12
“The fact that [redacted] use to say you have done a great job or that was really tricky to deal with and you dealt with it in a really good way.”

Evolving through learning opportunities. P.14
“Team of people to come in and teach us mindfulness and like I was the only one in the room that didn’t know much about it, which was so embarrassing almost. But like now when I am feeling stressed or overwhelmed, I literally force myself to come back into the moment.”

Needing Affirmation in clinical roles

Positive affirmation – needing this to carry on and take forward into clinical work for themselves and others. P. 10
“That affirmation for me was really valuable, maybe that goes back to my own schema’s and how I am as an individual but very much of the opinion that if somebody has done well at work then you should be able to say, do you know what you did a really great job and I take feeling into my work now.”

The power given to what affirmation mean to job performance. P. 11
“Positive affirmation definitely helps my wellbeing and wanting to be in work.”

Needing to be looked after

Confidence needs to build to allow growth in clinical abilities. P.10

“I think I’d worked long enough in the team to be literally questioning myself, I am doing the right bloody thing here and because no one was saying that was really good, the thing is I still need affirmation at the end of the day.”

Management of expectations and what is possible to achieve with in the specific clinical roles. P.13
“You know before I could quite hung up on, we had an assistant PMHT practitioner, whatever that’s supposed to be and that obviously our role was to support her but I use to find myself getting hung up about that stuff, because I didn’t feel very well looked after.”

D. Impact of stress

Recognising stress building

Acknowledgement of the increasing stress and pressure to prove there were working. P.4

"So overtime it started to feel like they need to see me at 9."

Building stress. P.7

"I think that had a knock on in the reflective session as on the Wednesday when we would have it, it use to feel like also, oh you are just checking to see if you have logged in at 9 o clock."

Stress playing a major factor in management of time and attendance at reflective practice. P.7

"I use to think you are so bothered about me logging in a 9 and saying good morning at 9 to prove that I am on teams but you don't give two hoots that, your not asking why is no one in the reflective session today."

Anticipation of stress with the clinical role. P.11

"When I was asked to call her back, I instantly felt really anxious about it, because I thought if she's abusive to me, I will have to deal with it, it's fine. Its not going to feel very nice that I can't say to somebody oh my god I had a really bad call with a parent"

Reducing stress

News ways of working. P.2

"The first thing people said was how nice it was they didn't have to stress about parking and things like that. So actually I could see the benefit to it."

Acknowledging that clinicians need to stop and allowing you to reflect and take notice to then move forward more thoughtfully. P.14

"I think everyone in community needs to be told, it alright, its ok to stop."

E. Building relationships through reflective practice

Building team cohesion

Building relationships with team members. P.1

"I do think it made the staff members come together a little bit more."

Relationships being managed within the space which led to feeling more safe with in the team. P.2

“There was a particular person at PMH, that I always struggled to get along with and in reflective practice I always use to like to be mindful that I might take his comments negatively, but genuinely, because the space was safe I like could learn a lot from him and realise that there was space for learning for him as well, I think that kind of helped build team moral as well.”

Contrast of face to face to online knowing that you are being heard and not dismissed. P.4

“Where as online, it use to feel dismissive, cause like I would, if the background was a bit darker, you could see other people, they have glasses on and you can see they are looking though their emails or something.”

Recognition of what others can bring or may need for their clinical role. P. 11

“I missed that email from [redacted] last week, thank you so much for picking that up, it was really helpful, I think you dealt with that in a really good way.”

Appendix 12

PET	Sub themes
Participant 1 **PET A: PERSONAL VALUE OF CLINICIANS NEED IN THE REFLECTIVE SPACE** **PET B: IMPACT OF THE PANDEMIC** **PET C: VALUE OF STRUCTURE IN REFLECTIVE PRACTICE** **PET D: GROWTH AND LEARNING IN THE CLINICAL ROLE** **PET E: IMPACT OF STRESS** **PET F: BUILDING RELATIONSHIPS THROUGH REFLECTIVE PRACTICE**	**1: Awareness of what I need from the space** **2: Understanding what was not helpful** **3: Past experiences influences** **4: What gets in the way** **1: The impact of change on working practices** **2: The need for maintenance** **1: Management of structure** **2: Intuitive understanding of what the structure provides** **1: Increasing learning opportunities** **2: Needing affirmation in clinical roles** **3: Needing to be looked after** **1: Recognising stress building** **2: Reducing stress** **1: Building team cohesion**
Participant 2 **PET A: GROWING IN THE CLINICAL ROLE THROUGH LEARNING** **PET B: VALUE OF REFLECTIVE PRACTICE** **PET C: PERSONAL VALUE OF REFLECTIVE PRACTICE** **PET D: FINDING CONTAINMENT IN ISOLATION**	**1: New ways of working** **2: Development in the clinical role** **1: Building self-awareness** **2: Feeling safe** **3: Building relationships**
Participant 3: **PET A: THE PERSONAL VALUE OF REFLECTIVE PRACTICE** **PET B: NEGATIVE EXPERIENCE OF REFLECTIVE PRACTICE** **PET C: IMPORTANCE OF STRUCTURE TO REFLECTIVE PRACTICE** **PET D: STRESS AND COPING**	**1: Supporting emotional wellbeing** **2: Sharing experience** **3: Attributes needed from reflective practice** **1: Feeling unsafe** **2: Barriers created to reflective practice** **3: Conflict within containment** **1: New ways of working**

PET E: GROWTH AND DEVELOPMENT THROUGH REFLECTIVE PRACTICE	**2: Development in the clinical role**
Participant 4 **PET A: BALANCING PERSONAL AND PROFESSIONAL EXPERIENCE**	**1: Allowing space for acknowledgement of needs.** **2: Impact of personal situation at work** **3: Service Demands**
PET B: REFLECTIVE PRACTICE AS A SUPPORTIVE SPACE	**1: Being able to stop and process** **2: Containment of the team** **3: Containment of feelings**
PET C: STRUCTURE AND TIME	**1: Support to attend reflective practice** **2: Structure being key**
PET D: REFLECTIVE PRACTICE AS A UNIQUE SPACE	
Participant 5 **PET A: STRUCTURE OF REFLECTIVE PRACTICE**	**1: Clearly defined roles** **2: Impact of the model of Reflective Practice**
PET B: IMPACT OF THE PANDEMIC ON REFLECTIVE PRACTICE	
PET C: IMPORTANCE OF ATTENDANCE	**1: Impact of attendance** **2: Barriers to attendance** **3: Consistency** **4: Improvements need to change attendance** **5: Conflicts of time**
PET D: REFLECTIVE PRACTICE FEELING PURPOSEFUL	
PET E: CLINICANS GAIN FROM REFLECTIVE PRACTICE	**1: Opportunity for openness of thinking in RP** **2: Looking after the clinician's wellbeing** **3: Benefit to the clinical role** **4: RP as a safe space**
Participant 6 **PET A: EFFECTIVE FACILITATION OF THE GROUP**	
PET B: INFLUENCE OF CHANGE (PANDEMIC)	
PET C: IMPORTANCE OF STRUCTURE FOR REFLECTIVE PRACTICE	**1: Model and guidelines creating safety** **2: Growth as a clinician through the structure**
PET D: EFFECTIVENESS OF REFLECTIVE PRACTICE	**1: Recognising the benefits of reflective practice** **2: Reflective thinking to allow exploration of thoughts**

PET D: IMPACT OF REFLECTIVE PRACTICE ON CLINICAL WORK	**3: Resilience of the clinician** **1: Over-worked** **2: Implications of management support** **3: Influence of reflective practice on good practice.**