Matrix Reflective Practice Framework

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1. INTRODUCTION

1.1 Why are we doing this?

The Forensic Matrix working group (FMWG) requested that a group be set up to investigate and address the issue of reflective practice (RP) for multi-disciplinary staff and teams in Forensic Mental Health settings. This was for a number of reasons, outlined below –

- Primarily, it was felt important by the FMWG that there should be a system to ensure the quality of delivery of RP. This included considering it within a governance framework that would help RP be delivered in a safe, effective and accessible way across the Forensic Network.

  To have a full set of discussions to agree and establish what is, and what is not, meant by the term Reflective Practice. It was felt that having an expert panel who would also review the relevant literature would allow for a clear definition to be obtained. This included delineating RP from clinical supervision, professional line management, consultation and psychological therapy.

- To aid this governance process it was agreed by the FMWG that it would be helpful to outline the skills required to facilitate RP. This included addressing the need for there to be a set of competency guidelines, which existing and potential RP facilitators could compare themselves to. This would hopefully ensure a greater quality in delivery of RP and outline the skills that are required to deliver it. Such a framework would require a description of the knowledge, skills and attributes required by people to deliver RP.

- The creation of these competence guidelines would hopefully then allow for a reduction in geographical variation in the practice of RP, ensure that facilitators were adequately trained and potentially provide the beginnings of the creation of a training pathway for practitioners who wish to facilitate RP.

- There is currently a limited provision of RP across the FN and it was hoped that the creation of a pathway might allow for there to be a general increase in access to RP for forensic mental professionals – especially as many professional frameworks consider it an important part of working, and surviving, in complex and kinetic forensic environments.

1.2 What is the context for this paper?

There have been a number of developments within forensic mental health both in Scotland and the UK that have provided the backdrop and impetus for this paper. These have included the Scottish Group of Forensic Clinical Psychologists' "Position Paper on Psychological Approaches to Personality Disorder in Forensic Mental Health Settings" (Russell, 2016), which outlines the need for a comprehensive, considered and reflective approach to the care and treatment of Personality Disorder (PD) – something which RP could be considered integral to.

Alongside the above, is the FMWG's subgroup that is addressing the provision of Structured Clinical Care (SCC) for Forensic Mental Health Services. This latter group is tasked with outlining how services can

provide comprehensive, wrap-around, psychologically minded reflective and responsive care for patients with PD and personality dysfunction. Such a service requires its practitioners to be reflective on their interactions and interventions with forensic mentally disordered offenders – a task that can be addressed through the medium of RP. This group is due to release its paper in Winter 2017.

Also within the forensic sphere there have been a number of UK documents that have outlined the need for staff to have access to reflective practice. These include the Royal College of Psychiatrists (RCPsych) "College Centre for Quality Improvement - Standards for Psychotherapy in Medium Secure Units" (Macallister & Jacobs, 2012 – CCQI132). This helpfully synthesises some of the evidence with regards to the importance of provision of RP in forensic settings. A second document that stresses the importance of relational security aided by having staff team's come together and engage in RP is the Royal College of Psychiatrists and Department of Health's "See, Think, Act – Your Guide to Relational Security" (RCPsych, 2nd Edition, 2015). Similarly, this is also recognised in Royal College of Psychiatrists "Standards for Low Secure Services" (Tucker et al., 2012).

A number of enquiries into the care and treatment of patients who have offended or are contained within forensic settings have all either alluded to the importance of staff engaging in a reflective process or have recommended it directly. These include the Fallon Inquiry into the PD unit at Ashworth Hospital (DOH, 1999), which deals with how staff and patients became caught in a pernicious, toxic and dangerous dynamic that led to serious breaches of security. Similarly, the "Falling Shadow: One Patient's Mental Healthcare 1978-1993" (Blom-Cooper, 1995) and "Too Close to See" (MWC, 2009) both illustrate how staff team's that are not being asked to formally reflect on both their relationships with and treatment of patients can lead to catastrophic, fatal consequences.

Across the UK and across professional disciplines, RP is regarded as an integral part of a clinician's work and responsibilities. For example, within nursing, the "Review of Mental Health Nursing" (DOH, 2006) and the "10 Essential Shared Capabilities for Mental Health Practice" (NES, 2011) both acknowledge the importance of professionals being reflective practitioners. The General Medical Councils' "Good Medical Practice" (GMC, 2013) also states that all doctors should regularly reflect on their own practice. The recently revised NMC Code is also hugely focused on requirements for nurses to be reflective; and providing evidence of being a reflective practitioner is now an essential requirement for future professional revalidation. In an influential document, '*New ways of working for applied psychologists in health and social care'*, psychologists are being encouraged to lead on reflective practice provision (DoH, 2007).

The literature reflects a growing recognition of the importance of this work in psychiatric settings. On acute inpatient wards there has been a particular emphasis on reflecting in groups since the policy implementation guidance for Adult Acute Inpatient Care Provision states:

- *"It is essential that staff have the opportunity to jointly reflect on the impact of the day to day work with users and their families in order to feel informed and empowered to make the most effective interventions."(Department of Health, 2002, p.33).* This guidance draws a clear link between staff being able to jointly reflect and being able to deliver the most effective interventions. This idea has been further promoted in the Ten Essential Shared Capabilities framework (Hope, 2004) which identified an ongoing commitment to personal and professional development through supervision and reflective practice as a necessary part of workforce development.

1.3 Who were the panel and why were they selected?

The panel were selected to be a diverse, multi-professional group coming from a variety of theoretical backgrounds. All were chosen because they have significant experience in attending, leading and delivering RP.

A fuller biography and description of the panel is found in Appendix A.

2. WHAT IS REFLECTION?

One of the key questions that the panel identified was – "What is reflection within a clinical context?" There are many definitions from the literature identified for reflection but the panel felt it was important to differentiate RP from "reflective learning" (Kolb, 1974).which is prevalent in pedagogic literature and exemplified by Kolb's Learning Cycle.

Although the concept of reflective learning overlaps with the idea of RP in forensic settings – and indeed, RP would hopefully encompass the idea of "reflective learning" – they are not the same. This is because RP groups (RPGs) also encompass a situation where reflection is taking place, often about relational situations, where the interpersonal dynamics both in the group and out of the group are being attended to explicitly and implicitly. RPGs are spaces where staff can have the opportunity to reflect, from the micro- to macroscopic level about their work – starting from patient dynamics, moving up through team, group and ultimately up to the scale of the wider organizational processes that might be impacting on situations and therefore usefully reflected on. This provides a further source of information for both the RP practitioners and facilitators to listen to and make us of in their work.

With the above in mind, the panel agreed to limit its focus to Reflective Practice Groups (RPG) rather than the multiplicity of other reflective contexts and tasks that can take place in healthcare settings – eg keeping reflective journals or critical incident reviews. It was felt that this delineation would be important for the following reasons -

- To ensure that the panel had a defined manageable domain to scope.
- To limit getting stuck in abstract, esoteric descriptions about what a 'process of reflection' is more generally.
- Forensic clinicians and organisations, for the reasons outlined in section 2.3, need to increase their capacity to be reflective about their work with complex forensic patients – particularly those with a diagnosis of PD.
- RPGs are created to increase reflectivity and are not just educational.
- RPGS explicitly attend to Interpersonal dynamics in group settings - wards, therapy teams, institutions, outpatient teams, and RP groups themselves.

3. LITERATURE REVIEW

The group spent their initial meetings trying to establish what evidence base might be available regarding RPGs. What became apparent from searching MEDLINE, EMBASE and other online resources was that there was moderate qualitative evidence about the RPGs with largely positive findings about effectiveness but a lack of quantitative data about this. There is a small amount of papers describing what constitutes RPGs in terms of how they are delivered but less on effectiveness in relation to staff or patient outcomes or experience. This is clearly an area that requires further study and is something for researchers across the Forensic Network to consider going forwards – alongside more rigorous studies looking at the impact and process of RPGs for staff. Were this group's work to result in an increase in RPGs being delivered around the country there would seem to be significant opportunities and need to look at the evaluation of the impact of groups on staff, patients, teams, organisations and the milieu.

The panel was aware of various sources of information that were then examined and their references subsequently hand-searched. All the evidence that was found has been summarized and included in appendix B, included doctoral theses, classic papers from the psychoanalytic canon and more recent descriptors from group analytic and other psychodynamic literature.

These sources were then reviewed by the group as a whole and discussed for their relevance of content to the papers and, more importantly, their applicability to developing a competence framework within Scottish Forensic Settings.

RPGs are poorly researched in terms of quantitative data and rigorous controlled studies. However, absence of evidence does not mean evidence of absent effect. Heneghan's Literature Review (Heneghan, 2014) summary is a reasonable overview. The summary of other studies in terms of process and outcome clearly highlights the value staff place on RPGs. The outcomes of: increasing ability to manage emotions, solve problems, increased reflection-in-action and improved team cohesion are recurrent themes. There were also similarities in the challenges identified, i.e. conflict between work demands and being freed up to attend RPG, the role of the facilitator and their ability to create a 'safe space'. Few studies were able to evidence changes in ward atmosphere or patient outcomes. However there is an acknowledgment that this is harder to measure in a controlled way given the many variables that can affect patient outcomes. More comprehensive and longitudinal research is required.

The factors in this document are therefore hypothesised and anecdotal experiences and processes that have been considered by the expert panel of the group and have been documented in the meta-psychological theoretical literature.

4. WHAT IS A REFLECTIVE PRACTICE GROUP AND WHAT ARE ITS PROCESSES?

Based on the literature review, we produced a definition of Reflective Practice Groups as:

- "Groups of healthcare staff, who meet regularly with a consistent facilitator. The facilitator is a clinician trained in one or many therapeutic modalities, which allows them to help the staff reflect on their day-to-day clinical work with complex forensic patients in a safe setting. Although the primary focus is on the patient, it is acknowledged that staff, team and organizational dynamics all interact with their work and are available to be thought about in RPGs"

- RPGs are distinct from line management as the purpose is not to critically evaluate and help with staff performance. Nor are RPGS places where discussions about bureaucratic functions such as annual leave requests should be taking place, or at least not without consideration as to what such conversations might mean in relation to unconscious processes!

- Similarly, RPGs have a different framework, ethos and task from clinical supervision. The latter is a forum to ensure clinical governance, with all that entails of work being safe, effective and person centred etc whilst ensuring fidelity to whichever treatment modality is being employed. Clinical supervision also usually has participants in an asymmetric relationship with one, the supervisor, having different knowledge, skills and authority from the other, the supervisee. Clinical supervision, although a process to help share and foster understanding and learning is not a democratic process whereas RPGS should be. In addition, clinical supervision is usually wholly focused on the therapist – patient interaction rather than explicitly attending to wider dynamics in the organization. Participants are from all levels of training including unregistered staff. What is important is that they are staff who are interacting with patients. Staff groups may be uni-disciplinary or multi-disciplinary.

- A fuller description of the group's thinking in relation to RPGs if found in Appendix C.

4.1 Processes of Reflective Practice Groups

4.1.1 Introduction – a relational account of the problem under consideration

Practitioners working with patients in forensic settings can face substantial challenges in their day-to-day work. Many patients have ingrained patterns of relating to themselves and others that are damaging to the individual or others around them (Craissati et al., 2015). This can lead to challenging situations for clinical staff, teams and the organisations they are held in, including –

Patient situations

- Patient appears to want and need help but is hostile and undermining of attempts to help him.
- Patient places high demands on staff time, with a sense of entitlement, and verbal abuse.
- Patient is chronically unwell with psychotic symptoms and does not seem to be making improvement.
- Patient is withdrawn and distant, refusing to engage with staff.

Team/Group situations

- A team is split between viewing a patient as being vulnerable and in need of care versus them being viewed as dangerous and manipulative.
- More junior members of a team perceiving "Management" as thoughtless and uncaring, with managerial colleagues perceiving more junior members as irresponsible and inconsistent.

Organisational situations

- A unit becomes plagued with increasingly high levels of staff sickness and absence – perhaps as a result of unspoken or unacknowledged anxieties about safety or staff being valued.
- Two services, geographically distinct, find it increasingly hard to negotiate referrals, admissions and transfers because of projected views about the others' contexts.

It is to be expected that staff, teams and organisations may have responses to such situations (e.g. frustration, feel helpless to make a positive change, worry about provoking the person). From a relational perspective, if a patient repeatedly and strongly experiences staff as, say angry or abandoning, this can induce others to actually feel that way towards the patient. This is a normal and inevitable process, and our own feelings in response to working with a patient can provide very useful information about him and how he interacts with others. However, over time, these responses can place a strain on practitioners and teams, potentially reducing our interest and satisfaction from the work.

Similarly, processes that may emanate from patients, staff, teams or the organization can reverberate up or down the organization's system affecting any or all of its component members. For example, if the organization is receiving critical media attention for a non-clinical issue – eg their budgetary problems - this may place increased psychological strain on indicudal staff and team members who are identified with the organization; which may then impact on patient care as staff feel more rundown in the perceived 'eye of the general public'. Alternatively, a very difficult and complex patient who is persistently assaulting staff may impact on team dynamics, which may then impact on the organisation as talk of this patient spreads throughout the service that contains the team.

Unless clinicians, teams and organisations have the opportunity to make sense of and process their feelings in relation to patients, sometimes these can hinder attempts to form consistent and long-term relationships with patients – as well as impacting on team and organizational functioning. One important way this can happen is by clinicians beginning to act on their feelings – i.e. their feelings start to affect their actual behaviour towards the patient. We can all do this, and this is inevitable to a degree. Via this interpersonal 'nudging' (Gabbard, 2010), which may occur without patient or clinician realising what is happening, there is the potential for aspects of the patient's expectations about (dysfunctional) relationships to be repeated in some form in his relationships with psychiatric staff (Hinshelwood, 2002) – or indeed in the way that teams inteact with other, the organization or even between larger organizational systems.

4.2 The set up of Reflective Practice groups

The overarching aim of the set-up of RPGs is to provide a setting where staff feel safe-enough to discuss their work with patients, so as to maximise the potential for staff to attend to the tasks as described in section 6.

The underlying framework and principles for RPGs were agreed by the group as below -

Group principles: -

- A regular, non-judgmental setting where participants work supportively with each other and the facilitator to explore clinical encounters with patients, team dynamics and organisational issues.
- A supportive and empathic stance is taken by group members, led and modelled by the facilitator
- The facilitator is someone who is not part of the team that is being worked with.
- Clinical situations and encounters with patients are explored with a constructively challenging and non-collusive stance where needed.
- Confidential – a rule of the group is that what is said remains within the group.
- Everyone is invited to participate in discussion – people contribute different perspectives
- Participants keep responsibility for their work (Hawkins and Shohet, 2007)
- The RPG is separate and distinct from other formal patient management meetings (such as ward rounds or CPAs). This allows staff to explore their responses to patients more easily and with less pressure to try and 'solve' problems too soon, which would foreclose the discussion.

Organisational aspects of the group: -

- Regular (at least monthly), at the same day, time and place
- Same facilitator(s)
- Management 'buy-in' and support from senior team members
- Confidentiality boundary (with appropriate limits to this)

The regularity of sessions is important for several reasons:-

- to create a predictable and secure frame within which the group can work
- ward managers need to know the time to support staff coming
- to reflect that the task of RPGs is not intended primarily as a reactive measure to incidents.

4.3 RPG Processes

There are a number of important underlying psychological processes, which support the function in box 2. These are largely drawn from group analytic and psychoanalytic theory. For a fuller description please see Appendix D.

5. REASONABLE EXPECTED OUTCOMES OF RPGs

From our review of the literature (including: Craissati et al., 2015; Macallister & Jacobs, 2012) staff report and what might be reasonably hypothesized the following might be regarded as reasonable outcomes of RPGs.

- Staff notice how they are affected by patients
- Staff can 'process' this form of communication from the patient (rather than act on it by, e.g. avoiding the patient) and communicate something helpful back or, at a minimum, take up the least harmful response
- Staff react in a reasonably unified way (as opposed to splitting occurring in teams)
- Staff process the emotional impact of the clinical work on themselves to help maintain a sustainable and resilient clinical team and healthy organization.
- There are improved interpersonal dynamics between staff, teams as well as between staff and patients. Splits between staff and patients can be identified earlier and coherent and thoughtful responses can be implemented. Wards become less tense and more functional.
- There is an increase in understanding of organization, team, staff and patient dynamics, i.e. trigger points for patients, understanding of stressor points for staff can improve relational security
- As a result of the above, there is an improvement in staff wellbeing which in turn will lead to less sickness and absence and less burnout.
- There is an improvement in dynamics and therefore ward atmosphere will result in less incidents including the blurring of boundaries with some patients
- Clinical teams will have a more reflective staff group, which will aid the development of psychological formulations.
- Teams and individuals will have improved psychological flexibility
- There will be improved patient outcomes. Better relationships on the ward that results in less incidents and improved ward environments, has the potential to reduce incidents and risk and make patients feel more contained.
- For the organisation there is less sickness and absence. There are also fewer incidents which means less need for significant incident reviews.

All the above of course requires further study and the group hope that this paper might be a starting point for further research.

6. SUMMARY – REFLECTIVE PRACTICE GROUPS

In short and for the purposes of this paper the *explicit* purpose of an RPG is: –

- To create and sustain a facilitated group where the prime foci are
  - To increase staff awareness of interpersonal dynamics
  - To reduce counterproductive staff responses to patients
  - To increase the degree to which staff process their emotional responses to their work.

The *implicit* purpose of an RPG is to: –

- Reduce staff sickness and burnout
- Improve staff morale
- Improve staff empathy and attitudes to patients – especially those with a diagnosis of PD
- Contributes to the creation of – and is a key part of - environments that will provide 'structured clinical care' for patients (Russell, 2016)
- Improve patient's engagement and response to treatment

The Working Group agreed that the processes or issues that are the focus of reflective practice are:

- Helping staff to understand intra/interpersonal dynamics
  - Between Patients
  - Between Staff – Patients
  - Between Staff
  - Between Staff – Teams
  - Between Teams
  - Between Team - Organisation
  - Intrapersonal

The aim of RPGs is therefore to encourage staff to discuss and consider the relationships that patients are having between each other, which may be causing conflict on the ward) as well as relationships between patients and staff ,which may be causing conflict on the ward or within the staff team. Additionally, RPGs should consider the relationships between staff - where there may be conflict between staff members about how particular patients or patients groups are managed). In addition staff are encouraged to consider how patients relate to themselves, i.e. how do they tolerate distress, levels of self-esteem and self-efficacy, manage mood. Staff are also encouraged to think about how they manage or cope themselves in relation to their work. Alongside this, RPGs should be able to facilitate reflection about the organisation and how it is functioning as a whole as well as its relation to staff, teams and patients.

This may seem like a lot, but it encapsulates the wide range of interpersonal and intrapersonal dynamics that staff are having to manage when they come to work. Importantly, they may not be consciously aware that this is something they are doing.

Rather than other aspects of staff supervision and management which focus on task related activities that are pertinent to the fulfilment of job roles, i.e. the activities often laid out in job descriptions, this is a space to think about the necessary role of managing relationships with others that is necessary to the fulfilment of many of these tasks, but are often not clearly stated or recognised as being required. Schön (1983) in his work, noted that the knowledge implicit in some of the actions taken is hard to describe as it has been developed intuitively and has been internalised.

7. ROLE AND STANCE OF FACILITATOR

7.1 Introduction

The role and stance of the facilitator of RPGs draws on ideas and skills from several domains (Johnson et al., 2004; Scanlon, 2012) namely relational, in the main psychodynamic/analytic and group dynamic/analytic therapy approaches. Alongside this theoretical underpinning, facilitators require group-work leadership skills, awareness of systemic approaches and skills as an educator.

Key aspects of the role and stance of the facilitator (Johnson et al., 2004; Johnston and Paley, 2013; Scanlon, 2012) include:

- Conducting and facilitating discussion and exploration by the group, as opposed to being overly didactic. This allows the clinical team to work things out at their own pace.
- Keeping the group thinking and exploring about what is being discussed, including looking for meaning, asking for feelings (in relation to the clinical work)
- To tolerate and keep in play contradictory and multiple views as expressed by group members, rather than coming in and giving a verdict on what is being said (Johnson et al., 2004).
- Setting and maintaining group principles.
- RPGs are not therapy for staff. The facilitator keeps the focus on work situations and staff members' responses to these, as opposed to personal exploration as found in therapy. The facilitator will step in when needed to keep members feeling safe and also to ensure that no one individual is 'in the spotlight'.
- Keeping the group on task.
- In addition, the group are clear that RPG facilitators not be part of the teams that they are helping to reflect. This 'outsider' status preserves facilitators' ability to hold a democratic, neutral stance in relation to the teams they work with. Furthermore, it will prevent them being part of the problems they are trying to assist with.

7.2 Facilitator Competencies and Qualities

In addition to the above, intrinsic to role of the facilitator is to have knowledge and experience of the RPG processes as described in Appendix D, and be able to direct the group to employ these productively.

Additionally, the RPG facilitator must be able to distinguish between working in an RPG and working in other clinical / therapeutic situations. With this in mind, the working group developed the table below outlining the difference between RPGs, Clinical Supervision, Case-Consultation and Therapy.

TABLE 1. DIFFERENTIATING BETWEEN RPGS, SUPERVISION, CASE-CONSULTATION AND THERAPY

FACTOR	REFLECTIVE PRACTICE	CLINICAL SUPERVISION	CASE-CONSULTATION	THERAPY
Definition	Reflective practice sessions seek to develop the capacity to reflect on actions so as to engage in a process of continuous learning. It involves paying critical attention to the practical values and theories which inform everyday actions, by examining practice reflectively and reflexively. This leads to developmental insight. (Kirkland, J. 2016).	Supervision (Roth and Pilling, 2009) is a formal but collaborative relationship which takes place in an organisational context, which is part of the overall training of practitioners, and which is guided by some form of contract between the facilitator and the participants. The expectation is that the participants offer an honest and open account of their work, and that the facilitator offers feedback and guidance which has the primary aim of facilitating the development of the participant's therapeutic competences, but also ensures that they practice in a manner which conforms to current ethical and professional standards.	Case consultation These sessions are a theoretically-based explanation or conceptualisation of the information obtained from a clinical assessment. The sessions seek to offer a hypothesis about the cause and nature of the presenting problems and are considered an adjunct or alternative approach to the more categorical approach of psychiatric diagnosis. In case consultation sessions, formulations are used to communicate a hypothesis and provide framework for developing the most suitable treatment approach.	Therapy offers a safe, confidential place to talk about a person's life and anything that may be confusing, painful or uncomfortable. It allows you to talk with someone who is trained to listen attentively and to help you improve things. (BACP, 2018)
Set agenda?	Free flowing	Goal directed	Model dependent and will be about a particular case.	May be free flowing or goal directed – model dependent
Facilitator Stance	Facilitator activity dependent on group dynamic	Facilitator active	Facilitator active	Model dependent

FACTOR	REFLECTIVE PRACTICE	CLINICAL SUPERVISION	CASE-CONSULTATION	THERAPY
Collaborative?	Facilitator encourages group to do the thinking	Facilitator collaborates with supervisee in thinking about the patient	Facilitator collaborates with group in applying the psychological model about the patient	Model dependent
Reflective Stance?	Facilitator supports reflection	Supervisor supports reflection but also educates around model and ensures fidelity	Consultant supports reflection but also educates around model and ensures fidelity	Model dependent
Group Focus?	One of the primary foci is on group dynamics	Some focus on group dynamics	More focussed on patient/client/presentin g dilemma but model may determine this	Model dependent
Link to patient management?	Ideas about patient management may emerge from group but not explicitly on the agenda	Explicit link to patient management	Explicit link to patient management	Not applicable
Goal directed?	Less emphasis on defined goals beyond enhancing reflection	Clear goal at maintaining fidelity to treatment model, enhancing patient outcome, ensuring quality of care	Emphasis on achieving outcomes in direct relation to patient care	Direct emphasis on improving patient/s outcome
Facilitator Knowledge?	Facilitator has expert knowledge of RPG processes but maintains non-expert view of situation	Facilitator has expert role in model and supervision	Facilitator has expert role in model and case-consultation	Therapist has expert knowledge and skills in model and may maintain non-expert view of situation depending on model
Educational Component?	Less emphasis on imparting theoretical and technical knowledge	Emphasis on imparting theoretical and technical knowledge	Emphasis on imparting theoretical and technical knowledge	Less emphasis on imparting theoretical and technical knowledge

FACTOR	REFLECTIVE PRACTICE	CLINICAL SUPERVISION	CASE-CONSULTATION	THERAPY
Confidentiality	Boundary of confidentiality within the group (but also held in professional registration frameworks so can be breached if risk to patients or worker)	Boundary of confidentiality within the group (but also held in professional registration frameworks so can be breached if risk to patients or worker)	Boundary of confidentiality may be held within the group but will be negotiated depending on task (but also held in professional registration frameworks so can be breached if risk to patients or worker)	Boundary of confidentiality within the group (unless serious, imminent risk to patient/s or others)
Group affect focus	Emphasis on identifying and then containing / processing affect of the group	Emphasis on identifying affect for goal directed outcome	Emphasis on identifying affect for goal directed outcome	Emphasis on identifying affect for goal directed outcome

7.3 RPG Facilitator Prerequisites

The working group agreed that for people to facilitate RPGs within a forensic setting, there are a set of prerequisite criteria that individuals need to have in order to do this or to be able to access further training to become RPG facilitators. Competencies are necessary because RPG facilitator training is at a post-graduate level. In addition, clinical practice takes place within the NHS and so NHS requirements for clinical governance (ensuring quality of delivery and patient safety) need to be met.

These are outlined below: –

- Significant experience of working in Forensic Mental Health directly or having an appreciation of issues in Forensic Mental Health through further education.
- A core mental health professional qualification (eg nursing, psychiatry, psychology, OT, social work etc) with at least 2 years post qualification experience in a forensic mental health setting.
- For people who are eligible to skill up as RPG facilitators – evidence of academic ability to complete RPG training. Facilitators would normally be required to have completed previous courses of a similar academic level such as a post-graduate diploma or above, which have included having prepared and written essays or similar academic texts.
- Adequate knowledge and experience of psychotherapy or counseling. Including elements of both theoretical input and clinical experience in which the professional would have treated patients in a formal therapy / counselling structure under regular expert clinical supervision. Such a training course will usually have been of at least one year's duration.
- Previous experience of being in RPGs for at least 1 year.
- Has an appropriate RPG supervisor and demonstrates ongoing attendance at own supervision for RPGs
- Can demonstrate competencies in running an RPG

- The role of RPG facilitator should be one that is voluntarily applied for or taken on. It will be unhelpful for professionals to be *made* to take this on as will be likely to cause difficulties in maintaining a helpful frame for RPGs.
- RPG facilitators should have their own supervision in place prior to running RPGs. Supervision should be weekly for novice RPG facilitators and then negotiated in frequency with increasing experience.

7.4 Core Competencies

In addition to the prerequisites above, The below are the core competencies the group agreed RPG facilitators require to run groups: -

1. Facilitate reflection within relational contexts
2. To understand and be able to work with affect in the RPG's
3. To be able to tolerate disturbing narratives
4. To be able to manage interpersonal conflict within the RPG
5. To be able to provide a safe space for RPGs including manage intra- and inter-group boundaries

We are aware that psychoanalytic theory is mentioned in the below but this shouldn't be regarded as a way to exclude professionals but rather a signpost on how to help professionals develop knowledge and skills to deliver effective RPGs. We also recognize the already present level of knowledge, skills and experience within the psychological workforce generally in understanding and using these concepts – even if they are not always branded as psychoanalytic directly.

The purpose of the below framework is to help practitioners focus on knowledge and skills they already possess and then identify areas that will need development in a training course. The latter will allow staff to demonstrate the competencies they already have and support them to build others to allow them to be accredited as RPG facilitators. The framework is not designed to be either an exclusionary set of 'tick boxes' to stop people delivering RPGs nor to direct them to a many years long psychoanalytic training (!). The group are aware that there is 'more than one way to skin a cat' to reach and demonstrate the competencies required. For example, - being able to "demonstrate an understating of psychoanalytic concepts that relate to individuals" may be attainable via different routes, different backgrounds or different trainings – be they therapeutic or professional. As such, we are not asking for practitioners to demonstrate qualifications but rather to establish their RPG facilitator competencies.

The purpose of the below section is also to help managers identify suitable clinicians for training in RPG facilitation and for clinicians attending RPGs to feel confident that their RPG facilitator has the relevant training, skills and experience to deliver a creative, well-boundaried and helpful group.

The tables below consider the above competencies in turn. In addition, they concentrate on three areas: what facilitators need to know (Knowledge), do (Skills) and why these items are important.

Table 2. Core competency 1 - facilitate reflection (Potter, 2013)

KNOWLEDGE	SKILLS	WHY ARE THESE IMPORTANT
Understand the concepts and experience of transference and countertransference	Be able to focus on the relationship and the push and pull of transference and counter-transference feelings from the staff member and elsewhere so as to be explored and processed in the room – keeping a consistent and interested stance in the patients	Reflecting on the process of care and treatment is not something that we can easily do on our own. Even the most experienced practitioner needs a bit of help in terms of understanding their work with complex forensic patients – as well as a setting that can help them understand and make use of their relationships with staff and patients.
Understand an interpersonal approach to focus upon creating a collaborative and reflective relationship	Be a skilled communicator, sensitively creating collaboration and reflection	
Understand psychoanalytic concepts that relate to individuals	Be able to draw upon and potentially teach RPG members about basic psychoanalytic concepts such as projection projective identification in a readily understandable way - as well as help them reflect on the relevance of these concepts to their everyday work	
Understand psychoanalytic concepts that relate to groups		
Understand psychoanalytic concepts that relate to organisations		
	Be able to hold and maintain a genuine, curious and empathic stance towards RPG members and material	
	Be able to reflect upon their own associations to material discussed in RPGs and share these when appropriate and in an affectively modulated way.	

Table 3. Core competency 2 - understand and be able to work with affect

KNOWLEDGE	SKILLS	WHY ARE THESE IMPORTANT
Understand that participants may find it more challenging to take part in groups where the expectations are that they discuss the emotional impact of the work – this may be seen in a lack of affect brought	Help group to notice, identify, safely manage, process and then aim to contain each others' affects. Do not avoid the affect in the group.	The purpose of RPGs is to help health professionals further understand themselves and their motives, perceptions, attitudes, values and feelings associated with patients care (Price, 2004)
Group members will bring different affective response that you will see when running the groups, facilitators will need to be aware of the impact of this upon themselves	Manage facilitator's own affect in relation to the group and try to avoid over- or under-engaging with the group's affect. This would include understanding that facilitators need their own supervision and reflective practice. This would include using supervision effectively for your RPG work.	
The importance of being supportive at times to staff struggling with difficult situations	Engage in an explicitly supportive and constructive dialogue themselves with staff and staff with each other during difficult situations	To help staff manage with the day to day complexities and strain of forensic environments
The importance of acknowledging positive interactions and outcomes both in and out of RPGs	Engage in an explicitly supportive and constructive dialogue themselves with staff and them with each other when things have gone well	To help staff recognize when things have gone well and build on these experiences and processes
Understand the importance and necessity for having supervision of facilitators' RPG work		

Table 4. Core competency 3 – tolerating disturbing narratives

KNOWLEDGE	SKILLS	WHY ARE THESE IMPORTANT
Understand that facilitators will sometimes hear difficult, challenging, grim, violent and perverse material	Be able to listen non-judgmentally, listen and tolerate the difficult material brought	Forensic mental health care presents a particularly high demand on clinicians' skills. Patients in forensic services pose significant management challenges, often presenting with violent or aggressive outbursts and with complex histories of serious offending and trauma, which can be difficult and distressing for staff and RPG facilitators to deal with.
Understand that facilitators will sometimes hear hopelessness and despair from staff	Be able to provide a safe space for staff to feel heard, held in mind, empathised with, understood and contained	
Understand that facilitators will sometimes hear hatred and guilt from staff	Be able to not react to this, not judge staff feelings expressed, work with this to build reflective capacity	
Understand that facilitators will sometimes hear anxiety and anger from staff	Be able to make sense of this in relation to the staff's work and context – then help them make sense of it and process it	

Table 5. Core competency 4 – managing interpersonal conflict in RPGs

KNOWLEDGE	SKILLS	WHY ARE THESE IMPORTANT
Understand that there may be conflict within the RPG because of the material RPGs are working with	Facilitators need to be able to form a neutral though empathic and understanding relationship that is sufficient to evoke within the team an increased interest in them in understanding themselves, colleagues, other disciplines and, especially, their patients.	"Relationships are crucial to successful RP groups. You will have to form a relationship with anything up to 30 people depending on the size of the ward team. Relationships are with each individual member of the team, with 'the team' as a whole and with the 'group' who turn up for sessions each week…." (Johnstone and Paley, 2013) It is important to hold in mind that teams will not always 'get along' even with the provision of containing spaces such as RPGs and, in fact, some disagreements may be important to be held in teams to ensure different perspectives can be held.
Understand that not all staff will hold similar views about each other or their work, there will sometimes be differences of perspective and conflicts within teams	Hold in mind that facilitators need to be available to anyone working in the team, with equal attention available to all. Facilitators will need to be able to accept and integrate differences, manage conflict ensuring that all are heard.	
Understand that forensic mental health work can push and pull staff in extremes ways. Staff may seek containment of their fears, challenges and difficulties by wishing to gain the 'support' of you to the detriment of opposing views/staff	Facilitators need to keep a high level of self-awareness to try to notice when, even inadvertently, they get split off into supporting any sub-groups. And to be able to reflect on groups when the facilitator gets deflected from their neutral stance.	

Table 6. Core competency 5 – provide a safe space for RPGs including manage intra- and inter-group boundaries

KNOWLEDGE	SKILLS	WHY ARE THESE IMPORTANT
Understand the need for consistency, coherence and regularity for RPGs to create ‘safe spaces’	Ensure the groups run regularly; that facilitators and groups are predictable and remain consistent and coherent with their model	RP groups focus more on the patient and professional relationship. The emphasis is on the experience of the professionals, their feelings about the patient and the situation evoking a dilemma that not infrequently has a moral dimension as in judging the patient, or themselves, sometimes excessively critically or uncritically
Understand the need for and limits of confidentiality in RPGs	Hold in mind that forensic environments deal with risk and can be risky contexts. Understand the need to hold confidentiality but also when to breach it if necessary.	
Understand the difference between reflective practice and therapy	Manage facilitators own and others’ self-disclosures. Not delve into staff’s personal histories nor intervene therapeutically during RPGs. Tactfully redirect where appropriate	Staff need to be able to feel safe within groups and know that their boundaries will be acknowledged and respected.
Understand the importance of distinguishing between information that should stay in the group and useful information that might leave it – such as concerns about risk of harm	Help the group respond in different, more productive ways to patients whilst preserving the boundary of the RPG and its members	
	RPG facilitators should be capable of running groups that contain professionals who may be of a higher grade and/or level of clinical experience than themselves.	

8. CONCLUSIONS

It is hoped by the group that the above document will serve to clarify the purpose and potentially helpful outcomes that might stem from the integration of RPGs into day-to-day clinical life in Forensic Mental Health Services.

There has been previously little written for commissioners about the why’s, what’s, who’s and how’s of reflective practice. This paper will hopefully serve as an important starting point and outline framework for services to begin to see how they can develop RPGs and RPG facilitators of their own.

The above is of particular relevance given the current paucity of RPG facilitators or an accreditation process to train more RPG facilitators – especially given the desire of services to help their staff reflect more.

9. RECOMMENDATIONS

As a group it seemed to us that there were a number of helpful recommendations that might come out of this work that individual clinicians as well as local and national services and organizations might usefully address: –

1. A strategy to begin to develop quantitative research in the field of RPGs in forensic mental health settings as well as more qualitative research. It is recommended that this have a particular focus on staff and patient outcomes.
2. A working party should be formed to implement this research strategy
3. The competence framework outlined in Appendix E should become the basis for devising and running standardised training courses in RPGs. This would allow potential facilitators to be nationally accredited but also to ensure that there is a robust governance process for RPG facilitation more generally.
4. It is recommended that local services also begin to develop and implement local strategies and procedures to ensure equity of access for staff to RPGs across the Forensic Network.

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APPENDIX A – MEMBERSHIP OF THE GROUP

Who were the panel and why were they selected?

The FMWG initially selected a chair, Dr Jon Patrick, who trained as a Forensic Psychiatrist, Medical Psychotherapist and Psychoanalytic Psychotherapist. He was the first Consultant Forensic Psychotherapist in Scotland and had a depth of experience in setting up and facilitating RP in different forensic contexts. These RP situations have stretched from the community to high-security and across team types, treatment programmes and disciplines. He has also set up and run Mentalisation Based Therapy Case-Consultation Groups in a variety of forensic and non-forensic clinical contexts.

In discussion with the FMWG it was then decided to appoint the following members who were selected because of their varied and deep, extensive experiences in delivering, teaching about and receiving RP and other reflective groups in forensic environments. This group therefore was a multidisciplinary expert panel who would be able to provide an expert consensus statement to "provide guidance to health care professionals, esp. on controversial or poorly understood aspects of care." (Farlex, 2009) has a history of being at times controversial and poorly understood.

Mrs Patricia Cawthorne is a Consultant Nurse who works across the Forensic Network, including in prisons. Mrs Cawthorne has advanced training in Group Analysis and other psychological models that focus on the individual's level of reflective functioning. She has led on providing RP groups and supervisory spaces for multi-disciplinary staff in secure and general adult mental health settings. Mrs Cawthorne is currently engaged in evaluating the impact of weekly RP groups in NHS Ayrshire and Arran. She has been a member of reflective practice groups continuously throughout the 30 years of her career to date.

Dr Jamie Kirkland is a Consultant Clinical Psychologist working in the Division of Forensic Mental Health and Learning Disabilities NHS Greater Glasgow & Clyde. He is currently the lead for this service for Reflective Practice. Dr Kirkland has extensive experience of creating and delivering reflective spaces for multi-disciplinary staff using a Cognitive-Analytic framework. He first became a member of a reflective practice group in 1993, at the start of his NHS career.

Dr Claire Maclean is a Consultant Clinical Psychologist who leads Clinical Psychology across the three prisons in Greater Glasgow and Clyde. She is a committee member of MBT-Scotland and has organised and delivered MBT Case-Consultation Groups across diverse forensic settings and was directly involved in the clinical arm of a Clinical Psychology Doctoral Thesis researching the impact of these groups on inpatient wards and ward staff. She has been a member of RP groups throughout her career.

Dr Adam Polnay is a Consultant Medical Psychotherapist working in a general setting at NHS Lothian's Psychotherapy Department and in a high-secure forensic setting at The State Hospital. He is a qualified Psychoanalytical Psychotherapist who has been responsible for creating RP and supervisory spaces for staff across general and forensic environments for a wide variety of multi-disciplinary groups.

Dr Katharine Russell is a Consultant Clinical Psychologist who is the lead for Forensic Clinical Psychology in Lothian. She has extensive experience in working with patients (offenders) with Personality Disorder (PD) and has been a member of a reflective practice group for 10 years. She is also the chair of the Forensic Matrix Structured Clinical Care Group whose work dovetails with this paper and her previous report on Psychological Approaches for Working with Patients with PD.

APPENDIX B – SUMMARY OF EVIDENCE

What is the evidence?

Overall, one of the challenges faced by the Working Group was the limited research into the effectiveness of Reflective Practice Groups. There is a lack of quantitative data and rigorous controlled studies. What is the best way to assess the effectiveness of RPGs? Whereas most studies in mental health focus on outcomes for patients, in the limited research that has been done, the primary focus of research into RPGs in terms of change outcome is staff wellbeing. The benefits for patients are not presumed to be absent but is seen to be affected indirectly, e.g. improved staff wellbeing will ensure better performing staff. A summary of the main published research in the area is provided below. These were found through an OVID search on 'reflective practice groups' and an analysis of reference of key texts found.

Heneghan, Wright & Watson (2014) provide a summary of an unpublished literature review they conducted on reflective practice groups prior to their 2014 study (see below). They highlight that certain themes could be identified, e.g.

- creating a safe space to reflect in order to contain anxiety and stress,
- helping staff to make links between their feelings and experience, and their interactions with patients, and
- developing a thoughtful and reflective culture, atmosphere and milieu.

The content of the groups mirrored these aims in that they described the discussion of staff feelings being aroused by patients, team dynamics and the dynamic between staff role and organisational demands. The groups were described as helping staff develop a strong professional identity and increasing team cohesiveness.

In the review various outcomes were identified. Improving the efficacy of the staff team was achieved through linking practice to theory, increased understanding of personal and group responses to the work, realising the centrality of relationship with patients, teamwork and gaining new insights. The facilitator's ability to encourage and contain alternative viewpoints and also challenge the status quo was a key issue. The articles demonstrated that groups were not only a forum for reflective practice but also a mechanism for teaching reflective practice skills (Heneghan & Wright, 2014, p.325).

James Johnston and Pauline McAvoy in Leeds have published some work online regarding RPGs. Pauline McAvoy was a Trainee Clinical Psychologist who has written a thesis on the RPGs running in Leeds Partnership Foundation Trust in 2011 and 2012. The 2011 study was a Service Evaluation Project that looked at staff wellbeing and burnout comparing staff who attended vs staff who did not attend RPGs. The study looked at 6 RPGs across the trust. The RPGs varied as a result of different facilitators and emphasis. Staff groups included untrained staff and students. This study found that, on the basis of those that responded to a feedback questionnaire, **staff placed a high value on RPG and attended for positive reasons**. A thematic analysis of feedback suggested that **RPGs can have a restorative/resourcing function** for at least some participants. The five themes identified were: **having time to reflect, managing feelings, solving problems, quality assessment (benchmarking against best practice) and benefit of a group setting (social aspect of RPG with team).** However, it was acknowledged it was not possible to draw conclusions about stress and burnout on the basis of standardised measures. (McAvoy, 2011, p.22)

McAvoy (2012) is a doctoral thesis looking at significant events in RPGs by recruiting participants just after an RPG session and asking them to write a summary of what they found to be most significant about the session they had just attended. Using grounded theory, a process model was constructed. This comprised a group process, an intrapersonal process and a moderating process, which pertained to how psychological safety was maintained in the group. The study found that **creating and maintaining a safe environment** was a key task for the facilitator. Another finding was that staff actively participate in accordance with how psychologically safe they feel in the group. The main uses for RPG identified were using them to learn to maintain status quo, to deal with feelings, as a source of support, and to test limits of authority

Other studies have reported participants placing a high value on the group whilst simultaneously failing to prove difference in ward atmosphere or staff stress levels on psychometrics (Amaral, Nehemkis and Fox, 1981). It should be noted that this study lacked power

Powell & Howard (2006) conducted an initial evaluation of RPGs in a group of trainee clinical psychologists and reported participants frequently cited the group as being **helpful in managing the emotional impact of work** but there was less evidence that there was a behaviour change as a result of this insight.

Knight, Sperlinger & Maltby (2010) looked at the perceived value of Personal and Professional Development groups in trainee clinical psychologists. A factor analysis of a validated questionnaire revealed two factors of 'value' and 'distress'. **Almost half reported experiencing distress as a result of attending groups but the majority saw benefit in having had this experience**. Participants who had been in groups of 10-13 were less likely to report distress. In terms of facilitation, two aspects were found to be important. Participants more likely to report the group as valuable when they knew what theoretical model was being used. It was unclear whether the value was attached to the model (group analytic or psychodynamic) or whether it was the fact that the use of the model was explicit. In addition, the participants described more distress and rated the group as less valuable when they thought the facilitator was remote.

A follow-up to this study (Fairhurst, 2011) found several processes to be associated with participants perceived value of the group. These were:

- **negotiating the unknown,**
- **managing emotions,**
- **negotiating self-awareness,**
- **negotiating reciprocal impact of others**
- **and reflecting on reflection.**

The issues of staff feeling safe within the group again arose in a staff survey on attitudes conducted by Hartman & Kitson (1995). Staff that found the RPG unhelpful were more likely to note concerns about the safety of the space and the contribution level of other participants.

Dickey, Truten, Gross, & Deitrick, (2011) used a mixed methods study and found that staff of all grades and experience positively rated an RPG. Positive consequences were noted to be **increased personal resilience, increased team cohesion and increased ability to deliver high quality care as a result of attending**.

Platzer and colleagues (Platzer, Blake, & Ashford, 2000a, 2000b) studied 2 cohorts of post-graduate nursing students attending reflective practice groups as part of their training. **They found that certain group processes facilitated changes in behaviour or attitude** (Platzer, et al., 2000b). Examples of helpful group processes included receiving validation, encouragement and reassurance from the group, having the opportunities to learn from others' experience and perspectives, being constructively challenged or criticised and feeling less isolated. **The outcomes included feeling more confident, more able to empathise with others and more assertive about offering challenge to poor practice**. The participants also reported being **more able to think critically about their practice, to apply theory to practice and having a greater awareness of their professionalism and value base**.

Vachon, Durand, & LeBlanc (2010a) found **improvements in critical thinking** in a study looking at the use of RPG to help OTs utilise research evidence in their practice.

Rizq, Hewey, Salvo, Spencer, Varnaseri, & Whitfield (2010) carried out a thematic analysis of RPGs in primary care mental health workers and found RPG **allowed participants to think more about their training and career structures, their professional role and the ways in which they managed complexity within their clinical caseload**.

Boucher (2007) found positive outcomes for staff when using RPG as a management development tool in that they reported being **more likely to think before acting and to have improved their ability to communicate with staff**. Positive outcomes improved with greater ongoing attendance.

Collins (2011) investigated the processes within an RPG on acute inpatient wards. He identified a three stage process – **Containment, Exploration and Growth** and key roles for the experience of receiving positive feedback from others and **increasing ability to empathise** with others, in moving successfully through these stages.

Heneghan, Wright & Watson (2014) looked at RPGs run by clinical psychologists across the UK and conducted online questionnaires and follow up interviews about participant's experiences. Common outcomes related to staff wellbeing, service culture and teamwork. Engagement, group dynamics and lack of management support were common challenges.

McVey & Jones (2012) conducted a study looking at themes in feedback from 5 RPGs in cancer care services. Themes identified were: Developing as a professional(finding ideas and solutions, learning professional skills, more than practical/solution based answers, developing assurance); Importance of group make-up (range of professional viewpoints); Importance of others in the group (helpfulness of sharing a problem, addressing feelings of isolation); Feeling safe (protected space, non-threatening/non-judgemental, feeling able to admit imperfections); Subconscious processes (not always knowing what to bring, but burning issues always emerging, normally keeping issues curled up).

Dawber (2013a, b) has described a model of RPG for nurses and midwives and carried out a preliminary evaluation using focus groups and a questionnaire. A further longitudinal study of the effects has started. Dawber found staff reported a positive impact on clinical practice, self-awareness and resilience. Most participants felt the groups had a positive impact on team functioning. Facilitator style and the addressing of workplace funding were identified as important factors in the group development and the increasing capacity for reflection. It was proposed that the data suggests RPGs can improve reflective thinking, promote team cohesion and support staff in clinical settings.

Locally, there has been an evaluation of a debriefing process and reflective practice sessions and how they affected staff sickness levels. The Glasgow Directorate of Forensic Mental Health introduced a debriefing process that aims to support staff following violent incidents and reflective practice sessions that seek to reduce the cumulative effect of occupational stresses. Despite 411 violent incidents there was no uptake of the debriefing process. The uptake of reflective practice was low and sessions were often cancelled due to lack of staff availability. However almost half of the staff felt quite supported in attending and over 90% of staff involved said they would recommend the service to a colleague. In general the sessions were noted by staff to provide an opportunity for discussion and expression of thoughts and feelings (Evans, 2013).

An independent evaluation by Health Improvement Scotland of seven reflective practice groups run for general psychiatry services found that staff reported highly positive outcomes, with improved mutual support, team dynamics, morale and motivation as a result of attending (Harley, 2017).

APPENDIX C - WHAT IS A REFLECTIVE PRACTICE GROUP? THE PROCESS OF CLARIFYING A DEFINITION

During the Working Group discussions it became clear that there was a need to clearly define our remit. When researching the term 'reflective practice' it became clear that it covered a range of practices including academic practice around supporting students of various disciplines in their work as well as helping clinical staff who are working with patients. As an example, reflective practice is a term used to describe the writing of diaries by students to encourage reflection on their work. We decided this example of reflective practice was not within our sphere of interest and decided to be clear that our focus is on reflective practice as run in groups where a practitioner provides a reflective practice space for clinical staff. The increased interest in this work in recent years has led to more attempts to clearly define reflective practice in healthcare. Price (2004) stated the purpose of reflective practice is to help health professionals further understand themselves and their motives, perceptions, attitudes, values and feelings associated with patient care. In reading the literature, although there were clear examples of Reflective Practice Groups described in some papers there was no one agreed definition. For this paper we therefore produced a definition of Reflective Practice Groups as:

- "Groups of healthcare staff, which meet regularly with a consistent facilitator. The facilitator is a clinician trained in one or many therapeutic modalities that allow them to help the staff reflect on their day-to-day clinical work with complex forensic patients in a safe setting."
- RPGs would be distinct from line management and clinical supervision as the purpose is not to critically evaluate staff performance. Participants can be at any level of training including untrained staff. What is important is that they are staff who are interacting with patients. Staff groups may be uni-disciplinary or multi-disciplinary.

The above definition states that the group is to 'help staff reflect'. Various authors have helped develop the concept of reflection. The notion of reflection is generally attributed to Dewey (1933) but reflective practice is a more recent term attributed to the work of Schön (1983) who wrote about how professionals 'think in action'. Schön proposed that professionals often 'reflect in action' whereby they construct unique solutions to problems based on the idiosyncrasies of the case, individuals involved and the environment. A separate process is 'reflecting on action' whereby staff reflect after the fact in order to consider outcomes and potential alternative outcomes. Staff can move from 'reflecting on action' to 'reflecting in action'. Reflective practice as described was a counterpoint to 'technical rationality' whereby problems are solvable by the application of science. John's (2009) has extended the model from 'doing reflection' to 'reflection as a way of being'. This model proposes it is desirable for practitioners to be mindful at the time of, or shortly after, acting. His proposition is that reflective practice helps staff avoid the implementation of working practices in a mechanistic way and increases the application of practices and techniques in a thoughtful way.

The Working Group agreed that the processes or issues that are the focus of reflective practice are:

- Helping staff to understand intra/interpersonal dynamics
    - Between Patients
    - Between Staff – Patient
    - Between Staff
    - Between Staff – Teams
    - Between Teams
    - Between Team - Organisation

- Intrapersonal

The aim of RPGs is therefore to encourage staff to discuss and consider the relationships that patients are having between each other (which may be causing conflict on the ward) as well as relationships between patients and staff (which may be causing conflict on the ward or within the staff team) as well as relationships between staff (where there may be conflict between staff members about how particular patients or patients groups are managed). In addition staff are encouraged to consider how patient's relate to themselves, i.e. how do they tolerate distress, levels of self-esteem and self-efficacy, manage mood. Finally staff are encouraged to think about how they manage or cope themselves in relation to their work. This may seems like a lot, but it encapsulates the wide range of interpersonal and intrapersonal dynamics that staff are having to manage when they come to work. Importantly, they may not be consciously aware that this is something they are doing. Rather than other aspects of staff supervision and management which focus on task related activities that are pertinent to the fulfilment of job roles, i.e. the activities often laid out in job descriptions, this is a space to think about the necessary role of managing relationships with others that is necessary to the fulfilment of many of these tasks, but are often not clearly stated or recognised as being required. Schön (1983) referred to this in his work, noting that the knowledge implicit in some of the actions taken is hard to describe as it has been developed intuitively and has been internalised.

APPENDIX D – RPG PROCESSES IN DETAIL

Supporting a process of containment of the patient via exploring staff responses to the patient

- Containment refers to the process by which we can feel understood and supported via certain interactions with others (Gabbard, 2010). In summary, we need others to help make sense of and tolerate our distressing and/or confusing feelings and experiences. All being well, the other person *notices* what is being communicated, can reflect on his feelings about this, and then can hand something back (Bion, 1962)to us about our distress in a modified and acceptable form. This interaction leads us to feel more "contained" about our original experience i.e. we have a sense of being understood and that our experience is more bearable than we first felt. It is well recognised that a considerable element of patients improving in psychiatric hospitals is as a results of their distress and disturbance being "contained" by interactions with steady, calm and receptive staff (Adshead, 1998).

- This process of staff acting as a container for patients' disturbed inner experiences can be challenging in the forensic setting, when staff may be faced with intense, disturbed, and disturbing emotional states and actions over long periods of time (e.g. marked aggression, anger, panic, paranoia, hopelessness, indifference).

- RPGs can help staff capacity to act as a container for patients' experiences in several ways. The safe and supportive setting is conducive to staff noticing and exploring what is happening in the patient's mind and how the clinician feels in the patient's presence. The RPGs can then help clinicians to make sense of their feelings in relation to the patient i.e. to explore what it is about the patient's sense of himself or others that ends up evoking certain feelings in others.

- Finding understanding and support in RPGs (Adlam, 2016) may increase clinicians' capacity to tolerate their experience, so that it may be more possible to sustain working with disturbing patients, without, for example, becoming short-tempered or overwhelmed with a sense of hopelessness.

Clarifying clinician's responses to patients

- Even for the most experienced and skilled clinicians, our own perception of and responses to patients may not always be clear to us (RÜTH, 2009). Bringing a clinical encounter for discussion with other clinicians in a group allows for multiple perspectives to emerge, and for other group members to 'pick up' aspects of the patient-clinician interaction that the clinician was initially unaware of (but may have been affected by). E.g. in an RPG, a clinician realized he had been acting somewhat harshly towards a patient due to feelings of dislike towards the patient that he previously had only been dimly aware of.

Exploring responses in the wider system to working with disturbed and disturbing patients

The facilitator can help the group to look at responses in the wider system, in connection to work with disturbed patients:

- If staff feelings in relation to patients are not adequately named and processed, as well as having the risk of counterproductive responses to the patient, these feelings may, without realising it, be displaced onto other parts of the organization (Moore, 2012).

- It is also recognized (Moylan, 1994) that an institution can pick up difficulties and defences of their particular client group. An institution or system can struggle to contain the distress and disturbance from working with many patients who may have similar kinds of difficulties. E.g. a general ethos within staff in a forensic institution may be somewhat suspicious, or the staff ethos within an anorexia nervosa service may be to over-work and not take proper lunch-breaks. Though observing and discussing "the ways this can happen, staff are more likely to be aware of when this is happening and to use feelings to tackle the problem in a direct and appropriate way" (Moylan, 1994).

Managing the level of emotional contact with patients

- For clinicians who are overly emotionally disturbed by the patients RPGs can help provide perspective and objectivity; and for clinicians who have become more detached and inured to clinical work the groups encourage closer awareness of the emotional aspects (Evans, 2016). The facilitator needs to adapt according to the level of emotional contact of the clinician – taking a more exploratory stance that is attentive the emotional aspects of the clinical work to help bring someone closer; and a more supportive or intellectual stance for someone overly emotionally connected to allow permission to step back and leave work at at the door.

Working with the parallel process within the group itself

- When discussing a disturbing or difficult staff-patient encounter in a group, sometimes a 'parallel process' can emerge in the group itself (Scanlon, 2012). Namely, one person(s) becomes more identified with the patient's position and another (or others) with the staff member's position. A version of the situation that is being discussed by the group actually gets replayed within the group itself. If carefully managed, this may provide an opportunity for greater understanding into the situation under discussion as it becomes a real 'live' situation rather than something more abstract.

- It is the facilitator's role to manage this situation according the particular circumstances and level of sophistication and development of the group. With a reasonably secure and experienced RPG, it may be possible for the facilitator to sensitively draw attention to the parallel process, normalise this, and attempt to use it as a vehicle for understanding. In other situations, the facilitator may need to fairly quickly reduce the level of affect in the group, use supportive explanations, and perhaps steer the group onto less emotionally charged ways of exploring the topic in hand.

The affiliation of the facilitator

- In order for the facilitator to provide a fresh perspective on complex clinical situations and not be caught up in the situations under discussion, it is important that the facilitator can take a stance that is objective-enough and “apart from yet alongside” (Scanlon, 2012) the staff in the groups. Some authors argue that to achieve enough objectivity the facilitator of an RPG cannot be a member of the participant’s clinical team, nor be manager for them (Hawkins and Shohet, 2007).

- Some of the present authors observed that, for pragmatic reasons, some RPGs are facilitated by a member of the clinical team and that these groups can function adequately. Although, one potential advantage of having an ‘insider’ facilitating a RPG is that the participants may value and trust this person more readily than an ‘outsider’ facilitator who would have to overcome initial uncertainties from participants, We would recommend that groups are not facilitated, if at all possible by ‘insider’ group members if at all possible. This is because such ‘insider’ led groups may function acceptably until there is a problem within a team – at which point, the facilitator who is also a member of the team will be in an untenable position. This is because they will be unable to hold a neutral, trusted stance with the group in any believable legitimate way – instead they will naturally be part of the process that has led to the problem within the team and will require an ‘outsider’ facilitator to help them, and the team, integrate their understandings and experiences.

If groups are facilitated by a member of the clinical team, where there is no other option, then a great deal of care must be taken by the facilitator:

- to be clear they are taking a different role when facilitating the RPG compared to their usual role;
- to ensure they have regular external supervision for their RPG work;
- and to utilise externally-led consultation for complex patient situations they are closely involved in

Role and stance of facilitator

- The role and stance of the facilitator of RPGs draws on ideas and skills from several domains(Scanlon, 2012), namely relational therapy approaches, group-work leadership skills, systemic approaches, and skills as an educator (see also section on competency framework). We acknowledge the overlap with Balint group leadership skills (Johnson et al., 2004).
- Key aspects of the role and stance of the facilitator (Johnson et al., 2004; Johnston and Paley, 2013; Scanlon, 2012) include:
  - Conducting and facilitating discussion and exploration by the group, as opposed to being overly didactic. This allows the clinical team to work things out at their own pace. This is in keeping with the principle of allowing the group participants adequate time needed to name, reflect on and process feelings. A RPG is not primarily about gaining factual knowledge from an ‘expert’ about what is happening (that aim is closer to what might be found in consultation or in formal teaching and training).
  - Keeping the group thinking and exploring about what is being discussed, including looking for meaning, asking for feelings (in relation to the clinical work)
  - To tolerate and keep in play contradictory and multiple views as expressed by group members, rather than coming in and giving a verdict on what is being said (Johnson et al.,

2004). This helps generate and preserve a plurality of ideas, which is important as, particularly for some disturbed patients, no one person can pick up on all aspects of the patient. This stance can also help teams to reflect on 'splitting' (Gabbard, 2010)within the team.

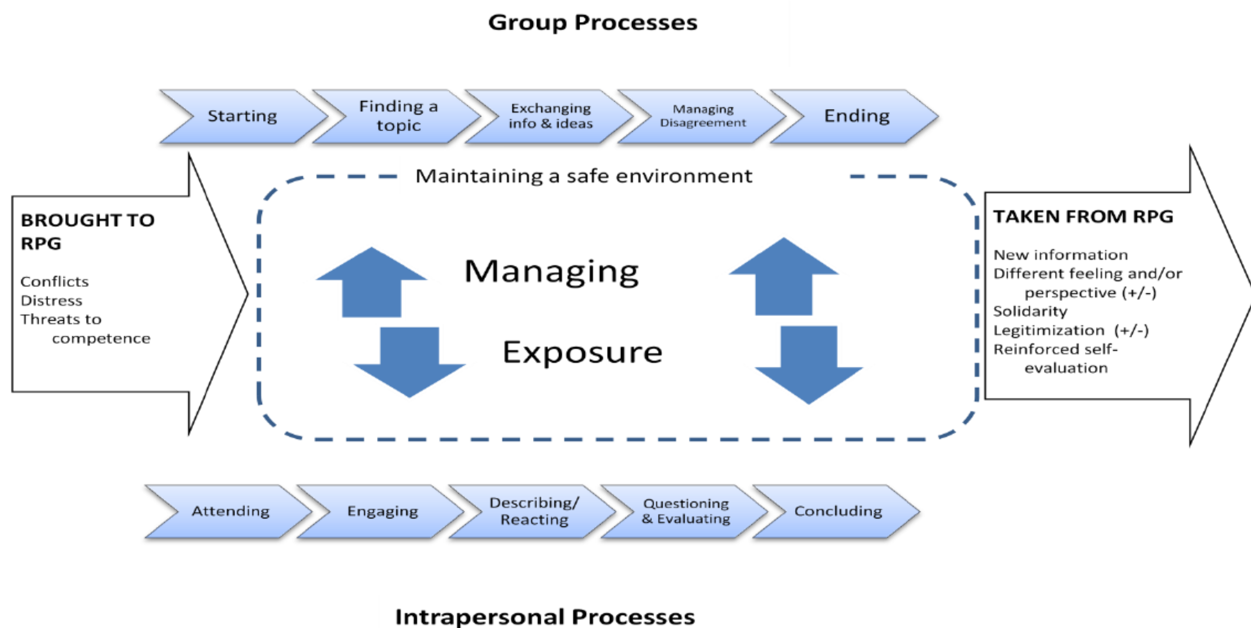
- Setting and maintaining group frame and norms
- Reflective Practice Groups are not therapy for staff. The facilitator keeps the focus on work situations and staff members' responses to these, as opposed to personal exploration as found in therapy. The facilitator will step in when needed to keep members feeling safe and also to ensure that no one individual is 'in the spotlight'.
- Keeping the group on task. In any group when difficult situations are being discussed there is often a "flight from the group" phenomena whereby the group, without realising it, discusses (or criticises) people that are outside the RPG. The role of the facilitator here is to steer group back to task, perhaps using humour, observation, or empathy (e.g. noticing how hard it may be to talk about the work with the patient)

In addition to the above specifics, intrinsic to role of the facilitator is to have knowledge and experience of the RPG processes as described below, and be able to direct the group to employ these productively.

Overview of a typical group session

Using a combination of observation of RPGs and qualitative accounts from participants, McAvoy (2012) developed the model as in figure 1.

Figure 1 - Theoretical model of processes within RPG



This diagram conveys the course of a typical RPG, from both a group perspective and the experience of individual participants. Both the individual and the clinical team as a whole bring to the RPG salient

clinical situations such as conflicts, distress, and perceived threats to staff competences. At a group level, there is often a sequence observed of:

- Starting the group, including introductions, setting (or reminding) the purpose and frame
- Finding a topic
- With the topic decided and some 'material' brought to the group there is typically a phase of exchange of ideas as different group members respond to what they have heard, or describe their own experience of the actual clinical situation if they have it.
- There sometimes emerges differences in opinion or disagreements, and here the facilitator's role is to help the group to make use of these divisions in the service of understanding the interpersonal situation better.

An individual participant typically experiences a sequence of attending to the topic as presented, followed by a phase of reacting to the topic and describing this reaction to the group if they feel able. The various views and discussion put forward by the group and the facilitator often result in the participant re-evaluating their initial response and reflecting on it (e.g. towards the end of a RPG a participant commented that that through hearing others talk about their patient, they felt less guilty and solely responsible for the fluctuations in his clinical presentation).

APPENDIX E – COMPETENCY FRAMEWORK CHECKLIST

Competency 1- Facilitate Reflection

Knowledge

1.1.1 Be able to demonstrate an understanding of the concepts and experience of transference and counter transference.
1.1.2 Be able to demonstrate an understanding of holding an interpersonal approach to focus upon creating a collaborative and reflective relationship.
1.1.3 Be able to demonstrate an understanding of psychoanalytic concepts that relate to individuals
1.1.4 Be able to demonstrate an understanding of psychoanalytic concepts that relate to groups
1.1.5 Be able to demonstrate an understanding of psychoanalytic concepts that relate to organisations

Skills

1.2.1 During group or individual session be able to demonstrate a focus on transferences (e.g. between staff and patient or staff and management etc.) and keep the focus on maintaining an interested stance in the patients.
1.2.2 Demonstrate skilled communication and an ability to create an atmosphere of collaboration and reflection.
1.2.3 Demonstrate an ability to teach RPG members about basic psychoanalytic concepts such as projection and projective identification in a readily understandable way - as well as help them reflect on the relevance of these concepts to their everyday work.
1.2.4 Demonstrate an ability to hold a genuine, curious and empathic stance.
1.2.5 Demonstrate an ability to reflect upon associations to material discussed in RPGs and share these when appropriate in an affectively modulated way.

Competency 2 - Understand and be able to work with affect

Knowledge

2.1.1 Be able to demonstrate an understanding that participants may find it more challenging to take part in groups where the expectations are that they discuss the emotional impact of the work – this may be seen in a lack of affect brought.
2.1.2 Be able to demonstrate an awareness that group members will bring different affective responses when running the groups, and that this may have an impact upon yourself
2.1.3 Be able to show understanding of the importance of being supportive at times to staff struggling with difficult situations
2.1.4 Be able to show understanding of the importance of acknowledging positive interactions and outcomes both in and out of RPGs
2.1.5 Be able to show an understanding of the importance and necessity for having supervision of facilitators' RPG work

Skills

2.2.1 Demonstrate being able to help groups to notice, identify, safely manage, process and contain each others' affects.
2.2.2 Demonstrate not avoiding the affect in the group.
2.2.3 Demonstrate that facilitator can manage their own affect in relation to the group and show that they can avoid over- or under-engaging with the group's affect. This would include using supervision effectively for RPG work.
2.2.4 Demonstrate an ability to engage in an explicitly supportive and constructive dialogue with staff and help staff do the same with each other during difficult situations.
2.2.5 Demonstrate an ability to engage in an explicitly supportive and constructive dialogue with staff and help staff do the same with each other during positive situations and when things have gone well.

Competency 3 - Tolerating disturbing narratives

Knowledge

3.1.1 Be able to demonstrate an understanding that facilitators will sometimes hear difficult, challenging, grim, violent and perverse material
3.1.2 Be able to demonstrate an awareness that facilitators will sometimes hear hopelessness and despair from staff
3.1.3 Be able to show an understanding that facilitators will sometimes hear hatred and guilt from staff
3.1.4 Be able to show an understanding that facilitators will sometimes hear anxiety and anger from staff

Skills

3.2.1 Demonstrate being able to listen non-judgmentally and tolerate the difficult material brought.
3.2.2 Demonstrate being able to provide a safe space for staff to feel heard, held in mind, empathised with, understood and contained.
3.2.3 Demonstrate being able to not react to staff's hatred and guilt, not judge staff feelings expressed, work with this to build reflective capacity.
3.2.4 Demonstrate an ability to make sense of staff's anxiety and anger in relation to their work and context – then help them make sense of it and process it

Competency 4 - Managing interpersonal conflict in RPGs

Knowledge

4.1.1 Be able to demonstrate an understanding that there may be conflict within the RPG because of the material RPGs are working with.
4.1.2 Be able to demonstrate an awareness that not all staff will hold similar views about each other or their work, and that there will sometimes be differences of perspective and conflicts within teams.
4.1.3 Be able to show an understanding that forensic mental health work can push and pull staff in extremes ways.
4.1.4 Be able to show an understanding that staff may seek containment of their fears, challenges and difficulties by wishing to gain the 'support' of you to the detriment of opposing views/staff.

Skills

4.2.1 Demonstrate being able to form a neutral though empathic and understanding relationship that is sufficient to evoke within the team an increased interest in them in understanding themselves, colleagues, other disciplines and, especially, their patients.
4.2.2 Demonstrate being able to hold in mind that facilitators need to be available to anyone working in the team, with equal attention available to all.
4.2.3 Demonstrate being able to accept and integrate differences as well as manage conflicts in groups.
4.2.4 Demonstrate being able to keep a high level of self-awareness in groups. This includes trying to notice when, even inadvertently, you get split off into supporting any sub-groups.
4.2.5 Demonstrate being able reflect on groups when the facilitator gets deflected from their neutral stance.

Competency 5 - Provide a safe space for RPGs including manage intra- and inter-group boundaries

Knowledge

5.1.1 Be able to demonstrate an understanding of the need for consistency, coherence and regularity for RPGs to create 'safe spaces'
5.1.2 Be able to demonstrate an awareness of the need for and limits of confidentiality in RPGs
5.1.3 Be able to demonstrate an understanding of the difference between reflective practice and therapy
5.1.4 Be able to demonstrate an understanding of the importance of distinguishing between information that should stay in the group and useful information that might leave it – such as concerns about risk of harm
5.1.5 Be able to demonstrate an understanding of the need to hold confidentiality and also the need to breach this when necessary

Skills

5.2.1 Demonstrate an ability to ensure the groups run regularly.

5.2.2 Be able to demonstrate that you can be predictable and remain consistent and coherent with the RPG model.

5.2.3 Demonstrate being able to hold in mind that forensic environments deal with risk and can be risky contexts.

5.2.4 Demonstrate being able to manage facilitators own and others' self-disclosures.

5.2.5 Be able to show that the facilitator does not delve into staff's personal histories nor intervene therapeutically during RPGs.

5.2.6 Be able to tactfully redirect where appropriate in RPGs.

5.2.7 Demonstrate being able to help the group respond in different, more productive ways to patients whilst preserving the boundary of the RPG and its members.

5.2.8 Demonstrate being capable of running groups that contain professionals who may be of a higher grade and/or level of clinical experience than themselves.