Evaluating reflective practice in a learning disability team

Evaluating a time-limited cognitive analytic reflective practice (CARP) group for practitioners working in an NHS learning disability intensive support team

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Abstract:

Aims. Research exploring and evaluating the impact of cognitive analytic reflective practice (CARP) groups is in its infancy. The current project sought to evaluate CARP sessions offered to an Adult Learning Disability (LD) Intensive Support Team (IST).

Methods. Six CARP sessions were offered to an IST over three months. N=10 practitioners attended at least one session. Valid and reliable self-report questionnaires assessed burnout severity and perceived quality of sessions at three timepoints. A questionnaire was also completed after the final session eliciting overall experiences and feedback. Quantitative and descriptive qualitative analyses were conducted on questionnaire data.

Results. No statistically significant differences across time were found for attendee burnout, nor quality/experience of specific sessions, though average trends indicated less burnout as sessions progressed. N=5 attendees (mean years of LD experience=24.75 years) completed overall feedback questionnaires. Respondents highlighted various helpful and hindering aspects of CARP sessions. All respondents expressed an interest in attending future CARP sessions.

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Conclusions. This evaluation suggests CARP sessions have potential for various positive impacts on IST practitioners working in LD services, including potentially reducing burnout and enhancing team cohesion. Much more research is needed in this area before firmer conclusions can be made regarding the value of CARP for LD practitioners and healthcare professionals generally.

Keywords: Cognitive Analytic; Reflective Practice; CAT; Learning [Intellectual] Disability; Crisis; Intensive Support.

Introduction

UK Learning Disability Services Context

In England over the past decade, health and social care services supporting people with Learning [Intellectual] Disabilities (LD) and/or Autism (hereafter 'LD/Autism') and their carers have undergone colossal change. A powerful driver behind changing the way these services are delivered has been the Transforming Care Programme (Houlden, 2015; Elliott, 2017). This programme was a response to significant and growing concern that a proportion of people with LD/Autism who display behaviour that challenges were spending substantial periods of time in restrictive inpatient settings. As part of Transforming Care, NHS England set out guidance for how services for people with LD/Autism should be designed. One of the primary changes set out was that all people with LD/Autism should have access to 'Enhanced/Intensive Support' in the community. Enhanced/Intensive Support teams were thus commissioned and tasked with providing numerous specific 'functions' of support, including: providing assessment, treatment and support for people who display behaviour that challenges, and providing crisis response (Elliott, 2017).

Learning Disability Staff Burnout

Given the high intensity and urgency inherent in supporting people with LD/Autism in crisis, it is not surprising that staff supporting these individuals are at high risk of experiencing work-related stress and burnout (Devereux, Hastings & Noone, 2009; Ryan, Bergin & Wells, 2021). Maslach, Schaufeli and Leiter (2001) described burnout as a prolonged response to chronic stressors at work, characterised by emotional exhaustion, depersonalisation and lowered personal accomplishment. In addition to burnout being extremely challenging for healthcare practitioners themselves, there are a range of other adverse outcomes associated with these factors; including higher staff absence/sickness (Peterson et al., 2008), lower staff retention (Spence Laschinger et al., 2009) and poorer quality of patient care (Johnson et al., 2017).

Attempts to elucidate the development of burnout in healthcare staff have been extremely valuable given that they have highlighted potential avenues to help reduce or prevent burnout in practitioners. Factors that have been shown to be meaningfully associated with staff burnout when supporting individuals with learning disabilities include individual characteristics (e.g., recreation, self-care and personal support, Aitken & Schloss, 1994; self-efficacy and resilience, Klaver et al., 2021) and organisational variables (e.g., feeling under benefitted, Van Dierendonck, Schaufeli & Buunk 1996; perceived support from supervisors, Gill-Monte & Peiro, 1998).

Reflective Practice

A source of support that may help reduce or prevent staff burnout is engagement in reflective practice. Reflective practice has been described as involving 'active attention to knowledge and beliefs, as well as focused reflection about our experiences, in relation to both ourselves and others, in order to understand them more deeply and with greater awareness' (Priddis & Rogers, 2018; p.89). Given that burnout is thought to be a gradual process of emotional exhaustion from relationally intense/challenging job roles leading to unhelpful relational patterns with colleagues and patients (Maslach, 1999), a safe and structured space to reflect on and enhance awareness of difficult feelings and relational patterns may intuitively help reduce or prevent staff burnout. It is perhaps not surprising that formal reviews and guidelines across various healthcare disciplines such as nursing (Department of Health, 2006) and medicine (General Medical Council, 2013) have emphasised the importance of reflective clinical practice.

Reflective practice groups have been structured by a variety of frameworks since early psycho-dynamically informed groups, developed in the 1950s, to support GPs to consider the relational aspects of their work (Patrick, Russell & Polnay, 2021). An approach to reflective practice that has garnered increased attention over recent years is one based on the principles of Cognitive Analytic Therapy (CAT).

CAT and Reflective Practice

CAT was developed as a time-limited and integrative model of individual psychotherapy that has a relational focus (Ryle & Kerr, 2020). Since its origin of being applied as a form of individual therapy, CAT has been expanded to inform other forms of 'direct' (e.g., group interventions; Hepple, 2012) and 'indirect' (e.g., consultation; Carradice, 2013) clinical work with a range of clinical populations (e.g., people with learning disabilities and their carers, Lloyd & Clayton, 2014). Cognitive Analytic Reflective Practice (CARP) is another example of how the core principles of CAT can be applied to help clients and the systems/individuals around them.

In common with CAT psychotherapy, there is no session-by-session manual that prescribes how CARP should be delivered. Rather, there is a collection of principles and tools that can be used flexibly to structure CARP sessions (Marshall & Kirkland, 2021). These principles (e.g., time-limited nature, clear contracting, collaboration, relationally focused) and tools (e.g., relational 'mapping') are used by CARP facilitators seeking to develop group attendees' capacity to 'reflect on actions so as to engage in a process of continuous learning' (Kirkland, 2021, p.68).

Although there has been limited research to date on the impact of CARP on individuals and teams, Priddy (2021) conducted one of the first studies exploring the implementation of CARP in a secure children's home (SCH) setting. Priddy proposed a model of how CARP may facilitate reflective thinking and awareness in SCH staff. Within the model, numerous linear and reciprocal processes are suggested to occur between facilitator and CARP group members, categorised into: 'facilitator processes', 'group processes', and 'outcomes'. The model proposed that through 'establishing a reflective space', group members were able to engage in processes that 'widened their awareness of the self, other and the system', to 'change relational dynamics and establish exits' from unhelpful patterns.

The current evaluation

Although the application of CARP to help prevent or reduce burnout in high-risk health practitioners appears intuitive, structured evaluation of the impact of CARP sessions on healthcare teams is in its infancy. The current project, therefore, was a small-scale service evaluation which aimed to evaluate a time-limited CARP provided to a learning disability IST over a period of three months. Quantitative and qualitative data were collected and analysed in order to measure; the severity of attendees' burnout throughout the evaluation period, explore attendees' experiences of CARP sessions throughout the period, and explore the overall perspectives and experiences of attendees after sessions were complete.

Methods

Ethics

Prior to commencement of the project, it was registered with the relevant clinical effectiveness team (audit and service evaluation department) who approved the registration.

Service Context & Participants

Participants were practitioners in a Learning Disability IST. The IST were a multi-disciplinary team of health practitioners based within a Community Learning Disability Service. The team comprised 1x team leader (LD/mental health nurse background), 6x LD Nurses, 1x Speech and Language Therapist, and 3x Support Workers. Facilitators of the CARP group were a Highly Specialist Clinical Psychologist working in the same service in a different team, and a second-year Trainee Clinical Psychologist on placement in the service. Prior to CARP group sessions being offered, the IST had no Practitioner Psychologist in post for over six months. The time-limited group sessions were therefore offered in part, to offer some psychological provision for the team in the absence of formal psychological staffing.

Cognitive analytic reflective practice (CARP)

Although there is no prescribed protocol for CARP, introductory texts, principles and techniques have been published to guide clinicians in facilitating CARP sessions (e.g., Marshall & Kirkland, 2021). The CARP sessions in the current evaluation were informed by the training and clinical experience of facilitators in applying CAT to various clinical problems and contexts. This included mental health services, learning disability services, individual psychological therapy, and team formulations, published guidance on applying CAT to reflective practice (RP) and in LD settings (e.g., Marshall & Kirkland, 2021; Lloyd & Clayton, 2014), and the Grounded Theory model of CARP developed by Priddy (2021).

All CARP sessions were 60 minutes in duration and took place in an appropriate room outside of the team's usual office (same room each session except one occasion where it was double-booked). The typical format of sessions included starting with a reminder of the main contracted agreements (e.g., confidentiality, difference between RP and personal therapy, no prior agenda, number of sessions remaining), followed by a check-in from each group member, choosing a session topic, discussion and 'reformulation' of the topic informed by CAT theory and tools, followed by a brief 'ending' exercise (e.g., reminder of how long is left and inviting final comments/thoughts). At each session, group members were reminded of appropriate potential content to be brought to the session (e.g., organisational issues, relational patterns within the team, or with specific service users or carers, self to self patterns associated with coping with an emotionally demanding job role, etc.). Facilitators used flipchart paper to diagram or 'map' content of discussions during sessions. Flipchart paper was always destroyed after sessions as per the CARP contract made during session 1. No other records or summary notes were made during or after sessions, in accordance with the contract, of which group members were reminded at each session.

Measures

Adherence to CAT model

Adherence to the CAT model was assessed through using an amended version of the original Competence in CAT tool (CCAT; Bennett & Parry, 2006) used in a previous study (Priddy, 2021). The amended CCAT assessed for adherence (presence/absence) of 10 specific domains. Percentage of adherence was calculated based on the number of domains present/observed across all domains.

Maslach Burnout Inventory (MBI)

The MBI (Maslach, Jackson & Leiter, 1996) is the most commonly used self-report tool to assess burnout severity (Schutte et al., 2000). The MBI is made up of 22 items that explore three components: exhaustion (7 items), depersonalisation (7 items) and personal achievement (8 items). The items are rated using a 7-point response scale ranging from 'never experienced such a feeling' (0) to 'experience such feelings every day' (6). The scores for each component are computed separately and can be coded as low, moderate, or high using cut-off scores. The range of burnout experienced is broken down as follows: exhaustion (low, ≤ 16; moderate, 17–26; high–≥ 27); depersonalisation (low, ≤ 6; moderate, 7-12; high, ≥ 13); and personal achievement (low, ≤ 31, moderate, 32-38, high, ≥ 39; Maslach, Jackson & Leiter 1997). Burnout is associated with higher scores on the exhaustion and depersonalisation subscales and a lower score on the personal achievement subscale. There is evidence that the MBI has acceptable properties of reliability (Rupert & Morgan, 2005) and validity (Maslach, Jackson & Leiter, 1996). The MBI was selected to assess change in burnout severity over time. Respondents completed the inventory at 3 time points over the CARP groups (session 1, session 3 and session 6).

Clinical Supervision Evaluation Questionnaire (CSEQ)

The CSEQ (Horton et al., 2008) measures overall staff perception of clinical supervision in group supervision models which emphasise reflective processes. The CSEQ consists of 14 items related to three factors: the Purpose, Process and Impact of clinical supervision. Respondents are asked to rate their agreement with 14 statements using a five-point Likert scale that ranges from 'strongly agree' (+ 2), to 'strongly disagree' (– 2). Gabrielsson, Engström and Gustafsson (2019) used the CSEQ to assess perceptions of RP groups and found it to be a valid and reliable tool in this context when translated to Swedish. The CSEQ was selected to assess changes in purpose, process and impact over the course of CARP sessions. The CSEQ was completed at three time points over the course of the CARP groups (session 2, session 4 and session 5). The CSEQ was anonymised.

CARP Feedback Questionnaire

An idiosyncratic questionnaire was developed to understand CARP group attendees' experiences of the sessions overall. The questionnaire was divided into three sections: background information, closed questions, and open questions. The content of the questionnaire was based on Priddy's (2021) CARP Grounded Theory themes of facilitator processes, group processes and outcomes. This was done to elicit information on each of these areas as they have been shown to be relevant to the positive impact of CARP in previous research (Priddy, 2021). These questionnaires were given to participants after the final (session 6) CARP group and were kept anonymous.

Procedure

The procedure of the current evaluation project involved facilitating brief introductory training on RPGs and CAT concepts to IST, an initial contracting session with participants, four CARP sessions, then a final CARP/ending session. This procedure was over four months – with the six CARP sessions contracted being over three months (two per month).

Analysis

For quantitative data (MBI and CSEQ), descriptive statistics and inferential tests were carried out. Cohen's d corrected for unequal sample sizes (Lenhard & Lenhard, 2016) was calculated as a measure of effect size for each MBI sub-scale (exhaustion, depersonalisation and personal achievement) from baseline (session 1) to final session (session 6), which was interpreted using the cut-offs 0.2, 0.5, and 0.8 for small, medium and large effects, respectively (Cohen, 1992). For both MBI and CSEQ, repeated measures Multivariate Analyses of Variance (MANOVA) were conducted with time (session number) as the independent variable and the three sub-scales of each measure (MBI and CSEQ) as the dependent variables in each MANOVA. A MANOVA was conducted as neither MBI nor CSEQ were designed to calculate a single, total score and thus sub-scales should be considered separately. Assumptions for MANOVA were tested and met (see supplemental information). Questionnaire responses from group members were summarised using a descriptive approach, grouping qualitative data by the question asked (e.g., facilitator factors, impact on relationships with team, etc.).

Results

Adherence to CAT model

Adherence to the CAT model was assessed through choosing a specific CARP session and discussing it in-depth in CARP group supervision. The amended CCAT (Priddy, 2021) was used to assess adherence to the CAT model in session 4. Session 4 was used due to this being most pragmatic (a group supervision session was arranged for the day after session 4 thus the process and content of the session could be recalled most clearly by facilitators). The total CAT adherence score for session 4 was 57%. Though there are no established cut-offs regarding levels of adherence (e.g., high, moderate, low) for the amended CCAT, a score of 20/40 (50%) is the competency cut-off used for the original CCAT (Bennett & Parry, 2006).

Burnout and evaluation of RP sessions

Both the MBI and CSEQ were analysed by their separate domains as they do not yield overall scores. Two repeated-measures Multivariate Analyses of Variance (MANOVA) were conducted, the first one (MBI) investigated the difference in areas associated with burnout – exhaustion, depersonalisation and personal achievement – over the time participants engaged in the CARP group. The second (CSEQ) investigated the difference in participants' understanding of the purpose, process and impact over the time participants engaged in the CARP group. Table 1 shows the mean (SD) scores of the MBI and the CSEQ from each time point of the group. Figure 1 (MBI) and Figure 2 (CSEQ) display the mean scores over time.

Scores on the MBI all improved pre to post CARP. These results suggest that group participants showed reduced exhaustion, reduced depersonalisation and improved personal achievement by the end of the CARP group. Scores on the CSEQ were more mixed and by the end of the CARP group, participants appeared to perceive the purpose of the group as less clear, had a more positive view of the process and felt an improved impact on their clinical work. Effect sizes indicated that from the first to final CARP session, exhaustion and depersonalisation improved with a small effect size, and personal achievement improved with a large effect size.

Although differences between means can be observed, there was no statistically significant difference in burnout over time, $F(6,16) = 0.61$, $p = 0.72$; Wilk's $\Lambda = 0.662$. There was also no statistically significant difference in evaluation of the CARP sessions over time – purpose, process and impact, $F(6,8) = 0.50$, $p = 0.79$, Wilk's $\Lambda = 0.53$. Given that there were no statistically significant differences on MBI nor CSEQ scores over the course of the group, no further analyses on the data were indicated.

Table 1. Descriptive statistics of group member burnout (MBI) and self-reported purpose, process and impact (CSEQ) scores from beginning to end of the CARP sessions

Measure	Session 1 Mean (SD) n=8	Session 3 Mean (SD) n=8	Session 6 Mean (SD) n=6	Cohen's D pre to post (95% CI)
MBI				
Exhaustion	17.25 (10.46) [moderate]	15.75 (12.23) [low]	15.17 (9.99) [low]	-0.2 (-1.26-0.86)
Depersonalisation	11.25 (11.35) [moderate]	11.13 (10.53) [moderate]	8.67 (13.22) [moderate]	-0.21 (-1.27-0.85)
Personal Achievement	31.63 (8.69) (low) [	[35.88 (8.77) moderate]	39.83 (3.76) [high]	1.16 (0.02-2.3)
CSEQ	**Session 2 Mean (SD) n=9**	**Session 4 Mean (SD) n=6**	**Session 5 Mean (SD) n=4**	**-**
Purpose	2.11 (2.32)	2.67 (1.75)	1.75 (2.97)	-
Process	8.22 (1.72)	7 (1.90)	9.25 (1.5)	-
Impact	3.22 (4.41)	5.67 (5.16)	6.75 (3.78)	-

Notes: MBI = Maslach Burnout Inventory, CSEQ = Clinical Supervision Evaluation Questionnaire. CI = confidence intervals, SD = standard deviation. MBI cut-offs: exhaustion (low, ≤ 16; moderate, 17–26; high–≥ 27); depersonalisation (low, ≤ 6; moderate, 7-12; high, ≥ 13); personal achievement (low, ≤ 31, moderate, 32-38, high, ≥ 39; Maslach et al., 1997).

Figure 1. Mean scores on the MBI over the CARP evaluation period

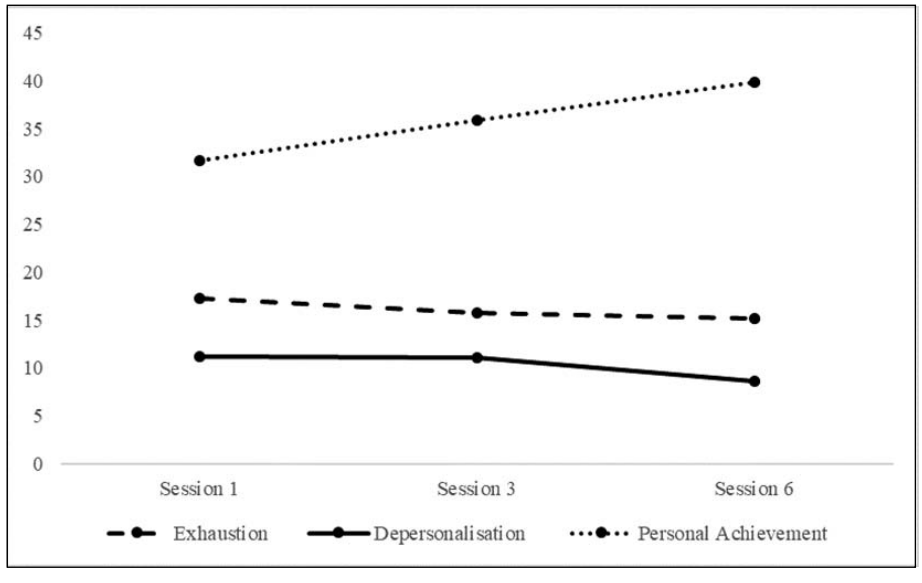
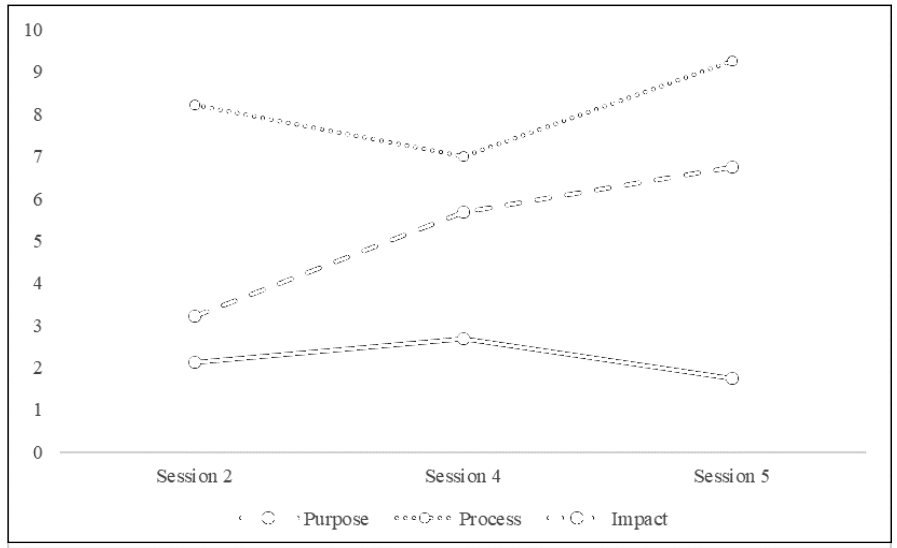


Figure 2. Mean Scores on the CSEQ over the CARP evaluation period



Experience of CARP after the contracted sessions were complete

Feedback questionnaires were distributed to n=10 individuals who attended at least one CARP session. N=5 (50%) were returned (n=3 female). Roles of respondents were: LD nurses (n=2), clinical lead (n=1), and care support workers (n=2). Years of experience among respondents was a mean of 24.75 years (min. 9 years, max. 35 years).

In terms of respondents' overall experience of the CARP sessions, all felt the sessions provided them with space that felt safe enough to reflect on the emotional aspects of their work (5/5 strongly agreed). All respondents also thought that CARP sessions increased their awareness of themselves, others and the wider system (3/5 strongly agreed, 2/5 agreed). Similarly, all respondents thought that CARP sessions gave them space to think differently about how they relate to clients, others and the wider system (3/5 strongly agreed, 2/5 agreed). All respondents (5/5) expressed that they would want to engage in further CARP sessions if they were offered.

Facilitator factors

Facilitator factors that respondents felt were helpful included having a safe and non-judgemental space to reflect on how their clinical and general work was impacting them. Having a space and time outside of their office helped limit distractions and protect the time for reflective practice. In terms of facilitator style, facilitators allowing conversations

to flow naturally (without frequent interruptions) if topics were relevant was found to be helpful in addition to a gentle and inclusive interpersonal style from facilitators. Respondents also fed back that facilitators sharing knowledge of relevant psychological theories and models helped structure and make sense of the experiences being discussed.

Respondents also shared some aspects they felt may have hindered the quality/helpfulness of the CARP sessions. Difficult topics not being adequately 'closed' before sessions came to an end resulted in attendees carrying unacknowledged feelings/anxiety back into their working day or evening. A number of respondents also highlighted that often the one-hour session duration did not feel long enough to meet the intended aims of the sessions at times. Additionally, more sessions overall were suggested as an area of improvement to the CARP groups generally.

Relationships with team

Having a planned and protected space to discuss dynamics within the team was said to have a particularly helpful impact on relationships within the team. More specifically, the experience of hearing how other members of the team felt about situations helped to reduce misunderstandings and enhance intra-team support and cohesion.

It was also noted that some attendees appeared to find the process of CARP sessions difficult (e.g., no planned agenda, or 'problem-solving' objective). This appeared to have an impact on how other attendees received and/or responded to the contributions and discussions in sessions, which affected the sense of group safety at times.

Relationships with patients/carers

Respondents felt that CARP sessions helped them to reflect on and understand relational boundary difficulties and challenges with service users and carers. The process of sharing, naming and acknowledging relational difficulties with clients appeared to help attendees enhance awareness of relationship patterns and consider alternative ways of relating to service users and carers. There were no aspects of the sessions that respondents thought hindered relationships with service users/carers.

CAT model in RP sessions

Respondents commented that they found using the principles and language of the CAT model (e.g., reciprocal roles, mapping on flipcharts) helpful in CARP sessions. Additionally, respondents highlighted that it was a useful way to recognise and understand the patterns that were occurring in relationships with service users, carers, within the team and with the wider system (e.g., other teams and agencies).

In terms of hindering factors, the respondents felt that six, one-hour sessions was not enough to fully explore difficult relational patterns occurring in the past and present in the team, adequately.

Discussion

The aim of the current small-scale study was to evaluate a time-limited cognitive analytic reflective practice group for practitioners in an LD Intensive Support Team. In order to meet this aim, we collected and analysed the following data: [1] burnout severity of attendees from first to final CARP session, [2] attendees' perceived quality of specific CARP sessions, and [3] attendees' overall perspectives of CARP sessions.

Average burnout severity among attendees improved across the course of the reflective practice groups. Although none of the scores on MBI subscales changed to a statistically significant degree over time, all three subscales showed a slight trend towards less burnout. Between the first and final CARP sessions, exhaustion reduced from moderate to low severity, depersonalisation remained moderate, and personal achievement increased from low to high (suggesting less severe burnout at the end of the sessions). It is worth pointing out that there was a high variance around the mean in participant MBI scores which may have reduced the likelihood of a statistically significant trend in MBI scores across time. Results from the CSEQ (measuring quality/experience of specific sessions) were less linear. Although none of the scores on CSEQ subscales changed to a statistically significant degree over time, average scores indicate that the perceived impact of sessions on attendees' day-to-day work increased over time, whereas purpose and process factors fluctuated across sessions, on average. Results also indicate that facilitators were generally adherent to the CAT model during the sessions.

Qualitative assessment of the CARP sessions, highlighted helpful facilitator factors, including a reliable time and place being set, and conditions of psychological safety. Some attendees felt that both the

session durations and number of sessions were not long enough and would have preferred longer/more. Generally, attendees found that CARP sessions had a beneficial impact on relationships within other team members and service users, though some members appeared to find the format of the sessions (e.g., no set agenda) challenging. All respondents expressed a desire to engage in more CARP sessions if they were offered.

Although remarkably few studies have investigated the impact of reflective practice groups (RPGs) on healthcare/LD practitioners, findings from the current study are generally consistent with previous research. Attendees of the CARP sessions, for instance, commented on the value of the safe and structured conditions of the sessions – aspects that have also been highlighted in other studies on RP with healthcare practitioners (O'Neill et al., 2019; McAvoy, 2012). Previous studies have reported on the positive impact on team cohesion and affiliation after attending RP sessions (Dickey et al., 2011), which was noted in this study. In addition to the overall feedback of attendees, severity of burnout showed a trend towards less severe burnout as sessions progressed in the current study, which is consistent with previous evaluations suggesting that RPGs can improve the capacity to manage the emotional impact of health and social care roles (Lees, 2017).

In one of the few studies that has been conducted on cognitive analytic reflective practice groups, Priddy (2021) developed a theory of how CARP sessions may influence relational awareness for practitioners working in a secure children's home. The theory consisted of three overarching factors: [1] establishing a reflective space (facilitator processes), [2] widening awareness of self/other/system, and [3] changing relational dynamics. By exploring LD clinicians' experiences of CARP sessions in the current study, support was found for each factor. Facilitator factors (e.g., a non-judgemental, structured and inclusive approach) were seen as foundational, in addition to widening awareness of self/other/system (e.g., through listening to and exploring the impact of work on self and other team members) and changing relational dynamics (e.g., by exploring and naming relational patterns with colleagues, service users and carers in a structured way).

Strengths of the current study included a clear and planned structure to providing CARP to the IST (e.g., including introductory training, explicit contracting and facilitating sessions at an agreed frequency). This hopefully enhances the replicability of this CARP evaluation model to other LD teams and other types of health and social care settings. Other strengths of the project include facilitators engaging in cognitive analytic informed group supervision through the evaluation period, and CAT model adherence being considered explicitly (which is less common in small-scale service evaluation projects).

There were limitations to the project. The authors evaluating the CARP sessions were also the facilitators of the sessions. Although this makes for a very rich experience of both engaging in indirect clinical practice and small-scale research, this may have naturally led to some bias when collecting and analysing data for the evaluation. Additionally, attendees may have been eager to report positive experiences from the group due to the facilitators collecting this data. Questionnaires were all anonymous in an attempt to minimise this risk. Another limitation related to the number of sessions and length of the evaluation as it only occurred over 3 months. Although this was consistent with the time-limited nature of CAT (Ryle & Kerr, 2020), this design did not allow for exploration of the longer-term impact of CARP on practitioners. Similarly, there was no follow-up data collected after CARP was complete – and thus long-term burnout data was not available.

In future, longer-term CARP groups and/or follow-up measures could help to understand the impact of CARP on teams vulnerable to burnout. Additionally, CAT model adherence was measured using an adapted tool to guide facilitators' reflections on model adherence in a group supervision context. This adherence-checking could have been improved by audio recording sessions, and an independent (ideally an accredited CAT therapist) scoring CAT adherence shown during the session(s). Future CARP evaluations should audio record at least one session in order to provide a more valid and reliable measure of CAT model adherence. Comparing outcomes between CARP and other forms of RPGs would also be enlightening in future studies in order to explore whether different types of RPGs have different impacts on participants or their clinical practice.

Finally, although facilitators had both been clinically supervised by CAT practitioners previously, neither were accredited CAT practitioners themselves. Ensuring facilitators achieved a minimum standard of CAT knowledge and expertise may have helped ensure the adherence and quality of CAT practice in sessions was to a high standard.

Given the infancy of CARP research, future studies should continue to develop, investigate and explore the impact, outcomes and theory of how CARP can help healthcare practitioners as individuals and teams in various health and social care settings. Particular factors that would build

on the current study might include longer evaluation periods, inclusion of a comparison RPG condition, collection of follow-up quantitative and qualitative data from attendees, audio-recorded adherence checking, interviews with attendees and collection/comparisons of service user data to assess the impact on direct clinical practice.

In conclusion, reflective practice groups explicitly informed by the CAT model are in an early stage of research and development. The current project set out to evaluate a brief, time-limited cognitive analytic reflective practice group offered to a Learning Disability Service Intensive Support Team. Findings suggest that burnout severity in the team may have reduced on average and attendees felt sessions had an increasing impact on their work as sessions progressed. Attendees fed back on the helpful and hindering aspects of the sessions from their experiences and all respondents expressed an interest in attending further CARP sessions if offered. □

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