RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

POSITION STATEMENT PS03/26

Reflective practice in mental healthcare

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Contents

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Royal College of Psychiatrists (2026) Position Statement PS03/26 – Reflective practice in mental healthcare

About this position statement

Purpose

This document outlines the Royal College of Psychiatrists' position on reflective practice for mental health organisations. It addresses what reflective practice is, why it is important, and provides a broad overview of the evidence base and the various forms and functions of reflective practice. It provides recommendations on implementation for organisations and for psychiatrists, and guidance on how to set up high quality team-based reflective practice groups. It concludes with examples of good practice.

This document is intended for all mental health organisations and practitioners across the UK.

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Executive summary

Healthcare organisations and staff inevitably face distress, disturbance and trauma on a regular basis as part of their work. Staff need support to sustain their work and to grow as professionals. This need goes well beyond staff wellbeing and can be met by reflective practice as part of continuing professional development and as an aid to good clinical care. Reflective practice is a professional activity that takes a variety of forms designed to enhance individual and team functioning and thereby benefit patient care.

The Royal College of Psychiatrists (RCPsych) strongly supports embedding reflective practice as a core component of clinical practice for all clinicians and clinical teams in mental health organisations to ensure the highest standard of patient care and to enhance team functioning. The RCPsych considers reflective practice an integral part of maintaining good clinical practice and its use is encouraged by the General Medical Council (GMC) for doctors. Time for reflective practice should be included in job plans as part of clinical care.

Guidance on how to set up high-quality reflective practice exists, and there are pockets of good practice in the UK. However, provision is both inconsistent and scarce. The College believes that all staff should be able to access effective reflective practice, which is supported by their organisations, facilitated by appropriately trained facilitators and provided systematically, rather than on an ad-hoc basis.

The College is calling for urgent action across the system to address this lack of provision. A number of actions will need to be undertaken by healthcare organisations, and by psychiatrists, which are set out as recommendations in this document.

Recommendations

Reflective practice should be a core component of high-quality medical practice, supporting staff teams and contributing to better standards of care.

Organisations should:

- Establish reflective practice as a routine standard of care with specific and measurable goals for implementation.
- Appoint a lead professional for reflective practice, supported by a multidisciplinary steering group responsible for promotion, co-ordination, and governance of reflective practice across the organisation.
- Provide appropriate forms of reflective practice to meet different needs.
- Allocate resources to allow reflective practice to take place, including protected time for staff to attend.
- Ensure facilitators are sufficiently trained and experienced in a recognised model of reflective practice. They will often be medical psychotherapists or psychologists but may also be from other professional backgrounds.
- Develop a culture in which all staff are expected to engage with and attend reflective practice, including senior leaders.

Psychiatrists should:

- Commit to developing reflective skills and becoming 'reflective' practitioners.
- Support the development of reflective practice within their organisations.
- Attend reflective practice themselves and encourage managers and other senior leaders to do the same.
- Ensure their resident psychiatrists have dedicated time for reflection and address any pressures that hinder this process.
- Consider presenting evidence of reflective practice in their appraisal.

Introduction

Healthcare is inherently relational, with effective patient and colleague relationships at its core. Without dedicated time and space for reflection, staff are likely to experience detrimental effects on their own learning and wellbeing, on the care they provide, and on team functioning.

Reflective practice can help staff to improve care quality by supporting them in their work and enhancing their ability to provide effective and safe care sustainably. It plays an important role in routine clinical care and in the response to serious incidents and can enhance individuals' and teams' ability to manage and learn from emotionally challenging experiences.

The National Suicide Prevention for England Strategy[1] has reviewed the evidence and supports the RCPsych recommendation (in College Report CR234) that staff should have access to both general and confidential reflective practice spaces specifically to address the impact of patient suicides.[2]

The need for reflective practice has become increasingly recognised in the wake of the Covid-19 pandemic[3,4,5] although high levels of clinician burnout and concerns about staff wellbeing and retention have been longstanding issues within healthcare settings.[6,7]

Currently, there is limited understanding of how to implement effective reflective practice structures, and organisations and teams often need help to prioritise it amidst other pressures.[8] These conflicting demands can lead to a feeling that there is not enough time to reflect.

However, reflective practice offers significant benefits to teams and organisations in meeting demands and coping with pressures[9]. The Royal College of Psychiatrists' Strategic Plan for 2024–26 highlights normalising reflective practice and embedding relational skills and psychological approaches to personal development as crucial parts of its approach to addressing the gap in provision of high-quality care in over-stretched and under-resourced services.[10]

Reflection in its various forms is a GMC requirement[11], and all doctors are expected to reflect as an integral part of maintaining good clinical practice (GMC Guidance for the reflective practitioner, 2021.)[12] UK healthcare regulators from various professions, such as the Nursing and Midwifery Council (NMC) have issued guidance underlining the crucial role of reflective practice.[13] and the GMC has highlighted that group reflection activities should be encouraged by employers and training providers, as they offer mechanisms to identify complex issues and effect change across systems. They recommend allocating time both for self-reflection and reflection in groups.[14]

What is reflective practice?

Definition

Whilst self-reflection is an important activity for healthcare professionals, the term 'reflective practice' as used in this document refers to interventions which provide staff with a facilitated setting in which to reflect on the impact of their work on themselves, colleagues and/or patients. Often, discussion will focus on the impact of distressing or challenging situations in which staff have conflicting roles, feelings or views. Reflective practice should be supported by a facilitator and can be conducted in an individual or group format. For it to be effective, staff must have protected time to step out of direct clinical care and reflect on what they are doing and what emotional responses have been aroused by their work.

Purpose

To provide an environment where participants can explore dilemmas and feelings stirred up by their work, including interactions with patients, colleagues, and the wider organisation. This can help to address clinical impasses, contain anxiety, and enhance communication between staff, thereby supporting safe and effective clinical decision-making. When carried out in a group setting, reflective practice can help team members learn from the experiences of their peers and appreciate one another's perspectives, feel less isolated, better understand how their team is functioning, and support team cohesion.

Models

Reflective practice models are based on a range of educational and/or psychotherapeutic frameworks (e.g., group analytic, psychodynamic, cognitive, compassion-focused, and Open Dialogue). They are work-based interventions aimed at staffs' professional lives rather than their personal lives, which distinguishes reflective practice from psychotherapy.

Differentiation from related activities

Reflective practice is not supervision, line management, psychotherapy, psychological debriefing or just a wellbeing activity. Supervision focuses on specific tasks, skill improvement, and career development. Line management addresses performance and work issues. Psychotherapy deals with psychological distress involving personal matters. Specific wellbeing activities provide support/relaxation (e.g., yoga for staff) or psychoeducation without focusing primarily on clinical reflection.

Forms of reflective practice

There is no single form of reflective practice which will meet the needs of all staff in all work situations. In addition to their regular team-based reflective practice group, at times, teams or individuals may need other inputs depending on the situation – for example a peer support group in the aftermath of a patient suicide, or a case consultation. Organisations should therefore provide, and staff should have available to them, appropriate forms of reflective practice over time and according to need. Some forms should be regular and frequent. Others are used 'on demand' and may be one-off meetings. This section summarises the main forms currently in use.

Regular forms of reflective practice:

- Balint-style groups:
  Small structured case-based discussion groups where one or more members present a clinical case. Focused on exploring the emotional aspects of doctor–patient encounters, Balint groups facilitate deep exploration of clinician–patient relationships, enhancing formulation skills and empathy. Balint groups are integral to psychiatric training, mandatory for core psychiatric trainees and recommended at other grades to develop reflective, empathic, and resilient clinicians.

- Team-based reflective practice groups:
  Small, relatively unstructured groups for teams to reflect on all aspects of the impact of their work on themselves and their patients. Common issues discussed are the preoccupations and concerns of team members about patients, team functioning and communication, and organisational pressures. This type of reflective practice can enhance team communication, cohesion and effectiveness through learning from others' experiences (see Appendix 1 and Appendix 2 for a suggested framework and an example of good practice).

- Peer support groups:
  Groups often used to support staff who have been through similar work difficulties, usually situations which are unusual, stressful or rare (e.g., psychiatrists who have experienced a patient suicide).

- Dialogical team meetings:
  An aspect of the Open Dialogue approach, in which team members who are working with a particular patient or family reflect on their experiences of that network. Rather than focus on symptoms or decisions, the group uses emotional sharing as a way of providing compassionate feedback and support to colleagues.

- Action learning sets:
  Small, structured groups who come together to reflect on actions taken and what can be learned from the outcomes. Often used in professional or leadership training. The facilitator acts as a tutor.

‘On demand’ forms of reflective practice:

- Case consultation:
  Often utilising psychodynamic frameworks, case consultations offer clinicians a space to develop a deeper understanding of patient behaviour and treatment responses, promoting reflective thinking about complex clinical situations. A case consultation is convened to discuss a specific patient.

- Complex case panels and risk panels:
  A panel of senior clinicians convened at the request of a team struggling to manage a challenging or high-risk case. Usually, a case consultation will have been tried previously. By reflection and discussion, the panel aims to understand situations of clinical impasse and the impact of the complex case upon the team. The aim of the panel is to offer high-level organisational support and help the team find creative, realistic and compassionate ways to provide clinical care (see Appendix 3 for an example of good practice).

- Organisational consultancy:
  This approach involves engaging external consultants to help senior managers to reflect on organisational practices and dynamics. It aims to enhance the overall effectiveness of the healthcare setting through strategic reflection and planning.

Evidence for reflective practice in healthcare settings

There is some lower-grade evidence which supports the use of reflective practice as a potentially useful intervention for healthcare staff. Most research studies have small sample sizes and rely on self-reported outcome measures. Nonetheless, taken together, the available research on this topic indicates that reflective practice (particularly in group formats) shows promise across various domains:

- Helping staff to process emotions and maintain compassion[15]
- Aiding clinical learning[16,17,18,19]
- Enhancing the ability of staff to provide effective and safe care[20] including by enhancing teamwork[21]
- Maintaining therapeutic relationships and promoting personal resilience[22]
- Helping psychiatrists process grief from patient homicide or suicide[23]
- Preventing burnout,[24] reducing psychological distress[25] and improving quality of work life. [16,26]

There is also evidence that psychological debriefing for staff immediately after a traumatic incident can be harmful, so this specific intervention should not be used[27].

The College recognises the need for further high-quality research, including studies into the impact of different forms of reflective practice for specific purposes, and into how to train facilitators most effectively. A systematic review of the quantitative and qualitative literature should be undertaken.

The importance of reflective practice

Healthcare professionals are frequently required to be in intense and intimate contact with the mental and physical suffering of their patients. Staff are often anxious about adverse outcomes for their patients including self-harm and suicide; experience vicarious trauma through hearing patients' histories and exposure to traumatic events at work, including extreme self harm and suicide; often work in climates with very limited resource yet high demand and risk; and can themselves be victims of violence or witness it in the workplace.

Space to share and reflect upon work experiences can help staff understand intense emotional communications from patients. Clinicians may end up feeling blamed, guilty, fearful or angry.[28] Without space to reflect, clinicians can act on these feelings, with a risk of iatrogenic harm despite their best intentions.[29] Such negative reactions might include rejecting, trying to rescue, or becoming over-involved with patients. Responses like these can distort the perception of risk, leading to issues like under-recognition of risk, or excessive anxiety which in turn can lead to overly coercive care. Strong emotional loads can also lead to fragmentation of care.[30]

Different team members carrying different emotions can have radically opposing views on the patient, leading to splitting and harm to working relationships within teams, inconsistencies in the care plan, poor communication, and poorly considered high-risk interventions (e.g., a team member discharging a patient from the ward without consultation).

If not recognised, discussed and addressed, repeated challenging events can develop into cultures of poor care, conflict within the team, or lead to staff absenteeism, presenteeism (staff working whilst unwell), and burnout. On the other hand, if teams are supported to discuss work issues together, the emotional impacts of caring can become important sources of information to help staff understand each other and their patients better. The chance to talk with colleagues in a safe, facilitated space, away from direct clinical work, can relieve immediate pressure and allow for more creative solutions.

Working clinically without a space in which to pause and think about the work is potentially dangerous; it can lead to errors in care if feelings are acted on without being understood. Participation in reflective spaces should therefore be seen as a routine and essential part of everyday psychiatry, not a remedial measure in response to crisis situations.

The presence of a framework of reflective practice activities has an impact on the whole organisation. It contributes to a culture in which the emotional impact of the work is recognised, and seen as both inevitable and important to understand. In normalising the need for spaces to reflect for staff at all levels and with different roles, the particular anxieties linked to these tasks can be contained, and staff can be supported to carry out their primary task without anxiety from various parts of the organisation leaking into different teams.

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Appendix 1:
Setting up a team-based reflective practice group

Before setting up reflective practice groups for specific teams, organisations are advised to set up a steering group to co-ordinate the delivery, supervision and governance of reflective practice, and the allocation of appropriate facilitators. Otherwise, the risk is that reflective practice groups can be set up in an inconsistent way without adequate oversight, some teams might have substantial reflective practice provision while others have none or receive reflective practice of varying quality, and teams may also end up using very different models. When receiving requests for reflective practice groups, it is important to set up an initial meeting(s) to identify the nature of the request, what the need is and which facilitator may be best placed to respond.

Contracting and review

- **Managerial support:** Obtain support from managers to allow participants time to attend.
- **Protected time:** Crosscover arrangements should be in place to enable all staff to attend.
- **Private space:** Secure a private, uninterrupted meeting space.
- **Commitment:** Ensure team members commit to attending sessions.

Considerations for implementation

- **Confidentiality:** Maintain confidentiality within the group.
- **Boundaries:** Address safeguarding and individual concerns, with appropriate supervision and support. Decide on the presence of managers and the impact.
- **Attendance:** Set minimum attendance expectations for stability.
- **Practical details:** Define group length, timelines, review mechanisms, and meeting location. If records are kept there should be transparency and clear guidance around this.
- **Regularity:** Hold sessions regularly, at least monthly but ideally more often (weekly or fortnightly).
- **Consistent setting:** Use a consistent private room for meetings away from clinical areas.
- **Defined timeframe:** Each session should last 60–90 minutes with a clear start and finish time.
- **Inclusive participation:** Ensure all team members are encouraged and enabled to attend, including the team manager and consultant.
- **Facilitators:** Must have relevant training and be experienced in managing emotional expression and group dynamics. Facilitators should be external to the team, not a member of the team.
- **Facilitator Supervision:** Provide facilitators with access to supervision, including peer supervision.

Appendix 2:
Examples of good practice

Example 1: A cross-team risk panel

The Risk Panel is a multidisciplinary group of senior managers and clinicians who support staff working with high-risk patients in a mental health trust. These patients may be at high risk of self-harm, suicide, extreme self-neglect, substance misuse, or harming others through violent and aggressive behaviour. The panel meets monthly to provide a reflective space for considering the patient's history and presentation in detail. By focusing on the emotional impact of the work, we deepen clinical understanding, alleviate staff anxiety, and improve clinical decision-making.

Staff often encounter histories of early trauma and abuse and situations of clinical impasse where management has become reactive trying to manage and contain risk, leading to staff burnout and fear of coming to work. This opportunity to reflect helps the team recover their thinking and creativity, fully formulate the case, and develop new clinical management ideas once their anxiety is acknowledged and understood.

Involving staff from all teams who know the patient, such as crisis services, inpatient wards, and community teams, improves clinical care and reduces the risk of iatrogenic harm. It helps staff share dilemmas and develop a joined-up understanding of the patient, decreasing the likelihood of fragmented care, unhelpful interventions, or the patient falling through service gaps. The panel does not replace clinical decision-making by the team, but supports it, and provides senior management support for the pressures and anxieties staff may carry. It offers an essential layer of containment outside the usual team activities for staff managing the most risky and vulnerable patients in the trust. It is widely recognised as an example of good organisational practice.

Feedback demonstrates the benefits of the meetings:

> ***"I found the meeting extremely useful, I believe that if there were more meetings like this and more people went, there would be less staff burn-out. So much responsibility is held by care-co-ordinators; opening up discussion at the meeting led to a sense of shared responsibility which is more healthy."***

> ***"Being an 'outside container' is a real strength of the group, being out of the usual system yet within broader system of the Trust."***

> ***"I have a better understanding of the wider support available when working with high risk clients, e.g., liaising with other teams, A&E departments etc."***

Example 2: Team based reflective practice in a forensic unit

The West London Forensic Service (WLFS) provides care for patients who suffer with severe mental illness and/or personality disorders and have a history of violence, sexual violence or other criminal behaviour, as well as of significant trauma. Reflective practice groups in the service are available for all ward-based teams, the forensic community teams, and other professional groups including the senior management team.

Provision is overseen by the Forensic Psychotherapy Department, including a weekly workshop that reflective practice facilitators attend for peer supervision. Reflective practice provides a reliable and confidential space where teams can discuss the experience of working with forensic patients and explore the emotional, and often physical, impact of the work on them. This helps staff maintain their curiosity and interest in the patients' internal worlds and stories and improve their capacity to manage their most challenging aspects, including dysfunctional relationship patterns, harmful and/or offending acts, as well as complex dynamics within the team.

Feedback demonstrates the benefits of the meetings:

> ***"A team caring for forensic outpatients had been using its reflective practice sessions to express frustration about not having access to a space where they can work and interact with each other in a way that would improve the cohesion of their team. The group moved from airing feelings of grievance towards 'Management', who had not thought to provide them with such a space, to exploring who they had in mind when they used this term –who was and who could or couldn't be a 'Manager'.***
>
> ***Over time, team members felt more confident about communicating their concerns and bringing on board those in their team with managerial roles who proved to be receptive and supported their request. Eventually, the team was able to gain access to a more welcoming work space where they felt they could come together and support each other. This led to a sense of empowerment and increased stability within the team with positive impact on retention of staff and their capacity to contain their patients."***