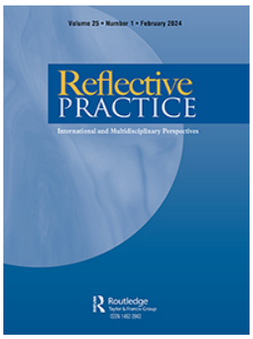

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Evaluating the experiences of a staff equality, diversity and inclusion reflective space

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ABSTRACT

Minoritised individuals (people identifying as belonging to groups experiencing socially constructed power inequalities) frequently experience mental health inequalities. Mental health services have often, intentionally or inadvertently, perpetuated these inequalities due to historic and ongoing systemic discrimination. To reduce inequalities, mental health services must address ongoing systemic discrimination and improve cultural-sensitivity of clinical staff. One method of improving clinician cultural-sensitivity is through reflective practice groups. This project evaluates a staff Equality Diversity and Inclusion (EDI) reflective space within a community psychological therapies team. A mixed methods approach of survey feedback and semi-structured interviews was used. Staff found the reflective space beneficial for improving their clinical skills relating to issues of EDI and helpful for their own wellbeing. Staff also found the EDI reflective space both acceptable and feasible and were keen to attend future sessions. However, some clinicians highlighted challenges relating to fear of judgment and evaluation from others. Findings are discussed in relation to the growing body of evidence of the usefulness of staff reflective spaces in healthcare generally, and provide specific support for the implementation of EDI reflective spaces. Guidance for developing an EDI staff reflective space for healthcare staff are discussed, alongside limitations and possible future research directions.

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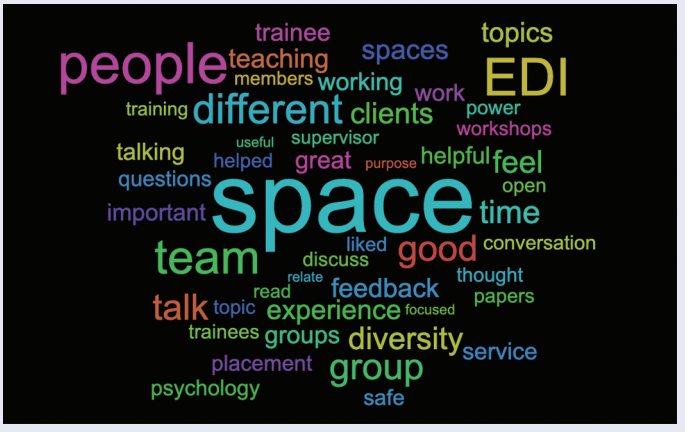


Introduction

Minoritised individuals identify with groups often experiencing socially constructed power inequalities (e.g. identifying as LGBTQIA+, ethnic and racially minoritised groups, people with physical disabilities, neurodiverse individuals, etc.). Evidence consistently shows that minoritised individuals experience poorer physical and mental health (Amos et al., 2020; Grey et al., 2013; Marshal et al., 2008, 2011). Whilst theories explain inequalities within specific minority groups (such as the minority stress theory for sexual minority individuals (Meyer, 2003)), people have multiple intersecting identities. Intersectionality acknowledges that individuals with multiple minority identities (e.g. ethnic and sexual minority individuals) may experience additional adversities and inequalities which can impact on mental health and wellbeing (Khanolkar et al., 2022; Sarno et al., 2021; Shidlo & Ahola, 2013). Healthcare providers must have an awareness of intersectional identities and the experiences of minority individuals which leads to health inequality.

The social determinants of health postulate that health inequalities are a result of experiencing inequalities within social and environmental health determinants (Compton & Shim, 2015). Minority individuals are more likely to experience inequalities in childhood adversity and trauma, victimisation, higher-cost education access, housing, employment, income, social support (Baams, 2018; Butt et al., 2015; Craig et al., 2020; Cronholm et al., 2015; Gayer-Anderson & Morgan, 2013; Gemelas et al., 2022; GOV.UK, 2023; Harrison et al., 2021; Li & Heath, 2020; Morgan et al., 2007; Mulcahy et al., 2017; Oduola et al., 2019; Office for National Statistics, Wealth and Assets Survey, 2022; Shankley & Finney, 2020). Despite increased rates of mental health difficulties, minoritised individuals are less likely to access mental health services (Cooper et al., 2013), more likely to be detained within a compulsory inpatient admission and often experience poorer outcomes (Edbrooke-Childs & Patalay, 2019; Moller et al., 2019; Oduola et al., 2019). Mental health services and professionals must be aware of the impact of systemic Equality, Diversity and Inclusion (EDI) related challenges experienced by minority individuals, to better support their mental health.

Mental health services must become culturally sensitive (i.e. able to provide care that meets the social and cultural needs of diverse populations) at both service and individual levels, to help mitigate mental health inequalities experienced by minoritised individuals. Internationally, healthcare services have begun responding to inequalities through cross-cultural teaching within healthcare education, cultural consultation services, development of specialist services for minoritised groups and systemic changes to service access and delivery (Ajekiigbe, 2023; Carrera et al., 2020; Gill et al., 2018). However, mainstream psychological models and practices used within psychotherapy were typically developed within the Western context and often fail to acknowledge the impact of colonialism and systemic discrimination (Naz et al., 2019; Pilgrim & Patel, 2015). Whilst efforts are being made to address institutional discrimination within the UK, the mental health workforce is not yet culturally sensitive or representative. Psychologists continue to experience racism, systemic barriers to training and are overrepresented by white heterosexual females (see Jameel et al., 2022; Leeds Clearing House, 2021; Wood & Patel, 2017, 2019). Addressing systemic discrimination within the UK is ongoing and required to build a culturally-sensitive psychological workforce to better mitigate the mental health disparities experienced by minoritised individuals.

Reflective practice is the process of reflecting both during and after events, and the impact of events on self and others, and relates to both personal and professional development (Lavender, 2003; Schon, 1983; Sheikh et al., 2007). Group reflective practice may be an effective method of improving cultural-sensitivity of mental health services and professionals. Group reflective practice is already used within the UK National Health Service (NHS) to improve staff wellbeing and increase insight (Flanagan et al., 2020; Taylor et al., 2018) and staff report it improves clinical practice and client care (Fisher et al., 2015). Furthermore, preliminary research suggests that reflective practice can improve the cultural-sensitivity of healthcare and allied health professionals (Howells et al., 2016; Tsuruda & Shepherd, 2016; Verdon, 2020; Wray & Mortenson, 2011). However, this research remains sparse and does not specifically explore reflective group spaces, but reflective practice generally. Therefore, implementing and evaluating an EDI reflective space for psychological professionals, will help highlight potential benefits or challenges, which have not been well established within the UK NHS context.

Research questions

(1) Is a group EDI reflective space acceptable and feasible to staff within a UK NHS psychological therapies team?
(2) Will a group EDI reflective space help develop clinical skills in relation to EDI for psychological professionals working within the UK NHS context?

Figure 1. Key themes, concerns and suggestions of the service user consultation.

Methods

Audit approval

The Health Research Authority ethics tool determined that ethical clearance from the NHS Research Ethics Committee was not required. Audit approval was gained from the NHS trust corporate audit committee.

The service

The EDI reflective space was implemented into a national and specialist psychological therapies services for people with psychosis. It consisted of psychological therapists (Assistant Psychologists, Trainee and Qualified Clinical Psychologists, and Cognitive Behavioural therapists) and peer recovery workers (previous service users who provide support to current service users and input on service development).

Staff EDI reflective space development

Service user consultation

A staff and service-user consultation informed the development of the EDI reflective space. In line with frameworks developed to support ethical Patient and Public Inclusion (PPI) in research (Hoddinott et al., 2018; Pandya-Wood et al., 2017) a scientific methodology was not used. The consultation process is described below.

Two peer recovery workers reflected about mental health access inequalities minoritised individuals experience. Key themes, concerns and suggestions were summarised and shared with the wider team (see Figure 1).

Staff consultation

An anonymous survey, emailed to all staff at the service, explored the importance of an EDI group (see Appendix A). Eleven staff completed the survey. 81% reported an EDI reflective space would be important to them. Staff suggested topics for sessions and provided feedback about the preferred format, duration, frequency and timing of the reflective space. The majority of respondents (73%) believed the group should be available to all staff.

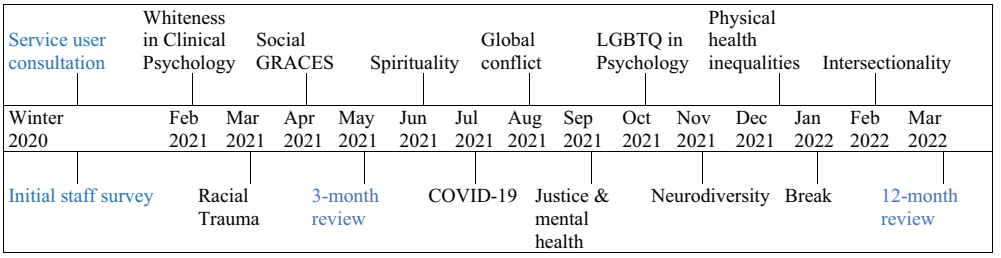


Figure 2. Timeline of development, content and evaluation of the EDI reflective space.

Staff EDI reflective space model

The EDI reflective space was developed using a decentralised management style known as shared leadership (see Doherty & Hope, 2000), by collaborating with staff and presenting and discussing the consultation findings in a team meeting. The EDI reflective space was open to all staff, held once monthly for 60 min and facilitated online due to the shift to remote working during the COVID-19 pandemic. Reminder invitations, including attached relevant reading was emailed prior to the session. Relevant reading included: peer reviewed journal articles presenting research or psychological theories and models, and clinical guidance papers. These were sometimes supplemented with other media, such as news reports or documentaries. Reading was optional, but encouraged as it helped to structure and stimulate discussions, learning and reflections. It was facilitated by either two qualified Clinical Psychologists, or one qualified member of staff and another unqualified member of staff (Assistant Psychologist or Trainee Clinical Psychologist). Facilitators introduced the topic and summarised the relevant reading. Then, the majority of the session focused on staff reflection and discussion, with feedback and take away points being summarised at the end. Each session focused on a different aspect or identity relating to EDI relevant to the population the clinic served. All staff were encouraged to suggest topics (see Figure 2 for timeline and topics of the EDI space). Sessions delivered from June 2021 onwards were informed by the 3-month review findings.

EDI reflective space evaluation

A mixed methods design of survey feedback at two time points and qualitative interviews was used. Two anonymous online surveys, were emailed to all current staff at time points one and two (see Figure 2). Nine participants completed the survey feedback at the first time point which explored group attendance and barriers to attendance, implications of the reflective space (including changes in self-reflexivity, awareness of EDI-related issues within clinical work with clients and other professionals) and perceptions of the space (including perceived bravery and safety, group dynamics and practicalities of attendance). Nine participants completed the survey at time point two which explored similar themes to the first survey, with additional exploration of group size and positionality of own identities.

Both surveys took approximately 10–15 min to complete. At both timepoints free-text responses were available for participants to elaborate on their answers. No identifiable information was collected (e.g. name, contact details or demographics) in order to ensure anonymity. See Appendix B,C for copies of the surveys. Survey data was analysed using descriptive statistical analysis.

Three Trainee Clinical Psychologists completed semi-structured interviews at time point two, about their experiences of the EDI reflective space. These interviewees had been invited to complete the 3-month review, but did not complete the 12-month survey review. Interviews explored staff experiences of the reflective space (both strengths and challenges), clinical implications and general feedback. Interviews were completed remotely via video-call and lasted between 15 and 30 minutes. See Appendix D for the interview protocol. The video-calls were recorded to support transcription, and then deleted.

All transcriptions were uploaded to NVivio and thematic analysis was conducted following guidance by Braun and Clarke (2006). The lead researcher familiarised themselves with the data through conducting, transcribing and re-reading the interviews and transcriptions. All data was coded for initial codes. A codebook was then created, and similar and repeated codes merged together. This process was repeated until key themes emerged. Final themes and related quotes were discussed with the co-author to ensure agreement and validity of themes and example quotes. The final themes and quotes were shared with the interviewees who provided consent for their inclusion in the final report and confirmed they represented their beliefs and experiences of the EDI reflective space, further ensuring validity.

Results

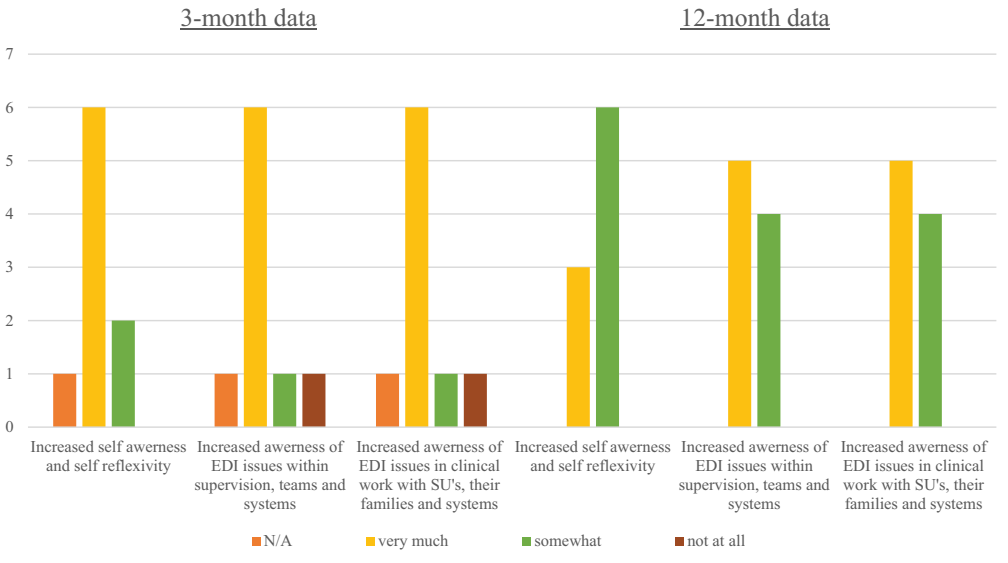
Survey data

Attendance

Participants provided information about their attendance of sessions at both time points and highlighted any barriers to attendance. Barriers mostly related to practicalities, 66% highlighted difficulties due to time commitments and diary clashes. Whereas 0% described irrelevance of the sessions or uncomfortableness in the space as barriers to attendance.

Implications

At both time points, the majority of participants found the EDI space to be beneficial for increasing reflexivity and awareness of EDI-related issues within supervision, teams and systems and within clinical work with clients, families and systems (see Graph 1). The majority of participants (83%) found the EDI reflective session very or somewhat helpful. However, 11% found the sessions very unhelpful.



Graph 1. Implications of the EDI group reflective space 3-month data 12-month data.

Group environment

Participants rated how psychologically 'safe' (e.g. the belief that they would not be punished or humiliated for contribution to the space) the EDI space was and how 'brave' they felt (e.g. the act of being able to speak up freely and openly) within the space. At 3-months the majority of participants described the group as very or somewhat safe (78%), but only 38% described themselves as very or somewhat brave. However, perceptions of group safety and individual bravery (very or somewhat) increased at the 12-month review to 100% and 89%, respectively.

At the 12-month review group size preference was assessed, with the majority (56%) preferring groups of five-to-eight. Participants also reported on breakout room use. Only

Table 1. 3-month free text responses.

Finding	Description	Quote
Barriers to bravery and safety	Whilst group size, and varying seniorities were barriers to safety and bravery for some, facilitators helped foster a safe environment, allowing members to feel brave.	*'I was "somewhat fearful" because of having more senior clinicians in the space, I worried something I said may make me look incompetent'. 'The facilitators' approach was welcoming and warm; it definitely helped to feel 'safe & brave".*
Relevant reading	Optional recommended reading helped facilitate discussions but prevented participants from feeling pressured to prepare.	*'I enjoy starting with a stimulus then moving onto discussion. I think the "no pressure" approach to pre-session reading materials is great, as many of us enjoy attending but may not always have time to prepare'.*
Open group format	Whilst some found the open group format impacted safety, others felt the benefits outweighed this. No one suggested changing the format.	*'I think the large group makes it harder for me to feel brave/safe, but having a diverse range of people makes it helpful and inclusive'*
Breakout rooms	Participants suggested using breakout groups to improve safety and bravery.	*'I believe it would be good to create smaller groups, so that every participant (even the shyest/less talkative ones) can have the time and space to express their thoughts'.*

Table 2. 12-month free text responses.

Construct	Finding	Quote
Helpfulness of the EDI space	Participants highlighted the helpfulness and novelty of the EDI dedicated reflective space.	*'I found sessions incredibly helpful to reflect on current, important EDI issues that I may not have otherwise had the time or space to consider'.* *'Opened up conversations I've never had before. Extremely interesting'.*
Positives of the group format	All responses stated the group format was working well. Participants reflected on the usefulness of optional reading.	*'I find the current format very engaging, safe, and informative. I enjoy the summary of the stimuli at the start of each session, as this means the space is accessible to all, regardless of whether or not we have had time to look through the text'*
Breakout rooms	Breakout rooms improved perceptions of safety. Having time for both smaller breakout rooms and one larger group was preferred.	*'I enjoy using breakout rooms to facilitate safe open conversations, and then coming back into the larger group for overall summaries. I enjoy the mix of having in-depth discussions in smaller groups, and hearing from a wider range of people, across groups'.*
	Breakout room usefulness depended on the size of the EDI group, and were detrimental to smaller groups.	*'One large group allows sharing of different perspectives. If groups are too small, they become an echo-chamber and perspectives are missed'*
Positionality of identities and	Participants attending sessions relevant to their identities reported this as restorative and validating.	*'Although I was initially nervous about possibly feeling pressured to self-disclose an identity I have only shared with a couple of people at work, I felt validated in the space, and at no point felt I had to share anything I was not comfortable with'*
Gratitude for the EDI space	Participants consistently reported benefits of the space and gratitude.	*'Thank you for hosting this excellent reflective group. It was incredibly validating of my own identities, and provided a safe space to have open conversations with colleagues about important issues that affect not only our clients, but our staff, too'.* *'Absolutely amazing to have EDI spaces. I am so grateful. It makes me feel empowered'.*

33% described wanting to use breakout rooms when the EDI group was smaller, this rose to 78% when the EDI reflective space was larger and well attended.

Practicalities

At the 3-month review, participants found the duration, frequency and timeslot of the group was acceptable.

Future content

Participants provided topic suggestions at the 3-month review which were later implemented. At the 12-month review further topics were suggested and the majority (67%) felt that some of the sessions had been relevant to their own identities. Participants also provided feedback on their intent to attend future sessions, with 94% across both time points indicating an intention to attend future sessions.

Table 3. Theme/sub-theme descriptions and quotes.

Themes/sub themes	Description	Quotes
Benefits of the EDI space		
Improved clinical skills	The space helped develop clinical skills and cultural-sensitivity when working with diverse clients. Clinicians were more confident and likely to initiate discussions related to EDI with clients, and reflect on EDI related issues within formulations.	*'It empowered me to ask more questions . . . and consider it in formulations'.* *'It highlighted the importance of making sure there is an open conversation when the clients need it'*
Learning	Clinicians benefitted from learning and developing their EDI knowledge, and took this forwards into their new teams.	*'In the team I'm working in, they don't always understand what impacts some of these injustices have on people. I've tried to be more vocal'.*
Restorative	The space was restorative and enjoyable. Clinicians described the environment as friendly, helpful and validating.	*'It was a cathartic space'* *'It's something that's important to have, and should be more the norm'* *'I really enjoyed it. I'm pleased to hear it's been carrying on'*
Challenges of the EDI space		
Concerns of evaluation	Clinicians expressed fears of judgment and evaluation. This was within the specific context of being a Trainee Clinical Psychologist as they felt that their performance was constantly evaluated by supervisors as a competency measure, to be used during trainee reviews.	*'At the end of placement your clinical supervisor is going to evaluate you, so you can't be open and honest'* *'When you're a trainee you're very conscious all the time of what you're saying in meetings. Did that sound right? Did I say something wrong?'*
Group size	Whilst a larger group size was helpful for prompting reflections and development, this at times increased anxiety.	*'I realised afterwards a smaller group might have helped me to be more comfortable to make mistakes'*
Sensitive topic	The sensitivity of topics could make the environment uncomfortable at times, but this highlighted the importance of the discussion.	*'The fact it was uncomfortable at times that's the nature of it, that's how it has to be if I want to improve'* *'At times it could be awkward, I don't think that's a bad thing. When that comes up, it's usually indicative of something important being talked about'.*
Need for the EDI space		
Developing a culturally-sensitive psychological workforce	Clinicians reflected on the need for clinical psychology to become more culturally sensitive, and how an EDI reflective space within teams can help achieve this.	*'The field has to become more comfortable with diversity in the room, not just race and culture but everything, class, disability'*
Lack of EDI spaces	Clinicians reflected on the lack of EDI spaces within mental health services and the value of accessing them.	*'It's great that such a space even exists because it doesn't in a lot of services and it's something that I've quite missed'.* *'I think the main strength is that it's actually happening, it isn't really happening In my other placements, It just doesn't exist'.*
Requirements for an effective EDI space		
Safe space	A strength of the space was the safe atmosphere, leading to more meaningful reflections.	*'If you only have an hour it can be difficult to get into this space, make it feel safe and contained, and then get to a deep enough level to actually make a meaningful conversation and then debrief afterwards. Because this was regular and with a safe group of people, we were able to contain that within an hour but still make it meaningful'.*

(*Continued*)

Table 3. (Continued).

Themes/sub themes	Description	Quotes
Service buy-in	Clinicians asserted that the service leadership viewed the reflective space as important and relevant as the EDI space was separate, dedicated and delivered regularly. Clinicians felt this was intrinsic to the success of the reflective space.	*'The time was given highlighted that the service wants to do even better, even more'* *'Having that monthly space is quite different. I've been to others before, but they were usually a lot more, irregular or it might just come up as a point of any other business in the team meeting rather than actually having a dedicated protected space every month to talk about it'*
Team buy-in	Having a team which are invested in exploring issues relating to EDI helped to increase engagement with the EDI reflective space.	*'It seemed like a lot of the team were really interested in EDI'.* *'It was a great idea well taken by the team'.*
Differing seniorities	Although having an EDI reflective space open to all staff at every seniority could lead to some staff feeling unsafe or intimidated, clinicians reflected on how this format increased opportunities for learning.	*'If your supervisor is in the room, there is power imbalance. But it isn't something I would remove because I learned so much from all the qualified clinicians'.* *'I still remember one qualified clinician really being open with what they were feeling about that topic, which was really touching seeing that it was OK, it's a journey for everyone'.* *'I liked that we were all different positions, it meant we could learn from each other'.*
Structure	Using a semi-structured approach, including optional relevant reading to introduce the topic and spark reflections and discussions, was a strength of the space.	*'It's great to have the paper beforehand for us to read and inform our thoughts beforehand, that was very good'.* *'I also appreciated the fact it was a bit structured, not too structured but not completely unstructured, which helped moderate the session'.*
Topic variety	Clinicians described how the variety of topics and ability to adapt topics to the current social and geopolitical context was helpful	*'It was a much wider variety of stuff than what you would cover in reflective spaces'.*

Free text responses

Across both time points participants provided free text responses elaborating on their survey responses, and these were grouped into key findings. See Tables 1 and 2 for the 3- and 12-month data respectively.

Findings from the 3-month free text responses indicated that the recommended reading was helpful in structuring the space and it being optional dispersed any pressure to prepare. Participants found that whilst a larger group size with a range of seniority of members were potential barriers to safety and bravery, this was outweighed by the benefits of it being inclusive and diverse. Participants suggested that breakout groups may help improve bravery and safety and that group facilitators were helpful with providing a safe space that helped participants feel brave.

Findings from the 12-month free text responses again highlighted the benefit of optional recommended reading. Participants expressed that breakout rooms helped improve safety and bravery, but were unhelpful if too small. Interestingly, participants with relevant identities to the reflective space topics found the space helpful and validating. Participants consistently expressed gratitude for being able to attend the EDI reflective spaces and reflected on the novelty of such spaces within the NHS.

12-month interview data

See Table 3 for the four overarching themes identified, their descriptions and quotes. Overall, participants found the reflective space helpful for developing their clinical skills and confidence in relation to EDI, and expressed how they took this learning forwards into new teams beyond the one in which the reflective space occurred. Some participants expressed concerns of being judged by others which impacted their experience of the reflective space. Whilst participants acknowledged the sensitivity of the topics being explored within the reflective space, this highlighted the importance of having a space to reflect on EDI topics and highlighted the novelty of such spaces currently within the NHS and the need for culturally sensitive psychological professionals. Participants also explored factors which made the space effective and offered suggesting for development of EDI reflective spaces.

Discussion

Overall, the findings support the implementation of staff EDI reflective spaces, and adds to a growing body of research highlighting the benefit of staff reflective spaces for personal and professional development within healthcare teams (Farr & Cressey, 2015). Our findings indicate that psychological professionals within the UK NHS context find reflective spaces helpful for developing awareness of EDI-related issues within clinical work, supervision and systems. Our findings also highlight the acceptability of such a reflective space within UK NHS mental healthcare teams, as the vast majority of staff described the space as safe and confirmed they wished to engage in further sessions. This is in keeping with recent evidence that EDI staff reflective spaces within medical training improve cultural-sensitivity through increasing medics' confidence in exploring issues relating to race, and also a desire to commit more time to EDI (Holdren et al., 2022). The interview feedback also strongly endorsed the benefits of the EDI reflective space, which included improved confidence in communicating about EDI-related issues with other professionals and service users, and positive implications for their own wellbeing. Previous findings have also highlighted the restorative benefits of staff reflective spaces within healthcare services which help maintain staff wellbeing (Flanagan et al., 2020; Maben et al., 2018).

Some survey and interview feedback highlighted possible considerations when developing an EDI reflective space; as one participant found the space unhelpful and others raised concerns relating to power dynamics, group size, and the sensitive nature of the topics discussed. Previous research also shows that reflective groups can cause distress, but that when psychological safety is established within the group the distress is often contextualised as an opportunity for greater learning and does not detract from the value of such spaces (Knight et al., 2010). Furthermore, exploring distress resulting from reflective spaces can develop self-understanding and foster professional development (Binks et al., 2013). Our findings also suggested that these challenges were simultaneously experienced as strengths of the space, allowing for meaningful reflection on issues that they might not otherwise have space to reflect on or discuss. It also allowed for normalisation and validation around feelings of discomfort or feeling deskilled when discussing sensitive EDI topics, and enhanced learning experiences, which added value to the space. Furthermore, although staff described

Planning the EDI reflective space	- Use a shared leadership model involving consultation with service-users and staff groups - Have a consistent and dedicated space for the group - Create an open access group to all staff of varying seniority levels - Consider optional recommended reading to help structure the space and initiate reflections
Facilitating the EDI reflective space	- Allocate breakout rooms if the reflective space is well attended (more than eight people) - Remain as one group if the reflective space is not well attended (eight or less people) - Be mindful of power dynamics (e.g. supervisory relationships) within the group and when allocating breakout rooms - Foster an environment that balances psychological safety with permission to be brave - Facilitators should model a safe environment, ensuring that attendees are aware that multiple and diverse viewpoints are appropriate - Facilitators should model that this is a space for learning where mistakes are expected and tolerated - Facilitators should feel confident in exploring issues relating to EDI and encouraging reflections and discussion
Evaluating the EDI reflective space	- Continue to evaluate the practicalities of attending the reflective space for your team - Continue to evaluate the usefulness of the reflective space for your team in a continual process of review and improvement - Continue to encourage and embody a shared leadership approach by providing multiple opportunities for feedback (e.g. surveys, informal discussions, team meetings and presentations) - Be transparent about feedback provided and any changes that are going to be implemented following this e.g. 'you said…. we did…'

Figure 3. Recommendations for developing an effective EDI group reflective space.

these difficulties, they also strongly endorsed that these challenges were not indicative of an unhelpful group and did not suggest changes to the EDI group format to alleviate this. Instead, they reflected that any difficulties were managed well within the group through support from the facilitators, and the sense of safety and shared ownership of the space that had been cultivated.

Staff and service user consultations, continuous staff input regarding the content, topics and materials of the reflective sessions and continuous assessment and re-evaluation, fostered a shared leadership model. Shared leadership models purportedly increase morale, job satisfaction, motivation, staff engagement, interpersonal relationships and increase ownership (Geoghegan & Farrington, 1995). The implementation of suggestions from participants at the 3-month review (i.e. using breakout rooms) were praised at the 12-month review. Safety and bravery were more strongly endorsed at the 12-month review, suggesting that the group environment was even more helpful for clinicians at this time point. Alongside the implementation of breakout rooms, group dynamics may have changed due to the space having been established for longer, allowing for psychological safety to be cultivated and participant confidence in participating to increase. Greater diary clashes were observed at the 12 versus 3-month review, which is unsurprising given the likely changes in staff composition, commitments and availability over a 12-month period. These findings highlight the benefit of using shared leadership and reflexively responding to team needs, as clinicians were able to see their feedback implemented, and continuing to assess diary availability highlighted potential new barriers. Previous research also highlights that shared leadership

and continuous staff involvement helps services flexibly respond to changing work environments (Scott & Caress, 2005). Therefore, EDI reflective spaces would benefit from regular reviews to ensure continued acceptability and feasibility.

Recommendations for developing an effective group EDI reflective space have been developed from the survey and interview feedback and are detailed below in Figure 3.

Care should be taken when interpreting the findings as the service was a national and specialist psychological therapies services for people with psychosis. Therefore, findings may not be easily generalised to other services which are structured differently (e.g. larger primary care community teams, multidisciplinary inpatient services, etc.) or have different team compositions (e.g. medical and nursing staff, allied health professionals), as different groups or professions may have different professional, personal or training experiences, which may impact their experience with a group EDI reflective space. Furthermore, as the EDI space was not compulsory, attendees were a subset of those the space was available to. Only one participant took part who had not attended the EDI space, so findings should be interpreted with caution as participants may already have had an interest within EDI, possibly introducing bias. However, it would be unethical to make the space compulsory, as professionals can find reflective practice psychologically harmful if they have experienced past trauma, are in an oppressive or demanding environment, or are experiencing mental or physical health difficulties (Yip, 2006). Furthermore, some key ideas about the value and implementation of the space may still be helpful for other services wishing to improve cultural-sensitivity.

The current project did not use a validated measure of cultural-sensitivity. Future research could use standardised measures of general clinical competence applied to the context of cultural-sensitivity (see Lee et al., 2020), or supervisory feedback of live or videotaped therapy sessions. System level indicators of service cultural-sensitivity could also be explored, such as access, outcome and experience data for minoritised service users. This offers an interesting avenue for future development and research, and highlights the need for developing and validating measures of cultural sensitivity within psychotherapy.

Conclusion

The current project highlights that group EDI reflective spaces help psychological therapy staff teams within the UK NHS context to improve their cultural-sensitivity through being more confident in discussing EDI-related issues within teams, their service users, service users' families/carers and within supervision. Furthermore, the space was highly valued by those who attended; an acceptable and feasible structure and group format has been identified. This might serve as a guideline for other mental healthcare teams who aim to improve their cultural-sensitivity, with the aim of improving outcomes and services for minoritised individuals.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributors

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Appendices

Appendix – A – Initial staff survey

1. How important is it for you to have a reflective space to discuss contemporary issues affecting you, the service and service-users?

0 - not at all important	50 - somewhat important	100 - very important

2. Here are some ideas of how we might use the space. What would be the most helpful issues to focus on? [participants rank them from most important (1) to least important (10)]

(a) How to integrate issues of difference (e.g. social graces) into formulations and interventions
(b) Issues of access, engagement, process and outcome in psychological therapy for those from minority backgrounds
(c) Health inequalities, and how these might be exacerbated by Covid-19
(d) How to discuss issues of difference (e.g. social graces) with clients
(e) Reflecting on issues of difference (e.g. social graces) and how to discuss these with colleagues/ bring to supervision
(f) Taking a strength-based approach to issues of difference (e.g. culture, language, disability)
(g) Working with clients who have experienced racism and racial trauma
(h) The impact of the socio-political context (e.g. Brexit, BLM, U.S election) on us and our service users
(i) The impact of COVID-19 on us, our service and our service-users

3. What kind of format do you think the reflective space should use? [participants rank them from most preferred (1) to least preferred (5)]

(a) Open and unstructured – completely up to group to bring what they would like from session to session
(b) Open, but structured around themes which are agreed in advance (e.g. where issues of power are getting in the way, working with racial dyads in therapy)
(c) Structured – case based (e.g. clinicians bring cases related to themes agreed in advance)
(d) Structured – paper based (e.g. facilitators share resources related to themes in advance of sessions for reflection and discussion)
(e) Structured – mixture of cases and papers

4. What else would you like to see? Do you have any other ideas in terms of themes or format? [free text response]

5. How often would it be fesible for you to attend a reflective space? [multiple choice]

(a) Bi-monthly / every fortnight
(b) Monthly
(c) Every 6 weeks
(d) Every 3 months/quarterly

6. Please indicate your availability of DAYS (Mon-Fri) and TIMES (AM or PM) for the reflective space. [free text response]

7. What do you think the membership of the group should be? [multiple choice]

(a) Open to everyone working in [Service Name]
(b) Allocated groups tailored to different staff groups (e.g. pre qual, peer, trainees, qualified and senior staff)

(c) Allocated groups to ensure a mixture of staff present, but being mindful of possible power dynamics (e.g. supervisor-supervisee relationships)
(d) Other (please specify) [free text response]

8. Are there specific models of reflective practice you think we should be drawing on? Are there resources you could share with us to help shape this project? [free text response]

9.How could we monitor and evaluate the effectiveness of the reflective groups? e.g. existing sources of data we could draw on, feedback survey, pre/post questionnaire or another measure? [free text response]

10. We welcome any other comments, thoughts or reflections. What are your hopes and expectations? Do you have any concerns or fears? [free text response]

Appendix B – 3-month survey

1.Which of the group sessions did you attend so far? [multiple choice response]

(a) None
(b) 1 - Feb – Whiteness in Clinical Psychology
(c) 2 - Mar – Racial trauma
(d) 3 - Apr – Social GRACES

2. If you missed some or all of the sessions then please let us know why. If you attended all sessions please select N/A

(a) N/A
(b) I could not find the time
(c) I had a diary clash (e.g. I was on leave/I do not work that day/I have a conflicting commitment)
(d) I did not feel comfortable to attend
(e) It did not feel relevant for me to attend
(f) Other

3.How helpful did you find the session(s) you attended? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very helpful
(c) Somewhat helpful
(d) Neither helpful nor unhelpful
(e) Somewhat unhelpful
(f) Very unhelpful

4. Participating in the group has increased my self-awareness and self-reflexivity. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

5. Participating in the group has increased my awareness of the importance of issues of EDI within supervision, teams and systems. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

6. Participating in the group has increased my awareness of the importance of issues of EDI in my clinical work with SU's, their families and systems. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

7. How 'safe' did the space feel? Prompts: Did you feel able to contribute to the discussion and share your experiences? If you did contribute – did it feel comfortable? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very safe
(c) Somewhat safe
(d) Neither safe nor unsafe
(e) Somewhat unsafe
(f) Very unsafe

8. How 'brave' did you feel able to be? Prompts: Did you feel able to speak freely without worrying about 'getting it wrong', or 'saying the wrong thing'? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very brave
(c) Somewhat brave
(d) Neither brave nor fearful
(e) Somewhat fearful
(f) Very fearful

9. Was there anything, in particular, you did or did not like about the group and its facilitation? Do you have any ideas of how we could make space feel 'safer', whilst also encouraging people to be 'brave'? [free text response]

10. Would you be interested in attending future sessions?

(a) Yes
(b) No
(c) Maybe
    (1) What do you think of the group format? Is it working? Please explain your answer. [free text response]
    (2) The group is held for 60 min once a month. What do you think of the length of the sessions?

11. What do you think of the group format? Is it working? Please explain your answer. [free text response]

12. The group is held for 60 min once a month. What do you think of the length of the sessions?

(a) Just right

(b) I would prefer 90 minutes
(c) Other

13. What do you think of the frequency of the sessions?

(a) Just right
(b) I would prefer every 6 weeks
(c) I would prefer every 3 months

14. The group is held at 9 am on the first Wednesday of each month. What do you think of the time and day of the sessions?

(a) This time/day works for me
(b) Other

15. The group is open to all [Service Name] team members. Are you happy with this, or would you prefer smaller or dedicated groups for different staff members based on experience or role? [free text response]
16. Do you have any ideas for future session themes? [free text response]

Appendix C – 12-month survey

1. Which of the group sessions did you attend so far? [multiple choice response]

(a) None
(b) 1 - Feb 2021 - Whiteness in Clinical Psychology
(c) 2 - Mar 2021 - Racial trauma
(d) 3 - Apr 2021 - Social GRACES
(e) 4 - June 2021 Social GRACES model revisited - spirituality focused
(f) 5 - July 2021 - COVID-19
(g) 6 - Aug 2021 - Global conflict
(h) 7 - Sep 2021- Justice and mental health
(i) 8 - Oct 2021 - LGBTQ in psychology
(j) 9 - Nov 2021 - Working therapeutically with neurodiversity
(k) 10 - Dec 2021 - Physical health inequalities/disabilities
(l) 11 - Feb 2022 - Intersectional identities
(m) 12 - Mar 2022 - Working with translators

2. If you missed some or all of the sessions then please let us know why. If you attended all sessions please select N/A

(a) N/A
(b) I could not find the time
(c) I had a diary clash (e.g. I was on leave/I do not work that day/I have a conflicting commitment)
(d) I did not feel comfortable to attend
(e) It did not feel relevant for me to attend
(f) Other

3. How helpful did you find the session(s) you attended? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very helpful

(c) Somewhat helpful
(d) Neither helpful nor unhelpful
(e) Somewhat unhelpful
(f) Very unhelpful

4. In what way did you find it helpful? [free text response]
5. In what way did you find it unhelpful? [free text response]
6. Participating in the group has increased my self-awareness and self-reflexivity. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

7. Participating in the group has increased my awareness of the importance of issues of EDI within supervision, teams and systems. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

8. Participating in the group has increased my awareness of the importance of issues of EDI in my clinical work with SU's, their families and systems. If you have not attended any sessions please select (N/A)

(a) N/A
(b) Very much
(c) Somewhat
(d) Not at all

9. How 'safe' did the space feel? Prompts: Did you feel able to contribute to the discussion and share your experiences? If you did contribute – did it feel comfortable? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very safe
(c) Somewhat safe
(d) Neither safe nor unsafe
(e) Somewhat unsafe
(f) Very unsafe

10. How 'brave' did you feel able to be? Prompts: Did you feel able to speak freely without worrying about 'getting it wrong', or 'saying the wrong thing'? If you have not attended any of the sessions please select N/A.

(a) N/A
(b) Very brave
(c) Somewhat brave
(d) Neither brave nor fearful
(e) Somewhat fearful
(f) Very fearful

11. Was there anything, in particular, you did or did not like about the group and its facilitation? Do you have any ideas of how we could make space feel 'safer', whilst also encouraging people to be 'brave'? [free text response]

12. Would you be interested in attending future sessions?

(a) Yes
(b) No
(c) Maybe

13.What do you think of the group format? Is it working? Please explain your answer. [free text response]

14.The group is open to all [Service Name] team members. Are you happy with this, or would you prefer smaller or dedicated groups for different staff members based on experience or role? [free text response]

15. What size groups do you prefer for the reflective space?

(a) 1-4
(b) 5-8
(c) 8-12
(d) 13-16
(e) 16+

16. When the group is smaller (less than 10 people) do you prefer to use breakout rooms or remain in one group

(a) I prefer breakout rooms
(b) I prefer being one group

17. Why? [free text response]

18. When the group is larger (more than 10 people) do you prefer to use breakout rooms or remain in one group

(a) I prefer breakout rooms
(b) I prefer being one group

19. Why? [free text response]

20. Have you found any of the sessions relevant to your own identities?

(a) Yes
(b) No
(c) Prefer not to say

21. How did you find this experience? [free text response]

22. Have any of your identities been missed, or underrepresented? [free text response]

23. Do you have any ideas for future session themes? [free text response]

24. Which group best describes your current role?

(a) Qualified practitioners - e.g. Qualified Psychologist, CBT Therapist, Specialist Psychologist
(b) Unqualified Practitioners – e.g. Assistant Psychologist, Trainee Psychologist, Honorary AP
(c) Prefer not to say

25. Any other comments/feedback [free text response]

Appendix D – Interview protocol

1) – What was your experience of the Equality Diversity Inclusion reflective space?
2) – How has the reflective space impacted on your:

(a) Development?
(b) Practice?
(c) Wellbeing?

3) – How does the space differ from:
(a) Other reflective spaces generally?
(b) EDI reflective spaces?
(c) Teaching or workshops on EDI-related issues?

4) – Where there any barriers or difficulties associated with the EDI space?
(a) If yes – What were they?
(b) If no – Why do you think this was?

5) – Where there any highlights or strengths associated with the EDI space?
(a) If yes – What where they?
(b) If no – Why do you think this was?

6) - Any other feedback?