Evaluation of Outcomes from Sussex Partnership MBCT Staff Groups

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Background

Mindfulness-Based Cognitive Therapy (MBCT) is an eight week course that can reduce stress in non-clinical populations (Chiesa & Serretti, 2009) and may be particularly helpful in workplace settings to reduce work-related stress (Virgili, 2013). Of all large public sector organisations in the UK, sickness absence is highest in the NHS, running at around 5% of the NHS workforce at any one time (ONS, 2014), with mental health related reasons being a prominent reason for sickness absence (ONS, 2014). Sussex Partnership have been offering MBCT groups to staff for over 15 years. This report presents outcomes from MBCT groups for Sussex Partnership staff between 2013 and 2015.

Method

The staff sample were 157 adults (125 females) who attended MBCT courses starting between the 16th of April 2013 and 19th of September 2015. Participants' ages ranged from 21 to 75 years (M = 45.5, SD = 10.45). Participants completed a pack of self-report measures pre and post-MBCT, participation in the MBCT groups was voluntary. 71% of staff participants completed both the pre- and post-MBCT questionnaires; 29% of participants either completed just the pre- or just the post questionnaires, or had large quantities of missing responses and thus were excluded from the data analysis. Staff self-referred themselves to MBCT but had to get approval from their line managers before they were allocated to MBCT groups in various locations in Sussex.

Measures

*The Five-Facet Mindfulness Questionnaire Short-Form (*FFMQ; Bohlmeijer, Klooster, Fledderus, Veehof, & Baer, 2011). The FFMQ is designed to measure levels of mindfulness. It contains 24 items within five facets; Non-reactivity to inner experience, Observing, Acting with awareness, Describing, and Non-judging of inner experience. Participants are asked to respond on a rating scale from 1 (never or very rarely true) to 5 (very often or always true) how frequently they had experienced the statements in the last month.

*Self-compassion Scale Short-form (*SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011). The SCS-SF is a 12 item measure of self-compassion. On a sub-scale level the it measures Self-Kindness, Self-Judgment, Common Humanity, over identification, Isolation, and Mindfulness. Participants were asked to indicate how often they behave according to the statements ranging from 1- (almost never) to 5- (almost always).

Compassion Scale – adapted (CS; Pommier, 2011). This 24 item scale measuring compassion towards others was introduced later on within the study, thus not all participants completed this measure. An additional 10 items were added by the researchers of the present evaluation to make a final 34 item compassion towards others scale. Participants were asked on a scale of 1 (almost never) to 5 (almost always) how often they behave in the stated manner.

Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983). This 10 item scale measured perceived stress during the past month. Respondents were asked to indicate how often they have felt or thought a certain way ranging from 0 (never) to 4 (very often).

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown et al., 2009). The SWEMWBS is a 7 item scale measuring psychological and eudemonic well-being. Respondents were required to rate themselves from 1 (none of the time) to 5 (all of the time) to how that item best described their experience over the last 2 weeks.

MBCT groups were facilitated by two trust-accredited MBCT teachers, closely adhering to the original MBCT manual (Segal et al., 2002) and receiving regular supervision from trust-accredited MBCT supervisors. Participants self-completed the pack of measures in the first and final session of their MBCT group with the facilitator present.

Results

Paired samples *t*-tests were used to compare participants' pre-MBCT and post-MBCT scores A total of 112 staff were included in the final data analysis, who had completed both pre and post measures; this accounted for 71% of the total initial participant sample of 157.

Perceived Stress: Perceived stress significantly decreased post MBCT (M = 23.23, SD = 7.21) compared to pre-MBCT with a large effect size (M = 29.88, SD = 7.11); t (111) = 9.30, p <.001, d = 0.93, 95% CI (0.70, 1.16).

Wellbeing: Well-being significantly increased post-MBCT (M = 25.72, SD= 3.12) compared to pre-MBCT with a large effect size (M = 22.39, SD = 3.73); t (111) = -9.93, p <.001, d = -0.97, 95% CI (-1.20, -0.74).

Mindfulness: There was a very large and significant increase in levels of Mindfulness post-intervention (M = 83.89, SD = 10.10) compared to pre-intervention (M = 69.61, SD= 11.37); t (111) = -13.65, p < .001, d = -1.33, 95% CI (-1.59,-1.07).

Self-compassion: Self-compassion significantly increased post MBCT (M =40.32, SD = 6.73) compared to pre-MBCT with a large effect size (M = 32.58, SD=7.52); t (111) = -11.05, p <.001, d = -1.09, 95% CI (-1.33,-0.85).

Compassion towards Others: Compassion towards others significantly increased post-MBCT (M = 140.28, SD = 15.75) compared to pre-MBCT (M = 134.66, SD= 14.43), with a small-medium effect size; t (71) = - 3.71, p <.001, d = -0.37, 95% CI (-0.58, -0.17).

Discussion

The aim of the current evaluation was to report on outcomes of MBCT groups for Sussex Partnership staff. Overall, MBCT was associated improvements in stress, wellbeing, compassion (for self and others) and mindfulness, with all but one effect size being in the large range.

The size of effect on perceived stress (d=0.93) is in line with findings from a meta-analysis of mindfulness-based interventions (MBIs) in non-clinical populations (Chiesa & Serretti, 2009) and from a meta-analysis of MBIs in workplace settings (Virgili, 2013). This suggests that the benefits of staff MBCT groups on staff stress are in line with what would be expected given the research evidence.

There are some limitations with this evaluation that need to be considered. One limitation is that participants completed the measures in the MBCT group which could increase demand characteristics and inflate effect sizes. There was a 39% non-completion rate. Those who did not complete the post-MBCT measures may have benefitted less from the MBCT course than measure completers. Having an independent researcher administer the measures could be a solution to this limitation.

Another limitation is that 29% of participants did not complete the post-MBCT measures. This may have been for reasons including but not limited to; pressures and time commitments of working within the NHS, pre-existing mental health conditions, time off work, or non-enjoyment of the course. Enhancing measure completion rates in future evaluations would be recommended.

Findings of this evaluation provide strong support for staff MBCT groups in Sussex Partnership. In order to reduce staff stress and improve wellbeing MBCT could be made widely available. Although further research is needed, reducing staff stress and improving wellbeing may lead to reduced levels of staff sickness absence or mindfulness skills could be a protective factor in managing highly stressful care giving roles.

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