The impact of an eight-week mindfulness-based course on levels of compassion and wellbeing in mental health professionals.

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Contents

Abstract

Background

Due to the nature of the work, health care members of staff are at increased risk of stress and burnout. This can influence their ability to produce quality care, can increase sickness rates and result in compassion fatigue. There is a growing body of evidence that mindfulness training is helpful in increasing wellbeing and compassion in health care staff. This study explores the impact of a mindfulness course of levels of wellbeing and compassion in staff who work in mental health clinical settings.

Methods

15 participants were recruited and 14 completed the course. The participants were males and females, aged between 23- 60 years old and were multi-disciplinary mental health professionals. Three outcome measures were completed the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS), Self- Compassion Scale (SCS) and the Compassion for Others Scale (CFOS) before and after an eight-week Mindfulness Based Stress Reduction (MBSR) course.

Results

The changes on WEMWBS was significant (p= .001) as was the improvement of the SCS (p= .004). There was no significant change in the CFOS but the pre score was regarded as high and this remained post intervention.

Conclusions

The findings of this study support the delivery of a MBSR course for staff to improve wellbeing and self-compassion. However, this was a small-scale study with no follow up post intervention. Therefore future research would benefit from long term follow up to determine if these benefits are enduring.

Introduction

It is well reported that staff that work in health care are particularly vulnerable to increased stress levels, maladaptive coping strategies and burnout in the workplace. Worryingly this lack of self-care and an inability to manage one's own stress can then hinder a healthcare professional's ability to produce quality and empathic care to patients (Shapiro and Burnham, 2011). These concerns about the deficits of compassionate practice in British healthcare have been widely discussed in policy reports, research and media (Egan, Mantzios and Jackson, 2016). Growing research suggests that healthcare professionals that have undertaken mindfulness training are better able to manage their own self care and wellbeing by utilizing the skills they have learnt (Irving, Dobkin, & Park, 2009) and it has been reported that staff that are better able to look after themselves are more likely to be compassionate and caring to those they look after (Raab, 2014; Shapiro, Brown & Biegel, 2007).

The Francis Report (2013) was published following the public inquiry into concerns raised over the failings in care in Mid Staffordshire NHS. The report highlighted that dignity, care and compassion in health care professionals was often absent and went on to identify that what was noticeable was that in contexts where staff felt valued and respected, it then followed that patients were treated with dignity and respect. What they had found was a culture where poor leadership and high sickness levels led to a decline in professionalism and poor standards of care and those who raised concerns were not heard. This failure of health care staff to act with sensitivity and compassion was echoed in The Andrew's report, Trusted to Care (2014). This report highlighted that there were deficiencies in basic respect which was ingrained in the culture of care. When a review team member described what

they had noted on the ward, what emerged was a chaotic atmosphere where the staff appeared stressed and not in control. Stress in health care workers has been shown to impact the quality of care, the amount of medical errors, ability to empathise and patient satisfaction (Vahey et al, 2004).

The nature of working in health care is that professionals work in complex settings and often are required to make high risk decisions. The workplace is an environment where there are numerous distractions, interruptions and stressors. The task of managing another person's suffering each working day can impact on a staff member's ability to meet both the patients and their own needs. There is an understandable expectation that staff should always be sensitive and compassionate, whilst being aware they are always under constant public scrutiny (Burton *et al*., 2017). In addition to this expectation, the very nature of the type of work of practitioners in the field of mental health can exact a large emotional toll (Brady, S. et al 2012). For staff working with people who are experiencing high levels of suffering, they know that managing another person's distress is an integral part to this type of work and the use of empathy a core skill. However, this type of work can create an increased risk of compassion fatigue. This might go some way in explain why mental health professionals are particularly vulnerable to high levels of emotional exhaustion and psychological tension (Moore & Cooper,1996; Sturgess & Poulsen, 2008). It has also been reported that they can experience increased levels in anxiety, depression, mental fatigue, and strained interpersonal relationships (Radeke & Mahoney, 2000; Tyssen et al 2001).

This toll on health care staff appears to be an increasing problem as figures for sickness rates for NHS staff are continuing to increase as are the rates for sickness related to anxiety, stress or other psychiatric illness. It was reported that in 2017 that 38% of NHS staff felt unwell due to work related stress which had been an increase of 1.3% since 2016 (Health

Education England). High levels of sickness rates in healthcare increase the burden on clinical staff as wards will often be short staffed, thus intensifying stress on existing staff and further increasing demands which results in an inability to retain staff. The importance of staff wellbeing is beginning to be recognised as is the need to find effective strategies to help improve their wellbeing (Burton et al, 2017).

Over the last decade there has been growing interest in the use of mindfulness-based interventions with healthcare professionals to reduce stress and increase self-compassion (Boellinghaus et al 2014) and there is a growing body of evidence to suggest that mindfulness-based interventions can have positive effects on work-related stress in healthcare professionals (Shapiro et al. 2005; Cohen- Katz et al., 2004; Galantino et al., 2005). Mindfulness Based Stress Reduction (MBSR) was developed in the 1970's in the University of Massachusetts Medical Center to provide training and education for those who suffer with stress, teaching them new ways to relate to life challenges (Kabat-Zinn, 2013).

Mindfulness can be defined as a way of purposely paying attention to the present moment and to whatever arises in the field of your experience in a non-judgemental way (Kabat-Zinn, 2003). The aim of mindfulness-based approaches is to give participants an increased awareness about concepts such as: how people relate to their experiences; attitude of acceptance and non-judgement; understanding meta-cognition and training in informal and formal meditation. The meditation training is fundamental for both the teacher and participants in a mindfulness course and underpins the theoretical model (Crane et al., 2017). It is recognised as an important quality that when training is being offered to staff that the teachers are also mindful practitioners (UK Network for Mindfulness-Based Teacher Training Organisations, 2016) because it is a skill that needs to be lived and experienced.

Through these contemplative practice's, participants are invited to bring awareness to their reactivity and the automatic habits and behaviours. An invitational and inquiry approach is offered by the teacher, so the participant can bring present moment awareness to their thought patterns and feelings, which often habitually increase distress. The course can help participants learn to start to see their thoughts as mental events that come and go in the mind, giving them the ability to meet the experience with compassion, curiosity and equanimity (Feldman & Kuyken, 2011).

Increasingly, studies have shown that attending a mindfulness-based programme has not only shown that stress-related psychological distress is reduced but in addition, there is evidence that presence on such a course can lower burnout (Martín-Asuero and García-Banda, 2010; Cohen-Katz et al., 2004). The research demonstrated that presence on the course resulted in an increase in perceived wellbeing and helped healthcare workers develop a non-judgemental attitude and degree of openness in their work.

Mindfulness is an important foundation and component of compassion as self-compassion and compassion for others is created in an atmosphere of awareness, openness and acceptance of experience (Gilbert, 2010; Tirch, 2010). In a literature review by Boellingfaus, Jones and Hutton (2014) they suggested that the findings of the studies their reviewed offered encouraging evidence that mindfulness-based interventions may increase self-compassion in healthcare professionals. Klimecki and Singer (2011) considered that this cultivation of other-focused concern through developing mindfulness skills, namely empathy and compassion for others, has the potential to help healthcare workers build stronger therapeutic relationships and offer protection against burnout. Raab (2014) additionally reported that mindfulness training has shown to have a positive effect on an

individual's professional skills, this was demonstrated by staff showing a greater kindness towards and acceptance of patients. Shapiro, Brown and Biegel (2007) found mindfulness training to be very relevant to those who deliver therapy and counselling, as the increase in compassion to one's self and others they argue is vital for effective therapy. Furthermore, it is reported that following mindfulness training, there are clinical benefits. An increased sense of calm, and the ability to demonstrate tolerance and compassionate response to suffering were all identified by Didonna (2009).

Egan et al (2016) defined compassion as being able to identify with the suffering of others and self, with a desire to alleviate that suffering. What Egan et al (2016) cautioned was when a health care professional demonstrated a high degree of care and compassionate feelings towards others, consequently the health care professional can in turn then suffer from compassion fatigue. This they report can be explained by staff not investing the time to support their own personal needs such as their physical and mental well-being. Previous literature reveals that health care professionals that work within mental health services are at a high risk for compassion fatigue and burnout due to prolonged exposure to suffering (Christopher & Marris, 2010).

There are numerous studies that propose that self-compassion and improvement in wellbeing were increased following mindfulness-based courses for healthcare professionals (Dobie et al., 2016; Foureur et al., 2013; Irving et al., 2014; Raab et al., 2015 and Shapiro et al., 2005). In a review and meta-analysis by Burton et al (2016) of mindfulness-based interventions for healthcare professionals, they concluded that they have the potential to reduce stress, and that the findings from the small scale studies could have benefits,

especially for those staff who have developed unhelpful ways of responding to stress then they suggest mindfulness could be of real help.

The emerging question is how can staff be enabled and supported to consistently act with compassion towards their patients without detriment to their own wellbeing?
The project explores the impact of a mindfulness-based course for staff and if there is a change in levels of compassion, self-compassion and wellbeing for mental health professionals working in frontline clinical settings.

The rationale for this study is to explore whether an 8-week mindfulness-based course can improve wellbeing and increase levels of compassion for mental health workers. The proposed research will build upon previous research in the following way: It will look at specifically mental health multi-disciplinary staff that are working in frontline clinical roles and build on the emerging evidence regarding the effect of an eight-week mindfulness course on levels of compassion and wellbeing. This differs from other studies because the course being offered to staff is a well-established routinely run course which adheres to the core elements of a mindfulness-based intervention (Crane et al 2016). The staff's managers are already agreeable to release staff as it is an ongoing opportunity and so staff can be released to fit the needs of the clinical area. The course is consistent with the same facilitators who have been trained in teaching mindfulness and who follow the format of the Mindfulness Based Stress Reduction course (MBSR). The participants in the study will be those who express interest in attending the next course and will come from a variety of mental health clinical settings which include both males and females over a variety of age and work grades hence representative of the working population. This is an ongoing course, which will remove potential bias created when a new opportunity is created for staff.

Hypothesis

Mental health staff who complete an eight-week mindfulness-based stress reduction course will self-report an increase in levels of compassion and wellbeing.

Method

Participants

15 Mental health clinicians working at Cardiff and Vale University Health Board (UHB) were recruited. The first 15 clinicians that enrolled were allocated to the group. The course is routinely offered four times a year and has been for the last four years. Clinicians are routinely invited to take part in the course via emails and posters in the staff rooms and invited to contact the researcher to book on the course. The clinical areas that the staff work in are: inpatient ward staff for mental health services for working age adults and mental health services for older people; staff working in the community mental health teams including crisis services; rehabilitation services both ward and community staff; eating disorders team members; addiction services and Perinatal staff. The staff that were invited included nurses, doctors, psychologists, occupational therapists and physiotherapists.

Procedure

Ethical approval was obtained from Bangor University. The 8-week mindfulness-based course is offered in standardised format by Cardiff and Vale University Health Board and runs on a regular basis 4 times a year. It includes both theory and practice in the 2-hour session per week and home practice is expected to be done between sessions.

The emails inviting clinicians to enrol in the study were sent through the internal health service email system, as members of staff are unable to access external emails. It was made clear on the emails and posters that participation on the course is entirely voluntary (Appendix 8).

The 15 staff allocated to attend the 8-week course prior to the study were each invited to participate in the research. The information sheet about the research project was provided in both English and Welsh (Appendix 1 & 3) and consent form (Appendix 2 & 4) was given to them by the research assistant, who also answered any questions they had. It was also made clear to them on the information sheet that they were welcome to attend the course and not be part of the research, as was also clear on the posters. All 15 participants consented to be part of the study.

The research assistant sent out the questionnaires via internal mail to all those participants who agreed and consented to be part of the study, one week prior to the course starting. The research assistant also then collect the consent forms which were all signed and dated by the participants and have been included in the study.

We requested that the participants who had enrolled on the course returned the measures prior to the beginning of the first session, sealed in an envelop and either sent to the research assistant via internal mail or handed in before the beginning of the first session.

The participants attended a 2-hour weekly session for 8 weeks in a training room which was on the hospital site. Each of the sessions consisted of meditation practice, inquiry and teaching that followed the MBSR format. This was facilitated by the researcher and research

assistant; the participants were also requested to complete home practice each day which included formal and informal mindfulness practices.

On the final session week 8, at the end of the session the participants were given the questionnaires and an envelope and requested they were returned to the research assistant via internal mail within a week. The 14 participants who completed the course all did this. The research assistant coded the questionnaires, so they were anonymised before being given to the researcher.

Following the collection and analysis of data, the anonymised results were sent out to participants via the workplace internal mail.

The inclusion criteria for the study were as follows: - Age 18-75 years - Mental Health workers who currently working for Mental Health services for Cardiff and Vale UHB.

Exclusion criteria: A recent trauma and/ or currently off work

Measures

The questionnaire pack contained three questionnaires; self-compassion (Appendix 5), compassion for others (Appendix 6) and looking at general wellbeing (Appendix 7). These are detailed below:

The Self-Compassion Scale -Short Form (SCS-SF; Neff, 2003) measures how kind and understanding we are toward oneself. It is also designed to identify how we relate to our experiences and the tone we use towards ourselves, identifying if it is harsh and self-critical. It has 12 self-reported items; each item is given a score between 1 and 5 and a total score is calculated. Responses are given on a 5-point scale from “Almost Never” to “Almost Always”.

The items of the scale that represents uncompassionate responses to suffering are reverse coded so therefore the higher the score will represent a lower frequency of these responses. The means are calculated for each subscale, and a grand mean is calculated that represents an overall measure of self-compassion. The items representing the lack of self-compassion are written in a manner that requires reverse scoring is in order to avoid the need to have a negatively worded item. Therefore, an item that assesses the lack of self-judgment is written as "I am not disapproving and judgmental about my own flaws and inadequacies," would then require a response of "almost never" by people which are high in self-judgment. The higher the participants score then the greater the level of self-compassion. The short scale has a near perfect correlation with the long scale when examining total scores and is identified as a psychometrically valid and theoretically coherent measure of self-compassion (Neff, 2015).

The Compassion for Others Scale (CFOS; Pommier, 2010) measures how understanding and kind we are towards others. This scale identifies that for someone to have compassion for others, they must first notice that the other person is suffering. This scale is a 24-itemed self-report scale and each item is given a score between 1 and 5, the score of 1 being "Almost Never" to 5 which would equate to "Almost Always". The score is then calculated with some scores reversed before establishing a mean value. The items which are reversed scored are the items that consider indifference, separation and disengagement and have such questions as "Sometimes when people talk about their problems. I feel like I don't care." Or "I don't feel emotionally connected to people in pain". The higher a participant scores then the greater the levels of compassion. This ccontent, convergent and validity of

the Compassion for Others Scale is supported in general populations and was rated satisfactory for validity (Pommier, 2011).

The Warwick-Edinburgh Mental Well-being scale (WEMWBS; Stewart-Brown, S. & Janmohamed, K., 2008) is a tool used for self-assessing mental well-being and psychological functioning. The items cover aspects of positive thoughts and feelings. It is a positively worded 14 item scale with five response categories. With questions such as "I've been feeling good about myself" and "I've had energy to spare". The scale is scored by adding the score of each of the responses for the items which are measured on a 1 to 5 Likert scale, 1 (none of the time) to 5 (all of the time). The minimum scale score is 14 and the maximum is 70. WEMWBS has been validated for use in the UK for those persons aged 16 and above. The validation involved both student and general population samples and focus groups (Tennant *el al*., 2007).

Research design

This is a within subject research design, utilising a quantitative methodology. Questionnaires were given to the participants at two time points, before starting the course (Baseline) and immediately post the mindfulness course on session 8. There is no training required to use these scales. The researcher is a registered mental health nurse who has used these and other outcome measures in the past.

Ethical considerations

This study gained ethical approval from Bangor University. This is an ongoing course, so approval was not needed from the University Health Board (UHB) however the Research and Development department was informed, and they were agreeable for it to proceed. Consent was obtained using a consent form, which is also available in Welsh, which was sent to participants prior to the intervention with an information sheet for participants who were interested in taking part in the study. The researcher and research assistant were available to answer any queries prior to the study.

Potential offence/ distress to participants

There was a low likelihood of distress for participants and all interventions are facilitated by two members of staff so one was always be available to provide support if required. Both facilitators are experienced mindfulness teachers. Facilitators were also available pre and post session to give participants opportunity to discuss any difficulties. Participants did not need to answer any questions on the outcome measures that they did not wish to answer, and this was made clear to them.

Procedures to ensure confidentiality and data protection

All forms were anonymised by the research assistant by coding before being seen by the researcher and stored securely in a locked filing cabinet in locked room in the researcher's office on the UHB site.

Any data held on a computer is password protected. All paper copies of questionnaires were shredded and disposed of in confidential waste following the completion of the project. Any computer files will be deleted after a 5-year period.

Feedback to participants

Following the collection and analysis of data, the results were sent out to participants via the workplace internal mail.

Results

There were 15 participants accepted into the study of those one dropped out after the first session due to workload. In total there were 14 participants which completed pre and post measures and these were analysed. Of the 14 who completed the course there were 3 males and 11 females and the ages ranged from 23 to 60 years of age. All participants attended at least 5 sessions out of eight and five attended all eight sessions.

Statistical analyses

A paired T test was employed to compare the differences in baseline and post -intervention ratings on each measure. The results was put onto the Statistical Package for the Social Science (SPSS) program and analysis was completed comparing the pre and post measures and the results compared. Given the small sample size, and the fact that the study is unlikely to be powered to detect statistically significant differences, the results was also analysed descriptively.

T-tests were performed on the outcome measures for wellbeing (WEMWBS), self-compassion (SCS) and compassion for others (CFOS) scores. The Compassion for Others scale, and Self-Compassion scale subscales were also compared for pre-post differences, to examine the any differences in overall scores which are driven by specific subscales (Table 1). WEMWBS, SCS and CFOS results (Table 1) were also examined descriptively in the discussion section.

Table 1 Summary of pre-post mean scores

Measure	Subscale	Pre-Mean (SD)	Post Mean (SD)
WEMWBS		**44.9** (7.3)	**52.3** (6.7)
SCS-SF Overall score		**32.9** (5)	**40.8** (8)
	Self-Kindness	2.7 (0.7)	3.4 (0.7)
	Self-Judgement	3.6 (0.7)	2.9 (1)
	Common Humanity	3.4 (0.7)	3.7 (0.8)
	Isolation	3.7 (1)	2.6 (1.9)
	Mindfulness	2.9 (0.7)	3.9 (0.7)
	Over-identified	3.6 (0.8)	3 (0.9)
CFOS Overall score		**97.4** (11)	**100.4** (11)
	Kindness	4.6 (0.5)	4.6 (0.6)
	Indifference	2 (1.2)	1.9 (1.2)
	Common Humanity	4.4 (0.9)	4.6 (0.9)
	Separation	2.2 (1.5)	1.7 (1.1)
	Mindfulness	3.8 (0.9)	3.8 (0.8)
	Disengagement	2.5 (1.2)	1.9 (1)

Notes – WEMWBS, Warwick Edinburgh Mental Wellbeing Scale; SCS-SF, Self-Compassion Scale short form; CFOS, Compassion for Others Scale; SD, standard deviation.

Within subjects t-tests were used to analyse the data. Prior to performing the analysis all variables were checked to determine whether they were normally distributed. All variables had skewness and kurtosis statistics within the range of -1.96 and 1.96 (Doane & Seward, 2011) Shapiro-Wilk's tests ($p > .05$; Razali & Wah, 2011; Shapiro & Wilk, 1965), as well as visual inspection of the histograms, normal Q-Q plots and box plots, indicated that most variables were approximately normally distributed both pre and post intervention. Inspection of the histogram suggested that the Compassion for Others pre score was not normally distributed. The pre scores taken before the intervention (figure 1) and normally distributed following the intervention (figure 2).

Figure 1. Distribution of compassion scores pre intervention

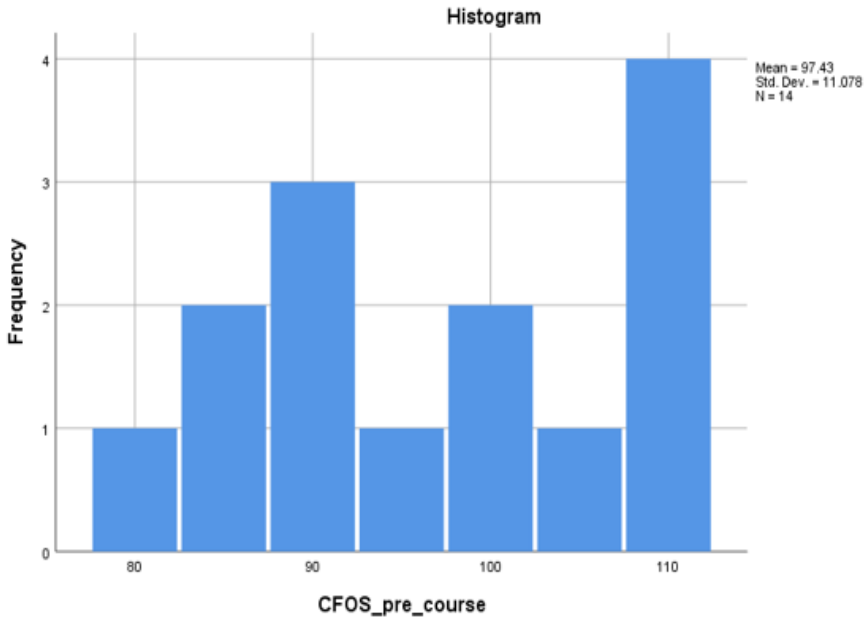
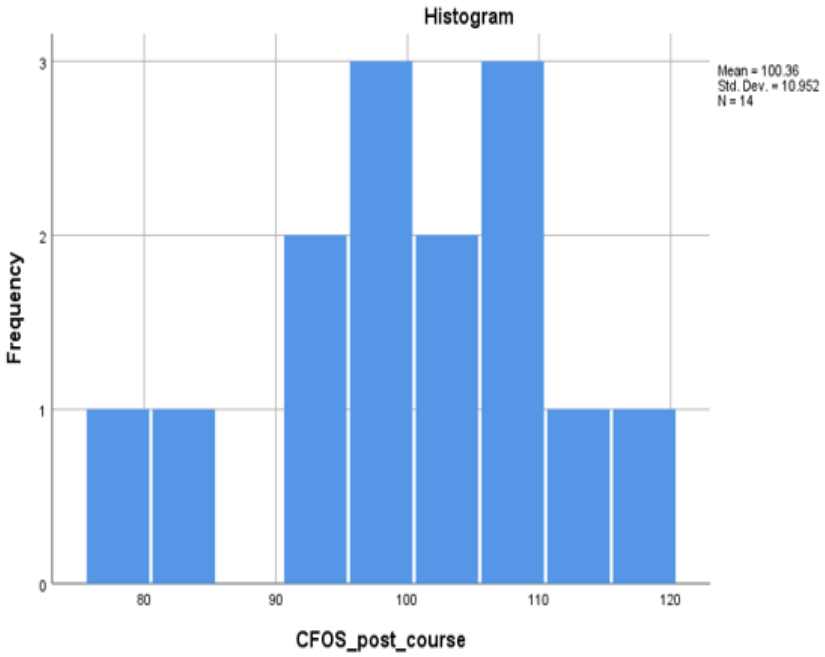


Figure 2. Distribution of compassion scores post intervention



As such, the Wilcoxon Signed-Rank Test was used to test whether pre and post scores on the Compassion for Others pre and post scores differed. This yielded similar results to the within subjects t-tests, as such only results for the t-test are reported (Table 2).

Table 2. Summary of T-test results for difference in pre and post scores

Measure	t	df	p (2-tailed)
WEMWBS	-4.163	13	.001
SCS-SF	-3.544	13	.004
CFOS	-1.165	13	.265

Notes- WEMWBS, Warwick Edinburgh Mental Wellbeing Scale; SCS-SF, Self-Compassion Scale short form; CFOS, Compassion For Others Scale, $p < .05$ statistical significance

A significant difference in well-being scores mean (44.9, SD=7.3) and after (52.3, SD=6.7) a Mindfulness-Based Stress Reduction Course was found, t(13) =-4.163, p= .001. There was also a significant difference seen in self- compassion scores before (SC =32.9, SD= 5) and after (SC = 40.8, SD 8) the MBSR course was identified, t(13) = -3.544, p=.004. However there was no significant difference in the compassion for others scale before (CFOS= 97.4, SD= 11) and after (CFOS= 100.36, SD 11) the course, t(13) -1.165, p= .265. Sub scales of the self-compassion scale were not analysed as the short form was used and this would be considered therefore unreliable data. The subscales of the Compassion for Others form were tested to see if this showed any significance in the sub-factors of compassion the results are in Table 3.

Table 3. Summary of T-test of the Compassion for Others subscales

Compassion for Others subscale	**t**	**df**	**p (2-tailed)**
Kindness	.563	13	.583
Indifference	.224	13	.826
Common Humanity	-.384	13	.707
Separation	2.11	13	.055
Mindfulness	-.186	13	.856
Disengagement	1.114	13	.286

Notes - $p < .05$ statistical significance

There was a mild significance in the Separation score (p= .05) with a reduction of 0.5 on the Likert scale there was no other significance in the scores.

Discussion

The results of the impact of an eight-week MBSR course on mental health staff saw improvements in wellbeing and self compassion and these results will be explored further in this discussion section, also consideration will be given the specific areas identified by the subscale within the measures. The results from Table 1 will now be discussed.

Wellbeing

The results have demonstrated that attending a mindfulness course can lead to a significant ($p = .001$) increase in the well-being score, this is consistent with previous research (Cohen-Katz, 2005). This study showed that there was an overall increase of wellbeing with an improvement of mean score of 7.4 points; this 7 point increase can be considered a meaningful increase (Putz et al, 2012). Both the pre and post results fall within the average range of wellbeing (Warwick Medical School, 2019) however the pre-score mean of 44.9 falls within the score of 41-45 which Taggart et al (2015) suggests could be considered puts the participants at an increased risk of depression and in high risk of psychological distress. This low end of the moderate score may be attributed to the nature of the work with complex caseloads and stressful environments being experienced by staff. This low score is consistent with other studies and re-enforces the concerns raised about poor wellbeing in mental health workers which was highlighted by Brady et al (2012) and identified by Sturgess & Poulsen (2008) and Moore & Cooper (1996).

The increase in this study to a mean of 52.3 points, positions staff into an higher average score of wellbeing which is consistent with findings from a study conducted by Goodman and Schorling (2012) that showed significant improvement in mental wellbeing following an

eight-week mindfulness course for doctors, nurses, psychologists and social workers. In addition, other similar studies which considered mental health staff wellbeing such as Dobie et al (2016) noted that there was a significant decrease in levels of anxiety for mental health staff following an eight week adapted MBSR course and Foureur et al (2013) whose study saw a decrease in nurses' perceived levels of stress, anxiety and depression, using an adapted MBSR course.

Although an increase was found in this study which is consistent to other findings, there are a variety of factors that may have influenced the scores that need to be considered. It can be concluded that attending a group session was helpful this can be evidenced by the very low dropout rate and by the participant's regular attendance. Burton et al (2016) suggest reductions in stress may be supported by the group effect, as the group-based normalization and reduced professional isolation can be therapeutic for participants (Michie & Williams, 2003). The combination of time away from a workplace, the sharing of experience with others or the course content and mindfulness practice could all go to explain the increase in levels of wellbeing and support the theory that attending an eight week mindfulness course improves levels of wellbeing.

Self-compassion

The psychometric outcomes have also high-lighted a significant increase in self-compassion scores following completion of the course, supporting the previous findings from Shapiro, Brown and Biegel (2007). The results from this study showed there was a significant (p= .004) increase in self-compassion with an increase in overall mean of 7.9 points using the SCS following the eight-week course. There is a mean per item of the 1-5 Likert scale of 2.7 before the course and 3.4 at the end, which falls into the moderate range of 2.4-3.5 for self-

compassion (Neff, 2003). This study's results are consistent with other finding with regards to self-compassion such as the study by Shapiro et al (2005) who offered an MBSR intervention for healthcare professionals and measured the results using the SCS. Their study also showed a significant increase in self-compassion (p=.004). In addition, Rabb et al (2015) which also had an eight-week MBSR course for mental health professionals which measured the outcomes using the Self-Compassion Scale with pre and post intervention points. Their study also showed significant changes on the SCS (p= .003) and improvement on 4 of the 6 subscales.

Although subscales weren't analysed using T-tests on this study as the short form was used, there was noticeable small improvements on all the subscales. The subscales in the SCS that showed improvements were firstly increases in self-kindness (2.7-3.4) and a decrease in self-judgement (3.6-2.9) which reduced it from high score to moderate. This demonstrates a shift towards a key component of self-compassion, that of becoming more understanding towards ourselves when we struggle rather than being critical and harsh (Neff, 2003). This shift can go some way in helping staff develop skills in self care so that they are better able to manage the stressors of working in complex and challenging environments. The improvement in score can be some way explained by the content of the course which has a theme of self-care running through it and the awareness of attitudes key to mindfulness such as non-judging and acceptance.

There was also an increase in common humanity (3.4-3.7) taking it from a moderate score to a high score and a reduction in feelings of isolation (3.7-2.7) which reduced it from a high score to a moderate score. These scores start to demonstrate a changing in perception from separateness to connectedness. The course offered opportunity for participants to share their experience of the meditations and often, as they spoke of the difficulties that arose,

the group in time became a place where participants appeared to feel able to feely discuss difficulties and often there were similar experiences, which might help reduce feelings of isolation. The course gave participants time to challenge the idea that difficulties are unique to us and therefore increasing their sense of commonality of suffering, it can be proposed might help reduces feeling of isolation. These improvements it can be suggested may help reduce compassion fatigue which can become more prevalent when staff feel isolated and detached.

In a literature review conducted by Boellinghaus, Jones and Hutton (2014) the authors concluded that their results indicated that mindfulness-based interventions designed to increase health care workers levels of self-compassion also have the potential to reduce burnout, empathetic distress and maintain wellbeing.

The increase of mindfulness on the subscale is unsurprising (2.9-3.9) but gives weight to the argument that the content of the mindfulness course impacted the results, thus taking the score from moderate to high and the reduction in over-identification (3.6-3) reduced it from high to moderate. The paying attention of present moment awareness is a key component in self-compassion, because as negative emotions are accepted rather than ignored and supressed, we start to see them as transient rather than being us. Germer (2004) has suggested that developing mindfulness as a skill, it can enable an individual to connect to all experiences in a less reactive way, and that this then can counteract the effects of stressors. This reduction of reactivity can be a very positive approach towards gaining a calmer workplace and helping to reduce feeling of being overwhelmed. Therefore it can be assumed that the increase in mindfulness can be attributed to the course content, group and home practices. The increase in levels of self-compassion can be attributed to the

mindfulness content of the course, as Neff (2003) suggests that for an individual to fully experience self-compassion they must be mindful.

Compassion for others

There was a small increase in compassion for others using the CFOS of 3 points (97.4-100.4). However, interestingly, what was noted was that the pre score mean on the 1-5 Likert scale was 4, which showed a high level of compassion, Pommier (2011) reported this can be considered a high score as the scores were already close to the 'almost always' range (5). In this study the participants had high levels of compassion for others before the intervention so perhaps unsurprisingly there was very little change post-intervention scores of a 1-5 Likert mean of 4.2. The pre-score showed a distribution of scores that were higher than would normally be expected. One possibility maybe that the scores may have been influenced by the researcher and research assistant being mental health clinicians, which may have created an effect on how the participants self-scored themselves on compassion, and unknowingly felt an increased sense of expectation on themselves when reporting to be viewed as compassionate. This is one hypothesis. A study by Fortney et al (2013) similarly reported a lack of change in the compassion scores in primary care clinicians following a mindfulness intervention and suggested that this could be attributed to the ceiling effect because the participants already had high compassion scores at baseline.

Following the course, the distribution of scores in figure 2 shows a more even distribution and results more evenly spread. It can be suggested that those who enter the health care profession would be considered to have high levels of compassion as it is a profession that helps those who are suffering on a day to day basis and interestingly the results from this

study confirm this. As the scores were all within the high range and remained so throughout the course, this increased the reliability of the scores against any potential false reporting at the pre scores.

The subscales of the CFOS were analysed (the results are shown in table 3) to identify if there were any changes in specific areas which make up compassion. They showed little to no difference except in slight improvements in feelings of separation (0.5) and disengagement (0.6) both areas that can affect wellbeing. This improvement, even small, in separation and disengagement are important in helping staff to feel more connected to others. One explanation is the group process which offers participants opportunity to form as a group and develop connections with one another. Other studies have also identified that mindfulness training can develop this greater sense of "shared humanity" (McCollum and Gehart, 2010).

The study showed that the staff started the intervention with self-reported high levels of compassion for others and although the course only slightly increased this score, it was maintained, and this was combined with significant increases in the other areas measured of wellbeing and self-compassion. It can be argued that this combination helps towards reducing the risk of compassion fatigue and gives members of staff the ability to both better look after themselves and others, as they come to terms with their own vulnerabilities and become better able to identify how their own experience of suffering can relate to that of the patients (Christopher et al , 2011). This is echoed by Fortney et al (2013) who suggest that an increase in emotional awareness by health care staff, can be associated with less burnout, higher work satisfaction, and higher patient satisfaction.

Study evaluation

This study set out to explore the impact of an eight-week mindfulness-based course on mental health staff on levels of wellbeing and compassion and it has done this. This study used an existing course that was being routinely run which had the benefit of staff working within the service were already were aware of it and thus it was unproblematic to recruit staff into it. The members of staff who had requested to attend were also all agreeable to being part of the study. It had good retention rates of staff with only one dropping out due to workload and all other staff able to attend at least 5 of the 8 sessions. The staff who were unable to attend some of the sessions did so because of pre-planned holidays or clinical demands. The researcher was able to address the difficulties around clinical demands as managers were already willing to release staff to attend because this is the agreement for those who attend a course. The study benefited from having the course run by clinicians who are experienced in teaching mindfulness so when staff found aspects challenging, the facilitators were on hand to help them explore and work through this. Facilitators offered an authenticity around some of the challenges of mindfulness and home practice and experience of the difficulties of combining this with working in a mental health clinical area.

The study did not show any significant difference in levels of compassion which was the hypothesis, but this can be explained by the high levels of compassion that the participants had before and during the course. These high levels of compassion may often be assumed to be prevalent when considering the qualities of health care workers; however there appears to be lack of studies that measure this important quality. So, although it didn't yield any significant results it was reassuring to see these high pre- and post-scores.

Study limitations

There are several limitations to this study that need to be considered. The study used self-selected participants, which is usual for mindfulness-based courses and standard practice (Burton et al, 2017). However when staff opt-in, this suggests an increased motivation and could contribute to any positive effects found. There was no control group to compare and rule out that the mindfulness-based intervention is the factor which caused the reported effects. The reported improvements may have been down to indirect benefits of attending a group programme within work time. Also, no specific mindfulness outcome measure was used so it is difficult to evidence that the mindfulness component to the course was what created the changes in wellbeing and self compassion.

The sample size was small and so the reliability of the study effects is limited. The outcome measures were collected pre and post the eight-week course and so there is no data regarding the ongoing effects following the course. There would be increased value in revisiting the measures 6 months post intervention to consider a longitudinal evaluation of effect.

It would also have been of added interest to have conducted qualitative questionnaires following the intervention to explore how these perceived improvements had translated into everyday life. That the measures were collected by a research assistant who is also a mental health professional may have affected the self-reported scores by participants and so by having someone independent, may well offer greater fidelity to the self-reporting.

Research Challenges

I had hoped to recruit more staff into this study but unfortunately there is no dedicated room to run the course. The only one available to me to run this course was a smaller one than usual which would only hold 15 participants. The venue was within the hospital setting so the majority of participants were coming from work environments which were close by and some were unable to attend all sessions because of the demands on the clinical area at the time. One staff member was called out during the middle of a session because of clinical need. This was managed by the researcher who sent an email as a reminder to managers about allowing staff to attend and it ceased to be an issue after a few weeks.

It was difficult for some staff to come straight from a work setting to the course and they would notice they felt tired, hungry and on high alert but it did give participants an increased awareness of some self-care aspects that they were usually ignoring when they were in work.

Having a venue so close to the clinical areas posed some problems as there were alarms audible in the distance and other clinical activity. This is one of the difficulties of running a course in healthcare setting and a venue away from the clinical area would be recommended. Having a venue that is away from the direct clinical environments would help staff engage with the course and be undisturbed in the sessions. This would help increase the amount of sessions some of the staff would be able to attend because although there was a good retention rate, only 5 of the 14 staff attended all eight sessions. The difficulty of using a room off site is that those not within the NHS sites could have a cost implication which would prove an added difficulty in ever increasing financial constraints of

healthcare also it would increase time staff would need away from clinical areas with travel which might reduce the number of staff able to attend.

Some staff were unable to access the online links as they didn't have use of a computer at home and one also did not have a CD player and so was unable to do the home practice for the first few weeks, the researcher was able to get one for them to use.

There were also some issues around the reasons members of staff had for attending. With a few staff, their intention for attending the course was to get resources so that they could teach mindfulness to their patients and as such came with an expectation of being taught to deliver mindfulness to others, rather than the intention of the course, which was inviting them to experience it for themselves. The move from professional to personal was a challenge for a couple of members of staff at first and they were a little resistant to home practice and inquiry. This identifies that some work needs to be done by the researcher to make the purpose of the course clearer on the poster and emails. Also, it might be useful to signpost staff to training opportunities for those who wish to start teaching mindfulness clinically.

There were issues around collection of pre-questionnaires and an assumption was made that the staff would be familiar with the measures and how to complete them but not all were returned before the first session, so the research assistant needed to get some staff to complete them before the session started. Others had data missing so the research assistant also had to get these completed by the relevant staff member before the course. This took more time than we had envisaged and was difficult for the research assistant, who is clinically based, to have time to do this.

Future Research

Future studies would benefit from a larger scale study with a randomly controlled trial to militate against positive results arising from time away from the clinical setting. It would be helpful to have qualitative feedback following the course to find out what staff identify as the benefits to attending an eight-week mindfulness course and what impact they are aware of regarding changes to working practice in a clinical area. Researchers should also consider conducting repeat measure at a six- and twelve-month interval post completion of the course to consider the lasting effect of the changes.

It would be useful to use an additional measure specifically for mindfulness to capture if mindfulness traits are embedded with the individual following the course. The Five Facets Mindfulness Questionnaire (FFMQ; Baer et al 2006) is a self reporting questionnaire that incorporates five factors that represent the elements of mindfulness as it is currently conceptualized. The five facets are observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. The results of a study by Choi (2015) confirmed that FFMQ was a reliable and valid tool for measuring mindfulness meditation. The results from a study by Klein et al (2015) suggest that a trait mindfulness measure such as the FFMQ can be shown to detect changes in mindfulness that is associated with health outcome measures.

It would be also be recommended to target a specific clinical area to see if it yields any reduction in staff sickness rates and consideration could be given whether it develops a mindful culture on a ward, through the use of quantitative and qualitative questionnaires.

Clinical Implications

Findings from this study have shown that attending an eight-week mindfulness course can increase levels of wellbeing and self-compassion in mental health staff. The feedback from the course was anecdotally positive and the low dropout rate supports this. This type of course offers staff an opportunity to take time to look at strengthening their self care skills. It also sends an important message by the employers to employees that by supporting participants to attend, that they are valued, and the wellbeing and self-care of their staff members is important. This culture of respect and leadership was very much highlighted as missing from clinical areas that were failing to provide compassionate care (The Francis Report, 2013) and recommendations were made for more attention to be given to compassionate care with the training of health care staff. Thereby offering staff mindfulness training opportunities away from a workplace, this could go some way towards helping develop a culture of respect. The course was for 2 hours per week over 8 weeks and so from a resource perspective it meant staff members were away from the workplace for approximately 16 hours, longer for some due to travelling time. This equates to just over 2 short shifts per staff member. This study has shown that within this time there was improvement in healthcare staff wellbeing and self-compassion then it could be argued that this intervention is a cost-effective resource. Even though this study did not measure sickness reduction or longevity of benefits, it did measure an increase a wellbeing score from one that was identified as being close to suffering from depression of psychological distress to one in the higher moderate range for the participants.

This increase in wellbeing has the expected potential to help reduce burnout and sickness in staff, which is reported as increasing in all areas of the NHS. The increase in levels of self-

compassion will help staff to explore ways to improve self-care and reduce levels of stress and develop coping strategies to combat the demands of highly complex clinical work.

The clinical implications for staff with higher levels of wellbeing and self compassion could arguably produce a less reactive culture. There is also reduced risk of compassion fatigue as staff can better manage the demands of work which is complex in nature and has a high degree of working with patients who are suffering. The key aspects of calmness and tolerance would be more easily met. The increase in connectivity will also help build stronger relationships.

The staff also after completing the course will better understand the therapeutic value of mindfulness and be better placed to identify the patients they work with who might also benefit from this intervention. They will be aware of some of the difficulties it might bring for the patient and so better support them when the patient attends a mindfulness course such as Mindfulness Based Cognitive Therapy (MBCT) as recommended by the National Institute for Health and Care Excellence (NICE) (2009) guidelines for recurrent depression and Matics Cymru (2017) recommended mindfulness based interventions for health anxiety, psychosis and recurrent depression for patients who live in Wales.

Conclusions

Mindfulness for healthcare professionals is a growing area of research and specifically for those working within the field of mental health. Research outcomes are beginning to help us recognise that for healthcare staff to provide compassionate and quality care and build therapeutic relationships with patients then they need to be able to manage their own self care needs. The constant demands on staff to work in understaffed areas, complex and stressful working environments, under public scrutiny and the emotional and physical toll of

very unwell people goes someway to help us understand why often staff experience high levels of stress, burnout, high sickness rates and resort to reactive coping strategies. There is a growing body of evidence to show that a mindfulness course for staff can improve wellbeing (Dobie et al., 2016; Foureur et al., 2013; Irving et al., 2014; Raab et al., 2015 and Shapiro et al., 2005) and this research project was designed to build on this. The study set out to explore the impact of an eight-week mindfulness-based course on levels of wellbeing and compassion in mental health professionals working in frontline clinical areas, it was hypothesised that there would be improvements in wellbeing and compassion following the course. The results demonstrated that there was a significant increase in levels of wellbeing and self-compassion but no significant increase in compassion. Notably the participants scored within the high range both pre and post the course in levels of compassion and the ceiling effect could explain this.

Offering a course to staff which explores their own wellbeing for those working in healthcare delivers an important message to staff, one of being valued and that good health is important for all. In effect we in mental health services need to show we practice what we preach. We could argue, we become more authentic as practitioners recognising, we are all vulnerable to suffering. We also encourage a supportive culture whereby the nature of a demanding environment is recognised and that the clinical work can take a physical and mental toll. The offering of a staff mindfulness course can in time influence healthcare culture and change it from one that is punitive, and instead breeds an attitude that staff are supported to better manage the demands of clinical work and an environment that respects the demands placed on staff and encourages self-care and openness to difficulties in a supportive way. Otherwise, if we continue to treat members of staff who are overwhelmed

as if this is a failure or weakness, the cost will continue to be burnout, sickness and a sense of failure.

This study has also shown that by providing staff an eight week mindfulness based course there can improvements in traits such as acceptance and kindness which studies show can help the wellbeing of staff; it also provides an environment to share experiences which has been shown to decreases the sense of isolation and feelings of separateness. This helps staff to be better equipped to relate to difficulties as they arise.

The mindfulness skills of “present moment” awareness helps with the fast-paced environment of the clinical areas and assists staff to become better able to manage the distractions and stressors of each shift. It can be concluded that if staff are better able to manage their own mental health, they will be better placed to provide effective therapy.

This study has reinforced and added to an expanding area of research and its implications are that running an eight week mindfulness based course provides a resource that can improve mental health staff wellbeing and levels of self-compassion, which in turn could improve the mental health patient experience within clinical settings.

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Appendix 1

COLEG GWYDDORAU IECHYD AC YMDDYGIAD

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YSGOL SEICOLEG

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Participants Information Sheet

Information about the research

You are being invited to take part in a research study. It is important that you understand why we are doing the research and what it will involve before you decide to take part. Please take the time to read this information sheet and if anything is unclear please feel free to contact me.

Research Team

Gail Evans, Research Officer, phone no 02920 715750 e-mail Gail.Evans2@wales.nhs.uk

Madelaine Watkins, Research Assistant

What is the purpose of the study?

We would like to find out whether mental health professionals such as nurses, medics, occupational therapists and physiotherapists who attend a 8 week mindfulness course benefit from doing so. We will be looking at wellbeing and compassion toward self and others.

We want to find out what the benefits are immediately after the course finishes. There are studies which show that health care professionals do benefit from mindfulness courses.

This research will help us understand whether mindfulness does benefit mental health professionals in their lives and further research could look at if this is translated into the work place or whether these benefits endure over time.

Why am I being invited to participate?

The research is aimed at mental health workers who wish to participate in the mindfulness course held at Hafan y Coed. If you wish to do the mindfulness course but not participate in this research, then that is absolutely fine.

It is entirely up to you to decide whether or not you wish to take part. If you do, you will be asked to sign a consent form. You can still withdraw at anytime even after signing consent- this will not affect your experience of the mindfulness course in any way.

What will happen to me if I take part?

The mindfulness course will be held at Hafan y Coed in Llandough Hospital (The 8-week course will commence from around May 2019, and each session will last for approximately 2 hours per week).

Gail Evans is currently undertaking the MSc in Mindfulness with the Mindfulness Centre of Research and Practice at Bangor, and she will teach the mindfulness classes. Although she is helping with the research side of the project too, your data will be collected by other members of the research team and they will be anonymised, so she will not know what your responses are.

There will be approximately 20 staff members from mental health services attending the sessions, depending on how many want to take part, as well as two mindfulness facilitators.

1) Before the first session, you will be sent a questionnaire pack to complete, this should take around 15 minutes to fill in. You will then put the questionnaires in a

sealed envelope and they will be returned by internal mail to the researcher assistant before the class starts.

2) At the end of the 8-week course you will be given another questionnaire pack to take home and complete, you will be provided with an envelope to return the questionnaires.

A member of the research team will be available by phone throughout the study to help complete any of the questionnaires. The questionnaires will ask you about how you are feeling and about mindfulness. It is ok to skip any questions that you feel uncomfortable in answering.

Payment

The Mindfulness course for staff is free, if you choose to participate on the course, but do not take part in the research project, that is ok, it will still be free of charge.

Benefits and harms

Mindfulness training has been shown to have many benefits for a wide range of people, and we anticipate that you may find it beneficial in your own life. Your involvement will enable a better understanding of how mindfulness-based support may benefit health care professionals, and could help lead to more such courses being run in the future.

We do not anticipate that taking part in the study will cause you any harm. There is a possibility that answering the questionnaires and reflecting on stressful experiences during the classes may cause some people distress. If you do feel at all distressed by any of the questions we encourage you to stop completing the questionnaire and it is fine to leave out questions you do not wish to answer. If you become distressed during the classes, the teacher will be on hand to support you. The mindfulness teacher may contact you following a class, if you have appeared to be distressed. It is important that you talk to your mindfulness teacher in the event that you find the research distressing.

Procedures to maintain confidentiality

At the start of the study you will be given a number by a research assistant that will be used to identify your questionnaires. This means that your name will never appear with your answers. The questionnaires will be stored in a locked filing cabinet and will be destroyed following the end of the study. Your name will not be used on any report or publication coming from the study.

Everything you say during the mindfulness class or outside it to the research team will be treated confidentially. However, if any information is disclosed that may cause concern (e.g. malpractice, abuse), then the researcher may discuss this with the rest of the research team. If the research team deems it necessary the information may be given to third parties (e.g. police, social services) for appropriate action to be taken.

What will happen to the results of the research?

If you participate, we will send you a summary of the research findings when the study is complete.

Further information about the study

Should you have any questions or require any further information regarding the study and/or your rights as a participant please contact:

Gail Evans: phone no. 02920 715750 e-mail: Gail.Evans2@wales.nhs.uk

Who has reviewed the study?

This study has received ethical approval from the school of psychology ethics board at Bangor University.

Complaints: Any complaints concerning the conduct of this research should be addressed to Mr. Huw Ellis, Collage Manager, School of Psychology, Bangor University, Gwynedd, LL57 2AS. (huw.ellis@bangor.ac.uk)

Appendix 2

CONSENT FORM

Please read the following information very carefully and if you agree with everything stated below, initial the boxes and please sign at the end of the page.

1.	I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions, and have these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3.	I understand that all information I give will be treated with the utmost confidentiality,	
4.	I agree to take part in this study.	

_____ _____ _____

Name of participant Date Signature

_____ _____ _____

Name of researcher Date Signature

Appendix 3

OLEG GWYDDORAU IECHYD AC YMDDYGIAD

COLLEGE OF HEALTH & BEHAVIOURAL SCIENCES

PRIFYSGOL BANGOR UNIVERSITY

YSGOL SEICOLEG

SCHOOL OF PSYCHOLOGY

Taflen Wybodaeth i Gyfranogwyr

Gwybodaeth am yr ymchwil

Rydych yn cael gwahoddiad i gymryd rhan mewn astudiaeth ymchwil. Cyn i chi benderfynu cymryd rhan, mae'n bwysig i chi ddeall pam ein bod yn gwneud yr ymchwil, a'r hyn y bydd yn ei olygu. Cymerwch amser i ddarllen y daflen wybodaeth hon, ac os oes rhywbeth yn aneglur mae croeso i chi gysylltu â ni.

Y Tîm Ymchwil

Gail Evans, Swyddog Ymchwil, rhif ffôn 02920 715750 e-bost Gail.Evans2@wales.nhs.uk

Madelaine Watkins, Cynorthwywr Ymchwil

Beth yw pwrpas yr astudiaeth?

Hoffem ddarganfod a yw gweithwyr iechyd meddwl fel nyrsys, meddygon, therapyddion galwedigaethol a ffisiotherapyddion sy'n mynd ar gwrs ymwybyddiaeth ofalgar am 8 wythnos yn elwa o wneud hynny. Byddwn yn edrych ar les a thosturi tuag atom ni ein hunain ac at eraill.

Rydym am ddarganfod pa fanteision sydd yn syth ar ôl i'r cwrs orffen. Mae yna astudiaethau sy'n dangos bod gweithwyr gofal iechyd proffesiynol yn elwa o gyrsiau ymwybyddiaeth ofalgar.

Mi wnaiff yr ymchwil hwn ein helpu ni ddeall a yw ymwybyddiaeth ofalgar yn fuddiol i weithwyr proffesiynol iechyd meddwl yn eu bywydau a gallai ymchwil pellach ystyried a yw hynny'n cael ei drosglwyddo i'r gweithle neu a yw'r manteision yn parhau dros amser.

Pam ydw i'n cael gwahoddiad i gymryd rhan?

Mae'r ymchwil wedi ei anelu at weithwyr iechyd meddwl sy'n dymuno cymryd rhan yn y cwrs ymwybyddiaeth ofalgar yn Hafan y Coed. Os ydych chi'n dymuno mynd ar y cwrs ymwybyddiaeth ofalgar a pheidio â chymryd rhan yn yr ymchwil, mae hynny'n iawn.

Chi sydd i benderfynu a ydych chi'n dymuno cymryd rhan ai peidio. Os byddwch chi'n penderfynu cymryd rhan gofynnwn i chi lofnodi ffurflen gydsynio. Cewch dynnu'n ôl ar unrhyw adeg hyd yn oed ar ôl llofnodi'r ffurflen gydsynio ac ni wnaiff hynny effeithio ar eich profiad chi o'r cwrs ymwybyddiaeth ofalgar o gwbl.

Beth fydd yn digwydd i mi os byddaf yn cymryd rhan?

Caiff y cwrs ymwybyddiaeth ofalgar ei gynnal yn Hafan y Coed yn Ysbyty Llandochau (Bydd y cwrs 8 wythnos yn dechrau fis Mai 2019, a bydd pob sesiwn yn para am tua 2 awr yr wythnos).

Mae Gail Evans ar hyn o bryd yn ymgymryd â'r MSc mewn Ymwybyddiaeth Ofalgar gyda Chanolfan Ymarfer ac Ymchwil yr Ymwybyddiaeth Ofalgar ym Mangor, a bydd hi'n dysgu'r dosbarthiadau ymwybyddiaeth ofalgar. Er ei bod hi'n helpu gydag elfennau ymchwil y project hefyd, bydd aelodau eraill o'r tîm ymchwil yn casglu eich data chi a bydd hynny'n gwbl ddienw, felly ni fydd hi'n gwybod beth yw eich ymatebion chi.

Bydd oddeutu 20 o staff y gwasanaethau iechyd meddwl yn mynd i'r sesiynau, gan ddibynnu faint sydd eisiau cymryd rhan, yn ogystal â dau hwylusydd yr ymwybyddiaeth ofalgar.

1) Cyn y sesiwn gyntaf mi gewch chi becyn o holiaduron i chi eu cwblhau; dylai hynny gymryd tua 30 munud. Yna byddwch yn rhoi'r holiaduron mewn amlen a'i selio, a byddant yn cael eu dychwelyd gan y post mewnol i'r cynorthwyydd ymchwil cyn i'r dosbarth ddechrau.
2) Ar ddiwedd y cwrs 8 wythnos byddwch yn cael pecyn arall o holiaduron i fynd gartref gyda chi i'w cwblhau, fe gewch chi amlen ar gyfer dychwelyd yr holiaduron.

Bydd aelod o'r tîm ymchwil ar gael dros y ffôn trwy gydol yr astudiaeth i'ch helpu chi gwblhau unrhyw holiaduron. Bydd yr holiaduron yn gofyn ichi sut rydych chi'n teimlo ac ynglŷn ag ymwybyddiaeth ofalgar. Mae'n iawn peidio ag ateb unrhyw gwestiynau sy'n gwneud i chi deimlo'n anghyfforddus.

Taliad

Mae cwrs Ymwybyddiaeth Ofalgar y staff yn rhad ac am ddim, ac os byddwch chi'n dewis cymryd rhan yn y cwrs, heb gymryd rhan yn y project ymchwil, mae hynny'n iawn, bydd yn dal i fod yn rhad ac am ddim.

Manteision a niwed

Mae nifer o fanteision hysbys i hyfforddiant ymwybyddiaeth ofalgar i amryw o bobl, ac mi dybiwn y byddai'n fuddiol i chi yn eich bywyd chwithau. Bydd eich cyfraniad yn fodd i ennyn gwell dealltwriaeth sut y gallai cymorth trwy ymwybyddiaeth ofalgar fod o fudd i weithwyr gofal iechyd proffesiynol, a gallai helpu arwain at gynnal rhagor o gyrsiau o'r fath at y dyfodol.

Nid ydym yn rhagweld y bydd cymryd rhan yn yr astudiaeth yn achosi dim niwed i neb. Mae'n bosib y gallai ateb yr holiaduron a myfyrio ynghylch profiadau gofidus yn ystod y dosbarthiadau achosi poen meddwl i rai pobl. Os byddwch chi'n teimlo bod unrhyw gwestiynau'n peri gofid ichi, rhowch y gorau i gwblhau'r holiadur. Mae'n iawn gadael rhai cwestiynau allan os nad ydych yn dymuno eu hateb. Os byddwch yn teimlo'n ofidus yn ystod y dosbarthiadau, bydd yr athro/athrawes wrth law i'ch cefnogi chi. Efallai y bydd yr athro ymwybyddiaeth ofalgar yn cysylltu â chi ar ôl y dosbarth, os buoch chi'n ofidus yr olwg.

Mae'n bwysig eich bod yn siarad gyda'r athro ymwybyddiaeth ofalgar os bydd yr ymchwil yn achosi poen meddwl i chi.

Trefniadau er mwyn cadw cyfrinachedd

Ar ddechrau'r astudiaeth mi gewch chi rif gan gynorthwywr ymchwil a gaiff ei ddefnyddio er mwyn adnabod eich holiaduron. Mae hynny'n golygu na fydd eich enw byth yn ymddangos wrth ochr eich atebion. Caiff yr holiaduron eu storio mewn cabinet ffeilio dan glo a chânt eu dinistrio ar ddiwedd yr astudiaeth. Ni ddefnyddir eich enw ar unrhyw adroddiad na chyhoeddiad a fydd yn deillio o'r astudiaeth.

Bydd popeth a ddywedwch yn ystod y dosbarth ymwybyddiaeth ofalgar neu y tu allan iddo wrth y tîm ymchwil yn cael ei drin yn gyfrinachol. Fodd bynnag, os datgelir gwybodaeth a allai beri pryder (e.e. camweithredu, camdriniaeth), yna gallai'r ymchwilydd drafod hynny â gweddill y tîm ymchwil. Os ystyria'r tîm ymchwil fod hynny'n angenrheidiol, mi ellid rhoi'r wybodaeth i drydydd parti (e.e. yr heddlu, gwasanaethau cymdeithasol) er mwyn cymryd camau priodol.

Beth fydd yn digwydd i ganlyniadau'r ymchwil?

Os byddwch yn cymryd rhan, mi wnawn ni anfon crynodeb o ganfyddiadau'r ymchwil i chi ar ôl cwblhau'r astudiaeth.

Mwy o wybodaeth am yr astudiaeth

Os oes gennych unrhyw gwestiynau neu os oes angen rhagor o wybodaeth arnoch am yr astudiaeth ac/neu eich hawliau fel cyfrannwr cysylltwch â:

Gail Evans: rhif ffôn. 02920 715750. Ebost: Gail.Evans2@wales.nhs.uk

Pwy sydd wedi adolygu'r astudiaeth?

Mae'r astudiaeth hon wedi derbyn cymeradwyaeth gan Fwrdd Moeseg Ysgol Seicoleg Prifysgol Bangor.

Cwynion: Os bydd gennych unrhyw gwynion ynglyn â'r modd y gwneir yr ymchwil hon, dylech gyfeirio'r rhain at Mr. Huw Ellis, Rheolwr yr Ysgol, Yr Ysgol Seicoleg, Prifysgol Bangor, Bangor Gwynedd, LL57 2AS. (huw.ellis@bangor.ac.uk)

Appendix 4

FFURFLEN GYDSYNIO

Darllenwch yr wybodaeth ganlynol yn ofalus iawn ac os ydych yn cytuno â phopeth a nodir isod, rhowch lythrennau blaen eich enw yn y blychau a tharo eich llofnod ar waelod y dudalen.

1.	Rwy'n cadarnhau imi ddarllen a deall taflen wybodaeth yr astudiaeth uchod. Cefais gyfle i ystyried yr wybodaeth, gofyn cwestiynau a chael atebion boddhaol i'r cwestiynau hynny.	
2.	Rwy'n deall fy mod yn cymryd rhan yn wirfoddol ac y caf i dynnu'n ôl unrhyw bryd, heb roi rheswm.	
3.	Deallaf y bydd yr holl wybodaeth a roddaf yn cael ei thrin yn gwbl gyfrinachol.	
4.	Rwy'n cytuno i gymryd rhan yn yr astudiaeth hon.	

_____ _____ _____

Enw'r Cyfranogwr Dyddiad Llofnod

_____ _____ _____

Llofnod yr Ymchwilydd Dyddiad Llofnod

Appendix 5

SELF-COMPASSION SCALE–Short Form (SCS–SF)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

_____1. When I fail at something important to me, I become consumed by feelings of inadequacy.

_____2. I try to be understanding and patient towards those aspects of my personality I don't like.

_____3. When something painful happens, I try to take a balanced view of the situation.

_____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

_____5. I try to see my failings as part of the human condition.

_____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

_____7. When something upsets me, I try to keep my emotions in balance.

_____8. When I fail at something that's important to me, I tend to feel alone in my failure

_____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

_____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

_____11. I'm disapproving and judgmental about my own flaws and inadequacies.

_____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix 6

Compassion for Others Scale

HOW I TYPICALLY ACT TOWARDS OTHERS

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				**Almost Always**
1	**2**	**3**	**4**	**5**

_____1. When people cry in front of me, I often don't feel anything at all.

_____2. Sometimes when people talk about their problems, I feel like I don't care.

_____3. I don't feel emotionally connected to people in pain.

_____4. I pay careful attention when other people talk to me.

_____5. I feel detached from others when they tell me their tales of woe.

_____6. If I see someone going through a difficult time, I try to be caring toward that person.

_____7. I often tune out when people tell me about their troubles.

_____8. I like to be there for others in times of difficulty.

_____9. I notice when people are upset, even if they don't say anything.

_____10. When I see someone feeling down, I feel like I can't relate to them.

_____11. Everyone feels down sometimes, it is part of being human.

_____12. Sometimes I am cold to others when they are down and out.

_____13. I tend to listen patiently when people tell me their problems.

_____14. I don't concern myself with other people's problems.

_____15. It's important to recognize that all people have weaknesses and no one's perfect.

_____16. My heart goes out to people who are unhappy.

_____17. Despite my differences with others, I know that everyone feels pain just like me.

_____18. When others are feeling troubled, I usually let someone else attend to them.

_____19. I don't think much about the concerns of others.

_____20. Suffering is just a part of the common human experience.

_____21. When people tell me about their problems, I try to keep a balanced perspective on the situation.

_____22. I can’t really connect with other people when they’re suffering.

_____23. I try to avoid people who are experiencing a lot of pain.

_____24. When others feel sadness, I try to comfort them.

Appendix 7

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

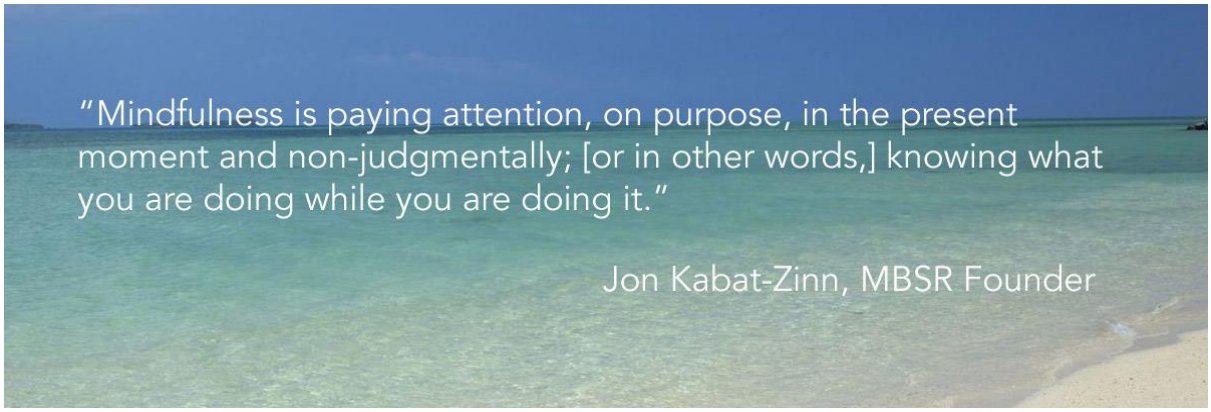
Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks STATEMENTS

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	**1**	**2**	**3**	**4**	**5**
I've been feeling useful	**1**	**2**	**3**	**4**	**5**
I've been feeling relaxed	**1**	**2**	**3**	**4**	**5**
I've been feeling interested in other people	**1**	**2**	**3**	**4**	**5**
I've had energy to spare	**1**	**2**	**3**	**4**	**5**
I've been dealing with problems well	**1**	**2**	**3**	**4**	**5**
I've been thinking clearly	**1**	**2**	**3**	**4**	**5**
I've been feeling good about myself	**1**	**2**	**3**	**4**	**5**
I've been feeling close to other people	**1**	**2**	**3**	**4**	**5**
I've been feeling confident	**1**	**2**	**3**	**4**	**5**
I've been able to make up my own mind about things	**1**	**2**	**3**	**4**	**5**
I've been feeling loved	**1**	**2**	**3**	**4**	**5**
I've been interested in new things	**1**	**2**	**3**	**4**	**5**
I've been feeling cheerful	**1**	**2**	**3**	**4**	**5**

Appendix 8

Course Available For Staff

Mindfulness is a mind-body approach, which helps develop awareness through paying attention to everyday experience. It is taught through a variety of structured practices, including focusing on the breath, thoughts, body sensations and daily activities to help learn to stay in the present moment.



We are offering staff the opportunity to experience mindfulness through an eight week course. You would be required to attend a 2 hour session once a week for *eight weeks*; also between sessions you would be encouraged to practice the meditations. For an information sheet and to book a place, please contact: Gail.Evans2@wales.nhs.uk or ring 02920 715750. The next course is due to start on:

Tuesday 14th May 2019, 9am-11am in Hafan y Coed

This is open to all staff working in Cardiff and Vale UHB, Mental Health services.

This group is part of a research project which you will be invited to join. However you are free to come to the course without being part of the research project. Information will be given to you on enrolment.

Appendix 9

WEMWBS Pre Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1	3	4	4	4	4	4	4	3	3	3	5	4	3	3
2	4	3	3	3	3	4	3	4	2	3	5	4	4	3
3	2	3	3	2	4	4	3	3	1	3	3	4	2	3
4	4	4	4	3	2	4	3	4	4	4	5	4	3	3
5	1	2	3	3	4	4	1	3	2	2	4	2	2	2
6	1	2	3	4	4	3	2	4	2	3	5	3	3	3
7	3	3	3	4	2	4	3	4	3	3	4	4	4	4
8	1	3	3	3	3	4	3	3	2	3	4	3	3	3
9	2	2	4	3	2	4	2	4	2	4	3	3	4	3
10	2	3	3	3	3	4	4	3	2	3	4	3	2	3
11	3	3	3	4	3	1	2	5	2	4	5	3	3	3
12	3	2	4	4	4	3	1	4	4	3	5	4	4	2
13	1	4	4	3	3	4	5	4	3	3	5	3	4	3
14	3	2	3	3	3	4	4	4	3	3	5	4	4	3
Total	33	40	47	46	44	51	40	52	35	44	62	48	45	41

WEMWBS Post Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1	4	4	4	4	4	3	4	3	2	4	5	5	4	4
2	5	3	4	4	4	4	4	4	4	4	5	5	4	4
3	3	4	4	4	4	3	4	2	3	4	4	4	3	4
4	4	5	4	4	3	3	5	4	4	4	5	5	4	4
5	1	3	4	4	3	3	3	3	4	3	5	3	3	4
6	5	3	4	4	3	4	3	3	4	4	5	4	4	4
7	4	3	4	3	3	3	4	4	4	3	5	4	4	4
8	3	3	4	4	4	3	3	3	3	3	5	4	3	4
9	3	2	4	4	3	3	2	4	3	4	5	5	4	4
10	3	3	4	4	4	3	4	3	3	3	4	4	3	4
11	3	3	4	4	3	4	5	4	4	4	5	4	4	4
12	3	2	4	4	3	4	2	3	4	4	5	5	4	4
13	2	3	5	4	3	3	5	4	4	5	5	4	3	4
14	4	3	4	4	3	3	4	3	4	4	5	5	3	4
Total	47	44	57	55	46	46	52	47	50	53	68	61	50	56

Self-Compassion Scale Short Form Pre Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1 (reverse)	5 (1)	5 (1)	3 (3)	3 (3)	3 (3)	4 (2)	3 (3)	3 (3)	3 (3)	5 (1)	3 (3)	4 (2)	3 (3)	4 (2)
2	2	3	3	3	3	3	1	3	2	3	3	4	3	2
3	3	3	3	4	3	3	2	2	2	2	3	4	4	3
4 (reverse)	2 (4)	5 (1)	3 (3)	3 (3)	3 (3)	5 (1)	5 (1)	4 (2)	5 (1)	4 (2)	2 (4)	3 (3)	4 (2)	4 (2)
5	3	4	3	2	4	3	4	4	2	4	3	4	3	4
6	1	1	3	3	3	4	1	2	1	3	4	5	3	2
7	2	3	3	4	4	3	4	3	2	2	2	2	3	3
8 (reverse)	2 (4)	4 (2)	3 (3)	2 (4)	4 (2)	4 (2)	3 (3)	4 (2)	2 (4)	3 (3)	3 (3)	2 (4)	3 (3)	5 (1)
9 (reverse)	5 (1)	5 (1)	3 (3)	3 (3)	3 (3)	5 (1)	2 (4)	3 (3)	2 (4)	5 (1)	3 (3)	3 (3)	3 (3)	4 (2)
10	4	4	3	4	3	4	5	4	2	2	4	3	4	2
11 (reverse)	5 (1)	4 (2)	3 (3)	3 (3)	3 (3)	4 (2)	3 (3)	4 (2)	5 (1)	4 (2)	3 (3)	3 (3)	3 (3)	4 (2)
12 (reverse)	3 (3)	4 (2)	3 (3)	3 (3)	3 (3)	3 (3)	4 (2)	3 (3)	5 (1)	3 (3)	3 (3)	3 (3)	3 (3)	4 (2)
Total	29	27	36	39	37	31	33	33	25	28	38	40	37	27

Self-Compassion Scale Short Form Post Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1 (reverse)	4 (2)	4 (2)	3 (3)	3 (3)	3 (3)	4 (2)	2 (4)	4 (2)	2 (4)	4 (2)	4 (2)	3 (3)	2 (4)	2 (4)
2	5	3	4	3	3	2	3	3	4	3	3	3	4	4
3	4	3	4	4	4	2	4	4	4	5	5	5	4	4
4 (reverse)	1 (5)	5 (1)	2 (4)	2 (4)	4 (2)	4 (2)	3 (3)	4 (2)	2 (4)	2 (4)	2 (4)	1 (5)	3 (3)	2 (4)
5	4	3	3	3	4	2	4	3	4	5	5	4	4	4
6	3	3	4	4	3	2	2	2	3	4	4	4	3	4
7	2	3	4	3	3	5	4	3	3	4	4	3	4	4
8 (reverse)	2 (4)	3 (3)	3 (3)	2 (4)	3 (3)	4 (2)	3 (3)	4 (2)	3 (3)	2 (4)	2 (4)	2 (4)	3 (3)	3 (3)
9 (reverse)	3 (3)	5 (1)	3 (3)	2 (4)	3 (3)	5 (1)	2 (4)	4 (2)	2 (4)	3 (3)	3 (3)	4 (2)	3 (3)	3 (3)
10	4	3	4	5	4	1	4	3	2	5	5	4	4	4
11 (reverse)	3 (3)	4 (2)	3 (3)	2 (4)	3 (3)	5 (1)	4 (2)	4 (2)	2 (4)	3 (3)	3 (3)	3 (3)	2 (4)	2 (4)
12 (reverse)	2 (4)	3 (3)	2 (4)	2 (4)	3 (3)	4 (2)	3 (3)	4 (2)	2 (4)	1 (5)	1 (5)	3 (3)	2 (4)	2 (4)
Total	43	30	43	45	38	24	40	30	43	47	47	43	44	46

Compassion for Others Scale Pre Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1 (reverse)	3 (3)	5 (1)	2 (4)	2 (4)	4 (2)	3 (3)	2 (4)	3 (3)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)	4 (2)
2 (reverse)	1 (5)	5 (1)	2 (4)	1 (5)	1 (5)	2 (4)	3 (3)	2 (4)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)	4 (2)
3 (reverse)	5 (1)	5 (1)	2 (4)	1 (5)	1 (5)	2 (4)	3 (3)	1 (5)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)	4 (2)
4	4	4	4	5	3	4	2	2	5	4	4	4	4	4
5 (reverse)	4 (2)	3 (3)	2 (4)	1 (5)	2 (4)	2 (4)	3 (3)	3 (3)	5 (1)	1 (5)	2 (4)	3 (3)	2 (4)	4 (2)
6	5	5	4	5	4	5	4	5	5	5	4	5	4	4
7 (reverse)	2 (4)	3 (3)	2 (4)	1 (5)	3 (3)	2 (4)	3 (3)	4 (2)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)	2 (4)
8	5	5	4	5	2	5	2	5	5	5	5	5	4	4
9	4	5	4	4	4	5	5	4	5	5	5	4	4	4
10 (reverse)	5 (1)	5 (5)	3 (3)	2 (4)	3 (3)	1 (5)	3 (3)	1 (5)	1 (5)	5 (1)	1 (5)	2 (4)	1 (5)	2 (4)
11	4	4	4	5	4	2	5	5	5	5	5	5	5	4
12 (reverse)	2 (4)	1 (5)	2 (4)	1 (5)	3 (3)	3 (3)	3 (3)	1 (5)	1 (5)	1 (5)	1 (5)	1 (5)	3 (3)	3 (3)
13	4	4	4	5	5	1	3	2	5	4	5	5	4	5
14 (reverse)	2 (4)	4 (2)	2 (4)	1 (5)	2 (4)	5 (1)	3 (3)	2 (4)	2 (4)	2 (4)	2 (4)	3 (3)	3 (3)	2 (4)
15	4	3	4	5	4	2	5	5	5	5	5	5	5	4
16	5	5	4	5	5	5	3	5	5	5	4	4	4	4
17	5	5	4	5	4	4	5	5	5	5	5	4	5	5
18 (reverse)	1 (5)	1 (5)	2 (4)	1 (5)	3 (3)	1 (5)	3 (3)	2 (4)	4 (2)	2 (4)	2 (4)	2 (4)	1 (5)	3 (3)
19 (reverse)	1 (5)	1 (5)	2 (4)	3 (3)	2 (4)	4 (2)	3 (3)	1 (5)	1 (5)	2 (4)	1 (5)	2 (4)	2 (4)	2 (4)
20	4	1	2	3	5	5	4	5	5	5	2	4	4	5
21	5	3	3	5	3	3	4	4	5	5	5	5	4	4
22 (reverse)	4 (2)	3 (3)	2 (4)	2 (4)	3 (3)	1 (5)	3 (3)	1 (5)	1 (5)	1 (5)	1 (5)	1 (5)	1 (5)	3 (3)
23 (reverse)	1 (5)	1 (5)	2 (4)	2 (4)	4 (2)	5 (1)	4 (2)	1 (5)	1 (5)	2 (4)	1 (5)	1 (5)	2 (4)	2 (4)
24	5	5	4	4	4	5	2	5	5	5	5	5	5	4
TOTAL	95	84	92	110	88	87	80	102	112	110	111	104	101	88

Compassion for Others Scale Post Scores

Participant	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Statement														
1 (reverse)	2 (4)	5 (1)	1 (5)	1 (5)	2 (4)	3 (3)	2 (4)	2 (4)	2 (4)	1 (5)	1 (5)	1 (5)	1 (5)	2 (4)
2 (reverse)	1 (5)	5 (1)	1 (5)	1 (5)	2 (4)	2 (4)	3 (3)	3 (3)	1 (5)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)
3 (reverse)	1 (5)	5 (1)	1 (5)	1 (5)	2 (4)	2 (4)	3 (3)	1 (5)	2 (4)	1 (5)	1 (5)	1 (5)	1 (5)	2 (4)
4	4	3	4	4	3	4	4	4	4	4	5	3	2	5
5 (reverse)	1 (5)	3 (3)	2 (4)	1 (5)	2 (4)	2 (4)	3 (3)	3 (3)	2 (4)	1 (5)	2 (4)	1 (5)	2 (4)	2 (4)
6	5	5	5	5	4	5	3	4	5	5	5	5	4	4
7 (reverse)	1 (5)	1 (5)	2 (4)	1 (5)	2 (4)	2 (4)	3 (3)	2 (4)	4 (2)	2 (4)	1 (5)	1 (5)	2 (4)	2 (4)
8	5	5	4	5	2	5	2	4	4	4	5	4	4	4
9	5	5	4	3	2	5	2	5	5	5	5	4	4	4
10 (reverse)	5 (1)	5 (5)	1 (5)	2 (4)	2 (4)	1 (5)	4 (2)	2 (4)	1 (5)	1 (5)	1 (5)	2 (4)	1 (5)	2 (4)
11	5	5	5	4	5	4	5	5	2	5	5	5	4	5
12 (reverse)	1 (5)	1 (5)	2 (4)	1 (5)	2 (4)	4 (2)	3 (3)	2 (4)	4 (2)	1 (5)	1 (5)	1 (5)	2 (4)	2 (4)
13	5	3	5	4	5	4	3	4	5	4	5	1	4	4
14 (reverse)	1 (5)	5 (1)	3 (3)	3 (3)	2 (4)	1 (5)	3 (3)	2 (4)	3 (3)	4 (2)	2 (4)	3 (3)	2 (4)	2 (4)
15	5	3	5	4	5	5	5	5	5	5	5	5	4	4
16	4	5	5	3	5	5	3	5	5	5	5	5	4	4
17	5	5	5	4	5	5	5	4	5	5	5	5	4	4
18 (reverse)	1 (5)	1 (5)	1 (5)	1 (5)	3 (3)	1 (5)	3 (3)	5 (1)	2 (4)	2 (4)	1 (5)	1 (5)	2 (4)	2 (4)
19 (reverse)	1 (5)	5 (1)	1 (5)	3 (3)	2 (4)	4 (2)	3 (3)	1 (5)	1 (5)	2 (4)	2 (4)	1 (5)	3 (3)	2 (4)
20	4	3	3	3	5	5	4	3	2	4	5	5	3	4
21	5	5	4	4	4	5	4	4	5	5	5	5	4	4
22 (reverse)	1 (5)	5 (1)	1 (5)	1 (5)	3 (3)	1 (5)	3 (3)	1 (5)	2 (4)	1 (5)	1 (5)	1 (5)	1 (5)	2 (4)
23 (reverse)	1 (5)	1 (5)	1 (5)	1 (5)	3 (3)	5 (1)	3 (3)	1 (5)	1 (5)	2 (4)	1 (5)	1 (5)	4 (2)	2 (4)
24	5	5	5	5	4	5	2	4	5	5	5	5	5	4
TOTAL	**112**	**82**	**109**	**103**	**94**	**101**	**78**	**98**	**99**	**109**	**117**	**109**	**95**	**99**