



# **An Evaluation of a short course in Mindfulness for Health Visitor Practice Teachers**

## **FINAL REPORT**

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## Executive Summary

Kindness gives birth to kindness

Sophocles (496- 406 BC)

Set against a background of professional regeneration in health visiting and driven by the *Health Visitor Implementation Plan 2011–15: A Call to Action* (Department of Health 2011), an introductory session on mindfulness was delivered to Specialist Community Public Health Nursing (SCPHN) practice teachers (PTs) in a study day in March 2014. The positive evaluation of this session led to a proposal to offer a full 8-week course for the PTs funded by Health Education Kent, Surrey and Sussex.

As part of the project both health visitor (HV) PTs and school nurse (SN) PTs were invited to attend the mindfulness training to enable them to develop this resource with students. There was an increase in numbers of students, especially in the health visiting pathway due to the government strategy. This change was challenging models of learning in practice, which deviated from the traditional arrangements, increasing concerns about student attrition from the programme. Any attrition was likely to affect the planned workforce trajectory. The expense of poor recruitment on employment and education budgets required cost effective processes. However, the reasons for student attrition are complicated but one explanation reflects the impact of personal circumstances on adult learning. This project did not seek to link the practice of mindfulness with reduced attrition but acknowledge the role of stress within this decision.

While mindfulness is not a therapeutic or relaxation intervention for students or their PTs, it is known to be a useful 'tool' as cognitive training. The project aims were to facilitate skills in mindfulness that would enable PTs to refresh their practice and support students. This approach was designed to review personal resources in the face of multiple stressors from home, work and study. In conjunction, students attended an introductory session on mindfulness during their studies and expressed their previous experience of mindfulness practice. Resources were available to SCPHN students on the virtual learning environment.

There were 16 female Practice teachers recruited through self-selection to attend the short course; 8-10 participants recorded as regular attendees. A qualified and experienced trainer delivered the mindfulness sessions (8) based on Mindfulness Based Cognitive Therapy (MBCT) at the Canterbury campus. The trainer provided handouts at each session, made available resources for practice outside the classes, as well as podcasts, handouts and reading lists.

The evaluation of the course was designed in three parts. Firstly, an adapted end of module evaluation, followed by evidenced based questionnaires: *Perceived stress (PSS)*

(Cohen et al 1983); *Self-Compassion Score SCS* (Neff 2003) and *Five Facet Mindfulness Questionnaire (FFMQ)* (Baer et al 2006) which were used to evaluate a range of behaviours linked to mindfulness. These were completed by participants before, at the end and eight (8) months after the course ended. Finally, participants offered comments about their subjective experiences and the impact of the training in a follow up questionnaire. This was sent to all participants 15 months after the course ended to ascertain the sustainability of the mindfulness training.

As the number of participants who completed the evaluation questionnaires was small the results were analysed manually, but the results showed significant changes in stress reduction, self-kindness and mindfulness practices. An unexpected increase in self-judgement at the end the course and 8 months later was explained by the participants' desire to practice mindfulness regularly and properly and the pressure they exerted on themselves to achieve this standard. The strategic targets placed on service providers at this time demanded organisational changes and new working arrangements, for example, the introduction of electronic records. Not all of these changes were well received but the practitioners had to accept this as part of the modernisation programme alongside an increased numbers of health visitors. Unfortunately, many did not feel that staffing had improved and the pressure of this situation may have led to greater self-judgement.

The short course module evaluation highlighted the positive regard the participants had for this course and the effect on behaviours in their professional practice and personal life. Longer-term positive impact was shown in the follow up of their mindfulness practice 15 months after the course had ended. Although some participants admitted they did not practice pure mindfulness after the course, it did encourage them to take up other activities they had neglected. Participants kept journals as part of their reflections after each session but also between sessions to reflect their practice journey in mindfulness.

The PTs reported mindfulness skills helped them to improve their responses with clients, colleagues and in their management of student anxiety and self-doubt. Although it was not possible to make direct links between these course participants and student attrition, the PTs did report the positive impact of mindfulness on professional relationships and managing their workload, as all of them experienced challenges in the progress of their students in practice. The evaluations identify the importance of face-to-face training in work time and at work venues, alongside the e-resources and self-directed practice to learn the skills of mindfulness.

Student health visitors and school nurses attended an introductory session on mindfulness during their studies but this seemed to them too little. This session was timetabled half way through the year and was difficult to manage alongside their course

studies. They did not refer to the experience within their studies or in practice with their PT.

The mindfulness course was held in the evenings with some participants travelling long distances after a full working day. Despite this and the pressures of the workplace, a consistent number of participants undertook to engage with the practice of mindfulness and shared their experiences and reflections on the difference it was making to them. Further development should be considered within the health visitor workforce to support areas of practice in which practitioners advise mindful approaches with clients, for example, antenatal and postnatal mental health, infant mental health and parenting.

## **Recommendations**

**Health Education England working across Kent, Surrey and Sussex:** Commissioning a strategy for mindfulness across the health economy, making it available in multiple formats. It is important practitioners are enabled to practice mindfulness if advising patients and clients about its uses and impact

**Community Healthcare:** Enable health visitor and school nurse practitioners to access mindfulness training and resources in the workplace. To support them to develop these skills in a range of therapeutic settings as part of their public health roles in the prevention of ill health and the promotion of well-being. For example: parenting, ante and post-natal care, infant & perinatal mental health and child and adolescent mental health

**Educators:** In the forthcoming revalidation of the SCPHN programme, consideration of pre-course preparation and training in mindfulness for students, their mentors and PTs is required. Training needs to be designed to support students with the challenges they bring to the health visitor training and build professional resilience. Supporting students early in their studies would facilitate the development of skills of resilience in their studies and future professional practice

## Introduction and context

Practice Teachers (PTs) are central to the delivery of high quality practice learning for all students on educational programmes leading to qualification as a Specialist Community Public Health Nurse (SCPHN) (NMC 2008) of which one pathway is health visiting. The Health Visitor Implementation Plan (Department of Health (DH) 2011), a strategy designed to increase the number of health visitors in England by 4,500 between 2011 and 2015 led to an increase in student numbers on these educational programmes and subsequently the demand on placements. Therefore, models of learning in practice were reconsidered. The role of the PT was adapted beyond the traditional, one student: one PT model, to one where PTs were responsible for multiple health visitor students with support from health visitor mentors (Appendix 12). The PTs maintained their assessment role as well as a clinical caseload (NMC 2008) to facilitate student learning and assessment in practice.

A feature of the health visiting workplace during this period was the increased and competing demands of top down driven targets specified in the Public Health framework (DH 2013). In turn, the perception of practitioners was, that despite the investment in health visitor numbers many felt that they did not experience increased capacity in their workplace. As a consequence, they felt this to be the reasons for low achievement of targets and outcomes required by the service. During this time, practitioners also experienced multiple changes not least of all the expectation of NMC revalidation but also reorganisation in practice. This included the introduction of electronic records which created extra service pressures.

Following local and national campaigns, increased student applications to the SCPHN programme were received. There was acceptance of wider entry gates for candidates agreed to by stakeholders, including accepting applicants on completion of pre-registration programmes. These newly qualified nurses and midwives were, anecdotally, considered a risk because of their lack of experience as they had not consolidated their nursing and midwifery studies as registrants. Nevertheless, the SCPHN course offered them an excellent opportunity; a salary while studying and higher qualifications on successful completion. Despite this perceived risk, newly qualified students did not overly represent those students leaving the programme before completion.

An explanation given by students for leaving their studies on the programme locally included personal stress and or health problems and from our records estimated at 16.5% in 2013-14. Similar reasons were also emerging from other University courses around the country as circumstantial evidence during this period. The nature of adult learning includes developing the personal capacity to balance family life with studying but when tensions arise stress from either side can become overwhelming contributing to students' reason to end their studies.



The SCPHN teaching team have identified a number of students for whom reflection on new learning causes personal turmoil, which seems to be compounded by the reality of practice exposure. However, students do value their practice placement as highlighted in multiple end of SCPHN programme evaluations and in particular the importance to them of the PT. Students have referred to their PT as the person who 'kept them going' in a programme of study known nationally 'to be tough'. It is with this profile of the PT and their role in the student experience, which drove this initiative.

In health visiting practice, one of the main principles, searching for health needs requires practitioners to be particularly resilient and personally resourceful. PTs are responsible for modelling this to students and enabling students to support families who will eventually be competent to facilitate clients' resilience. PTs, as experienced practitioners may use transferable skills from other models with which they are clinically familiar to support students, e.g. by 'containing emotions' a psychodynamic approach used in parenting support from Solihull Approach training (Douglas 2007).

This project, in no way sought to find a quick answer to any of these issues through mindfulness training. It was purely designed to offer instruction in a contemporary resource and evaluate the behaviour change of these senior practitioners. Therefore, the intention of introducing mindfulness training was to enable the PTs to practice the use of a new tool and in turn be better equipped to cope with the workplace stressors and support students transitioning from nurse or midwife to health visitor. The evaluation was designed to inform future developments in the SCPHN programme as well as nursing education in general. Mindfulness practice considers stress as not being limited to an event with a single cause but a response, which can be mediated with effective tools. This is a timely approach in the scrutiny of investment in increased health visitor students and ultimately qualified health visitor practitioners in the workforce.

## **Mindfulness: what is it?**

Mindfulness is a way of being aware of what is happening to us, both inside and outside, with a clear focus of attention so that we become fully present in our daily living. It can lead to a sense of calm and clarity as well as connection with others through the development of empathy and compassion. Mindfulness based cognitive therapy (MBCT) is a specific programme developed by Segal et al (2013) with an evidence-base, delivered by weekly sessions, for 8 weeks with particular curricula and teaching processes (Crane et al. 2013:1). MBCT has had success in the development of mindfulness and self-compassion in many different settings, with both clinical and non-clinical populations (Segal et al., 2013, Kabat-Zinn 2003, Kuyken et al 2010) and this includes health care settings (Albrecht et al., 2012:11) as well as educational settings (McAlpine 2013, Roeser et al 2013) around the world. Face-to-face sessions in MBCT have been found to reduce

stress and burnout for teachers and to play a role in the development of resilience and wellbeing (Singh et al., 2013), such that teachers benefit both personally and professionally and these benefits can enhance their classroom management practices (Singh et al 2013, Roeser 2013). In the UK, MBCT is now widely used in clinical settings in, for example, the treatment of depression in primary care and mental health services (NICE 2009, 2016).

MBCT helps develop positive mental states, which may include:

- Mindful attitudes, such as paying attention, on purpose with non-judgemental awareness in the present moment (Kabat- Zinn 1990).
- Social aspects (Gilbert and Choden 2013) which relate to deliberately intended prosocial behaviour (Leary et al. 2007). The relationship nature of MBCT (Crane et al., 2013, Gilbert, 2014) has shown to have particular relevance for school teachers, who work in school communities. It is expected that similar relevance may apply to Health Visitor practice teachers.
- Self-compassion and the attitude of kindness in interpreting personal experiences (Germer 2009, Feldman and Kuyken 2013).

Mindfulness and self-compassion are equally important components in mediating positive outcomes in MBCT (Van Dam et al. 2011) and MBCT is effective in reducing difficulties, in part, because it cultivates compassion (Kuyken et al. 2010). In MBCT the cultivation of self-compassion is implicit and not direct (Segal et al., 2013, Kabat-Zinn,2005) there is no explicit emphasis on loving kindness or compassion to cultivate these.

## Literature review

The aim of the literature review was to search for key documents combining the terms of '*health*' and '*education*' with '*mindfulness*' when the terms 'practice teacher', 'health visitor' or 'health visiting' and 'school nursing' revealed no available literature. This project on mindfulness was timely as at about the same time mindfulness was being introduced to 90 Members of Parliament as a concept to practice and the evaluation (MAPPG 2015) makes specific recommendations for those employed in the health and social care workforce and beyond.

The stressful and emotionally challenging nature of health and social care professions is well recognised and despite a greater focus on support for staff, the 2015 NHS Staff Survey (National NHS Staff Survey Coordination Centre) highlighted that 37% of respondents reported work related stress, a figure that has been largely constant for the

past few years. It is likely that ongoing stress is a factor in absenteeism, long-term sickness and burnout. This figure for health visitors was significant in NHS Staff Survey (2014) which found 41% of health visitors have felt unwell in the previous 12 months because of work-related stress.

Raab (2014) highlighted that a workforce with 'compassion fatigue' would be less able to provide compassionate care to clients. This has led to an interest in looking at ways to support staff to develop resilience and coping strategies to alleviate stress and is particularly pertinent to health visitors, who through the Health Visitor Implementation Plan (DH 2011), had experienced a dramatic increase in the number of health visitor students. This was known to exacerbate workplace pressures for practitioners (Manley and Greaves 2016), with perhaps the greatest impact on Practice Teachers (Devlin et al 2014). The need for staff to develop self-compassion and resilience was recognised by the Institute of Health Visiting (iHV) (Pettit and Stephen 2015) concluding that a variety of approaches were needed to support health visitors which could be in part due to the assertion that health visiting is a complex role (Appleton & Cowley 2008). Until recently, there has been little attention paid to professional coping mechanisms on which to draw, such as compassionate resilience especially in challenging situations (De Zuleta 2014 cited by iHV 2014). Brook and Salmon (2015) consider this to be due to poor levels of communication in relationship building with families and a product of professional decline.

As mindfulness has grown in popularity as a clinical intervention so has its influence, the Mindfulness All Party Parliamentary Group (MAPPG) convened in 2014 to explore the impact of mindfulness within Health, Education, the Criminal Justice System and the workplace. The subsequent report 'Mindful Nation' (The Mindfulness Initiative, 2015) recommended that as well as utilising mindfulness as a therapeutic intervention for a variety of physical and psychological health conditions, the development of mindfulness programmes for staff within the public sector should be encouraged and supported.

The Department of Health had previously commissioned 'Mindfulness for Stress' programme as part of a Staff wellbeing pilot for their staff (Breathworks 2013) and mindfulness interventions have been offered to clinical staff in a variety of healthcare roles in the United Kingdom. The National Institute Health Service Research concluded;

*'... Mindfulness training could result in positive outcomes for health care workers and their clients, across a range of health care disciplines but urge caution because of the limitations in the evidence (Breathworks 2013)*

There has been little exploration about the mechanisms through which mindfulness achieves the beneficial results documented. Shapiro et al (2006) has proposed a theoretical model based on three components; *intention, attention and attitude,*

resulting in a shift in perspective referred to as '*reperceiving*' which enables participants to view their experiences more objectively. Shapiro was keen to highlight that this was an hypothesis which requires further testing rather than a definitive model, but interestingly it is *the participants initial intention* which forms the basis of effectiveness based on the ability to overcome barriers in practice to take their mindfulness to a 'deeper level' (Morgan et al 2016).

The effectiveness of mindfulness in clinical situations is now well established. From Jon Kabat-Zinn's original Mindfulness Based Stress Reduction (MBSR) course, developed to help people with chronic illness to manage their pain and symptoms, similar interventions have been used for a wide variety of physical and psychological conditions, for example cancer, ADHD, heart disease and addiction (Mindfulnet.org accessed 21 March 2016). Relevant to health visiting and midwifery is the assertion of mindful parenting and in the approach to perinatal mental health, for example, but also for ante natal preparation for parents (Warriner et al 2012) and infant mental health (IHEALTH VISITOR 2014). A Mindfulness Based Cognitive Therapy (MBCT) intervention, based on MBSR was developed and found to be effective in reducing episodes of recurrent depression (Segal et al date) and now embedded in NICE guidance (NICE 2009, updated 2016) as part of the pathway for managing depression in adults.

As mindfulness has become more popular as a treatment in the clinical situation, the possible benefits for clinicians were also recognised and courses targeting health professionals proliferated. Raab (2014) conducted a literature review and found that the evidence showed that mindfulness reduces perceived stress for health care workers and also increased the effectiveness of the clinical care they gave as the intervention reduced 'compassion fatigue'. Gustin and Wagner (2013) highlighted the link between self-compassion and the ability to give compassionate care, an area highlighted by the Chief Nursing Officer (CNO) in the declaration of the 6 C's (Cummings and Bennet 2012). Hitherto, the application of this model in the practice of health visiting has been neglected but nonetheless is relevant (Chambers 2013). McGarrigle and Walsh (2011) highlight that how staff who 'manage or do not manage their stress' impacts on the client. Similarly, Bond et al (2013) found mindfulness training increased medical student's confidence in using mind-body skills in patient consultations alongside positive effects on their own stress management and self-regulation. Dobkin et al (2016) used patient ratings of consultations alongside clinician's pre and post MBSR course assessment tool scores to measure stress and mindfulness and found positive improvements in both.

Despite the wealth of research attesting to the positive effects of mindfulness interventions for health professionals there are some acknowledged limitations. Irving et al (2009) conducted a review of empirical studies, which confirmed the benefits for clinicians but also highlighted that small sample numbers, differences in length of

interventions and assessment tools used as well as a lack of information on participant attendance and practice hinders comparison and transferability of findings.

To address some of these issues, researchers have undertaken randomised controlled studies, presumably to ensure a hard scientific approach. Jain et al (2007) compared mindfulness meditation with somatic relaxation training for 83 US medical and nursing students reporting distress, alongside a control group without intervention. Both intervention groups reported decreased distress and improved positive mood compared to control group but the mindfulness intervention proved particularly effective in reducing distractive thoughts and rumination. De Vibe et al (2013) provided a seven-week MBSR course to medical and psychology students comparing the outcomes with a control group who received no intervention. The mindfulness group showed improved scores for mental distress and subjective wellbeing, which correlated with higher course attendance and reported practice. However, the results were only statistically significant for female students, who formed 76% of the total cohort, highlighting the gendered nature of health and social care roles, but also introducing the possibility that the impact of mindfulness is gender specific. A point identified by Morgan et al (2016) and relevant to this study as all the participants were female.

Poulin et al (2008) compared mindfulness with a traditional relaxation intervention and although both interventions improved relaxation and life satisfaction, the mindfulness participants demonstrated improvements in emotional exhaustion. Wolever et al (2012) compared two mindfulness interventions, one online and one face to face, with yoga based intervention and a control group. The online and face-to-face mindfulness group participants and the yoga based groups all demonstrated significant improvements in perceived stress and sleep quality compared to the control group. This suggests the need for more comparative research to demonstrate which interventions are most effective but also raises the possibility that online courses can be utilised in the delivery of mindfulness training, thereby increasing reach and reducing cost. An online approach to pilot a mindfulness course for Occupational Therapy students (Reid, 2013) was found to be effective whilst acknowledging the difficulty of maintaining student engagement.

McGarrigle and Walsh (2011) ran a course for 12 human service workers<sup>1</sup> demonstrating the increased mindfulness amongst participants evaluated by the Mindfulness and Attention scale (MAAS) (Brown and Ryan 2003) with accompanied stress reduction documented using the Perceived Stress Scale (PSS). 'Journaling' was undertaken as an integral part of the course, similar to recording of reflective practice encouraged in health visiting. This study also demonstrated that impact of attendance at taught

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<sup>1</sup> Human services worker is a generic term for people who hold professional and paraprofessional jobs in such diverse settings as group homes and halfway houses; correctional, developmental delay, and community mental health centres; family, child, and youth service agencies, and programs concerned with alcoholism, drug abuse, family violence, and ageing (Morgan et al 2016).

sessions and engagement with home practice, shown to increase the positive effect of the intervention. Participants identified that 'time, permission and place' were necessary to develop the practice and although provided on the course, it is an important consideration for those looking to replicate the research within employing organisations. A study by Shapiro et al (2006) demonstrated the proportion of participants who failed to complete the intervention (44%), of whom half cited insufficient time for practice. Teacher training participants in a mindfulness based wellness education programme (Poulin et al, 2008) also reported finding the home practice demands were too stringent.

If organisations, particularly public service bodies, are to support practitioners to access mindfulness training, cost effectiveness is also a consideration. The National Health Service has a higher sickness rate than many private companies (ONS 2014), which creates more stress for those covering services on reduced numbers, possibly increasing sickness rates even more, but also creating cost pressures if agency staff have to be contracted to cover absences. In his book 'Developing resilient individuals and resonant organisations with MBSR' Michael Chaskalson (2011) reports organisations supporting staff to access MBSR courses have lower levels of stress and illness related absenteeism, greater employee engagement and productivity and less employee turnover.

One area, which has received minimal research attention but has been reported in other media (Foster, The Guardian; Jenkins, Radio 4) is the possibility that Mindfulness participants may experience adverse effect. Devibe et al 2013 stated that some participants in their study did report adverse emotional, mental or physical effects during mindfulness exercises and practice, but this was not considered unintended effects of the intervention but an expected result of mindfulness. This does highlight the importance of making participants aware of this possibility while ensuring that they have access to appropriate support if needed.

In conclusion, there is a wealth of evidence supporting the beneficial effects of mindfulness interventions, both in clinical treatment of patients and for staff providing that care as well as to lesser extent those in training or indeed the educators in practice. Mindfulness also appears to be more effective than other interventions, which have been trialled and well received by participants. This supports the need to explore further how such practice can be developed in the education and work environments of health care professionals. Ongoing research to reinforce findings and address some of the weaknesses identified in this review, particularly the lack of longer-term follow-up of participants, could cement mindfulness as a valuable tool to reduce the negative impact of unmanaged stress in health care professionals, improving the professional lives of staff and supporting them to deliver compassionate care.

## Health visiting and the role of practice teachers

In the UK, health visitors are the key professional leading the delivery of a universal preventative health care service for families with children under 5 years of age as set out in the Healthy Child Programme (HCP) (DH 2009). However, with a very real crisis within the workforce since 2000, because of diminishing numbers of practitioners and outdated working practices a strategy was devised by the coalition government. The purpose of the government strategy, with its investment in health visiting was to increase numbers of practitioners and steer a cohesive strategy in service delivery (DH 2011). Ultimately, the purpose was to improve Public Health outcomes for children and families (PHE 2014) by 'giving children the best start in life' Marmot (2011). PTs are the senior health visitor practitioners responsible for the practice element of student health visitor training and supported an increased number of health visitor students in the workplace between 2012 and 2015.

By the end of the DH strategic plan in 2015 the number of health visitors in Kent and Medway, was projected to double but this aim was compromised by a number of workforce factors. Firstly, the challenge of recruitment of health visitor students followed by attrition from the programme and when qualified the retention of the new health visitor workforce. Furthermore, tensions arose from within the workforce because of the proportion of newly qualified health visitors.

*(If) growth is achieved, approximately half of the workforce will be newly or recently qualified in April 2015, presenting a potential risk to the level of experience of the overall workforce, but also an opportunity to embed new ways of working (Mouchel for Centre for Workforce Intelligence 2012)*

When considered within this context the aim of this proposal was to enable a range of support mechanisms in the workplace and learning environment to support the PT role acknowledged as complex (Brook and Salmon 2015).

Nursing Midwifery Council (NMC) guidance (NMC Circular 08/11) reiterated acceptable models of practice learning to support the increased numbers of students, with PTs being responsible for more students at any one time in contrast to the more traditional 1:1 pupillage. Managing this change was vital to the success of placement learning. Mindfulness was suggested as a way to enable PTs to prepare, review and refresh their practice alongside other available support mechanisms such as clinical supervision (Wallbank and Woods 2012). Ultimately, it remains important to manage long-standing low morale and job satisfaction amongst the health visiting workforce and diminish further workforce losses but also to enable the profession, to respond effectively to increased demand and demographic changes

*It is also likely that health visitors who are psychologically engaged with their jobs are less likely to consider leaving*

(p9 Whittaker, Grigulis, Hughes, Cowley, Morrow, Nicholson, Malone and Maben 2013)

Using a mindfulness approach allows consideration of their experiences in context enabling students to proceed in their professional career from nurse or midwife to health visitor. Appendix 11 shows the distribution of PTs on the mindfulness course, the number of students allocated to them and their progress on the health visitor programme during 2014-15.

### Student Attrition during 2014-15

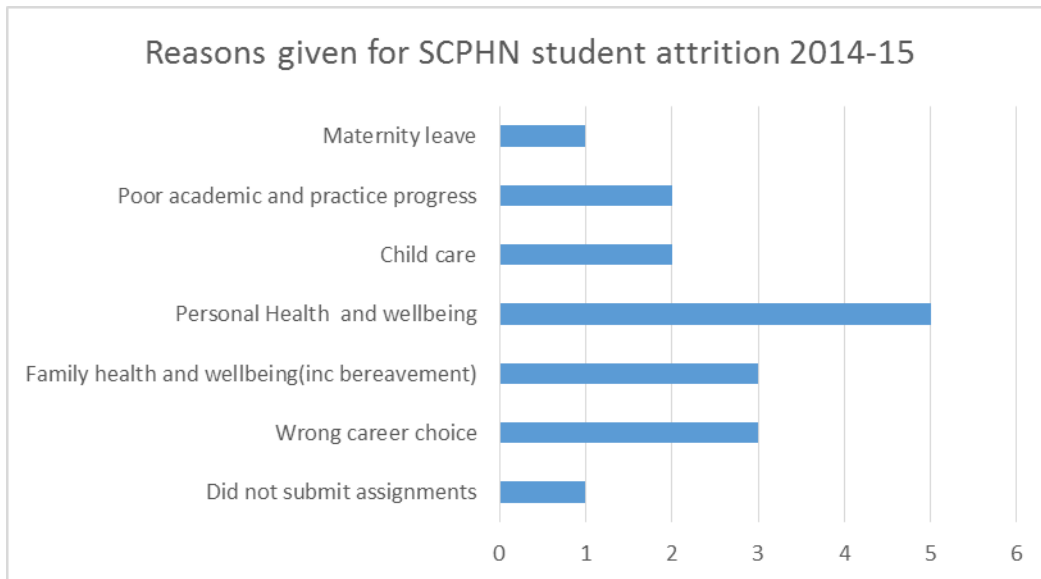
Any suggestion that mindfulness was an antidote to maintain the numbers of students was limited. The early exit rate rose during the period of this project from 16.5% (2013-14) to 22% (2014-15) and is indicative of the complex nature of student attrition. This project was about acknowledging the crucial role of the PT to student progress but also about the impact of student progress on PTs, who have a primary function to enable students to flourish in their studies through effective placement facilitation.

*'Students' experiences varied, but commonly the qualified health visitor primarily responsible for providing learning opportunities was of central importance to their experience* (p 107 Whittaker et al 2013)

The reasons students give for leaving the programme are themed and shown in Graph 1. These are often personal matters and part of the broad life experiences adults bring to the learning environment. While circumstances may arise suddenly or as an emergency, more often it seems the student has experienced personal challenges prior to commencing their studies and believed these to be 'under control'. To an extent the traditional reasons based on childcare and pregnancy are lesser factors involved in leaving. Although some reasons are due to poor progress academically, this too can have a personal circumstances component.



**Graph 1: Reasons given for student attrition from the SCPHN programme during 2014-15**



The SCPHN teaching team have identified a number of students for whom new learning has led to greater reflection on their own life circumstances and experiences. If painful memories are triggered they become stressful and at times seem overwhelming to them. What may be considered as a response to 'troublesome knowledge' described as 'knowledge that is conceptually difficult, counter-intuitive or 'alien' (Meyer and Land 2003) can become an explanation for distress. This distress can ultimately interfere with academic studies and placement progress. Lindley (2015) relates student and even practitioner role dissatisfaction as expressed tensions between 'expectations and reality', comprising the elements of practice which bring personal satisfaction. These include, for example, health promotion and continuity of care as compared with those stressful and perhaps distasteful aspects of the role, e.g. child protection and lack of resources. More recently the part played by inadequate resources on resilience and retention of the health visitor workforce has been highlighted as it faces inevitable job losses following the gains made during the strategy (DH 2011) (Letter to The Times 16-8-2016).

## **Purpose of the project**

The ultimate purpose of the mindfulness sessions was to enable the PTs to develop skills in mindfulness as a support mechanism in the facilitation of student learning in placement. To enable them to balance the demands of multiple students and possibly lessening the impact of student attrition on the health visitor programme. However, mindfulness was not promoted as a way to control or even manage attrition by being reduced to one intervention.

Commissioned by Health Education Kent, Surrey and Sussex, a series of 8 sessions of mindfulness training was delivered. There was an evaluation of the impact of this experience using a range of evidenced based questionnaires. The training was open to all SCPHN PTs from the two employing organisations in Kent, Kent Community Health Foundation Trust (KCHFT) and Medway Community Interest Company (MCH), who were invited to attend the sessions held from 6-8pm on Wednesday evenings between September and December 2014.

### Proposal and introductory session

The trainer, Jean Watson introduced school nurse (SN) and health visitor PTs to the practice of mindfulness<sup>2</sup> during a study day in July 2014 in a practical 2-hour session. The evaluation of this session indicated an overwhelming amount of interest from PTs to attend a proposed 8-week course in autumn 2014. When the funding arrangements were completed, a flyer circulated to both organisations for PTs to apply for the short course (Appendix 2).

### Aims of the project

- To enable Practice Teachers to develop their own practice in mindfulness with application to their role as health visitor practitioners as well as in their practice placement role.
- To evaluate of the impact of *mindfulness training*
- To analyse the attrition rates in light of mindfulness training
- To present an introductory session of mindfulness with the 2014-15 SCPHN cohort and evaluate the impact of this at the end of the programme in August 2015.

### Course Facilitation

The mindfulness trainer facilitating this course, Jean Watson had completed the MSc in Mindfulness at the University of Oxford. As a qualified Secondary School Teacher, she had an interest in mindfulness for educators as well as for mothers in the antenatal period and was involved in mindfulness training for primary school teachers. This resonated with the professional background of participants. The dates were circulated in advance with some subsequent alterations. The course was presented over 8 weeks between September and December 2014.

### Venue

For the convenience of the trainer, the course was delivered at the North Holmes Road campus Canterbury. The Canterbury campus was chosen as an accessible venue with a flexible room of adequate size for ease of movement as well as mat work.

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<sup>2</sup> This introductory session was also delivered to SCPHN students in March 2015

## Ethics

Ethics approval was sought within the University ethics framework and it was considered a course with an evaluation of its content expected. Participants gave consent to the collection and use of the data from the questionnaires at the beginning of the sessions.<sup>3</sup>

## Recruitment

The flyers were circulated advertising the course and inviting applications from the PT community in KCHFT and MCH to participate in the project. The flyers contained course information: pre reading, details of the venue, dates and times. Participants were encouraged to wear loose clothing and bring a blanket and pillow (Appendix 3). Planned to take place in the evening between 7-9pm, this represented an opportunity for personal development outside work hours, which was acceptable to the managers of the health visitor service. The course presented was entitled ***Mindfulness Based Cognitive Therapy for wellbeing and resilience***.

The mindfulness trainer agreed to a maximum number of 18 participants and the criteria for acceptance to the course was aligned to the purpose of the project,

- An active PT on the local PT register with an allocated CCCU SCPHN(s) student for the academic year 2014-15
- or active role organising, co-ordinating the management of learning with CCCU SCPHN student(s) for the academic year 2014-15

Interested practitioners who did not fulfil this criteria, were contacted after places had been allocated to PTs. Participants recruited to the course included, current and recent past PTs who had moved to new roles as team co-coordinators or returned to Band 6 health visitor without student assessment responsibility (1). Both stakeholder Trusts were represented, 16 health visitors were recruited to the course; with distribution by employer and role in Table 1. All practitioners who attended chose to attend as it was in their own time and all were female.

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<sup>3</sup> Internal Email from Roger Bone Research Governance Manager, Research and Enterprise Development Centre. Canterbury Christ Church University

Table 1: Number of participants by role and stakeholder employing organisation

<b>Medway Community Healthcare CIC</b>	<b>Kent Community Healthcare (Foundation) Trust</b>
5 Practice Teachers	7 Practice Teachers (health visitors) 1 Practice Teacher (SN)
1 Practice Teacher in Team Leader role	1 Practice Teacher in Team leader role
	1 manager of SCPHN students

### Attendance at the sessions

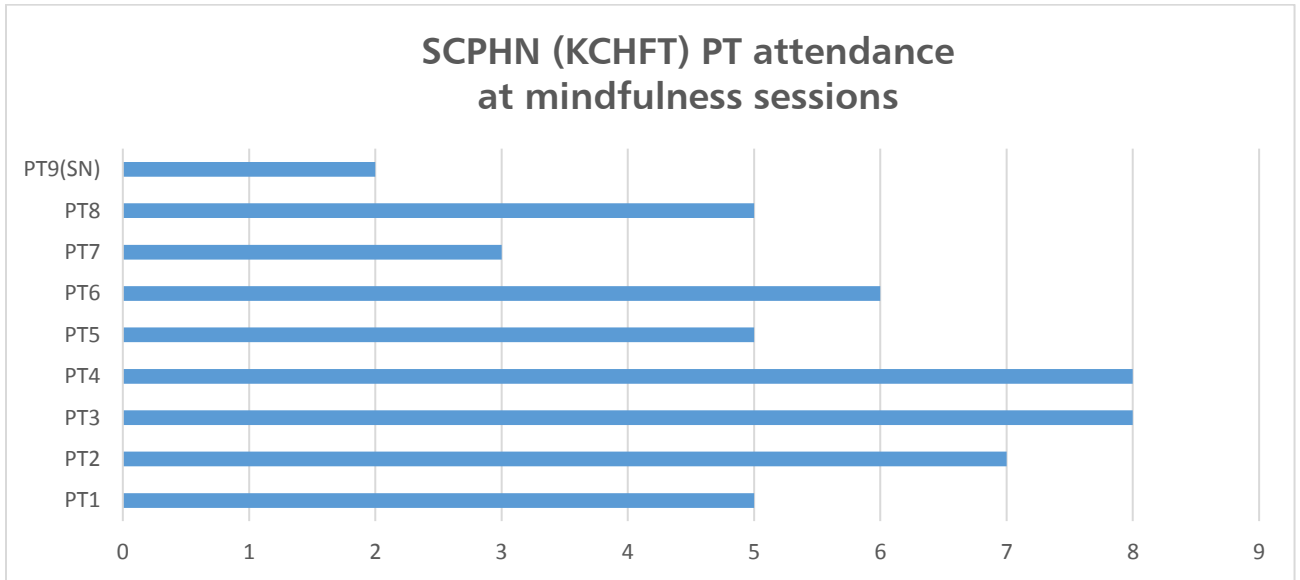
The course was presented in a set of 8 sessions of 2 hours and although the dates were specified in advance, some changes were made by arrangement with the group. Consequently, the course ended a few weeks later than expected. Thirteen (13) participants attended the first session and subsequently there was a core attendance between 6-16 PTs. Attendance decreased after the 5<sup>th</sup> session which meant the participants had learned the theory and skills of mindfulness (sessions 1-4) and most attended one session of the application sessions (5-8). Table 2 shows the dates, attendance recorded and title of each session.

Table 2: Attendance and session title (Segal, Williams and Teasdale 2013)

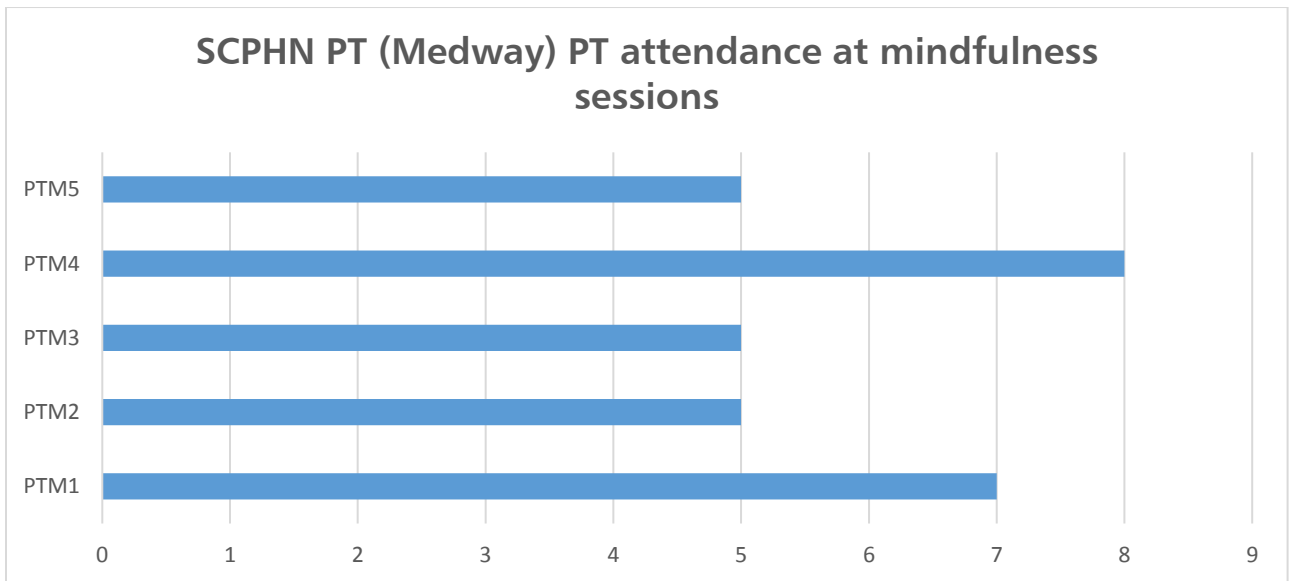
	<b>Dates 2014</b>	<b>Number in attendance</b>	<b>Title of session</b>
1.	24 <sup>th</sup> September	13	<b>Awareness and Automatic Pilot</b>
2.	October 1 <sup>st</sup>	16	<b>Keeping the Body in Mind</b>
3.	October 8 <sup>th</sup>	16	<b>Gathering the scattered mind</b>
4.	October 15 <sup>th</sup>	15	<b>Staying present</b>
5.	November 12 <sup>th</sup>	7	<b>Allowing letting be</b>
6.	November 19 <sup>th</sup>	11	<b>Thoughts are not facts</b>
7.	November 26 <sup>th</sup>	9	<b>How can I best take care of myself</b>
8.	December 3 <sup>rd</sup>	6	<b>Using what has been learned to deal with future moods</b>

The following graphs, 2 & 3, show the breakdown of attendance from the registers at each session and are indicative of the consistency of attendance with only two (2) participants managing to attend all eight (8) sessions. Although both graphs indicate the participants' employing organisations, it should be remembered they were attending this course in their own time and had volunteered to attend.

**Graph 2: SCPHN Kent Community Health Foundation Trust (KCHFT) Practice Teacher attendance at mindfulness classes**



**Graph 3: Medway Community Health (MCH) Practice Teacher attendance at mindfulness classes**



# Evaluation

## Methods of evaluation

As well as the end of module evaluation, (Appendix 4) this course was evaluated using a range of specific tools to identify the outcomes for mindfulness training which were relevant to the aims of the study but also because they have been used extensively in research studies about the effectiveness of mindfulness. Appendix 1 refers to the literature reviewed for this study and the variety of evaluation scales used to analyse the effectiveness of mindfulness.

**Perceived Stress Scale (PSS):** The first questionnaire completed was the 10-item Perceived Stress Scale a widely used psychological instrument for measuring perception of stress ‘... the degree to which situations in one’s life are appraised as stressful...’ (Cohen, Kamark & Mermelstein 1983) (Appendix 6).

**Self-Compassion Score (SCS):** The Neff Self-Compassion Scale (Neff 2003). This study used the original version in which research evidence demonstrates that one of the most important factors in MBCT programmes is learning kindness and self-compassion; supported by the ‘befriending’ approach in cultivating mindfulness (Appendix 7). The revised scale and is now shorter but the original remains an effective version (Neff 2016).

‘Although the Self-Compassion Scale should be valuable in pursuing these and other research questions, it should be mentioned that a self-report scale will necessarily be limited in its ability to accurately assess individual levels of self-compassion. This is because many people may not be aware enough of their own emotional experiences to realize the extent to which they lack self-compassion’ (Neff 2003).

**Five Facet Mindfulness Questionnaire (5 FFMQ):** The 39-item Five Facet Mindfulness Questionnaire (5FFMQ) (Baer, Smith, Hopkins, Krietemeyer & Toney 2006) was developed from a factor analytic study of five independently validated mindfulness questionnaires. The five facets are *observing, describing, acting-with-awareness, non-judging of inner experience and non-reactivity to inner experience*. This multi-faceted-construct scale informs our understanding of ‘mindfulness’ and enables analysis of its components with other variable (Appendix 8).

Participants were asked to complete these questionnaires on three (3) occasions;

- Before attendance, providing baseline data
- After the attendance at the training and analysed to identify the impact of the training
- Eight (8) months after the course ended to identify the sustainability of their mindfulness practice.

Fifteen (15) participants completed these course specific questionnaires at the first session of the training; between eight (8) and nine (9) participants completed the same questionnaires at the end of the final session of the training. Some questionnaires received were incomplete sets with seven (7) participants returning the three specific mindfulness evaluations eight (8) months after the course ended.

A further follow up open-ended questionnaire was sent to all participants 15 months after the course ended (Appendix 9) and six (6) replies were received.

All the questionnaires received were analysed by hand and no T- test applied. Questionnaire papers were coded with an individual unique identifier which provided anonymity to respondents, for example, PT1, 2 & 3, etc. and PTM 1, 2 & 3. The employing organisation was defined by the code.

## Results and findings from the evaluations

### 1. End of module evaluation

A standard end of module evaluation was adapted to reflect the training and participants completed the form at the end of the taught sessions. The questionnaire (Appendix 4) used a standard 5 point Likert scale of strongly disagree to strongly agree; participants ticked the section that closely fitted their opinion.

Eight (8) end of module evaluation forms were completed and received at the end of the taught sessions. The results (Appendix 5) indicated the participants felt the course was well organised (**mean=4.8**). There was overall satisfaction with the course (**mean =4.51**) and is indicative of the value placed on this course by the participants. This was supported in their response to the teaching and learning strategies, both of which scored the maximum 5 to the statements: *the teaching was clear, informative and effective, followed by the mindfulness information was helpful.*

The following results indicate the impact of the course on respondents' understanding, competency and the resources available to support their learning.

- *The course has made a positive contribution to my understanding of mindfulness* **mean = 4.6**
- *The use of practice competencies enhanced my practice* **mean = 4.5**
- *Resources were found to be very useful in developing skills in mindfulness* **mean= 4.5**

Respondents felt tutorial support was not as readily available (**mean=3.75**) indicating that participants would have appreciated more tutorial support from the facilitator and this response will be discussed later.

Comments from respondents in the module evaluation (Appendix 5a) are themed and shown in Table 3. These comments indicate the positive nature and contribution of the training to respondents' learning and their satisfaction with this type of personal development. The respondents believed this to be important for themselves and their students but also beneficial in the workplace. The respondents found the handouts and resources particularly helpful but were already starting to feel the need to practice more and find the time for the mindfulness activity. Respondents disliked the venue in terms of location and comfort but also the time of the sessions at the end of a working day. This maybe significant in relation to the lower attendance after session 5 as the weather became colder and the nights darker and after a working day travelling to the venue may have been prohibitive.

Table 3: Comments from end of module evaluation: themes

Qualitative information from end of module evaluation	Themes
Three things you liked about the Mindfulness sessions	Learning; facilitation & Practice; Self-fulfilment: The group, Paperwork& handouts provided & organisation
Three things you liked least about the Mindfulness sessions	The venue: temperature, outside noise & distance Timing and tiredness after a full day of work: Evoked feelings: Some people in the group were dominant
Where are you on your Mindfulness journey?	Feeling positive & Need to practice more
Other reflections or comments – related to your role in Practice Teaching	Students: beneficial to them managing anxiety and self-doubt Practice teacher: role useful beyond this role& in the workplace Situations: responding differently as a consequence
Three things I have liked about the classroom activities	Sharing experiences Mindfulness exercises and practices The voice of Jean Watson-thank you Ample time for discussion & variety of activities Size of group was comfortable and Feeling of progress being made at each session
Three things I have liked least about the classroom activities	Time to commit; Room Activities & Group dynamics
Please comment on any support you have or not from other participants	Group moaning Good peer support in the workplace

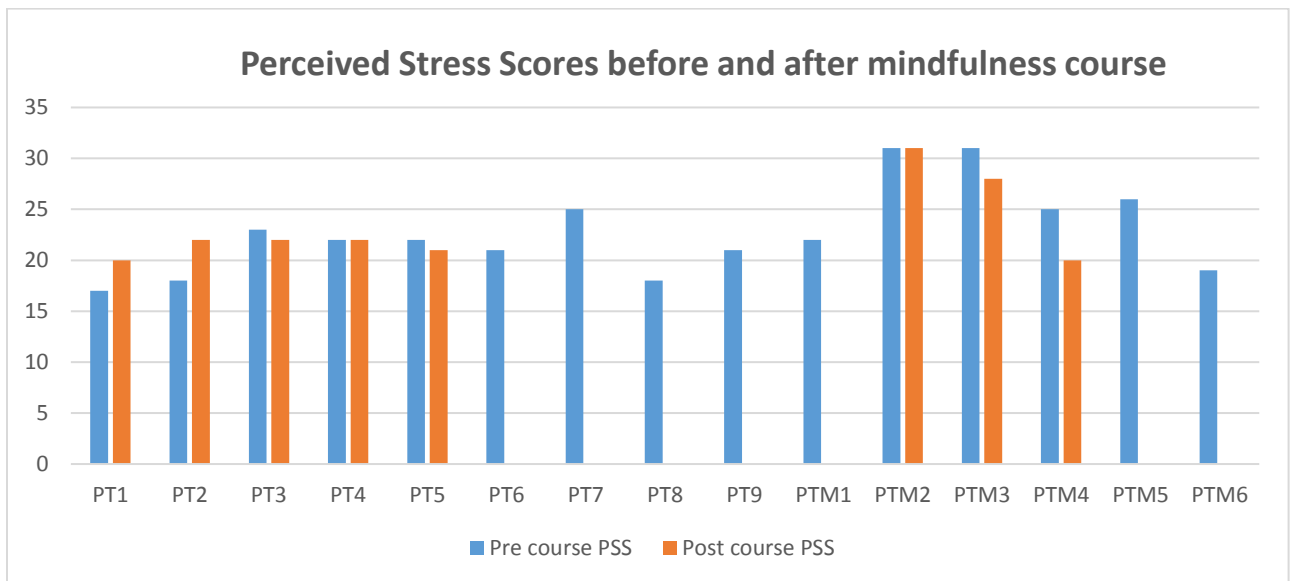


## 2. Findings from the specific mindfulness questionnaires

### Perceived Stress Scale (PSS)

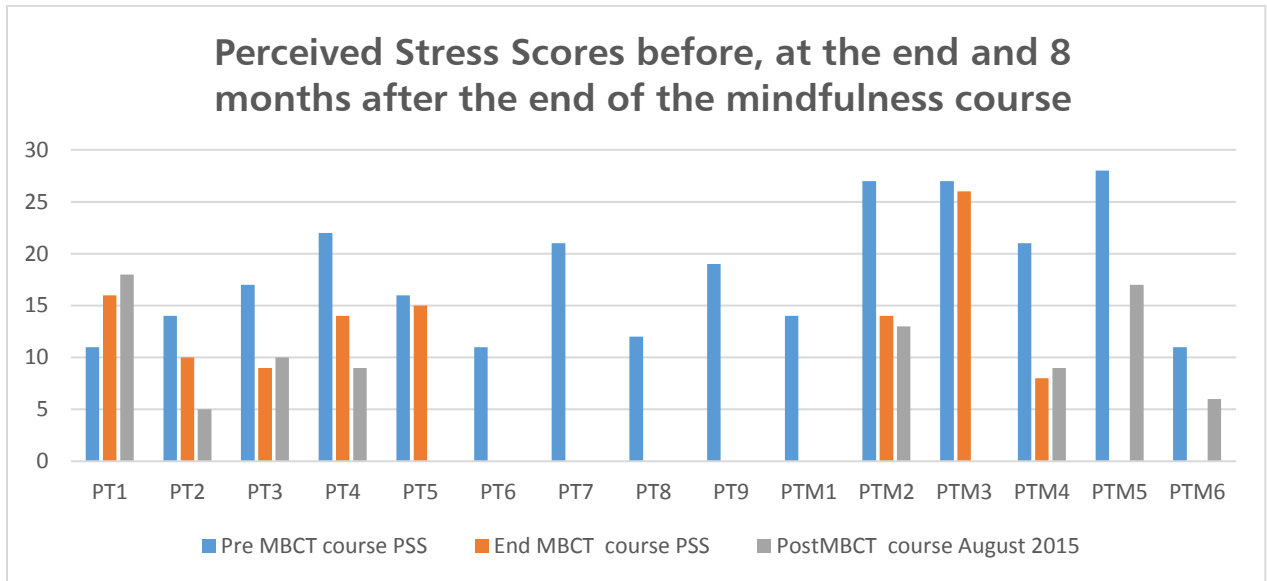
Responses were received to the PSS questionnaires (Cohen et al 1983) (Appendix 6) from 15 participants at the beginning of the course (indicated on the graph in blue) and from 8 at then at the end of the taught sessions (indicated on the graph in orange). Graph 4 shows the levels of stress before the course (blue) in the numbers of PTs (n=15) prior to the course and at the end of the course in those who continued to course completion (n=8). Although 2 PTs demonstrated an increase in stress at the end of the course, three (3) times this number, (n=6) indicated a reduction in stress at the end of the course.

Graph 4: Results of the Perceived Stress Scale



Following on from Graph 4, Graph 5 includes the final comparison between the perceived stress scores before the course commenced, on completion and eight (8) months after the end of the course. The findings indicate an overall reduction in stress from the beginning to eight (8) months after the course ended. Some respondents who completed the end of course evaluation reported a small rise in stress since the previous questionnaire was completed, but overall there was a reduction in the perceived stress of respondents.

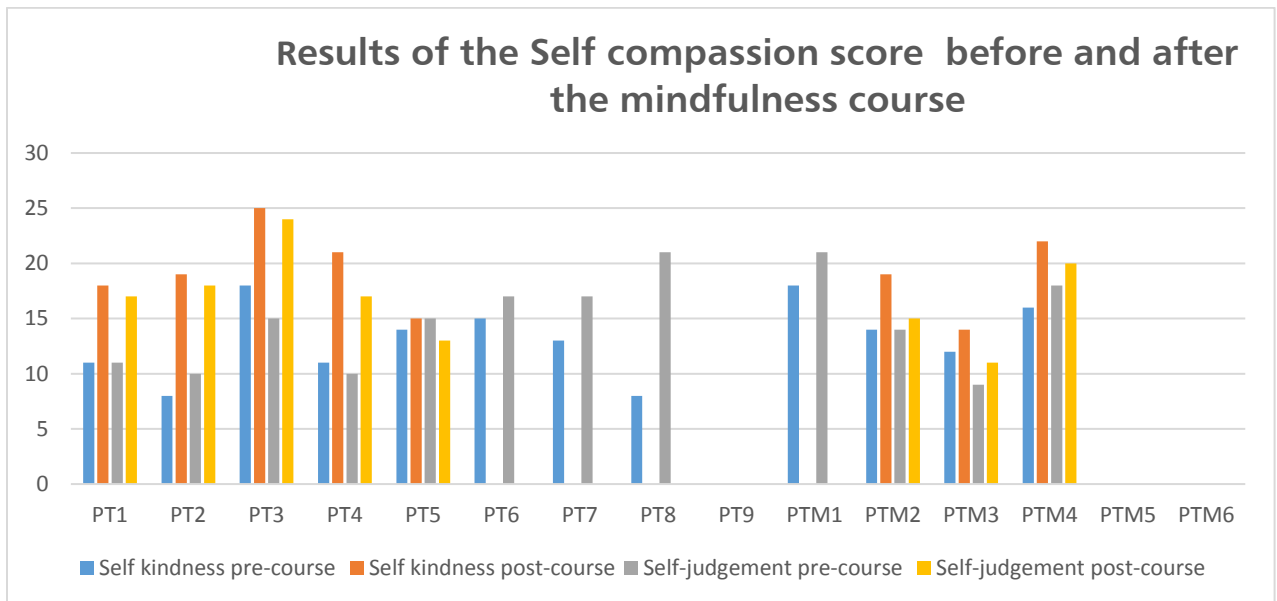
Graph 5: Results of the Perceived Stress Scale 8 months after the course has ended compared with before and on ending



### The Neff Self-Compassion Scale

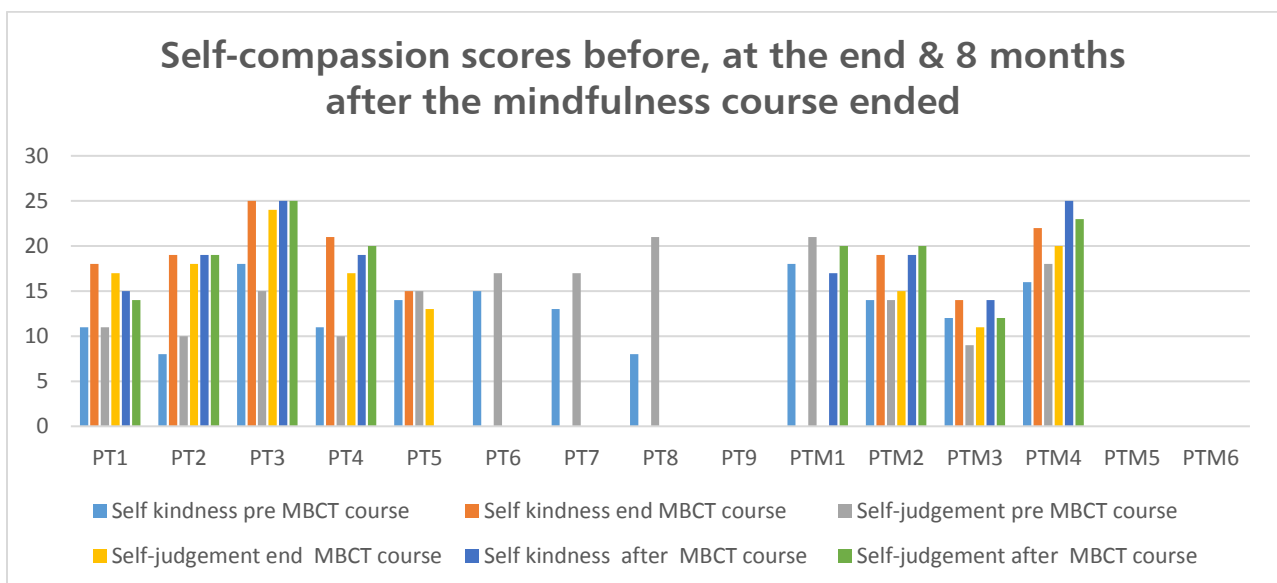
The following graph (6) indicates pre and post course scores for self-compassion (SCS) comprising two factors, self-kindness and self-judgement (Neff, K. D., 2003) (Appendix 7). Again, some of the results are incomplete representing those participants who did not attend the final session. Of the completed results received all eight (8) respondents showed considerable improvements in self-kindness and this was marked across both employing organisations. However, of note and unexpected was the overall increase in self-judgement after the course, in all but one (1) respondent who showed a small decrease (PT 4). The PTs from KCHFT demonstrated a greater increase in self-judgement than those from Medway.

Graph 6: Results of the Self Compassion scores before and on ending the mindfulness course for Kent CHFT and Medway CH employed PTs



In the follow-up SCS completed 8 months later, the rate of self-judgement stayed constant or increased for six (6) respondents (n=6) (Graph 7) and this seems an exceptional response which will be discussed further.

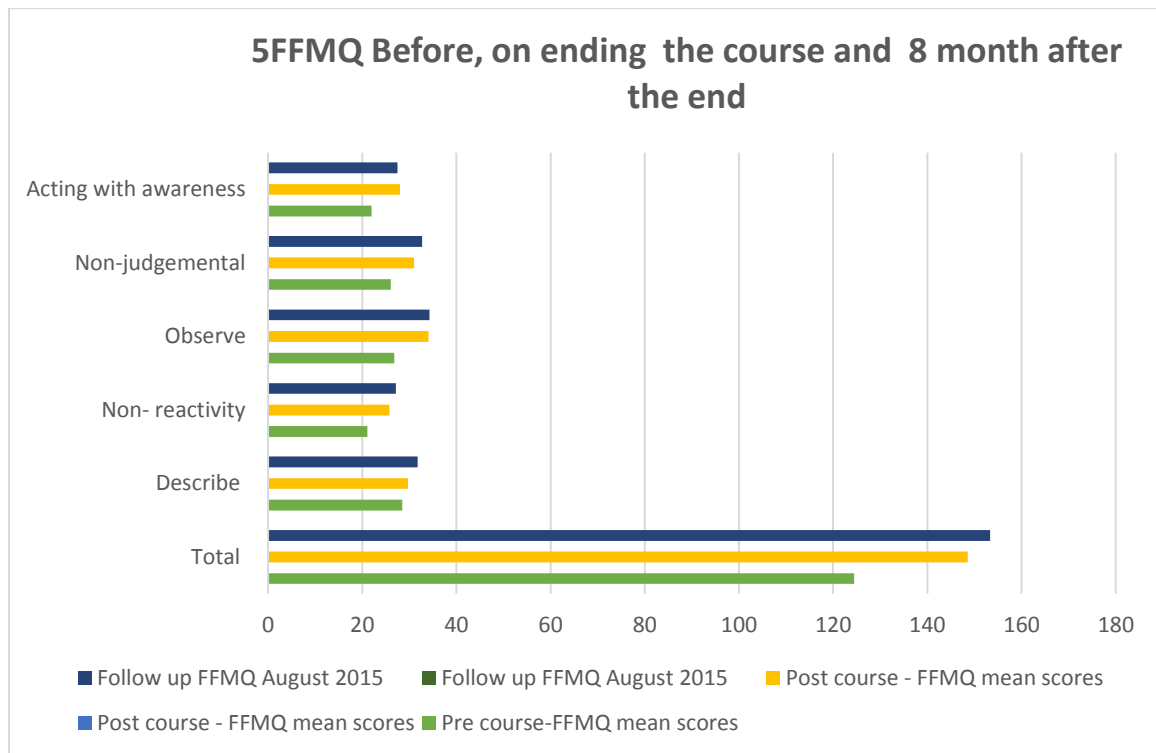
Graph 7: Results of the self-compassion scores before, at the end and 8 months after the course ended for both Kent CHFT and Medway CH employed PTs



## The 39-item Five Facet Mindfulness Questionnaire (5FFMQ)

The findings from this questionnaire are important because it is designed to measure the effect of mindfulness training based on five (5) factors; *observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience* (Baer et al 2006) (Appendix 8). Due to the complexity of this questionnaire and the low numbers, the responses are not divided into differing employing organisations; graph 8 indicates the results. All five factors individually indicate improvement in the skills practised by the respondents as part of mindfulness course, with perhaps less improvement initially in the field of description. The questionnaire has relevance for each specific domain as well as the overall outcome (Baer 2006) and indicates an approximate 20% improvement in all factors on completion of the course. These factors are maintained and even improved in the eight (8)-month follow up, indicating continuation in the practice of mindfulness. There is a slight decrease in the scores for 'acting with awareness' but description shows a continual improvement.

Graph 8: Results from the 5FFMQ



### 3. Follow up evaluation of the impact of mindfulness training

In March 2016, 15 months after the mindfulness training course was completed, a short questionnaire consisting of open ended questions was circulated to all participants to find out the longer term impact of the training (Appendix 9). Responses were received from 6 participants and their responses are themed in Table 4.

In this follow up questionnaire, participants were asked to comment on their experience and provide three (3) key points of how the practice of mindfulness had influenced them in the months after completion of the training. Full results are in Appendix 10. Table 4 shows the themes from the results received; the respondents wrote about the impact across their personal and professional lives, with clients as well as students and managing emotions in the workplace. Comments referred to, for example, '*...positive energy, a way of life, accepting self and.... Contain(ing) both students and client's emotions by reflecting on thoughts, actions and the effect on behaviour*'.

There was, however, a common theme in these responses, which referred to *Guilt*; and relates to the increase in self-judgement. The *sharing, managing & peer support* alluded to their concern for colleagues who had not accessed the mindfulness training as they expressed the impact of the training on managing themselves and their emotions in the workplace.

Table 4: Themes from follow up of Mindfulness Training Practice Teachers March 2016

Questions	Themes
<i>What three things have you found most helpful since attending the Mindfulness training in October 2014?</i>	<ul style="list-style-type: none"> <li>• A way of life</li> <li>• With Clients &amp; Students</li> <li>• Personal, Private &amp; professional: positive energy</li> <li>• At work</li> <li>• After work</li> </ul>
<i>What three things have you found less helpful about Mindfulness training since attending?</i>	<ul style="list-style-type: none"> <li>• Nothing: it wasn't not helpful</li> <li>• Guilt; sharing, managing &amp; peer support:</li> </ul>
<i>What are you learning about yourself and your role by attending the Mindfulness training ?</i>	<ul style="list-style-type: none"> <li>• Using it to help contain both students and client's emotions by reflecting on thoughts on actions and the effect on behaviour</li> <li>• Accepting of self: remove emotion from situation</li> <li>• Accepting self</li> </ul>

## Discussion

*I have learned that my mind is a positive energy that keeps the rest of me well. I feel comforted and strong in having this skill*

*(Practice teacher 2 Evaluation 15 month follow up)*

The Mindfulness Nation report (MAAPG 2015) has raised the profile in the UK of mindfulness and instilled its importance in public services as a way of being, that supports interaction with clients, service users and the public while at the same time enabling a kinder and more compassionate reflection on self. This approach has been highlighted as a means to prevent professional burnout and enhance relationships in the workplace, all of which impact on productivity. Multiple studies have attested to the practice of mindfulness as a stress reduction tool to prevent professional burnout (Shapiro et al 2005, Poulin et al 2008, Irving et al 2009, Roesser et al 2012, Wolever et al 2012). This small scale evaluation of mindfulness training was undertaken at a time of imperative professional regeneration in which health visitor practice teachers were critical to 'growing the workforce' through increased numbers of students in placements (DH 2011). The practice teachers, who committed to the mindfulness training, travelled long distances at the end of a full working day to participate demonstrating their professional commitment, which is highly commendable.

### 1. Learning about mindfulness

The 5FFMQ (Baer et al 2006), a standard measure of mindfulness training offers a way of exploring and reflecting on the impact of mindfulness through a range of experiences or factors. These factors showed small but incremental changes in the respondents on completion. They improved 8-months after the course ended. The results of this questionnaire indicated respondents had acquired the skills to practice mindfulness but were also learning how these skills prepared them for heightened awareness with clients, students and colleagues in the workplace. The results show the mindfulness training was successful and made an impact on a set of behaviours commensurate with professional and personal well-being of those who attended and undertook to complete and return the evaluations. All of which could be summarised,

*I make less rash or reactive decisions, which has helped me make better choices at work and at home*

(Practice teacher 2 evaluation 15 month follow up)

The practice teachers indicated that through their learning and practice of mindfulness they were able to start to apply this experience to their work with service users. Consequently, reflecting the requirements of a range of interventions in practice by understanding the link between their feelings and behaviour,

*Using strategies in practice with clients has enabled me to be more aware of how thoughts affect my feelings that in turn, lead to a calmer attitude as I am more in control of both*

(Practice teacher 4 evaluation 15 month follow up)

The respondents indicated how they incorporated mindfulness as a way of life and applied it across a range of situations, at home, with students and with colleagues. In so doing, mindfulness was a powerful tool, which could be used to prevent burnout and absenteeism as it connects practitioners with other activities which they may have forgone,

*The longer term effect was found in a range of activities at and afterwork; with clients and with students*

(Anonymous end of module evaluation)

## **2. Mindfulness as a way to manage and achieve stress reduction**

At a time of intense organisational, professional and regulatory change, it is to be expected that these practitioners experienced a level of stress. The Perceived Stress Score results (PSS) (Cohen et al 1983) showed a reduction in stress in most respondents following the mindfulness training which was sustained in the 8-month follow up. Managing stress in the workplace and building resilience are areas of workforce development under scrutiny (Pettit and Stephen 2015) and for which mindfulness is a

powerful approach as recommended in the health and social care workplace (MAPPG 2016). The following comment summarises how respondents felt about the impact of mindfulness on their coping mechanisms.

*It has increased my resilience in times of stress and chaos*

(Practice teacher 2 evaluation 15 month follow up)

Although it was not the intention of this study to collect practitioner workforce data we are aware from PT records that none of the participants who attended mindfulness training left the health visitor service during the academic year. Sick leave data is unknown for this cohort.

### **3. Student impact and attrition**

The original proposal was candid about the student attrition rates and the personal reasons why students terminate their studies on the health visiting programme (Graph 1). This decision is neither an easy nor a straightforward decision for students or PTs and considered a stressful situation for all concerned. Any scepticism that mindfulness alone could address attrition was sound, as some PTs on this mindfulness course experienced their student/s, to 'drop-out'. The remainder of the PTs also experienced challenging situations with their students (Appendix 11), and the following statement is indicative of the complex process involved,

*This cannot nor should it be considered a quick fix 'taster' it must be nurtured and developed*

(Anonymous comment end of module evaluation)

Nevertheless, PTs did demonstrate the impact of mindfulness when used with students in practice, indicative of, how compassionate responses from educationalists can be used to build self-judgement and kindness in students,

*Useful to help students manage anxiety and self-doubt*

(Anonymous comment End of module evaluation)



The PTs indicated how clients and students benefitted from a 'mindful' health visitor and the following comment demonstrates transferable skills and the language shared with psychodynamic practices (Douglas 2007),

*Using it to help contain both students and client's emotions by reflecting on thoughts on actions and the effect on behaviour*

(Practice Teacher 1 15 month follow up)

Students in the 2014-15 cohort attended the 2-hour introductory session. The informal evaluation highlighted the inadequacy of the setting to this type of learning, as the room was uncomfortable because it was too small and too hot. Despite this experience, many students were interested in using the skills of mindfulness aided by the resources on the Virtual Learning Environment. Some students informed us that they already practised mindfulness having attended training in a previous role or accessed it via a mobile phone App. PTs believed in the benefit of mindfulness for students, and recognised the importance of permission and time for students to be able to incorporate mindfulness into their studies and their role.

*Would love the students to have this course but as an academic year course*

(Anonymous comment end of module evaluation)

Students were not seemingly aware their PT was involved in the mindfulness course and PTs believed a 'taster' session for the students was inadequate. The students did not indicate the impact of mindfulness in the end of programme evaluation, suggestive of the poor timing of the session in the academic year.

While some PTs adopted a mindful approach and seemed to make links with their teaching role in practice,

*Using thoughts and feelings to aid self-awareness and reflective activity with my students*

(Anonymous comment end of module evaluation)

other respondents were honest about the difficulty they faced in making the connection between their mindfulness practice and student learning,

*I struggle to know how to integrate this into the student arena, how to allow others to benefit from it*

(Practice teacher 4 15 month follow up)

The end of module evaluation asked for reflections on their role as a PT and their practice of mindfulness but it seemed the PTs needed more structure in the course to make these links. This could have been achieved through tutorial support which respondents indicated they were least satisfied with on the end of module form.

Malone et al (2016) have commenced a discussion on the future of health visitor education suggesting how pre-preparation modules could be developed to homogenise the diverse nursing backgrounds students bring to their studies. Mindfulness training, as a preparation for study would enable prospective SCPHN students to prepare for their new career and refresh reflective capacities of which mindfulness has a part.

#### **4. Workplace and Tutorial support**

The end of module evaluation score indicated that respondents would have appreciated greater tutorial support during the mindfulness course (**mean = 3.5**), the area of least satisfaction with the course. Tutorial sessions to reflect on mindfulness practice and professional roles could have addressed this difficulty. However, the intention of the course was to learn about mindfulness and practice the skills of mindfulness. The respondents appreciated the time allowed for discussion and reflection within the 2-hour sessions. Links to practice need to be emphasised as the PTs expressed some tension over sharing mindfulness with colleagues in the workplace reflecting the importance of time, place and permission to develop practice (Shapiro 2006). Participants did find their own support with each other in workplace,

*It feels like a personal thing that I do and that others do not really understand. This can be a little frustrating, but I do discuss it as a tool for management of depression with clients and have had some positive feedback from this*

(Practice teacher 4 15-month follow up)

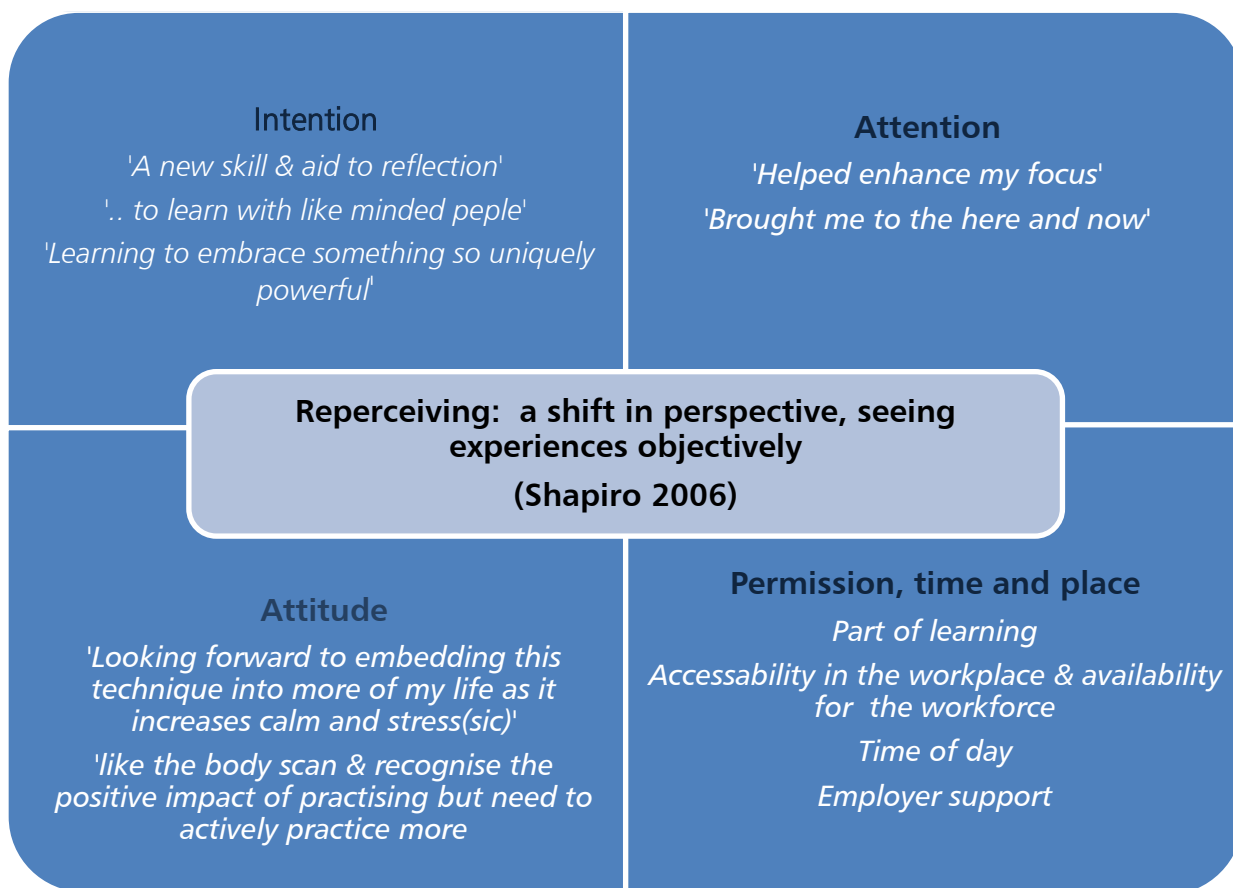
## **5. Developing a hypothesis of mindfulness training for health professionals**

The intention of this study was for health visitor practice teachers to develop the practice of mindfulness to enable them to refresh and review their professional practice with clients and health visitor students. All the participants, by their attendance demonstrated intention and commitment, shown to contribute to sustaining mindfulness training (Shapiro 2006). In the first instance, by their response to the introductory session and followed by the initial intention to attend and to practice whether or not they completed the full 8 sessions. Although we do not know the specific reasons for the decline in attendance, this being one of the shortcomings of the study, those remaining participants who completed the course and submitted their evaluations, indicated the power of their learning.

The respondents indicated the positive experiences of their mindfulness skills with clients, students and colleagues as well as in their personal lives. This reinforced the benefits of their practice and seemed to maintain their intention to continue mindfulness practice. For some, they described their ongoing practice as being a mode which suited them rather than a pure mindfulness practice. In so doing, there was a display of the intention, attention and attitude needed for mindfulness effectiveness (Figure 1) (Shapiro et al 2006). Further to this, several participants expressed how they had explored taking their practice to a deeper level with further study in mindfulness and trying out their practice in real life settings. The role of the employer in supporting mindfulness skills and practice was identified by the respondents as needing, (permission) to learn; access and availability (of a course) and time of day. This is now increasingly relevant for employers and commissioners, as clinical interventions highlight the importance of mindfulness. Effective for service users in a range of situations, mindfulness has an additional benefit, as a way to maintain stress reduction in the workforce,

*It is inherent that Health care professionals need support in addressing the numerous stressors in their work (P165 Sharpio et al 2006)*

Figure 1 Requisites for mindfulness practice – leading to improved self-regulation, as they ‘reperceive’ their experiences objectively (adapted from Shapiro et al 2006)



## 6. Health Visiting and Self Compassion

The Self-Compassion Scale (SCS) is a psychometrically sound and theoretically valid measure of self-compassion (Neff 2003). Recent studies have indicated the link between a high level of self-compassion and psychological well-being (Neff 2016). The positive and negative worded items in the scale are intended to identify the three main components of self-compassion (self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification). Despite the emphasis placed on compassionate care in nursing (Cummings and Bennet 2012) and health visiting (Chambers 2013), little evidence is available about the contribution of

mindfulness as an indicator of self-compassion (measured by self-kindness and self-judgement) to empower care and compassion in nursing.

The majority of participants attended the first 5 weeks of the course in which they learnt the skills of mindfulness including one session on the application. Attending this section of the course may have enabled non-completing participants to satisfy their curiosity, believing they had an adequate introduction to mindfulness. However, by not attending the final 3 weeks of the course, where the application of mindfulness to difficult situations was explored and practiced, may have been too challenging in a group situation for these participants. Nevertheless, for the remaining participants the responses to SCS increased score in self-judgement<sup>4</sup>, defined as,

*'...a dynamic balance between the compassionate versus uncompassionate ways that individuals emotionally respond to pain and failure (with kindness or judgment)' (Neff 2016)*

Self-judgement differs from self-esteem (Neff 2016), as being less focused on comparison with others or dependent on worthiness of self and without the narcissistic tendencies of self-esteem. Self-judgement, is focussed on wanting to do one's best and when failing being harsh on one's self and then self-critical. This was expressed within the evaluations 'as guilt at not practising' for example. Therefore, it seems the practice teacher respondents, although they valued the mindfulness approach at work and at home, struggled to achieve an adequate level of practice. They felt this was necessary, giving rise to the recorded increase in self-judgment (Graph 7). Captured in the end of module evaluation these qualitative comments are indicative of their desire to 'do it (mindfulness) and do it well' in the face of competing demands,

*Time to commit and feeling guilty if not completed and feeling pressurised to commit and being too tired by the evening to participate fully*

(Anonymous comment end of module evaluation)

In the 15 month follow up, this admission of 'guilt' about their practice was still evident as the practice teachers expressed their desire to sustain and practice mindfulness. This was identified to be because they could see the benefits to their practice and personal lives. It did nevertheless worry some respondents,

*I still frequently forget to put it into practice*

(Practice Teacher 4 evaluation 15 month follow up)

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<sup>4</sup> This was not the case for non- judgment in the 5FFMQ

while others expressed how they utilised mindfulness but it had motivated them to return to other activities,

*In its purest form I am not practicing it however it has helped me re engage with things that do help me and I had abandoned*

(Practice teacher M1 evaluation 15 month follow up)

## **7. Health Visitor Practice Teachers and continued professional development**

*Thank you for allowing me to participate in this life skill. I feel honoured to have been part of the innovative work provided by the CCCU*

(Practice teacher 2 evaluation 15 month follow up)

Practice teachers appreciated this opportunity to explore mindfulness as an innovative approach to their continuing professional development but also as they found the methods used were preferable to other courses,

*I am aware that there is so much more that I can learn about this and I really want to. I have since attended a weekend that was advertised 'A time to pause – mindfulness techniques'. It was not as helpful as the 8 sessions we did at Christchurch and when I spoke of what I had learned, other attendees said that this sounded a much better method, as it allowed a build-up of habitual techniques. I really appreciate what I learnt as it built on my practice*

(Practice teacher 2 evaluation 15 month follow up)

They also expressed the way mindfulness develops their personal coping mechanisms as a part of effective stress management which can ultimately protect against 'burnout'.

*Thank you for giving me the opportunity to attend the course. Although I don't follow the mindfulness ethos to the full, I have positively modified it to benefit me in both my professional life and personal*

(Anonymous comment evaluation 15 month follow up)

## Conclusion

The project achieved its aim of presenting an 8 week course on MBCT to 15 health visitor practice teachers and 1 school nurse practice teacher (16 participants) and developing their mindfulness practice. The respondents demonstrated the impact on their personal and professional lives at the end of the training, 8 months after it ended and again 15 months after it ended. Based on the pre course baseline assessment a decrease in stress and an increase in self-kindness was shown in the self-reported scales. The unexpected results increase self-judgment at the end of the course, and continuing 8 months after the course ended were explained by the respondents commitment to their practice and the pressure they placed on themselves to work hard at mindfulness, *'to do it well, and do it properly'*. All of which is contradictory to the ethos of mindfulness, but at a time when there were multiple stressors in the workplace these practitioners were seeking ways to support and sustain themselves in stressful times. Nevertheless, if mindfulness is to be considered a skill the practitioner can utilise within healthcare settings, the first indicator is the ability to treat oneself compassionately (measured by self-kindness and self-judgement) to enable care and compassion for others. The participants were supplied with a range of resources for self-directed practice at their own pace which is important to continuing practice (Poulin 2008) and to guard against mindfulness training attrition (Shapiro 2006).

There is now keen recognition of the use of evidence based strategies to support health care practitioners from burn out and preventable absences caused by stress and long term illness from the workplace. The tools of mindfulness enable practitioners to build their resilience and develop skills that transcend personal and professional spheres, but require a supportive workplace to pursue practice. In so doing, employers are enabling a productive culture as mindfulness enhances individuals' ability to manage competing demands of home and work. This study successfully showed how, for a small group of senior health visitors, there was reduced stress and self-kindness enhancing their professional capacity. Cross-reference to public health outcomes data and service user satisfaction information were not part of the study.

The evaluation of the course enabled further development of a model for future mindfulness training (Shapiro 2006), with the requisites of intention, attention, attitude and permission. This serves as a structure to support employers and commissioners to plan mindfulness training in in the workplace as well as programmes of learning which lead to health professional qualifications. Reflective time should be built into mindfulness courses to enable the application to specific work related scenarios.

Although the evidence of the impact on students of mindfulness was inconclusive and PTs believed the 2-hour introductory session was inadequate, many students were already involved in the practice of mindfulness to some extent. Validation of mindfulness

practice as a professional coping tool is now accepted and has the potential to support students in balancing their studies but also to enhance recruitment if carefully planned and managed. Employers have a role in mindfulness practice by permitting it to be learnt and practised with work time and at accessible venues. This development undoubtedly adds value to the health and wellbeing of the workforce.

There are now numerous clinical interventions calling for *mindfulness* or a *mindful approach*, which requires health care professionals to be knowledgeable but also have experienced the practice of mindfulness skills. The study and practice of mindfulness as a basic proficiency should be encouraged in those who advise and recommend it. This is in order that the effect and impact of mindfulness is fully realised in student learning with service users and as part of a healthy workplace.

## Limitations

- The number of PTs who attended the course decreased after session 5 only half of those who commenced the course completed it and returned the questionnaires. This was despite many telephone and email reminders to participants who did not finish the training. This resulted in missing data for the evaluation.
- To address this missing data, it would have been useful to find out the reasons for participants not completing the course, for example, *was it not useful, not to their liking or just perhaps too much at the end of the working day*
- The students' introductory day was positively received with many expressing existing commitment to mindfulness practice via an app on their mobile phone or experience from their previous role. However, the room was not suitable for the session with pre-occupied students with their studies.

## Recommendations

This small-scale study and evaluation has shown there are benefits to all health visitor practitioners being trained and skilled in the practice of mindfulness, but the timing and venue is important as well as the ability to be supported in mindfulness practice. There are multiple representations of mindfulness as advice to clients in ante and post-partum care, parenting and infant mental health. Mindfulness needs to be practised and understood by practitioners if this advice is to be followed through effectively. Mindfulness practice is linked with reflective practice and has the power to transform



the retention of the workforce and enhance productivity if shared and embedded in the workforce with employer support.

### **Commissioners**

Commission services, which have mindfulness approaches that require health visitor practitioners to practice mindfulness so they can draw on this expertise in their understanding of the needs of children, their parents and families within public health

### **Health Service Providers**

- To invest in the quality of health visitor knowledge, practice and application of mindfulness as a priority, to enable the service to deliver on the Public health outcomes it aspires to achieve
- Commit to investing in this training for the wider health visitor workforce in the workplace and during the working day to support the development of compassion in the workplace
- To further grow the quality of workplace mindfulness to ensure all health visitor practitioners have the skills required to demonstrate the effectiveness of mindfulness which has been shown to impact on retention as well as sick leave and staff turnover
- Work with educators at CCCU to establish mindfulness in the forthcoming revalidation of the programme

### **Educationalist responsible for continuing professional development and programmes leading to professional registration**

- To embed mindfulness training with students and practice teachers as a learning tool that enables students to manage the competing demands of life, home and study which contributes to continuous improvement and compassionate practice

### **Health Visitors in Kent and Medway**

- Value and share the mindfulness resource from this short course for the benefit of clients, students and colleagues as supported by employers
- Sustain mindfulness across Kent and Medway so as to create a vibrant testbed in practice, and the workplace for health visiting practice

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## Appendix 1 Literature search analysis

Author	Course Length	Scales used	Other tools
Bond et al (2013)	11 weeks 3 days/week home practice	Scale of physician empathy (Jefferson) Perceived stress scale (Cohen) Self-Regulation Questionnaire Self-compassion scale	Reflective post course essay
DeVibe et al (2013)	7 weeks 30 minutes daily home practice	General Health Questionnaire Maslach Burnout Inventory (student version) Perceived Medical School stress Subjective wellbeing Five facet mindfulness questionnaire	
Jain et al (2007)	4 weeks and a 6 hour one-day retreat home practice (no time specified)	Brief symptom inventory Positive states of mind scale Daily emotion report Index of core spiritual experiences Marlowe-Crowne short form	Practice Log
McGarrigle and Walsh (2011)	8 weeks	Perceived stress scale Mindfulness attention and awareness scale	Reflective journal
Poulin et al (2013) Study 1	4 weeks 15 – 20 minutes daily home practice	Maslach burnout inventory Satisfaction with life scale Smith relaxation disposition inventory Kentucky inventory of mindfulness skills Kessler 10 psychological distress scale Satisfaction with life scale	
Study 2	8 weeks 15 – 20 minutes home practice 5 days a week	Teachers sense of efficacy scale	
Reid (2013)	8 weeks online course	Mindfulness attention and awareness scale	Journal
Shapiro et al (2005)	8 weeks	Brief symptom inventory (Derogatis) Maslach burnout inventory Perceived stress scale Satisfaction with life scale Self-compassion scale	
Wolever et al (2012)	12 weeks (half cohort face to face, half online course)	Perceived stress scale Pittsburgh sleep quality index Centre for epidemiological studies depression scale Work limitations questionnaire Cognitive and affective mindfulness scale (Feldman)	Blood pressure Breathing rate Heart rate variability



## MINDFULNESS SKILLS, WELL BEING AND RESILIENCE

Learning to apply these skills to daily life.

Jean Watson

Wednesday: 7-9pm

2014 September 24<sup>th</sup> October 1<sup>st</sup>; 8<sup>th</sup>; 15<sup>th</sup>

November: 5<sup>th</sup>; 12<sup>th</sup>; 19<sup>th</sup> & 26<sup>th</sup>

The practice of mindfulness can have an influential effect on health, well-being and resilience, as shown by scientific and medical evidence. This experiential course is not a therapy but it is a non-religious and effective means of helping to alleviate stress and promoting well-being and flourishing. Skills for supporting top performance and good mental health will be taught in eight two-hour sessions in a group of about 18 people. The course draws on the approach of Mindfulness Based Cognitive Therapy, where we learn to bring our attention to the present moment, enabling more choices.

You will be introduced to a range of skills that you can draw from to help relax, improve memory, focus, problem solving and improve performance as well as reduce stress. Full instructions will be provided and there will be periods of inquiry to discuss and share experiences arising through the practices and the chance to apply the skills to daily life.

Practice at home for 40 minutes each day, in between sessions, will be encouraged and guided practices will support you with this.

The course texts are:

1. **Mindfulness: a Practical Guide to finding Peace in a Frantic World** (2014)- by Professor Mark Williams and Danny Penman. Piatkus. (approximately £4.99)
2. **The Mindful Way Workbook: an 8-week program to free yourself from depression and emotional distress.** (2014)- by John Teasdale, Mark Williams and Zindel Segal. The Guilford Press. (approximately £17.99)

It would be useful if you can obtain copies before the course starts and bring them to each session. Each book includes an MP3 CD and downloads of guided meditations.

You will need to bring your own mat, blanket and a cushion

## Appendix 3 Information for Practice Teachers about the Mindfulness course

### What is the project about?

The project will be facilitated by Jane Greaves and of Canterbury Christ Church University (CCCU) and commences in September 2014

Following an introductory session of Mindfulness with the SCPHN Practice Teachers in March 2014 and on which we reported informally, we were invited to submit this proposal by Jane Butler, HEE/KSS. The purpose of the proposal is to offer a plan for training in Mindfulness for Health Visitor PTs who are responsible for the practice element for the increased number of HEALTH VISITOR students since 2012. The purpose of this professional investment and regeneration is driven by the need to improve Public Health outcomes for children and families (PHE 2014). However, the student attrition rate has been substantial during this period and reasons given by students for leaving the HEALTH VISITOR programme have been based on personal stress and mental health problems. While Mindfulness is not considered therapeutic, it will enable PTs to support all students with an approach designed to review personal resources in the face of multiple stressors from home, work and study. In brief, using a Mindfulness approach allows consideration of these experiences as dependent on personal and contextual factors and not in response to any one event as a cause

### What will the project involve?

The purpose of the project is to provide a series of 8 sessions of Mindfulness training for about 18 HEALTH VISITOR (and SN) Practice Teachers

Practice Teachers were introduced to the concept of Mindfulness through a set of 8 x 2 hour sessions and introduced to a range of skills that can be drawn from to help relax, improve memory, focus, problem solving and improve performance as well as reduce stress. Full instructions will be provided and there will be periods of inquiry to discuss and share experiences arising through the practices and the chance to apply the skills to daily life.

Offer a series of Mindfulness training to enable Practice teachers to support HEALTH VISITOR students in this professional transition

To enable PTs to develop their own practice in Mindfulness and how this is applied to their role as HEALTH VISITOR practitioners as well as in their practice placement role

To undertake an evaluation of the impact of Mindfulness training

To analyse student attrition in light of Mindfulness training

To undertake an introductory session of Mindfulness with the 2014-15 SCPHN student cohort & evaluate the impact of this at the end of the programme in August 2015

### How will the project be monitored and disseminated?

There are a series of outcome measures planned as part of the evaluation for students and PTs evaluation through questionnaires will be collected at the beginning at end of the Mindfulness course

There will be regular feedback to HEE/KSS

### Deciding whether to participate?

If you have any questions or concerns about the nature, procedures or requirements for participation do not hesitate to contact Jane Greaves, email: [jane.greaves@canterbury.ac.uk](mailto:jane.greaves@canterbury.ac.uk) or telephone 01227782343. Should you decide to participate, you will need to complete a brief expression of interest form but will be free to withdraw at any time without having to give a reason

## Appendix 4 End of module evaluation

### CANTERBURY CHRIST CHURCH UNIVERSITY END OF MODULE (HEALTH) QUESTIONNAIRE

Module:	Date:
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Please complete this questionnaire by ticking the box, which most readily corresponds to your feelings or opinions about this module.

1.	ACHIEVEMENT OF AIMS	Strongly Agree 5	Agree 4	Unsure 3	Disagree 2	Strongly Disagree 1
a.	The module made a positive contribution to my understanding of <b>Mindfulness</b>					
b.	Learning outcomes were clearly stated and addressed					
2.	<b>MODULE CONTENT</b>					
a.	The issues were dealt with in sufficient depth					
b.	The module was well organised					
3.	<b>LEARNING AND TEACHING</b>					
a.	The teaching was clear, informative and effective					
b.	The Mindfulness information was helpful					
c.	The library resources were adequate for the requirements of the module					
d.	Podcast resources were adequate for the requirements of the module					
e.	The e-learning resources signposted to were adequate for the requirements of the module					
4.	<b>TEACHING GUIDELINES</b>					
a.	The teaching guidelines were informative and clear					
b.	The teaching was appropriate to the learning outcomes					
5.	<b>SUPPORT AND SUPERVISION</b>					
a.	Tutorial support was readily available					
b.	I was provided with constructive feedback on developing my <b>Mindfulness</b> practice					
6.	<b>EVALUATION</b>					
a.	The overall procedures were appropriate					
b.	I was provided with constructive feedback on developing my mindfulness practice					
7.	<b>ACHIEVEMENT OF MINDFULNESS PRACTICES</b>					
a.	The practice competencies reflect the learning outcomes					
b.	The use of practice competencies enhanced my practice					

**ANY FURTHER COMMENTS**

**1. Three things you liked about the mindfulness sessions**

**2. Three things you liked least about the mindfulness**

**3. Where are you on your mindfulness journey**

**4. Other reflections or comments – related to your role as a PT**

**5. Three things you liked about classroom activities**

**6. Three things you have liked least about the classroom activities**

**7. Please comment on any support you have or not from other participants**



Qualitative information from end of module evaluation	Themes
<b>Three things you liked about the Mindfulness sessions- all the headings in this column in bold</b>	<p><b>Learning:</b> a new skill &amp; an aid to reflection, to learn with likeminded people Learning to embrace something so uniquely powerful</p> <p><b>Facilitation:</b> Calm and effective delivery with Jean herself is a brilliant advocate and teacher She was so approachable &amp; encouraging Facilitators style and approach</p> <p><b>Practice:</b> The mindfulness session each evening was brilliant Helped to enhance my focus Brought me to the here and now Using my skills to remain calm and professional Time for me particularly liked body scans</p> <p><b>Self-fulfilment:</b> Focusing on myself to care so that I can better care for others The protective time to explore my thoughts and feelings Opportunity to add skills and tools for my emotional health and aware of xx (illegible)</p> <p><b>The group:</b> Group interactions and sharing of experiences</p> <p><b>Paperwork and organisation:</b> Clear objectives of what would be delivered at each sessions The weekly handouts were useful and slowed insightful reflection, Thee paperwork was excellent</p>
<b>Three things you liked least about the Mindfulness sessions</b>	<p><b>The venue:</b> Too noisy for me personally x 3; and distance quite a long distance after a long day</p> <p><b>Timing and tiredness:</b> Timing 7-9 not good would have preferred to have sessions start at 5,30 pm; Main problem was trying to concentrate when you have been working since 8am and really had no break before it started at 7pm &amp; feeling tired after a long day at work and at the end of a long day <b>Evoked feelings:</b> sometimes these were painful Time of the sessions (following a long working day) <b>Some people in the group were dominant</b></p>
<b>Where are you on your Mindfulness journey?</b>	<p><b>Feeling positive:</b> looking forward to embedding this technique into more of my life as it increases calm and my stress and like the body scan &amp; recognise the positive impact of practising mindfulness but need to actively practice more!</p> <p><b>Need to practice more:</b> Using effectively I am able to set aside time daily and understand it but I still feel I compartmentalise it – and do not sue it effectively in my daily life automatically, and feel more confident to utilise but knowing I ned to spend d more time 'practising' to become more proficient</p>
<b>Other reflections or comments – related to your role in Practice Teaching</b>	<p><b>Students:</b> Useful to help students manage anxiety and self-doubt Would love the students to have this course but as an academic year course. This cannot nor should it be considered a quick fix 'taster' it must be nurtured and developed Using thoughts and feelings to aid self-awareness and reflective activity with my students</p> <p><b>Practice teacher role:</b> I am no longer a PT but have used mindfulness to maintain a calm manner in my new role. I have been able to consider how others are not always able to demonstrate mindfulness It helps me manage the role of the PT with all the difficulties that involved rather than being able to teach it to others- I feel I am too new in my journey to do that yet</p> <p>Very useful in helping to maintain a calm and positive approach in practice where the learning environment is a challenge</p> <p><b>Situations:</b> Recognise that most of the time I am more mindful in my response to situations/events rather than automatic response. I approach particular people in a calmer manner</p>
<b>Three things I have liked about the classroom activities</b>	<p><b>Sharing experiences</b> and hearing the impact of practice on others and Spending time with colleagues other than at work and their feedback</p> <p><b>Mindfulness exercises and practices</b> Visualisation techniques x2 Reinforcing thoughts and practice</p> <p><b>The voice of Jean Watson-thank you</b></p> <p><b>Ample time for discussion, Size of group was comfortable and Feeling of progress being made at each session</b></p> <p><b>The variety of activities</b> enabled all participants to find their own way</p>
<b>Three things I have liked least about the classroom activities</b>	<p><b>Time to commit</b> and feeling guilty if not completed and feeling pressurised to commit and being too tired by the evening to participate fully</p> <p><b>Room</b> gets hot, noisy interfered with me as well as the lighting</p> <p><b>Activities</b> I did not particularly like all the activities e.g. Walking sessions</p> <p><b>Group dynamics</b> Sometimes I was unwilling to open up in front of colleagues The moaning</p>
<p><b>Please comment on any support you have or not from other participants</b></p> <p><b>Group moaning</b></p> <p><b>Good peer support</b> used to discuss mindfulness and what it means to individuals</p> <p>Support in the workplace &amp; beneficial to see others in work and bounce ideas and experience off this has helped the quality of the experience outside the formal sessions</p>	

## Appendix 6 Perceived Stress Scale – PSS

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress based on 10 questions and takes about 5-10 minutes to complete. It is a measure of the degree to which situations in one's life are appraised as stressful. Items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. The scale also includes a number of direct queries about current levels of experienced stress. The PSS was designed for use in community samples with at least a junior high school education. The items are easy to understand, and the response alternatives are simple to grasp. Moreover, the questions are of a general nature and hence are relatively free of content specific to any subpopulation group. The questions in the PSS ask about feelings and thoughts during the last month. In each case, respondents are asked how often they felt a certain way' (Cohen et al 1983).

### Perceived Stress Scale- 10 Item

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, please indicate with a check how often you felt or thought a certain way.

1. In the last month, how often have you been upset because of something that happened unexpectedly?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

2. In the last month, how often have you felt that you were unable to control the important things in your life?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

3. In the last month, how often have you felt nervous and "stressed"?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

5. In the last month, how often have you felt that things were going your way?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

8. In the last month, how often have you felt that you were on top of things?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

9. In the last month, how often have you been angered because of things that were outside of your control?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

\_\_\_0=never      \_\_\_1=almost never      \_\_\_2=sometimes      \_\_\_3=fairly often      \_\_\_4=very often

## Appendix 7 Self-Compassion scale

Neff (2003) has developed the self-compassion scale (SCS) The positively and negatively worded items in the self-compassion scale are intended to tap into the three main components of self-compassion (self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification).

'The Self-Compassion Scale is a psychometrically sound and theoretically valid measure of self-compassion. Results also indicate that having high levels of self-compassion is linked to psychological well-being, without being associated with narcissistic tendencies in the way that high self-esteem appears to be' (Neff 2003).

### 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<br>never<br>1 | 2 | 3 | 4 | Almost<br>always<br>5 |
|-----------|----------------------|---|---|---|-----------------------|
| _____ 1.  |                      |   |   |   |                       |
| _____ 2.  |                      |   |   |   |                       |
| _____ 3.  |                      |   |   |   |                       |
| _____ 4.  |                      |   |   |   |                       |
| _____ 5.  |                      |   |   |   |                       |
| _____ 6.  |                      |   |   |   |                       |
| _____ 7.  |                      |   |   |   |                       |
| _____ 8.  |                      |   |   |   |                       |
| _____ 9.  |                      |   |   |   |                       |
| _____ 10. |                      |   |   |   |                       |
| _____ 11. |                      |   |   |   |                       |
| _____ 12. |                      |   |   |   |                       |
| _____ 13. |                      |   |   |   |                       |
| _____ 14. |                      |   |   |   |                       |
| _____ 15. |                      |   |   |   |                       |
| _____ 16. |                      |   |   |   |                       |
| _____ 17. |                      |   |   |   |                       |
| _____ 18. |                      |   |   |   |                       |
| _____ 19. |                      |   |   |   |                       |
| _____ 20. |                      |   |   |   |                       |
| _____ 21. |                      |   |   |   |                       |
| _____ 22. |                      |   |   |   |                       |
| _____ 23. |                      |   |   |   |                       |
| _____ 24. |                      |   |   |   |                       |
| _____ 25. |                      |   |   |   |                       |
| _____ 26. |                      |   |   |   |                       |



Appendix 8 Five Facet Mindfulness Questionnaire (FFMQ)

The Five Facet Mindfulness Questionnaire is a 39 item measure consisting of five subscales (observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience). It is used to give a measure of the mindfulness training. (Baer et al 2006) Each of these measures can be considered on their own or as part of the overall FFMQ result (Baer et al 2008). Please note the individual facets and the overall facets in the results table.

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

- \_\_\_ When I'm walking, I deliberately notice the sensations of my body moving.
- \_\_\_ I'm good at finding words to describe my feelings.
- \_\_\_ I criticize myself for having irrational or inappropriate emotions.
- \_\_\_ I perceive my feelings and emotions without having to react to them.
- \_\_\_ When I do things, my mind wanders off and I'm easily distracted.
- \_\_\_ When I take a shower or bath, I stay alert to the sensations of water on my body.
- \_\_\_ I can easily put my beliefs, opinions, and expectations into words.
- \_\_\_ I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
- \_\_\_ I watch my feelings without getting lost in them.
- \_\_\_ I tell myself I shouldn't be feeling the way I'm feeling.
- \_\_\_ I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
- \_\_\_ It's hard for me to find the words to describe what I'm thinking.
- \_\_\_ I am easily distracted.
- \_\_\_ I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
- \_\_\_ I pay attention to sensations, such as the wind in my hair or sun on my face.
- \_\_\_ I have trouble thinking of the right words to express how I feel about things.
- \_\_\_ I make judgments about whether my thoughts are good or bad.
- \_\_\_ I find it difficult to stay focused on what's happening in the present.
- \_\_\_ When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
- \_\_\_ I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.

\_\_\_ In difficult situations, I can pause without immediately reacting.

\_\_\_ When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.

**Page 2**

1	2	3	4	5
never or very rarely true	rarely true	sometimes true	often true	very often or always true

\_\_\_ It seems I am "running on automatic" without much awareness of what I'm doing.

\_\_\_ When I have distressing thoughts or images, I feel calm soon after.

\_\_\_ I tell myself that I shouldn't be thinking the way I'm thinking.

\_\_\_ I notice the smells and aromas of things.

\_\_\_ Even when I'm feeling terribly upset, I can find a way to put it into words.

\_\_\_ I rush through activities without being really attentive to them.

\_\_\_ When I have distressing thoughts or images I am able just to notice them without reacting.  
\_\_\_ I think some of my emotions are bad or inappropriate and I shouldn't feel them.

\_\_\_ My natural tendency is to put my experiences into words.

\_\_\_ When I have distressing thoughts or images, I just notice them and let them go.

\_\_\_ I do jobs or tasks automatically without being aware of what I'm doing.

\_\_\_ When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

\_\_\_ I pay attention to how my emotions affect my thoughts and behaviour.

\_\_\_ I can usually describe how I feel at the moment in considerable detail.

\_\_\_ I find myself doing things without paying attention.

\_\_\_ I disapprove of myself when I have irrational ideas.

\_\_\_ I notice visual elements in art or nature, such as colours, shapes, textures, or patterns of light and shadow.

**Canterbury Christ Church University**  
**Post Evaluation of Mindfulness Training**  
**Practice Teachers**  
**September–December 2014**

*Please specify if your comments as necessary*

**What three things have you found most helpful since attending the Mindfulness training in October 2014?**

- 1.
- 2.
- 3.

**What three things have you found less helpful about Mindfulness training since attending?**

- 1
- 2.
- 3.

**What are you learning about yourself and your role by attending the Mindfulness training?**

- 1
- 2.
- 3.

**Please type any other comments and feedback on another side of document please return electronically**

## Appendix 10 Results of follow up questionnaire March 2016

<b>Themes</b>	<b>What three things have you found most helpful since attending the Mindfulness training in October 2014?</b>
<b>Clients &amp; Students</b>	<ul style="list-style-type: none"> <li>• <i>Using strategies in practice with clients as well as students</i></li> <li>• <i>Using strategies in practice with clients &amp; This has enabled me to be more aware of how thoughts affect my feelings that in turn, lead to a calmer attitude as I am more in control of both</i></li> </ul>
<b>Personal , Private &amp; professional: positive energy</b>	<ul style="list-style-type: none"> <li>• <i>.... using mindfulness in my private life</i></li> <li>• <i>I have made a conscious effort to observe my thought patterns &amp; enabled me to be more aware of how thoughts affect my feelings that in turn; calmer attitude as I am more in control of both</i></li> <li>• <i>less madly busy, more contemplative and hopefully, more productive</i></li> <li>• <i>I have learned that my mind is a positive energy that keeps the rest of me well. I feel comforted and strong in having this skill.</i></li> <li>• <i>I feel very different about myself. I no longer berate myself or feel I don't "Fit in". I now have lots of positive regard for myself and know I am a worthwhile human being and deserve respect and love.</i></li> <li>• <i>A way of life: Honestly, mindfulness for me, cannot be considered less helpful in life</i></li> </ul>
<b>At work</b>	<ul style="list-style-type: none"> <li>• <i>I no longer pressure myself to get things done for example, lists of tasks that have to be done. I will pick the most important one and do that, instead of feeling a failure because I did not exhaust myself to finish the list.</i></li> <li>• <i>Taking time out at work having a break&amp; allowing myself time to reflect and take stock of my immediate surroundings&amp;</i></li> <li>• <i>Body scanning to check in &amp; it has increased my resilience in times of stress and chaos and prepare for any event I am facing</i></li> </ul>
	<b>After work: <i>Deciding to take more physical exercise and return to yoga</i></b>
	<b>What three things have you found less helpful about Mindfulness training since attending?</b>
	<b>Nothing:</b>
	<ul style="list-style-type: none"> <li>• <i>Nothing really, it was all helpful; Difficult because the course has had a powerful effect on me;</i></li> <li>• <i>Essentially it wasn't not helpful</i></li> </ul>
	<b>Guilt ;sharing, managing &amp; peer support:</b>
	<ul style="list-style-type: none"> <li>• <i>I miss the sharing of how we managed mindfulness as a group; peer support was really helpful.</i></li> <li>• <i>I feel sad that others haven't had the opportunity to share in our training.</i></li> <li>• <i>I still frequently forget to put it into practice. In its purest form I am not practicing it however it has helped me re engage with things that do help me and I had abandoned</i></li> </ul>
	<b>What are you learning about yourself and your role by attending the Mindfulness training ?</b>
	<b>Competency Containing students and clients</b>
	<ul style="list-style-type: none"> <li>• <i>That I was using mindfulness in a unconscious competent manner.</i></li> <li>• <i>Now aware of my mindfulness as a positive aspect of my practice and life</i></li> <li>• <i>[ conscious competent]</i></li> <li>• <i>Using it to help contain both students and client's emotions by reflecting on thoughts on actions and the effect on behaviour.</i></li> <li>• <i>I am able to concentrate on the "Hear and Now" which helps with listening and responding skills with clients.</i></li> </ul>
	<b>Accepting of self: remove emotion from situation</b>
	<ul style="list-style-type: none"> <li>• <i>That I am accepting of who I am. I am at peace with myself and feel more available to others. A knock on effect has been that I have been much more confident in myself and made more friends and my social life is busier than ever.</i></li> <li>• <i>I have learned to be much more accepting of myself; that it is ok to be as I am, not to beat myself up about this. However, I feel; that's ok.</i></li> <li>• <i>This is very releasing and takes the emotion out of the situation, for some reason.</i></li> <li>• <i>I have learnt that negativity is a time consuming emotion. I would rather be doing other things. I can block negative thoughts and know that is all they are, thoughts.</i></li> </ul>

### Other comments and feedback:

*Thank you for giving me the opportunity to attend the course. Although I don't follow the mindfulness ethos to the full, I have positively modified it to benefit me [ as stated before] in both my professional life and personal*

*I am aware that there is so much more that I can learn about this and I really want to. I have since attended a weekend that was advertised 'A time to pause – mindfulness techniques'. It was not as helpful as the 8 sessions we did at Christchurch and when I spoke of what I had learned,*

*other attendees said that this sounded a much better method, as it allowed a build-up of habitual techniques. I really appreciate what I learnt as it built on my practice*

*I struggle to know how to integrate this into the student arena, how to allow others to benefit from it. It feels like a personal thing that I do and that others do not really understand. This can be a little frustrating, but I do discuss it as a tool for management of depression with clients and have had some positive feedback from this. Somehow, because the PT/SCPHN relationship has the risk of being very close, I avoid sharing personal things with the student, and this feels like such a thing, so have not used it with the students yet*

*Thank you very much for providing us the opportunity to do this course. I have appreciated it and am determined to progress further with it.*

*Overall, although I do not think pure mindfulness is right for me it has helped me as stated above. I find I am generally just more "mindful" about lots of things.*

*Thank you for allowing me to participate in this life skill. I feel honoured to have been part of the innovative work provided by the CCCU.*

*My mood is balanced and my ability to manage stressful situations, others' challenges and our over complicated lifestyles is enhanced by gently reminding my mind not to get tangled up but listen to my breath and follow its calm, measured path in and out.*

*I still listen to the recorded sessions and have purchased a Nepalese meditation bell and chanting music, which is addictive.*

**Appendix 11 Student progression of PTs attending Mindfulness course**

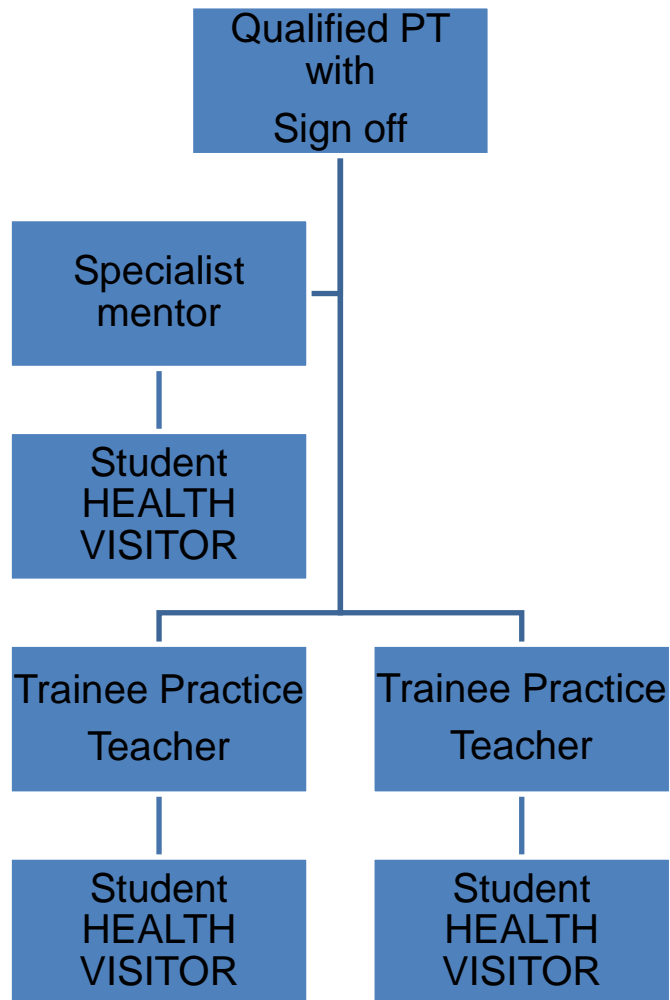
Practice Teacher code KCHFT	PT1	PT2	PT3	PT4	PT5	PT6	PT7	PT8	PT9(SN)
Number of students	2	3	1	3	None	2	3	None	1
Student progress	1 poor progress and extended time on programme  1 completed successfully	1 DNS assignments  1 – wrong career choice  1 completed successfully	Withdrew very early- family problems & bereavement	1 poor progress & moved placement did not pass practice (NMC 2008)  1X 'struggling' & WITHDREW  1 successfully completed		1 successfully completed on extension from 2013-14 1 did not return from interruption (family mental health)	2 completed successfully 1 interrupted due to mental health and well being		Successfully completed
Practice Teacher code MCH	PTM1		PTM2		PTM3		PTM4	PTM5	
Number of students	NONE		3		3		NONE	2	
Student progress			2 completed successfully 1 withdrew mental health/family issues		1 successfully completed 1 withdrew wrong career choice 1 poor progress academically and in practice			2 successfully completed	

**Appendix 12 Student PT Models**

**Medway Community Trust and Kent Community Health Trust.**

The following flow charts demonstrate the models the Stakeholder Trusts applied to placement learning and is specifically designed to reflect individual PT workloads in line with the NMC Guidance 8/20

Medway Community Health care PT/mentor /student placement model example September 2012



**Kent Community Health NHS Trust Model for Practice Teacher and SCPHN Students**

**Practice Teachers**

Will be responsible for 3 students where possible and can include a number of variations, including the examples as outlined below

**PT with own SCPHN Student and one of the following scenarios**

