The Integration of Mindfulness Groups into a Psychological Therapies Service

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Summary

The paper describes how mindfulness training fits into a matched care system in a NHS primary care psychology service. The mindfulness courses were evaluated and appear to be effective in reducing depression and anxiety.

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Mindfulness is derived mainly from traditional Buddhist meditation practices (e.g. Hanh, 2008) which have been reframed in a secular context as a therapy for psychological and physical problems. Mindfulness-based Cognitive Therapy (MBCT) is becoming increasingly used in mental health settings, while Mindfulness-based Stress Reduction (MBSR) - on which MBCT is based and which has about 90% content in common with MBCT – is also being in used in both physical and mental health settings. The cognitive component of MBCT is teaching about the role and effects of negative automatic thoughts. The usual format of both MBCT and MBSR is eight weekly group sessions with daily homework practice. This eight week practice period helps participants to gain sustained and direct experience of a different way of relating to thoughts, feelings and physical sensations. In essence, this involves accepting these as part of a constantly changing moment-to-moment reality rather than either trying to either avoid or become enmeshed with them, using (for a fuller description see Kabat-Zinn, 2001 and Williams *et al.,* 2007). As this process is relevant to any form of distress, basically the same course format is used whatever the nature of the presenting problems and it is, therefore, possible to have mixed groups of clients on a single course, or a mixture of clients and staff. Staff can use it for themselves or as the first step towards becoming a mindfulness teacher. For health professionals in Scotland, teacher training is a process taking a minimum of one year and involving ongoing personal practice.

MBCT is a recommended treatment in the NICE Guideline for Depression, based on two randomised controlled trials which demonstrate a reduction of

the recurrence of depression by 55% over 12 months in people with 3 or more depressive episodes (Teasdale *et al*., 2000; Ma & Teasdale, 2004). Other evidence suggests that MBCT can be effective in treatment-resistant depression (e.g. Kenny & Williams, 2007), general anxiety & panic disorder, (Miller et al., 1995; Lee *et al*., 2007), chronic fatigue syndrome (Surawy *et al*., 2004) and that MBSR is helpful to people with psychological stress arising from physical health problems (Kabat-Zinn *et al.*, 1998; Witek-Janusek *et al*., 2008). In another study, 47% of people who chose to learn MBSR in the context of their individual psychotherapy terminated their therapy within the 6 months following the group, compared to only 6% of patients who did not choose to learn it. MBSR participants reported a strong positive impact of mindfulness and had higher ratings of goal-achievement than those having only individual therapy (Weiss *et al*., 2005).

In NHS Forth Valley, mindfulness has been routinely used in the Primary Care Service as in a group format over the past nine years, with over 200 participants completing the programme. In this article we describe how mindfulness operates within a psychological therapies system and report an evaluation of participant outcomes.

Mindfulness courses are offered as part of a matched care system for common mental health problems which also includes web-based self-help (www.moodjuice.scot.nhs.uk), computerised CBT (Beating the Blues) and individual therapy. For people with mild or moderate problems, GPs make extensive use of the Moodjuice downloads and can refer directly to Beating

the Blues. GPs can also refer to local counselling services. For people with more complex problems, which do not require community mental health team intervention, referral can be made to the Primary Care Psychology Service and the mindfulness course is open to people who have been accepted for treatment by this service. People initially offered mindfulness therapy are those with anxiety and depression who are regarded, on the basis of the referral letter, as being too complex for stand-alone computerised CBT but not necessarily requiring individual therapy with a clinical psychologist. Complexity is assessed by the presence of problems in addition to psychological symptoms e.g. physical problems, or a recurring pattern of depression or anxiety. Clients deemed suitable are sent a letter describing the three options from which they can make once choice:

- go straight on the waiting list for individual therapy
- an “enhanced” Beating the Blues intervention consisting of an individual assessment appointment and a follow-up interview
- the mindfulness course.

The letter clarifies that the last two options can be followed by individual therapy if necessary. People who opt for mindfulness are then seen for an individual assessment and offered the group if it is appropriate. People with complex problems who are receiving individual therapy can also attend the course either in parallel or as a follow-on. Most groups also have 2 or 3 staff members who attend for training out of personal and professional interest (these individuals were not included in the evaluation below).

The Mindfulness programme consists of 7 two-hour weekly evening sessions plus a six-hour Saturday workshop towards the end of the course. It is run by two experienced mindfulness practitioners. The format is essentially educational, with course leaders teaching the practices and giving short talks. It also includes small group discussion of issues arising from practice each week (except for session 1). The format is a combination of MBCT and MBSR and up to 35 people are invited to each course, which is run twice a year. Participants can also bring a supportive friend or relative, providing they are willing to participate. Typically 25 people attend the first session and 15-20 complete the course. These figures are very similar to the CBT-based psychoeducational groups we have also run (White,1998). At the last session, participants are invited to contact the service within six weeks if they wish to have individual follow-up. In practice few people take this up. Participants completing the programme are invited to the Saturday workshops of subsequent courses, allowing indefinite follow-up contact.

One reason an 8-week course is necessary is that there is a period about half way through the course when participants typically feel challenged by letting go of attempts to inwardly manipulate feelings. By the end of the course, however, people often feel they have a way of being grounded – and more peaceful - within difficult emotions and situations as well as having a greater appreciation of everyday life. Sometimes, it is only with continuing practice after the end of the course that a person feels the usefulness of the approach.

Allowing for set-up time, each course takes around 60 hours of therapist time (both therapists combined). This is the equivalent of around 7 sessions courses of individual therapy, based on eight sessions per client. Training in teaching mindfulness is essential for the course leaders and these figures do not include the time required for this initial training.

Evaluation: Comparison of Mindfulness and CBT Courses

The mindfulness courses were evaluated by a comparison with the CBT-based Stress Control (SC) (White,1998) groups run by our service. This aimed to assess whether either intervention was more effective at reducing levels of self-reported stress, anxiety, and depression. Two measures were used for evaluations. The Hospital Anxiety and Depression Scale (HADS) is a well-validated and easily administered scale which independently measures anxiety and depression (Zigmond & Snaith, 1983). The Perceived Stress Scale (PSS, Cohen & Williamson, 1988) was also used, as it has been shown to measure the subjective appraisal of stress, which is consistent with the experiential nature of the mindfulness course. However, the PSS is not designed to capture the core experience of mindfulness, and to attempt to do so was felt to be outside the scope of the present study, especially given the presence of a CBT-based comparison group. The scales were administered at the following three points:

- Pre-intervention (PI)
- End of the course (EC)
- 6 months post-intervention follow-up (FU)

Twenty-four, twenty-two and nine people from the SC group completed the assessments at PE, EC and FU respectively. For the mindfulness course, the corresponding figures were 25, 24 and 15.

Results of Evaluation

Preliminary analysis revealed that the data was not normally distributed. Accordingly, non-parametric statistical tests were used to compare the effectiveness of the groups. For the purposes of between group comparison, index scores (PI-EC/PI and PI-FU/PI) were calculated for participants' scores on each measure. This was done in order to account for possible confounding effects resulting from differences in the baseline scores of the two groups. The index scores were then entered as the dependent variable in the subsequent analyses.

The within-group analysis of change scores from PI-EC was conducted using Wilcoxon matched-pairs tests. These revealed a statistically significant decrease at the $p<0.01$ level for anxiety, depression, and stress for both groups from baseline to end-of-course. Between group analysis was conducted using Mann-Whitney tests which revealed a significant difference in PI-EC change scores in favour of the mindfulness group on all the measures: HADS anxiety ($z=2.86$, $p<0.01$), HADS depression ($z=2.25$, $p<0.05$), and PSS ($z=2.25$, $p<0.05$).

Within group analysis of the PI-FU change scores showed that the significant decreases in HADS anxiety ($p<0.01$) and depression ($p<0.01$) seen at EC were maintained by both groups at 6 month follow-up. However, the significant decrease in PSS levels only remained significant for the mindfulness group ($p<0.01$). Between groups analysis of PI-FU change scores revealed that there was no longer a significant difference between the two groups on any of the measures.

Discussion

Traditionally, psychological therapy services have been organised around individual therapy and it has not always been easy to integrate group work in a sustainable way. There are a number of possible reasons for this, including perceived lack of cost-effectiveness and increased administrative workload. Our mindfulness courses address these issues in the following ways. First, the large size of the groups tends to make them cost-effective in terms of therapist time. An alternative but equally efficient approach would be to have a smaller group size with one therapist instead of two. This is the approach used by MBCT, where typically there is one therapist to 12 participants. Second, our courses minimise secretarial and therapist time by using standard letters (apart from the assessment letter) at the end of the course or if a client drops out. Nonetheless, the decision to run a course should result in more people receiving a service with an increase in record keeping and telephone enquiries as well as in the production of written materials, CD copying (for the guided practices) and entry of evaluative data. Extra therapist

and administrator time should therefore be allocated, particularly for the first group in order to establish an efficient system.

This evaluation suggests that mindfulness compares well with CBT psychoeducational courses. It is encouraging that the improvements from these relatively short interventions appear to be sustained over a longer-term follow-up. This sustained effect is consistent with the RCTs of MBCT for depression mentioned above, where the relative reduction in depression relapse was over a 12 month follow-up (Teasdale *et al*., 2000; Ma & Teasdale, 2004). Similarly, Miller *et al.* (1995) found that, for MBSR, improvement in anxiety symptoms compared to pre-intervention was sustained at 3 years, with 83% of course completers reporting still using mindfulness regularly at that time.

These longer-term outcomes highlight some specific features of mindfulness as a therapy. Participants are being taught a new way of relating to life in general as well as an improved ability to manage their own distress. For many participants, the course can be seen as the start of a process that continues long-term. Related to this is the non-problem and non-diagnostic focus of the training. Many people who would not be regarded as having mental health problems have found benefit from meditation generally and continue to use it long-term. This helps to make mindfulness training a relatively non-stigmatising intervention which has potential for community-level intervention (Williams *et al*., 2001).

Our experience has shown that mindfulness courses can become an effective component of a matched-care psychological therapies service, which is valued as a resource by therapists as well as clients. The main requirements for effective implementation, as described above, are adequate planning, attention to cost-effectiveness, administrative resources, and therapist training. The final requirement is the support of managers , but this is more likely to be forthcoming if the other conditions are fulfilled.

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