Wales Survey Report

This project aimed to assess the impact on health professionals of the introduction of the Positive Mental Training (PosMT) workshops and resources in South Wales.

Three validated, self completed questionnaires were chosen to measure well-being, burnout and attitudes. These questionnaires were completed prior to the first workshop and then followed up six months later.

34 individuals were involved in the initial questionnaire during March 2012 and 18 of these individuals completed the follow up questionnaire six months later, between September and October 2012.

Methods

The 3 questionnaires were the Warwick and Edinburgh Mental Health Well-Being Scale (WEMWBS), Maslach Burnout Inventory (Human Services Survey, MBI-HSS) and the Depression Attitude Questionnaire (DAQ), Section 3).
As the data set was small and did not fit the requirements of normal distribution (Right hand skew, Figure 1) a non-parametric permutation test, with 1000 replications, was used to test for significance in stage 1 and 2.

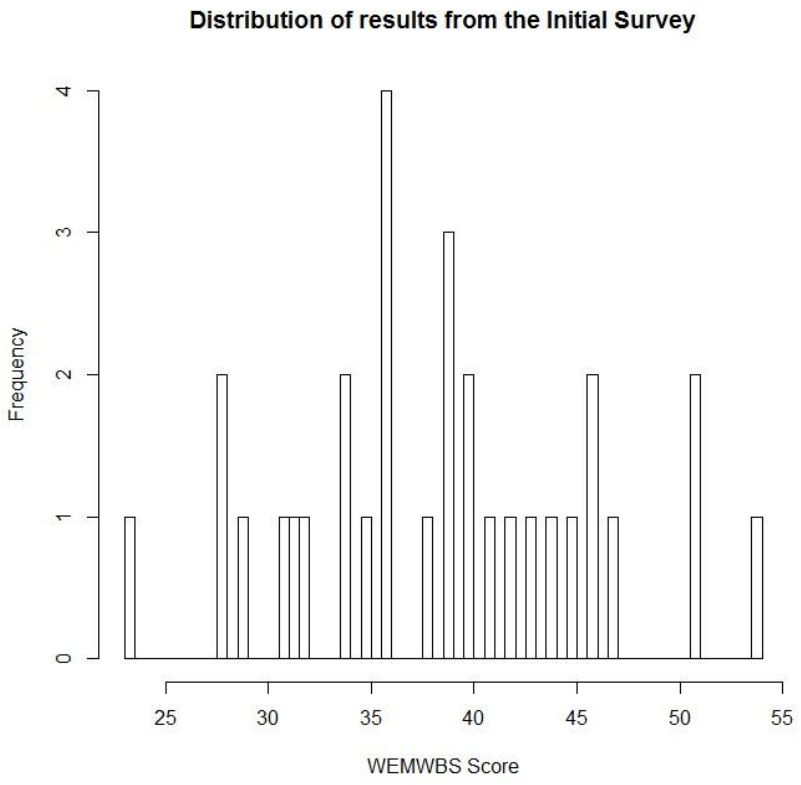

Fig.1 The above figure shows the distribution of different scores for the WEMWBS of the first survey. It should be noted that only the first survey is displayed as the second survey has too small a sample size to be considered for parametric tests.

Results

The number of individuals who completed the initial and follow up surveys can be seen below.

Profession	Initial Survey	Follow up Survey
Total	31*	18
Doctors	12	8
Nurses	13	8
Counsellors	5	2

Table.1 Number of participants that completed each survey. The total number of participants from the initial survey has a star as one individual did not give their profession.

WEMWBS

The statistical testing on the WEMWBS showed a significant change, with a mean difference of 15.55, between the start and follow up questionnaire scores. The results of individual professions were also tested and both doctors and nurses showed a statistically significant change. Counsellors were not tested due to insufficient data. A table showing the recorded figures and their standard error can be seen below

	Initial Survey Mean (SE)	Follow up Survey Mean (SE)	Mean Difference	Significance (P value)
All Professions	38.51 (1.32)	54.06 (1.72)	15.55	P<0.001
Doctors	35.83 (1.81)	53.13 (3.47)	17.29	P<0.001
Nurses	42.5 (2.47)	49.63 (3.62)	14.77	P<0.001

Table.2 Results of the WEMWBS and their standard error for both surveys.

Maslach Burnout Inventory

The classifications for different burnout scores can be seen below.

	Emotional Exhaustion (EE)	Depersonalization (DP)	Personal Accomplishment (PA)
High	27 or over	14 or over	0 to 30
Moderate	17 to 26	9 to 13	31 to 36
Low	0 to 16	0 to 8	37 or over

Table 3 MBI- HSS categories that different scores fall into.

The results of the burnout section of the surveys can be seen below.

	Initial Survey			Follow up Survey		
	EE	DP	PA	EE	DP	PA
All Professions	24.91	6.41	38.57	28.25	5.38	38.88
Doctors	30.83	9.5	38.25	29.5	6.25	31.13
Nurses	23.21	5.21	37.17	26	4.58	40.57
Counsellors	16.67	3	39.08	17	2	44.5

Table 4. Shows the average burnout scores obtained for each category by each group of professionals, as well as the average score across all professions, for both the initial and follow up surveys.

Statistical testing of all and individual professions showed no significance.

DAQ

A full list of the questions asked can be found in the appendix. Each person either agreed with the category by selecting the two most positive answers or disagreed by selecting an alternative. The results can be seen below

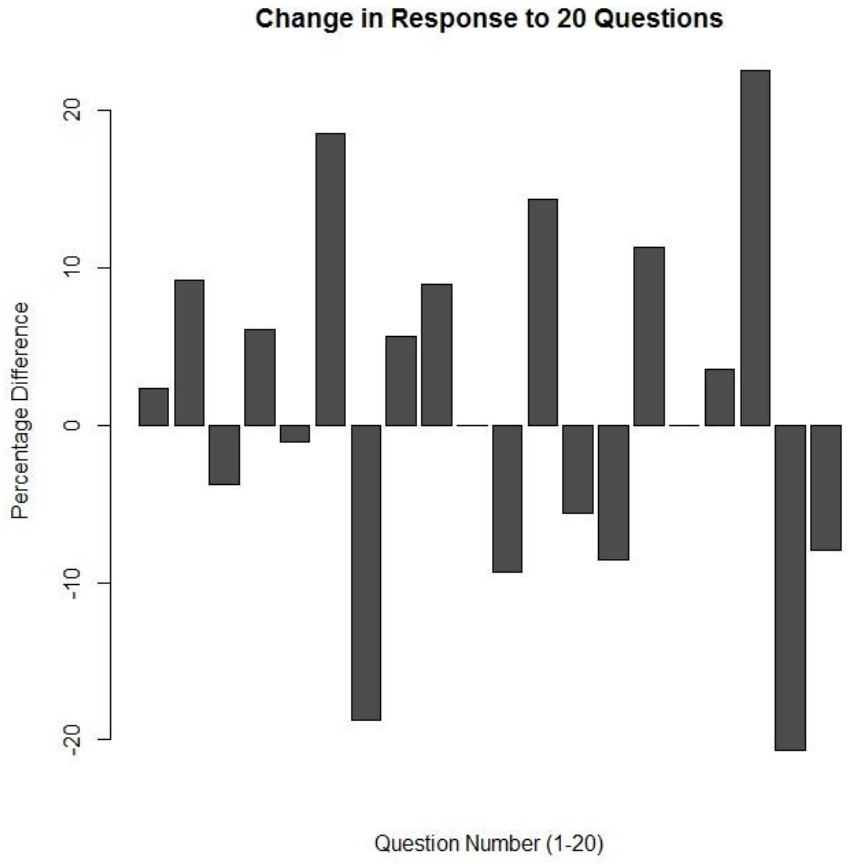

Fig. 2. The change in the individual item responses between the initial and follow up questionnaires. A positive difference shows the increase in the percentage of the group agreeing with a statement and a negative difference shows the increase in the percentage of the group disagreeing with a statement.

Discussion

WEMWBS

A significant improvement can be seen in the WEMWBS after the introduction of PosMT. Whilst there may have been other factors accounting for this (as there was no control group), this increase in wellbeing may well be due to the fact that training and access to using Positive Mental Training had had a positive influence on professionals as well as patients. This supports our previous course evaluations that many people attending training report coping better, see http://www.foundationforpositivementalhealth.com/wp-content/uploads/2011/10/Summary-Report-of-Online-Evaluation-of-Positive-Mental-Training-in-Halton-and-St-Helens.pdf .

The mean population WEMWBS score has been reported as 51 (95%CI 51-52). We can see that at the time of the first survey wellbeing was low compared to the national average but became higher than average at the second time point.

Burnout

Although no significant difference was found, it can be seen in table 4 that the doctors showed a positive improvement in all three categories, with their DP and PA scores going into new category levels on the second survey (from moderate to low DP and low to moderate PA).

DAQ

The statements with a large change (>15%) in their level of agreement were as follows:

S6: It is possible to distinguish two main groups of depression: one psychological and the other caused by biochemical mechanisms (Increase in agreement).

S7: Becoming depressed is a way that people with poor stamina deal with life's difficulties (decrease in agreement).

S18: Antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice (Increase in agreement).

S19: Psychotherapy for depressed patients should be left to a specialist (Decrease in agreement).

These results suggest that health professionals who use the programme feel that they have a better understanding of depression and how to treat it and feel confident that effective psychotherapy (in this case PosMT) does not have to be given and supervised by a specialist. This may indicate increasing self confidence, and also reflects the increase in personal efficacy increased observed in doctors. Interestingly the programme seems to strengthen the view that antidepressants are an effective way of treating depression, this could be seen as a positive outcome in that we do emphasise in our workshops that they have a very powerful placebo effect. It should be noted here that because somebody does not agree with a statement it does not mean they disagree. Also if somebody noted “I don't know” (this did not happen often but there were 3 instances) it was taken to not be an agreement. These factors, along with a small sample size could be under-estimating (or over-estimating) the candidates response.

The depression attitudes questionnaire (DAQ) is in a state of flux at the moment the questionnaire is being redesigned and I will feed back our findings to the committee doing this.

Appendix

Below is a list of all the twenty statements that participants were asked to state their agrrement with. Each statement had the following options as answers.
Totally agree
Slightly agree
Neither agree or disagree
Slightly Disagree
Totally Disagree
Don't Know

S1. During the last 5 years, I have seen an increase in the number of patients presenting depressive symptoms.
S2. The majority of depression seen in general practice originates from patients' recent misfortunes.
S3. Most depressive disorders seen in general practice improve without medication.
S4. An underlying biochemical abnormality is at the basis of severe cases of depression.
S5. It is difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder that needs treatment.
S6. It is possible to distinguish two main groups of depression: one psychological in original and the other caused by biochemical mechanisms.
S7. Becoming depressed is a way that people with poor stamina deal with life.
S8. Depressed patients are more likely to have experienced deprivation in early life than other people,
S9. I feel comfortable in dealing with depressed patients' needs.
S10. Depression reflects a characteristic in patients which is not amenable to change.
S11. Becoming depressed is a natural part of being old.
S12. The practice nurse could be a useful person to support depressed patients.
S13. Working with depressed patients is heavy going.
S14. There is little to be offered to those depressed patients who do not respond to what GPs do.
S15. It is rewarding to spend time looking after depressed patients.
S16. Psychotherapy tends to be unsuccessful with depressed patients.
S17. If depressed patients need antidepressants, they are better off with a psychiatrist than with a general practitioner.
S18. Antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice.
S19. Psychotherapy for depressed patients should be left to a specialist.
S20. If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed patients.