St Patrick's
Mental Health Services

Outcomes Report 2014

Annual Review of St Patrick's Mental Health Services' Outcomes.

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SECTION 1

Introduction

1. Introduction

This report presents outcomes relating to clinical care, clinical governance processes, clinical programmes and service user satisfaction rates, within St Patrick's Mental Health Services (SPMHS). It is the fourth of its type produced by SPMHS and is central to the organisations promotion of excellence in mental health care. By routinely measuring and publishing outcomes of the services we provide, we strive to understand what we do well and what we need to continue to improve. Where ever possible validated tools are utilised throughout this report and the choice of clinical outcome measures used is constantly under review, to ensure we are attaining the best possible standards of service delivery.

Leading healthcare providers around the world are capturing outcome measures for their treatments and making the results available through their websites, in order to enable service users and referrers to make informed choices about what services they access. Such transparency is essentially providing a report card for all to access. This level of transparency also informs staff and volunteers' regarding the outcomes of services provided and advances a culture of accountability for the services we deliver. It enables debate about what treatment modalities to deliver and crucially how best to measure their efficacy. The approach of openly sharing treatment outcome results has also been utilised by the Mental Health Commission in Ireland (Mental Health Commission, 2012).

The 2014 Report is divided into 6 Sections. Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPMHS are structured and were accessed in 2014. This includes how services are accessed through the hospital's three distinct entry points. SPMHS provides a community and outpatient care through its Dean Clinic Community Mental Health Clinics while the Wellness & Recovery Centre provides day-patient care. Finally, SPMHS's three approved centres provide our inpatient care. These include St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

Section 3 summarises the measures and outcomes of the organisation's Clinical Governance processes. Section 4 provides an analysis of clinical outcomes for a range of clinical programmes and services, a number of which have been added or enhanced since the 2013 Outcomes Report. This information provides practice-based evidence of interventions and programmes delivered to service users during 2014. These outcomes are not generated from research protocols but rather reflect the use and measurement of evidence-based mental health practice across SPMHS.

SPMHS considers service user participation and consultation to be a valued and integral aspect of clinical service development. Section 5 summarises the outcomes from a number of service user satisfaction surveys which assist the organisation in continually improving its services so that more people have a positive experience of care, treatment and support at SPMHS. In addition, these service user evaluations provide a method of involving and empowering service users to improve mental health service standards.

Finally, Section 6 summarises the Report's conclusions regarding the process and findings of outcome measurement within the organisation.

SECTION 2

Service Accessibility.

2. St Patrick's Mental Health Services

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our services are accessed through the hospital's three distinct entry points. These include our community care accessed through our Dean Clinic network of community mental health clinics, our day-patient care accessed through our Wellness and Recovery Centre and our in-patient care accessed through our three approved centres. This Section provides information about how our services were accessed through these entry points in 2014.

2.1. Dean Clinics

The SPMHS strategy, Mental Health Matters: Empowering Recovery (2013-2018), reinforces the organisation's commitment to the development of community mental health clinics. Over the past six years, a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the organisation. SPMHS operates a total of seven Dean Clinics. Free of charge multi-disciplinary mental health assessments continue to be offered through the Dean Clinic network to improve access to service users. A further Dean development took place in 2013 with the expansion of our community network now including a number of Associate Dean Clinics, where new assessments are carried out on behalf of SPMHS. There are 7 Associate Deans located in Kildare, Dublin and Belfast.

2.1.1. Dean Clinic Referrals Volume

Seven Dean Clinics have been established to date and provide multi-disciplinary mental health assessment and treatment for those who can best be supported and helped within a community setting and for those leaving the hospital's in-patient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community Mental Health Services, Day Services and Inpatient Care. The Dean Clinics encourage early involvement with mental health services which improves outcomes. In 2014, there was a total of 2,047 (including adolescents) Dean Clinic referrals received from General Practitioners. This compares with a total of 1,889 in 2013, representing an increase of 9.2% year on year. A summary of the annual referral totals made to Dean Clinics from 2009 to 2014 are included in the table below.

Year	2009	2010	2011	2012	2013	2014
Referral Totals	365	692	1376	1759	1,889	2,047

2.1.2. Dean Clinic Referral Source by County

The following table illustrates the geographical spread of Dean Clinic Referrals by county from 2011 to 2014 in ranked order of frequency by county . The highest referral volumes continued to be from Dublin in 2014 with 897 referrals. However, a small number of other counties showed growth in 2014 including Galway, Meath, Longford, Wicklow and a number of Northern Ireland counties also.

County	2011	2012	2013	2014
Dublin all postal codes	607	769	841	897
Cork	114	133	158	135
Kildare	98	115	132	146
Galway	76	113	113	129
Westmeath	54	71	52	48
Tipperary	49	61	57	48
Wicklow	41	52	39	54
Meath	52	54	53	101
Louth	41	52	66	72
Laois	17	34	28	43
Kerry	18	33	28	19
Offaly	23	31	33	41
Mayo	21	29	49	40
Limerick	21	27	27	24
Clare	20	24	32	34
Kilkenny	16	20	21	28
Waterford	14	20	25	24
Carlow	13	18	18	20
Wexford	23	17	32	32
Roscommon	13	18	10	18
Cavan	9	15	15	19
Sligo	9	10	13	18
Donegal	6	10	13	5
Monaghan	1	7	9	12
Leitrim	4	6	7	9
Longford	16	17	16	23
Tyrone	0	1	0	0
Derry	0	1	0	1
Down	0	1	2	0
Antrim	0	0	0	3
Fermanagh	0	0	0	2
England	0	0	0	1
Luxembourg	0	0	0	1
Unknown	12	0	0	0
Totals	**1376**	**1759**	**1889**	**2047**

2.1.3. Dean Clinic Referral Source by Province

The Table below summarises the proportion of Dean Clinic referrals by Province for 2011 to 2014. The proportion of Dean Clinic referrals from Connaught has shown an increase of 5.6% since opening in 2014, while Ulster continued at 2% of overall referral totals. The proportion of referrals from Leinster showed an increase of 2.8% in 2014 compared to 2013 but a 3% decrease over the 4 years since 2011.

Province		Leinster	Munster	Connaught	Ulster	Other
	2011	76.5%	16.3%	4.9%	1.5%	0.8%
	2012	76.0%	16.0%	6.0%	1.9%	0.0%
	2013	70.7%	16.8%	10.3%	2.1%	0.0%
	2014	73.5%	14.1%	10.5%	2.1%	0.0%
%Change since	**2011**	-3%	-2.20%	5.60%	0.60%	-0.80%

2.1.4. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic referrals for 2014 was 60% female to 40% male.

2.1.5. Dean Clinic Activities (2009-2014).

2014 was a busy year clinically across all Dean Clinics. The tables below summarise the volume of clinical activity across Deans including assessments and treatment appointment types.

The table below summarises the number of mental health assessments provided to new referrals across Dean Clinics over the last six year period.

Year	Dean Clinic New Assessments
2009	395
2010	573
2011	924
2012	1,398
2013	1,422*
2014	1,287*
Totals	**5,999**

* 2013 and 2014 New Assessments include Assessments carried out by Associate Dean Consultant Psychiatrists.

A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Psychiatrist and another member of the multidisciplinary team. An individual care plan is agreed with the referred person following assessment which may involve follow-on community-based therapy, a referral to a day-patient programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the person to make a full recovery through the most appropriate treatment and care.

The following table summarises the total number of outpatient appointments or visits provided across Dean Clinics nationwide from 2009 to 2014.

Year	Total No of Dean Clinic Appointments
2009	2,965
2010	5,220
2011	7,952
2012	12,177
2013	12,826*
2014	13,541*
Totals	**54,681**

*Includes Associate Dean Assessment appointments

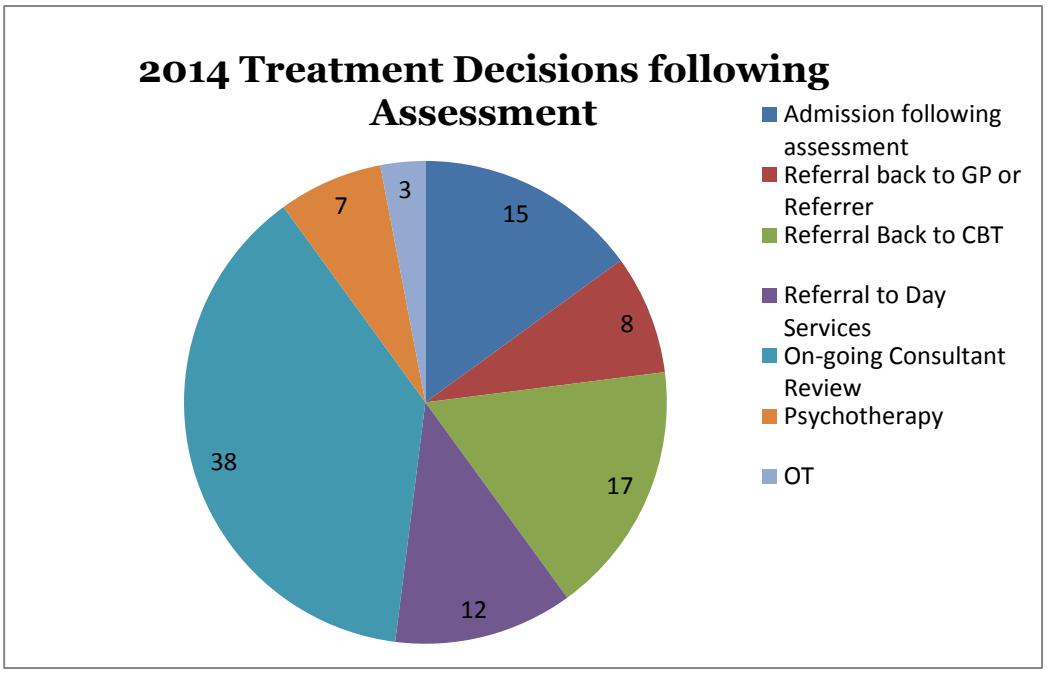
Dean Clinic referrals have increased year on year since 2008. Another indicator of demand is the actual number of mental health assessments. Of note, the number of assessments carried in 2014 was lower when compared to 2013. However, the overall volume of Dean Clinic appointments was higher than 2013, explained by an increased demand for treatment for the existing service user cohort.

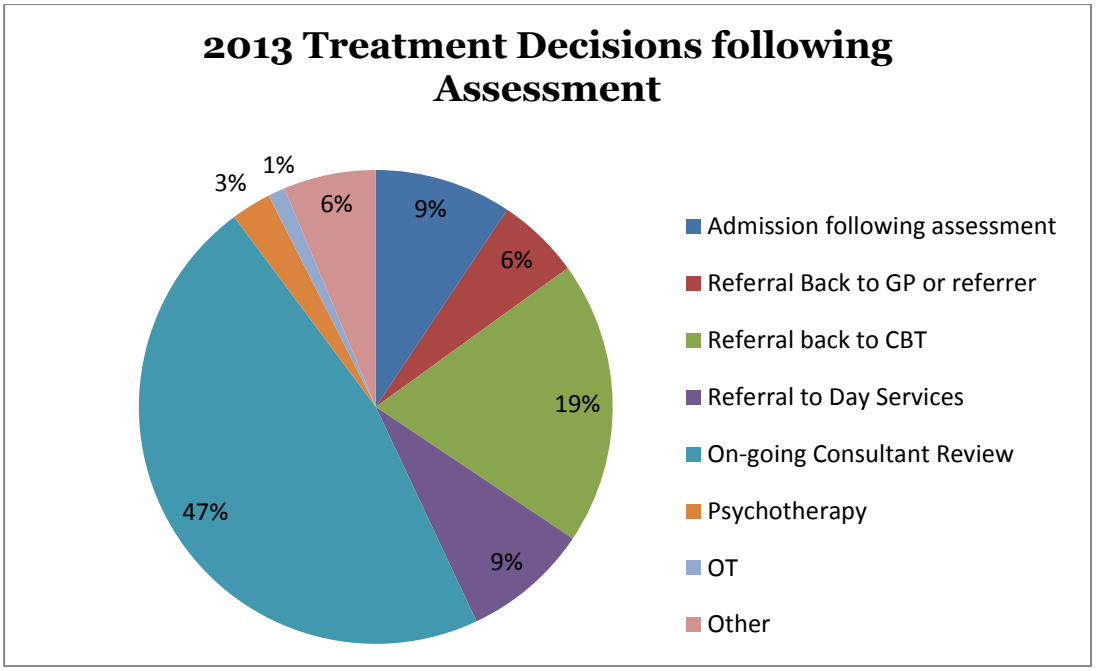
The table below summarises the ratio of referrals that convert into assessments (conversion rates), across the 7 Dean Clinics and Associate Dean Clinics. The highest conversion rate was in Cork at 103%. The conversion rate exceeded 100% in Dean Cork because a number of December 2013 referrals were assessed in 2014.

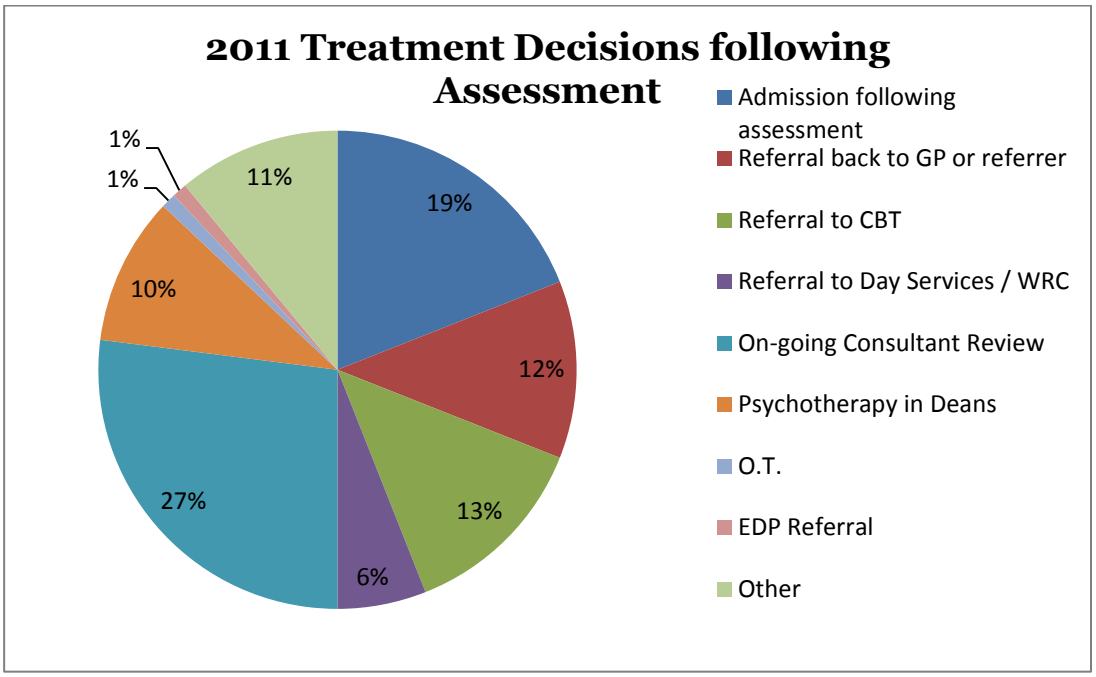
Dean Clinic Referral Conversion Rates			
Clinic	**No Referrals**	**No of Assessments**	**Conversion Rate**
Capel	222	123	55%
Donaghmede	166	136	82%
Lucan	70	68	97%
Lucan Adol	393	81	21%
Cork	150	154	103%
Sandyford	388	286	74%
Galway	204	166	81%
SPUH	145	84	58%
Glasnevin Assoc	53	43	81%
Naas Assoc	53	39	74%
Sandyford Assoc	109	107	71%
Inappropriate Referrals	94	0	
	2047	1287	
% of referrals converted to assessments			72%
% of referrals converted to assessments excluding Adolescent Service			78%

2.1.6 Dean Clinic: Outcome of Assessments

The three charts below summarise and compare the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics for 2014, 2013, 2012 and 2011.







The table below summarises the number and type of admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2014.

Year	First Admission	Readmission	Total
2014	202	540	742
2013	225	107	332
2012	180	123	303
2011	150	125	275
Total	**757**	**895**	**1652**

2.2. SPMHS's Inpatient Care

SPMHS comprises three separate approved centres including St Patrick's University Hospital (SPUH) with 238 inpatients beds, St Edmundsbury Hospital (SEH) with 50 inpatient beds and Willow Grove Adolescent Unit (WGAU). In 2014, there were a total of 3,015 inpatient admissions across the organisation's three approved centres compared to 3,113 for 2013 and 2,893 for 2012.

2.2.1. SPMHS Inpatient Admission Rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the hospital's three approved centres; SPUH, SEH and WGAU for 2014.

The table below shows inpatient admission numbers across the 3 approved centres for 2014 including the percentage rates for Male and Female admissions. In 2014, 62.3% of admissions across all three Approved Centres were female, compared to 62.9% in 2013.

No. of Admissions (% of Admissions) 2014

	SEH	SPUH	WGAU	Total
Female	336 (70.0%)	1,473 (60.2%)	70 (77.8%)	1,879 (62.3%)
Male	144 (30.0%)	972 (39.8%)	20(22.2%)	1,136 (37.7%)
Total	**480 (100%)**	**2,445 (100%)**	**90 (100%)**	**3,015 (100%)**

The table below shows the average age of service users admitted across the 3 Approved centres was 47.71 years in 2014. This compares to 47.75 years in 2013. The average age of adolescents admitted to WGAU was 15.67 years which was consistent with 2013 at 15.49 years. The average age of adults admitted to SEH was 53.62 years in 2014 & 52.21 years in 2013. In addition, the average age of adults admitted to SPUH was 47.72 years in 2014 compared with 47.71 years in 2013.

Average Age at Admission 2014

	SEH	SPUH	WGAU	Total
Female	53.49	49.04	15.61	48.59
Male	53.92	45.73	15.85	46.24
Total	53.62	47.72	15.67	47.71

2.2.2. SPMHS Inpatient Length of Stay 2014

The following Tables present the 2014 average length of stay (ALOS) for adult inpatients (over 18 years of age) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis and presentation of inpatient length of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges across temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2014 Adults	Number of Discharges	Percentages
Under 1 week	456	15%
1 -<2 weeks	281	10%
2-<4 weeks	592	20%
4-<5 weeks	354	12%
5-<6 weeks	351	12%
6-<7 weeks	239	8%
7-<8 weeks	169	6%
8-<9 weeks	142	5%
9-<10 weeks	100	3%
10-<11 weeks	83	3%
11 weeks -< 3 months	86	3%
3-<6 months	80	3%
6-12 months	8	0%
>3 year	1	0%
Total Number of Adult Discharges 2014	**2942**	**100%**

SPMHS Length of Stay (LOS) for Adolescents (WGAU)

2014 WG	Number of Discharges	Percentages
Under 1 week	5	6%
1 -<2 weeks	6	7%
2-<4 weeks	12	14%
4-<5 weeks	5	6%
5-<6 weeks	9	10%
6-<7 weeks	7	8%
7-<8 weeks	8	9%
8-<9 weeks	8	9%
9-<10 weeks	6	7%
10-<11 weeks	6	7%
11 weeks -< 3 months	6	7%
3-<6 months	9	10%
Total Number of Adolescent Discharges 2014	**87**	**100%**

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpateints discharged in 2014)

The table below outlines the prevalence of diagnoses across SPMHS three Approved Centres during 2014 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded upon admission and at the point of discharge are presented for all three of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Edmundsbury Hospital combined. The data presented was based on all inpatients discharged from SPMHS in 2014.

SPMHS Analysis of Inpatient Primary ICD Diagnoses

(For all inpatients discharged in 2014)

SPUH: St Patrick's University Hospital. SEH: St Edmundsbury Hospital. Willow Grove Adolescent Mental Health Unit

ICD Codes: Admission & Discharge For All Service Users Discharged in 2014	SPUH Admissions		SPUH Discharges		SEH Admissions		SEH Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	40	1.6	32	1.3	2	0.4	0	0	42	1.4	32	1.09	0	0	0	0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	358	14.5	368	14.9	36	7.5	24	5	394	13.4	392	13.3	2	2.3	2	2.3
F20-F29 Schizophrenia, schizotypal and delusional disorders	171	6.9	185	7.5	20	4.2	18	3.7	191	6.5	203	6.9	1	1.15	1	1.15
F30-F39 Mood [affective] disorders	1315	53.4	1259	51.6	327	68	344	71.5	1642	55.8	1603	54.5	49	56.3	44	50.6
F40-F48 Neurotic, stress-related and somatoform disorders	360	14.6	351	14.3	91	19	86	17.9	451	15.3	437	14.9	12	13.8	15	17.2
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	100	4	97	3.9	2	0.4	1	0.2	102	3.47	98	3.3	17	19.5	18	20.7
F60-F69 Disorders of adult personality and behaviour	108	4.4	160	6.5	2	0.4	8	1.7	110	3.74	168	5.7	4	4.6	4	4.6
F70-F79 Mental retardation	1	0.04	0	0	0	0	0	0	1	0.03	0	0	0	0	0	0
F80-F89 Disorders of psychological development	1	0.04	4	0.1	0	0	0	0	1	0.03	4	0.1	1	1.1	1	1.1
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	2	0.08	1	0.04	1	0.2	0	0	3	0.1	1	0.03	1	1.15	2	2.3
F99-F99 Unspecified mental disorder	5	0.2	4	0.16	0	0	0	0	5	0.17	4	0.14	0	0	0	0
Totals	2461	100	2461	100	481	100	481	100	2942	100	2942	100	87	100	87	100

2.3. SPMHS's Day-patient: Wellness & Recovery Centre

The Wellness & Recovery Centre (WRC) was established in November 2008, following a reconfiguration of SPMHS Day Services. As well as providing a number of recovery-oriented programmes, the Centre provides service users with access to a range of specialist clinical programmes which are accessed as a step-down service following inpatient treatment or as a step-up service accessed from the Dean Clinics. Clinical programmes are delivered by specialist multi-disciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports and include the following:

1. Anxiety Programmes
2. Bipolar Disorder Programmes
3. Depression Programme
4. Addictions Programme
5. Eating Disorders Programme
6. Links to Wellbeing
7. Mental Health Support Programme (Pathways to Wellness)
8. Recovery Programme
9. Young Adult Programme
10. Psychosis Recovery Programme
11. Living Through Distress Programme
12. Radical Openness Programme

The data below provides a clear indication of the types of services provided by SPMHS. In 2014, the WRC received a total of 2,046 day programme referrals compared to a total of 1,686 for 2013, a year on year increase of 21%. 815 of the day programme referrals for 2014 came from a Dean Clinic. This compares to a total or 664 day programme referrals from Dean Clinics in 2013.

In 2014 a range of new day programmes were added to reflect service user demand and international best practice, including;

Schema therapy: an integrative psychotherapy combining theory and techniques from therapies including cognitive behavioral therapy, psychoanalytic object relations theory, attachment theory, and Gestalt therapy. Schema Therapy aims to help patients meet their basic emotional needs by helping them; diminish the intensity of their emotional memories, change their cognitive patterns, replace maladaptive coping styles and learn adaptive patterns of behaviour.

Compassion Focused Therapy: a group based psychotherapy focused on the development of the attribute of compassion as a means of addressing the high self-criticism and shame that underlies many mental health difficulties. Group members work towards developing compassion through the practice of skills in the areas of attention, imagery, behaviour, reasoning, sensation and feeling.

Driving Assessment: Changes to driving legislation have been accommodated through day services by the inclusion of a comprehensive driving assessment using both off road (driving simulator) and on road (driving instructor) assessment, where indicated.

2.3.1. Day-Patient Referrals by Clinical Programme

The table below compares the total number of day programme referrals to each clinical programme for 2013 and 2014. In addition, day programme referrals received from the Dean Clinics are presented.

Day-Patient Referrals for Clinical Programmes

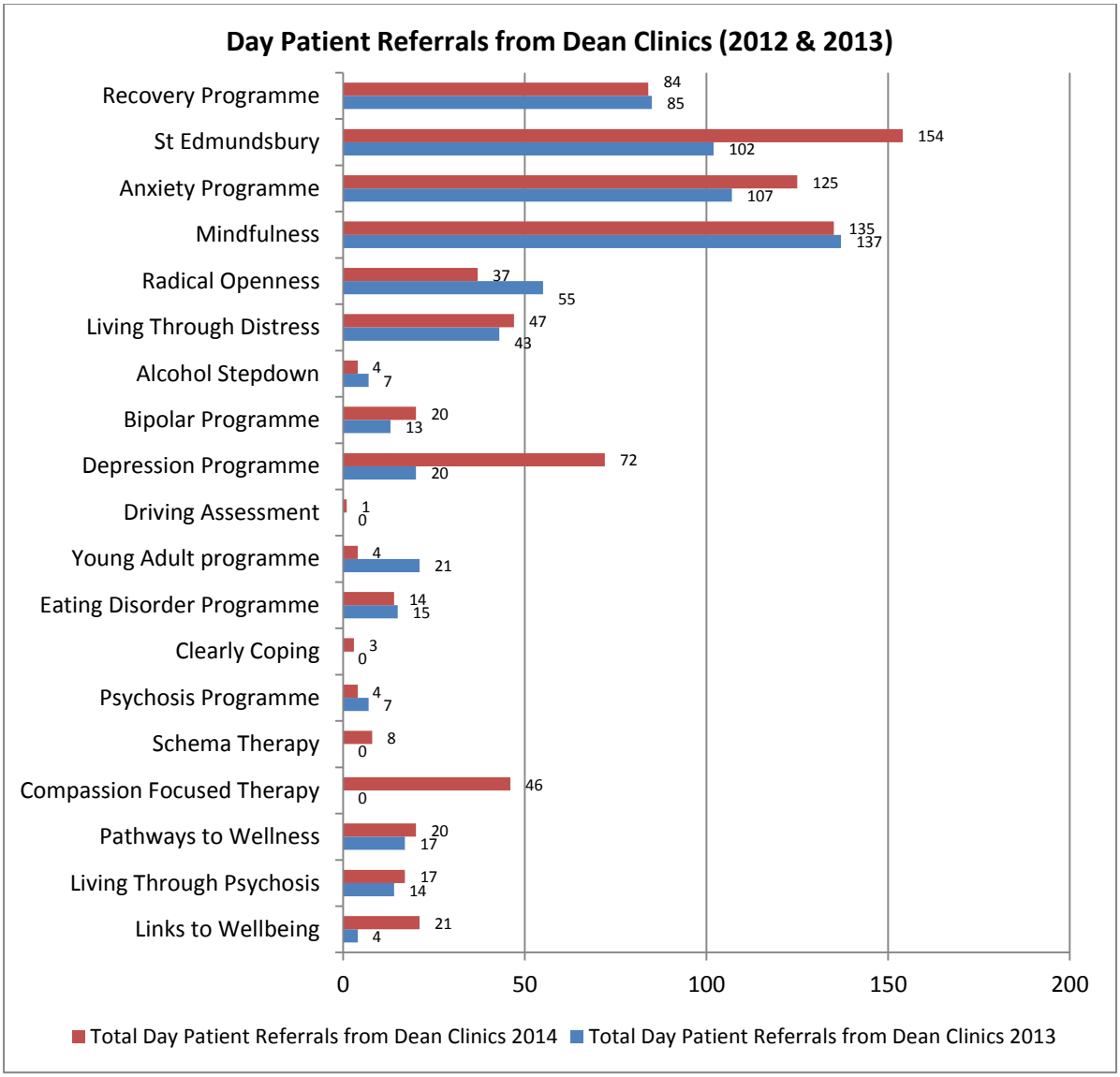
SPMHS Day Programmes	Total Day Patient Referrals 2013	Total Day Patient Referrals 2014	Total Day Patient Referrals from Dean Clinics 2013	Total Day Patient Referrals from Dean Clinics 2014
Links to Wellbeing	5	49	4	21
Living Through Psychosis	31	52	14	17
Pathways to Wellness	46	55	17	20
Compassion Focus Therapy	N/A	95	N/A	46
Clearly Coping	N/A	10	N/A	3
Psychosis Programme	17	9	7	4
Schema Therapy	N/A	13	N/A	8
Eating Disorder Programme	60	50	15	14
Young Adult programme	41	8	21	4
Driving Assessments	N/A	2	N/A	1
Depression Programme	61	142	32	72
Bipolar Programme	89	101	13	20
Alcohol Stepdown	128	102	7	4
Living Through Distress	152	227	43	47
Radical Openness	140	169	55	37
Mindfulness	227	184	137	135
Anxiety Programme	192	191	107	125
Recovery Programme	279	242	85	84
St Edmundsbury	201	349	102	154
Total	**1686**	**2046**	**664**	**816**

2.3.2. Day-patient Referrals by Gender

The gender divide in 2014 was Female 1469, Male 577 representing a 71.8% Female and 28.2% male.

2.3.3. Day-patient Referrals from Dean Clinics

In 2013, a total of 664 day patient referrals were made from Dean Clinics, representing 39.4% of the total referrals (1686) to Day Programmes. This compares to a total of 816 day patient referrals from Dean Clinics in 2014 representing 39.9% of the total referrals to Day Programmes. Referrals to day programmes through Dean Clinics increased by 0.4% from 2013 to 2014. Overall referral numbers from Dean Clinics to day Services increased by 22.9%



2.3.4. Day-patient Attendances for Clinical Programmes 2013-2014

In 2013, 1262 day patients commenced day programmes. A similar number (1258) commenced in 2014. These registrations represented a total of 11707 and 13313 half day attendances respectively. Therefore in 2013 each registered day service user attended on average 9.27 half days while in 2014 each registered day service user attended on average 10.58 half days.

Day-Patient Attendances for Clinical Programmes

SPMHS Day Programmes	Total Day Patient Registrations 2013	Total Day Patient Registrations 2014	Total Day Patient Attendances 2013	Total Day Patient Attendances 2014
Links to Wellbeing	N/A	26	N/A	455
Living Through Psychosis	30	30	163	156
Pathways to Wellness	26	28	181	242
Compassion Focus Therapy	N/A	48	N/A	537
Clearly Coping	N/A	3	N/A	11
Psychosis Programme	7	8	23	33
Schema Therapy	N/A	8	N/A	73
Eating Disorder Programme	45	40	1640	1944
Young Adult programme	19	6	128	63
Driving Assessments	N/A	2	N/A	2
Depression Programme	19	65	83	713
Bipolar Programme	52	49	460	449
Alcohol Stepdown	150	115	1024	856
Living Through Distress	158	106	786	783
Radical Openness	124	103	940	1041
Mindfulness	131	117	781	753
Anxiety Programme	126	99	1166	1094
Recovery Programme	171	156	2696	2460
St Edmundsbury	204	249	1636	1648
Total	**1262**	**1258**	**11707**	**13313**

2.3.5. Section Summary

In 2014, service users received a range of clinical programmes and services accessed through structured and defined inpatient, day-patient and outpatients care based on need, urgency and service user preference. Whilst measures of access do not define the quality or outcomes of programmes and services, they do provide information about how the organisation structures and resources its services. Day programmes were changed or added to allow for greater choice of services for service users and referrers. Overall, the number of referrals to all 3 of the SPMHS entry points increased, indicating a sustained demand.

SECTION 3

Clinical Governance

3. Clinical Governance & Quality Management

SPMHS aspires to provide services to the highest standard and quality. Through its Clinical Governance structures, it ensures regulatory, quality and relevant accreditation standards are implemented and monitored within the Quality Framework.

3.1 Clinical Governance Measures Summary

Governance Measure	2012	2013	2014
Clinical Audits	**25**	**19**	**10**
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**608**	**635**	**627**
Number of Incidents An event or ciscumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	**1707**	**2098**	**2227**
Root Cause Analyses & Focused Reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	**5**	**6**	**11**
Number of Section 23's – Involuntary detention of a voluntary service user A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the Approved Centre (SPUH) - where the person indicates an intention to discharge from the Approved Centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	**94**	**107**	**107**
% Section 23's which progress to Involuntary admission (Section 24 - Form 13 Admissions) Following Section 23 an examination by the Responsible Consultant Psychiatrist and a second Consultant Psychiatrist the person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	**46% (43)**	**37 % (40)**	**43% (46)**
Number of Section 14's – Involuntary Admissions An involuntary admission that occurs as a result of an application from a spouse or relative, a member of An Garda Síochána, an Authorised Officer or a member of the public and a recommendation from a GP (the person is admitted as involuntary). A person subject to such an admission may decide to remain voluntarily.	**35**	**46**	**52**
% of Section 14's which progress to Involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	**86% (30)**	**76% (35)**	**80% (42)**
Number of Section 20/21 - Transfers Where an involuntary patient is transferred to an approved centre under *Section 20 or 21* of the Mental Health Act 2001, the clinical director of the centre from which he or she has been transferred shall, as soon as possible, give notice in writing of the transfer to the MHC on Statutory Form 10.	**8**	**21**	**13**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**22**	**33**	**37**
Number of Section 60 – Medication Reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of 3 months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	**5**	**15**	**11**
Number of Section 19 – Appeal to Circuit Court A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness.	**5**	**6**	**2**
Number of Tribunal's held	**72**	**96**	**91**
Mental Health Commission Reporting – Number of ECT Treatments 2012	**119**	**129**	**143**
Mental Health Commission Reporting – Number of Physical Restraint Episodes	**157**	**219**	**129**

3.2. Clinical Audits

This section summarises briefly the clinical audit activity for St. Patrick's Services in 2014. Clinical audit is an integral part of clinical governance and its purpose is to monitor and to improve the quality of care provided to service users and the resulting outcomes.

3.2.1. Overview of Audit Activity

The table below demonstrates the breakdown of projects by type undertaken in 2014 including those facilitated by clinical staff at local level and those carried out throughout the organization led by the Hospital committees.

No.	Audit Title	Audit Lead	Status at year end
1.	**Adherence to the HIQA National Standards for the prevention and control of healthcare associated infection** Examine and evaluate the current St. Patrick's Mental Health Services programme for the prevention of HCAI	Clinical Governance Committee	Completed
2.	**The Clinical Global Impression (CGI) and Children's Global assessment Scale (CGAS) level of change of change pre and post inpatient treatment** To measure the CGI /CGAS outcomes for service users pre and post admission	Clinical Governance Committee	Completed
3.	**Admission Nursing Assessment and Nursing Intervention Sheets** To strengthen the nursing process within the context of multidisciplinary service user centred & recovery focused care	Nursing Department	Completed
4.	**Adherence to hospital protocol of the management of service users with more than one fall episode** To ensure that service users with more than one fall episode are managed appropriately to reduce any future fall incidents to increase service users' safety	Falls Committee	Completed
5.	**Benzodiazepine and Hypnotic Usage Snapshot** The aim of this audit is to determine the percentage of in-patients prescribed benzodiazepines and night sedation (z-drugs) and feedback the findings to the multidisciplinary teams.	Clinical Governance Committee	On-going

No.	Audit Title	Audit Lead	Status at year end
6.	**Infection Control Audits** Theses audits measure the implementation of policies and procedures relating to infection control	Infection Control Committee	On-going
7.	**Comprehensive Discharge Summaries** Determine if the comprehensive discharge summaries are currently sent within 3 working days of discharge, which is in compliance with the Mental Health Commission Code of Practice	Clinical Governance Committee	Completed
8.	**Prescribing anti-dementia drugs (audit facilitated by Prescribing Observatory for Mental Health-UK)** To assess adherence to best practice standards derived from NICE dementia clinical guideline (Dementia. CG42;2012)	Multidisciplinary Teams	Completed
9.	**Individual Care Plan Key Worker System,** Ensure compliance with the Mental Health Commission standards and local policies at St. Patrick's University Hospital, St. Edmundsbury Hospital and Willow Grove Adolescent Unit.	Clinical Governance Committee	On-going
10.	**An Audit of Psychiatric Trainees Assessment and Management of the Risk of Venous Thromboembolism (VTE)** To assess adherence to best practice in the treatment of VTE	Multidisciplinary Teams	Completed

3.2.2. Key Audit Outcomes for 2014

- The Assessment Scales audit showed a noticeable improvement in the completion rate of the baseline Clinical Global Impressions (CGI) score and the final score in comparison to the audit for 2013.
- On-going audit of the prescribing of Benzodiazepines is being used to monitor adherance to best practice.
- St Patrick's Mental Health Services through it's Infection Control Committee continues to use audit to measure and strenghten adherance to the HIQA national standards for the prevention and control of healthcare assosciated infection.
- Audit of Nursing Interventions and feedback from stakeholders has facilitated review of the process in place to enable improvements to be made.
- Audit continues to be an integral part of the on-going work to strengthen the Key Worker and Care Planning process. The 2014 audit has supported a comprehensive review of the care planning process and key worker role.
- Outcomes from the audit on completion of Comprehensive Discharge Summaries showed a strenghting of compliance with the standards in comparison with the 2013 audit.
- An audit on adherance to the hospital protocol on falls risk prevention interventions post slip, trip or fall has enabled improvement in the existing interventions. A re-audit is scheduled for September 2015.

SECTION 4

Clinical Outcomes

4. Clinical Outcomes

The results presented in this Section summarise the findings from routine outcome measurement of St Patrick's Mental Health Services in 2014. Outcome measurement has been in place since 2011 and is a priority for the service, embedded within the context of clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2014 outcome measurement expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing shift towards an organisational culture that recognises the value of routine outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important Considerations for Interpretation of Outcomes.

The following important considerations should be borne in mind when reading these findings:

- The data reported in this chapter represent pre and post programme measurements.
- Pre and post measurement is linked to the start and finish of programmes but other facets of care, other simultaneous interventions, time, medications etc. may also play a part (any effects cannot be solely attributable to clinical programme intervention).
- Where appropriate to the analysis of outcomes, paired sample t-tests were used to determine if, across the sample, post scores are statistically significantly different from pre scores. **Statistical significance** indicates the extent to which the difference from pre to post is due to chance or not. Typically the level of significance is set at $p > 0.05$ which means that there is only a 5% probability that the difference is due to chance and therefore it is likely that there is a difference. Statistical significance provides no information about the magnitude or clinical or practical importance of the

difference. It is possible that a very small or unimportant effect can turn out to be statistically significant e.g. small changes on a depression measure can be statistically significant, but not clinically or practically meaningful.

- **Statistically non-significant findings** suggest that the change from pre and post is not big enough to be anything other than chance but does not necessarily mean that there is no effect. Non-significant findings may result from small sample size, issues to do with the sensitivity of the measure being used or the time point of the measurement. As such non-significant findings are not unimportant; rather they provide useful information and an invitation to investigate further.
- **Practical significance** indicates *how much* change there is. One indicator of practical significance is effect size. **Effect size** is a standardized measure of the magnitude of an effect. This means effect sizes can be compared across different studies that have measured different variables or used different scales of measurement. The most common measure of effect size is known as **Cohen's *d*.** For Cohen's *d* an effect size of:
    - 0.2 to 0.3 is considered a "small" effect
    - 0.5 a "medium" effect
    - 0.8 and upwards a "large" effect.

  As Cohen indicated '**The terms 'small,' 'medium,' and 'large'** are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation. In the face of this relativity, there is a certain risk inherent in offering conventional operational definitions for these terms for use in power analysis in as diverse a field of inquiry as behavioral science. This risk is nevertheless accepted in the belief that more is to be gained than lost by supplying a common conventional frame of reference which is recommended for use only when no better basis for estimating the ES index is available." (p. 25) (Cohen, 1988)
- **Clinical significance** refers to whether or not a treatment was effective enough to change a patient's diagnostic label. "For example, a treatment might significantly change depressive symptoms (statistical significance), the change could be a large decrease in depressive symptoms (practical significance- effect size), and 40% of the patients no longer met the diagnostic criteria for depression (clinical significance)". ("Clinical

Significance," 2013, para 7). It is therefore possible for a treatment to yield significant difference and medium or large effect sizes, but doesn't demonstrate a positive change in service users' level of functioning.

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for Inpatient Care 2014

4.2.1. Objective

This report sets out the results of an evaluation of severity of illness measures completed at point of inpatient admission and measures of global improvement outcomes for service users carried out following in-patient care, treatment and intervention. The evaluation was achieved by comparing baseline and final global assessment scales scores – the Clinical Global Impressions (CGI) in case of adults and the Clinical Global Assessment Scale in the case of adolescents.

Following admission each service user's level of functioning and illness severity is evaluated by a clinician or multidisciplinary team (MDT) either between admission and the first MDT meeting or at a first MDT meeting. This is referred to as the CGIS or CGAS baseline score and this scoring is repeated at each MDT meeting including at the final MDT meeting preceding discharge. This is referred to as the final CGIC or CGAS score. An audit of the CGI completion rate was also carried out.

4.2.1.1. Background

The Clinical Global Impressions Scale (CGI) is a standard, widely used mental health assessment tool. The complete CGI scale consists of three different global measures designed to rate the effectiveness of a particular treatment: the CGI-Severity (CGIS) that is used to establish the severity of psychopathology at point of assessment; the CGI-Change or Improvement (CGIC) which compares the service user baseline condition to her/his current condition following care, treatment or intervention; the efficacy index that compare the service user's baseline condition to a ratio of current therapeutic benefit and severity of side effects. Out of these three measures the CGIS and the CGIC are used frequently in clinical and research settings.

The CGIS asks a clinician the question: "Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?" which is rated on the following seven-point scale: 1=normal, not at all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.

The CGIC rates on a seven point scale the following query:" Compared to the patient's condition on admission to this project (prior to intervention), this patient's condition is: 1=very much improved since the initiation of treatment; 2=much improved; 3=minimally improved; 4=no change from baseline (the initiation of treatment); 5=minimally worse; 6= much worse; 7=very much worse since the initiation of treatment."

The Children's Global Assessment Scale (CGAS) provides a global measure of level of functioning in children and adolescents. CGAS is scored by the MDT on a scale of 1 to 100 which reflects the individual's overall functioning level where impairments in psychological, social and occupational/school functioning are considered. Scoring for the CGAS ranges from 1, in need of constant supervision, to 100, superior functioning.

4.2.1.2. Data Collection Strategy

This report used data extracted from the Patient Administration System (PAS) which provided details on the St. Patrick's University (SPUH) and St. Edmundsbury (SEH) Hospital admissions and admissions to the Willow Grove Adolescent Unit (WG).

A random sample was chosen from admissions to SPUH and SEH. The sample size was calculated for each approved centre separately with 90% confidence level and 5% level of accuracy. Then the cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases for each ward within the services.

An electronic database of CGAS scores recorded for admissions maintained by the Willow Grove MDT provided CGAS data for the Adolescent sample. All WGAU inpatient admissions were included for CGAS adolescent dataset.

The anonymised dataset collected for each selected case included the following variables:

- Service user age and gender,
- Admission ICD code (primary and additional),
- Date of admission,
- Admission ward,
- Re-admission rate,
- Date of discharge,
- Baseline assessment scale score (CGIS or CGAS respectively)– recorded on the Individual Care Plan on or before the first MDT meeting,
- Date recorded against the baseline score,
- Final assessment scale score (CGIC or CGAS respectively)– recorded on the MDT meeting care plan review document,
- Date recorded against the final score.

4.2.2. Sample Description

		TOTAL ADULT SERVICE	WGAU
Sample size		447	68
Admissions	1st admission	32%	82%
	Re-admission	68%	18%
Average age ± standard deviation		51±16	16 ± 1
Gender breakdown	Female	67%	82%
	Male	33%	18%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

The percentage of primary admission ICD-10 diagnosis codes recorded in the sample.

The primary admission diagnosis was analysed. The percentage of treatment episodes in the sample with more than one admission diagnosis was 10% for adults and 15% for adolescents (WGAU).

ICD-10 Admission Diagnosis Category		2012 TOTAL ADULT SERVICE	2013 TOTAL ADULT SERVICE	2014 TOTAL ADULT SERVICE	2014 WGAU
F30-F39	Mood disorders	60%	58%	58%	54%
F40-F48	Neurotic, stress-related and somatoform disorders	15%	16%	15%	12%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	13%	13%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	6%	4%	1.5%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	1%	4%	3%	23.5%
F00-F09	Organic, including symptomatic, mental disorders	1%	2%	0.5%	0%
F60-F69	Disorders of adult personality and behaviour	1%	2%	3.5%	9%
F80-F89	Disorders of psychological development	1%	0%	0%	0%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0.2%	1.5%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *Total adult service*

CGIS -Baseline measure of severity of illness		2012 TOTAL	2013 TOTAL	2014 TOTAL
1	Normal, not at all ill	0%	0%	0.2%
2	Borderline mentally ill	1%	0%	2%
3	Mildly ill	7%	8%	9%
4	Moderately ill	21%	20%	32%
5	Markedly ill	34%	33%	33%
6	Severely ill	18%	19%	16%
7	Extremely ill	2%	1%	2%
	Not scored	17%	19%	6%

Table: *Total adult service*

CGIC – Final Global improvement or change score		2012 Total	2013 Total	2014 Total
1	Very Much improved	10%	11%	15%
2	Much Improved	44%	39%	43%
3	Minimally Improved	23%	16%	13%
4	No Change	7%	6%	4%
5	Minimally Worse	0%	0%	1%
6	Much Worse	0%	0%	0%
7	Very Much Worse	0%	0%	0%
	Not scored	15%	26%	24%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		2013		2014	
		Baseline	Final	Baseline	Final
100-91	Superior functioning	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	0%
80-71	No more than a slight impairment in functioning	0%	0%	0%	1.5%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	19%	0%	24%
60-51	Variable functioning with sporadic difficulties	33%	63%	33%	65%
50-41	Moderate degree of interference in functioning	58%	9%	58%	4%
40-31	Major impairment to functioning in several areas	5%	2%	5%	1.5%
30-21	Unable to function in almost all areas	0%	0%	0%	0%
20-11	Needs considerable supervision	0%	0%	0%	0%
10-1	Needs constant supervision	0%	0%	0%	0%
	Not scored	5%	6%	5%	3%
Mean ±SD		50±5	57±6	50±5	57±16
Median		50	58	50	58
Wilcoxon Signed Ranks Test:		Z=-6.584, p<.001		Z=-5.7017,p<.05	

4.2.4. Audit on Completion Rates of Baseline and Final CGI Scores

4.2.4.1. Clinical Audit Standards

1. Baseline score is taken no more than 5 days following admission;
   Exception: Short admission;
   Target level of performance: 100%.

2. Final CGI score is taken no more than 5 days prior to discharge;
   Exception: Short admission, unplanned discharge;
   Target level of performance: 100%

4.2.4.2. Results

	2012	2013	2014	2013	2014
	TOTAL ADULT SERVICE	TOTAL ADULT SERVICE	TOTAL ADULT SERVICE	WGAU	WGAU
Baseline Assessment Scale Score					
% of admission notes with recorded baseline scores	83%	81%	94% (↑)	95%	100%(↑)
% compliance with clinical audit standard 1	64%	61%	90% (↑)	Not recorded	85%
Final Assessment Scale Score					
% of admission notes with recorded final scores	85%	74%	77% (↑)	94%	98.5%(↑)
% compliance with clinical audit standard no. 2	73%	73%	70% (↓)	Not recorded	61%

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Mental Health Services discharges for 2014.

2. Female to male ratio was for adult service user's 2:1 for adults and WGAU 4.6:1 for adolescents.

3. Within the sample, there was a 3% increase in the number of service users who were re-admitted, in comparison to 2013. In the 2014 sample, re-admissions accounted for 68% of adult service users.

4. 82% of WGAU admissions in 2014 were first admissions to a mental health service. This was equal to the number of first admissions in comparison to the 2013 data.

5. Based on a sample of 343 (total cases with discharge CGI Score documented) 93% of the sample were rated with an overall improvement (1 - very much improved (19%), 2 - much improved (57%) and 3 - minimally improved (17%)).

6. 2014 analysis of the primary ICD-10 codes showed the most frequent reasons for admission to be mood disorders followed by neurotic, stress related, somatoform disorders and disorders of adult personality and behavior.

7. In 2014 the breakdown of baseline clinical global improvement scores on admission shows that 33% of SPUH and SEH service users were markedly ill. The data also shows an increase in service users who were moderately ill in comparison to the 2012 and 2013 data.

8. Overall improvement rate for Willow Grove Adolescent Unit was 65%. Of the sample 32% were found to have no change and the remaining 3% were found to have dis-improved following in-patient treatment.

9. There were 39 service users identified in the sample who were admitted to Dean Swift Ward, 10% were rated to be Moderately ill on admission. 31% were rated as Markedly ill compared to 55% on Grattan Ward, 43% on Stella Ward and 38% on Vanessa Ward. 10% were rated as Extremely ill.

10. The majority (58%) of WG service users were scored as having a moderate degree of interference in functioning on admission, the figure is equal to that of 2013 data.

11. The audit shows a noticeable improvement in the completion rate of the baseline CGI score in comparison to the audit for 2013.

4.3. Acceptance & Commitment Therapy Programme

Acceptance and Commitment Therapy (ACT) is an evidence-based psychotherapy which aims to teach people "mindfulness skills", to help them live in the "here and now" and manage their thoughts and emotions more effectively. ACT supports service users to identify and connect with their core personal values and integrate them into everyday action. Though ACT does aim to reduce symptoms, it primarily aims to change people's relationship with anxiety and depression, and to increase value-led behavioural activation.

The ACT programme, which was implemented in SEH in 2010, runs recurrently over an 8-week period, for one half-day per week. During the eight week programme, participants engage in a range of experiential exercises to help them develop the six core processes of ACT; mindfulness, thought defusion, acceptance, perspective taking, values and committed action. Participants are given three CDs to accompany the experiential exercises covered in session which assists in integrating ACT processes into their daily lives. The essential aim of this programme is to help people connect with what matters most to them and develop skills to help overcome the obstacles that get in the way of living a value-guided life. The programme aims to foster a key shift in terms of helping people to look at their lives in terms of workability; what helps them move closer towards who and where they want to be, and what brings them further away. This programme is primarily facilitated by a counselling psychologist who has several years' experience in ACT and trains clinicians in the ACT approach.

4.3.1. Descriptors

Data was available for a total of 60 participants, (66.6% female, 33.3% male). Both pre and post measures were available for 43 those completing the programme, representing 82.7% of the sample.

4.3.2. ACT Outcome Measures

The following programme measures were used:

- **Acceptance & Action Questionaire II**

The Acceptance and Action Questionnaire (AAQ II: Bond et al., 2011) is a 10 item measure of experiential avoidance or the tendency to avoid unwanted internal experiences – the opposite of which is psychological flexibility. Service users are asked to rate statements on a seven point likert scale from 1 "Never True" to 7 "Always true". Scores range from 1 to 70 with higher scores indicating greater psychological flexibility/less experiential avoidance. The AAQ II has good validity, reliability (Cronbach's alpha is .84 (.78 - .88)), and 3- and 12-month test-retest reliability (.81 and .79, respectively) (Bond et al., 2011).

- **Behavioural Activation for Depression Scale**

The Behavioural Activation for Depression Scale (BADS: Kanter, Mulick, Busch, Berlin & Martell, 2007) measures behaviours hypothesized to underlie depression and examines changes in: activation, avoidance/rumination, work/school impairment, and social impairment. The BADS consists of 25 questions; each rated on a seven point scale from 0 "not at all" to 6 "completely". Scores range from 0 to 150 with higher scores representing increased behavioural activation. Mean scores for a non-clinical sample of undergraduate students were 110.51 (*SD* = 21.04) (Kanter et al., 2007) and for a community sample with elevated depressive symptoms the mean was 69.83 (SD = 20.15) (Kanter, Rusch, Busch & Sedivy, 2009). The measure has good internal consistency (Cronbach's α ranging from .76 - .87), adequate test-retest reliability (Cronbach's α ranging from .60 - .76), and good construct and predictive validity (Kanter et al., 2007)

- **Five Facet Mindfulness Questionnaire**

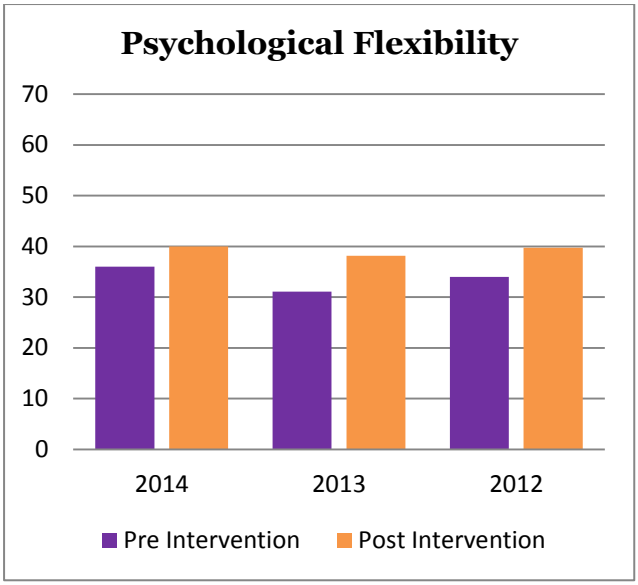
The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting

with awareness, non-reactivity- to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 "never or very rarely true" to 5 "very often or always true". Scores range from 39 to 195 with higher scores suggesting higher levels of mindfulness. In a study of non-clinical samples participants who regularly practice mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practice mindfulness had a mean of 138.9 (*SD* = 19.2) (Lykins & Baer, 2009). The measure evidences good reliability (alpha co-efficient ranging from .72 to .92 for each facet) (Baer et al., 2006). Evidence for construct validity comes from analysis of data from samples with mindfulness meditation and no mindfulness meditation experience (Baer et al., 2006).

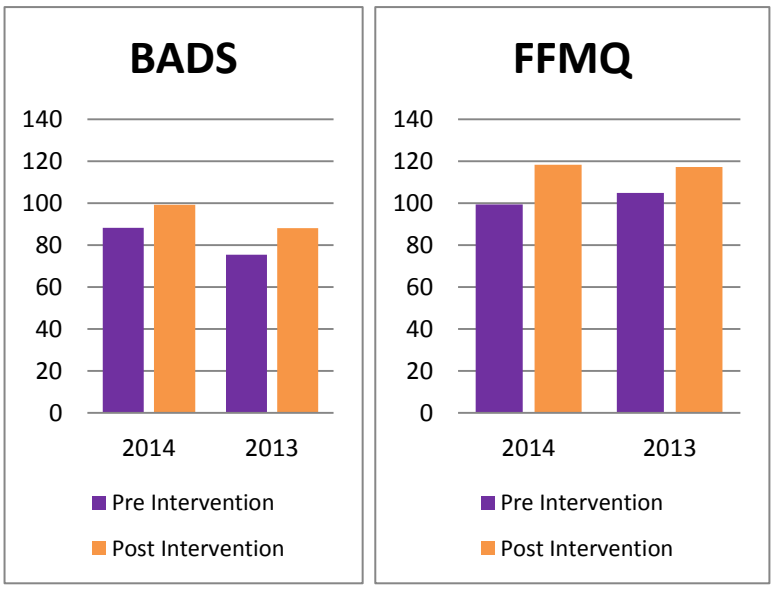
• Work and Social Adjustment Scale

The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a 9-point Likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in functioning. In a study including participants with Obsessive Compulsive Disorder or Depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Marks, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

4.3.3. Results

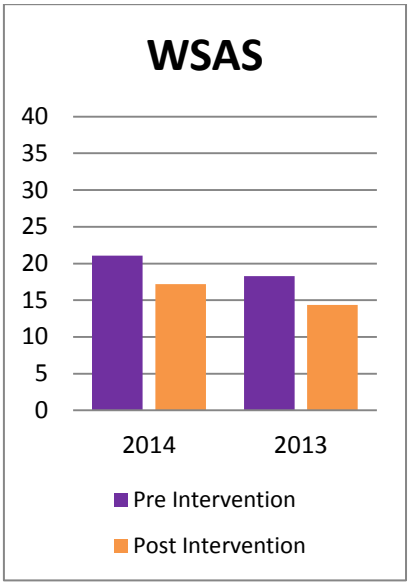


Total scores on the AAQ-II showed a statistically significant increase, t (44) = -2.696, $p < .05$, suggesting greater psychological flexibility post programme. An effect size (d) of -0.48 indicates a medium effect. Pre and Post mean scores on the AAQ-II were similar to those reported in previous years.



Mean post BADS scores increased significantly, from (M = 88.2, SD = 24.09) to (M = 99.23, SD = 22.181) indicating greater behavioural activation, t (42) = -3.473, $p < .01$, representing a medium effect size (d = -0.47). The percentage of those completing the programme with scores below 70 (the mean reported

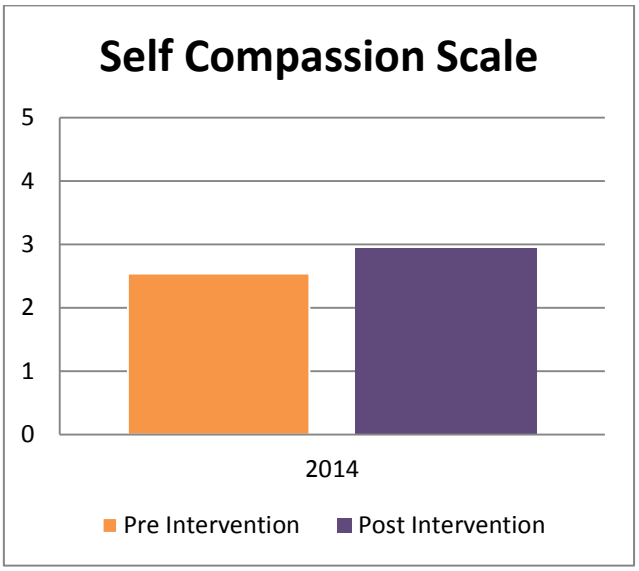
by Kanter et al. (2009) for a sample with elevated depressive symptoms) reduced from 32.8% to 9.1% at the post measurement time point.



Total FFMQ scores increased significantly, t (40) = -4.00, $p < .001$, from pre (M = 111.29, SD = 19.3) to post (M = 124.6829, SD = 18.98) indicating greater levels of overall mindfulness. A medium effect size was observed (Cohen's d = -.70). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (43) = 3.677, p = .001, from 16.88 (SD = 7.53) to 13.1 (SD =8.05), indicating less functional impairment. The effect size d of 0.48 suggests a medium effect. Both pre and post means are within the range suggesting significant functional impairment, but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 11.7% of those who completed the programme had scores below 10 when they started the programme, while 40% had scores below 10 on completion of the programme.

These findings are in line with the 2012 and 2013 outcomes report that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.



A new measure for 2014 was the Self Compassion Scale. Total SCS scores increased significantly, t (31) = -4.50, $p < .001$, from pre (M = 2.54, SD = .51) to post (M = 2.96, SD = .61) indicating higher overall self compassion. A medium effect size was observed (Cohen's d = -.75). Self compassion is operationalised by this measure through in six domains; Self-Kindness, Self-Judgement Humanity, Isolation , Mindfulness and identification or "Over-Identified" with thoughts.

4.3.4. Summary

Those people who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. Comparison of outcomes across 2012, 2013 and 2014 shows consistent results over this period. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of mindfulness. This also allows for the potential comparison with published research. Programme facilitators added a measure of self-compassion for 2014 (Neff, 2003) and analysis of this measure suggests promising change, between pre and post intervention, in its first year of use.

4.4. Alcohol and Chemical Dependency Programme.

The Alcohol and Chemical Dependence (ACDP) Programme is designed to help individuals with alcohol and/or chemical dependence/abuse to achieve abstinence by enabling them to develop an increased awareness of the implications and consequences of their drinking/drug taking. The 'staged' recovery programme is delivered by Psychiatrists, Addiction Counsellors, Ward based nursing staff, with input from other disciples including Psychology, Social Work and Occupational Therapy and includes:

- In-patient, residential service for four weeks
- Twelve week Step-Down programme
- Aftercare

The Programme caters for adults who are currently abusing or dependent on alcohol or chemical substances. Referral criteria include:

1. The service user is over the age of 18 years.
2. The service user is believed to be experiencing alcohol and/or chemical dependence/abuse.
3. The service user has the cognitive and physical capability to engage in the activities of the programme such as psycho-education, group therapy and addiction counselling.
4. The service user is not intoxicated and is safely detoxified.
5. The service user's mental state will not impede their participation on the programme.

The programme includes the following elements:

• **Individual multidisciplinary assessment** and subsequent individualised programmes based on evidence based treatment models including the Community Re-enforcement Model (CRA), Motivational interviewing, and Solution Focused Brief Therapy.

Group based interventions:

- **Addiction Counselling Groups:** These are part of the in-patient programme and involve 3 group therapy sessions, facilitated by a counsellor, where topics relevant to substance abuse/ dependence are discussed.
- **Women's Group:** This is a gender specific group, facilitated by a Counsellor, where women meet and discuss issues pertaining to females and addiction in a therapeutic environment.
- **Psycho-education lectures:** Weekly educational lectures are given on a weekly basis, designed both for in-patients and their families. People in recovery are also invited in to speak at these lectures. A weekly psycho-educational lecture is also offered to the 'Step-Down' programme.
- **Motivation for Change Group:** This group is facilitated by therapists. It is specifically for 'Goal setting' and 'Change planning', and is most relevant to patients who are embarking on periods of time outside the hospital.
- **Orientation Group:** This is where a number of recovering alcohol dependant people who have completed the Programme in the past chair a weekly meeting for in-patients, and host a question and answer session.
- **Recovery skills groups:** These groups teach and re-educate 'living skills' i.e. drink/drug refusal skill training, communication skills, recovery skills, relapse prevention etc.
- **Family Sessions/Meetings:** Providing support for the relatives of patients attending the Programme.
- ***Reflection group:*** This group provides a safe place to support clients through the process of change; an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- ***Relapse prevention and management groups:*** This group focuses on developing successful relapse prevention and management strategies.

4.4.1. Alcohol and Chemical Dependency Programme Outcome Measures

•Leeds Dependency Questionnaire (LDQ)

The Leeds Dependence Questionnaire (LDQ; Raistrick et al., 1994) is a 10-item questionnaire, designed to screen for mild to severe psychological dependence to a variety of different substances, including alcohol and opiates.

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence including: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Paton-Simpson & MacKinnon, 1999).

Items are scored on a 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

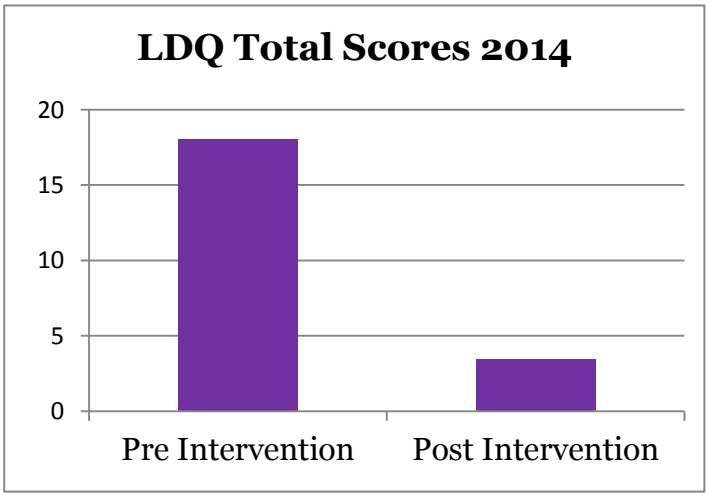
This measure was completed by service users pre and post programme participation.

4.4.2. Descriptors

A total of 159 participants completed the full or modified programme in 2014. Pre and post data were available for 41 participants, which represents 26% of those who attended the programme. This means that findings presented may not be representative of all participants who completed the programme and that findings need to be interpreted in light of this. 43.9% of participants were male and 56.1% were female.

4.4.3 Results

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post programme participation. Following completion of the programme, participants showed statistically significant decreases in psychological markers of substance and/or alcohol dependency from pre (M = 18.08, SD = 6.12) to post (M = 3.46, SD = 5.46), representing a large effect size (d = 2.52).



4.4.4 Summary

Following completion of the Alcohol and Chemical Dependency programme, significant and large reductions in psychological markers of substance and/or alcohol dependency were observed.

These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and its use is expected to continue in 2015.

Despite efforts from staff, collecting post data has been challenging and resulted in the data capture of only 26% of those who completed the programme in 2014. According to Tober et al. (2000), service users with substance difficulties can find it difficult to commit to completing follow-up measures for many reasons including motivation, difficulties with attendance and convenience of appointment times given. To overcome this difficulty, completion of post measures will be completed in session with therapists during the exit interview and will become part of each client's discharge plan. This will be monitored using the referral spread sheet for service users and reviewed monthly by the Addiction Service coordinator.

4.5. Anxiety Disorders Programme

The Anxiety Disorders Programme provides a clinical intervention programme for service users with primary anxiety disorders. The Anxiety Programme provides group and individual intervention and support based on the cognitive behaviour therapy (CBT) model. CBT has been found to be efficacious for adult anxiety disorders (Butler, Chapman, Forman & Beck, 2006; Hofmann & Smits, 2008; Olantunji, Cisler & Deacon, 2010). All programme facilitators are CBT and Mindfulness trained.

The programme is structured into two levels. Level 1 is a 5-week programme and includes group-based psycho-education and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based therapy through behaviour workshops which aide experiential goal work, fine tune therapeutic goals and identify possible obstacles in order to address an individual's specific anxiety difficulties (Anderson & Rees, 2007). Service users with more complex clinical presentations of anxiety are referred to Level 2 of the programme, a closed group which builds on therapeutic work carried out during Level 1. Level 2 provides a structured 6-week programme which is also based on a CBT approach focusing on shifting core beliefs, emotional processing and regulation and increased exposure work. Service users typically attend Level 2 following discharge from hospital as an inpatient.

At the end of 2011 a separate OCD strand of the Anxiety Programme was piloted in order to provide a more tailored and focussed service for those with OCD including aspects like challenging meanings of obsessions and more tailored goal work. The success of the pilot has led to the continuation of this as a separate strand within the programme.

4.5.1. Anxiety Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2014. All service users attending the Anxiety Programme complete (or are rated on) the following measures, before starting the programme, after completing level

one of the programme and again after completing level two (if they have attended this level). Participants either completed the Life Adjustment Scale or the Work and Social Adjustment Scale before starting the programme, and after completing level 1 and / or level 2 of the programme.

- **Beck Anxiety Inventory**

The Beck Anxiety Inventory (BAI: Beck & Steer, 1993) is a 21-item multiple-choice self-report inventory that measures the severity of anxiety in adults and adolescents. The respondent is asked to rate how much each of the 21 symptoms has bothered him/her in the past week. The symptoms are rated on a four-point scale, ranging from "not at all" (0) to "severely" (3). The BAI scores range from 0 - 63 and scores can be interpreted in relation to four qualitative categories: minimal level anxiety (0-7), mild anxiety (8-15), moderate anxiety (16-25) and severe anxiety (26-63). The instrument has excellent internal consistency (α= .92) and high test–retest reliability (r = .75) (Beck & Steer, 1990).

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses. Its long form is composed of 21 questions, each designed to assess a specific symptom common among people with depression. Individual questions on the BDI assess mood, pessimism, and sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores can range from 0 – 63 with higher scores indicating more severe depressive symptoms. Scores can be described as minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

- **Clinical Global Impression Scale**

The Clinical Global Impressions Scale (CGI: Guy 1976) is a standardised assessment tool. It is used by clinicians to rate the severity of illness, change over time, and efficacy of medication, taking into account the patient's clinical condition and the severity of side-effects. The first sub-scale, Severity of Illness, assesses the clinician's impression of the patient's current illness state and it is often used both pre and post treatment. The second sub-scale, Global Improvement, assesses the patient's improvement or worsening from baseline. The third sub-scale, the Efficacy Index, attempts to relate therapeutic effects and side-effects by deriving a composite score that reflects both the therapeutic effect and the adverse reactions or side-effects. Scores on the Severity of Illness sub-scale range from 1 "not ill at all" to 7 "among the most extremely ill". The Global Improvement sub-scale also goes from 1 "very much improved" to 7 "very much worse".

- **Fear Questionnaire**

The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items including questions measuring the extent to which situations are avoided using a 9-point likert scale ranging from 0 "Would not avoid" to 8 "Always avoid". Four scores can be obtained from the Fear Questionnaire, including Main Phobia Level of Avoidance, Total Phobia Score, Global Phobia Rating and Associated Anxiety and Depression. For the purposes of this analysis Global Rating, was used. This measure has been found to be psychometrically sound with good discriminant validity and internal consistencies from .71 to .83 (Oei, Moylan, & Evans, 1991).

- **Work and Social Adjustment Scale**

The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a 9-point Likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in

functioning. In a study including participants with Obsessive Compulsive Disorder or Depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Mark, Shear & Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

- **Yale Brown Obsessive Compulsive Scale**

Yale Brown Obsessive Compulsive Scale (Y-BOCS: Goodman et al., 1989) is widely considered the gold standard for assessing the severity of OCD and to measure the response to treatment. It was designed specifically to measure the severity of OCD regardless of the type of obsessions and compulsions. The Y-BOCS enables the clinician to rate the severity of the obsessions and compulsions separately e.g. (five items assess obsessions and five items assess compulsions) which enables the clinician to discern between the severity of obsessions and compulsions as well as have a global score of severity and response by adding the two separate scores.

Obsessions and compulsions each are assessed on a 5-point scale ranging from 0 "no symptoms" to 4 "severe symptoms" measuring the following: time spend engaging with obsessions and / or compulsions, the level of distress, the ability to resist and level of control over obsessions and compulsions. The Y-BOCS showed inter-rater reliability, validity and internal consistency and is sensitive to measure change in OCD symptoms (Anderson & Rees, 2007; Foa et al, 2005; Taylor, 1995; Goodman et al, 1989). Scores are rated on five levels: Sub-clinical: 0 – 7; Mild: 8 – 14; Moderate: 16 – 23; Severe: 24 – 31, Extreme: 32 – 40. Taylor (1995, p289) states that: "When breadth of measurement, reliability, validity, and sensitivity to treatment effects are considered together, the YBOCS appears to be the best available measure for treatment outcome research".

- **Penn State Worry Questionnaire**

The Penn State Worry Questionnaire (PSWQ: Meyer, Miller, Metzger, & Borkovec, 1990) is designed to capture the generality, excessiveness, and uncontrollability of pathological worry. The PSWQ allows clinicians to identify individuals with Generalised Anxiety Disorder (GAD) who present for treatment for anxiety disorders (Fresco et al, 2003).

The PSWQ is a 16-item self-report measure. Participants are asked to rate worries on a 5-point scale ranging from 'Not at all typical of me' to 'Very typical of me', capturing the generality, excessiveness, and uncontrollability of pathological worry. Total scores range from 16 to 80, with higher scores indicating greater worry. The reliability and validity of the PSWQ has been widely researched positively correlating with other self-report measures of worry and aggregate peer ratings showing it to be of sound psychometric properties.

- **Liebowitz Social Anxiety Scale**

The Liebowitz Social Anxiety Scale (LSAS: Cox et al, 1998) assesses fear and avoidance across a variety of situations likely to elicit social anxiety. Participants are asked to rate 24 items on the degree of fear of anxiety and avoidance they would feel in a hypothetical situation. Fear of anxiety is rated on a 4-point scale ranging from 0 'None' to 3 'Severe'. Avoidance is similarly rated on a 4-point scale ranging from 0 'Never' to 3 'Usually'. It LSAS yields two subscale scores, out of 72, fear and avoidance which are summed together to give the total score, yielding a maximum score of 144. For those individuals with social phobia scores are typically greater than 60. The LSAS has been shown to have strong internal consistency, inter-rater reliability and validity (Fresco et al, 2001).

4.5.2. Descriptors

Data were available for 89 people, of which 48 (54%) were female and 41 male (46%). Programme attendees ranged in age from 18 to 75 with an average age of 39 (*SD* = 16). Post data was collected after Level 1 and Level 2

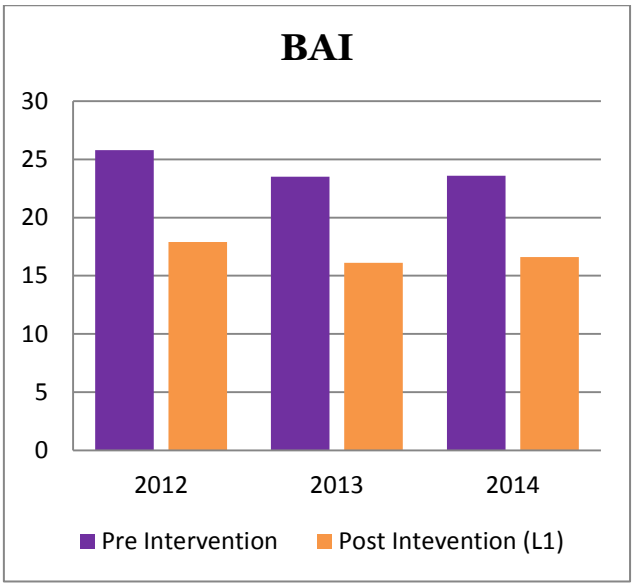
of the anxiety programme. Pre and Post data was available for 26 service users who started Level 2 in 2014 (12 with OCD).

There were six primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (44.9%), followed by Social Phobia/Anxiety (20.2%), Generalised Anxiety Disorder (16.9%), Disorder (10.1%), Agoraphobia (with/without panic) (5.6%), Panic and Health Anxiety (1.1%). The percentage of people with each diagnosis is represented in the table below, including figures for 2011, 2012 and 2013 for purposes of comparison.

The majority of individuals with a diagnosis of OCD (n = 46) attended the OCD specific strand of the anxiety programme Level 1. The GASSP strand included two individuals with a primary diagnosis of OCD.

	2011		**2012**		**2013**		**2014**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Obsessive Compulsive	48	37.5	55	35	50	42.0	40	44.9
Generalised Anxiety	24	18.8	30	19.1	21	17.6	15	16.9
Social Phobia/Anxiety	25	19.5	26	16.6	20	16.8	18	20.2
Panic Disorder	13	10.2	22	14	9	7.6	9	10.1
Agorophobia	14	10.9	17	10.8	9	7.6	5	5.6
Health Anxiety	3	2.3	4	2.5	7	5.9	1	1.1
Specific Phobia	-	-	3	1.9	2	1.7	-	-
Habit and Impulsive Disorders	1	0.8	-	-	-	-	-	-
Post-Traumatic Stress Disorder	-	-	-	-	1	0.8	-	-

4.5.3. Level 1 Results

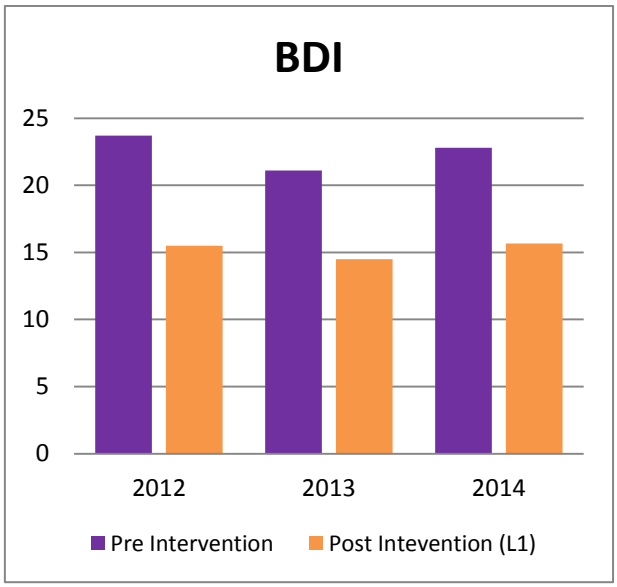


Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved from the higher end of the moderate (*M* = 23.6, *SD* = 11.8) to the lower end of the moderate (*M* = 16.6, *SD* = 10.3) range on the measure. Changes were statistically significant, t(80) = 5.59, p = .000, and represent a medium effect (Cohen's *d* = 0.63). At the pre measurement time point, 40% had anxiety scores in the severe range, this dropped to 17% by the end of Level 1 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	**POST**	**PRE**	**POST**
Minimal	9.4	18.3	4.5	28.2
Mild	17.7	31.7	29.6	34.2
Moderate	32.9	32.9	42	28.2
Severe	40	17.1	23.9	9.4
Totals	**100**	**100**	**100**	**100**

These results are broken down into the four main diagnostic subgroups in the table below.

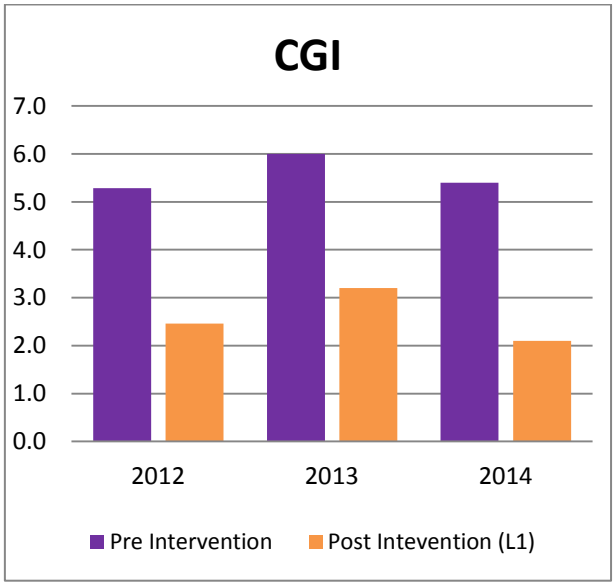
BAI	N	Pre Mean	Pre SD	Post Mean	Post SD	T value	df	Sig.
Agorophobic	4	25.75	5.19	25.25	8.22	0.09	3	0.94
Social Phobia	17	23.65	12.54	19.29	13.52	1.73	16	0.10
Panic Disorder	9	15.56	6.00	34.44	15.31	3.85	8	0.01
GAD	13	21.77	8.91	14.54	9.54	2.57	12	0.03
OCD	37	21.65	11.04	13.89	8.75	4.16	36	0.00



Average depression scores for those who completed the programme (indicated on the graph above) were in the moderate range (M = 22.8, SD = 9.39) and showed a statistically significant drop to within the mild range (M = 15.67, SD = 9.17), t(83) = 7.25, p = .000, which represented a medium effect (Cohen's d = 0.77). While 21.6% were classified has having severe depression before the programme, 8.2% were classified as such by the end (See the table above).

A comparison of change across the four main diagnostic categories is available in the table below.

BDI	N	Pre Mean	Pre SD	Post Mean	Post SD	T value	df	Sig.
Agorophobic	4	25.75	4.35	24.75	5.25	1.00	3	0.39
Social Phobia	17	23.94	12.42	18.94	11.14	2.89	16	0.01
Panic Disorder	9	26.78	6.55	15.56	6.00	4.02	8	0.00
GAD	13	19.31	7.61	14.54	9.53	2.91	12	0.01
OCD	39	22.26	9.27	13.49	8.56	5.22	38	0.00

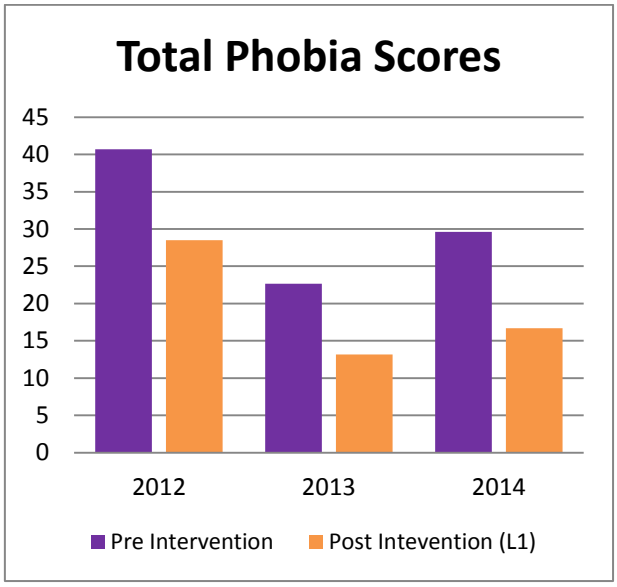


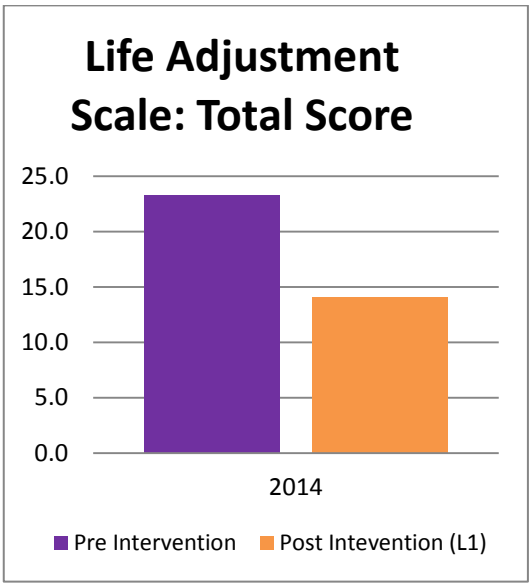
The mean pre programme Severity of Illness (measured using the CGI) was 5.4 (*SD* = 0.53) out of a possible 7. This suggests that patients were, on average, *markedly ill* prior to intervention but were in the *much improved* category (M= 2.1; SD = .57) after completing level 1 of the programme. This change was statistically significant t(83) = 35.8, *p* = .000.

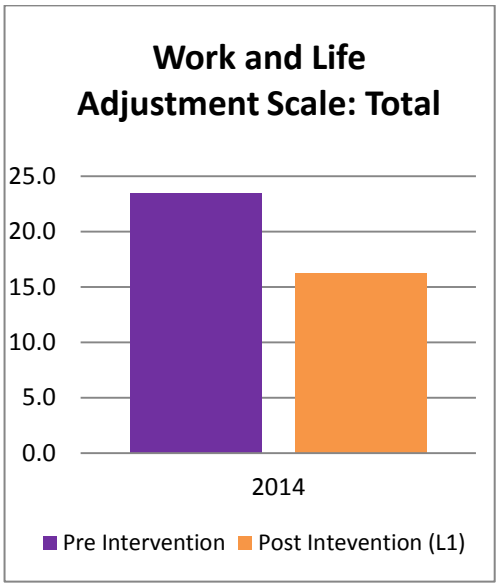
A breakdown of the result by diagnosis is available in the table below.

CGI	N	Pre Mean	Pre SD	Post Mean	Post SD	T value	df	Sig.
Agorophobic	4	5.25	0.50	1.75	0.50	7.00	3	0.01
Social Phobia	16	5.56	0.51	2.19	0.40	16.74	15	0.00
Panic Disorder	9	4.89	0.33	2.00	0.71	11.09	8	0.00
GAD	14	5.21	0.58	1.93	0.47	14.89	13	0.00
OCD	39	5.46	0.51	2.31	0.61	23.33	38	0.00

Total phobia scores showed a significant drop, t (81) = 5.2, p = .00, from a mean of 29.6 (SD = 21.1) to 16.7 (SD = 15.1) suggesting less phobia. The effect size d =0.69 indicates a medium effect.

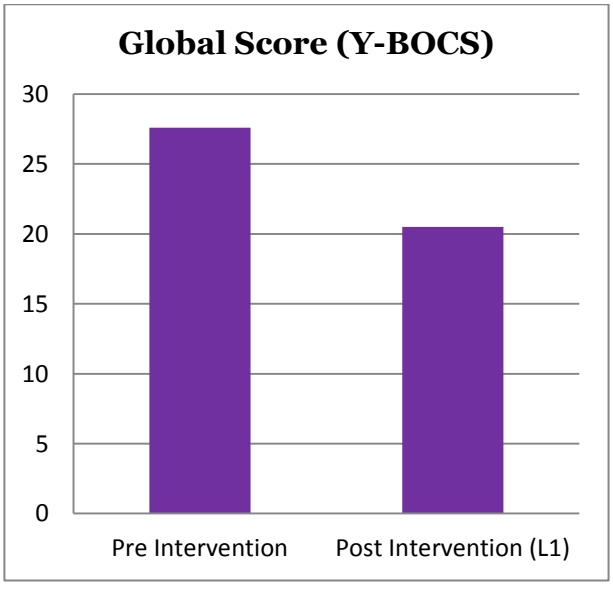




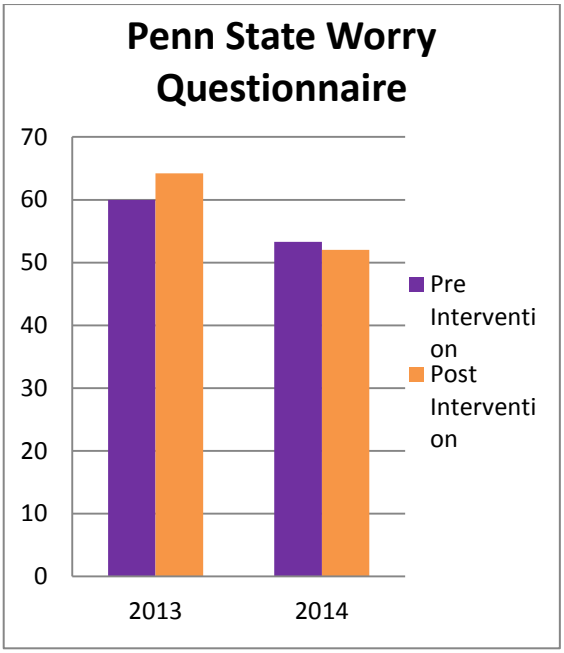


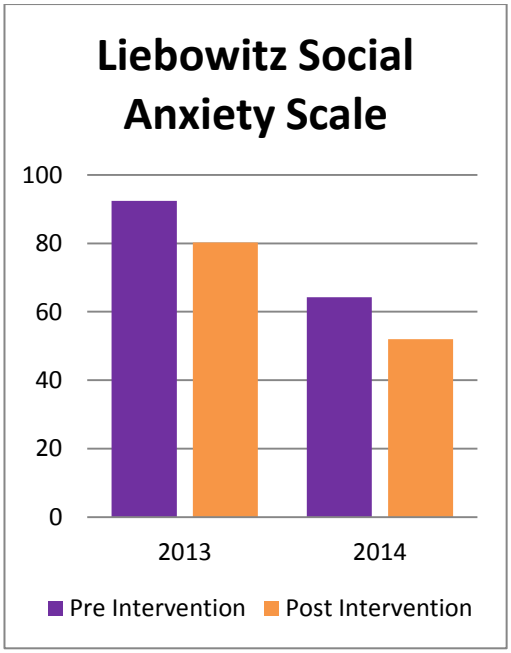
Of those who completed measures in 2014, 17 completed the Life Adjustment Scale while 70 completed the Work and Social Adjustment Scale. Statistically significant improvements were reported for overall impairment on the Life Adjustment Scale (LAS). Mean total LAS scores decreased from 23.23(SD = 9.16) to 14.06 (SD = 7.59), indicating a large effect (Cohen's d = 1.09) on improving functioning $t(16) = 3.8$, $p < .05$.

Significant improvements in impaired functioning is also indicated by the Work and Social Adjustment Scale, $t(64) = 7.31$, $p = .00$, with Cohen's d representing a large effect ($d = 0.961$).



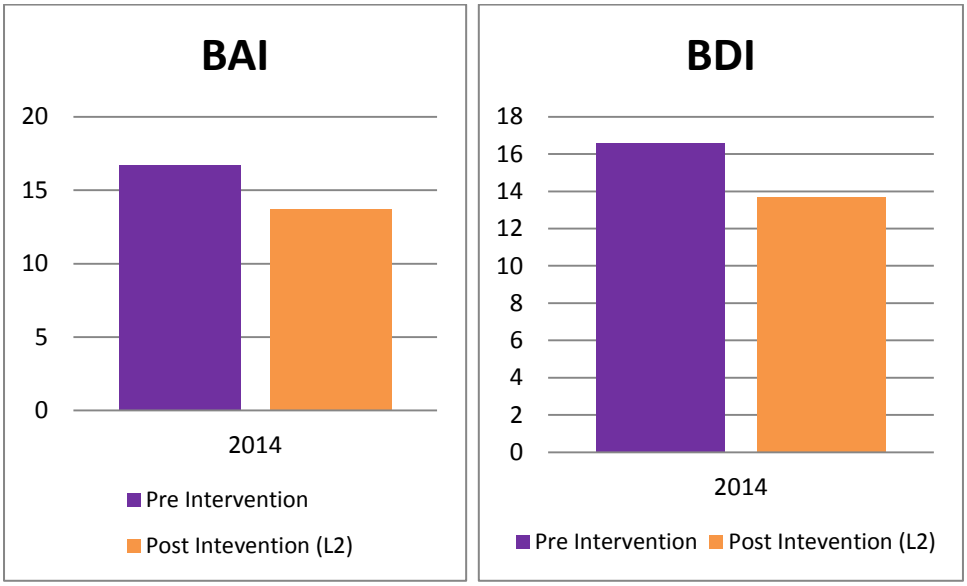
For those with OCD (n = 39), global (Y-BOCS) scores dropped significantly from 23.7 (*SD* = 5.34) to 16.7 (*SD* = 6.28), *t* (39) = 6.11, *p* = .00, (Cohen's *d* = 1.2), indicating an overall reduction in the severity of OCD symptoms with a large effect size.





For those 22 participants with generalised anxiety disorders (GAD) scores on the PSWQ dropped significantly from 64.21 (SD = 8.15) to 52.0 (SD = 8.35), t (13) = 5.9, p = .00, Cohen'd = 1.47. The percentage of those who completed the programme (19 individuals) scoring above 60 (indicating greater levels of social phobia) on the LSAS at the start of the programme reduced from 89.5 % to 66.7% after completing Level 1. This decrease in the mean score for social phobia did not reach significance.

4.5.4. Level 2 Results

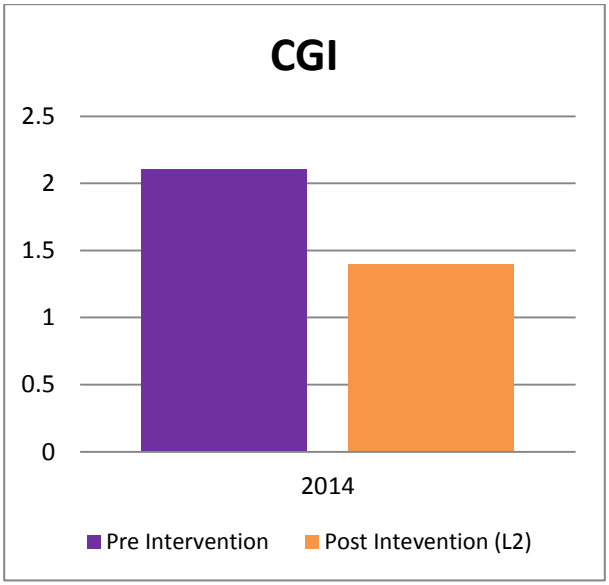


Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved from the moderate (M = 16.7, SD = 7.5) to the mild (M = 13.7, SD = 7.8) range on the measure. Changes were statistically significant, t(25) = 3.18, p<.05, and represents a medium effect (Cohen's d = 0.40). At the pre measurement time point, 17.1% had anxiety scores in the severe range, this dropped to 3.6% by the end of Level 2 (See the table below).

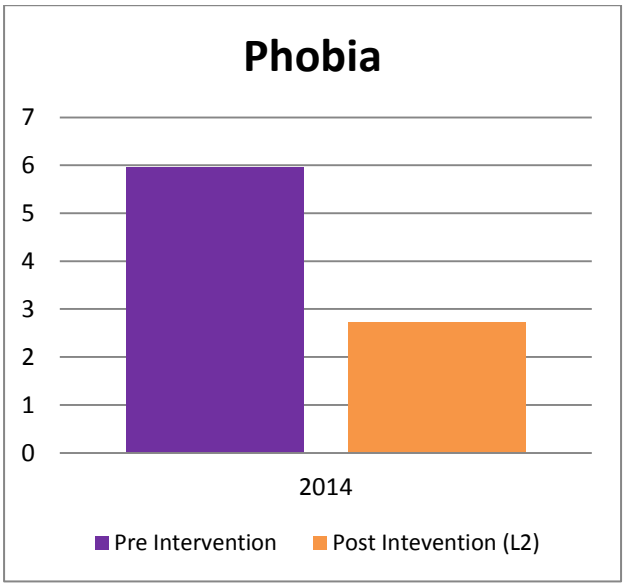
% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	18.3	31.0	28.2	40.7
Mild	31.7	38.0	34.2	33.4
Moderate	32.9	27.4	28.2	22.2
Severe	17.1	3.6	9.4	3.7
Totals	**100**	**100**	**100**	**100**

Average depression scores for those who completed the programme (indicated on the graph above) were in the mild range (M = 16.58, SD = 7.56)

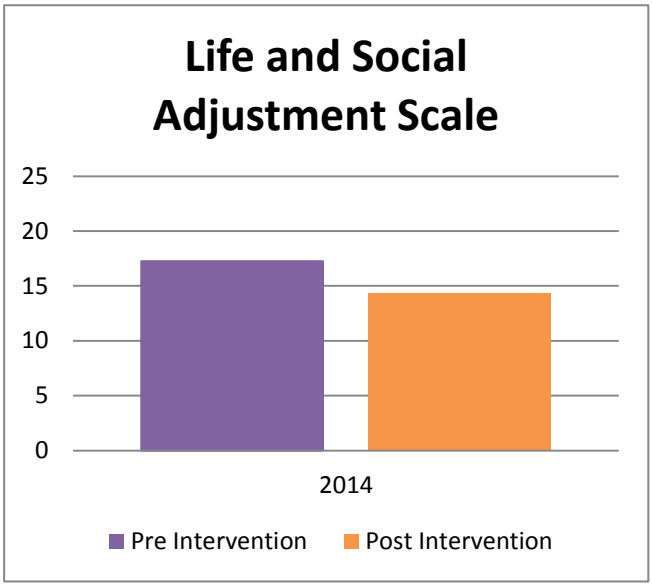
and dropped to (M = 13.7, SD = 7.84) though this was not statistically significant. While 9.4% were classified has having severe depression before the programme, 3.7% were classified as such by the end of Level 2 (See table above).



The mean pre programme Severity of Illness (measured using the CGI) was 2.1 (SD = 0.58) out of a possible 7 which dropped to 1.4 following Level 2 suggesting that on average those who completed the programme were rated in the *very much improved* category after completing level 2 of the programme.



Global phobia Ratings showed significant drop from a mean of 5.95 (*SD* = 8.2) to 2.72 (*SD* = 2.8) t(21) = 2.162 p > .05 suggesting reduced ratings following the intervention.



Of those who completed measures in 2014, 12 completed the Life Adjustment Scale while 12 completed the Work and Social Adjustment Scale. A statistically significant improvement in scores on the Life Adjustment Scale (LAS), t(11) = 2.19, p = .05, representing a medium effect (Cohen's d = 0.67) on functioning. No statistically significant change was apparent on the Work and Social Adjustment Scale, though examination of the means shows a lower mean score following intervention.

In level 2 no statistically significant change was apparent on the global (Y-BOCS) for those with OCD, the Penn State Worry Questionnaire or the Liebowitz Social Anxiety Scale.

4.5.5. Summary

Level 1: Outcomes for the 87 service users who completed Level 1 of the Anxiety Programme between January and December 2014 suggested

significant reductions in anxiety and depression symptoms, levels of phobia related avoidance, OCD symptoms, pathological worry and impairment in functioning. All changes were statistically significant with medium to large effect sizes.

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the Anxiety Programme in 2013 were positive and suggested further improvements in anxiety and depression symptoms, global OCD symptoms, and Phobia Ratings post Level 2. Statistically significant changes on the Y-BOCS, PSWQ and LSAS were not found in this data set. This may be in part as a result of low sample sizes for these comparisons (n <12) and/or scores on these measures meeting a "ceiling effect" following significant improvements on these measure post level 1. Improvements on these more specific measures were maintained post Level 2 and trended towards further symptom reduction though these changes were non-significant.

Changes in mean scores for most measures have been consistently positive across data from 2011, 2012, 2013 and 2014, following both Level 1 and Level 2. It should be noted that differences in results between years may relate to changes in sample sizes across cohorts.

4.6. Compassion Focused Therapy

Compassion focused therapy (CFT) is based on what we know and understand about how humans have evolved and the way our brain works. CFT recognises the importance of being able to engage with rather than avoid or own suffering and that feeling cared for, accepted and connected with others is important for our psychological health.

CFT was initially developed by Professor Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Leaviss & Uttley, 2014), thus making it difficult for these individuals to make lasting changes with Cognitive Behaviour Therapy (CBT) alone, even though they might be able to work within CBT models.

CFT encourages clients to develop key attributes of compassion, identified by Gilbert (2009) as care for wellbeing, sensitivity, distress tolerance, empathy and -non-judgement. To enhance self- compassion, group members work towards developing these attributes through the development of skills in the areas of attention, imagery, behaviour, reasoning, sensation and feeling (Gilbert, 2009; Leaviss & Uttley, 2014).

Research has demonstrated the importance of self- compassion for psychological functioning (Neff & McGehee, 2010). Jazaeir et al. (2012) identified compassion as a predictor of psychological health and wellbeing and found that it was associated with decreased negative affect and stress as well as increased positive affect and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for clients experiencing high shame and criticism. Research has found that CFT is associated with a reduction in depression, anxiety, shame, and self-criticism and increased ability to self soothe in response to emotional distress (Lucre & Corten, 2012).

The Compassion Focused Therapy group commenced in St Patrick's University Hospital in February 2014 and in St Edmundsbury in July 2014. Groups are facilitated by members of the Psychology Department. Groups

run twice weekly for five weeks, once weekly for four weeks and once per month for four months.

4.6.1. Compassion Focused Therapy Outcome Measures

Participants completed measures pre and post group.

• Fears of Self-Compassion

The Fears of Self-Compassion Scale (FSCS; Gilbert, McEwan, Matos & Rivis, 2011) is a 15 item subscale of a longer measure designed to explore the fears of compassion for self (15 items e.g. I fear that if I am to compassionate towards myself, bad things will happen). Higher scores are indicative of greater fears of self-compassion. The measure has been shown to have satisfactory reliability (Gilbert et al., 2011).

• Social Comparison Scale

The Social Comparison Scale (SCS; Allan & Gilbert, 1995) is an 11 item scale designed to measure judgements concerned with rank, attractiveness and how well the person thinks they 'fit in' with others in society. Low scores are indicative of feelings of inferiority and general low rank self-perceptions. Responses to items are rated using a 10 point-likert scale (1= incompetent and 10 = More competent). This scale has been shown to have satisfactory reliability with clinical populations and student populations (Allan and Gilbert, 1995).

• Brief Symptom Inventory

The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item measure of psychological distress experienced by service users within the previous week. Psychometric evaluations (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004) have shown that the BSI is a reliable and valid measure. Each item is rated on a 5- point scale of distress from 0 (Not at all) to 4 (Extremely). Higher scores are indicative of greater psychological difficulty. It

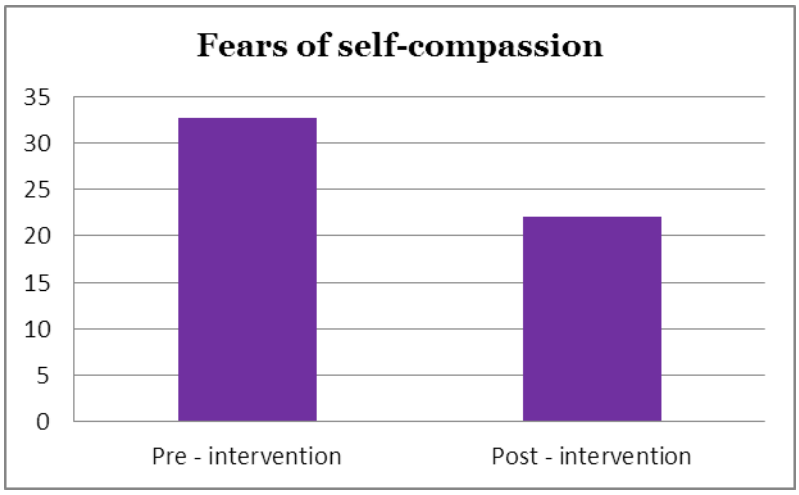
has good test-retest reliability and internal consistency, and it shows high convergence with comparable scales on the SCL-90-R and MMPI.

4.6.2. Descriptors

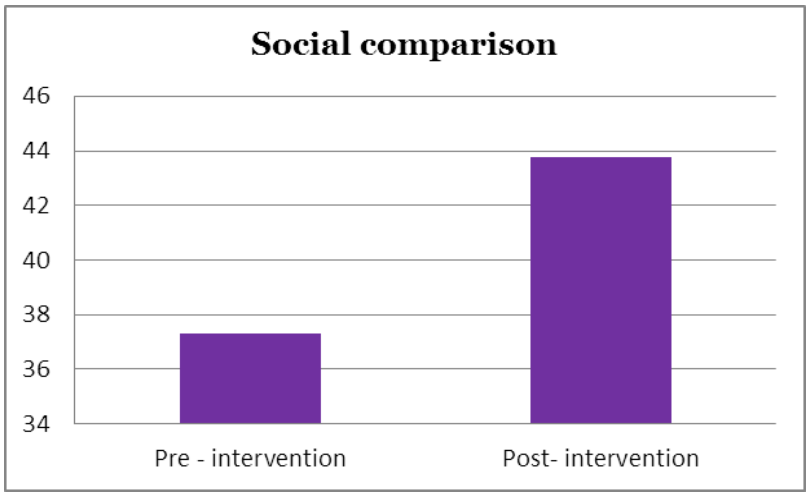
Pre and post data were available for 52 participants who attended the group in either St Patrick's University Hospital or St Edmundsbury Hospital, of which 37 (71.2%) were female and 15 male (28.8%). This represents approximately 75% of those who attended and completed the groups in 2014. Programme attendees ranged in age from 20 to 70 years old with an average age of 48 years (*SD* = 13.26).

4.6.3. Results

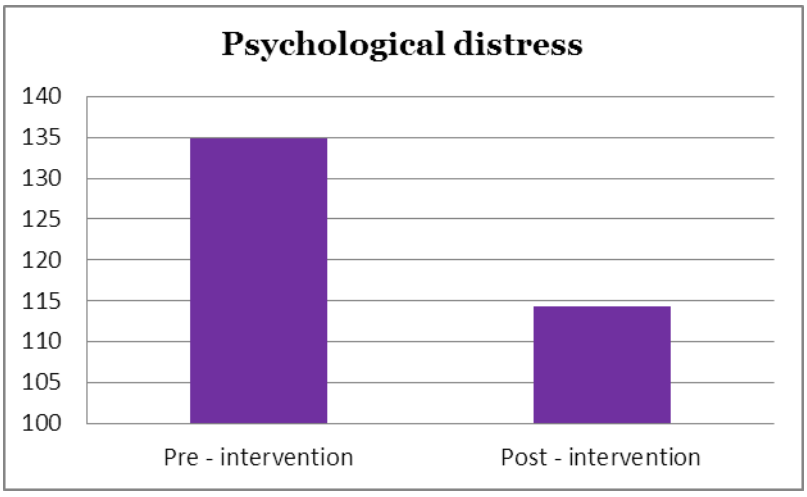
A significant decrease in fears of self-compassion was observed in service users who completed the group. A moderate effect size was observed in this regard (d = 0.70). These findings suggest that fears of developing and having self-compassion decreased from pre to post programme participation.



Significant increases from pre to post were observed in scores of social comparison, reflecting a moderate effect (d = 0.57). These findings indicate that following completion of the group, service users' self-perceptions in terms of rank, attractiveness and the degree to which they felt they "fit" into society, had improved.



Service users reported a significant decrease in symptoms of psychological distress following completion of the group. A moderate effect size was observed (d = 0.57).



4.6.4. Summary

The Compassion Focused Therapy groups commenced in SPMHS in 2014, during the course of which five groups have been facilitated. The programme has received considerable interest within the hospital. Research by a Clinical Psychologist in training is ongoing on the programme, the results of which are expected to contribute to the growing research in the area of CFT.

Anecdotal feedback from clients who attended these groups has been mostly positive, with clients reporting noticeable improvements in how they subsequently deal with psychological distress. This feedback has been supported statistically by the findings of this report; specifically by the reduction of symptoms of psychological distress as measured by the BSI following completion of the group.

Fears of self-compassion were found to significantly decrease while service user self-perceptions (ranking, attractiveness, "fitting in" etc.) significantly increased following completion of the group.

Service users who attended the group in St Patrick's Hospital have noted that the format of the group is somewhat intensive in that sessions take place twice weekly for the first 5 weeks. Their feedback is that they would prefer weekly sessions. The facilitators of the group in St Patrick's Hospital have considered this feedback.

The group will continue to run in 2015 but will take up a new format from April 2015 in St Patrick's Hospital. The programme will run once weekly for eleven weeks with three monthly sessions while the development of a longer term intervention group has been proposed.

4.7 Depression Recovery Programme

The Depression Recovery Service offers a group-based stepped level treatment programme in line with international best practice guidelines. The programme consists of Level A (Activating Recovery), Level B (Building Recovery-CBT Workshop) and Level C (Compassion Focused Therapy Workshop).

Level A (Activating Recovery) is a group based programme, facilitated two days per week for three weeks. The group includes twelve to fourteen individuals and is open to inpatients and day patients. Activating Recovery focuses on Behavioural Activation, Education about Depression, Building Personal Resources and Introduction to WRAP (Wellness Recovery Action Plan).

Level B is a four week programme that aims to introduce the concepts of CBT and Compassion focused therapy. Workshops have been designed as a means for exploring the thought mood connection, the development of the vicious cycle and how to unravel them.

Level C is an eight week closed Psychotherapy Programme that runs one day a week open to people who wish to build on work completed in level B. This level of the programme utilises CBT, Compassion Focused Therapy and Mindfulness.

4.7.1 Outcome Measures

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses. Its long form is composed of 21 questions, each designed to assess a specific symptom common among people with depression. Individual questions on the BDI assess mood, pessimism, and sense of failure, self-dissatisfaction, guilt, punishment, self-

dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores can range from 0 – 63 with higher scores indicating more severe depressive symptoms. Scores can be described as minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

- **Patient Health Questionnaire (PHQ-9)**

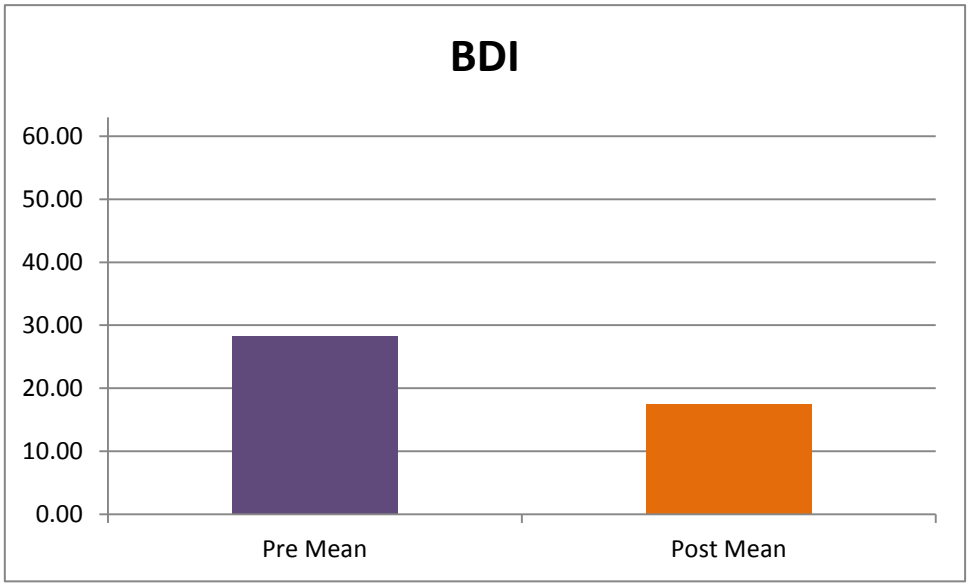
A self-administered version of the PRIME-MD diagnostic instrument for common mental disorders; the PHQ-9 is the depression module. It scores each of the nine DSM-IV criteria from "0" (not at all) to "3" (nearly every day). It is commonly used to monitor the severity of depression and response to treatment. Reliability and validity of the tool have indicated it has sound psychometric properties. Internal consistency of the PHQ-9 has been shown to be high and studies of the measure have produced Cronbach alphas of .86 and .89 (Kroenke and Spitzer, 2001). PHQ-9 total score for the nine items ranges from 0 to 27. Scores of 5, 10, 15, and 20 represent the cut-off points for mild, moderate, moderately severe and severe depression, respectively.

4.7.2 Descriptors

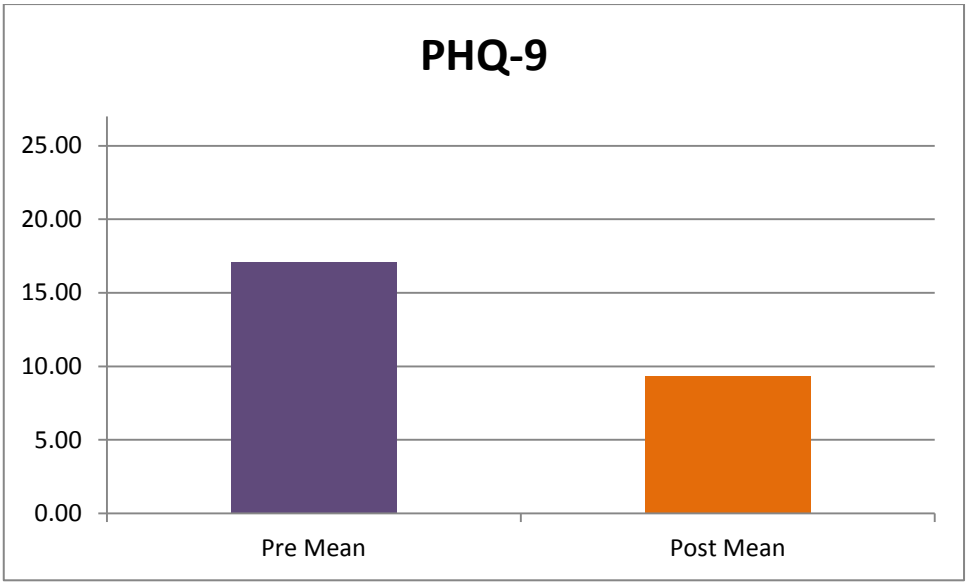
Complete pre and post data sets were available for 67 people for the BDI, of which 28 were male and 39 female. For the PHQ-9 data were available for 66 of those who completed the programme, 28 male and 38 female. All those who completed the programme had a primary diagnosis of Major Depressive Episode with Recurrent Melancholic features.

4.7.3 Results

Pre and post scores on the Beck Depression Inventory (see graph below) suggest that the average score for people who completed the Depression Programme moved from the upper moderate range (M = 28.30, SD = 10.72) to the mild range (M = 17.42, SD = 10.74) on the measure. This reduction in the mean score is statistically significant, (t(65) = 8.5, p = .00), and shows a large effect size (Cohen's d = 1.01). In relation to the clinical significance of these results, prior to intervention, 32% of those who completed the programme had scores in the severe range for depression, while 10.4% had scores in this range post intervention.



Comparison of patient scores on the PHQ-9, pre and post completion of the depression recovery programme, indicated that, on average, those who completed the programme rated themselves in the moderately severe range (M = 17.06, SD = 6.5) prior to the intervention and in the mild range (M = 9.03, SD = 6.10) following intervention on this measure. This reduction in mean scores is statistically significant, (t(65) = 9.1, p = 0.00), and shows a large effect size (Cohen's d = 1.22). Prior to the intervention, 36.6% of those who completed the programme had depression scores in the severe range which dropped to 9.1% post intervention.



4.7.4 Summary

This is the first year the depression programme has been included in the SPMHS outcomes report. Two well established outcomes measures were used to investigate the programme's effectiveness at reducing symptoms of depression. Both measures showed significant reductions in service users' mean scores following completion of the programme with large effect sizes. The results also showed that a significant proportion of participants moved out of the severe range on the BDI and PHQ (21.6%, 27.5% respectively) following the treatment programme. These results provide evidence to suggest that, on average, people who complete the programme experience a reduction in depressive symptoms. In future years the programme may wish to include more demographic information on patients who complete the programme (e.g. age) and may wish to measure model specific outcomes such as "compassion" or use/ understanding of CBT/ use of skills. This may help provide further evidence that the programme is effective and operating by its hypothesised mechanisms.

4.8. Dual Diagnosis Programme

The Dual Diagnosis Programme is designed for adults who are currently abusing (clients must meet the criteria for dependence) or dependent on alcohol or chemical substances, and in addition, have a co-morbid diagnosis of a mental health difficulty such as depression, anxiety or bipolar disorder (Axis 1 disorder).

The aim of this programme is not only to enable clients to achieve abstinence and recovery in relation to substance use, but also to facilitate awareness, understanding and provide practical support and knowledge in relation to their mental health difficulties.

The aim of this programme is to assist the client in the recovery process by providing a bio-psychosocial support structure and the therapeutic environment necessary to foster such a recovery. This includes a combination of group and 1:1 support to help in the transition from complex mental health and addiction issues to a more sustainable and healthy life in sobriety.

The Dual Diagnosis is a staged recovery programme, delivered by Psychiatrists, Addiction Counsellors, Ward based nursing staff, with input from other disciplines including Psychology, Social Work and Occupational Therapy and includes:

- Initial detox and assessment by MDT
- In-patient, residential service for approximately four weeks (longer if required)
- 12 week Stepdown programme (not always required, pending treatment pathway)
- Aftercare for 12 months

The programme includes the following elements:

- **Individual multi-disciplinary assessment:** This facilitates the development of an individual treatment care plan for each client.

- ***Psycho-education lectures:*** A number of lectures are delivered weekly with a focus on providing education on substance misuse and recovery, as well as approaches for managing mental health issues e.g. ACT, CBT, and Mindfulness. There is also a weekly family and patient lecture, facilitated by Addiction Counsellors, providing information on substance misuse and recovery to clients and their families.
- ***Goal setting and change plan*:** This group is facilitated by therapists and encourages participants to put plans and structure in place for time spent outside of the hospital.
- ***Mental health groups:*** This is a psycho-educational group focussing on Mental Health related topics such as include Depression, Anxiety and Recovery.
- ***Role play groups:*** This group aims to allow clients to actively practice drink/drug refusal skills, to learn how to communicate about mental health, and to manage relapse in mood and substance misuse. The group creates opportunities to role play real life scenarios that may have been relevant to the client or may be relavant in the future.
- ***Recovery plan:*** This group facilitates and supports clients in developing and presenting an individual recovery plan. It covers topics such as Professional Monitoring, Community Support groups, Daily inventories, Triggers, Physical care, problem solving, Relaxation, spiritual care, Balance Living, family/friends, work balance etc.
- ***Reflection group:*** This group provides a safe place to support clients through the process of change; an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- ***Relapse prevention and management groups:*** This group focuses on developing successful relapse prevention and management strategies.

4.8.1. Dual Diagnosis Outcome Measures

Leeds Dependency Questionnaire (LDQ

The Leeds Dependence Questionnaire (LDQ; Raistrick et al., 1994) is a 10-item questionnaire, designed to screen for mild to severe psychological dependence to a variety of different substances, including alcohol and opiates. This measure was completed by service users pre and post programme participation.

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence including: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Paton-Simpson & MacKinnon, 1999).

Items are scored on a 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

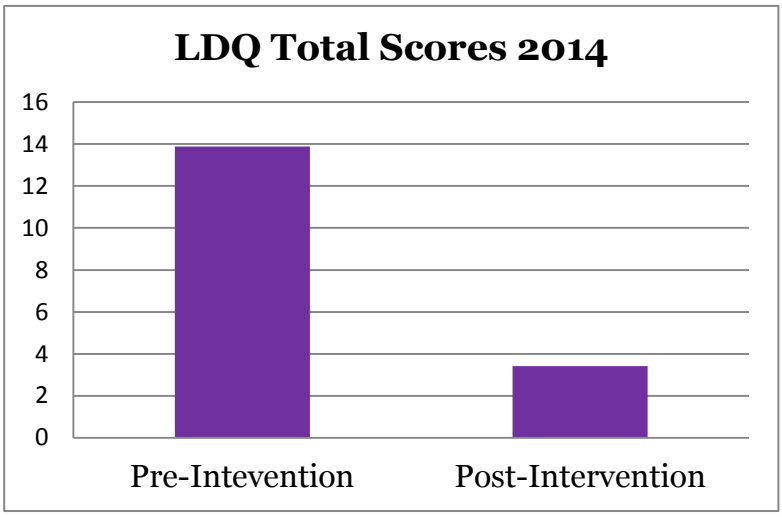
4.8.2. Descriptives

196 participants completed the full or modified programme in 2014. Pre and post data were available for 52 participants, representing approximately 26% of participants who attended the programme in 2014. This means that findings presented may not be representative of all participants who

completed the programme and that findings need to be interpreted in light of this. 40.38% and 59.62% of participants were male and female respectively.

4.8.3. Results

Statistically significant decreases in psychological markers of substance and/or alcohol dependency were observed from pre (M = 13.88, SD = 8.27) to post (M = 3.42, SD = 4.72), representing a large effect size (d = 1.36).



4.8.4. Summary

Following completion of the Dual Diagnosis programme, significant and large reductions in psychological markers of alcohol/substance dependency were observed. These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and its use is expected to continue in 2015.

These findings support previous studies and literature which regard the LDQ as a suitable tool for the evaluation of interventions for adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000) and psychiatric difficulties (Ford, 2003).

Despite efforts from staff, collecting post data has been challenging and resulted in the data capture of only 26% of those who completed the programme in 2014. According to Tober et al. (2000), service users with substance difficulties can find it difficult to commit to completing follow-up measures for many reasons including motivation, difficulties with attendance and convenience of appointment times given. To overcome this difficulty, completion of post measures will be completed in session with therapists during the exit interview and will become part of each client's discharge plan. This will be monitored using the referral spreadsheet for service users and reviewed monthly by the Dual Diagnosis Service coordinator.

4.9 Eating Disorder Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the needs of people with Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. The objective of the programme is to address the physical, psychological and social issues arising as a result of an eating disorder in an attempt to resolve and overcome many of the struggles associated with it. The programme is a multidisciplinary programme with an emphasis on a cognitive behaviour therapy (CBT) treatment model which is applied throughout inpatient, day patient and outpatient treatment stages, as needed by the patient. The programme is structured into three stages. Initially service users are assessed at the Dean Clinic. The typical care pathway then involves inpatient care, day care, and follow-up outpatient care. Inpatient care consists of a variety of interventions including:

- Stabilisation of Weight
- Medical Treatment of physical complications where present
- Meal supervision
- Nutritional assessment and treatment
- Dietetics group: discuss nutrition, meal planning, shopping, food portions, etc.
- Methods to improve self-assertiveness and self-esteem
- Enhancement of self-awareness
- Body image group
- Occupational therapy groups: Weekly groups addressing lifestyle balance, stress management, and social, leisure and self-care needs. A weekly cookery session is also included in the programme.
- Family therapy
- Individual Psychotherapy
- Psychology groups for compassionate mind training, which aims to help participants begin to understand, engage with, and alleviate their distress.

Following inpatient treatment, service users will usually attend day services. Often service users will attend daily for the first two weeks and subsequently

reduce attendance, which is decided by the service user and treating MDT. The day programme runs Monday to Friday and offers a number of group interventions delivered by Nursing, Occupational Therapy and Psychology MDT members, including:

- Occupational therapy groups
- Goal setting groups
- Cooking groups
- Body-image, self-esteem and relaxation/self-reflection groups
- Psychology groups for skills training in regulating emotions and tolerating distress

Following day services, outpatient care is offered in the Dean Clinic. Services offered at the Dean Clinic include Psychiatry, Nursing, and Dietician reviews, along with CBT sessions, in order to support service users in their recovery. Currently there is a monthly aftercare group held to support service users in goal setting and maintaining motivation.

4.9.1. EDP Outcome Measures

The following measures have been chosen to capture eating disorder severity and co morbidity, and to assess readiness for change.

- **Eating Disorder Examination – Questionnaire**

The Eating Disorder Examination Questionnaire (EDE-Q: Fairburn and Beglin, 1994) is a self-report version of the Eating Disorder Examination (EDE: Fairburn and Cooper, 1993) which is considered to be the "gold standard" measure of eating disorder psychopathology (Guest, 2000). Respondents are asked to indicate the frequency of certain behaviours over the past 28 days as well as attitudinal aspects of eating-disorder psychopathology on a seven point rating scale.

Twenty-seven items contribute to a Global score and four subscales including: Restraint, Eating Concern, Weight Concern, and Shape Concern. Items from each subscale are summed and averaged with the global score

generated by summing and averaging the subscale scores (resulting scores range from 0 – 6 for each subscale and the global score). Higher scores suggest greater psychopathology. Evidence in support of the reliability and validity of the measure comes from a number of studies (e.g. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

	Binge Eating Disorder Sample (n=52)	Control group of UK school girls (n=808)	Anorexia Nervosa Sample at Time 1	Anorexia Nervosa Sample at Time 2
Restraint	2.5 (1.5)	1.4 (1.5)	3.1 (1.9)	3.0 (1.9)
Eating Concern	3.4 (1.4)	1.0 (1.0)	2.2 (1.7)	1.8 (1.4)
Weight Concern	4.1 (1.1)	1.8 (1.7)	2.6 (1.7)	2.2 (1.8)
Shape Concern	4.8 (1.1)	2.2 (1.7)	3.4 (1.9)	3.0 (2.6)

1. Wilfley et al, 1997; *N = 6 Males & N= 46 females; Mean age= 45.4 years (SD=9.1).*

2. Carter et al, 2001; *All female; Mean age = 13.4 years (SD=0.5, range=12-14 years); Items rated based on a 14 day period rather than a 28 day period and question wording simplified due to age of subjects.*

3. Passi et al, 2003; *All female; Mean age = 15.8 years (SD=1.5). Time two data: patients completed the EDE-Q for a second time. The interview version of the EDE was administered between the two questionnaire versions.*

- ## Clinical Impairment Assessment

The Clinical Impairment Assessment questionnaire (CIA) is a 16-item self-report tool that measures the impact an eating disorder may have on an individual's social, personal, and cognitive aspects of life. Focusing on the past 28 days, respondents are asked about their mood, self-perception, cognitive functioning, interpersonal functioning and work performance. Each question is given a response of either 'not at all' (0), 'a little' (1), 'quite a bit' (2), or 'a lot' (3). Total scores range from 0 to 48, with higher scores indicative of a greater impact on the respondent's psychosocial functioning. Scores above 16 have been found to predict eating disorder status in previous research (see Bohn et al., 2008).

- **University of Rhode Island Change Assessment Questionnaire**
  The University of Rhode Island Change Assessment Questionnaire (URICA: McConnaughy, DiClemente, Prochaska & Velicer, 1982) captures four subscales which represent stages of change/motivational readiness to change:

  - *Pre-contemplation* – people in this stage are not ready to change, are not intending to take any action in the near future and may not be aware of problematic behaviour.
  - *Contemplation* – people in this stage are getting ready to make changes, recognizing certain behaviours may be problematic and looking into the pros and cons of their behaviour.
  - *Action* – people in this stage are making specific and overt changes to problem behaviour or acquiring new healthy behaviours.
  - *Maintenance* – people in this stage are managing to sustain changes and are working to prevent relapse.

  Thirty-two questions were responded to on a five-point scale from 1 "Strongly Disagree" to 5 "Strongly Agree". A total readiness to change score can be generated by summing the means of the contemplation, action, and maintenance subscales and then subtracting the pre-contemplation mean. In a treatment seeking sample with anxiety the average Readiness to Change score was 10.40 (SD = 1.51). The measure developers provide cut-off scores for the general population and suggest that scores of 8 or lower indicate 'Pre-contemplators', 8-11 'Contemplators', 11-14 'Preparators' and 'Action takers'. The measure has good internal consistency (Cronbach's alpha = 0.73-0.90) with mixed evidence for its validity (Dozois, Westra, Collins, Fung & Garry, 2004).

4.9.2. Descriptors

A total of 41 service users attended the EDP as an inpatient in 2014 and 50 attended as a day-patient. As there are potentially multiple entry points within the EDP, data was collected at four time points:

- At initial assessment in the Dean Clinic (time point 1)
- At commencement of inpatient services (time point 2)
- At inpatient discharge or upon beginning day patient care (time point 3)
- At discharge of day patient services (time point 4)

While most attend each entry point (Deans, In-Patient & Day-Patient), it has been challenging to collect data for services users' at all four time points. This has been achieved for only one service users. Thus analysis cannot be carried out using data from all four time points. In order to carry out a pre and post intervention analysis scores from all four time points were grouped into two new categories, pre intervention (including data from time points 1 or 2) and post intervention (including data from time points 3 or 4). While this will offer some indication of change, it should be considered when interpreting the results that there will be variation in the amount of intervention received by each service user included in this analysis. For example, data may be used for someone at time point 2 and 3, after they have received inpatient care. For another service user, data may be used at time points 1 and 4, after they have received inpatient, day patient and outpatient care.

The following table shows the mean scores (average scores) and standard deviations (amount of variation of scores) for service users at each time point, followed by a description of what this may represent.

Table: *Mean scores at initial assessment (time point 1)*

Measure	Mean	SD	N
EDE-Q Global	5.22	8.29	65
Clinical Impairment Assessment	29.62	14.01	65
Motivation (URICA)	9.47	1.84	55

Previous research in the Netherlands using the EDE-Q has suggested that a 'normal' global score for adult women without an eating disorder would be on average 0.93, and 4.02 for someone experiencing an eating disorder (Aardoom et al., 2012). The average global score for service users at initial assessment was 5.22.

The average score for the CIA was 29.62, suggesting that service users' eating disorders were having a high impact on the social, personal, and cognitive aspects of their lives. Scores above 16 have been found to predict eating disorder status in previous research (see Bohn et al., 2008). The average

score observed at time 1 (29.62), which is lower than the mean pre-treatment score of 31.2 observed in Bohn et al. 2008.

At the initial assessment, the average URICA score was 9.47 which falsl within the contemplation stage. Upon investigation of individual scores, 20% fell within the pre-contemplation, 67.3% fell within the contemplation stage and 12.7 % fell within the preparation and action stage. With the exception of a higher EDE-Q Global score, average scores at this time point were similar to those reported in 2012 and 2013.

Table: *Mean scores at initial assessment (time point 2)*

Measure	Mean	SD	N
EDE-Q Global	3.26	1.64	17
Clinical Impairment Assessment	29.68	13.88	25
Motivation (URICA)	10.29	2.36	23

The mean EDE-Q Global score (3.26) is suggestive of eating difficulties. The mean CIA score (29.68) suggests that upon entering inpatient treatment, eating difficulties were likely having a strong negative impact on the social, personal, and cognitive aspects of service user's lives.

The average URICA score was 10.29, again falling within the contemplation stage. Looking closer at the scores, 8.7% fell within the pre-contemplation stage, 43.5% in the contemplation stage, and 47.8% in the preparation and action taking stage.

Table: *Mean scores at initial assessment (time point 3)*

Measure	Mean	SD	N
EDE-Q Global	2.91	1.26	24
Clinical Impairment Assessment	23.24	12.01	25
Motivation (URICA)	10.68	1.73	19

The EDE-Q Global mean score was 2.91, while the CIA mean score was 23.24. Upon finishing inpatient care/ beginning day patient care the average URICA score was 10.68, suggestive of the contemplative stage. At this time point, the majority of service users were in the preparation/action stage (52.6%), 42.1% were in the contemplative stage and only 1.1% of respondents were in the pre-contemplative stage.

Table: Mean scores at initial assessment (time point 4)

Measure	Mean	SD	N
EDE-Q Global	2.13	1.30	10
Clinical Impairment Assessment	17.56	14.08	9
Motivation (URICA)	10.21	1.39	8

The small number of data available for participants at time point 4 must be taken into consideration when interpreting these results (N = 10).

At discharge the average global EDE-Q score was 2.13, which appears lower than Aardoom et al.'s 2012 reported norm score (4.02) for those experiencing an eating disorder, and higher than the norm score for those not experiencing an eating disorder (0.93). The mean CIA score at discharge was 17.56. In one study, Bohn et al. (2008) found that at post treatment the average CIA score was 8.22.

At discharge the average URICA score (10.21) again fell into the contemplation stage. The majority of respondents scored within this range (75%), while 25% scored within the preparation/action stage.

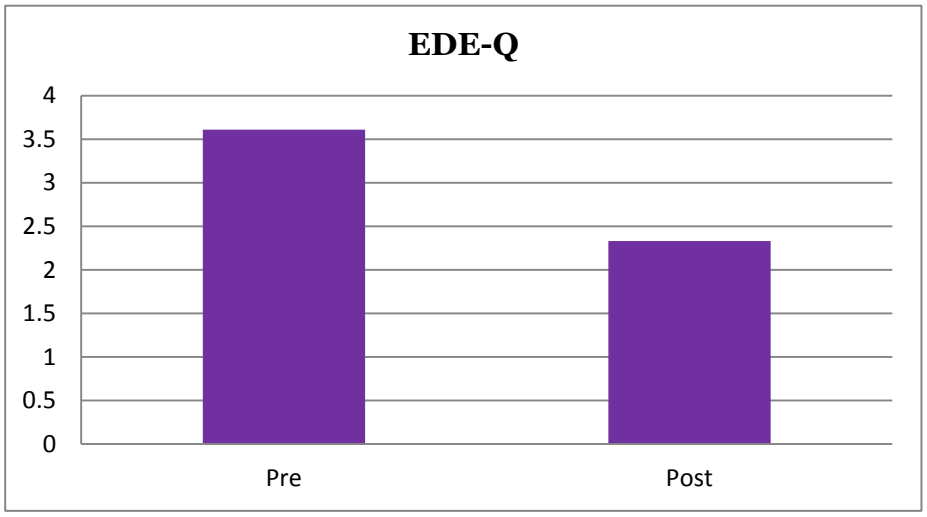
4.9.3. Results

Data from 22 service users at either time point one or two was compared with data collected at either time point time three or four. If data for a service user was available at more than two time points, the data points with the greatest distance between them were used.

Data was collected from 89 service users in total and so this analysis represents findings for 24% of service users who attended EDP in 2014. Thus the sample is not representative of all those who received EDP treatment in 2014, but still offers important information for a sub-group of those who received care. Results from paired sample t-tests for each measure used can be seen in the table below.

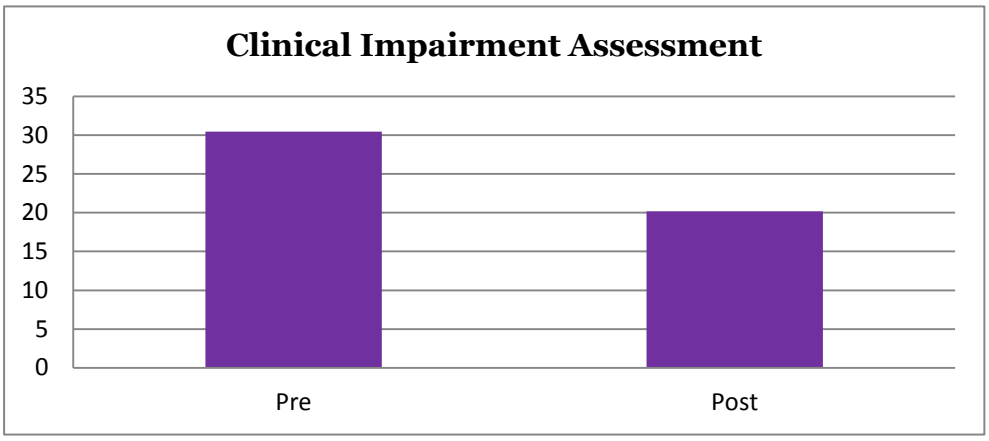
A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed yet no did not meet statistical significance. However a large effect size (d=0.95) was observed, a meaningful trend in scores. The failure to observe statistical differences may be due to many factors and it is not possible to determine these in this report.

The post intervention EDE-Q score (M=2.33), which is still above previous recorded scores for the general population (M=0.93). These finding suggest that while scores reduced from to pre to post, some disordered eating remains for service users upon finishing the programme.



Scores on the CIA significantly decreased from pre to post, representing a moderate effect size (0.76). At pre intervention the average score (M=30.48) was similar to previous research looking at the clinical impairment associated with eating disorders, before treatment (see Bohn et al. 2008). The average

post intervention score (M=20.19), however, does appear to be greater than post intervention scores reported in previous research (M=8.22).



No significant change was seen in readiness for change. The average score at both pre (M=10.41) and post (M=10.18) intervention fall within the contemplation stage, suggesting that service users may have been in a position to get ready to make change, considering the pros and cons of their behaviours.

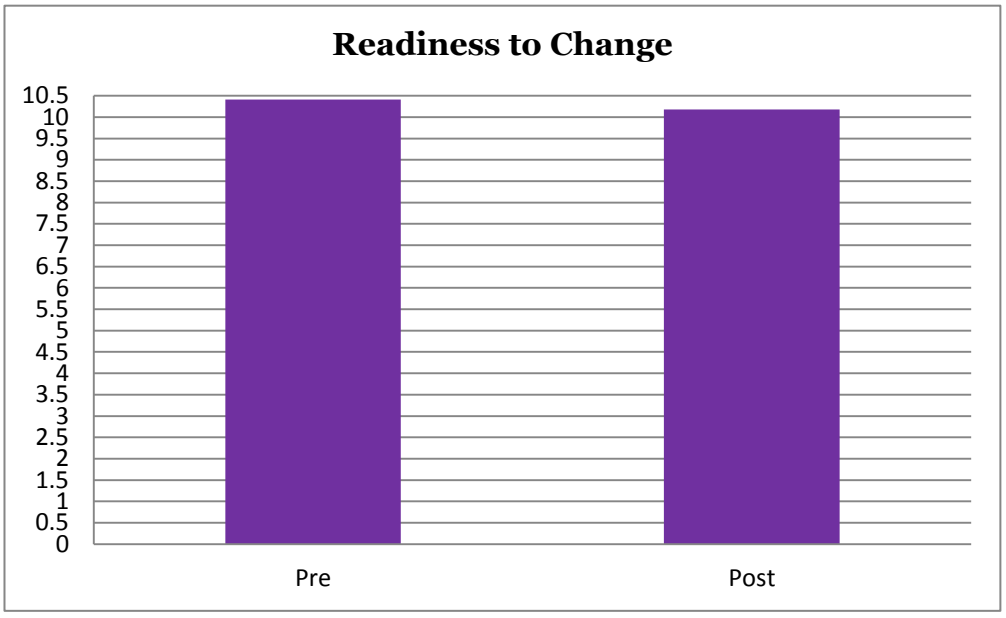


Table: *Results from paired samples t-tests for measures pre and post Eating Disorder Programme.*

Measures	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
EDE-Q	3.61 (1.46)	2.33 (1.21)	2.36	13	.034	0.95
CIA	30.48 (13.51)	20.19 (13.56)	3.83	20	.001**	0.76
URICA	10.41 (1.92)	10.18 (1.28)	.404	147	.692	0.13

A Bonferroni correction was applied and thus significance is shown at $p<.01$=* *and* $p<.001$=**. EDE-Q=Eating Disorder Evaluation-Questionnaire, CIA=Clinical Impairment Assessment, URICA=University of Rhodes Island Change Assessment Questionnaire .

4.9.4. Summary

Statistically significant differences were observed from pre to post intervention on CIA. While scores were observed to be moving in the expected direction on the EDE-Q and the URICA, these differences were not statistically significant.

The assessment battery for the EDP is comprehensive and provides a useful profile of patients attending the service. However, the comprehensive nature of the measures possibly contribute to a difficulty in collecting data at all chosen time points, in turn contributing to less representative results and greater variation in the services being measured. This is despite efforts from EDP staff in collecting data. Plans to increase data collection will be discussed and explored over the coming months.

4.10. Living through Distress Programme

Living through Distress (LTD) is a Dialectical Behaviour Therapy informed, group based intervention. The programme aims to provide emotional regulation, distress tolerance and mindfulness skills for individuals with problems of emotional under-control who frequently present with self-harmful behaviours. Linehan (1993a) proposed that emotional dysregulation underlies much maladaptive coping behaviour. Research suggests that behaviours such as deliberate self harm (DSH) may function as emotion regulation strategies (Chapman et al., 2006).

Linehan's bio-social theory posits that difficulties with emotional under-control are disorders of self-regulation and skills deficit. Emotional regulation difficulties result from biological irregularities combined with certain dysfunctional environments, as well as from their interaction and transaction over time (Linehan, 1993a). Dialectical Behaviour Therapy informed interventions are described in a Cochrane review (2009) as effective evidence based interventions for DSH behaviours, emotional under-control difficulties and Borderline Personality Disorder.

Skills which aid patients to regulate their emotions are at the core of LTD. LTD focuses on both change and acceptance skills. The content is informed by Linehan's skills-based group intervention and modified to meet the needs of the hospital, based on research. Further skills such as interpersonal effectiveness skills are introduced in a once monthly Aftercare programme.

The format of the Living Through Distress skills group has changed since March 2014. The new format of LTD provides patients with a phased model of support that moves from high to low intensity. This is to facilitate patients to generalise their use of skills beyond the hospital setting, applying them increasingly to situations within their lives outside the hospital.

The programme provides 16 skill-group sessions, three times a week. Following these 16 sessions, each LTD group receives an additional 4 skill-group sessions, once a week for 4 weeks. This enables introduction of

additional skills that help to address areas of need such as interpersonal effectiveness in more depth.

Following these additional 4 sessions, each LTD group is invited to attend Aftercare, which is provided for a time-limited period of once a month for four months. This is to ensure that patients are provided with a finite course of treatment that allows them to transition back into their own lives having developed a new set of skills to cope with distress.

The department has undertaken research relating to the programme since its start and the measures being used have evolved over time, and continue to evolve. Previous research conducted here with LTD attendees has demonstrated that participants show significant reductions in reported deliberate self-harmful behaviours and increases in distress tolerance skills (Looney & Doyle, 2008). In another study, those who attended LTD showed greater improvements in DSH, anxiety, mindfulness, and aspects of emotion regulation than people receiving treatment as usual. Further analysis showed that group process/therapeutic alliance and changes in emotion regulation were related to reductions in DSH (Gibson, 2011).

4.10.1. Living Through Distress Programme Outcome Measures

• Difficulties in Emotion Regulation Scale

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dys-regulation, comprising six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 “almost never” to 5 “almost always”. Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal

reliability (α = .93), construct and predictive validity, and test-retest reliability in the development study.

• Distress Tolerance Scale

The Distress Tolerance Scale (DTS; Simons & Gaher, 2005) is a 15-item measure of levels of distress and readiness to tolerate distress. The DTS comprises of 4 subscales assessing tolerance, appraisal, absorption and regulation. Respondents are asked to rate each statement on a 5-point scale from 1 "Strongly Agree" to 5 "Strongly Disagree", higher total scores on the DTS scale indicate greater distress tolerance.

• Five Facet Mindfulness Questionnaire – Short Form

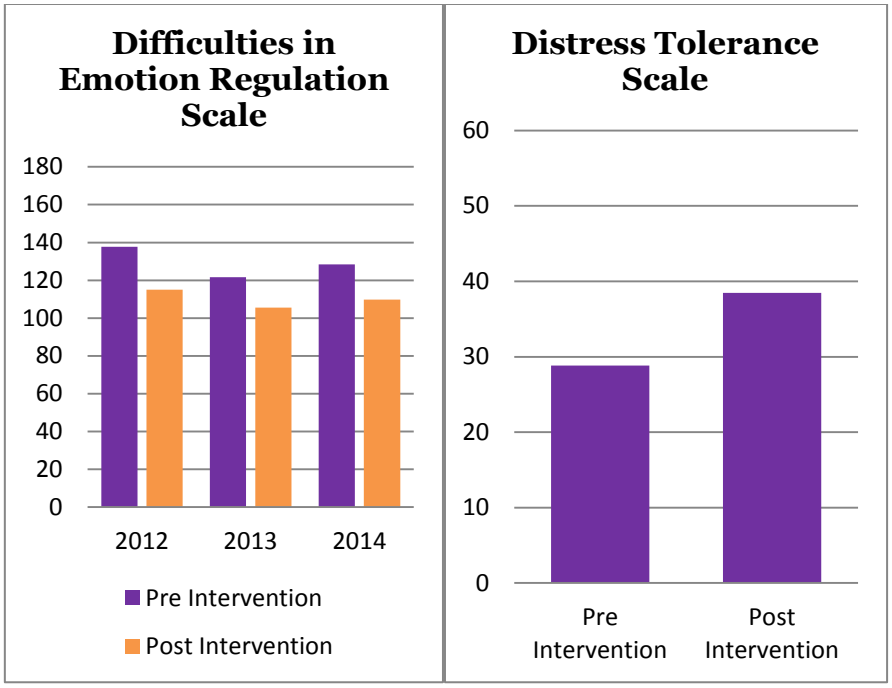
The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity to inner experience, and non-judgement of inner experience. For the purposes of the current analysis the FFMQ-short form (Bohlmeijer, ten Klooster et al., 2011) was used. This version consists of 24 items which reflect the same five mindfulness factors which are responded to on a 5-point rating scale ranging from 1 "never or very rarely true" to 5 "very often or always true". Total scores on the short form can range from 24 to 120 with higher scores indicating greater mindfulness.

4.10.2. Descriptors

86 service users attended the LTD programme in 2014. Pre and post data were available for 41 participants, which represents approximately 48% of those who attended the programme in 2014. While findings need to be interpreted in light of this, data can still provide meaningful insight into the effectiveness of the programme for those who attended.

Of those who had pre and post data, 78.4% were female and 21.6% were male. LTD attendees ranged in age from 18 to 67 years (M = 34.37, SD = 11.9). 68.6% of participants reported engaging in self-harm.

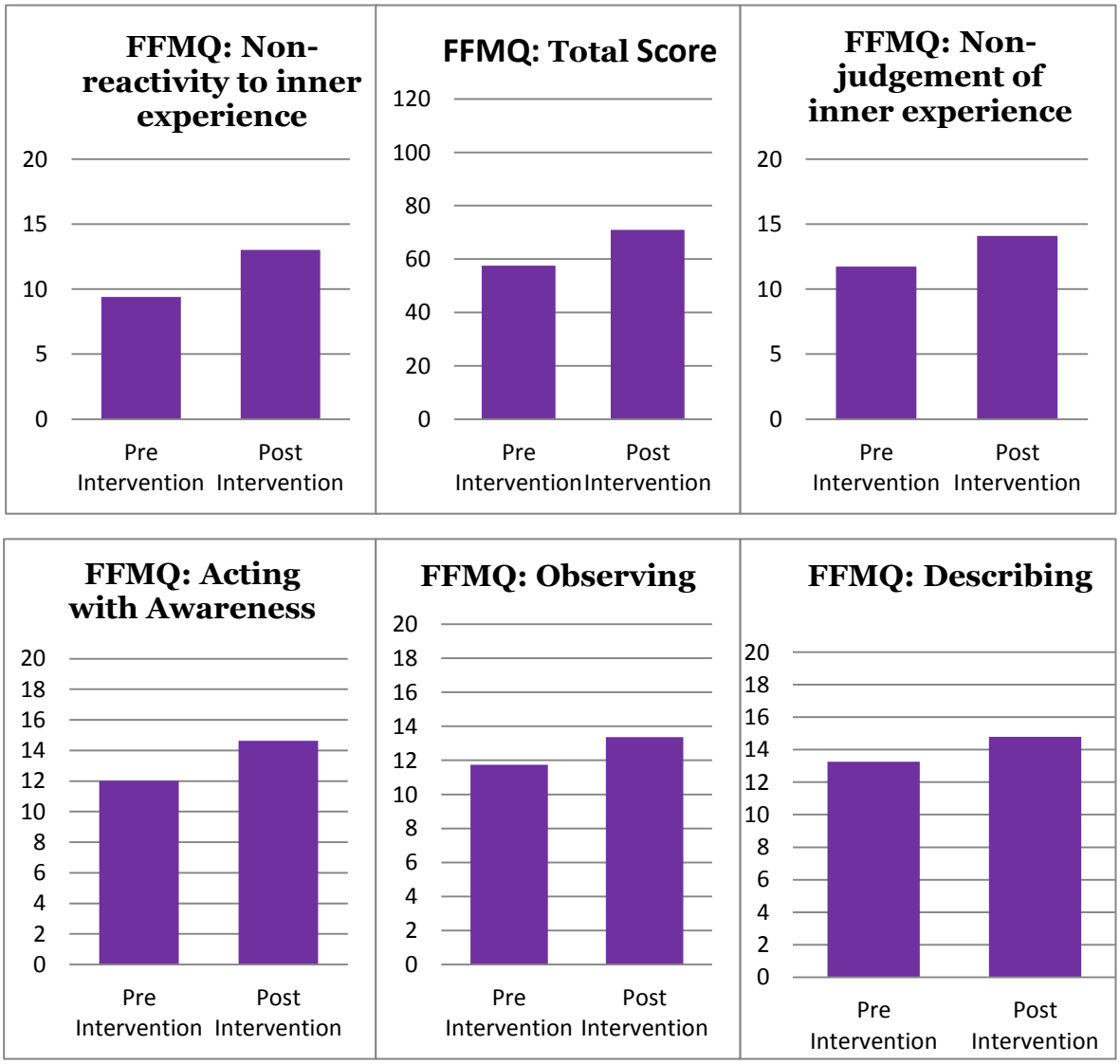
4.10.3. Results



Note: Higher scores indicate greater difficulties regulating emotion and greater distress tolerance.

Significant gains were made across measures from pre to post programme participation. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 128.43 (SD = 17.09) on the DERS pre to 109.77 (SD = 23.66) post completion of the programme, t (29) = 4.58, p < .001. This change represented a large effect (d = .90).

Participants also experienced a significant increase in distress tolerance moving from an average score of 28.85 (SD = 4.87) before the programme on the DTS to 38.45 (SD = 9.61) after completing the programme, t (39) = -5.73, p < .001, representing a large effect (d = 1.26).



Statistically significant improvements were reported for levels of mindfulness in three of the five domains of the FFMQ: non-reactivity to inner experience, non-judgement of inner experience and acting with awareness. Effect sizes calculations indicated medium to large effects in this regard.

While improvements in scores were observed for the remaining domains: describe and observe, differences were not statistically significant. Small effect sizes were obtained for both domains.

Total levels of mindfulness also increased significantly from an average of 58.56 (*SD* = 11.91) at the start to 70.92 (*SD* = 14.16) at completion of the programme, *t* (33) = -9.623, < .001, representing a large effect (*d* = .95).

4.10.4. Summary

For those participants with pre and post data, significant improvements were observed in terms of emotion regulation, distress tolerance and levels of overall mindfulness following engagement with LTD. Effect size calculations suggest overall large effects for these three measures.

Outcome measures for the programme are expected to remain the same for the coming year. Research is expected to continue on the programme in 2015. The programme was recently nominated for three awards at the Irish Health Care Centre Awards 2015.

4.11. Mindfulness Programme

The mindfulness programme provides eight weekly group training sessions in mindful awareness. The course is offered in the afternoon and evening in order to accommodate service users. The group is facilitated by staff trained with Level One teacher training in Mindfulness from Bangor University, Wales. The programme aims to introduce service users to the practice of mindfulness for stress reduction, through group discussion and experiential practices. The programme aims to help service users develop the ability to pay attention to the moment and to be more aware of thoughts, feelings and sensations, non-judgementally. Developing and practicing this non-judgemental awareness has been found to reduce psychological distress and prevent relapse of some mental illhealth experiences (see Piet & Hougaard, 2011).

4.11.1. Mindfulness Programme Outcome Measures

- **Five Facet Mindfulness Questionnaire**

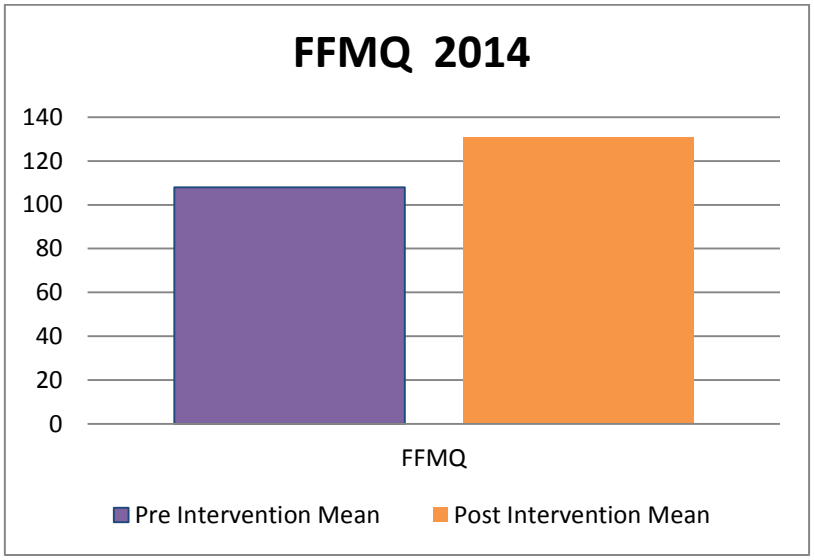
The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five specific facets of mindfulness: observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 “never or very rarely true” to 5 “very often or always true”. Scores range from 39 to 195 with higher scores indicative of greater mindfulness. The measure has shown good reliability in previous research (alpha = .72 to .92 for each facet; Baer et al., 2006).

4.11.2. Descriptors

The Mindfulness Programme was delivered SPUH and St Edmundsbury. The data from each site is analysed for the programme overall.

Data was collected on 205 participants 74 males (36%) and 131 females (63%). Pre and post data were available for 98 services users who completed the mindfulness programme across both sites. Participants age ranged from 20 to 82 years old (mean = 50).

4.11.3. Results



An examination of the combined data from across both sites revealed a significant increase in total scores on the FFMQ from pre intervention (M=107.99; SD=19.54) to post intervention (M=130.81; SD=16.94), t(96)=-10.76, *p*=.000, with a large effect size (*d*=-1.2). These results suggest that, on average, service users who completed the outcome measure showed an increase in their tendency to be mindful in daily life.

Statistically significant increases were reported on all subscales with a medium effect size for the "observing" domain (cohen's D = -0.68) a small effect size for the "describing", (cohen's D = -0.44) domain and a large effect size for the "non-reactivity to inner experience" (cohen's D = -0.80), "non-judgement of inner experience" (cohen's D = -0.80) and "acting with

awareness" (cohen's D = -0.94) domains of the measures" post intervention (see table below).

FFMQ	N	Pre Mean	Pre SD	Post Mean	Post SD	T value	df	Sig.	Effect size
Total	97	107.99	19.54	130.81	16.94	-10.76	96	.00	-1.2
Observe	112	24.75	6.07	28.857	6.07	-8.2	111	.00	-.68
Describe	108	26.01	7.25	28.79	5.34	-4.7	107	.00	-.44
Non-Judgement	108	20.41	6.30	25.47	6.33	-7.94	107	.00	-.80
Awareness	114	19.34	5.50	24.17	4.787	-9.30	113	.00	-.80
Non-Reactivity	110	17.75	4.72	22.58	4.29	-9.07	109	.00	-.94

4.11.4. Summary

In line with the 2013 report, results for 2014 suggest that the programme continues to be successful in helping service users develop their capacity for mindfulness in daily life. The analysis revealed significant change with large effect sizes apparent for changes on the measure overall and most of the subscales. This year's report expanded on last year's by including: 1) greater demographic information on programme participants 2) a closer analysis of individual sub-scales in order to identify whether the programme appears to be equally helpful in contributing to change, across the five facets of mindfulness and 3) analysis expanded to include of results from SPUH.

4.12. Radical Openness Programme

The Radical Openness (RO) Programme is a therapeutic skills group delivered by the Clinical Psychology Department. The programme is based on an adaptation of DBT for "emotional over-control", developed by Tom Lynch (Lynch, Morse, Mendelson, and Robins, 2003; Lynch et al., 2007; Lynch and Cheavens, 2008). The programme is for those who have developed an emotionally over-controlled style of coping.

The Radical Openness programme aims to enhance participants' ability to 1) experience and express emotion, 2) develop more fulfilling relationships, and 3) be more open to what life can offer. The group is underpinned by a model that suggests that behavioural over-control, psychological rigidity, and emotional constriction can underlie difficulties such as recurrent depression, obsessive-compulsive characteristics, and restrictive eating difficulties. Radical Openness is offered at two levels over an eight month period. Level 1 is held twice a week over nine weeks. Level 2 consists of eight sessions run once a week for four weeks, and once a month for four months. Currently, only level one of the programme is reported on.

4.12.1. Radical Openness Programme Outcome Measures

- **Acceptance and Action Questionnaire - II**

The Acceptance and Action Questionnaire (AAQ II: Bond et al., 2011) measures experiential avoidance (the tendency to avoid unwanted internal experiences), the opposite of which is acceptance or psychological flexibility. The Radical Openness Programme utilised the 7-item version of the measure. Service users are asked to rate statements on a seven point likert scale from 1 "Never True" to 7 "Always true". Scores range from 1 to 49 with higher scores indicative of greater experiential avoidance. The AAQ II has good validity, reliability (Cronbach's alpha = .78 - .88), and 3- and 12-month test-retest reliability (Cronbach's alpha = .81 and .79, respectively; Bond et al., 2011).

- **Brief symptom Inventory**

The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item measure of psychological distress experienced by service users within the previous week. Psychometric evaluations (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004) have shown that the BSI is a reliable and valid measure. It has good test-retest reliability and internal consistency, and it shows high convergence with comparable scales on the SCL-90-R and MMPI.

- **Dialectical Behaviour Therapy Ways of Coping Checklist**

The Dialectical Behaviour Therapy Ways of Coping Checklist (DBT-WCCL; Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010) is a measure developed from the Revised Ways of Coping Checklist (RWCCL; Vitaliano, Russo, Carr, Maiuro, & Becker, 1985) consisting of two subscales, the DBT Skills Subscale (DSS) and the Dysfunctional Coping Subscale (DCS). The DBT-WCCL is a 59-item measure. Service users are asked to rate statements on a four point likert scale from 0 "Never" to 3 "Regularly". The DBT-WCCL has shown strong validity and reliability (Cronbach's alpha ranged from .84-.96).

- **The Social Safeness and Pleasure Scale**

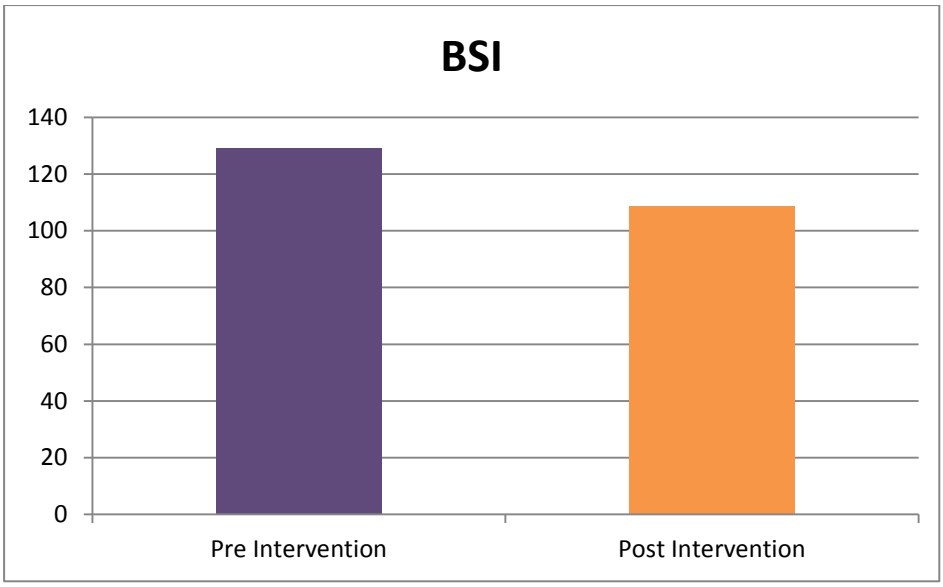
The Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009) aims to measure service users' feelings of safety, warmth, acceptance, and belonging within their social world. The measure is a brief 11-item, 5 point likert scale, with responses ranging from 0 'Almost never' to 4 'Almost all the time'. Previous research has suggested the scale is reliable (alpha=.92; Gilbert et al., 2009).

4.12.2. Descriptors

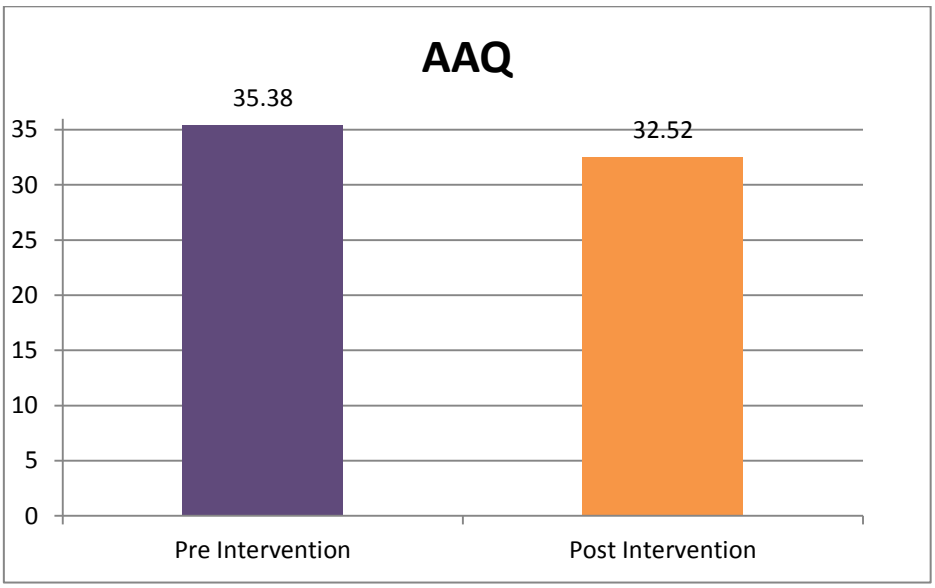
Pre and post data were available for 35 people who completed the programme in 2014. Twenty three were male (65.7%) and twelve were female (34.3%), and they ranged in age from 20 to 58 years (M=42.17; SD=11.22).

4.12.3. Results

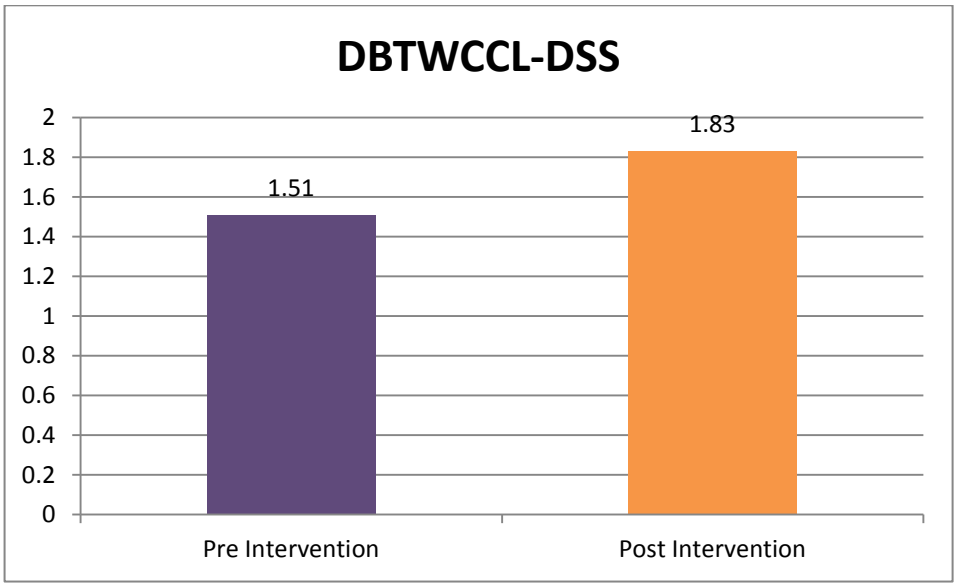
A significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in scores on the BSI, reflecting a medium effect size (*d*= -0.58).



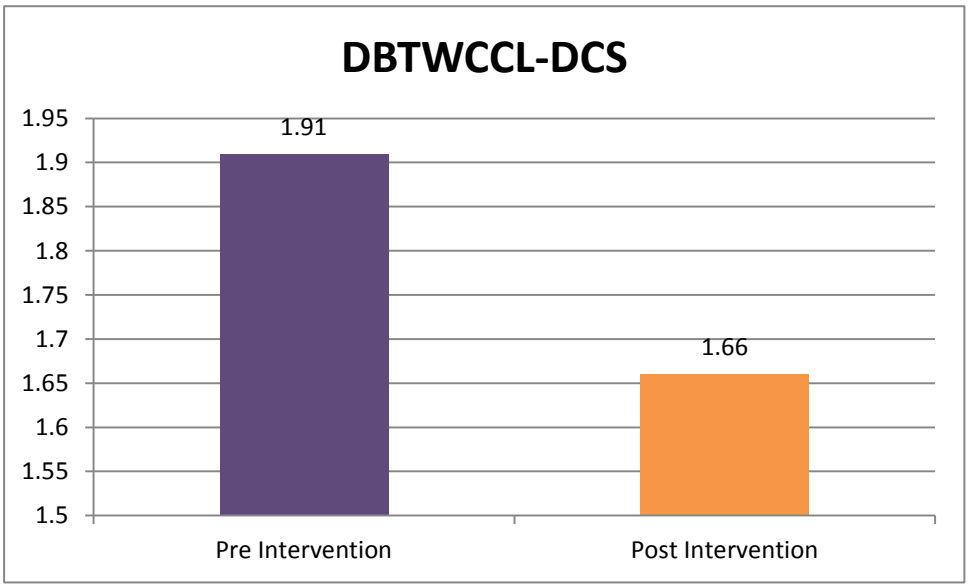
A significant change was also observed on the AAQ-II, reflecting a small effect (*d*=. -0.34), suggesting that after the programme participants were less avoidant of their emotions and more able to accept and acknowledge their emotional experiences.



Participants were also found to be using significantly more of the DBT skills/ways of coping after completing the programme. This was reflected by a significant increase in the DBT-WCCL Skills Use Subscale, and a medium effect size (*d*=-0.7).



A significant change was also observed on the DBT-WCCL Dysfunctional Coping Scale, suggesting that change seen in participants' use of maladaptive ways of coping. A medium effect (*d*=. 0.51) was observed suggesting that there a meaningful reduction in unhelpful coping.



There was a significant change in participant's scores on the SSPS, reflected by a medium effect size (d = -.51), suggesting an increase in general feelings of safeness, belonging, and acceptance in a social context after completing the group.

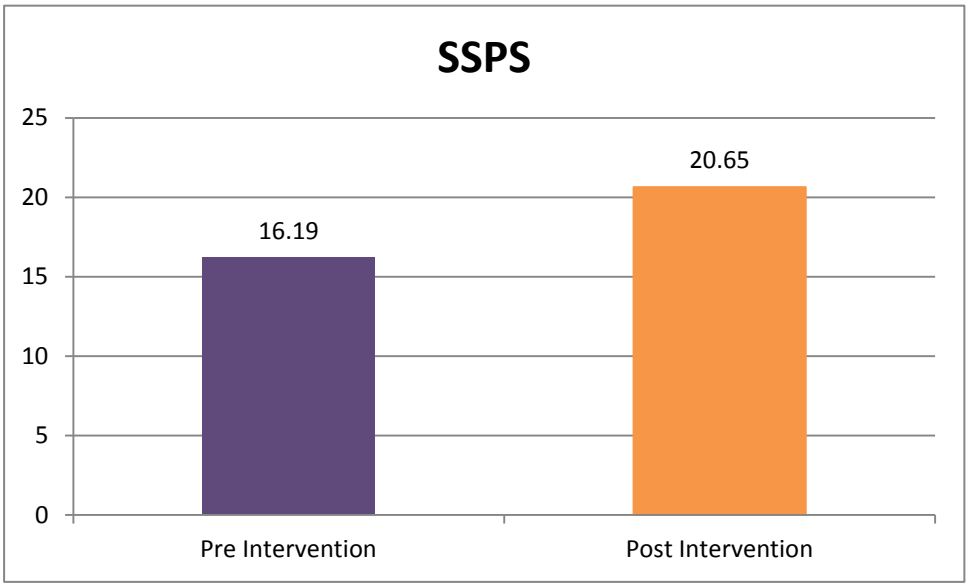


Table: *Results from paired samples t-tests for measures pre and post Radical Openness intervention.*

Scale	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
BSI	129.28 (37.89)	108.69 (32.9)	4.12**	34	.000	-.58
SSPS	16.19 (8.11)	20.65 (9.26)	-3.33	31	.002	-.51
AAQ	35.38 (7.54)	32.52 (9.16)	-2.63**	33	.013	-.34
DBTWCCL-DSS	1.51 (.45)	1.83 (.48)	-3.942**	34	.000	-.7
DBTWCCL-DCS	1.91 (.43)	1.66 (.55)	2.78	34	.009	-.51

BSI=Brief Symptom Inventory, SSPS=Social Safeness and Pleasure Scale, PNS-DFS=Personal Need for Structure-Desire for Structure, PNS-RLS=Personal Need for Structure-Response to Lack of

Structure, AAQ=Acceptance and Action Questionnaire 2, DBTWCCL-DSS=DBT Ways of Coping Checklist-DBT Skills Subscale, DBTWCCL-DCS=DBT Ways of Coping Checklist-Dysfunctional Coping Scale

4.12.4. Summary

The Radical Openness programme teaches skills that provide new ways of coping for individuals who find it difficult to relax their emotional control. This is a targeted approach for service users who are often underserved in mental health care. In 2014 service users who completed Radical Openness showed reductions in psychological distress as measured by mental ill health symptoms as well as emotional avoidance (i.e. avoiding the internal experience of emotion) and increases in social connectedness. These findings were consistent with previous years. On average, service users showed a significant increase in the use of adaptive coping skills and a reduction in the use of maladaptive coping strategies.

4.13. Psychosis Recovery Programme

The psychosis recovery programme is an intensive three-week programme catering for both inpatients and day patients. It aims to provide education around psychosis, recovery, and specific cognitive behavioural therapy (CBT) skills to help participants cope with distressing symptoms. In particular, groups focus on recovery strategies, practical information about psychosis, social support, staying well, effective use of medication, CBT techniques, building resilience, and occupational therapy. The programme is delivered by members of a multi-disciplinary team (MDT) which includes a Consultant Psychiatrist, Clinical Nurse Specialist, Clinical Psychologist, Occupational Therapist, Social Worker and a Pharmacist.

4.13.1. Psychosis Programme Outcome Measures

• Recovery Assessment Scale

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. The RAS is a 41-item survey rated on a 5-point scale from 1 "Strongly Disagree" to 5 "Strongly Agree". Twenty four of these items make up five sub-scales: 'Personal confidence and hope', 'Willingness to ask for help', 'Ability to rely on others', 'Not dominated by symptoms' and 'Goal and success orientation'. The RAS was found to have good test-retest reliability (r = 0.88) along with good internal consistency (Cronbach's alpha = 0.93; Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

• Drug Attitude Inventory

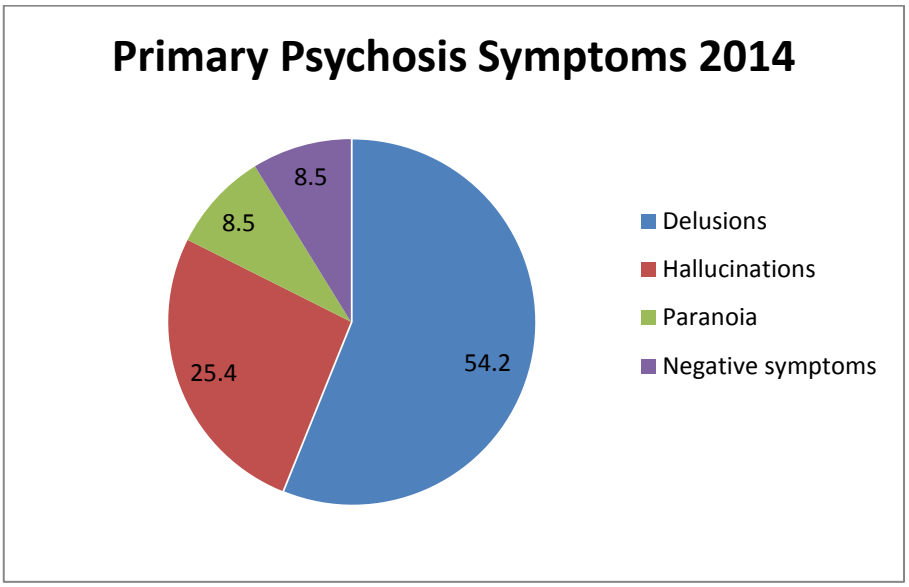
The Drug Attitude Inventory (DAI: Hogan, Awad & Eastwood, 1983) is a 30 item questionnaire to measure service users' attitudes towards psychotropic treatment. Each statement has true or false response options. Scores range

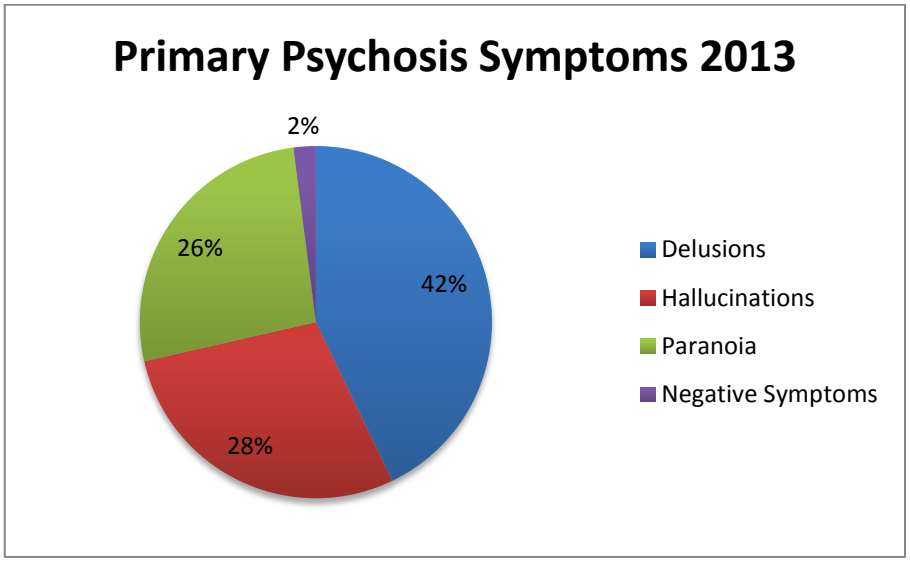
from 0-30 with higher scores indicating more positive views about medication. The measure has been shown to have good reliability (alpha=0.93) and test-retest reliability (alpha=0.82; Hogan et al., 1983).

4.13.2. Descriptors

In 2014 pre and post RAS scores were available for 30 participants, and pre and post DAI scores were available for 29 participants. The average age of psychosis programme participants was 38.55 years (ranging from 19 to 80 years) and 66.1% were male (n=39). Seventy-seven percent were single, 79.7% married, 5.1% separated or divorced. Similar proportions were employed (28.8%) and unemployed (35.6%), 16.9% were students, 8.5% were retired and a further 1.7% worked in the home. One fifth had attained a third level degree, compared to one third in 2013. Twenty-four percent had completed the leaving certificate, 45.8% had a non-degree third level qualification, with the remaining 10% having left school before the leaving certificate. The majority lived with family (76.3%) followed by living alone (16.9%). Seven percent were living with friends, or cohabiting. The majority of service users reported their ethnicity as white Irish (98.3%). Comparing 2013 to 2014, services users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

There were similar trends identified in the primary psychosis experience reported for service users in 2013 and 2014. In 2013 the primary reported symptoms were delusions, followed by hallucinations, and paranoia. In 2014 the primary reported symptoms occurred in the same order, delusions, followed by hallucinations, paranoia and negative symptoms. See the figures below for reported primary psychosis symptoms in 2013 and 2014. Attendance data were available for 56 participants and indicated that the average number of days attended in 2014 was 7.7 days (SD= 5.6) compared to 4.9 days (SD=3.5) in 2013. Attendances ranged from 1 to 21 days in 2013 and 0 to 33 days in 2014. Participants are permitted to attend multiple cycles of the programme.





4.13.3. Results

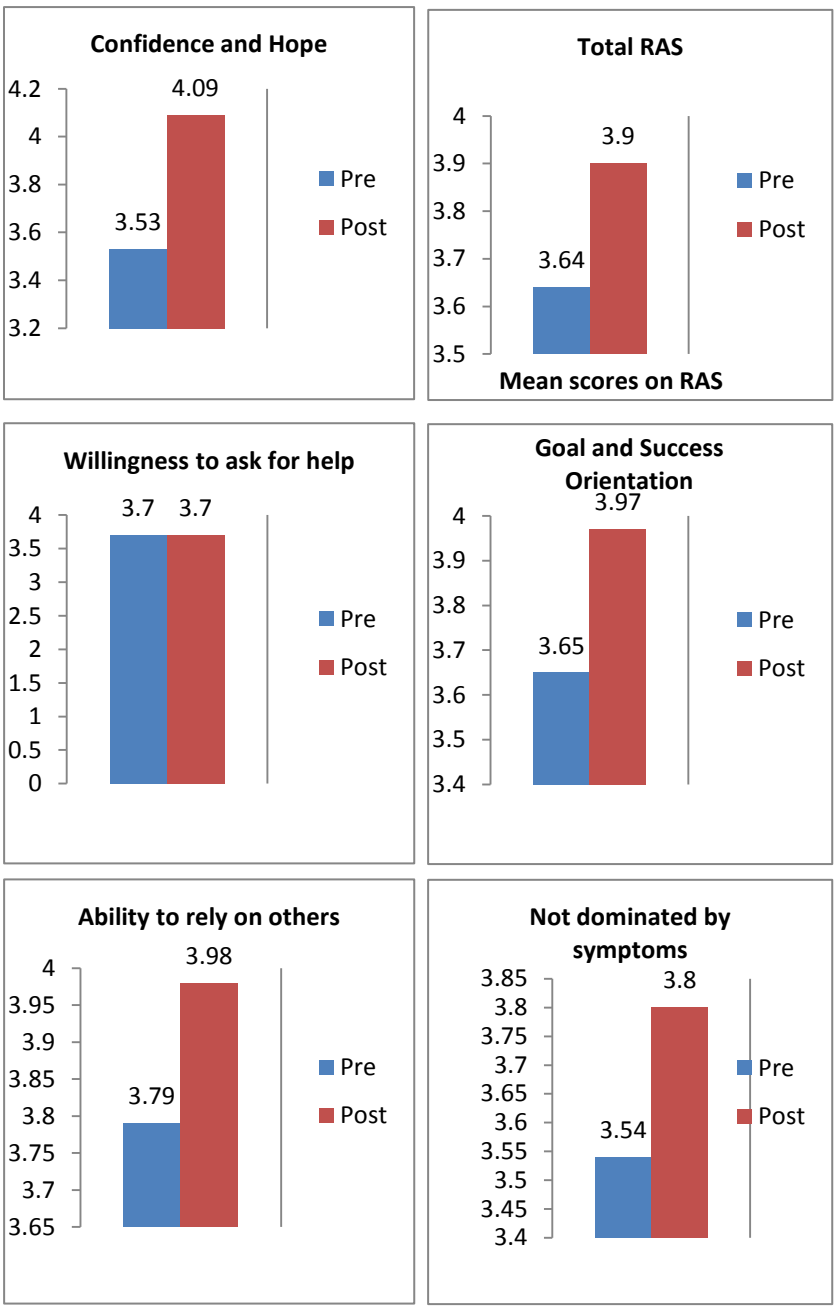
A significant increase in total scores for the RAS was apparent at the post intervention time point ($t(21) = 2.25$; $p < 0.05$, reflecting a small effect size (Cohen's d: .19). Looking at the RAS sub-scale scores, significantly higher scores are apparent post intervention for users on the 'Confidence and hope' subscale ($t(22) = 2.14$; $p < 0.05$). The differences between pre and post intervention means on the 'No domination by symptoms', the 'goal orientated' and the 'ability to rely on others' subscales were not statistically significant, but indicated positive trends. There was no change identified on

the 'willingness to ask for help' sub-scale. See the table below for test statistics, and figures for differences in pre and post intervention means.

Table: *Results from paired samples t-tests for the RAS pre and post Psychosis Recovery Programme.*

RAS	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
Total	3.64 (.69)	3.9 (.66)	-2.25	21	.035	.19
Confidence and Hope	3.5 (.81)	4.1 (1.5)	-2.14	22	.043	.17
Willingness to ask for Help	3.70 (.79)	3.70 (.78)	-.000	22	1.00	0
Goal and Success Orientation	3.65 (1.00)	3.97 (.76)	-1.746	22	.095	.12
Ability to Rely on Others	3.79 (.81)	3.98 (.60)	-1.479	22	.153	.09
No Domination by Symptoms	3.54 (.87)	3.80 (.80)	-1.969	22	.062	.15

RAS = Recovery Assessment Scale.



A significant increase in scores was seen for the DAI, from pre intervention (M=18.22; SD=11.12) to post intervention (M = 23.68; SD = 8.11) on the DAI, $t(21) = -2.673$, $p=.014$, reflecting a small effect size ($d = -0.25$). This indicates that service users who completed the measures reported more positive views towards medication after completing the programme.

4.13.4. Summary

Outcomes for the psychosis programme were captured for the first time in 2012 and analysis of data from the programme has consistently suggested benefits for service users since this time. Average scores on the RAS and DAI have been seen to increase post intervention, suggesting the Psychosis Recovery Programme is helpful in supporting service users' recovery and in encouraging more positive views towards medication.

These positive results were consistent in 2014 despite there being data from a lower number of service users available. A valid and reliable 10 item brief version of the DAI has been developed (see Nielsen, Lindstrom, Nielsen and Levander, 2012) and is planned for use in data collection in January 2015. This may help to reduce client and clinician burden in completion of measures for this programme.

4.14. Recovery Programme

The recovery programme is a structured 12-day programme based on the Wellness and Recovery Action Plan (WRAP) approach designed by Mary Ellen Copeland of the Copeland Centre (1992). The WRAP approach focuses on assisting service users who have experienced mental health problems to regain hope, personal responsibility through education, self-advocacy, and support. The recovery model emphasises the centrality of the personal experience of the individual and the importance of mobilising the person's own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. The Recovery Programme at SPUH is delivered through the Wellness and Recovery Centre for day-patients.

The programme is aimed at service users who are either recently discharged and need structured and continued support to stay well or those that prefer structured day programme attendance.

The programme is primarily group based, but each participant works individually with a key worker to manage their progress through the programme. The group dimension to the programme focuses on accessing good health care, managing medications, self-monitoring their mental health using their WRAP; using wellness tools and lifestyle, keeping a strong support system, participating in peer support; managing stigma and building self-esteem. The option of attending fortnightly meetings at the recovery-focused 'Connections Cafe' is available to all participants. The programme is delivered by three mental health nurses and two part-time social workers with sessional input from a pharmacist, a service user who is drawn from a panel of experts by experience, consumer council and carer representatives.

4.14.1. Recovery Programme Outcome Measures

• Recovery Assessment Scale

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and

quality of life. The RAS is a 41-item survey rated on a 7-point scale from 1 "Strongly Disagree" to 7 "Strongly Agree". Twenty four of these items make up five sub-scales: Personal Confidence and Hope, Willingness to ask for Help, Ability to Rely on Others, Not dominated by Symptoms and Goal and Success Orientation. The RAS was found to have good test-retest reliability (r = 0.88) along with good internal consistency (Cronbach's alpha = 0.93) (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

4.14.2. Descriptors

126 service users took part in the Recovery Programme in 2014. Pre and post data were available for 96 participants which represents approximately 76% of those who attended in 2014. The average age of participants was 47.51 years and 66.9% were female.

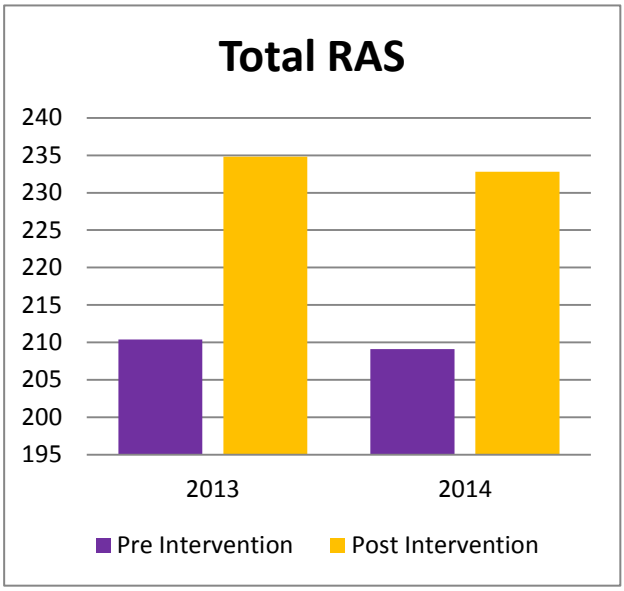
4.14.3. Results

Total RAS scores increased from pre measurement (M = 209.13, SD = 31.69) to post measurement (M = 232.82, SD = 26.32) on the Recovery Assessment Scale indicating greater overall recovery. This increase was statistically significant, t (86) = - 8.23, p < .001, and represented a large effect (d = 0.81).

There are five sub-scales within the RAS and the figures below show pre and post scores on the total and each of the five subscales including: Personal Confidence and Hope, Willingness to ask for Help, Ability to rely on others, not dominated by Symptoms and Goal and Success Orientation. Mean scores, standard deviations, t, df, p values and effect sizes (d) for each of the subscales are shown in the following table.

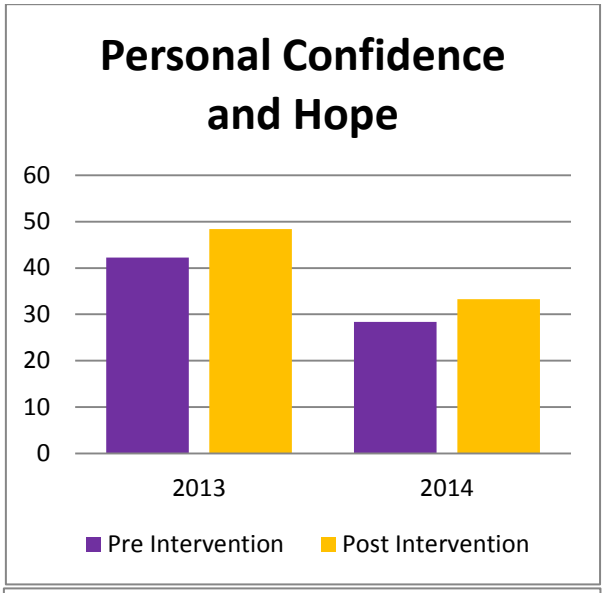
RAS	Pre	Post	*t*	*df*	*p*	*D*
Personal confidence	28.37 (6.18)	33.26 (5.17)	-8.54**	96	<.001	0.86
Willingness To Ask For	13.88 (3.51)	16.16 (2.74)	-7.07**	94	<.001	0.72
Ability To Rely On	21.12 (3.98)	22.04 (3.60)	-2.75	96	.008	0.24
Not Dominated	14.14 (3.37)	16.36 (2.81)	-7.55**	96	<.001	0.72
Goal and Success	25.70 (5.15)	29.66 (3.94)	-8.81**	95	<.001	0.86

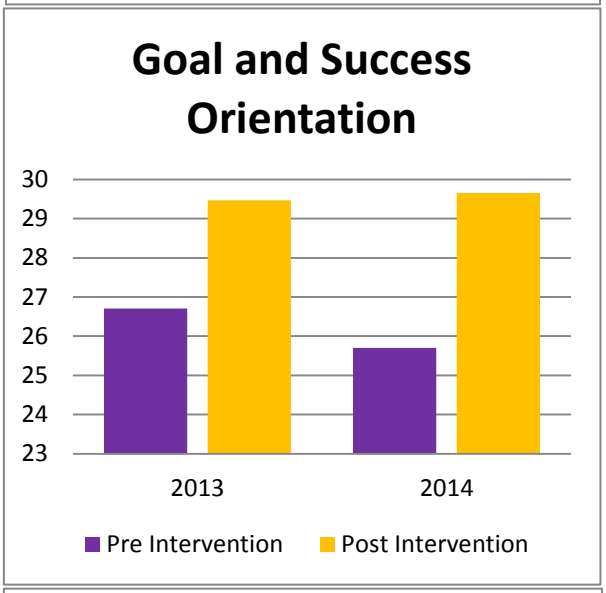
A Bonferroni correction was applied to account for multiple tests, and thus significance was set at .006, and is indicated as: $p<.006$=* and $p<.001$=**. RAS = Recovery Assessment Scale.

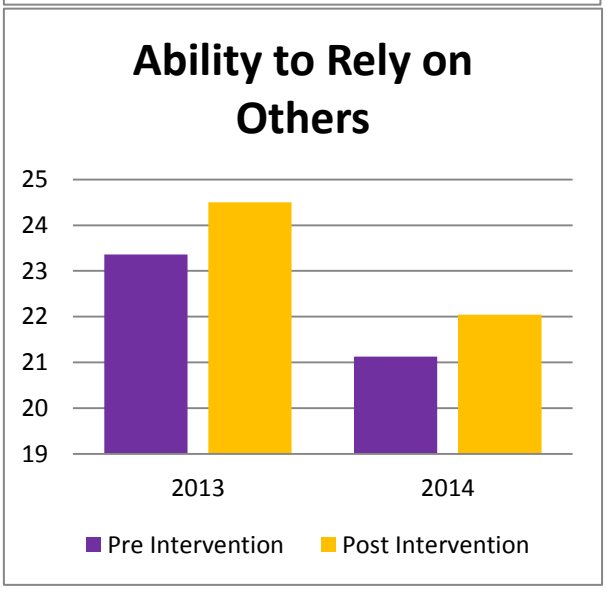


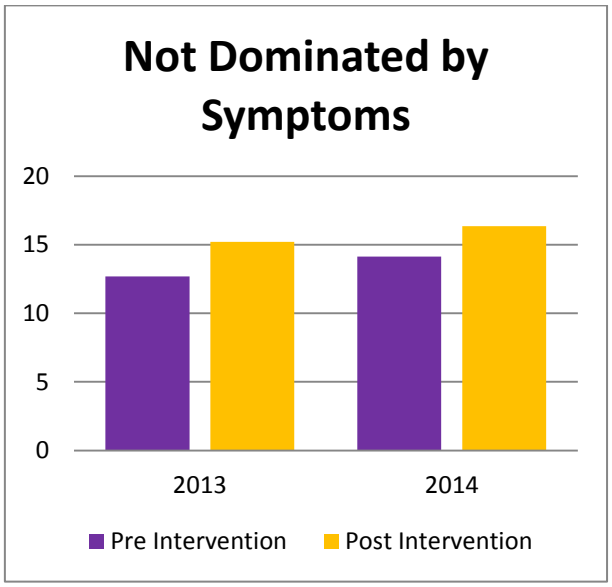
Scores on 4 of the 5 subscales improved significantly from pre to post measurement (see the following graphs). Medium to large effect sizes were evident for 4 of the 5 subscales, Personal Confidence and Hope, Willingness to Ask for Help, Ability to Rely on Others, Not dominated by Symptoms and Goal and Success Orientation (d = 0.86, 0.72, 0.72 and 0.86 respectively). Although investigation of means is indicative of a small increase of scores on

the Ability to Rely on others subscale from pre to post (d = 0.24), this was not found to be statistically significant.

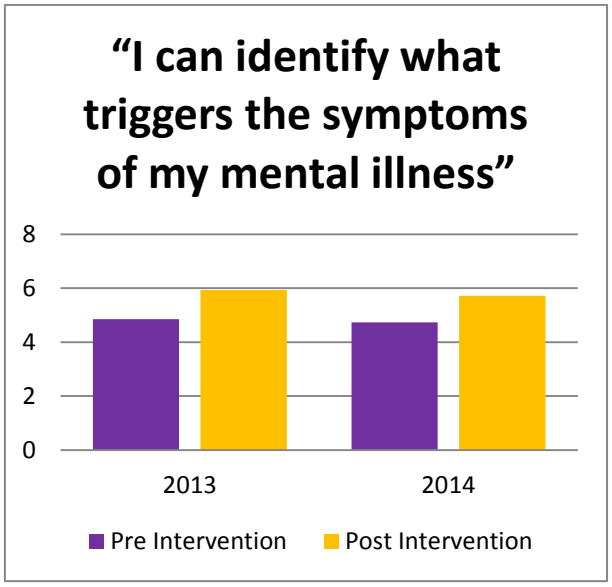


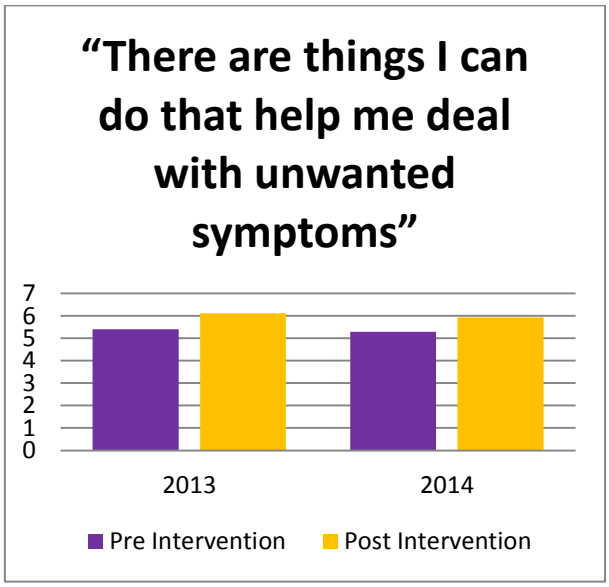




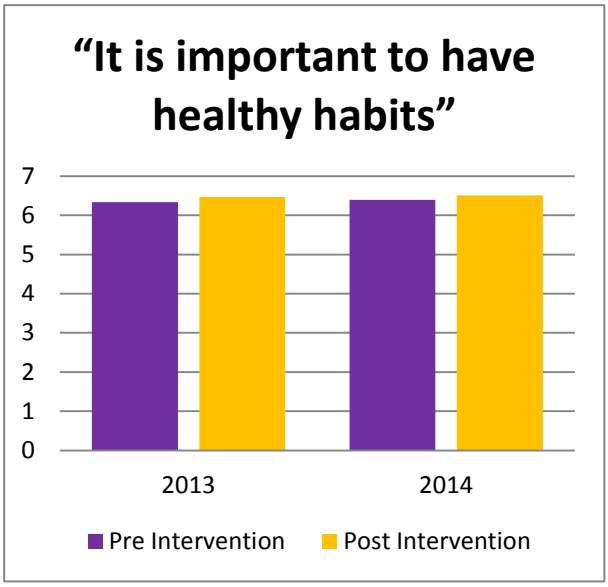


From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 "I can identify what triggers the symptoms of my mental illness", item 13 "There are things I can do that help me deal with unwanted symptoms" and item 41 "It is important to have healthy habits". Scores on two of the items improved significantly, $p<0.01$, from pre to post measurement (see the following graphs). These two items 9 and 13 evidenced large and medium effect sizes, 0.84 and 0.66, respectively.





On the other hand there was no significant effect for item 41, "It is important to have healthy habits", pre to post measurement (see the following graph).



4.14.4. Summary

Despite a slight decline from 78.5% in 2013 to 76% in 2014, completion rates for 2014 appear consistent with previous years. The findings presented provide a meaningful insight into the effectiveness of the programme. Careful consideration has also been given to the retention of the RAS as the primary outcome measure for the Recovery Programme. While there is no "gold standard" measure of recovery, the RAS has strong support for its

psychometric properties. The RAS was found to meet a number of criteria set out by Burgess, Pirkis, Coombs and Rosen (2010), in their assessment of existing recovery measures including; measuring domains related to personal recovery, is brief, takes a service user perspective, is suitable for routine use, has been scientifically scrutinised, and demonstrates sound psychometric properties.

In summary, those who completed the programme showed significant improvements in 4 out of 5 subscales of the RAS: Personal Confidence and Hope, Willingness to Ask for Help, Not dominated by Symptoms and Goal and Success Orientation. In addition two of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements pre to post measurement.

4.15. Willow Grove Adolescent Unit

Willow Grove is the inpatient adolescent service associated with St Patrick's Mental Health Services. The 14 bed unit opened in April 2010 and aims to provide evidence based treatment in a safe, comfortable environment to young people between the ages of 13 and 17 years who are experiencing mental health difficulties.

The unit offers an intensive structured clinical programme designed to assist and support young people and their families to manage and alleviate mental health difficulties. These difficulties include:

- Mood Disorders
- Anxiety Disorders
- Psychosis
- Eating Disorders

Treatment is delivered from a multidisciplinary perspective, consisting of medical and nursing personnel together with a Clinical psychologist, Cognitive behavioural therapist, Social worker/Family therapist, Occupational therapist, Nurse Psychotherapist and teaching staff. The unit provides a group programme in addition to individual therapy and we focus on skills to assist and maintain recovery and promote personal development. Groups include Living through Distress, Psychotherapy, Self Esteem, Assertiveness, Communication Skills, Recovery Group, Advocacy, Music, Drama, Gym, and activity groups. Education is also a central component of the programme and is tailored for individual needs.

4.15.1. Willow Grove Outcome Measures

Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was developed as an outcome measure for children and adolescents (3-18 years) engaging with mental health services (Gowers, Levine, Bailey-rogers, Shore & Burhouse, 2002). This measure provides a

global assessment of the behaviour, impairments, symptoms and social functioning of children and adolescents with mental health problems. Studies such as Garralda et al. (2000) have found the validity and inter rater reliability of the HoNOSCA to be satisfactory. Lesinskiene, Senina & Ranceva (2007) investigated the use of the HoNOSCA in an inpatient child psychiatric unit and found satisfactory inter-rater reliability amongst multi-disciplinary team members. The measure has been regarded as suitable for use as a routine measure in mental health services and is used internationally.

The HoNOSCA is used to assess the most pertinent problems presenting during the previous two weeks. The measure is comprised of 15 items in total, with the first 13 items used to compute a total score (Bilenberg, 2003). These include: disruptive/aggressive behaviours, over-reactivity/concentration problems, self-injury, substance misuse, scholastic skills, physical illness, hallucinations/delusions, nonorganic somatic symptoms, emotional symptoms, peer relationships, self-care, family relationships and school attendance. All scales are scored on a 0-4 point rating from "no problems" to "severe problems". Higher scores are indicative of greater severity.

While the clinician rated HoNOSCA is the principal measurement tool, self-rated (HoNOSCA-SR) and parental rated versions of the HoNOSCA have also been developed to facilitate a more collaborative assessment. While the HoNOSCA has been found to correlate adequately with other measures of child psychopathology (Bilenberg, 2003; Yates et al., 1999), there appears to be little research investigating the relationship between clinician, parental and self-rated scores. Correlations between clinician rated and self-reported total scores were found to be poor in a study by Gowers, Levine, Bailey-Rogers, Shore & Burhouse (2002).

In line with the collaborative ethos of the unit, the HoNOSCA's were completed at admission and discharge by the young person (self-rated), multi-disciplinary team (clinicians) and parent.

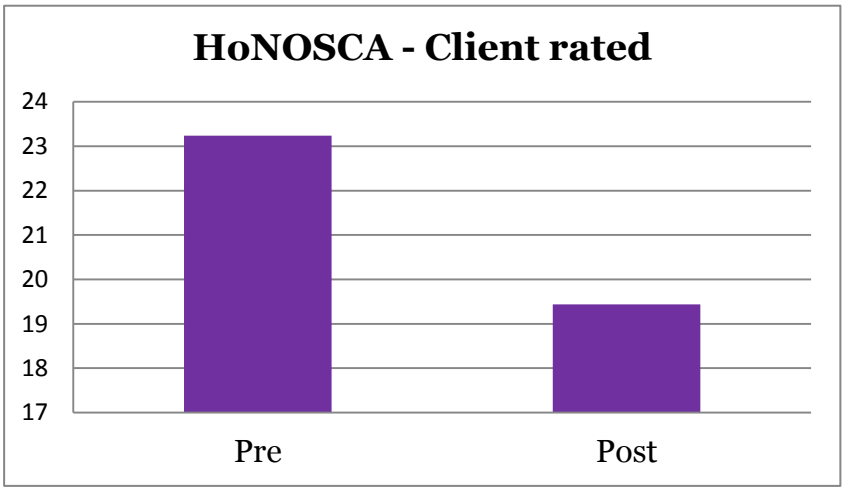
4.15.2. Descriptors

77 young people attended Willow Grove Unit in 2014. Pre and post data were available for 71 participants (92.2%), with the majority of participants (82.86%) female.

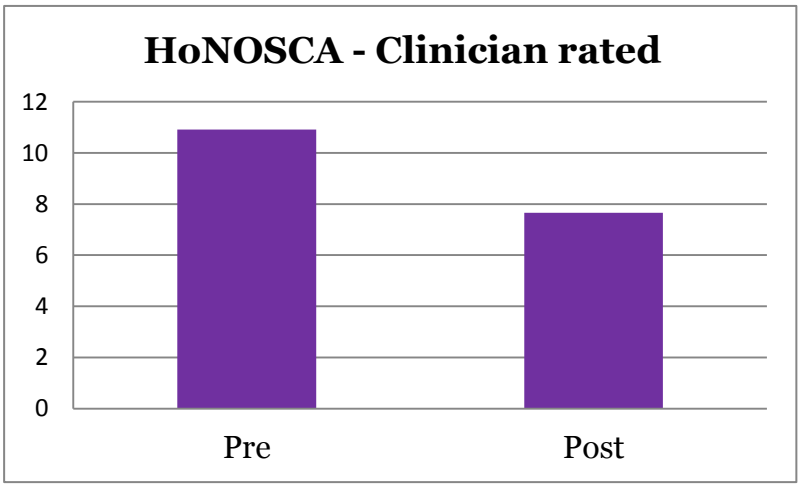
4.15.3. Results

	Pre	Post	*t*	*df*	*p*	*D*
Client Rated	23.25 (10.16	19.44 (9.61)	3.43	40	.001	0.39
Clinician Rated	10.91 (7.03)	7.66 (6.16)	3.14	31	.004	0.49
Parent Rated	22.20 (9.11)	16.11 (9.30)	4.24	36	.001	0.66

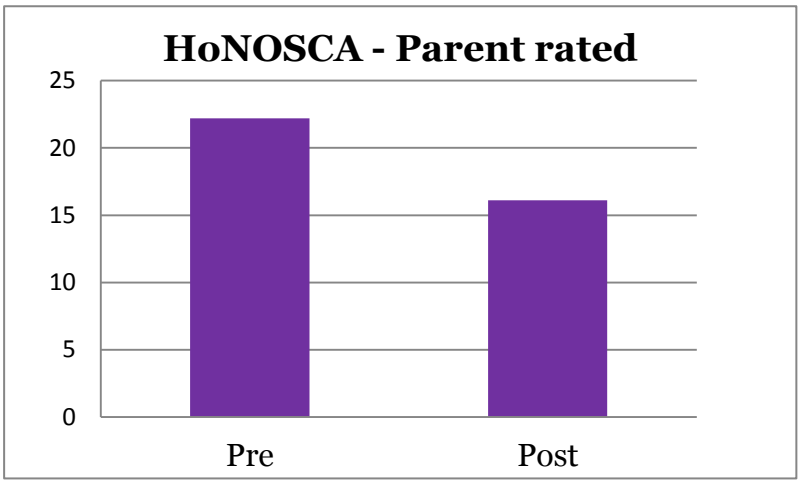
Significant decreases in client/young person reported HoNOSCA scores were observed from pre to post, representing a small effect size *(d = 0.39)*.



Significant decreases in clinician reported HoNOSCA scores were observed from pre to post, representing a small effect size *(d = 0.49)*.



Significant decreases in parental reported HoNOSCA scores were observed from pre to post, representing a moderate effect size *(d = 0.66)*.



4.15.3 Summary

Significant decreases in HoNOSCA scores from admission to discharge were observed, as reported by young people attending the unit, treating clinician's and parents. Small to medium effect sizes were observed in this regard.

As previously indicated, Gowers et al. (2002) reported poor correlations between self-rated and clinician rated HoNOSCA scores. While the HoNOSCA has been found to correlate adequately with other measures of

child psychopathology (Yates et al., 1999), research investigating the relationship between parental, clinician and self-rated HoNOSCA scores appears to be quite limited. While small effect sizes were observed for clinician's and young people attending Willow Grove Unit and a moderate effect size reported by parents, a more comprehensive analysis would be necessary to investigate the statistical difference, if any, between these scores.

The measure has been commended in the literature for its ease of access for adolescents (Levine, Bailey-Rogers, Shore & Burhouse, 2002) and clinicians (Jaffa, 2000). It is expected to continue to serve as the primary outcome measure for 2015.

SECTION 5

Measures of Service User Satisfaction

5.1 Service User Satisfaction Questionnaires

5.1.1 Introduction

St Patrick's Mental Health Service is committed to listening to and acting upon the views of those who use and engage with its service. In order to enhance communication between service users and providers, a Service User Satisfaction Survey is distributed to service users who attend the Dean Clinics, Inpatient, and Day Programme services. This report outlines the views of Dean Clinic, Inpatient, and Day Programme service users from January to December 2014.

5.1.2 Survey design

The report is structured to reflect the design of the survey. Responses for each survey item are depicted in graph and/or table form. The Inpatient survey was initially created based on the Picker Institute National Inpatient Survey for Mental Health Services in the UK. Adaptations were made to include topics of importance to service users (as identified by previous service user complaints) and to services providers (e.g. service users' perception of stigma after receiving mental health care). The Dean Clinic and Day Programme surveys were adapted from the Inpatient survey and tailored to the respective services.

5.1.3 Data collection

Satisfaction surveys were continually distributed from January to December 2014, in order to gather information about service users' experience of Inpatient, Dean, or Day services, thus creating a medium through which service users can provide feedback and influence the provision of care. The Service User's Satisfaction Survey is a part of the ongoing quality improvement process within St Patrick's Mental Health Services. Data collection will be continually facilitated as a key strategic objective to continually improve services. Service users were made aware that participation was voluntary and anonymous. Collected data was managed using SPSS statistical package, and descriptive graphs were created using Excel.

Dean Clinics

Dean Clinic administration staff gave all attendees an opportunity to complete the questionnaire and return it in person or by post to St Patrick's Mental Health Services. All service users were given an opportunity to complete the questionnaire with the exception of those attending a first appointment or assessment with the exception of those whom Dean Clinic administration staff felt were too unwell to complete the questionnaire.

Inpatient Adult Services

Ward staff in St Patrick's Mental Health Services gave all service users an opportunity to complete the questionnaire at discharge and return it in person, or by post. All service users admitted during this period and subsequently discharged were sent a questionnaire by post for completion along with a stamped addressed envelope for return.

Day Programme Services

Programme coordinators in St Patrick's Mental Health Services invited all services users finishing a programme to complete a copy of the questionnaire and return in person, or by post, to St Patrick's Mental Health Services.

5.1.4. Findings

5.1.4.1. Dean Clinic

Percentage of surveys received from Dean Clinics:

Dean Clinic	n	%
St Patrick's	18	40.9
Sandyford	4	9.1
Capel Street	10	22.7
Donaghmede	4	9.1
Galway	1	2.3
Lucan Adolescent	1	2.3
Cork	2	4.5
Lucan Adult	2	4.5
No Answer	2	4.5
Total	44	100

Service User Responses

How long did you wait for a first appointment?

Percentage of respondents who endorsed each first appointment waiting time frame

1st Appt. Waiting Time	n	%
<1 week	2	4.5
<2 weeks	5	11.4
<1 month	15	34.1
<2 months	11	25.0
>2 months	3	6.8
>4 months	5	11.4
No Answer	3	6.8
Total	44	100

Were you seen at your appointment time?

38.6% of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic, 31.8% of respondents reported being seen on time and 15.9% of respondents reported a half hour wait for their appointment on arrival to the clinic.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	14	31.8
Seen within 15 minutes	17	38.6
Seen within a half hour	7	15.9
Seen within hour	4	9.1
Seen within over 2 hours	2	4.5
No Answer	44	100.0
Total	14	31.8

Tell us about your experience of assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

Experience of assessment/therapy/review?	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did a member of the clinic staff greet you?	134	94.4	3	2.1	2	1.4	3	2.1
Did a member of the clinic staff explain clearly what would be happening?	101	71.1	23	16.2	6	4.2	12	8.5
Were you told about the services available to you to assist you in looking after your mental health?	73	51.4	38	26.8	12	8.5	19	13.4

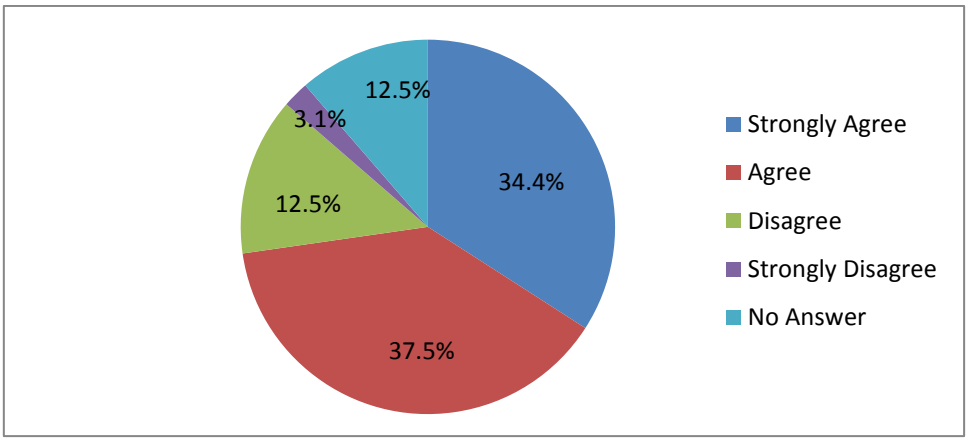
Tell us about your experience of care and treatment at the clinic following assessment

Respondents were asked about the quality of their care at the Dean Clinic following assessment. Service users were offered a number of statements describing their care which they were asked to endorse.

Respondents experience of care and treatment at the Clinic following assessment

Experience of Care & Treatment following your assessment?	Agree		Neither Agree or Disagree		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Treated as an individual	41	93.2	1	2.3	0	0	0	0	2	4.5
Treated with dignity & respect	41	93.2	1	2.3	1	2.3	0	0	1	2.3
Confidentiality was protected	41	93.2	1	2.3	0	0	0	0	2	4.5
Privacy was respected	42	95.5	1	2.3	0	0	0	0	1	2.3
Staff were courteous	40	90.9	2	4.5	1	2.3	0	0	1	2.3
Felt included in decisions about my treatment	37	84.1	2	4.5	2	4.5	0	0	3	6.8
Trusted my doctor/therapist/nurse	40	90.9	0	0	2	4.5	0	0	2	4.5
Appointments were flexible	31	70.5	4	9.1	2	4.5	2	4.5	5	11.4

In your opinion was the service you received value for money?

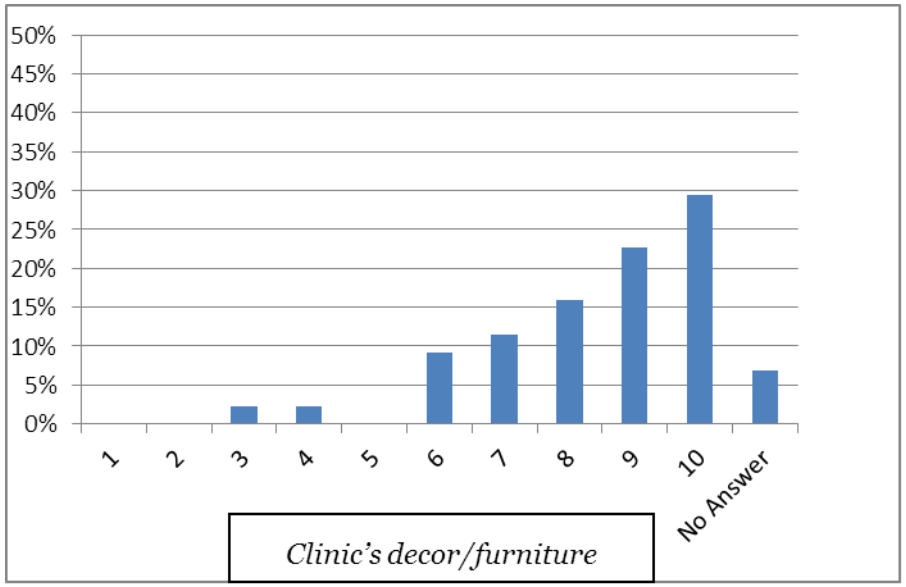


How would you rate the Dean Clinic facilities?

Respondents were asked to rate Dean Clinic facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Dean Clinic facilities, with all means above 8. Furthermore the standard deviation was below 2 across all four areas showing small variation between responses, i.e. the majority of respondents responded favourably and similarly (see Table below).

Respondents' scores of Dean Clinic facilities

Rate the following in relation to the Clinic...	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	41	8.34	1.726
Cleanliness of Clinic	43	8.93	1.316
Calmness of environment	43	8.74	1.513
Welcome environment	42	8.67	1.720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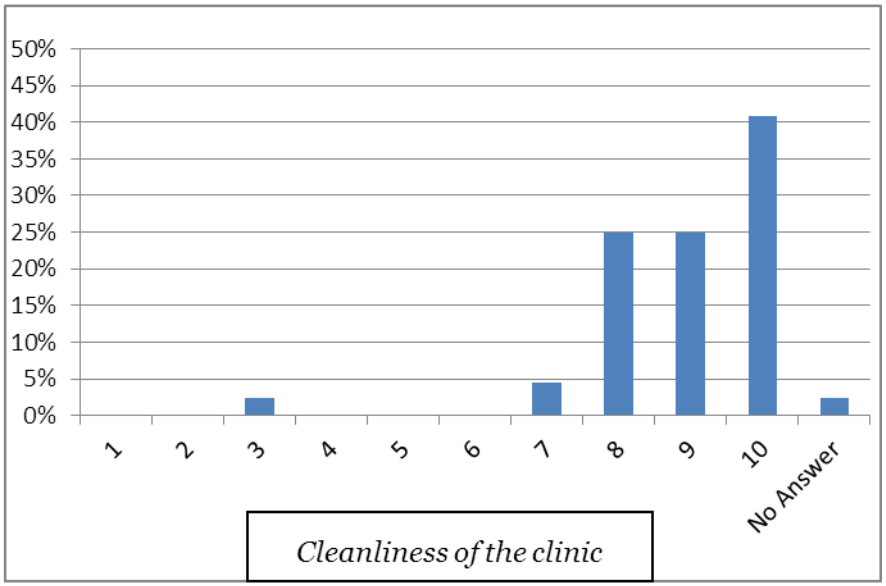
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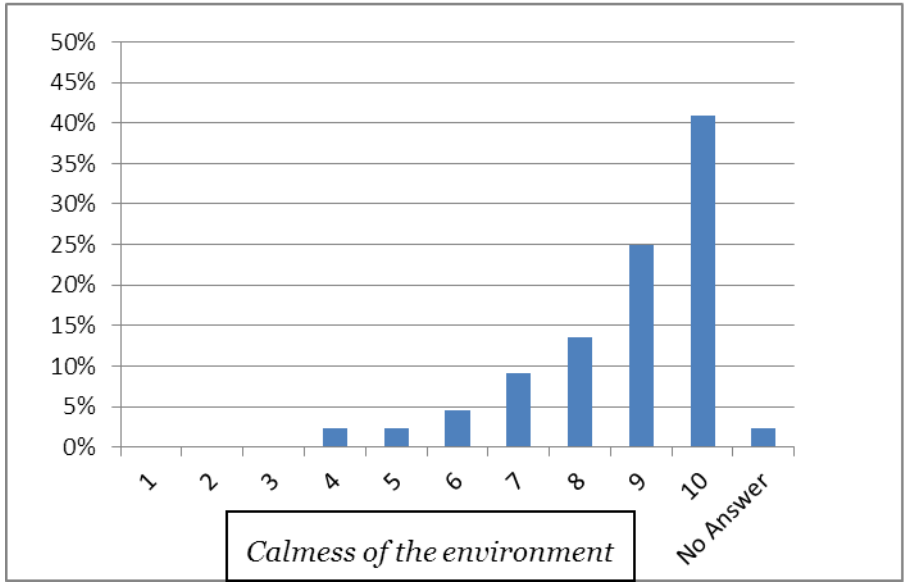
Cleanliness of the clinic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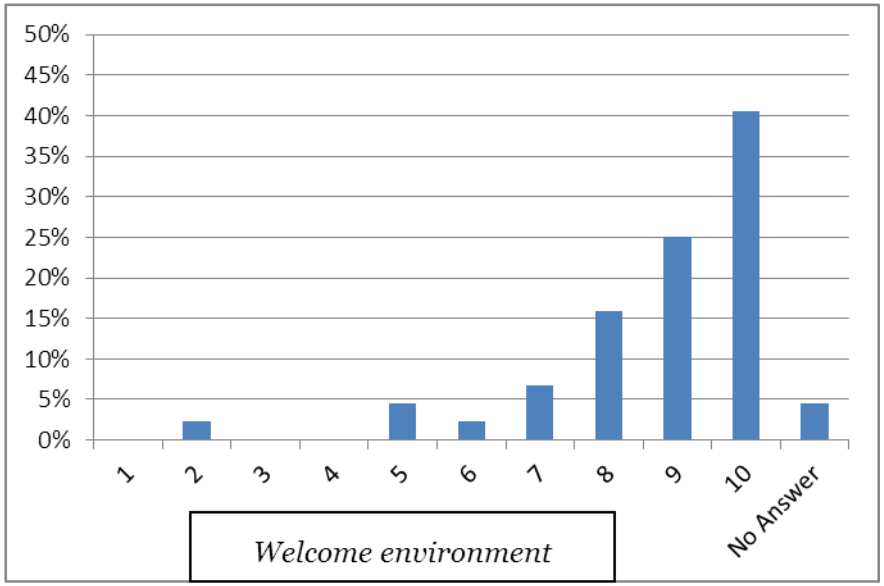
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No Answer
Welcome environment

How would you rate your care and treatment at the Dean Clinic?

Service users who completed and returned the Service User Satisfaction Survey between January and December demonstrated a high level of satisfaction with the care they received. Service users rated their care and treatment at the Dean Clinic on a scale of 1 to 10; showing a mean score of 8.7 (N=42; SD=2). Respondents also indicated a high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.7 (N=42; SD=1.81).

Table: *Respondents' ratings of care and treatment and overall Dean Clinic*

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	**%**	**n**	**%**
1	0	0	0	0
2	1	2.3	1	2.3
3	2	4.5	1	2.3
4	0	0	0	2.3
5	0	0	0	0
6	1	2.3	1	2.3
7	3	6.8	5	11.4
8	6	13.6	5	11.4
9	8	18.2	10	22.7
10	21	47.7	19	43.2
No Answer	2	4.5	2	4.5
1-5	3	7.15	2	4.76
6-10	39	92.85	40	95.24
Total	44	100	44	100

Table: *Respondents' ratings of care and treatment and overall Dean Clinic*

How would you rate...?	**N**	**Mean (μ)**	**Standard Deviation (∂)**
Your care and treatment at the Dean Clinic	42	8.7	2
Overall, the Dean Clinic	42	8.7	1.81

Further Service User Views

Dean clinic respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the users' experiences. Not all respondents answer these questions. Please find below a sample of answers.

Q: Is there anything else you would like to tell us about your experience of attending the Clinic?

Positive Comments include:

- "My experience in the Dean Clinic has been very positive. I have always been treated with dignity and respect.
- "Receiving praise from my doctor for my efforts gave me confidence.
- "Supportive and professional – I felt listended to and that I mattered.
- "Very calm and reassuring clinical staff - Consultant was great.
- "Perhaps it was unofficial but having travelled a distance to the clinic, I was offered a cup of tea which relaxed me and helped me face my appointment.
- "It is pleasant to attend the calm atmosphere and be seated in the comfortable waiting room.

Comments to learn from include:

- "Signage outside main building could be improved.
- "The Consultations feel rushed and I feel sometimes that I need to be super quick. It would be nice to have more time.
- "Expensive – surely if there are no changes and it is just a quick review, the fee should be reduced.
- "Difficulties in making appointment to see Consultants.
- "Waiting too long for appointments.

Q: Was there anything particularly good about your care at the Dean Clinic?

- “Staff were excellent, professional and sensitive”.
- “Seen straight away by Psychiatrist”.
- “I felt supported”.
- “Welcome, safe, clean and bright atmosphere; calm and unhurried”.
- “Location is ideal”.
- “Good food menus”.
- “The courses being offered e.g. Recovery, Mindfulness”.
- “Dr X is the most kind, understanding and helpful Doctor I have ever met. Dr X understands and shows great empathy”.
- Dr X goes the extra mile and you know you can always get hold of Dr X if needed which is a huge comfort”.
- “Group work for ADHD”.

Q: How could we improve your experience of the Dean Clinic Services?

Comments to learn from include:

- “Coffee”.
- “Help filling out VHI forms”.
- “The Consultant review appointment is very expensive and I am not working at present”.
- “Fees need to be looked it. It is beyond reach for alot of people”.
- “Allow the patient to be more involved in the decision making process about medication”.

Positive Comments:

- “Nothing – a very positive experience”.
- “More time for each patient, less of a focus on just medicine”.
- “I think location should be looked at; surely people in Lucan should be seen in Lucan. I have to come into town”.
- “Disability assistance installed in the toilets”.
- “You could open more clinics in other accessible areas for people and have more available appointments with Consultants. The follow up courses in St Pat’s could be made more available to patients”.

5.1.4.2 Adult Inpatient Services

Demographics

Demographics

Service users discharged between January and December 2014 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge or by post following discharge. A total of 479 were returned to St Patrick's Adult Inpatient services in 2014. Previous research has suggested that a response rate of under 50% may be indicative of a response bias and thus findings should be considered with caution. SPMHS is actively working on methods to improve response rates and of note the numbers of returns increased from 187 in the first half of 2014, to 291 in the second half of 2014. The 291 returns in the last 6 months of 2014 also compares favourably with 162 returns in the same period in 2013.

Table: *Number of adult inpatient surveys returned and discharges in 2014*

Month	Surveys Returned	Discharges
January	5	221
February	61	224
March	55	258
April	17	242
May	25	267
June	25	237
July	6	225
August	34	257
September	78	218
October	65	270
November	60	226
December	48	297
Total	479	2942

Service User Responses

"Can you recall how long you waited for an admission to hospital?"

The most endorsed waiting time frames reported by respondents were between 1 and 3 days' (26.5%), and 'between four and seven days' (24.4%), between January and December (see table below). 16.9% waited <1 day.

Table: *Percentage of respondents who endorsed each first appointment waiting time frame*

Waiting Time	n	%
<1 day	81	16.9
1-3 days	127	26.5
4-7 days	117	24.4
1-2 weeks	63	13.2
3-4 weeks	49	10.2
Don't know	19	4.0
No answer	23	4.8
Total	479	100.0

"When you came to the hospital for assessment/admission how long did you have to wait before you were seen by a member of staff?"

The most endorsed waiting time frame reported by respondents was 'less than 1 hour'. 54.9% of respondents endorsed this time period. (see table below).

Table: *How long respondents waited to be seen by staff at admission.*

Waiting Time	n	%
<1 hr	263	54.9
1-2 hrs	120	25.1
2-3 hrs	43	9.0
3-4 hrs	11	2.3
>4 hrs	3	.6
Don't know	13	2.7
No answer	26	5.4
Total	479	100.0

"Please tell us how long it took from your arrival in admissions to your arrival on the ward?"

The most endorsed waiting time frames reported by respondents were '1-2 hours' (35.1%) and 'less than 1 hour' (20.9%) (see table below).

Table: *How long respondents waited to arrive on ward at admission*

Waiting Time	n	%
<1 hr	100	20.9
1-2 hrs	168	35.1
2-3 hrs	91	19.0
3-4 hrs	52	10.9
>4 hrs	23	4.8
Don't know	17	3.5
No answer	27	5.6
Total	479	100.0

"Tell us about your experience of admission."

Table: *Respondents' opinions between regarding their experience of admission to Hospital*

Tell us about your experience of admission.	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
When you came to the Hospital did a member of the assessment unit greet you?	354	73.9	61	12.7	36	7.5	28	5.9
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	352	73.5	62	12.9	41	8.6	23	5
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	353	73.7	65	13.6	35	7.3	26	5.4
Were you given written information about the Hospital and the services provided?	264	55.1	150	31.3	38	7.9	27	5.7

"In relation to your care plan, can you tell us the following…"

In relation to your care plan…	Agree		Neither		Disagree		Don't know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I understand what a care plan is	367	76.6	32	6.7	16	3.3	22	4.6	40	**8.8**
Involved in the development of my care plan	256	53.4	77	16.1	71	14.8	26	5.4	48	10.3
Offered a copy of my care plan	194	40.5	40	8.4	135	28.2	57	11.9	53	11
Involved in the review of my care plan	234	48.9	54	11.3	98	20.5	37	7.7	56	11.6
Focus was on recovery in the care and treatment offered	342	71.4	35	7.3	34	7.1	21	4.4	47	9.8
Care plan is key to recovery	312	65.1	49	10.2	41	8.6	24	5.0	53	11.1

"During my stay in hospital I was given enough time with the following health professionals…"

	Agree		Neither		Disagree		Don't know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Consultant Psychiatrist	373	77.9	25	5.2	44	9.2	6	1.3	30	**6.4**
Registrar	324	67.6	51	10.6	38	7.9	11	2.3	55	11.6
Key Worker	239	49.9	57	11.9	98	20.5	19	4.0	63	13.7
Nursing Staff	388	81.0	17	3.5	17	3.5	7	1.5	49	10.5
Psychologist	154	32.2	55	11.5	105	21.9	28	5.8	133	28.6
Occupational Therapist	192	40.1	60	12.5	85	17.7	25	5.2	112	24.5
Social Worker	121	25.3	60	12.5	92	19.2	44	9.2	159	33.8
Pharmacist	112	23.4	59	12.3	101	21.1	48	10.0	155	33.2
Other	109	22.8	49	10.2	74	15.4	34	7.1	208	44.5

If you were referred to a therapeutic programme, how long did you wait to attend the programme?

Waiting Time	n	%
<1 week	61	12.7
1-2 weeks	74	15.4
2-3 weeks	53	11.1
>3 weeks	54	11.3
Not on programme	96	20.0
No Answer	141	29.4
Total	479	100.0

Tell us about your care…

Table: *Respondents experience of the team during their in-patient stay*

Experience of the team that worked with you	Strongly Agree		Agree		Disagree		Strongly Disagree		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Trusted the team members	310	64.7	96	20.0	19	4.0	3	.6	48	**10.7**
Treated with dignity and respect	329	68.7	84	17.5	19	4.0	4	.8	40	9
Protected my confidentiality	328	68.5	89	18.6	11	2.3	3	.6	47	10
Respected my privacy	324	67.6	94	19.6	11	2.3	2	.4	48	10.1
Were courteous	327	68.3	94	19.6	5	1.0	3	.6	50	10.5
Felt included when my team discussed medical issues at my beside / in my room	292	61.0	91	19.0	19	4.0	6	1.3	70	14.7
Respected me as an individual	325	67.8	88	18.4	15	3.1	4	.8	44	9.9

Tell us about your experience of discharge…

Table: *Respondents' perceived involvement in discharge*

Experience of Discharge from Hospital	Yes		No		Don't Know		No Answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Did you discuss and agree your discharge with your treating team?	393	82.0	28	5.8	8	1.7	43	10.5
Do you think you were given enough notice of your discharge from hospital?	404	84.3	26	5.4	8	1.7	40	8.6
Do you have a discharge plan?	300	62.6	93	19.4	29	6.1	56	11.9
Do you know what to do in the event of a further mental health crisis?	360	75.2	62	12.9	15	3.1	42	8.8

Tell us about your experience of hospital activities…

Tell us about your experience of hospital activities	Yes		No		Don't Know		No Answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Did you attend any of the activities during the day?	406	84.8	44	9.2	2	.4	27	5.6
Did you attend any of the activities in the evenings and at weekends?	298	62.2	139	29.0	5	1.0	37	7.8
Was there a range of activities that you could get involved in?	384	80.2	53	11.1	7	1.5	35	7.2
At the weekend were there enough activities available for you?	140	29.2	198	41.3	40	8.4	101	21.1

The majority of respondents felt that there was a range of activities they could get involved in (80.2%). However, 41.3% indicated that there were not enough activities available in the hospital at weekends.

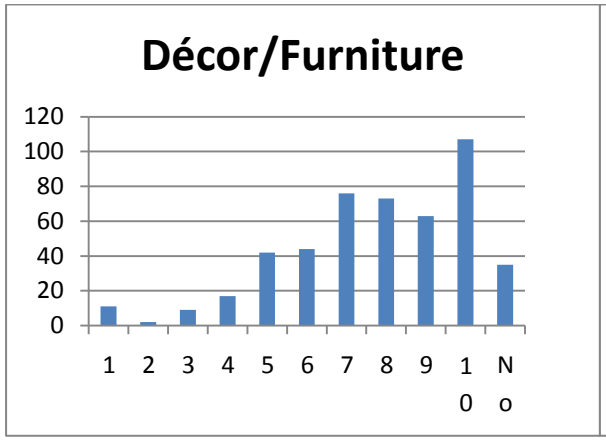
Tell us about your experience of hospital facilities…

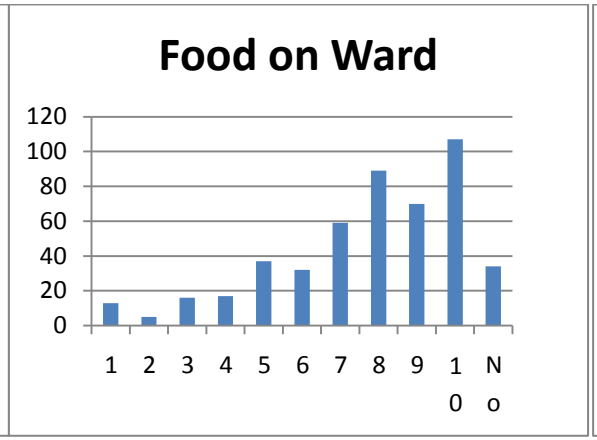
A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with all means at or above 7.5. In particular, the Garden Spaces (8.4) and the cleanliness of the ward (8.8) and Communal areas (8.6) received high scores, with means scores 8.3 or above. The standard deviation across all areas was close to 2 indicating that

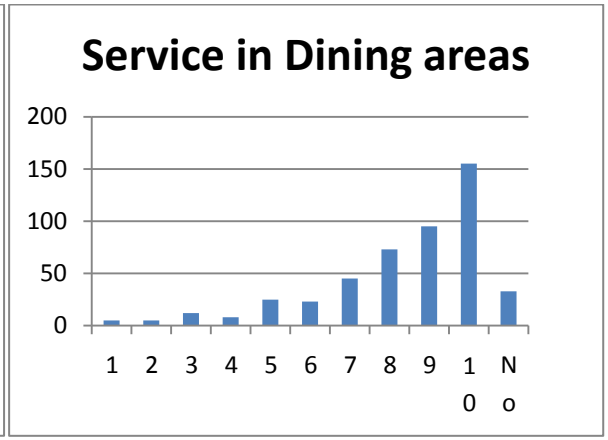
there was significant variation in responses, particularly in relation to the service in ward dining areas (SD = 4.4).

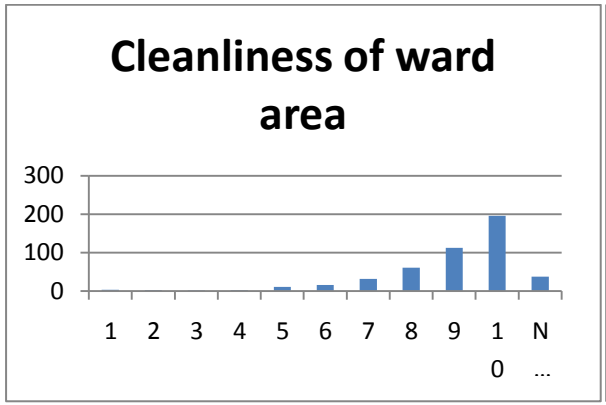
Table: *Respondents' scores of Hospital facilities*

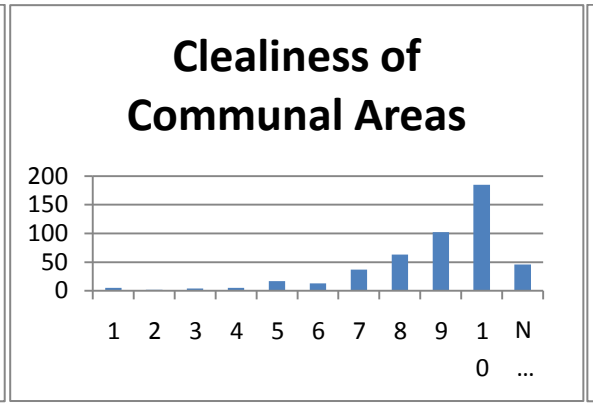
Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	444.0	7.5	2.2
Food on Ward	445.0	7.5	2.3
Service in ward dining areas	446.0	8.4	4.4
Cleanliness of ward areas	441.0	8.8	1.7
Cleanliness of Communal areas	433.0	8.6	1.8
Hospital Facilities	410.0	8.0	2.3
Garden Spaces	441.0	8.4	2.0

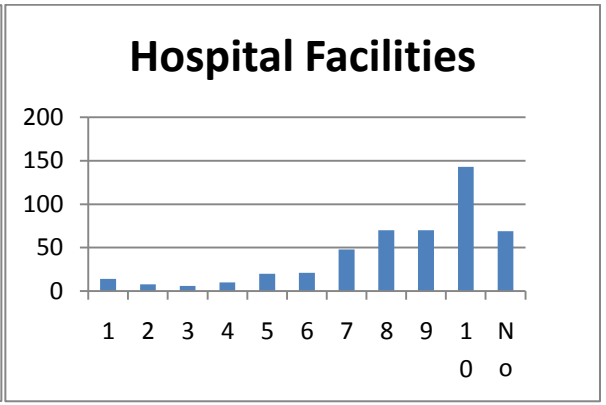

Décor/Furniture
120
100
80
60
40
20
0
1 2 3 4 5 6 7 8 9 10 No

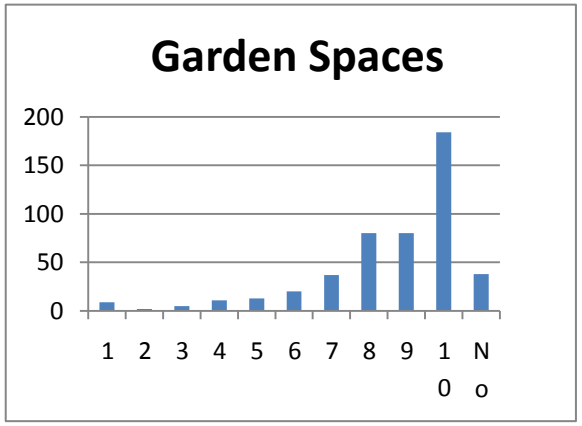

Food on Ward
120
100
80
60
40
20
0
1 2 3 4 5 6 7 8 9 10 No


Service in Dining areas
200
150
100
50
0
1 2 3 4 5 6 7 8 9 10 No


Cleanliness of ward area
300
200
100
0
1 2 3 4 5 6 7 8 9 10 N...


Clealiness of Communal Areas
200
150
100
50
0
1 2 3 4 5 6 7 8 9 10 N...


Hospital Facilities
200
150
100
50
0
1 2 3 4 5 6 7 8 9 10 No


Garden Spaces
200
150
100
50
0
1 2 3 4 5 6 7 8 9 10 No

Tell us about your experience of stigma following your experience in hospital…

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would share with others that they received support from St Patrick's. The majority of respondents felt they had more positive views towards mental health difficulties in general (76%) and their own experience of mental health difficulties (76.8%) and felt that they would share with others that they received support from St Patrick's (66.4%).

Table: *Experiences of stigma*

Tell us about your views and perceptions regarding mental illness following your stay…	Yes		No		Don't Know		No Answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
In general are they more positive than they were?	364	76.0	53	11.1	29	6.1	33	6.9
Regarding your own mental illness are they more positive than they were?	368	76.8	49	10.2	27	5.6	38	7.9
Will you tell people that you have stayed in St Patrick's?	318	66.4	70	14.6	49	10.2	44	9.1

Overall views of St Patrick's Mental Health Services

Service users who completed and returned the Service User Satisfaction Survey demonstrated a high level of satisfaction with the care they received. Rating their care and treatment in Hospital on a scale of 1 to 10, with a mean of 8.6 (N=162; SD=1.8). Respondents also demonstrated a high level of satisfaction with the Hospital overall (refer to table 19). Rating the Hospital on a scale of 1 to 10, with a mean of 8.8 (N=158; SD=1.5).

Table: *Respondents' ratings of care and treatment and overall experience of Hospital*

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	**%**	**n**	**%**
1	5	1.0	2	.4
2	3	0.6	6	1.3
3	5	1.0	2	.4
4	4	0.8	9	1.9
5	8	1.7	17	3.5
6	23	4.8	29	6.1
7	32	6.7	93	19.4
8	81	16.9	98	20.5
9	104	21.7	197	41.1
10	186	38.8	2	.4
No Answer	28	6	26	5.4
1-5	25	5	19	4.0
6-10	426	89	434	90.6
Total	479	100.0	479	100.0

Table: *Respondents' ratings of care and treatment and overall experience of Hospital*

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	451	8.6	1.8
The Hospital	453	8.8	1.5

Further Service User Views

Inpatient respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the users' experiences. Not all respondents answered these questions. Please find below a sample of answers:

Q: Is there anything else you would like to tell us about your experiences of being in Hospital please do so here.

Positive Comments include:

- "All staff were excellent. Extremely friendly place. Was made feel so welcome when I walked through the door. Nurses could not have done more for me".
- "I was amazed that there is such good care available and will always be grateful for the care I have received and the kindness shown to my family".
- "I would like to compliment the whole team - they were all fantastic to a person. Made me feel so safe & couldn't do enough for me when I was very vulnerable. So many thanks to them all. They have helped me on the road to recovery".
- "Very positive first experience with a mental health hospital, treated with respect and dignity by all staff".
- "The poetry and jewellery classes were excellent and provided day to day activities, also the twilight programme was excellent".
- "I really enjoy my stay here ... I really had a sense of being in a centre of excellence and that my healthcare was in the best hands. The professionalism, expertise and empathy of all the staff from the cleaner to the consultant was second to none".
- "Overall hugely positive - a very caring, supportive and safe place with a very 'normal' feel to the place - not like a typical hospital - lobby, cafe, art spaces etc. all create a stimulating, creative, reassuring".
- "Multi- disciplinary approach and the fact that they knew what each other were doing and I was actively involved also".

Comments to learn from include:

- "I felt that the toilet on the bay could have been kept a little cleaner. No facilities are provided for when toilets became dirty after cleaners leave".
- "The communication within the MDT and between nurses on the ward is non-existent. I was repeatedly told one thing and then another".
- "Food needs to be improved - healthier choices".
- "Staff need to talk to patients more".
- "Seeing the psychiatrist more than once a week would be better".

- “Not enough psychologists or therapists, programmes do not suit everyone as they may fall into a category but their treatment may need to be individualised”.
- “Until I requested my care plan I wasn’t aware of who my key worker was and during my stay I had no contact with her”.
- “More planned activities would be useful and more widely promoted”.
- “Difficult to get info on a programme very difficult to get a meeting with key worker or registrar”.

Q: Was there anything particularly good about your care?

- “I was very distressed one day and one of the nurses sat with me for 1 hour for that I am very grateful”.
- “I was involved in my recovery and not just medicated”.
- “The peace and knowing I could talk to people who really understand me”.
- “Variety of activities. Availability of a lot of information regarding mental illness and mental health. Frequent consultations and review of care plan”.
- “Overall I found the care from the nursing to the medical team and the support staff cleaners, porters, catering, shop assistants excellent”.
- “I'm not sure it qualifies as care but the entertainments & activities provided by the twilight programme were by far & away the most beneficial part of the stay in St. Pats”.
- “The overall care I received was excellent - caring compassionate, professional. I am glad to have this opportunity to give feedback. I arrived really ill + exhausted and went home a new person. Thank you for giving me my life back”.
- “Psychologist delivery of therapy was excellent and helped me greatly come to terms with my mental health difficulties”.
- “The nursing staffs were very courteous and kind; you could approach them when you were worried about something. Nurse X was very approachable and gave you hope that there was light at the end of the tunnel. Catering and cleaning staff very cheerful”.
- “Group therapy, yoga, one to one with counsellor”.

- "The kindness and support of the staff and from the consultants to the kitchen staff, was a great help and the space and time to heal and recover".
- "Commitment support and caring attitude of my psychiatrist and psychologist".

Q: What could we improve?

- "More OT classes in Eds. Arts / crafts + painting classes. Never had previous experiences of any of the above, but found them extremely therapeutic".
- "Be listened to more, have my voice heard + be able to contribute my opinion on my care plan, not to be left so long w/o seeing psychologist + OT".
- "I noticed a lot of the activities such as art and crafts and pottery seemed to appeal more to women than men".
- "Issues of availability of beds on certain wards such as Stella. It can be a bit disruptive to have to move wards".
- "The gym is open when most people are in group or attending a course".
- "Allow patients more access to the available health care professionals at their own discretion".
- "The nurses do not have personal 1:1 time with you like they used to".
- "More counsellors are needed as existing are stressed".
- "The various activities e.g. pottery/art, these should be available in the evening when patients need to relax after their programmes".
- "Nutrition and diet plan, healthy eating".
- "More psychological interventions, faster assessments for patients".
- "Shower and toilet facilities on the ward could be better".
- "Talks were cancelled at late notice. Some lectures were excellent, others seem not to want to be there just going through the motions".
- "The food was very good and the deserts delicious. Unfortunately the dinner plates were piled high with food. This was very unappetising to ill patients and over all very few ate food provided - a lot of waste (food & financially)".

5.1.4.3 Day Services

St Patrick's Mental Health Services offer mental health programmes through the Day Service's Wellness and Recovery Centre. A range of programmes are offered which aim to support recovery from mental ill-health, and promote positive mental health.

Day Services Service User Satisfaction Survey Response Rate

Month	Surveys Distributed	Surveys Returned
January	76	21
February	99	32
March	106	27
April	98	53
May	96	36
June	116	39
July	91	19
August	126	47
September	62	13
October	93	35
November	85	17
December	111	23
Total	1159	362

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Mindfulness	105	29
Recovery	95	26.2
Anxiety	12	3.3
Depression	27	7.5
St Edmundsbury	24	6.6
Alcohol Step Down	4	1.1
Bipolar	5	1.4
Living Through Distress	25	6.9
Other	24	6.6
Eating Disorder	11	3.3
Radical Openness	6	1.7
Young adult	1	0.3
Pathways to Wellness	4	1.1
No answer	19	15.2

"Other" included programmes such as ACT, Compassion Focused Therapy, Self-Esteem, Roles in Transition and Living with Psychosis.

Over three quarters of respondents reported living in Leinster (85.9%).

Province	n	%
Connaught	14	3.9
Leinster	311	85.9
Munster	19	5.2
Ulster	4	1.1
Don't want to say	1	0.3
Missing	13	3.6
Total	362	100

The majority of respondents had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. 37% had experienced an in-patient stay and 41.4% had attended as an outpatient at the Dean Clinic.

Service	n	%
In-patient stay	134	37.0
Dean Clinic	150	41.4
In-patient day programme	10	2.8
Other day programme	23	6.4
Not applicable	22	6.1
Associate Dean consultation	16	4.4
No answer	7	1.9

Service User Responses

'After you were referred how long did you wait for communication from a member of the programme staff?'

Wait time	n	%
Less than 1 day	39	10.8
1-3 days	96	26.5
4-7 days	91	25.1
1-2 weeks	58	16.0
2-4 weeks	41	11.3
More than 4 weeks	22	6.1
No answer	15	4.1

Service Users were asked about their experience of beginning the programme. The majority agreed that they were greeted by staff when first coming to the hospital, and that the structure and organisation of the programme was clearly explained to them before commencement. See table below for further details of respondents' experiences of beginning a programme.

Tell us about your experience of starting a programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
When you came to the hospital did a member of Day Services greet you?	289	79.8	31	8.6	32	8.8	10	2.8
When you came to hospital did a member of Day Services explain clearly what would be happening?	307	84.8	29	8.0	14	3.9	12	3.3
When you commenced the programme did a member of staff explain the timetable?	335	92.5	10	2.8	8	2.2	9	2.5
Were you given a written copy of the timetable and other relevant information?	286	79	45	12.4	20	5.5	10	2.8

Respondents also generally reported an informed ending to the programme, with 93.9% agreeing that they knew when the programme was to end. Over 80% of respondents felt that the programme met their expectations and felt that they know what to do in the event of a further mental health crisis. The majority of respondents

reported not receiving information regarding the hospital's support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme.

	Yes		No		Don't know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Did you know in advance when the programme was due to end?	340	93.9	31	8.6	1	0.3	6	1.7
Did the programme meet all your expectations?	306	84.5	37	10.2	8	2.2	11	3.0
Have you been given details of the hospital's support and information service?	279	77.1	50	13.8	16	4.4	17	4.7
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	311	85.9	30	8.3	13	3.6	8	2.2

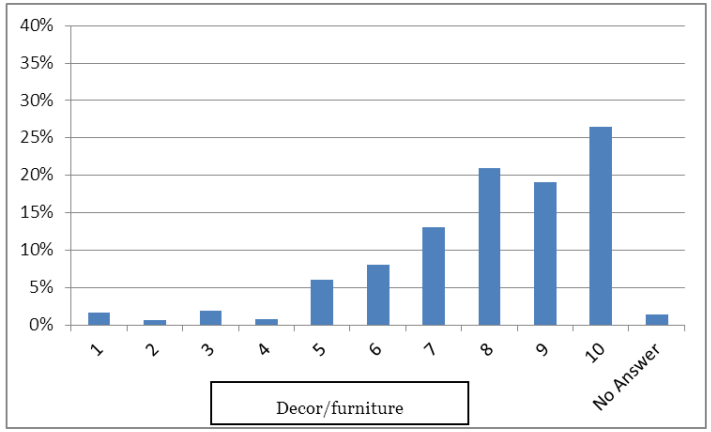
The Service User Satisfaction Questionnaire is also interested in service users' experiences of stigma after having attended St Patrick's.

Tell us about your experience of stigma following your attendance at St Patrick's.

As you are prepared to leave the programme…	Yes		No		Don't know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Do you feel that your views regarding mental ill-health in general are more positive than they were?	311	85.9	26	7.2	15	4.1	8	2.2
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	319	88.1	23	6.4	15	4.1	5	1.4
Will you tell people that you have attended St Patrick's	241	66.6	58	16.0	56	15.5	7	1.9

How would you rate the Day Services Facilities?

Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of one to ten. For each of the facilities, the most endorsed score was a score of 10.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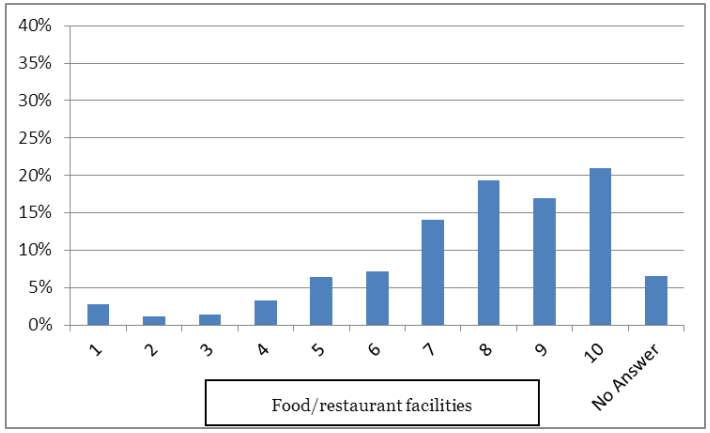
Decor/furniture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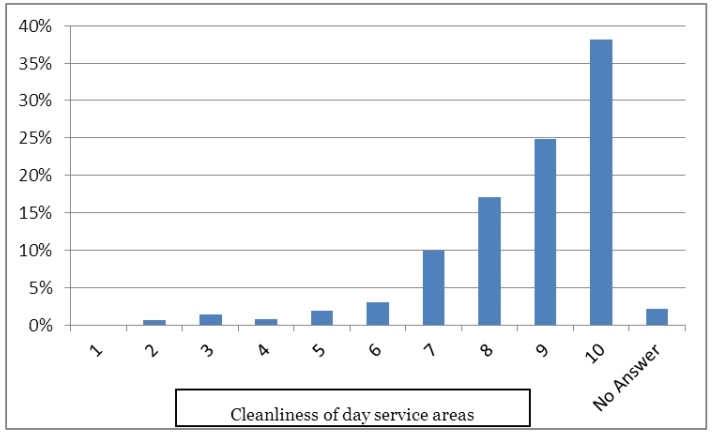
Food/restaurant facilities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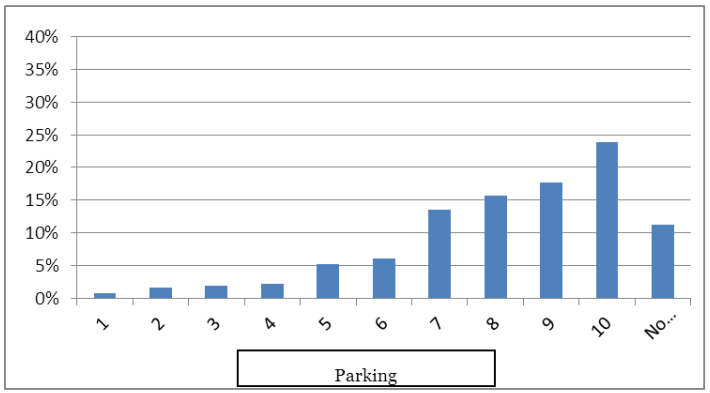
Cleanliness of day service areas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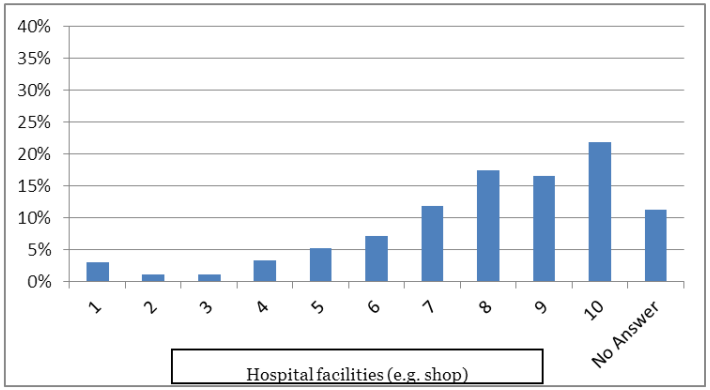
Parking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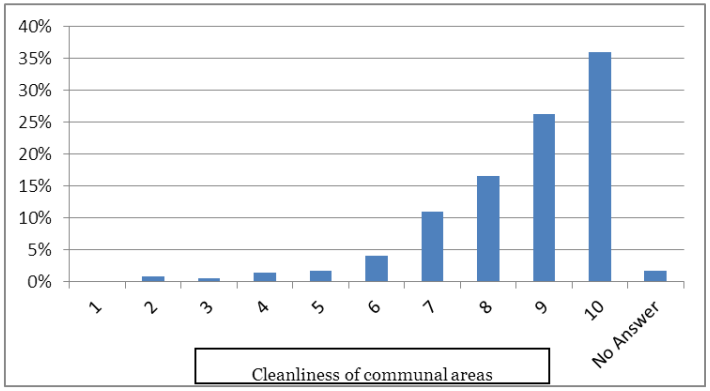
No Answer
Hospital facilities (e.g. shop)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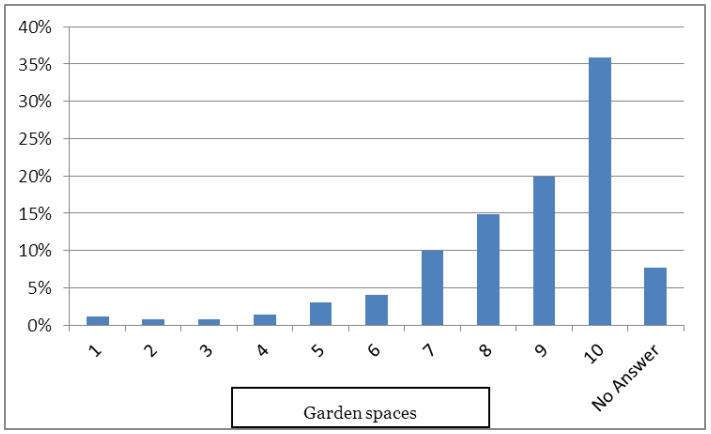
No Answer
Cleanliness of communal areas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No Answer
Garden spaces

Respondents were also asked to rate their care and treatment, and the hospital, overall, on a scale of 1 to 10. Over 95% rated their care and treatment and the hospital in general, between 6 and 10.

Overall, on a scale of 1-10, how would you rate your care and treatment in St Patrick's Mental Health Day Services?

Score	n	%
1	2	.6
2	1	.3
3	1	.3
4	4	1.1
5	5	1.4
6	5	1.4
7	32	8.8
8	67	18.5
9	87	24.0
10	154	42.5
No answer	4	1.1
1-5	13	3.6
6-10	345	95.3

Overall, on a scale of 1-10, how would you rate St Patrick's Mental Health Day Services?

Score	n	%
1	1	.3
2	0	0
3	1	.3
4	2	.6
5	6	1.7
6	4	1.1
7	29	8.0
8	68	18.8
9	91	25.1
10	155	42.8
No answer	5	1.4
1-5	10	2.76
6-10	347	95.86

Further Service User Views

Lastly respondents were invited to give open-ended feedback to three questions. Not all respondents answer these questions. Please find below a selected sample of answers:

Q: Is there anything else you would like to tell us about your experience of attending St Patrick's Mental Health Day Services?

Positive comments include:

- "I really appreciate the care I was granted during the most difficult period of my life to date. I felt completely understood and supported. Dr X is a wonderful Consultant".
- "Very positive experience. Very enthusiastic helpful informative staff running course. They were very prepared for each group, lots of background work carried out".
- The service and team (Psychology) were excellent".
- "I like the "follow-up" care after discharge such as ongoing support through day services programmes".
- "I found both the Depression recovery programme and the follow on ACT sessions to be very helpful in assisting me to understand my mental health difficulties. I found the interactions with various professionals to be good and overall it has helped me to overcome my sense of stigma regarding mental health".
- "I have found that the instruction and practices have helped me to reduce my negative thoughts and stress. What I have been taught actually works for me. The two instructors explained and taught me a lot about how I can help myself think more positively".
- "I found the service welcoming, the facilitators and administration were very helpful".
- "The nursing staff are without doubt the backbone of this hospital without them I would not be where I am today".
- "Open, friendly, positive and inspiring. Particularly enjoyed practicing mindfulness and morning group discussions. Led by a very thoughtful and

ever evolving X. Excellent being able to learn and explore and share with the group different solutions to different difficulties".

- "The nature and gardens made a huge impact on my recovery time, please please leave Ed's grounds untouched".
- "It has given me more tools more optimism and insight to cope with my day to day life and onwards into the future. I don't feel so bad that I suffer from depression now and feel better able to cope".
- "Good experience pressure taking off us by parking and canteen voucher, facilitators genuinely care".

Comments to learn from include:

- "Everything is very good while you are in the hospital but when you are phoning in beforehand you don't get the same level of care, constantly out of put through to different people other no calling back no clarity on cost etc".
- "Food in the canteen and layout of the canteen could be better".
- "I think that smaller groups work better than larger ones. In my opinion 10 or 12 should be the most in one groups or less if possible".
- "Feel there should be more activities to do during the day and weekends i.e. yoga, mediation".
- "More feedback on a personal level is needed - a week / 6 weeks / 3 months / 12 months / every 6 months thereafter after leaving any course / stay".
- "When I was first referred it took over 6 weeks to have the initial appointment. This was a long time to have to wait".
- "St Patrick's is too expensive".

Q: Was there anything particularly good about your care in Day Services?

- "I think the care from the whole team is exemplary. This includes the Consultant, the course facilitator , the manager of the day care services, the person who dealt with phone queries".
- "The team being so non-judgemental and patient. The overall feeling and ambience of the hospital. Lack of pressure. I loved it".
- "Lunch vouchers and free parking".

- “Day team on ACT very professional and passionate about the programme and these Tuesday mornings have been something I look forward to”
- “The instructors made us all feel welcomed and relaxed and were excellent in guiding us through the various practices. The advice they gave us has helped me to understand how thoughts can affect the mind and body. I am more calm, relaxed and confident person after doing the course”.
- “X and Y were absolutely excellent in delivering the ACT course. They are inspirational”.
- “The setting in St Edmundsbury particularly lends itself to the therapeutic nature of the course. The setting itself is therapeutic and a real retreat”.
- “Met some lovely service users - I felt a great support from listening to their experiences”.
- “People were so kind they made me feel like I mattered. I was taken care of not only as a group member but as an individual. I could speak my mind and confide about anything, and the follow up care is a great bridge for getting back to normal”.

Q: **What could we improve about your experience of Day Service?**

- “I'd like more feedback, I'd like courses to be longer. A return 2 course for a day or 2 after a month etc”.
- “Canteen facilities for evening courses”.
- “Big delay between referred and starting the courses but that was the Dean Clinic I had to keep ringing them and lack of communication”.
- “Water cooler far from group room. No coffee/tea facilities nearby”.
- “Let us have a review day - a recap day after 1 month. We would gather with co-ordinator. We should get written feedback after each course (sorry for the mention of more form filling to staff)”
- “I would like to see a more holistic approach to mental health where regardless of which site you are located in (I was in St Eds) that there is a comprehensive programme of recovery available from day one including mindfulness and Tai Chai for example. I found art very helpful in my recovery.
- “Bigger dining room, better salad bar, fresh fruit, more yoghurt and night time programme a few nights a week”.

- “I think that having an after care service would be very helpful to help me keep using mindfulness/ACT. Even once per month or two would keep me on track”.
- “Car Parking”
- “Room for improvement in the Day room facilities, better ventilation”

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2014

Willow Grove is the inpatient adolescent unit of St Patrick's Mental Health Services which opened its doors in 2010. The 14 bed unit offers treatment to young people between the ages of 13 and 17 years, who are experiencing mental health difficulties. The multi-disciplinary team includes a variety of professions including Psychiatry, Nursing, Psychology, Psychotherapy, Occupational Therapy, Social Work and Education. Further activities are offered in art, music and sport. The unit has an associated outpatient Dean Clinic located in Lucan, Co Dublin, which also offers assessment and treatment services for adolescents.

The unit provides evidence based treatment in a safe, comfortable and young person friendly environment. The multi-disciplinary team are committed to on-going quality improvement. Young people's views were taken on board in the design and development of the unit and the team continue to work collaboratively with young people and their parents/carers. The Willow Grove Service User Satisfaction Survey is one aspect of the collaborative approach taken by the unit. This report presents the responses from the survey which was distributed to young people and parents/carers following an inpatient stay in the Willow Grove Adolescent Unit in 2014.

5.2.1. Methodology

Willow Grove is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (Q.N.I.C.), a group of similar units which conduct yearly peer review cycles. The Network is co-ordinated by the Royal College of Psychiatrists in the United Kingdom and every two years their standards are reviewed and updated in line with best practice. The satisfaction survey used is an adapted version of a standard Child and Adolescent Mental Health Service (CAMHS) inpatient satisfaction questionnaire, taken from the COSI-CAPs study, recommended by Q.N.I.C.

5.2.1.1. Respondents

This questionnaire was posted to parents and young people 1 month post discharge from the unit. Eleven young people and 24 parents/carers completed the questionnaire. Response rates were 12.6% and 27.6% respectively. Given that the completion rate was below 50% these results should be interpreted with caution.

A number of reasons have been suggested by staff to possibly contribute to a low completion rate, including:

- A month long delay between being discharged and receiving the questionnaire. This is to allow time for young people and parents to notice differences in their lives which the questionnaire asks about.
- That young people may not be interested in completing the questionnaires, and would rather focus on their life outside of the unit.
- The length of questionnaire.

For 2015 the questionnaire has been shortened to improve completion rates whilst still using many of the questions in the original questionnaire. It will also be given to parents and young people on the day of discharge. Some of the questions that have been omitted relate to how the young person experienced the effectiveness of the service in helping them maintain their recovery and the utilisation of coping skills acquired in the Unit to help them optimise their functioning in school, home and social life. To capture this information a postal questionnaire will be sent to parents/young people post discharge.

5.2.1.2. Survey Design

The questionnaire asked young people a set of questions which gather information on their experiences of access to services, the environment and facilities, the therapeutic services offered, the ability of the service to help young people and parents manage mental health difficulties, discharge preparation, professionalism of staff, and confidentiality and rights.

The questionnaires asked parents and young people to rate a number of statements precede by the statement, 'What is your overall feeling about…'. Answers ranged from 1 'Very unhappy' to 5 'Very happy'. The young person's questionnaire also included a 5 point likert scale ranging from 1 'Very poor' to 5

'Very good', printed with corresponding smiley faces to help young people to understand the response options.

5.2.2. Results

5.2.2.1. Quantitative Responses

The median response (i.e. the most common response) for each question is listed in the table below. In order to be concise, the median response for the young people and their parents/carers are presented in a single table. As a consequence the questions are presented generically. The questionnaires that were given to the young person and parent/carer were worded slightly differently in order to frame the question as to whether it referred to their child or for the young person. For example; *'the effect of services in helping you deal with your problems'* compared to *'the effect of services in helping your child deal with his/her problems'*.

Overall the young people and the parents who answered the survey appear pleased or very pleased with the service. The majority of median responses for young people were a 4 'Good' (38%), followed by 5 'Very good' (32%) and 3 'Average' (20%). For the parents/carers, the most common response across questions was 5 'Very happy' (39%), followed by 4 'Happy (38%) and 3 'Mixed' (15%).

The least positive answers were in relation to cost of service according to both young people and parents, in relation to the service helping the young person to improve relationships outside of the family according to the young person themselves, and the length of time between discharge and follow-up appointments according to the parent/carer. Items for which both young people and carer's had a median rating of 5 included the appearance and comfort level of the rooms and the information offered about the unit.

Table: *Median responses to Willow Grove Service User Satisfaction Questionnaire*

What is your overall feeling about…	Median rating	
	Young person	Parent/ Carer
The effect of services in helping you deal with your (child's) problems	4	5
The appearance and comfort levels of the rooms	5	5
How the professionals listened and understood the difficulties	4	5
The personal manner of professionals	4	5
Professionals keeping time of appointments	3	5
How much it cost your family to use the service, for example in travelling cost, time off work etc.	3	4
The effect of services in helping to prevent return of mental health difficulties	2	5
The confidentiality and respect or your (child's) rights	4	5
The explanation given of treatment	4	5
The effect of services in helping your child to feel better	3	5
The response of services to crises and urgent needs outside of working hours	4	5
The arrangements after working hours	2	5
Being referred to other services if needed	4	4
How well different services worked together to help	3	5
The information offered about the unit	5	5
The kinds of services offered	4	5
The service received, in a general sense	4	5
The advice given to family/carers about how to help	3	5
How effective the service was in helping improve the young person's understanding of their difficulties	3	5
How effective the service was in helping the relationship between child and parent/carer	3	4
How information was given to the young person about the nature of the difficulties and what to expect in the future	2	5
The ability of professionals to listen and understand the worries and concerns of parents/carers	2	5
How effective the service was in helping the young person establish good relationships with people outside of the family	3	5
How information was given to the family/carers about the young person's difficulty, and what to expect	4	5
The advice given to young people about what to do on leave	3	5
How effective the service was in helping the young person do better at school	3	5
The continuity of care the young person received	4	5
The length of time before a first appointment was arranged	2	5
The length of time between discharge and follow-up appointments	3	4

SECTION 6

Conclusions

6.1. Conclusions

1. The 2014 SPMHS Outcomes report represents the organisations continued commitment to continuous quality improvements through the measurement of its clinical activities, clinical processes, clinical outcomes and service user satisfaction levels. This report builds on the outcomes reports from 2012 and 2013. Service evaluation, outcome measurement, clinical audit and service user satisfaction surveys continue to be used routinely in the context of improving the quality of service delivery.

2. Demand for SPMHS services in 2014 increased across all of its three distinct but integrated community, inpatient and day services.

3. Clinical outcomes data was added for the Addictions, Dual Diagnosis, Mindfulness (in SPUH) and Depression Programmes in 2014. Work was also commenced in 2014 to establish further additional services for the outcome measures in 2015.

4. Clinical and non-clinical staff are once again to be commended for contributions in further establishing routine outcome measurement within services and programmes in 2014. Work will continue in 2015 regarding how best to make data entry more efficient, with a view to incorporating outcome measurement into the plans for an electronic health record in the coming years.

5. Service user satisfaction surveys are now established as an essential element of service evaluation and improvement. There has been a lot of thought, energy and planning with regard to improving completion rates for the service user satisfaction surveys in all of the three distinct but integrated community, inpatient and day service pathways. Results indicate the service user experience of SPMHS services continued to be very positive overall.

6. All clinical programmes involved in publishing their outcomes in the 2014 report, continued to review the clinical utility and psychometric strength of measures used and where appropriate measures were changed or added. This process will continue and improvements are already in place for the 2015 outcomes measurement process.

7. Clinical audit continues to be one of the essential pillars of clinical governance within SPMHS, leading to continuous quality improvements. This is consistent with SPMHS objectives of adherence with national and international standards of best practice, including full compliance with Mental Health Commission standards and regulations.

SECTION 7

References

7.1. References

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