St Patrick's
Mental Health Services

Outcomes Report 2015

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 fifth year that an outcomes report has been produced by SPMHS and is central to the organisation's promotion of excellence in mental health care. By 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. Wherever 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 capture outcome measures related to care and treatment and make the results available (through their websites and other means), in order to enable service users, referrers and commissioners to make informed choices about what services they choose. This transparency informs staff and volunteers of the outcomes of services they provide and advances a culture of accountability for the services being delivered. It provokes debate about what care and treatment should be provided and crucially how best to measure their efficacy. The approach of sharing treatment outcome results has also been utilised by the Mental Health Commission in Ireland (Mental Health Commission, 2012).

The 2015 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 services are structured and how community, day-patient and inpatient services were accessed in 2015. SPMHS provides community and outpatient care through its Dean Clinic Community Mental Health Clinics and day-patient services through its Wellness & Recovery Centre. It provides inpatient care through its three approved centres, 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. This information provides practice-based evidence of the efficacy of interventions and programmes delivered to service users during 2015, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

SPMHS considers service user participation and consultation to be essential 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 in a number of ways. 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 services in 2015.

2.1. Community Services (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 seven 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. In 2013 the expansion of our community network continued with the establishment of a number of Associate Dean Clinics, where new assessments are carried out on behalf of SPMHS.

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 provision of continued care 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 clinics encourage and facilitate early intervention which improves outcomes. In 2015, there was a total of 2,236 (including adolescents) Dean Clinic referrals received from General Practitioners. This compares with a total of 2,047 in 2014, representing an increase of 9.2% from the previous year. A summary of the annual referral totals made to Dean Clinics from 2010 to 2015 are included in the table below.

Year	2010	2011	2012	2013	2014	2015
Referral Totals	692	1376	1759	1889	2047	2236

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 2015 in ranked order of frequency by county. The highest referral volumes continued to be from Dublin in 2015 with 898 referrals. However, a small number of other counties showed referred growth in 2015 including Clare, Cork, Kerry and Tipperary.

County	2011	2012	2013	2014	2015
Antrim	0	0	0	3	1
Carlow	13	18	18	20	21
Cavan	9	15	15	19	23
Clare	20	24	32	34	49
Cork	114	133	158	135	225
Derry	0	1	0	1	0
Donegal	6	10	13	5	14
Down	0	1	2	0	4
Dublin all postal codes	607	769	841	897	898
England	0	0	0	1	0
Fermanagh	0	0	0	2	1
Galway	76	113	113	129	119
Kerry	18	33	28	19	35
Kildare	98	115	132	146	164
Kilkenny	16	20	21	28	27
Laois	17	34	28	43	31
Leitrim	4	6	7	9	19
Limerick	21	27	27	24	33
Longford	16	17	16	23	13
Louth	41	52	66	72	73
Luxembourg	0	0	0	1	0
Mayo	21	29	49	40	53
Meath	52	54	53	101	88
Monaghan	1	7	9	12	14
Offaly	23	31	33	41	39
Roscommon	13	18	10	18	14
Sligo	9	10	13	18	51
Tipperary	49	61	57	48	60
Tyrone	0	1	0	0	0
Waterford	14	20	25	24	29
Westmeath	54	71	52	48	57
Wexford	23	17	32	32	38
Wicklow	41	52	39	54	43
Totals	**1376**	**1759**	**1889**	**2047**	**2236**

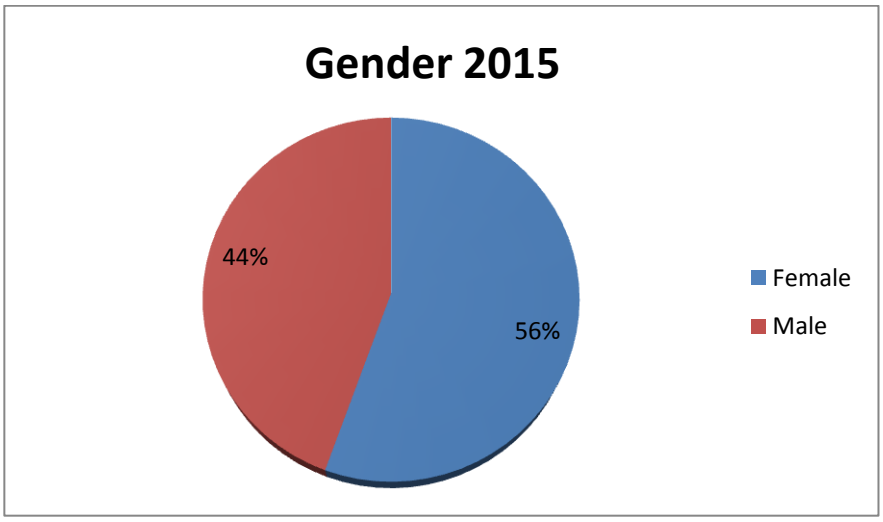
2.1.3. Dean Clinic Referral Source by Province

The Table below summarises the proportion of Dean Clinic referrals by Province from 2011 to 2015 with increases across all provinces from 2014 to 2015.

Year	Leinster	Munster	Connaught	Ulster	Other
2011	1053	224	68	11	20
2012	1337	281	107	34	0
2013	1336	317	195	41	0
2014	1503	287	214	43	0
2015	1494	427	257	58	0

2.1.4. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic referrals for 2015 was 56% female to 44% male.



2.1.5. Dean Clinic Activities (2010-2015)

2015 was a busy year clinically across all Dean Clinics. The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics over the last six year period. Not all referrals result in an assessment, there are a number of reasons for this. In some cases a decision is made not to progress with an assessment as the service user is already under the care of another service.

Others do not attend their appointments and other service users have a more immediate need and are assessed for possible urgent admission to inpatient care.

Year	No. of Referrals	No. of Assessments
2010	**692**	**573**
2011	**1376**	**924**
2012	**1759**	**1,398**
2013	**1889**	**1,422***
2014	**2047**	**1,287***
2015	**2236**	**1,461***
Totals	**9,999**	**7,065**

* From 2013 onwards, 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 other members 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 2010 to 2015.

Year	Total No of Dean Clinic Appointments
2010	5,220
2011	7,952
2012	12,177
2013	12,826*
2014	13,541*
2015	16,142*
Total	67,858

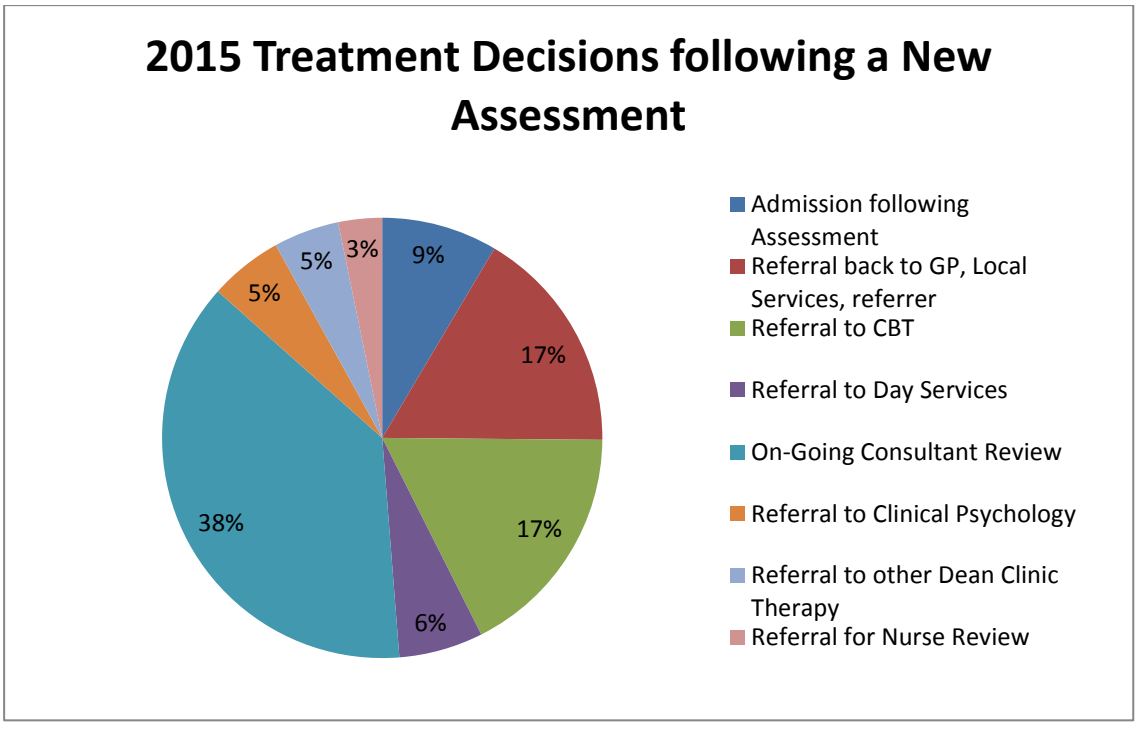
*Includes ALL Associate Dean Assessment appointments

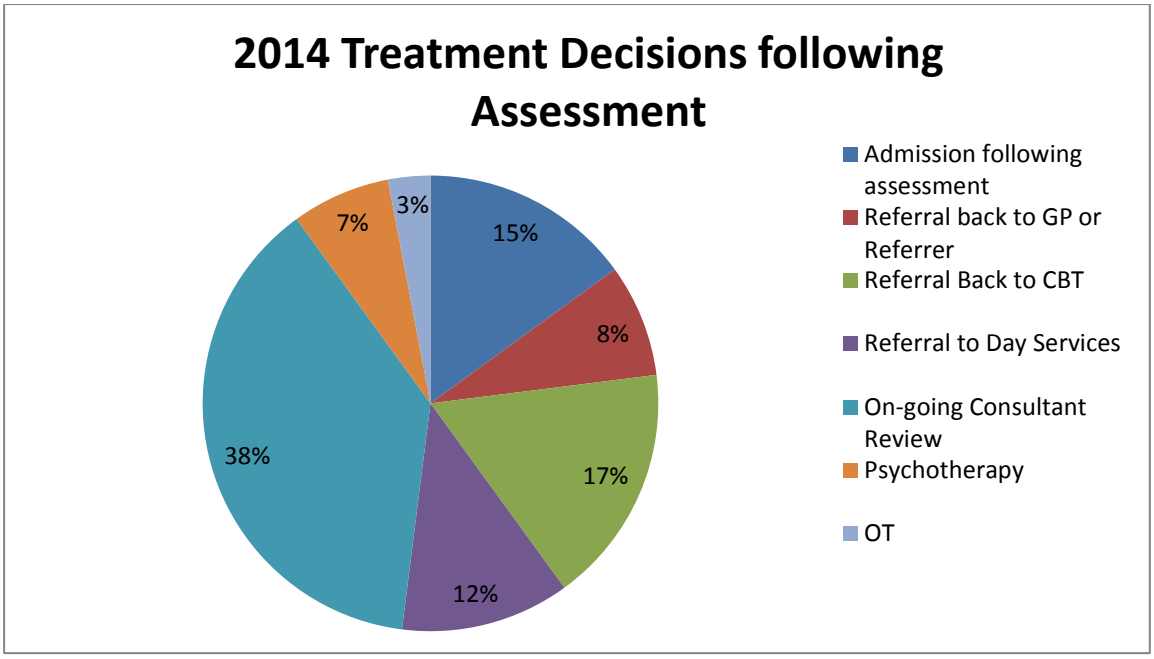
The table below summarises the number of first time inpatient admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2015.

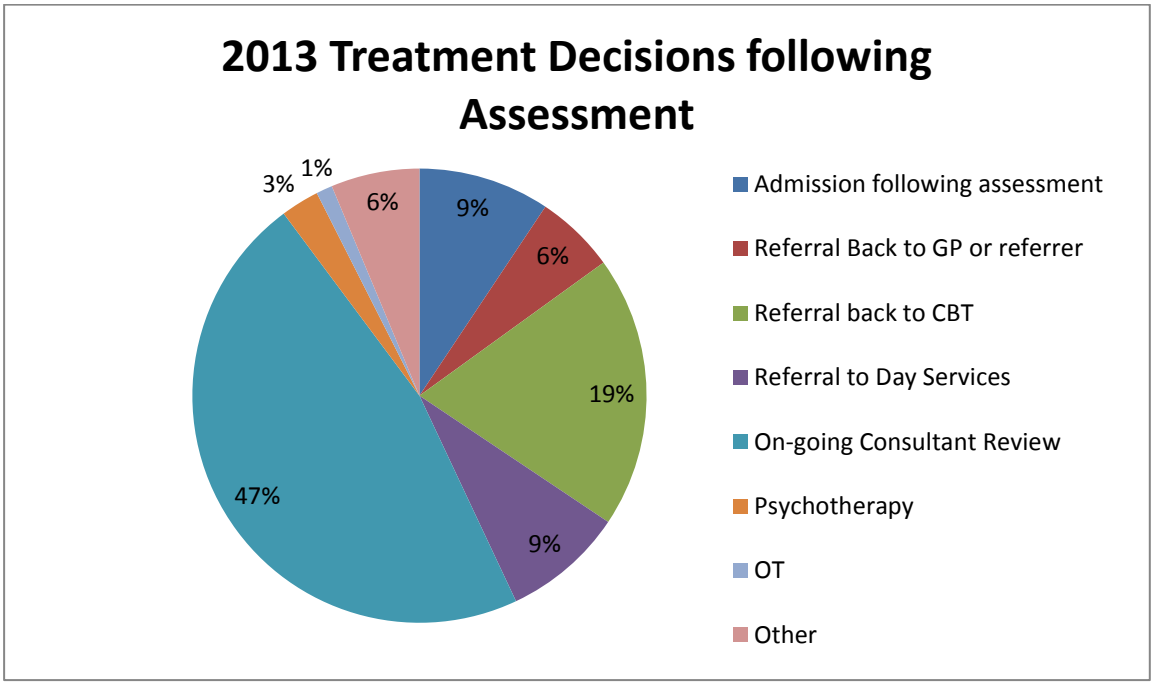
Year	First Admission
2011	150
2012	180
2013	225
2014	202
2015	235

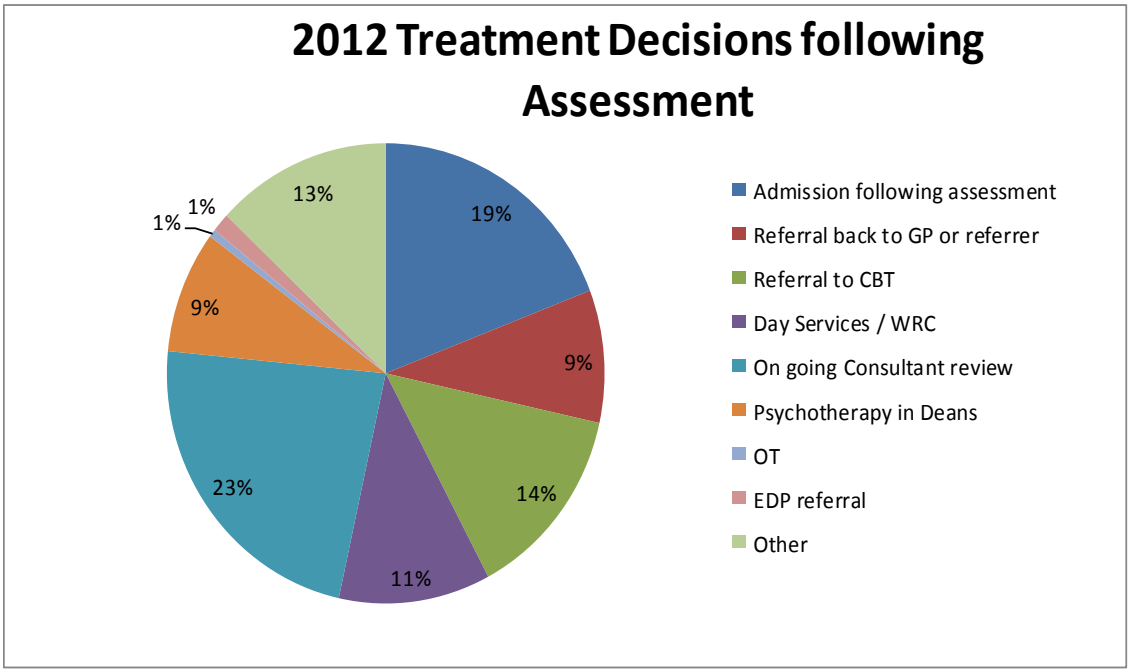
2.1.6 Dean Clinic: Outcome of Assessments

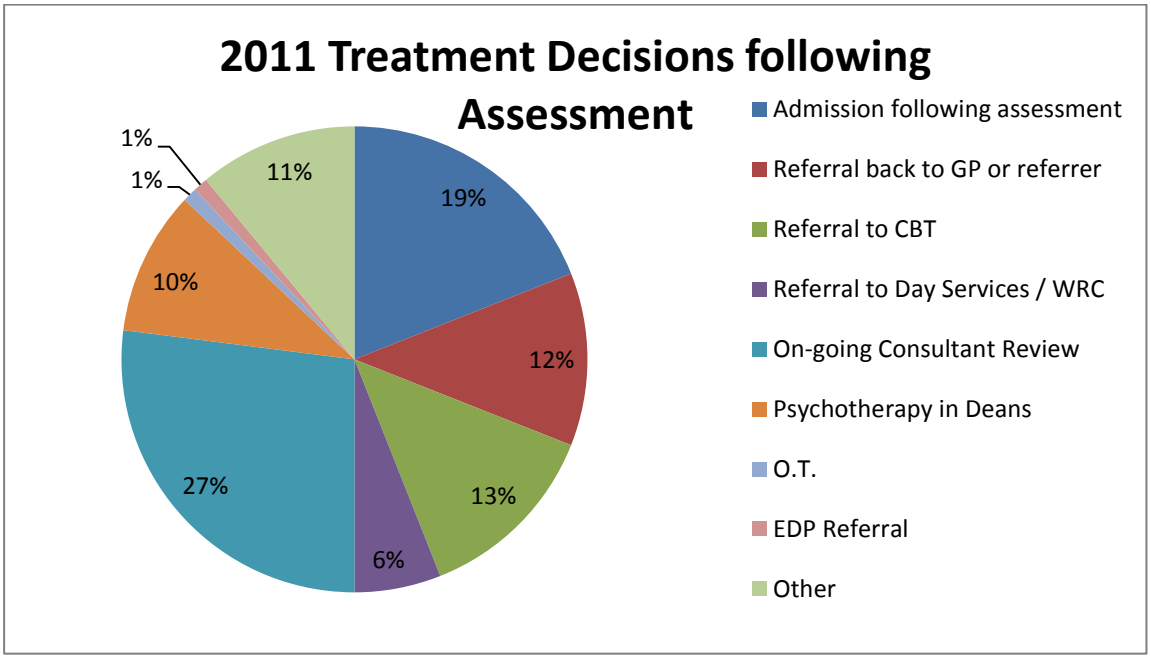
The five charts below summarise and compare the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics for 2015, 2014, 2013, 2012 and 2011.




2014 Treatment Decisions following Assessment
15%
8%
17%
12%
38%
7%
3%
Admission following assessment
Referral back to GP or Referrer
Referral Back to CBT
Referral to Day Services
On-going Consultant Review
Psychotherapy
OT


2013 Treatment Decisions following Assessment
9%
6%
19%
9%
47%
3%
1%
6%
Admission following assessment
Referral Back to GP or referrer
Referral back to CBT
Referral to Day Services
On-going Consultant Review
Psychotherapy
OT
Other


2012 Treatment Decisions following Assessment
19%
9%
14%
11%
23%
9%
1%
1%
13%
Admission following assessment
Referral back to GP or referrer
Referral to CBT
Day Services / WRC
On going Consultant review
Psychotherapy in Deans
OT
EDP referral
Other


2011 Treatment Decisions following Assessment
19%
12%
13%
6%
27%
10%
1%
1%
11%
Admission following assessment
Referral back to GP or referrer
Referral to CBT
Referral to Day Services / WRC
On-going Consultant Review
Psychotherapy in Deans
O.T.
EDP Referral
Other

2.2. SPMHS's Inpatient Care

SPMHS comprises three separate approved centres including St Patrick's University Hospital (SPUH) with 241 inpatients beds, St Edmundsbury Hospital (SEH) with 50 inpatient beds and Willow Grove Adolescent Unit (WGAU) with 14 inpatient beds. In 2015, there were a total of 3,001 inpatient admissions across the organisation's three approved centres compared to 3,015 for 2014 and 3,113 for 2013.

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 2015.

The table below shows inpatient admission numbers and the percentage rates for Male and Female admissions. In 2015, 60.4% of admissions across all three Approved Centres were female, compared to 62.3% in 2014.

No. of Admissions (% of Admissions) 2015				
	SEH	**SPUH**	**WGAU**	**Total**
Female	313 (65.2%)	1,438 (59.1%)	61 (70.9%)	1,812 (60.4%)
Male	167 (34.8%)	997 (40.9%)	25 (29.1%)	1,189 (39.6%)
Total	**480 (100%)**	**2,435 (100%)**	**86 (100%)**	**3,001 (100%)**

The table below shows the average age of service users admitted across the 3 Approved centres was 48.58 years in 2015. This compares to 47.71 years in 2014. The average age of adolescents admitted to WGAU was 15.44 years which was consistent with 2014 at 15.67 years. The average age of adults admitted to SEH was 54.69 years in 2015 & 53.62 years in 2014. In addition, the average age of adults admitted to SPUH was 48.58 years in 2015 compared with 47.72 years in 2014.

Average Age at Admission 2015					
	SEH	**SPUH**	**Total Adult**	**WGAU**	**Total**
Female	55.55	49.47	50.55	15.39	49.37
Male	52.8	47.27	48.07	15.56	47.38
Total	**54.69**	**48.57**	**49.56**	**15.44**	**48.58**

2.2.2. SPMHS Inpatient Length of Stay 2015

The following Tables present the 2015 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 within temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2015 Adults	Number of Discharges	Percentage
Under 1 week	480	16%
1 -<2 weeks	281	10%
2-<4 weeks	585	20%
4-<5 weeks	340	12%
5-<6 weeks	336	11%
6-<7 weeks	254	9%
7-<8 weeks	171	6%
8-<9 weeks	140	5%
9-<10 weeks	74	3%
10-<11 weeks	62	2%
11 weeks -< 3 months	88	3%
3-<6 months	102	3%
6-12 months	2	0.1%
Total Number of Adult Discharges 2015	**2915**	**100%**

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

2015 WG	Number of Discharges	Percentage
Under 1 week	10	12%
1 -<2 weeks	5	6%
2-<4 weeks	6	7%
4-<5 weeks	5	6%
5-<6 weeks	7	8%
6-<7 weeks	7	8%
7-<8 weeks	10	12%
8-<9 weeks	7	8%
9-<10 weeks	9	11%
10-<11 weeks	4	5%
11 weeks -< 3 months	8	10%
3-<6 months	5	6%
Total Number of Adolescent Discharges 2015	**83**	**100%**

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpatients discharged in 2015)

The table below outlines the prevalence of diagnoses across SPMHS three Approved Centres during 2015 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded on 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 is based on all inpatients discharged from SPMHS in 2015.

SPMHS Analysis of Inpatient Primary ICD Diagnoses
(For all inpatients discharged in 2015)

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

ICD Codes: Admission & Discharge **For All Service Users Discharged in 2015**	SPUH Admission ICD		SPUH Discharge ICD		SEH Admission ICD		SEH Discharge ICD		Total Adult Admission ICD		Total Adults Discharge ICD		WGAU Admission ICD		WGAU Discharge ICD	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	36	1.5	32	1.3	3	0.6	1	0.2	39	1.3	33	1.1	0	0	0	0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	393	16.2	418	17.2	30	6.1	28	5.7	423	14.5	446	15.3	0	0	1	1.2
F20-F29 Schizophrenia, schizotypal and delusional disorders	218	9.0	234	9.7	18	3.7	20	4.1	236	8.1	254	8.7	2	2.4	3	3.6
F30-F39 Mood [affective] disorders	1228	50.7	1145	47.2	348	70.9	349	71.1	1576	54.1	1494	51.3	40	48.2	36	43.4
F40-F48 Neurotic, stress-related and somatoform disorders	356	14.7	345	14.2	86	17.5	81	16.5	442	15.2	426	14.6	12	14.5	14	16.9
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	74	3.1	68	2.8	0	0.0	0	0	74	2.5	68	2.3	26	31.3	27	32.5
F60-F69 Disorders of adult personality and behaviour	109	4.5	170	7.0	6	1.2	12	2.4	115	3.9	182	6.2	2	2.4	1	1.2
F70-F79 Mental retardation	0	0.0	0	0.0	0	0.0	0	0	0	0.0	0	0.0	0	0	0	0
F80-F89 Disorders of psychological development	5	0.2	6	0.2	0	0.0	0	0	5	0.2	6	0.2	0	0	0	0
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	2	0.1	1	0.0	0	0.0	0	0	2	0.1	1	0.0	1	1.2	1	1.2
F99-F99 Unspecified mental disorder	3	0.1	5	0.2	0	0.0		0.0	3	0.1	5	0.2	0	0	0	0.0
Totals	2424	100	2424	100	491	100	491	100	2915	100	2915	100	83	100	83	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 dificulty-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
13. Compassion Focused Therapy
14. Living Through Psychosis

The data below provides a clear indication of the types of services provided by SPMHS. In 2015, the WRC received a total of 2,439 day programme referrals compared to a total of 2,046 for 2014, a year on year increase of 19%. 868 of the day programme referrals for 2015 came from a Dean Clinic. This compares to a total of 816 day programme referrals from Dean Clinics in 2014. In 2015 a range of new day programmes were added to reflect service user demand and international best practice, including;

- Psychology Skills Older Adults
- Psychology Skills Adolescents
- Living with ADHD
- CFT Eating Disorders

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 2015 and 2014. In addition, day programme referrals received from the Dean Clinics are presented.

SPMHS Day Programmes	Total Day Patient Referrals 2014	Total Day Patient Referrals 2015	Total Day Patient Referrals from Dean Clinics 2014	Total Day Patient Referrals from Dean Clinics 2015
Links to Wellbeing	49	59	21	21
Living Through Psychosis	52	127	17	22
Pathways to Wellness	55	50	20	18
Compassion Focus Therapy	95	193	46	46
Clearly Coping	10	0	3	0
Psychosis Programme	9	16	4	3
Schema Therapy	13	27	8	13
Eating Disorder Programme	50	50	14	20
Young Adult programme	8	5	4	5
Driving Assessments	2	18	1	13
Depression Programme	142	271	72	87
Bipolar Programme	101	74	20	24
Alcohol Stepdown	102	129	4	2
Living Through Distress	227	155	47	38
Radical Openness	169	144	37	36
Mindfulness	184	183	135	106
Anxiety Programme	191	236	125	127
Recovery Programme	242	261	84	86
St Edmundsbury	349	384	154	155
Psy Skills Older Adults	0	25	0	17
Psy Skills Adolescents	0	21	0	14
Living with ADHD	0	10	0	10
CFT Eating Disorders	0	27	0	5
Total	**2046**	**2465**	**816**	**868**

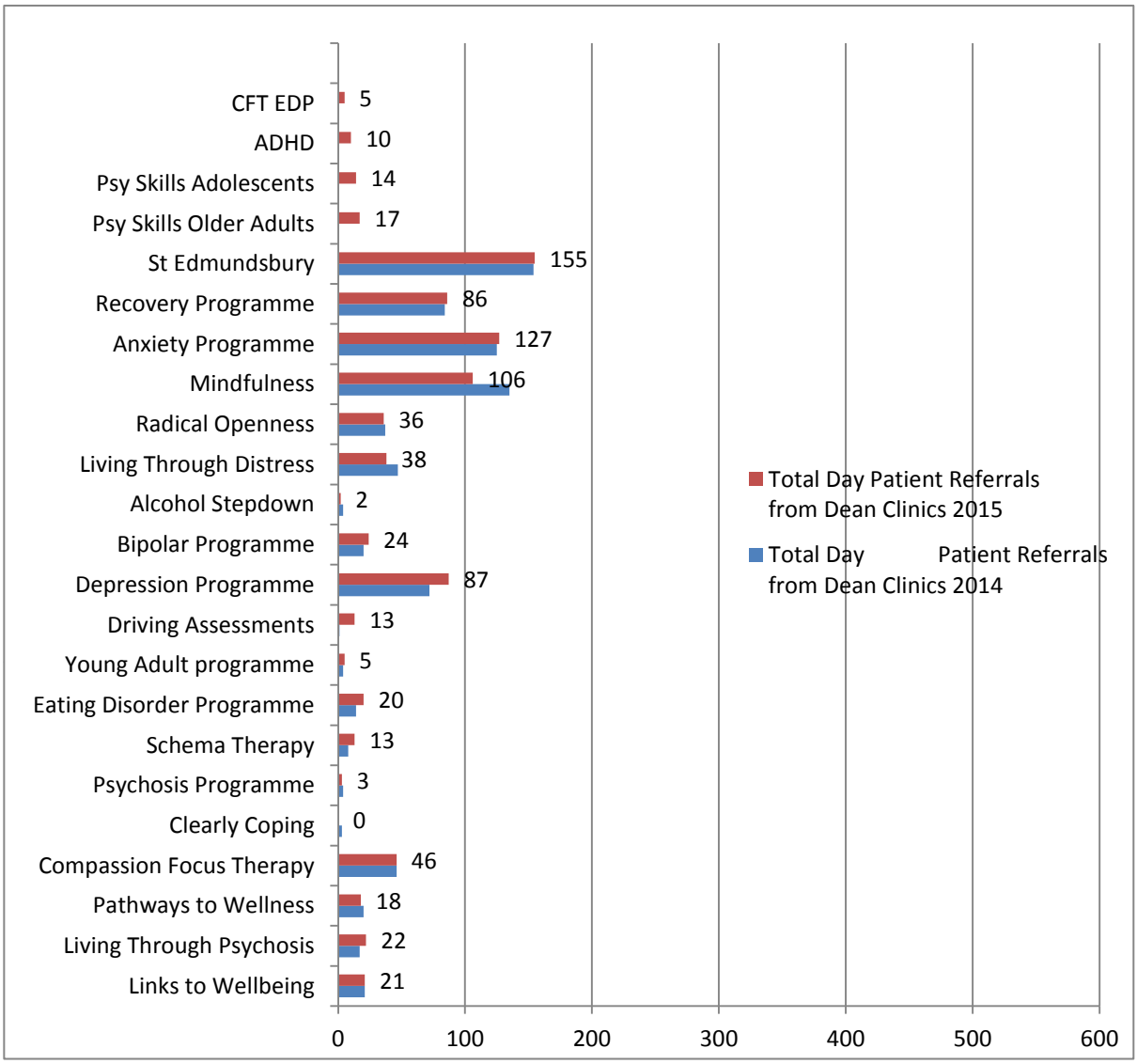
2.3.2. Day-patient Referrals by Gender

The gender divide in 2015 was Female 1668, Male 797 representing a 67.7% Female and 32.3% male.

2.3.3. Day-patient Referrals from Dean Clinics

In 2015 a total of 868 day patient referrals were received from Dean Clinics representing 35.6% of the total referrals to Day Programmes.

In 2014, a total of 816 day patient referrals were made from Dean Clinics, representing 39.9% of the total referrals to Day Programmes, 4.3% more than in 2015. However, there were 6.5% fewer attendances among those referred from Dean Clinics in 2014 than in 2015.



2.3.4 Day-Patient Attendances for Clinical Programmes 2014-2015

In 2015, 1397 day patients commenced day programmes. 1258 commenced in 2014. These registrations represented a total of 13317 and 13343 half day attendances respectively. Therefore in 2015 each registered day service user

attended on average 10.24 half days while in 2014 each registered day service user attended on average 10.58 half days.

Day Patient Attendances at Clinical Programmes

SPMHS Day Programmes	Total Day Patient registrations 2014	Total Day Patient registrations 2015	Total Day Patient Attendances 2014	Total Day Patient Attendances 2015
Links to Wellbeing	26	19	455	334
Living Through Psychosis	30	62	156	342
Pathways to Wellness	28	23	242	358
Compassion Focus Therapy	48	68	537	736
CFT Eating Disorders	0	15	0	152
Clearly Coping	3	0	11	0
Psychosis Programme	8	9	33	43
Schema Therapy	8	13	73	190
Eating Disorder	40	36	1944	1523
Young Adult programme	6	2	63	19
Driving Assessments	2	13	2	13
Depression Programme	65	112	713	1148
Bipolar Programme	49	46	449	428
Alcohol Stepdown	115	116	856	1009
Living Through Distress	106	74	783	593
Radical Openness	103	75	1041	1000
Mindfulness	117	126	753	710
Anxiety Programme	99	101	1094	1048
Recovery Programme	156	153	2460	2526
Living with ADHD	0	5	0	31
Psychology Skills Adolescents	0	11	0	124
Psychology Skills Older Adults	0	16	0	134
Day Services Based at St Edmundsbury				
Acceptance Commitment Therapy	53	87	378	600
Compassion Focused therapy	9	26	86	225
Healthy Self Esteem	19	38	182	398
Mindfulness	83	53	467	315
Mood Management	12	10	81	38
Radical Openness	10	10	170	191
Roles in Transition	31	26	115	86
Other Programmes*	32	0	169	0
	1258	1397	13313	14317

*Until March 2014 all St Edmundsbury day programmes were captured under the heading of 'St Edmundsbury day programmes'. Since this date they are captured per individual programme.

2.3.5. Section Summary

In 2015, 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. Demand is a parameter of health service quality to provide information about how the organisation structures and resources its services, and thus the quality of these services. Information regarding service demand allows for the timely and appropriate resourcing of all day services. In 2015 day programmes were improved and enhanced to allow for greater choice of services for service users and referrers. Overall, the number of referrals to SPMHS 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, monitored and reviewed.

3.1 Clinical Governance Measures Summary

Governance Measure	2012	2013	2014	2015
Clinical Audits	**25**	**19**	**10**	**16**
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**608**	**635**	**627**	**666**
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**	**2423**
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**	**9**
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**	**92**
% 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)**	**44% (41)**
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**	**39**
% 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)**	**87% (34)**
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**	**19**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**22**	**33**	**37**	**18**
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**	**10**
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**	**2**
Number of Tribunals held	**72**	**96**	**91**	**63**
Mental Health Commission Reporting – Number of ECT Programme's (Signed off) in 2015	**119**	**129**	**143**	**103**
Mental Health Commission Reporting – Number of Physical Restraint Episodes (SPUH + WGAU)	**157**	**219**	**129**	**178**

3.2. Clinical Audits

This section summarises briefly the clinical audit activity for St. Patrick's Mental Health Services in 2015. Clinical audit is an integral part of clinical governance. Its main purpose is to improve the quality of care provided to service users and the resulting outcomes. The clinical audit process is a cycle which involves measurement of the quality of care and services against agreed and proven standards for high quality and taking action to bring practice in line with these standards. A complete clinical audit cycle involves re-measurement of previously audited practice to confirm improvements and make further improvements if needed.

3.2.1. Overview of Clinical Audit Activity

The table below demonstrates the breakdown of projects by type undertaken in 2015 including those facilitated by clinical staff at local level and those carried out throughout the organization led by various committees.

No.	Audit Title	Audit Lead	Status at year end
1.	**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	Yearly audit completed
2.	**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	Re-audit completed in 2015. Consecutive re-audit is scheduled for 2016.
3.	**The MHC Judgement Support Framework Audits** To ensure compliance with the Mental Health Commission guidelines and rules of practice	Departmental Audits	Baseline audits and re-audits completed in 2015. Re-audits planned in 2016.
4.	**Clozapine Pathway** To prescribe and monitor Clozapine in line with guidance issued from the Clozaril Patient Monitoring System (CPMS) and the SPMHS Clozapine Initiation Pathway.	Clinical Governance Committee	Baseline audit completed in 2015. Re-audit planned in 2016.
5.	**Agomelatine** To ensure the sufficient monitoring of service users prescribed agomelatine to detect possible side effects	Clinical Governance Committee	Baseline audit completed in 2015. Re-audit planned in 2016.
6.	**Monitoring of service users prescribed Lithium** To ensure that lithium therapy is effacious and monitored effectively.	Clinical Governance Committee	Re- audit completed
7.	**Prescribing and Monitoring of High Dose Antipsychotic Therapy (HDAT)** To determine whether appropriate monitoring is carried out for service users who are prescribed High Dose Antipsychotic Therapy HDAT.	Clinical Governance Committee	Baseline audit completed in 2015. Re-audit planned in 2016.

No.	Audit Title	Audit Lead	Status at year end
8.	**Prescribing for people with a personality disorder (audit facilitated by Prescribing Observatory for Mental Health-UK)** To assess adherence to best practice standards derived from NICE clinical guidelines 78: Borderline personality disorder, (NICE 2009)	Clinical Governance Committee	Completed
9.	**Appropriateness and effectiveness of antibiotic prescribing practice** To increase the effectiveness of infection management and to meet SARI guidelines on antimicrobials prescribing practice audits conducted and reported back to prescribers.	Infection Control Committee	Re-audit completed in 2015.
10.	**Adherence to the organisations protocol on falls risk prevention interventions** Ensure that service users identified as medium or high risk of fall or with fall episode are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Baseline audit completed in 2015.
11.	**ECT Booklet** To assess consistency and appropriateness of the ECT documentation in accordance with the MHC guidelines.	Clinical Governance Committee	Re-audit completed
12.	**Social Work Screening Tool Assessment Audit** To assist the Department of Social Work in promoting positive parenting and to ensure child welfare in the context of mental illness.	Social Work Department	Baseline audit completed.
13.	**Nursing Metrics** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit. The process is to be continued in 2016.

No.	Audit Title	Audit Lead	Status at year end
14.	**Audit on the degree of Enquiry About Previous Psychotherapy and Counselling in Admission Assessment in SPUH** To measure the proportion of new patients that are being asked about their previous experience of talk therapy	Multidisciplinary Team	Completed
15.	**Infection Control Audits** Theses audits measure the implementation of policies and procedures relating to infection control	Infection Control Committee	These are yearly routine audits. Audits scheduled for 2015 were completed. Re-audits are planned for 2016.
16.	**Accurate, timely and efficient use of the PAS medical record tracking system** To identify any weaknesses in the chart tracking process and recommend and implement steps to improve these weaknesses.	Clinical Governance Committee	Re-audit completed.

3.2.2. Key Audit Outcomes for 2015

- Two audit cycles on the Key Worker and Care Planning process showed a further improvement in reported compliance with the Mental Health Commission guidelines.
- A Clinical Audit Programme for the Mental Health Commission's Judgement Support Framework has been developed and all Departments are actively involved.
- A fifth audit cycle of the antibiotic prescribing practice adherence to best practice has been completed.
- A re-audit on monitoring of service users' prescribed lithium therapy showed improvement in practice following implementation of changes.
- An audit on the Clozapine Pathway showed a high compliance achieved with the majority of standards and enabled further improvements.
- An audit on prescribing and monitoring service users' receiving Agomelatine has led to the development and implementation of a new hospital protocol.
- A Nursing Metrics audit has facilitated review of the Nursing Metrics process in place to enable improvements to be made.

SECTION 4

Clinical Outcomes

4. Clinical Outcomes

Clinical outcome measurement has been in place in St Patrick's Mental Health Services since 2011 and is a priority for the service, embedded within clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2015 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 intergrated 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 carried out at the start and finish of programmes but other elements of care, 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 are used to determine if, across the sample, post-scores are statistically significantly different from pre-scores. Where a t-test is not appropriate the non-parametric alternative, a Wilcoxin Signed Rank test is used. **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, 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, 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:

  > 0.3 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 behavioural 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 whether or not a patient met the criteria for a clinical diagnosis at the end of treatment. It is possible for a treatment to produce a significant difference and medium to large effect sizes but not to demonstrate a positive change in the service user's level of functioning.

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for Inpatient Care 2015

4.2.1. Objective

An evaluation of severity of illness measures completed at the point of inpatient admission, measures gradual inpatient outcomes for service users' and carried out when inpatient treatment is concluded. These scales are completed by clinicians using 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 and CGAS completion rates was also conducted.

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 both approved centres together 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 generated by the Willow Grove MDT provided CGAS data for the Adolescent sample. 88% of WGAU inpatient admissions were included for the 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		351	69
Admissions	1st admission	30%	87%
	Re-admission	70%	13%
Average age ± standard deviation		50±17	16 ± 1
Gender breakdown	Female	64%	70%
	Male	36%	30%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

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

		TOTAL ADULT SERVICE				WGAU	
ICD-10 Admission Diagnosis Category		**2012**	**2013**	**2014**	**2015**	**2014**	**2015**
F30-F39	Mood disorders	60%	58%	58%	58%	54%	51%
F40-F48	Neurotic, stress-related and somatoform disorders	15%	16%	15%	14%	12%	13%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	13%	13%	12%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	6%	4%	7%	1.5%	1%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	1%	4%	3%	3%	23.5%	30%
F00-F09	Organic, including symptomatic, mental disorders	1%	2%	0.5%	1%	0%	0%
F60-F69	Disorders of adult personality and behaviour	1%	2%	3.5%	6%	9%	4%
F80-F89	Disorders of psychological development	1%	0%	0%	0%	0%	0%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0.2%	0.3%	1.5%	0%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *Total adult service*

CGIS -Baseline measure of severity of illness		**2012**	**2013**	**2014**	**2015**
		TOTAL	**TOTAL**	**TOTAL**	**TOTAL**
1	Normal, not at all ill	0%	0%	0.2%	0%
2	Borderline mentally ill	1%	0%	2%	0%
3	Mildly ill	7%	8%	9%	9%
4	Moderately ill	21%	20%	32%	30%
5	Markedly ill	34%	33%	33%	30%

6	Severely ill	18%	19%	16%	18%
7	Extremely ill	2%	1%	2%	0%
	Not scored	17%	19%	6%	12%

Table: *Total adult service*

CGIC – Final Global improvement or change score		**2012**	**2013**	**2014**	**2015**
		Total	**Total**	**Total**	**Total**
1	Very Much improved	10%	11%	15%	13%
2	Much Improved	44%	39%	43%	49%
3	Minimally Improved	23%	16%	13%	16%
4	No Change	7%	6%	4%	6%
5	Minimally Worse	0%	0%	1%	0%
6	Much Worse	0%	0%	0%	0%
7	Very Much Worse	0%	0%	0%	0%
	Not scored	15%	26%	24%	16%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		**2014**		**2015**	
		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%	1.5%	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	24%	0%	12%
60-51	Variable functioning with sporadic difficulties	33%	65%	33%	68%
50-41	Moderate degree of interference in functioning	58%	4%	55%	10%
40-31	Major impairment to functioning in several areas	5%	1.5%	6%	0%
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%	3%	6%	10%
Mean ±SD		50±5	57±16	49±5	57±4
Median		50	58	50	57
Wilcoxon Signed Ranks Test:		Z=-5.7017,p<.05		Z=-5.983, p<.001	

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

	TOTAL ADULT SERVICE				WGAU		
	2012	2013	2014	2015	2013	2014	2015
Baseline Assessment Scale Score							
% of admission notes with recorded baseline scores	83%	81%	94%	88%	95%	100%	94%
% compliance with clinical audit standard 1	64%	61%	90%	67%	Not recorded	85%	72%
Final Assessment Scale Score							
% of admission notes with recorded final scores	85%	74%	77%	84%	94%	99%	90%
% compliance with clinical audit standard no. 2	73%	73%	70%	81%	Not recorded	61%	80%

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Mental Health Services discharges for 2015.

2. Female to male ratio was for adult service user's 1.8:1 for adults and WGAU 2.3:1 for adolescents.

3. In the 2015 sample, re-admissions accounted for 70% of adult service users, representing a 2% increase from 2014.

4. 87% of WGAU admissions in 2015 were first admissions to a mental health service. There was a 7% increase in the number of first admissions in comparison to the 2014 data.

5. 2015 analysis of the primary ICD-10 codes for adults showed the most frequent reasons for admission to be mood disorders followed by neurotic, stress related, somatoform disorders and mental and behavioural disorders due to psychoactive substance use.

6. In 2015 the breakdown of baseline clinical global improvement scores on admission shows that 30% of SPUH and SEH service users were markedly ill. Another 30% were moderately ill. 18% were severely ill. One service user was extremely ill on admission.

7. Based on a sample of 294 (total cases with discharge CGI Score documented) 93% of the sample were rated with an overall improvement (1 - very much improved (15%), 2 - much improved (59%) and 3 - minimally improved (19%)).

8. The majority (55%) of WG service users were scored as having a moderate degree of interference in functioning on admission.

9. Overall improvement rate for Willow Grove Adolescent Unit was 75% which gives a 10% increase in comparison to 2014 data. Of the sample 9% were found to have no change and the remaining 6% were found to have dis-improved following in-patient treatment.

10. The audit shows a dis-improvement in the completion rate of the baseline CGI score and CGAS in comparison to the audit for 2014. At the same time there was an improvement completion rate of the final CGI score and a dis-improvement in the completion rate of the final CGAS in comparison to 2014 findings.

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 St Edmundsbury Hospital 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 an experienced counselling psychologist who also trains other clinicians in the ACT approach.

4.3.1. Descriptors

In 2015, data were available for a total of 62 participants, (69.4% female, 30.6% male). Both pre and post measures were available for 48 of those completing the programme, representing 77% 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.

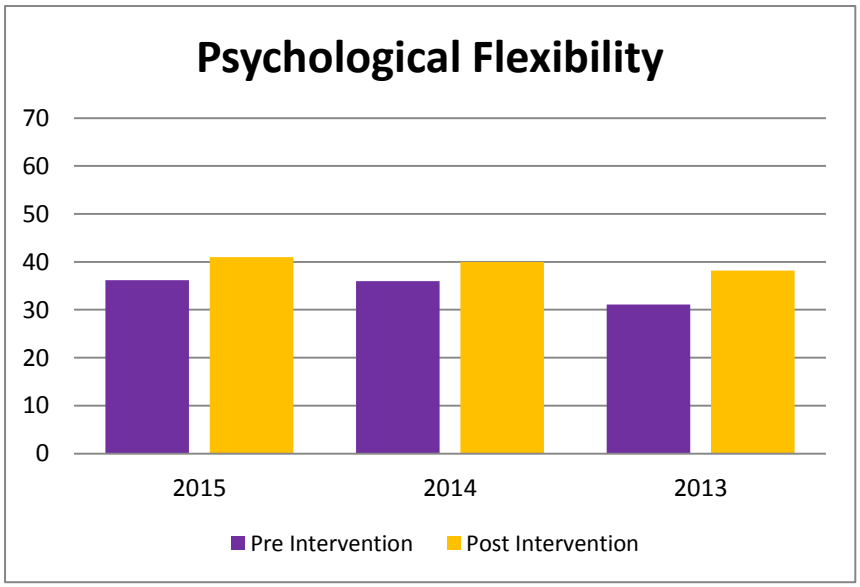
- **The Self-Compassion Scale**

The Self-Compassion Scale (SCS) is a twenty-six item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts. Each item is rated on a 5 point Likert scale, from 1 Almost Never to 5 Almost Always.

4.3.3. Results

Acceptance & Action Questionnaire-II

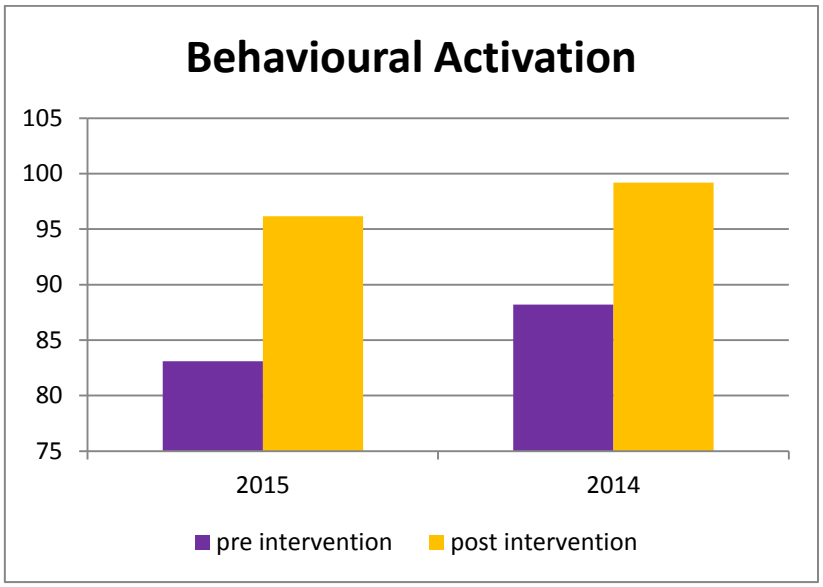
Graph: Psychological Flexibility as measured by the AAQ-II



Total scores on the AAQ-II showed a statistically significant increase, t (46) = 4.36, p < .01, which indicates greater psychological flexibility post programme. An effect size (*d)* of .59, indicates a medium effect size. Pre and Post mean scores on the AAQ-II were similar to those reported in previous years.

Behavioural Activation for Depression Scale (BADS)

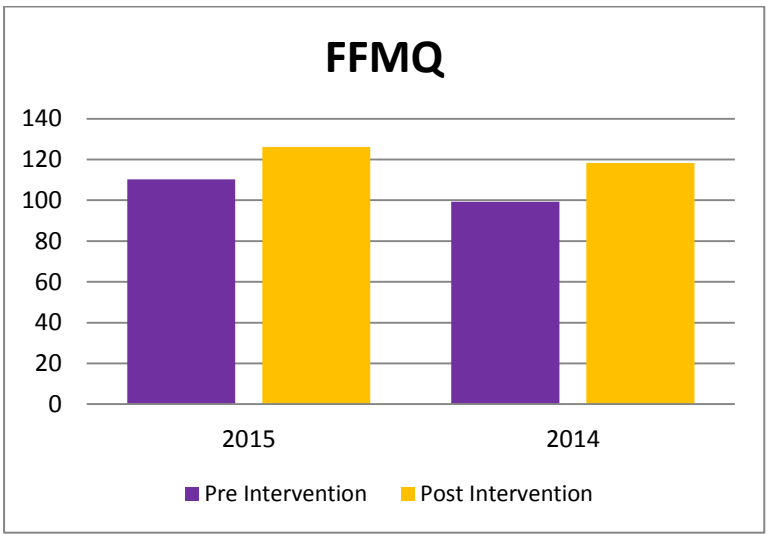
Graph: Behavioural Activation as measured by the BADS



Mean post BADS scores increased significantly, from (M = 83.09, SD =23.20) to (M = 96.17, SD = 24.82) indicating greater behavioural activation, t (46) = 3.65, p < .01, representing a medium effect size (d = .54). 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 28.3% to 19.1% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

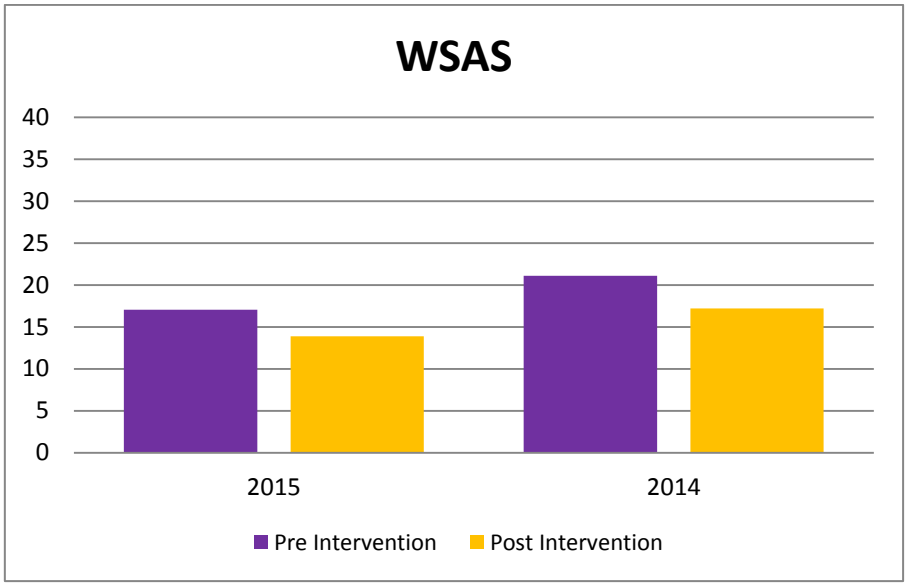
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (47) = 5.15, p < .001, from pre (M = 110.33, SD = 19.74) to post (M =126.13 , SD = 20.38) indicating greater levels of overall mindfulness, with a large effect size observed (Cohen's d =.79). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

Work and Social Adjustment Scale (WSAS)

Graph: Total Work and Social Adjustment Scale Scores



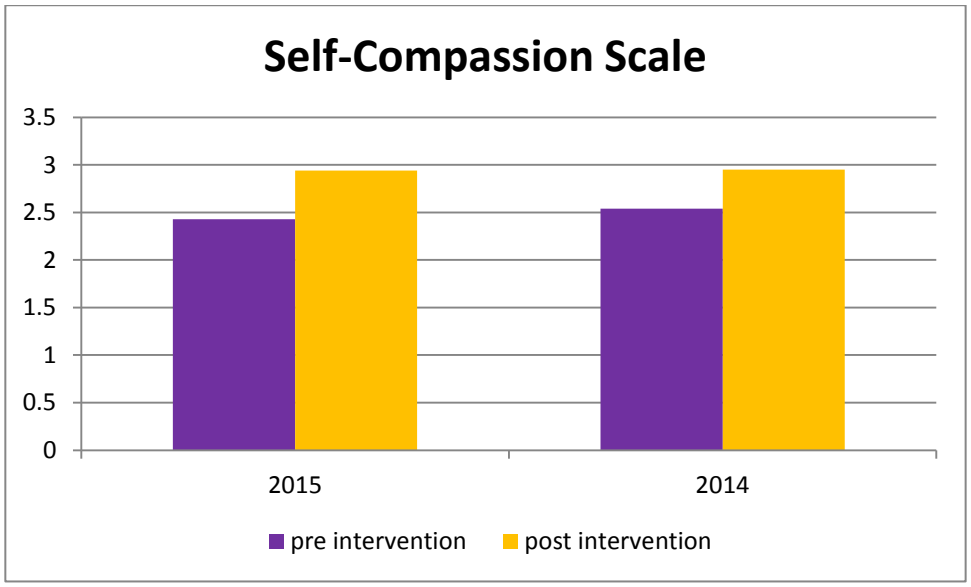
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (47) = 2.84, p <.01, from 17.06 (SD = 8.65) to 13.86 (SD =8.39), indicating less functional impairment. The effect size of Cohen's d =.38 indicates a small effect.

The scores on both pre and post means are within the range which indicates significant functional impairment but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 20% of those who completed the programme had scores below 10 when they started the programme, while 33.3% had scores below 10 on completion of the programme.

These findings are in line with the 2014 and 2013 outcomes report that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

Self-Compassion Scale

Graph: Total scores on Self-Compassion Scale



Total SCS scores increased significantly, t (43) = 5.09, $p < .001$, from pre (M = 2.43, SD = .57) to post (M = 2.94, SD = .55) indicating higher overall levels of self-compassion post intervention. A large effect size was observed (Cohen's d = .91). Self-compassion is measured in six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts.

4.3.4. Summary

People who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. Comparisons show consistent results across 2015, 2014 and 2013. 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 in 2014 (Neff, 2003) and analysis of this measure suggests that promising change has continued between pre and post intervention scores, in its second 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:** 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. alcohol/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 psychological dependence to a variety of different substances. The LDQ was designed to be sensitive to change over time and to range from mild to severe dependence (Raistirck et al.,1994).

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence, the 10 items map on to the ICD-10 and DSM-IV criteria for substance dependence which include: 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 (Kelly, Magill, Slaymaker & Kahler, 2010).

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

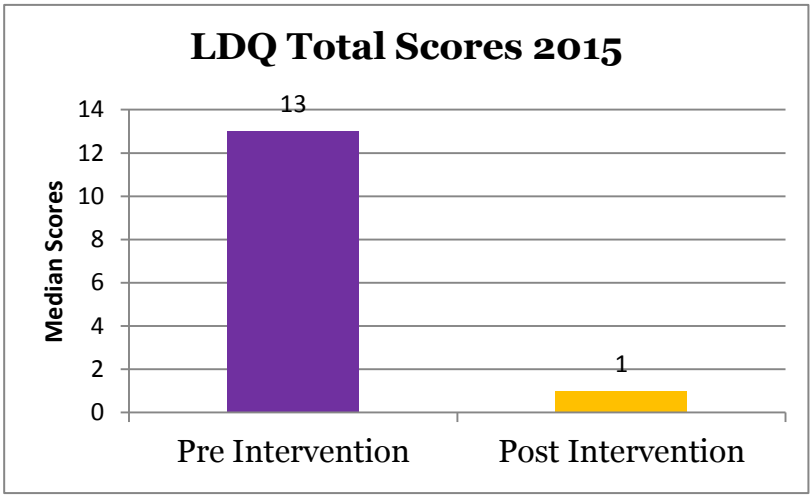
A total of 111 participants attended the full or modified programme in 2015, of whom, 67 participants completed the programme. Pre and post data were available for 64 participants, which represents 96% of those who completed the programme. Of those that completed the programme, 57.8% of participants were male and 42.2% 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, a Wilcoxin Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, $z=6.79$, $p<.001$, with a medium effect size ($r=.52$). The median score on the total LDQ scores decreased from pre-programme to post-programme, as depicted in the graph below.

Leeds Dependency Questionnaire (LDQ)

Graph: Total scores on Leeds Dependency Questionnaire



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 and the compliance in data collection with a rate of 96% for those who completed the programme, suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and will continue to be used as the primary outcome measure in 2016.

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 have received training in both CBT and Mindfulness.

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 aid 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.

A separate Obsessive Compulsive Disorder (OCD) strand of the Anxiety Programme provides a tailored and focussed service for those with OCD. This incorporates tasks such as challenging the meanings of obsessions and more tailored goal work.

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 2015. 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).

- **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 21-item questionnaire developed to measure the intensity, severity, and depth of depression symptoms in patients with psychiatric diagnoses. Individual questions on the BDI assess mood, pessimism, 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 range from 0 – 63, where higher scores indicate, increased depressive symptoms. Scores can be interpreted in four qualitative categories: 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. This report focuses on the Severity of Illness and change over time. Scores on the Severity of Illness sub-scale range from 1 “not ill at all” to 7 “among the most extremely ill” and are rated pre-treatment. Change over time is rated post treatment on a scale for 1 “very much improved” to 7 “very much worse”.

- **Fear Questionnaire**

The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items which measure the extent to which potentially anxiety provoking 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: Main Phobia Level of Avoidance, Total Phobia Score, Global Phobia Rating and Associated Anxiety and Depression. For the purposes of this analysis the Total Phobia Score, 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 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 best available measure 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 are each assessed on a 5-point scale ranging from 0 "no symptoms" to 4 "severe symptoms" measuring the following: time spent engaging with obsessions and / or compulsions, the level of distress, the ability to resist and level of control over obsessions and compulsions. Scores are rated across five levels: Sub-clinical: 0 – 7; Mild: 8 – 14; Moderate: 16 – 23; Severe: 24 – 31; Extreme: 32 – 40. Taylor (1995, p. 289) 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 or anxiety and avoidance they would feel in a hypothetical situation. Fear or 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'.

The LSAS yields two subscale scores, fear and avoidance, which are summed together to give the total score, with 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).

- **Social Safeness and Pleasure Scale (SSPS)**

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 that this scale's psychometric reliability is good (alpha=.92; Gilbert et al., 2009). This instrument was administered at time points, pre and post level 2.

4.5.2. Descriptors

Data were available for 98 people who completed the programme in 2015, of which 56 (57.1%) were female and 42 male (42.9%). Programme attendees ranged in age from 19 to 80 with an average age of 41 years (*SD* = 14.3). Post data were collected after Level 1 and Level 2 of the anxiety programme.

There were seven primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (35.7%), followed by Social Phobia/Anxiety (21.4%), Generalised Anxiety Disorder (13.3%), Agoraphobia (with/without panic) and Panic Disorder (11.2%), Specific Phobia and Health Anxiety (2%). The table below shows the percentage of people with each diagnosis over the past 4 years.

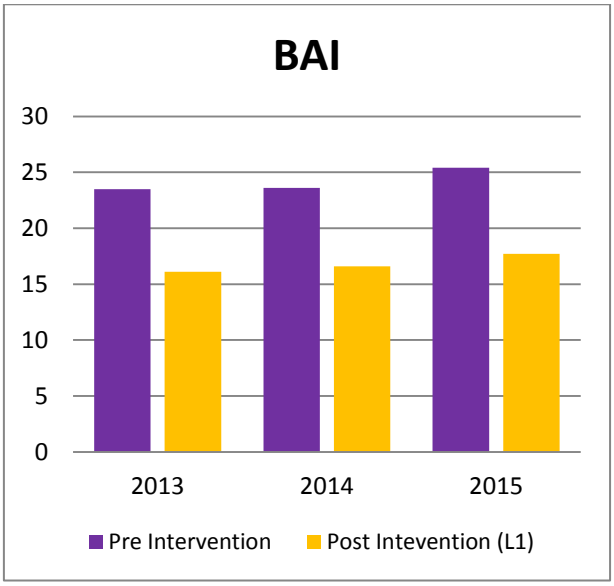
The majority of individuals with a diagnosis of OCD (n = 35) attended the OCD specific strand of the anxiety programme Level 1.

	2012		2013		2014		2015	
	N	%	N	%	N	%	N	%
Obsessive	55	35	50	42.0	40	44.9	35	35.7
Generalised	30	19.1	21	17.6	15	16.9	13	13.3
Social	26	16.6	20	16.8	18	20.2	21	21.4
Panic Disorder	22	14	9	7.6	9	10.1	11	11.2
Agorophobia	17	10.8	9	7.6	5	5.6	11	11.2
Health Anxiety	4	2.5	7	5.9	1	1.1	2	2
Specific Phobia	3	1.9	2	1.7	-	-	2	2
Habit and Impulsive	-	-	-	-	-	-	-	-
Post-Traumatic Stress	-	-	1	0.8	-	-	-	-

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



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* = 25.4, *SD* = 10.2) to the lower end of the moderate (*M* = 17.7, *SD* = 11.3) range on the measure. Changes were statistically significant, t(82) = 6.73, p = .000, and reflect a moderate effect size (Cohen's *d* = 0.72). At the pre measurement time point, 45.8% had anxiety scores in the severe range, this dropped to 22.6% by the end of Level 1. See the table below for how these scores redistributed into the other categories.

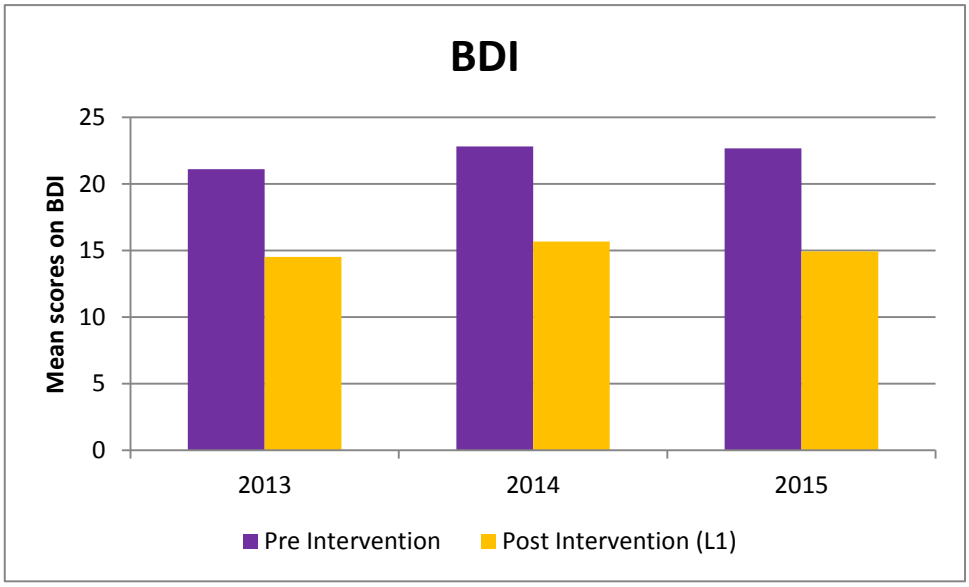
% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	4.1	15.5	8.3	31.3
Mild	15.7	36.9	20.9	35
Moderate	35.4	25	52.1	26.2
Severe	45.8	22.6	18.7	7.5
Totals	100	100	100	100

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	10	31.80	9.34	22.00	12.68	2.97	9	0.16
Social Phobia	19	24.68	8.98	16.11	9.65	3.46	18	.003
Panic Disorder	8	27.13	15.75	18.25	17.69	2.00	7	.086
GAD	12	20.67	6.26	18.17	12.08	1.05	11	.315
OCD	29	24.00	9.27	15.59	8.89	4.60	28	.000

Beck Depression Inventory (BDI)

Graph: Beck Depression Inventory Scores



Mean scores on the Beck Depression Inventory were in the moderate range pre-intervention (*M* = 22.68, *SD* = 8.55) and showed a statistically significant drop to within the mild range post-intervention, (*M* = 14.92, SD =9.31), t(77) = 9.71, *p* = .000, which represented a small effect (Cohen's *d* =.*31*). While 18.7% were classified has having severe depression before the programme, 7.5% 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	10	27.00	7.42	18.30	12.23	3.04	9	.14
Social Phobia	19	22.32	8.52	13.32	8.74	4.66	18	.000
Panic Disorder	8	16.38	9.74	13.38	8.88	1.61	7	.151
GAD	12	23.92	7.38	16.50	7.01	4.93	11	.000
OCD	26	22.58	9.00	15.12	9.93	6.22	25	.000

Clinical Global Impression Scale

On the Clinical Global Impression Scale, patient's pre treatment scores on the Severity of Illness are depicted in the table 1 below. Their scores on improvement over time following level 1 are depicted in table 2.

Pre Treatment level 1 Severity of illness	2015
1) **Normal, not ill at all**	-
2) **Borderline mentally ill**	-
3) Mildly ill	-
4) Moderately ill	3.1 %
5) Markedly ill	56.1 %
6) Severly ill	27.6%
7) Extremely ill	3.1%
Not scored	10.2%

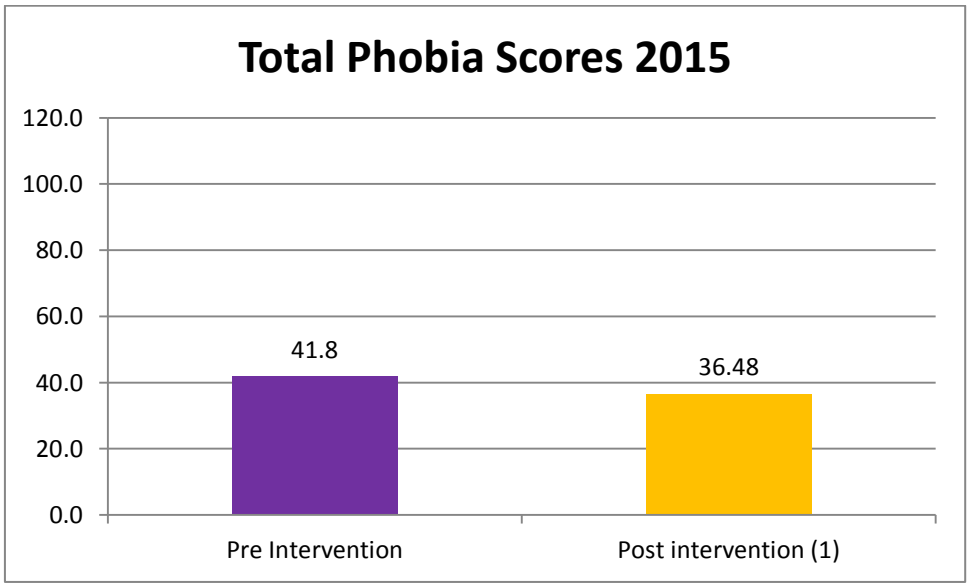
Table 2: Improvement over time.

Improvement/ change over time level 1	2015
1. Very much improved	3.1%
2. Much improved	56.1
3. Minimally improved	22.4%
4. No change	-
5. Minimally worse	-
6. Much worse	1%
7. Very much worse	-
Not scored	17.3 %

The Clinical Global Scale scores suggest that patients were, on average, *markedly ill* prior to intervention level 1 but were largely in the *much improved* category post level 1.

The Fear Questionnaire

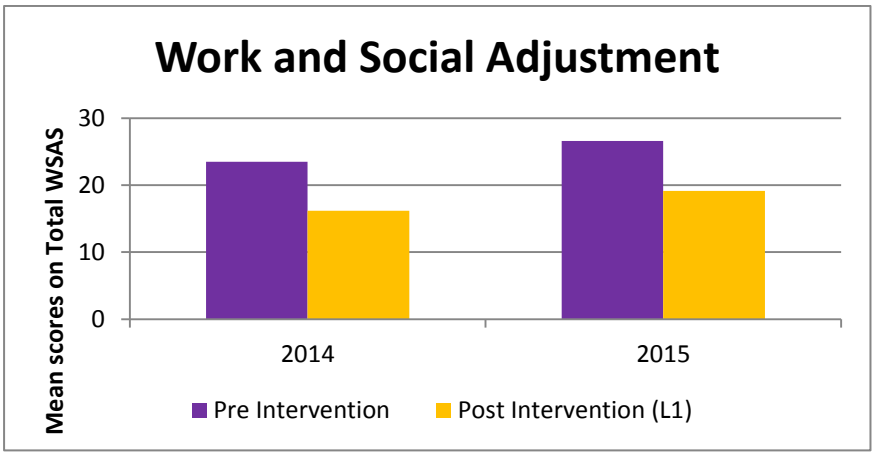
Graph: Fear Questionnaire Total Phobia Scores



There was no significant difference identified on the total phobia score on the Fear Questionnaire post intervention level 1, t (95) = 1.61, p >.05. The mean phobia score decreased from 41.83 (SD= 23.45) to 36.48 (SD=32.55), which was a change in the intended direction.

The Work and Social Adjustment Scale

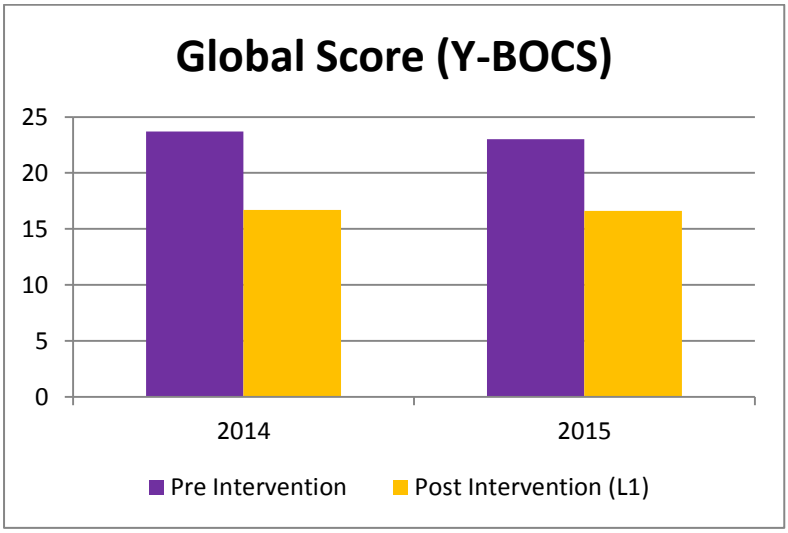
Graph: The Work and Social Adjustment Scale



Of those who completed measures in 2015, 84 completed the Work and Social Adjustment Scale (WSAS), significant improvements in impaired functioning were indicated, t (83) = 8.43, p = .000, with a moderate effect size (Cohen's *d* = .74).

The Yale Brown Obsessive Compulsive Scale

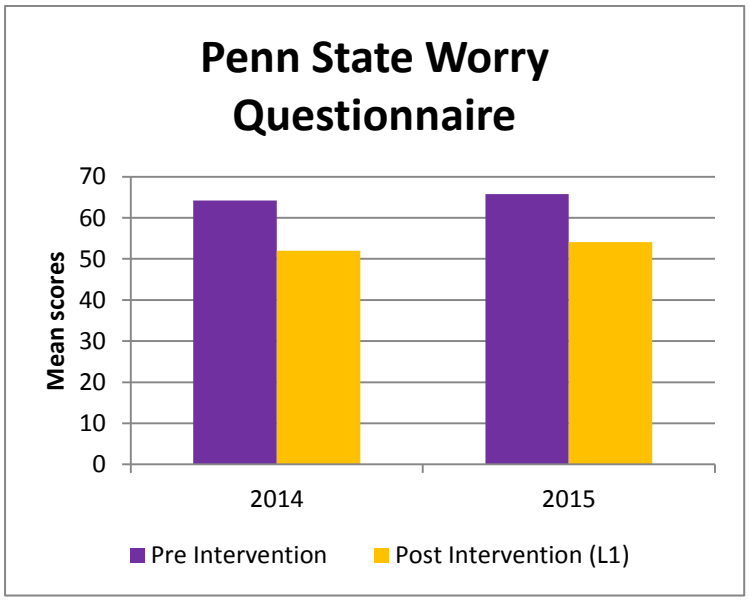
Graph: Yale Brown Obsessive Compulsive Scale



For those with OCD (n = 30), global (Y-BOCS) scores dropped significantly from 23.03 (*SD* = 6.57) to 16.60 (*SD* = 15.55), *t* (29) = 2.41, *p* = .23, (Cohen's *d* = .54), indicating an overall reduction in the severity of OCD symptoms with a moderate effect size.

Penn State Worry Questionnaire (PSWQ)

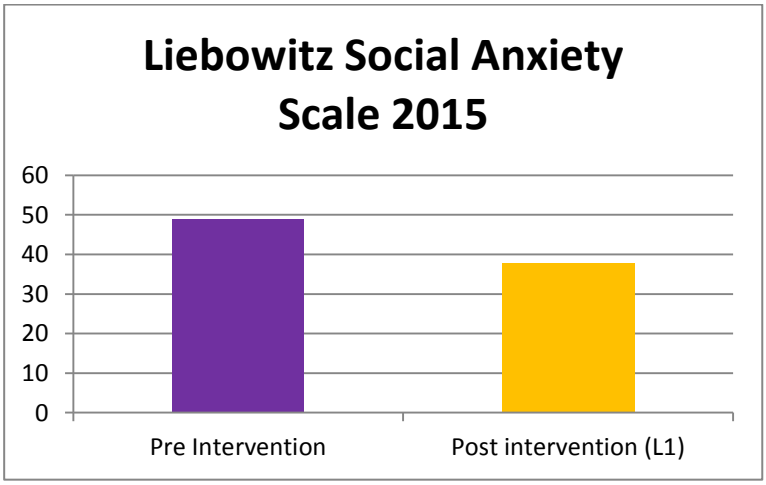
Graph: Penn State Worry Questionnaire



For those 9 participants with generalised anxiety disorders (GAD) scores on the Penn State Worry Questionnaire dropped from 65.78 (SD = 12.15) to 54.11 (SD = 12.69), t (8) = 4.73, p = .001, which reflects a large effect size (Cohen's d=.94).

Liebowitz Social Anxiety Scale 2015

Graph: Liebowitz Social Anxiety Scale

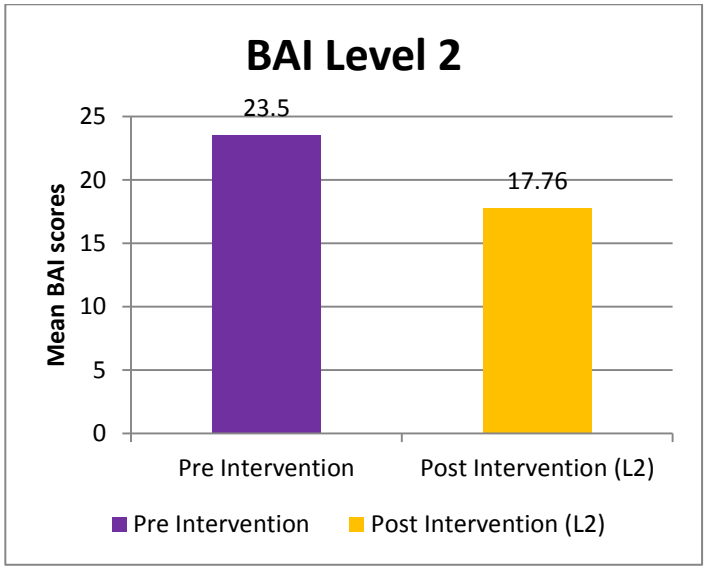


For those 18 participants who completed the Liebowitz Social Anxiety Scale, there was a significant difference identified pre and post intervention, t (17) =6.28, p=.000, where a large effect size was observed (Cohen's d= 1.09).

4.5.4. Level 2 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



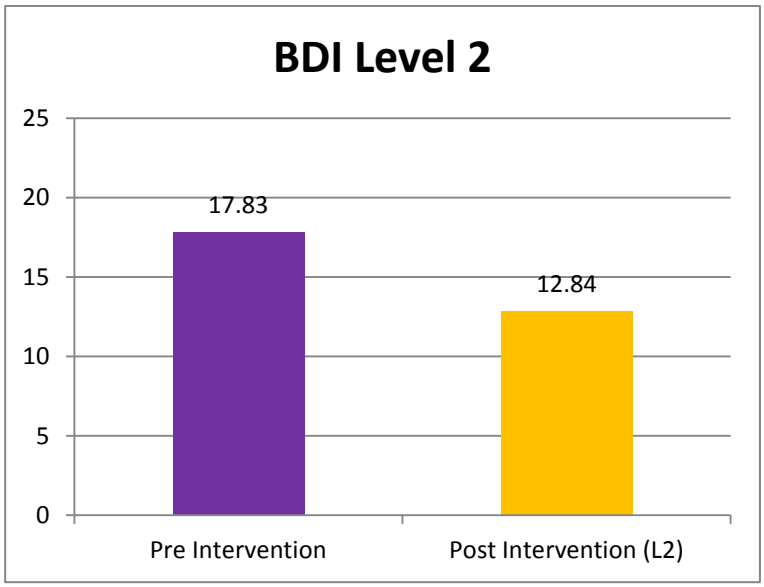
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programmes mean score decreased from M= 23.5 (SD=10.04) pre intervention 2 to M=17.76 (SD=11.84) post intervention 2. A Wilcoxin Signed Rank Test revealed a statistically significant reduction on BAI scores following participation in the programme, z=2.44, p<.05, with a moderate effect size (r=.41).

At pre Level 2, 38.9% had anxiety scores in the severe range, this dropped to 20% by the end of Level 2 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	0%	20%	5.6%	44%
Mild	16.7%	32%	50%	44%
Moderate	44.4%	28%	38.8%	-
Severe	38.9%	20%	5.6%	12%
Totals	100	100	100	100

Beck Depression Inventory (BDI)

Graph: Beck Depression Inventory Total Scores



Average depression scores for those who completed the programme (indicated on the graph above) were in the mild range pre-intervention (*M* = 17.83, *SD* = 6.54) and remained within the mild range (*M* =12.84 , *SD* =10.98) post intervention level 2. A Wilcoxin Signed Rank Test revealed a statistically significant reduction on BDI scores following participation in the programme, z=2.75, p<.01, with a moderate effect size (r=.46).

Clinical Global Impression Scale

On the Clinical Global Impression Scale, patient's pre treatment scores on the Severity of Illness are depicted in the table 3 below. Their scores on improvement over time following level 2 are depicted in table 4.

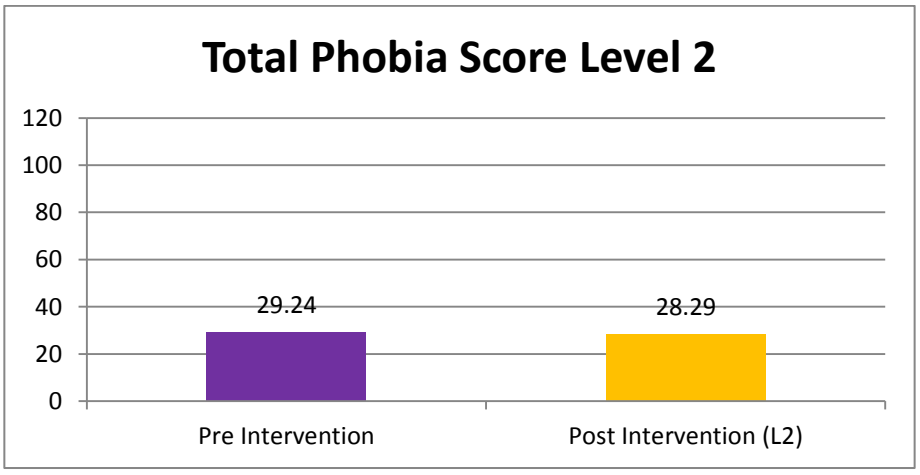
Pre Treatment level 2 Severity of illness	2015
3) Normal, not ill at all	-
4) Borderline mentally ill	-
3) Mildly ill	-
4) Moderately ill	44%
5) Markedly ill	44%
6) Severly ill	12%
7) Extremely ill	-

Table 4: Improvement over time.

Improvement/ change over time level 2	2015
1) Very much improved	60%
2) Much improved	28%
3) Minimally improved	12%
4) No change	-
5) Minimally worse	-
6) Much worse	-
7) Very much worse	-

The Fear Questionnaire

Graph: The Fear Questionnaire

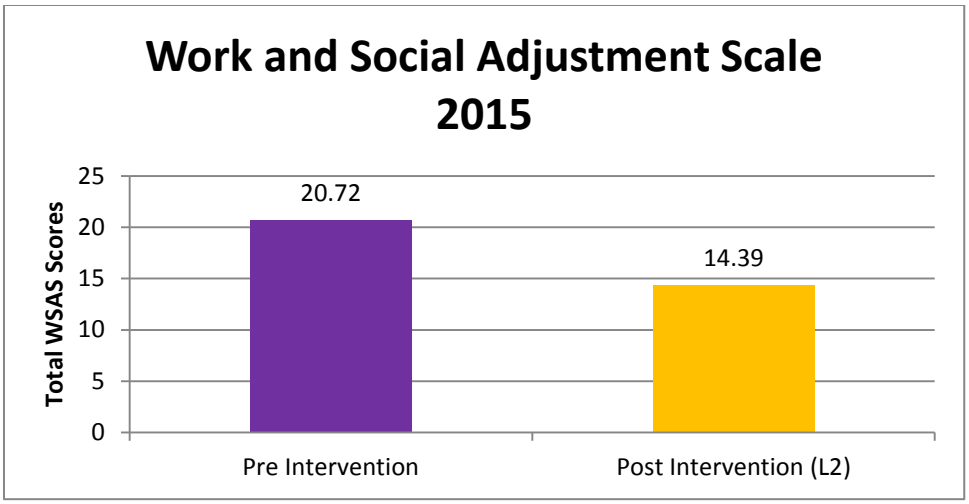


Total Phobia Scores dropped from a mean of 29.24 (*SD* = 11.97) to 28.29 (*SD* =12.71), whereby t (16) = .546, p ≥ .05, which indicates that there was no statistically significant change identified post level 2.

The Work and Social Adjustment Scale

Following level 2, there was a statistically significant change apparent on the Work and Social Adjustment Scale, whereby t (17) =3.24, p <.01, with a moderate effect size (Cohen's *d*= .63).

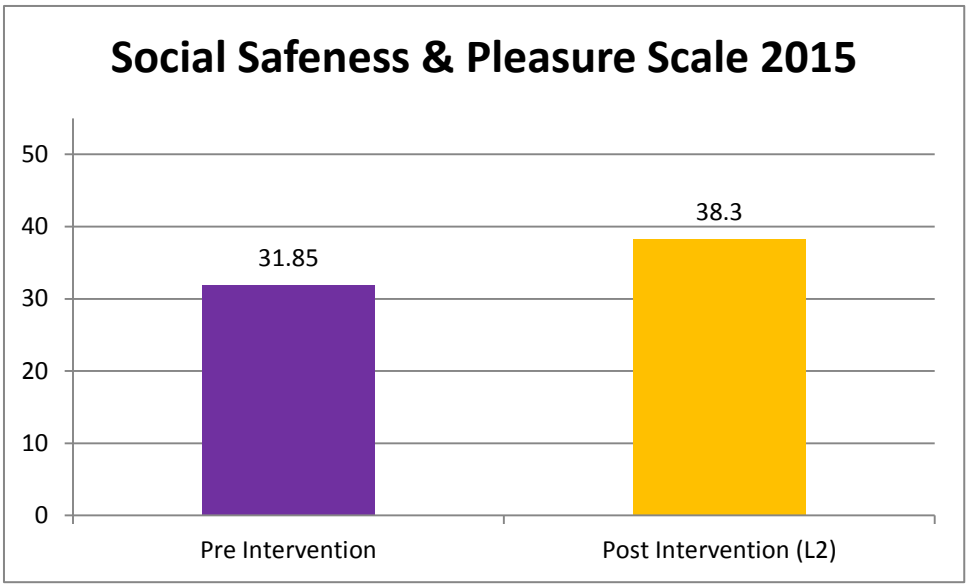
Graph: The Work and Social Adjustment Scale



The Social Safeness and Pleasure Scale

There was a significant change in participant's scores on the Social Safeness and Pleasure Scale, from a mean of 31.85 (SD= 8.44) pre intervention 2 to 38.3 (SD=6.6) post intervention 2, t (19) = 3.00, p=.007, which suggests an increase in general feelings of safeness, belonging, and acceptance in a social context after completing the group, with a large effect size (Cohen's d =. 85).

Graph: The Social Safeness and Pleasure Scale



4.5.5. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2015 suggested significant reductions in anxiety and depression symptoms, OCD symptoms, reduced impairment in functioning in work and social activities, reductions in pathological worrying and social anxiety. The majority of effect sizes observed were within the moderate or large range as shown on the table below.

Table 1: Identified effect sizes on each of the measures in level 1

Instrument	Effect Size(Cohen's *d*)
BAI	.72
BDI	.31
Work & Social Adjustment Scale	.74
Y-BOCS (Global Score)	.54
Penn State Worry Questionnaire	.94
Liebowitz Social Anxiety Scale	1.09

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the anxiety programme in 2015 were positive and

suggested further improvements in anxiety symptoms, depression symptoms and work and social adjustment. There was no significant difference identified in phobia ratings post Level 2, however, the clinical team were not surprised by this given that the majority of phobia work was covered in Level 1.

In 2015, the Social Safeness Pleasure Scale was used for the first time for those who completed level 2 of the anxiety programme. Results found a significant difference between pre and post intervention, which suggests an increase in feelings of safeness, belonging and acceptance in social contexts.

Changes in scores for most measures have been consistently positive across the data since 2011, following both Level 1 and Level 2. It should be noted that the differences in results between years may be attributable to changes in sample size.

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 our own suffering and acknowledges that feeling cared for, accepted and connected with others is important for our psychological well-being.

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).

CFT encourages clients to develop key attributes of compassion, identified by Gilbert (2009) as care for wellbeing, sensitivity, distress tolerance, sympathy, empathy and -non-judgement. To enhance self- compassion, group members work towards developing these attributes through learning 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 Hospital in July 2014. Groups are facilitated by the Psychology Department.

4.6.1. Compassion Focused Therapy Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the Compassion Focused Therapy Programme in 2015. All service users attending the CFT Programme are invited to complete the following measures, before starting the programme and again after completion.

- **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-2.

- **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 (e.g. “I fear that if I am too 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 Safeness and Pleasure Scale**

This 11-item scale (Gilbert et al., 2008) measures the extent to which people perceive their social world as safe. The items relate to clients perceptions of feelings of warmth, acceptance, and belonging from others. Participants were asked to complete this scale about their experiences of relationships with both fellow group members and others in their lives.

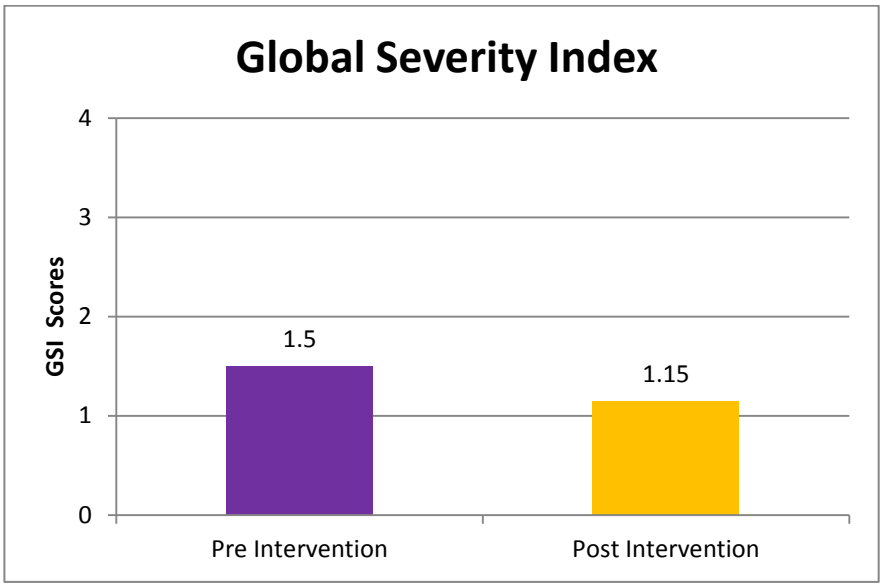
4.6.2. Descriptors

There were pre and post data available for 51 participants who completed the programme either at St Patrick's University Hospital or at St Edmundsbury Hospital in 2015. This represents approximately 69% of those who completed the programme in either location in 2015. Of these 51 service users, 33 (64.7%) were female and 18 (35.3%) were male. Programme attendees ranged in age from 19 to 69 years with an average age of 39.67 years.

4.6.3. Results

Brief Symptom Inventory

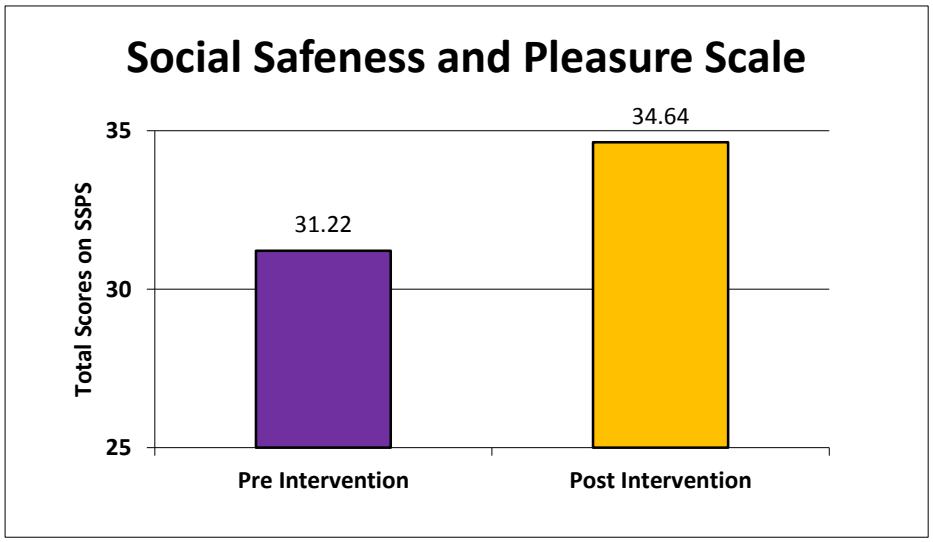
Graph: Brief Symptom Inventory GSI Scores



A significant decrease in psychological distress as measured by the Brief Symptom Inventory was observed in service users who completed the Compassion Focused Therapy programme in 2015, where t (40)=4.99, p<.001. A medium effect size was observed (*d* = .54).

Social Safeness and Pleasure Scale (SSPS)

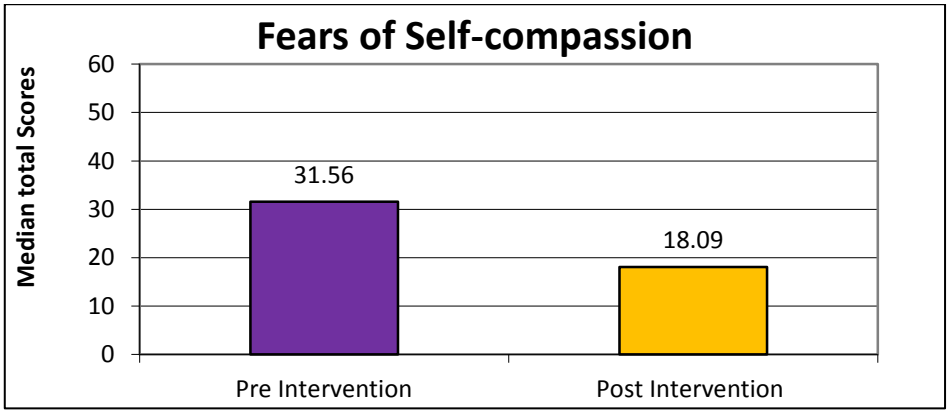
Graph: Social Safeness and Pleasure Scale (SSPS) Scores



A Wilcoxin Signed Rank Test revealed significant increases from pre to post intervention on the Social Safeness and Pleasure Scale, whereby z=2.73, p<.01, with a small effect size (r=.28). These findings suggest that following completion of the programme, service user's perception of how comfortable they were in interpersonal relationships and of how pleasurable they found interactions with others had improved.

4.6.3.2 The Fears of Self-Compassion Scale

Graph: The Fears of Self-Compassion Scale



A significant decrease in fears of self-compassion was observed in service users after they completed the CFT programme. A Wilcoxin Signed Rank Test revealed a statistically significant reduction in total Fears of Self-compassion, z=5.49, p<.001, with a large effect size (r=55). These findings suggest that

fears of developing and having self-compassion decreased from pre to post programme participation.

4.6.4. Summary

The Compassion Focused Therapy programme started in SPMHS in 2014. Since it began eleven groups have been facilitated. The programme has received considerable interest within the hospital. Research by a Clinical Psychologist in Training was undertaken in 2014-5, titled "An Evaluation of a Compassion Focused Therapy Group Programme Designed for Individuals with High Self-Criticism and Shame", the results of which are expected to contribute to the growing research in the area of CFT. The results of this study are currently being prepared for submission for publication in a peer-reviewed journal.

Anecdotal feedback from clients who attended these groups has been largely 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.

Following feedback from service users in 2014 related to the intensity created by the twice weekly sessions for the first 5 weeks, the group format was adapted in 2015. The newer format included 11 weekly sessions and 3 monthly sessions.

Feedback from service users on the format of sessions to ensure it is meeting service users' needs is continuing to be requested. There will be additional research on the CFT Programme in 2016 undertaken by a Clinical Psychologist in Training. This research is titled "Investigating changes that occur as a result of engaging in a Compassion Focused Therapy group intervention".

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 an Introduction to WRAP (Wellness Recovery Action Plan).

Level B is a four week programme that aims to introduce the concepts of CBT (Cognitive Behavioural Therapy) and Compassion Focused Therapy. Workshops have been designed as a means of 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. Depression Recovery Programme 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 such as pessimism, sense of failure, mood, 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)**

The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic tool for common mental disorders. The PHQ-9 is the depression component, which scores each of the 9 DSM-IV criteria as "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

Data was available for 407 participants who started the programme in 2015, 169 males and 232 females. Of those who started the programme, 351 (86%) were presenting with a primary diagnosis of Major Depressive Episode, 8 (2%) with a Major Depressive Episode with melancholic Features, 2 with Dysthemia (0.5%) and 35 were not currently presenting with a depressive episode (they may have historically presented with depression).

4.7.3. Results

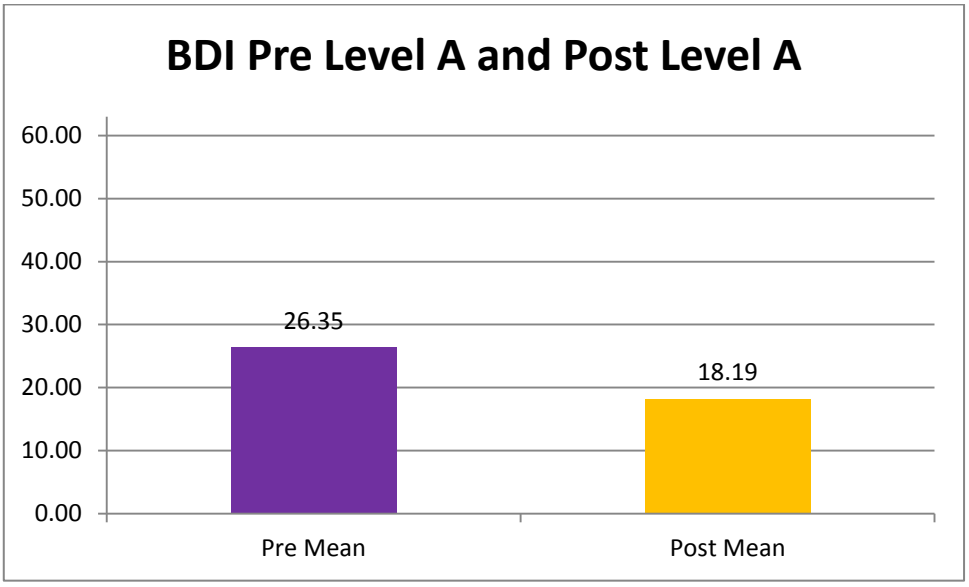
Pre Level A and Post Level A

Beck Depression Inventory (BDI)

Pre and post scores on the Beck Depression Inventory was available for 68 males and 99 females who completed Level A and data suggest that the

average score for people moved from the moderate range (*M* = 26.35, *SD* = 10.18) to the mild range (*M* = 18.19, *SD* = 9.61) on the measure (see graph below). This reduction in the mean score is statistically significant, (t(169) = 13.5, p = .000), and shows a large effect size (Cohen's *d* = 0.82).

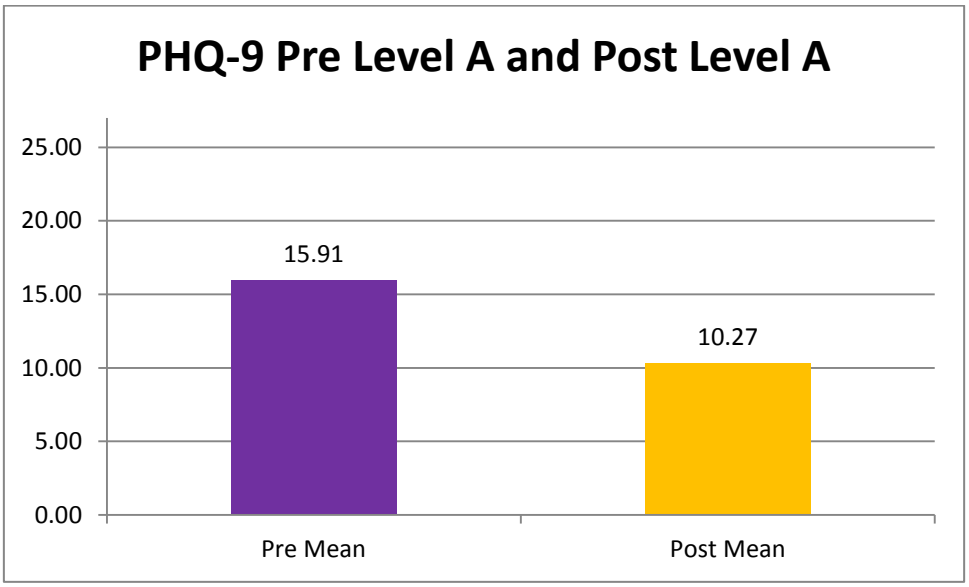
Graph: Beck Depression Inventory Total Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, pre and post Level A indicated that, on average, those who completed rated themselves in the moderately severe range (*M* = 15.91, *SD* = 6.68) prior to the intervention and in the lower end of the moderate range (*M* = 10.27, *SD* = 6.20) following intervention on this measure. This reduction in mean scores is statistically significant, A Wilcoxin Signed Rank test revealed z=10.44, p = .000, with a medium effect size (r = 0.44).

Graph: Patient Health Questionnaire-9 Scores

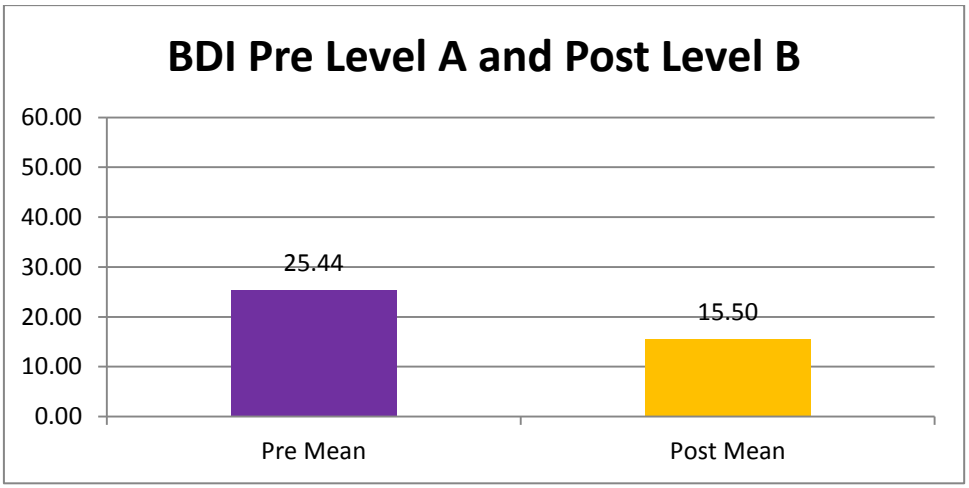


Pre Level A and Post Level B

Beck Depression Inventory

Pre and post scores on the Beck Depression Inventory (see graph below) suggest that the average score for people who completed Level B of the Depression Programme moved from the moderate range pre Level A (M = 25.44, SD = 8.63) to the mild range (M = 15.5, SD = 7.86) on the measure post Level B. This reduction in the mean score is statistically significant, t(15) = 5.45, p = .000, with a medium effect size (Cohen's d = 0.66).

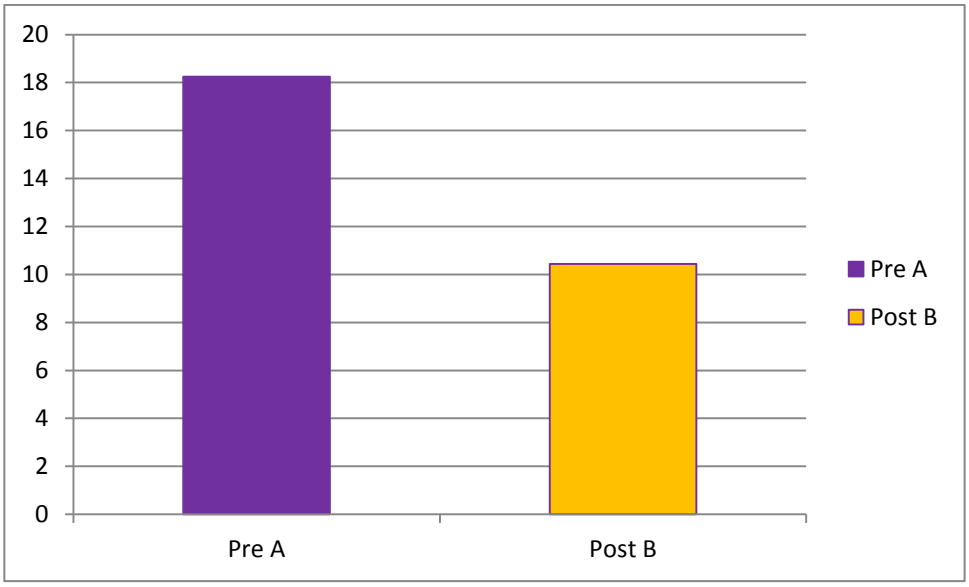
Graph: Beck Depression Inventory Scores



Patient Health Questionnaire-9 (PHQ)

Comparison of patient scores on the PHQ-9, indicated that, on average, those who completed Level B rated themselves in the moderately severe range (*M* = 18.25, *SD* = 8.10) prior to Level A and in the lower end of the moderate range (*M* = 10.44, *SD* = 5.54) following Level B on this measure. This reduction in mean scores is statistically significant, (t(15) = 3.97, p = .001), with a medium effect size (Cohen's *d* = 0.51).

Graph: Patient Health Questionnaire-9 Scores

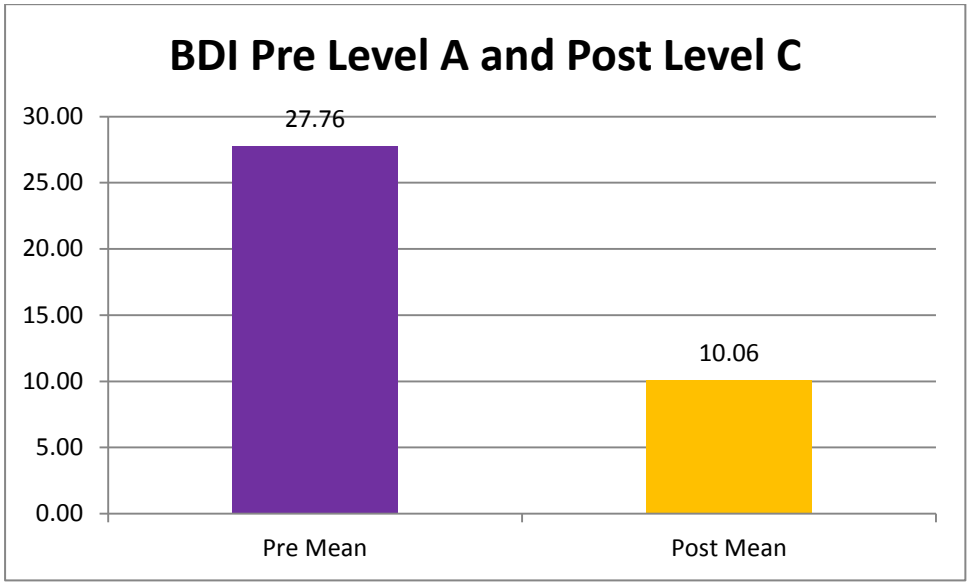


Pre Level A and Post Level C

Beck Depression Inventory

Scores on the Beck Depression Inventory (see graph below) suggest that the average score for people who completed Level C of the Depression Programme moved from the upper end of the moderate range pre Level A (*M* = 27.76, *SD* = 6.84) to the the lower end of the mild range (*M* = 10.06, *SD* = 9.62) on the measure post Level C. This reduction in the mean score is statistically significant, (t(16) = 8.42, p = .000), with a large effect size demonstrated (Cohen's *d* = 0.82).

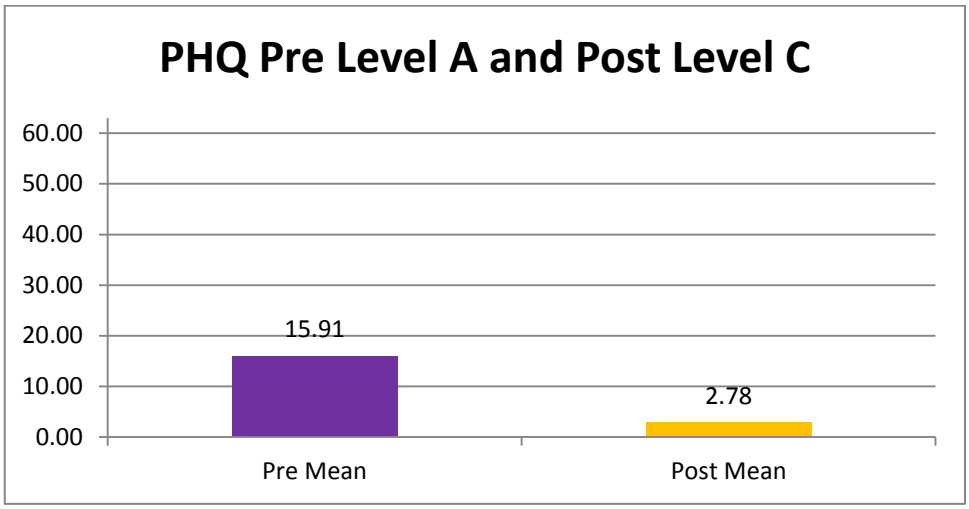
Graph: Beck Depression Inventory Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, indicated that, on average, those who completed Level C rated themselves in the moderately severe range (*M* = 15.91, *SD* = 6.68) prior to Level A and in the minimal range (*M* = 2.78, *SD* = 5.45) following Level C on this measure. A Wilcoxin Signed Rank test identified that this difference was statistically significant, z=2.67, p=.008, with a small effect size (r=.13).

Graph: Patient Health Questionnaire-9 Scores



4.7.4. Summary

This is the second year the depression programme has been included in the SPMHS outcomes report. Two well established outcome 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 across all three levels of the programme. The results showed that across all three levels of the programme significant numbers of participants moved out of the moderate depression range to the mild depression range on the BDI and from the moderately severe to the moderate or mild range on the PHQ-9, with those who did all three levels experiencing the most significant improvement.

These results provide evidence to suggest that, on average, people who complete the programme experience a significant reduction in symptoms associated with depression at each level of the programme. In future years the programme will consider providing more data for Levels B and C of the programme and including more demographic information on patients who complete the programme (e.g. age). Model-specific outcomes such as "compassion" or understanding and implementation of CBT skills may also be measured. This may help provide further evidence that the programme is effective and operating by its hypothesised mechanism.

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.

It aims to assist the client in the recovery process by providing a bio-psychosocial support structure and the therapeutic environment necessary to foster their 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. 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 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, the 10 items map on to the ICD-10 and DSM-IV criteria for substance dependence which include: 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 (Kelly, Magill, Slaymaker & Kahler, 2010).

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. Descriptors

94 participants completed the full or modified programme in 2015. Pre and post data were available for 58 participants, 36.2% of those participants were male and 63.8 % were female. This data represents approximately 60% of those participants who completed the programme in 2015. This means that findings presented may not be representative of all participants who completed the programme and these findings need to be interpreted in light of this.

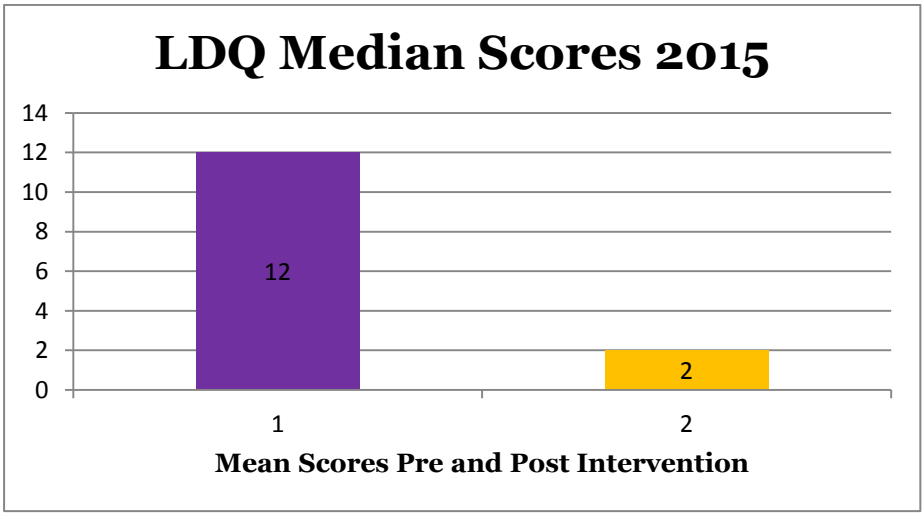
4.8.3. Results

Leeds Dependency Questionnaire

A Wilcoxin Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, $z=5.73$, $p<.001$, with a moderate effect size ($r=.57$).

The median score on the total LDQ decreased from pre-programme to post-programme, as depicted in the graph below.

Graph: Leeds Dependency Questionnaire Median Scores



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 will continue in 2016.

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).

It is recognised that it can be challenging to collect psychometric data from individuals with substance use difficulties. 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.

In 2014, despite efforts from clinical staff, collecting post data proved challenging and resulted in the data capture of only 26% of those who completed the programme in 2014.

To overcome this difficulty, it was decided that completion of post measures would happen in session with therapists during the exit interview and would become part of each client's discharge plan. This would be monitored using the referral spread sheet for service users and reviewed monthly by the Dual Diagnosis Service coordinator.

In 2015, there was pre and post data available for 60.4% of participants who completed the programme in 2015. This represents a promising trend in improvements in data collection.

4.9. Living Through Distress Programme

Living Through Distress (LTD) is a Dialectical Behaviour Therapy (DBT) 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 arising from a skills deficit. Emotional regulation difficulties result from biological irregularities combined with certain dysfunctional environments, as well as from the interaction between them 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 has been modified to meet the needs of the organisation, based on clinical research on the efficacy of the group. 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 18 skill-group sessions, three times a week for 6 weeks. Following these 18 sessions, each LTD group receives an additional 6 skill-group sessions, once a week for 6 weeks. This enables introduction of additional skills that help to address areas of need such as interpersonal

effectiveness in more depth. While the structure of the programme changed slightly in 2015, the content remained the same.

The department has undertaken research relating to the programme since it commencement and the measures being used have changed over time and continue to evolve. Previous research conducted 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).

4.9.1. Living Through Distress Programme Outcome Measures

• Difficulties in Emotion Regulation Scale

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dysregulation. It comprises 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 ($\alpha = .93$), construct and predictive validity, and test-retest reliability in an article which described the development of this scale.

• 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, absorption, appraisal 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.

- **Cognitive and Affective Mindfulness Scale-Revised**

The Cognitive and Affective Mindfulness Scale-Revised (CAMS-R; Feldman et al. 2007) was administered for the first time in 2015 to replace the Five-facet mindfulness questionnaire (FFMQ; Baer et al., 2006). Mindfulness as measured by the CAMS-R is unique in two ways, firstly, it is understood as the willingness and ability to be mindful rather than as a mindfulness experience and secondly, it is particularly related to psychological distress (Bergomi et al., 2012). The new measure was deemed more accessible to users as it captures their mindfulness experience in a shorter measure and additionally it is particularly relevant for use in clinical studies (Bergomi et al., 2012).

4.9.2. Descriptors

63 service users completed the LTD programme in 2015. Pre and post data were available for 45 participants, which represents approximately 70% of those who completed the programme in 2015. This is a significant increase in data collection from 2014, when data were available for 48% of those who completed the programme.

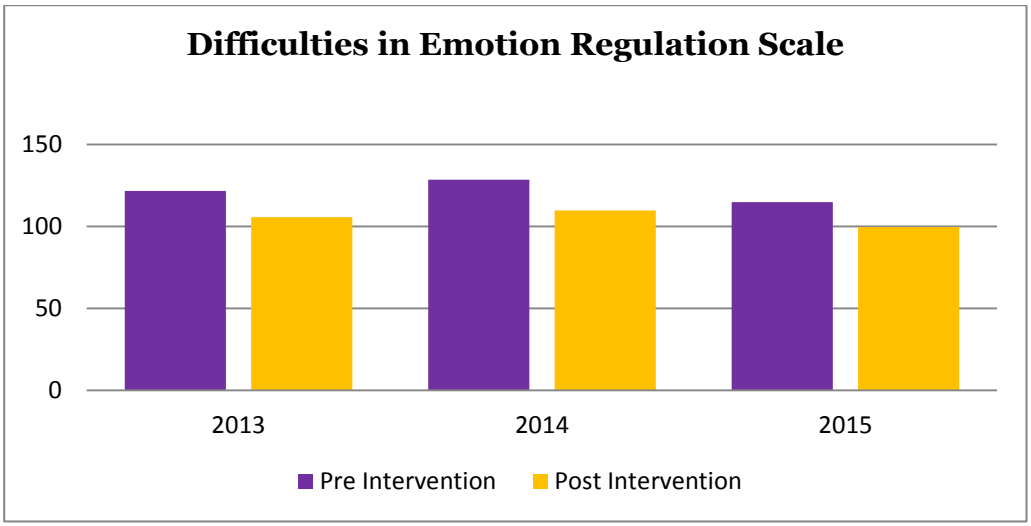
Of those who had pre and post data, 91.2% were female and 8.8% were male. LTD attendees ranged in age from 18 to 52 years (M = 29.74, SD = 11.38). Their highest level of educational attainment ranged from primary school (1.7%), to Junior Certificate (16.9%), to Leaving Certificate (39%), to 3rd level qualification (22%), to 3rd level degree (13.6%) to postgraduate qualification (6.8%). Those who attended the group’s current employment status was also recorded, 5.1% worked in the home, 13.6% were in part-time employment, 18.6% were in full-time employment, 23.7% were unemployed, 1.7% were retired, 23.7% were students and 13.6% chose other.

4.9.3. Results

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 114.89 (*SD* = 18.56) on the DERS pre to 99.59 (*SD* = 26.20) post completion of the programme, t (33) = 5.29, $p < .001$. This change represented a medium effect size (Cohen's d = .67). See graph below for visual representation.

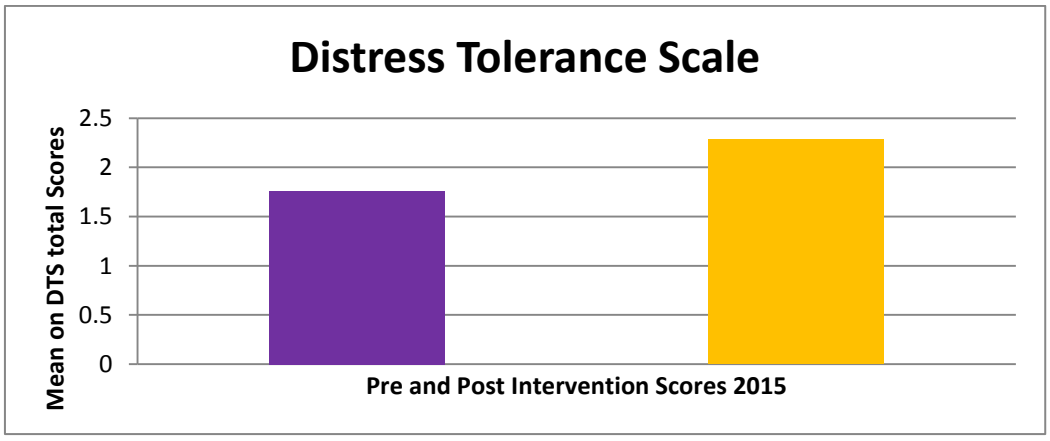
Graph: Difficulties in Emotion Regulation Scale Total Scores



Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale

Graph: Distress Tolerance Scale Total Scores

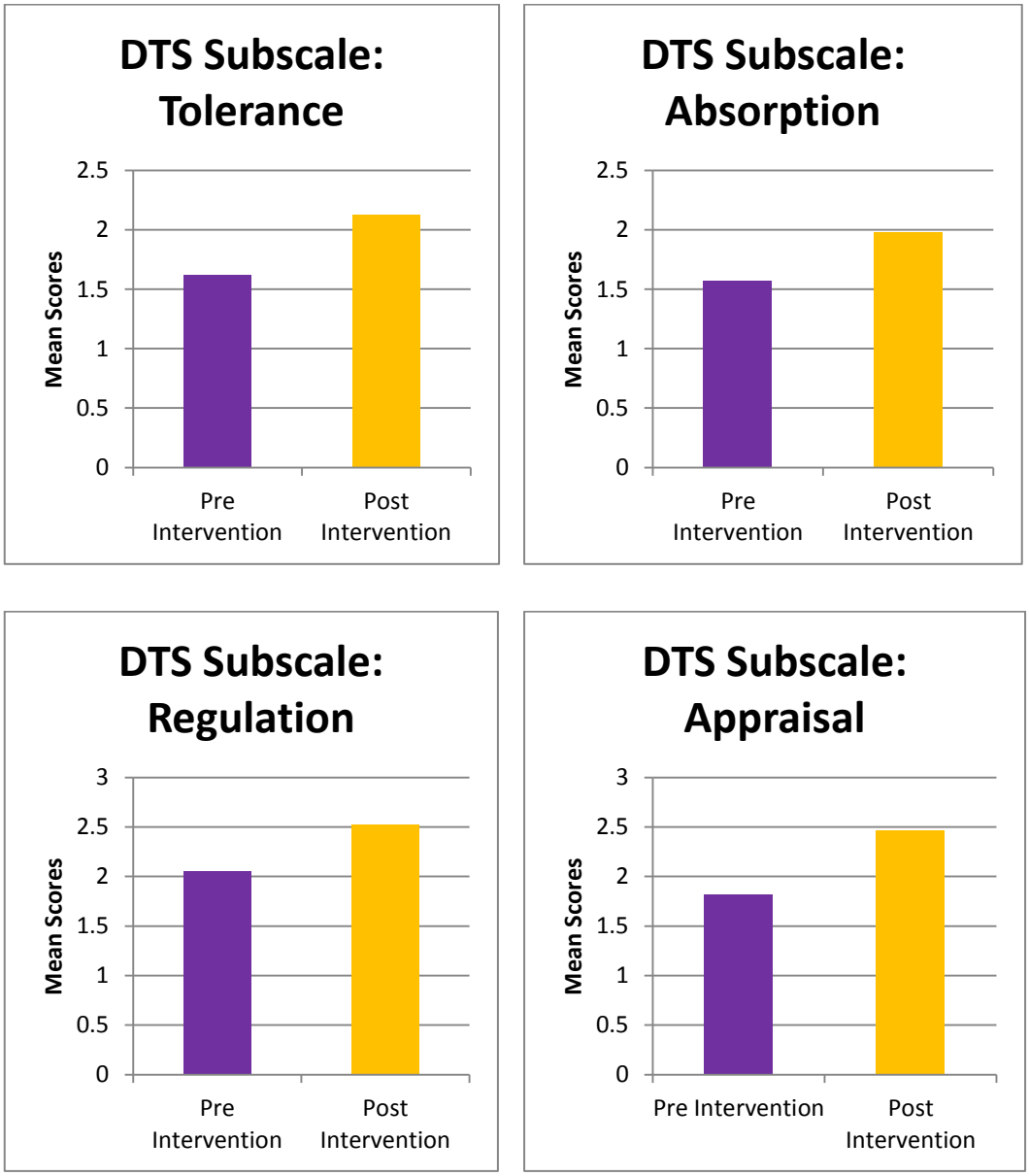


Note: Higher scores indicate increased ability to tolerate distress

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 1.76 (*SD* = .57) before the programme on the DTS to 2.28 (*SD* = .86) after completing the programme, t (35) = 3.98, p < .001, representing a large effect size (Cohen's d = .92).

The DTS comprises of 4 subscales assessing tolerance, absorption, appraisal and regulation. There were statistically significant differences identified between pre and post intervention, which indicate that participants' distress tolerance increased post-programme as expectated. The differences between pre and post intervention subscale scores are represented in the graphs below.

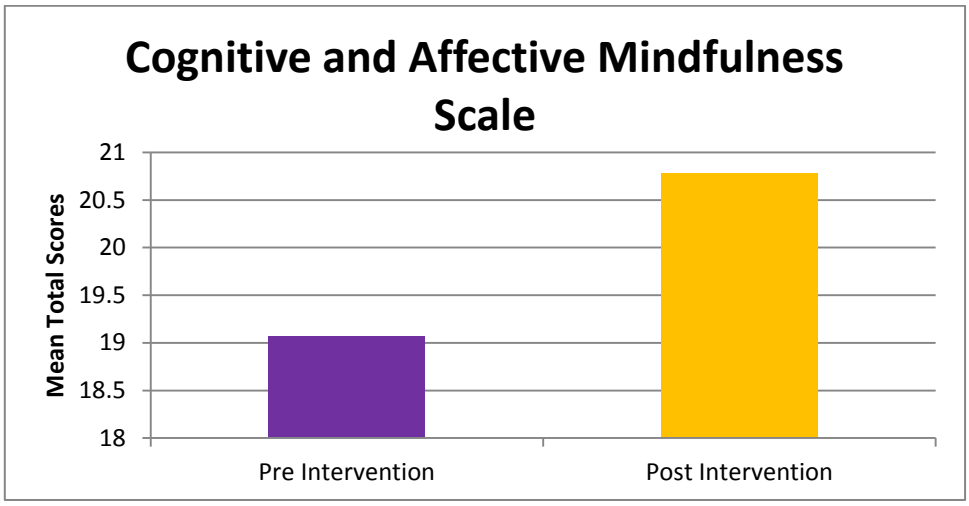
Graph: Distress Tolerance Scale Sub-scales



Cognitive and Affective Mindfulness Scale

Participants also had greater mindful qualities post intervention moving from a mean score of 19.07 (*SD* = 4.81) before the programme on the CAMS-R to 20.78 (*SD* = 4.96) after completing the programme, t (40) = 2.52, $p < .05$, representing a small effect size (Cohen's d = .35).

Graph: Cognitive and Affective Mindfulness Scale Total Scores



4.10.4. Summary

For those participants with pre and post data, significant improvements were observed in increased mindfulness, increases in emotion regulation and improved distress tolerance. Effect size calculations showed a small, medium and large effect size, respectively.

Outcome measures for the programme are expected to remain the same for the coming year. There is research ongoing on this programme which is looking at understanding problems of emotional over and under- control and response to the DBT informed interventions (i.e. LTD and RO). All the data for this project has been collected and it is currently being written up.

The programme was nominated for three awards at the Irish Health Care Centre Awards 2015.

4.10. Living through Psychosis Programme

Living through Psychosis (LTP) is an innovative psychology group intervention that addresses the primary issue of emotional dysregulation which is understood to be a significant vulnerability and co-morbidity factor in psychosis. The programme aims to provide emotional regulation, distress tolerance and mindfulness skills for individuals with psychosis (Psychosis, Schizophrenia, Schizo-affective Disorder, Acute psychotic episode and Bipolar affective disorder) to maintain gains made in hospital and to reduce the likelihood of relapse.

LTP has been developed in line with established models of cognitive behavioural therapy for psychosis which promotes normalising and coping with both positive and negative symptoms. These models have been enhanced by integrating coping skills from dialectical behaviour therapy. Given that each patient is impacted uniquely by psychosis a limited number of individual sessions are also provided.

This group has a particular focus on relapse prevention. Thus the programme aims to address beliefs about psychosis, to reduce distress and preoccupation associated with symptoms, and to increase hope and everyday functioning (Garety, 2005, Morrison, 2004 & Chadwick, 2006).

The programme provides eight acceptance and change skills which have been found to be important factors and a safe environment where the personal impact of psychosis can be explored. Following these eight sessions, each LTP group member is offered monthly aftercare sessions which provide an opportunity to review and learn further skills.

The department has undertaken research relating to the programme and is currently working with a clinical doctorate student from Trinity College Dublin examining the effectiveness of the programme. The research started in March 2015 and finishes in March 2016.

4.10.1 Living Through Psychosis Programme Outcome Measures

- **Difficulties in Emotion Regulation Scale (DERS)**

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

- **The Psychotic Symptom Rating Scales (PSYRATS)**

The Psychotic Symptom Rating Scales PSYRATS (Haddock, McCarron, Tarrier & Faragher, 1999) are semi-structured interviews designed to assess the subjective characteristics of hallucinations and delusions. The auditory hallucinations subscale (AHS) has 11 items: for frequency, duration, controllability, loudness, location; severity and intensity of distress; amount and degree of negative content; beliefs about the origin of voices; and disruption. The delusions subscale (DS) has six items: duration and frequency of preoccupation; intensity of distress; amount of distressing content; conviction and disruption. The scales had excellent inter-rater reliability and good validity in sufferers from chronic schizophrenia (Haddock et al. 1999).

- **Fear of Recurrence Scale (FORSE)** (Gumley & Schwannauer, 1999)

The Fear of Recurrence Scale (FORSE) is a 23-item self-report inventory, which measures to what extent individuals with psychosis appraise their thinking and intrusions as threatening and indicative of relapse (Gumley & Schwannauer, 2006a). Higher total scores on FORSE are associated with

greater positive symptoms, general psychopathology, and more negative illness beliefs (White & Gumley, 2009).

• **Recovery Assessment Scale** (RAS 21: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995). The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. The RAS-21 is a 21-item survey rated on a 5-point scale from 1 "Strongly Disagree" to 5 "Strongly Agree". 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). #

4.10.2. Descriptors

Data were available for 44 people who completed the programme in 2015, of whom 19 (43.2%) were female and 25 were male (56.8%). Programme attendees ranged in age from 20 to 69 years with a mean age of 37 (SD=12.9). The mean age of onset was 24.8 years, with a range from 12-66 years. Of note 15 (34%) were first episode psychosis patients. Of those who attended 45.5% were employed, 40.9% were unemployed and 13.6% were currently in education courses. Their levels of education ranged from Junior Certificate (6.8%), Leaving Certificate (20.5%), Apprenticeship (15.9%), Undergraduate (36.4%) to Postgraduate (20.5%).

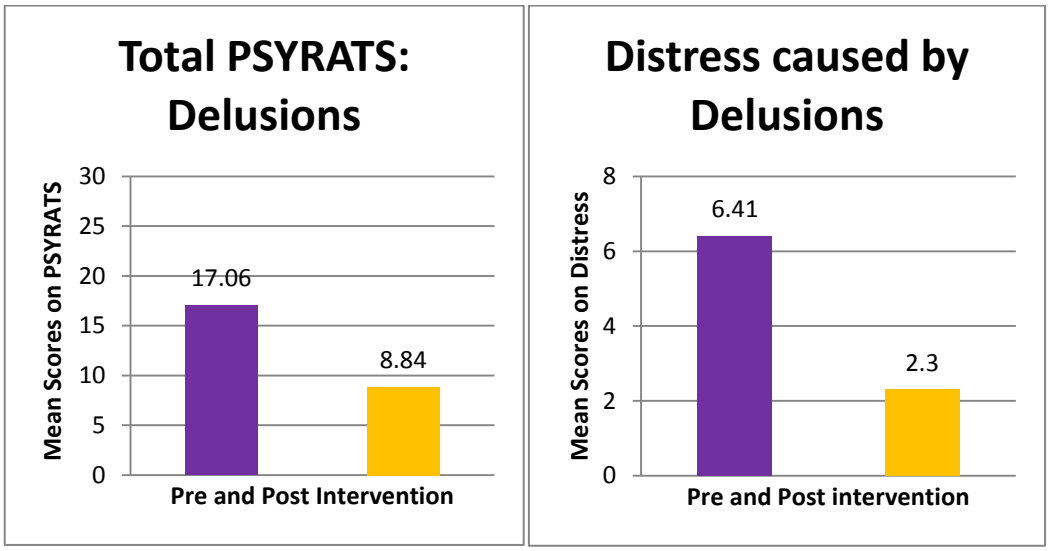
4.10.3. Results

The Psychotic Symptom Rating Scales (PSYRATS)

Pre and post intervention symptoms were measured using the Psychotic Symptom Rating Scales (PSYRATS), the scale examines delusions and hallucinations separately. In terms of delusions, a Wilcoxin Signed Rank Test

revealed a statistically significant reduction in total PSYRATS scores following participation in the programme, z=4.24, p<.001, with a large effect size (r=.50). The median score on the total PSYRATS decreased from pre-programme to post-programme, as depicted in the graph below.

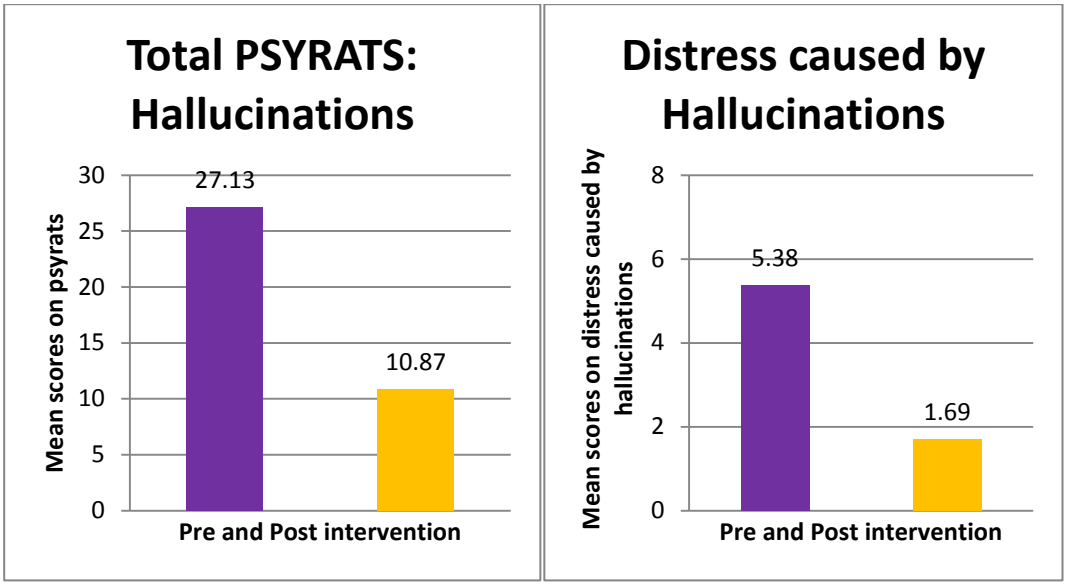
Graphs: Psychotic symptom Rating Scale (PSYRATS): Delusions



The distress caused by their delusions was also significantly reduced, a Wilcoxin Signed Rank Test revealed a statistically significant reduction in PSYRATS distress scores following participation in the programme, z=4.26, p<.001, with a large effect size (r=.50). The median score on the PSYRATS distress score decreased from pre-programme to post-programme, as depicted on the graph above.

In terms of hallucinations, a Wilcoxin Signed Rank Test revealed a statistically significant reduction in total PSYRATS scores following participation in the programme, z=3.41, p<.01, with a medium effect size (r=.46). The median score on the total PSYRATS decreased from pre-programme to post-programme, as depicted in the graph below.

Graphs: Psychotic symptom Rating Scale (PSYRATS): Hallucinations



The distress caused by their hallucinations was also significantly reduced, a Wilcoxin Signed Rank Test revealed a statistically significant reduction in total PSYRATS scores following participation in the programme, z=3.43, p<.01, with a medium effect size (r=.45). The median score on the PSYRATS distress score decreased from pre-programme to post-programme, as depicted on the graph above.

The Fear of Recurrence Scale (FORSE)

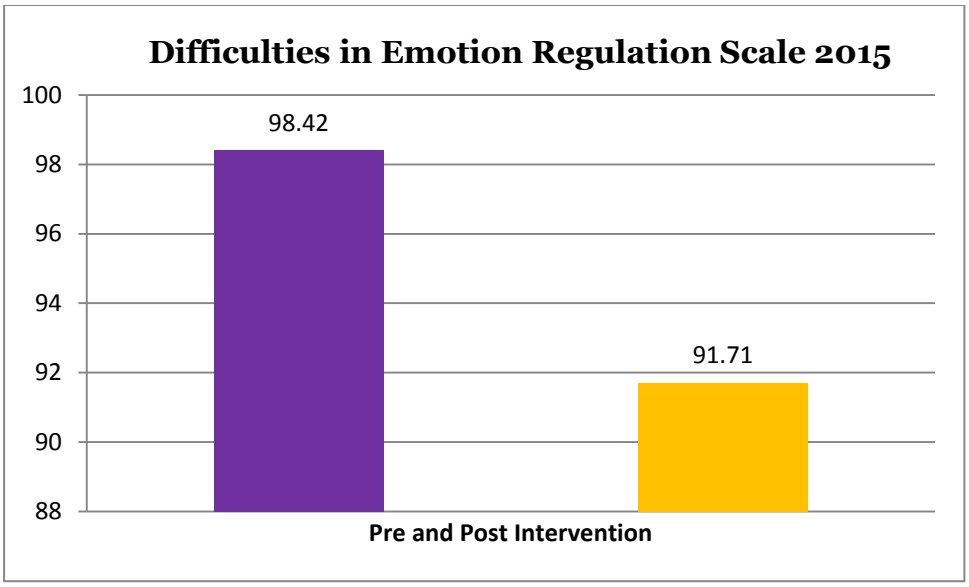
In terms of patients fear of recurrence measured by the Fear of Recurrence Scale (FORSE), there was no statistically significant change identified immediately after completion of the programme, however this measure was completed again 4 weeks after programme completion, where a statistically significant improvement was observed, t(36)=3.40, p<.01, with a moderate effect size (Cohen's d =. 59).

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 98.42 (*SD* =

21.48) on the DERS pre to 91.71 (*SD* = 20.69) post completion of the programme, *t* (40)=2.40, p<.05. This change represented a small effect size (Cohen's *d* = .32). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

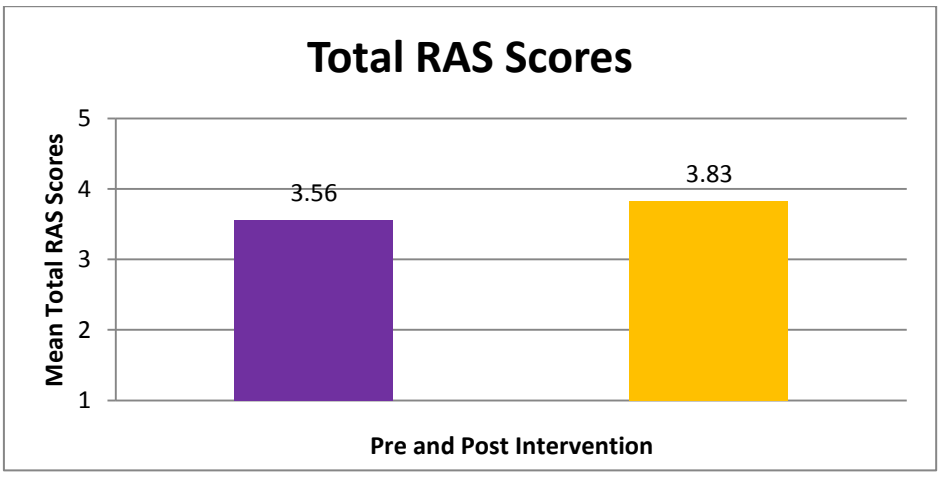


Note: Higher scores indicate greater difficulties with emotion regulation

Recovery Assessment Scale

Total Mean RAS scores increased from pre measurement (*M*=3.56, *SD* =.46) to post measurement (*M*=3.83, SD=.50) on the Recovery Assessment Scale indicating greater overall recovery. This increase was statistically significant, t (41) = 4.54, *p* < .001, and represented a moderate effect size (Cohen's *d* = .54).

Graph: Recovery Assessment Scale Total Scores



There are five sub-scales within the RAS and the figures below show pre and post scores on 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'. Following a series of Wilcoxin Signed Rank tests, Median scores, z scores, *p* values and effect sizes (*r)* for each of the subscales are shown in the following table.

Table: Recovery Assessment Scale Subscale Scores

RAS	Pre *Median*	Post *Median*	*z*	*P*	*r*
Personal confidence	3.33	3.83	4.08	.000	.44
Willingness To Ask For Help	3.33	3.66	1.28	.201	.14
Ability To Rely On Others	4.00	4.00	1.22	.224	.13
Not Dominated By Symptoms	3.66	4.00	4.62	.000	.50
Goal and Success	3.80	4.20	2.84	.004	.31

RAS = Recovery Assessment Scale.

Scores on 3 of the 5 subscales improved significantly from pre to post measurement. Moderate to large effect sizes were observed on the three significant subscales, 'Personal Confidence and Hope', 'Not dominated by Symptoms' and 'Goal and Success Orientation'.

4.10.4. Summary

Group interventions for patients diagnosed with schizophrenia, schizoaffective disorder and bipolar affective disorder are rare at this time, yet there is increasing research to indicate the essential and effective role that group psychological interventions can have. LTP is providing important data as part of this evidence base. Improvements were observed in reduction of the psychotic symptoms delusions and hallucinations total scores, an increase in patient's ability to regulate their emotions and their reduced fear of reoccurrence. Their overall recovery scores significantly improved. While

this programme is in an early phase of development, the outcomes to date are promising.

It is important to note that the above results are based on pre-post within-group effect sizes, so are likely an over-estimate of effect sizes by comparison to a Randomised Control Trial.

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, in a non-judgemental way. Developing and practicing this non-judgemental awareness has been found to reduce psychological distress and prevent relapse of some mental ill-health 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

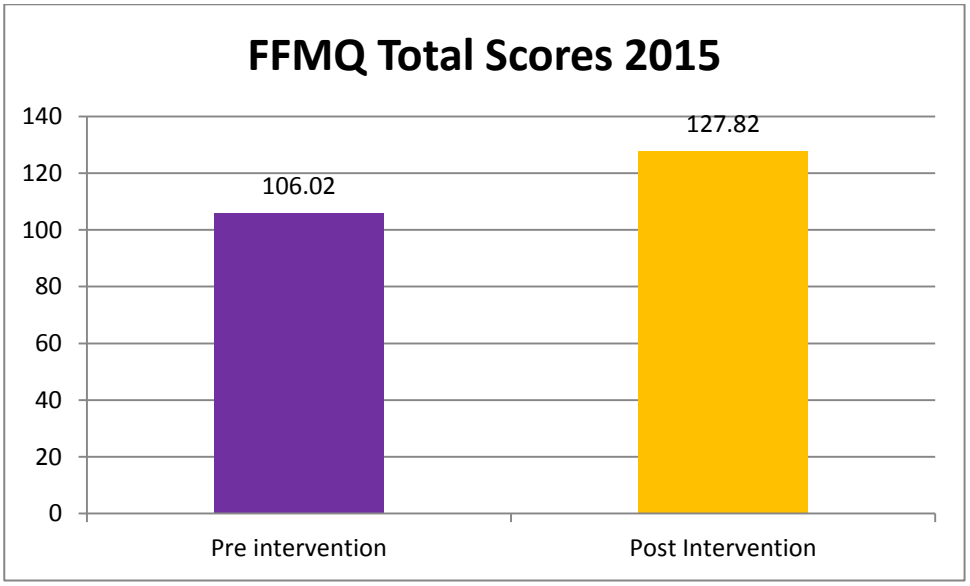
The Mindfulness Programme was delivered in St Patrick’s University Hospital and St Edmundsbury Hospital. For the purpose of this report the data has been collated, and has been analysed and reported on together.

Data was collected on 163 participants 66 males (40.5%) and 97 females (59.5%). Pre and post data were available for 99 services users who completed the mindfulness programme across both sites. Participants age ranged from 20 to 78 years old (mean = 51 years).

4.11.3. Results

Five Fact Mindfulness Scale (FFMQ)

Graph: Five Facet Mindfulness Scale Total Scores



An examination of the combined data from across both sites revealed a significant increase in total scores on the FFMQ from pre intervention (M=106.02; SD=18.56) to post intervention (M=127.82; SD=18.26). A Wilcoxin Signed Rank test, revealed a statistically significant increase in FFMQ total scores following participation in the programme, z=7.67, p<.001, with a medium effect size (r = .48). 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 large effect size for the "observing" domain (Cohen's *d* =1.08) and medium effect sizes on "non-reactivity to inner experience" (Cohen's r = .44), "acting with awareness" (Cohen's *r* =.30), "describing" (Cohen's *r* = .36) and for the "non-judgement of inner experience" (Cohen's *r* = .39), (see tables below).

Table: FFMQ Mean scores by subscales, t values and effect size for parametric tests.

FFMQ	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*P value*	*Cohen's d*
Observe	22.93 (5.32)	28.61 (5.22)	9.58	106	.000	1.08

Table: FFMQ Mean scores by subscales, z values and effect size for non-parametric tests.

FFMQ	Pre Mean (SD)	Post Mean (SD)	*z*	*P value*	*Cohen's r*
Describe	24.61 (5.96)	28.24 (6.37)	5.96	.000	.36
Non-Judgement	21.25 (6.46)	24.88 (6.06)	6.44	.000	.39
Awareness	19.25 (5.52)	23.75 (4.88)	4.92	.000	.30
Non-Reactivity	17.85 (4.08)	22.12 (3.80)	7.12	.000	.44

4.11.4. Summary

In line with the 2014 report, results for 2015 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 medium effect sizes apparent for changes on the measure overall and on most of the subscales, with the exception of "observing" domain, which had a large effect size.

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.

4.12.1. Radical Openness Programme Outcome Measures

In consultation with the clinical team a number of changes were made to the measures used in 2015 from those used in 2014. This was to include measures considered to be more theoretically consistent and in line with an on-going large multisite Randomised Clinical Trial of Radically Open DBT and to build on the published research that has already happened relating to LTD and RO in St Patrick's Mental Health Services in the past (i.e., Keogh, 2015 and Gibson, 2014).

The Social Safeness and Pleasure Scale was replaced with a more theoretically consistent measure – Social Connectedness Scale-Revised (SCS-R: Lee, Draper, & Lee, 2001).

- **Brief symptom Inventory**

The Brief Symptom Inventory (BSI; Derogatis, 1983) is a 53-item measure of symptoms that cause the service users' to experience psychological distress 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. Service users rate each symptom on a scale of 0 Not at all to 4 Extremely. The Global Severity Index score, which is used in this report, is the best indicator of current distress levels.

- **The Social Connectedness Scale-Revised**

The SCS-R (Lee & Robins, 1995) is a fifteen-item self-report scale, which was designed to assess an individual's subjective sense of social connectedness to their social world. Increased scores reflect higher social connectedness. Each item is rated on a 6 point Likert scale, from 1 Strongly Disagree to 6 Strongly Agree.

- **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, absorption, appraisal 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.

4.12.2. Descriptors

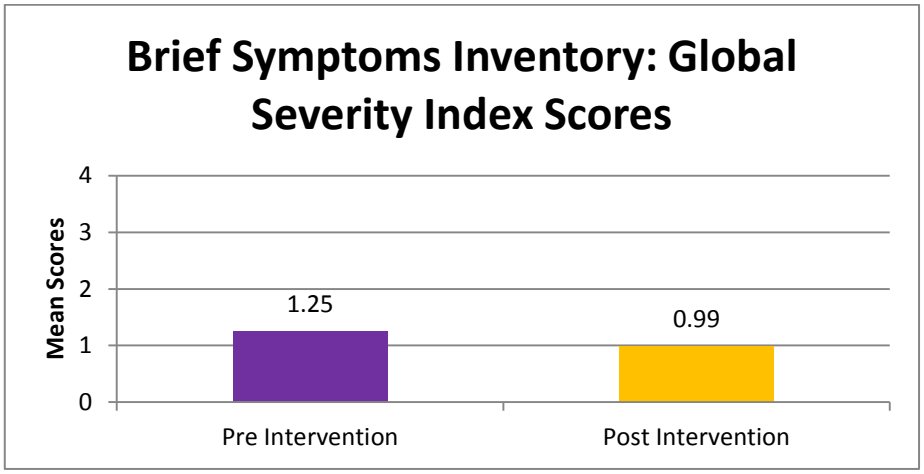
Pre and post data were available for 25 people who completed the programme in 2015. Where gender data was available, 51.7% were female and 48.3% were male and they ranged in age from 18 to 67 years (M=37.04; SD=13.09).

4.12.3. Results

Brief Symptoms Inventory

A significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale on the Brief Symptoms Inventory (BSI), whereby t(22)= 3.45, p<.01, reflecting a small effect size (*d*= .42).

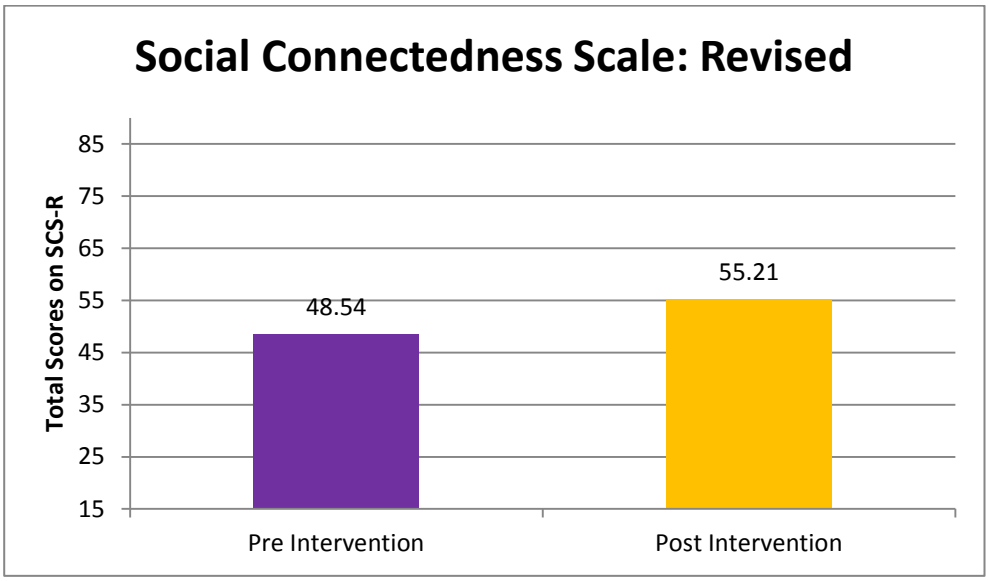
Graph: Brief Symptoms Inventory Global Severity Index mean scores



Social Connectedness Scale: Revised

A significant change was also observed on the SCS-R, whereby t (23) = 2.63, p< .05, reflecting a small effect size (Cohen's *d*=.35), suggesting that after the programme participants felt more connected to their social world.

Graph: Social Connectedness Scale: Revised



4.12.3.3 Distress Tolerance Scale

Participants also experienced a significant increase in their ability to tolerate distress after completing the programme, whereby $t(22) = 2.81$, $p \leq .01$, reflecting a moderate effect size (Cohen's $d = .53$).

Graph: Distress Tolerance Scale

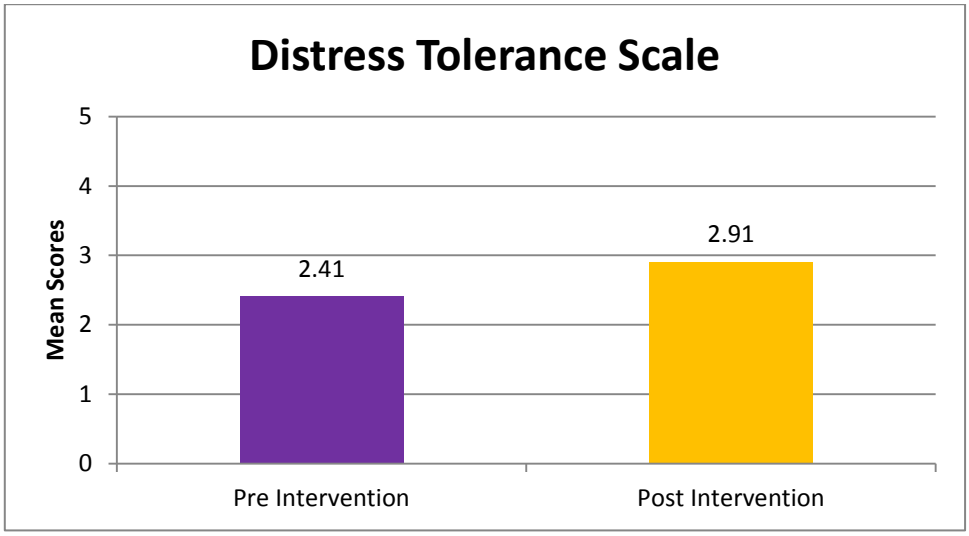


Table 1: *Results from paired samples t-tests for measures pre and post Radical Openness intervention.*

Scale	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
BSI	2.25 (.62)	1.99 (.61)	3.45	21	.002	.42
SCS-R	48.54 (17.35)	55.21 (20.93)	2.63	23	.002	.35
DTS	2.41 (1.00)	2.91 (.87)	2.81	22	.01	.53

BSI=Brief Symptom Inventory, SCS-R=Social Connectedness Scale-Revised, DTS= Distress Tolerance 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 2015 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.

There is ongoing research on this programme being undertaken by a doctoral student in Clinical Psychology, which is looking at understanding problems of emotional over- and under- control and response to the DBT informed interventions (i.e. LTD and RO) offered at St Patricks Mental Health Services.

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 commonly used to measure service users' attitudes towards psychotropic treatment. A valid and reliable 10 item brief version of the DAI has been developed (see Nielsen, Lindstrom, Nielsen and Levander, 2012) and was

used in data collection for the psychosis programme from January 2015. The DAI-10 scoring ranges from -10 to 10. Whereby a total score of >0, indicates a positive attitude toward psychiatric medications. DAI-30 and DAI-10 were homogenous (r=0.82 and 0.72, respectively) with good test–retest reliability (0.79). The correlation between the DAI versions was high (0.94).

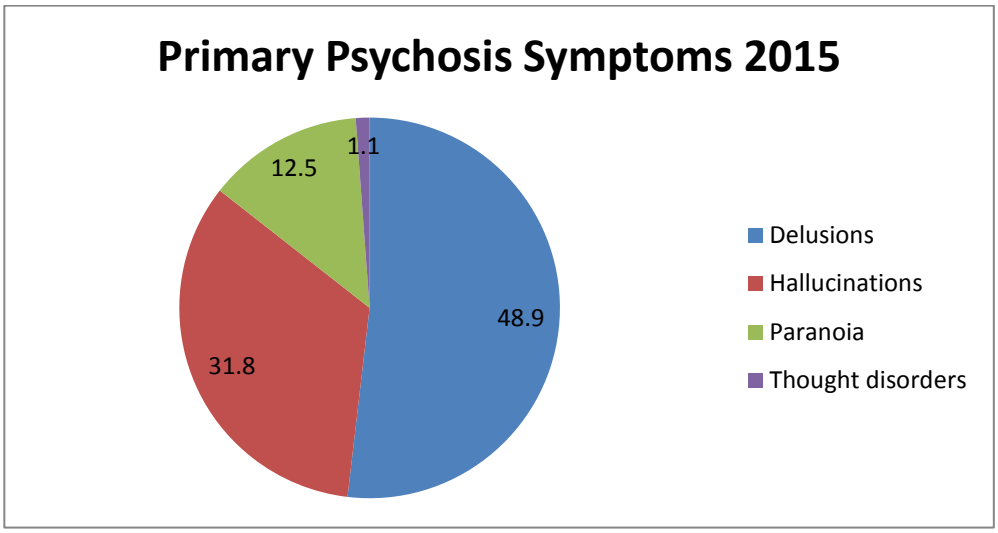
This shorter measure was introduced to reduce client and clinician burden in completion of measures for this programme, which had previously resulted in low response rates.

4.13.2. Descriptors

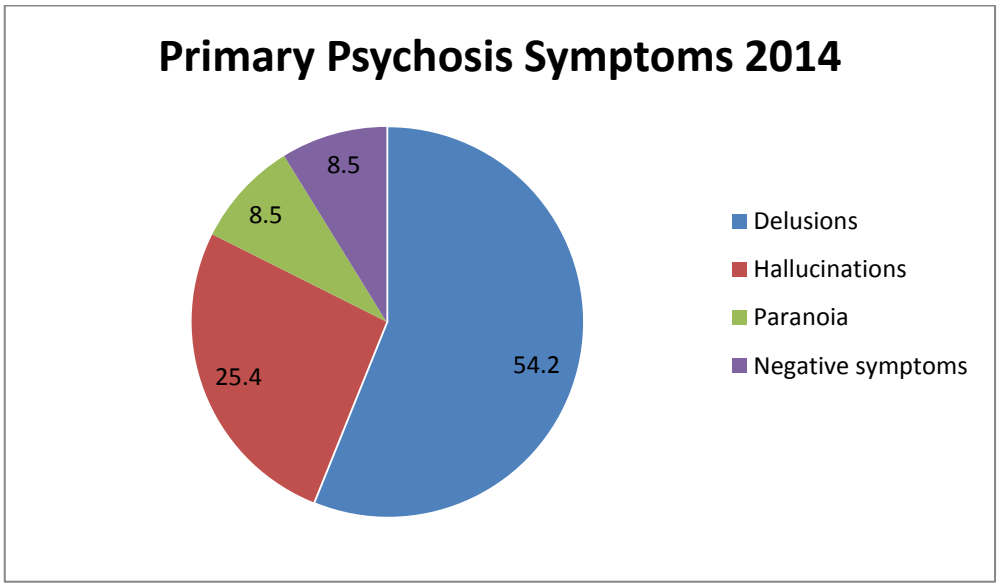
In 2015 pre and post RAS scores were available for 26 participants, and pre and post DAI scores were available for 17 participants. The average age of psychosis programme participants was 38.64 years (ranging from 18 to 87 years) and 70.51% were male (n=62). Seventy-five percent were single, 18.2% married, 5.7% separated or divorced. Similar proportions were employed (28.4%) and unemployed (26.1%), 14.8% were students, 10.2% were retired and a further 3.4% worked in the home. Over one quarter had attained a third level degree, compared to one fifth in 2014. Twenty-seven percent had completed the leaving certificate, 30.7% had a non-degree third level qualification, with the remaining 8% having left school before the leaving certificate. The majority lived with family (68.2%) followed by living alone (25%). 5.7%were living with friends, or cohabiting. The majority of service users reported their ethnicity as white Irish (96.6%). Comparing 2014 to 2015, 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 2014 and 2015. In 2014 the primary reported symptoms were delusions, followed by hallucinations, and paranoia. In 2015 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 2014 and 2015. The average attendance per client in 2015 was 4.82 days. Participants are permitted to attend multiple cycles of the programme.

Graph: Primary Psychosis Symptoms 2015



Graph: Primary Psychosis Symptoms 2014



4.13.3. Results

Recovery Assessment Scale

A Wilcoxin Signed Rank test identified a significant increase in mean total scores for the RAS at the post intervention time point z= 3.82, p <.001, reflecting a large effect size (Cohen's *r* : .44). Looking at the RAS sub-scale scores, significantly higher scores were identified post intervention for users on the 'Confidence and hope' subscale, z=2.70, p<.01, on the 'Willingness to

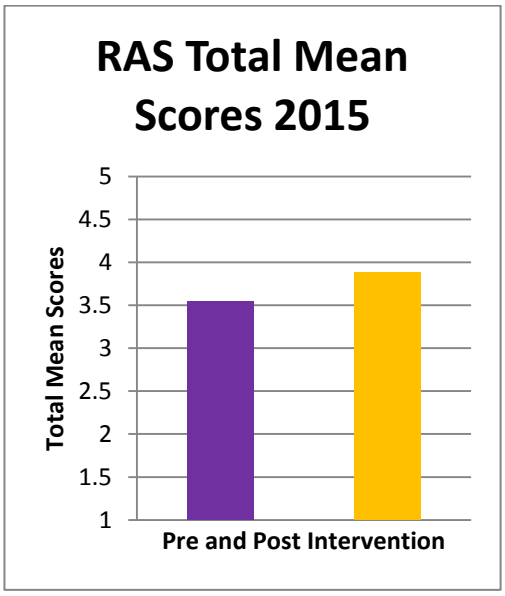
ask for Help' subscale, z=2.16, p<.05, on the 'Goal and Success Orientation' subscale, z=2.64, p < .01 and on the 'No domination by symptoms' subscale, z=3.52, p (< .001) . The difference between pre and post intervention means on the 'Ability to rely on others' subscale was not statistically significant, but indicated positive trends. See the table below for test statistics and figures for differences in pre and post intervention means and graphs on the following page for visual representations.

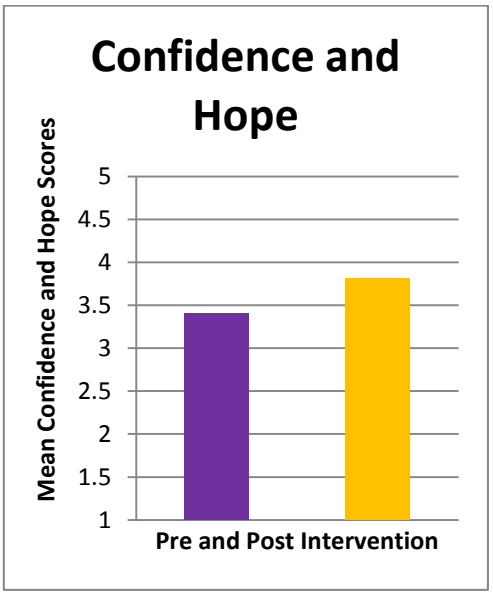
Table: *Results from Wilcoxin Signed Rank tests for the RAS pre and post Psychosis Recovery Programme.*

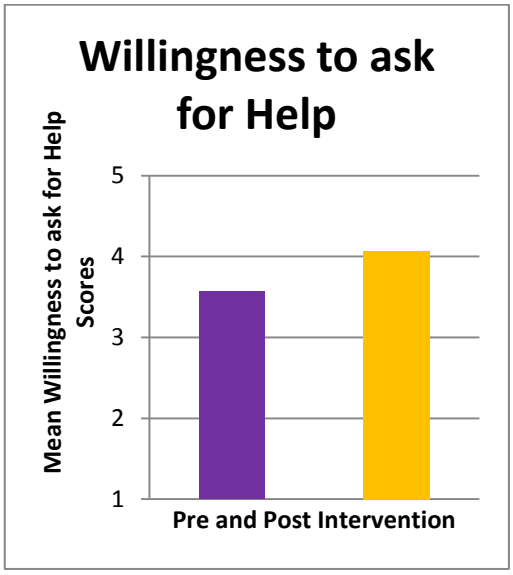
RAS	Pre Mean (SD)	Post Mean (SD)	*z*	*p*	Cohen's *r*
Mean Total	3.54 (.62)	3.88 (.59)	3.82	.000	.44
Confidence and Hope	3.40 (.83)	3.81 (1.27)	2.70	.007	.31
Willingness to ask for Help	3.57 (1.04)	4.07 (1.22)	2.16	.031	.25
Goal/ Success Orientation	3.73 (.90)	4.18 (1.14)	2.64	.008	.30
Ability to Rely on Others	4.14 (.75)	4.37 (1.15)	1.85	.065	.21
No Domination by Symptoms	2.91 (.88)	3.60 (1.45)	3.52	.000	.40

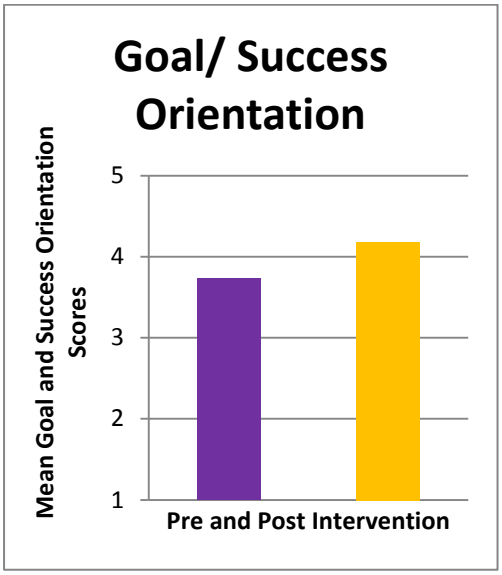
RAS = Recovery Assessment Scale.

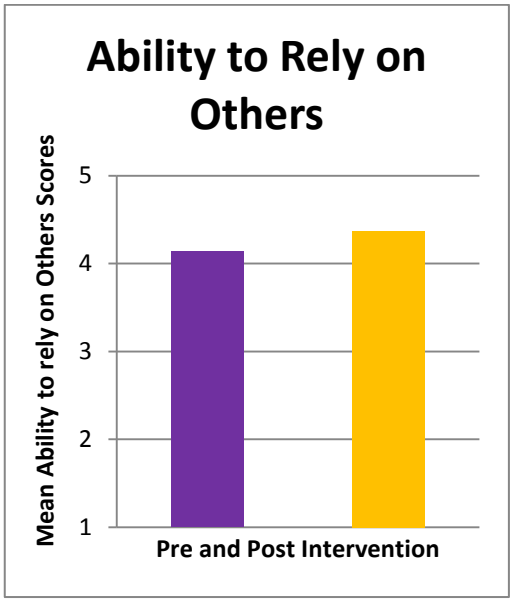
Graphs: Recovery Assessment Scale sub-scales

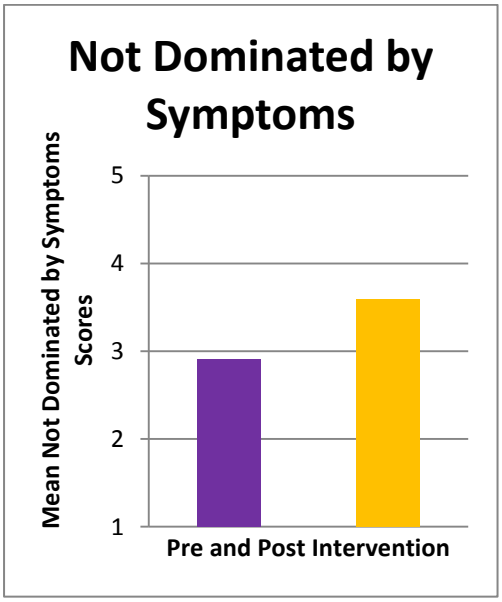












Drug Attitude Inventory

A Wilcoxin Signed Rank test identified no statistically significant difference in mean scores on the DAI-10 from pre intervention (M=2.71 SD=3.04) to post intervention (M=2.20; SD=2.59) z=1.90, p>.05. This indicates that service users who completed the measures reported less 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 consistently shown to increase post intervention, suggesting the Psychosis Recovery Programme is helpful in supporting service users' recovery and in encouraging more positive views towards medication.

In 2015 there were positive increases identified on all subscales on the RAS with one exception. This indicates that the skills people have learnt throughout the programme have had a positive impact on their lives. The improvement on the 'not dominated by symptoms' is particularly significant, with a large effect size identified. This indicated that through the programme people have learnt skills to manage their negative symptoms without being dominated by them.

In 2015, the DAI-10 was used for the first time as a measure of people's attitudes towards drugs. The results indicated that individual's positive attitudes towards medication were reduced following their engagement with this program. Programme staff explained that the programme has not changed during the past year and hence differences in this year's findings could not be attributed to this. It is important to note that these results are based on 17 participant's pre and post DAI-10 scores which represent less than 20% of attendees. Given that the completion rate was below 20% these results should be interpreted with caution.

Programme staff explained that their client's inability to complete the measures accurately at the pre time point due to the acute nature of their illness has resulted in significant amount of lost data.

As a result of the above factors including the low response rate in 2015 and lost data, it has been decided to continue collecting data in 2016 using the DAI-10, as participants are more likely to complete the shorter measure. Programme staff will be proactive in encouraging completion of measures accurately in order to increase response rates in 2016.

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 group based and 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 four 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. 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).

In 2015, it was decided to make a minor adjustment to the reporting of the RAS figures in this outcomes report. The change involved moving from reporting total scores to reporting mean scores, which makes the data more meaningful to the reader, whereby it is easier to draw comparisons across the subscales on the RAS.

4.14.2. Descriptors

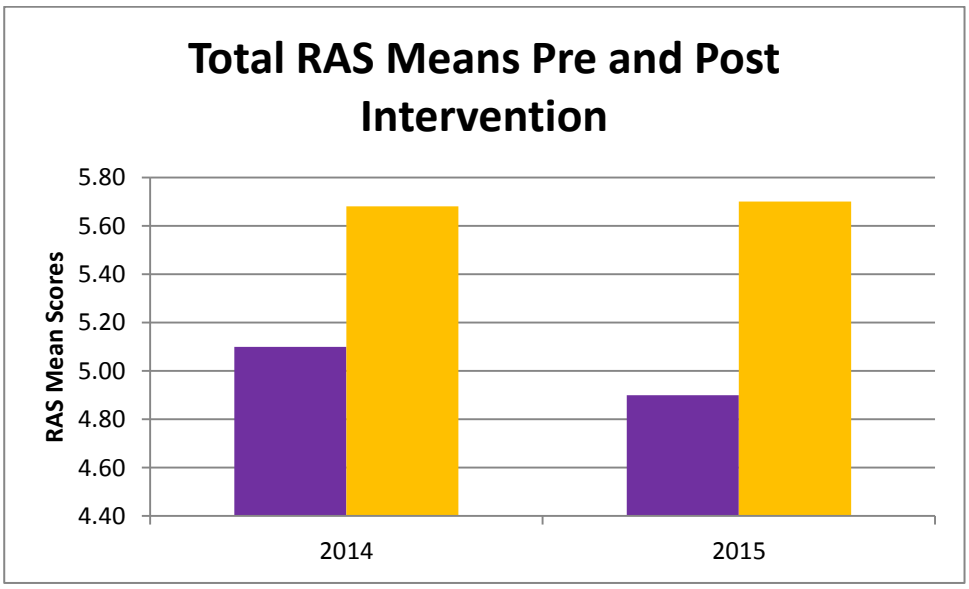
105 service users took part in the Recovery Programme in 2015. Pre and post data were available for 79 participants which represents approximately 75% of those who attended in 2015. The average age of participants was 48.26 years and 60% were female.

4.14.3. Results

Recovery Assessment Scale

Total Mean RAS scores increased from pre measurement (M = 4.90, SD =.74) to post measurement (M =5.70, SD = .65) indicating greater overall recovery. This increase was statistically significant, t (66) = 9.14, p < .001, and represented a large effect (d = 1.03).

Graph: Recovery Assessment Scale: mean scores



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'. A series of Wilcoxin Signed rank tests were run in order to compare pre and post scores, the mean scores, standard deviations, z values, *p* values and effect sizes (Cohen's *r:* .1 = small effect, .3 =medium effect and .5 =large effect. (Cohen, 1988) for each of the subscales are shown in the table below.

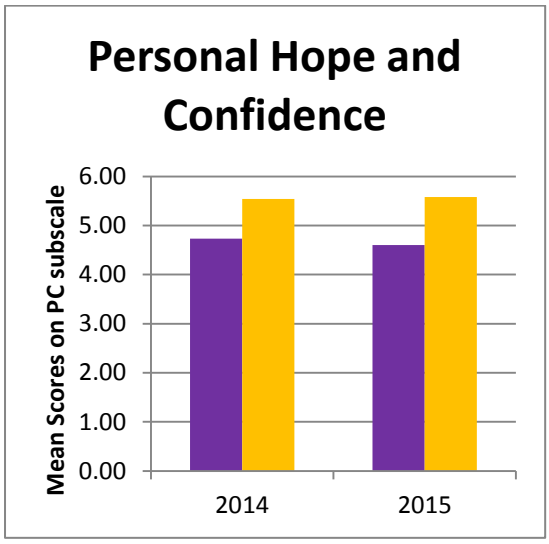
Table 1: Pre and Post Intervention Mean scores on RAS

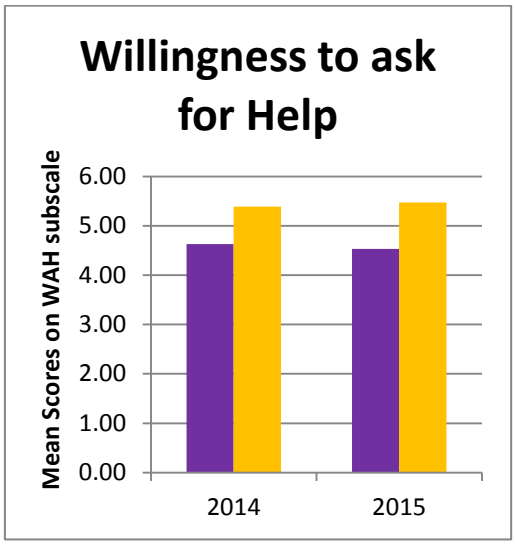
RAS	Pre *Mean (SD)*	Post *Mean (SD)*	*Z value*	*P*	*Cohen's r*
Personal confidence	4.59 (1.01)	5.62 (.71)	6.37	.000	.53
Willingness To Ask For Help	4.47 (1.06)	5.44 (.83)	6.01	.000	.50
Ability To Rely On Others	5.03 (.85)	5.60 (.70)	5.02	.000	.42
Not Dominated By Symptoms	4.60 (1.18)	5.50 (.80)	6.05	.000	.50
Goal and Success Orientation	4.99 (1.00)	6.04 (1.84)	5.63	.000	.47

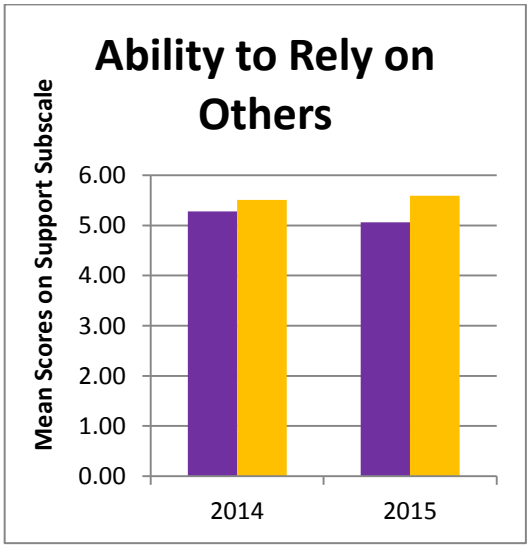
RAS = Recovery Assessment Scale.

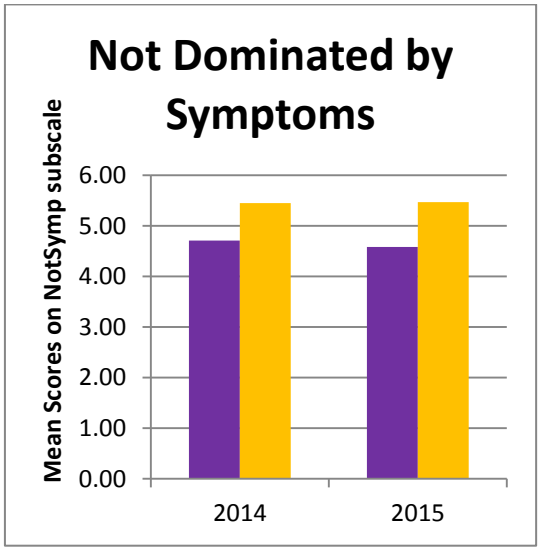
Scores on each of the 5 subscales improved significantly from pre to post measurement (see the graphs below). Medium to large effect sizes were evident for all of the 5 subscales, 'Personal Confidence and Hope', 'Willingness to Ask for Help', 'Ability to Rely on Others', 'Not dominated by Symptoms' and 'Goal and Success Orientation' (*r* = .53, .50, .42, .50, .47 respectively).

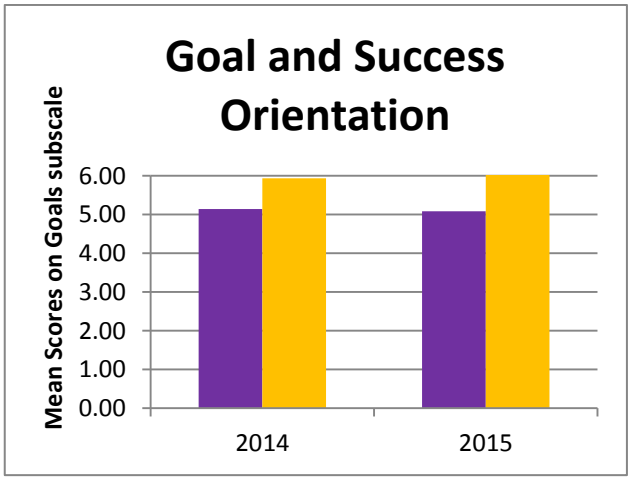
Graphs: Recovery Assessment Scale sub-scales







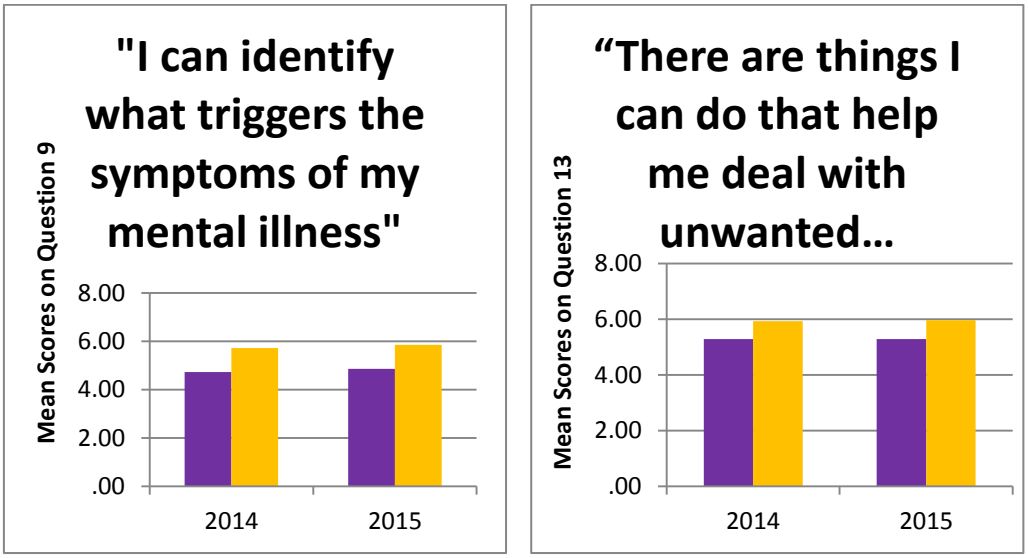




From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 “I can identify what triggers the symptoms of my mental illness”, item 13 “There are things I can do that help me deal with unwanted symptoms” and item 41 “It is important to have healthy habits”.

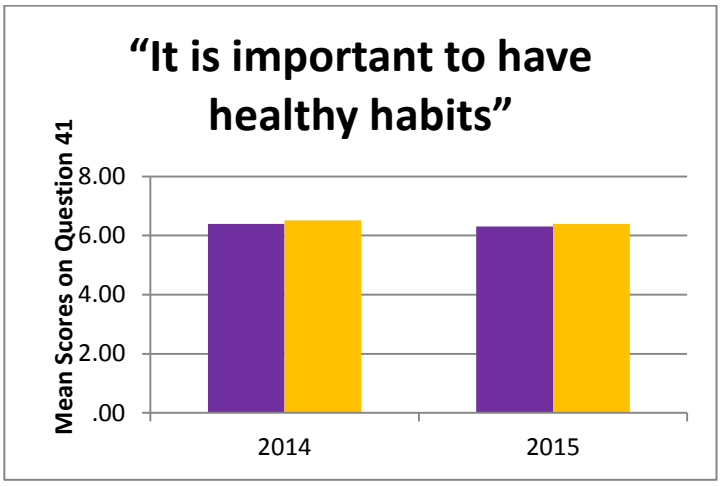
A series of Wilcoxin Signed Rank tests were run and scores on two of the items improved significantly, $p<0.001$, from pre to post measurement (see the following graphs). These two items 9 and 13 evidenced medium effect sizes, $r = .41$ and .36, respectively.

Graphs: Recovery Assessment Scale sub-scales



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).

Graph: Recovery Assessment Scale sub-scale



4.14.4. Summary

Despite a slight decline from 76% in 2014 to 75% in 2015, completion rates for 2015 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 on each of the 5 subscales of the RAS. These improvements demonstrated medium or large effect sizes. This is an improvement on 2014, where only 4 of the subscales were significantly improved at post intervention.

In addition, two of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements at post intervention, both with medium effect sizes.

4.15. Willow Grove Outcome Measures

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 and comfortable environment to young people between the ages of 13 and 17 years who are experiencing mental health difficulties. The Unit is an approved centre accepting voluntary and involuntary admissions.

The team consists of medical and nursing personnel together with Clinical psychologists, Cognitive behavioural therapists, Social worker/Family therapist, Occupational therapist, Registered Advanced Nurse Practitioner, and teaching staff.

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

Our Treatment Approach

Care is delivered from a multidisciplinary perspective. The unit provides a group programme in addition to individual therapy and treatment focuses on skills to assist and maintain recovery and promote personal development. Groups include Psychotherapy, Self Esteem, Assertiveness, Life skills, Communication Skills, WRAP Group, Advocacy, Music, Drama, Gym, and activity/creative groups. Education is also a central component of the programme and tailored for individual needs.

4.15.2 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.

4.15.3. Descriptors

There were data available for 78 patients who were admitted in 2015. Of those, there were gender data available for 69 participants, of whom 68.1% were female and 31.9% were male. The age ranged from 12- 18 years, with a mean of 15.97 (SD=1.48).

4.15.4 Results

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

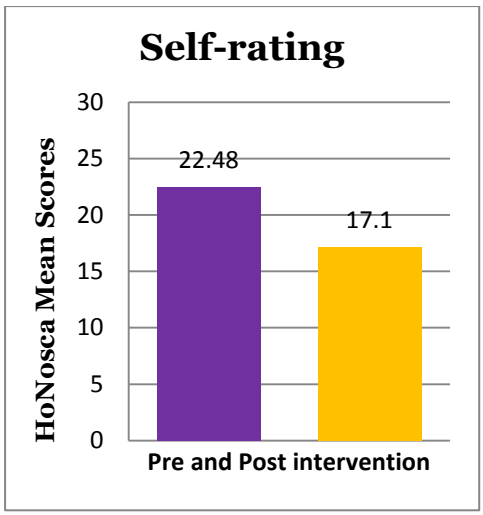
	Pre	Post	*t*	*df*	p	*d*
Client Rated	22.48 (8.98)	17.10 (9.63)	3.02	30	.005	.58
Clinician Rated	8.63 (5.45)	8.88 (4.22)	1.06	7	.918	-
Mother Rated	22.96 (8.25)	14.63 (8.34)	4.95	26	.000	1.00
Father Rated	19.53 (5.90)	10.47 (7.41)	4.01	14	.001	1.35

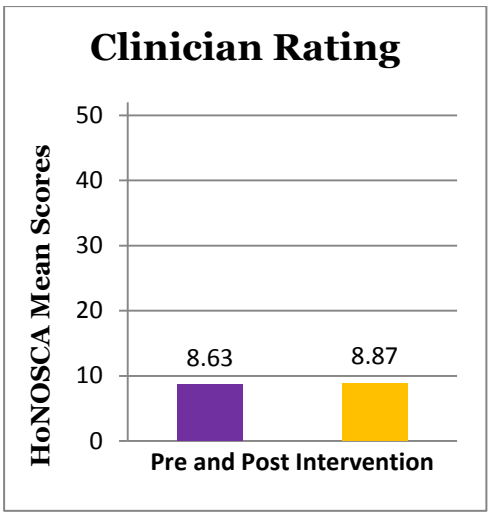
In order for the analysis to be run, each participant had to have a pre and a post score on the measure. Hence, the completion rates reported are not representative of all the data in the sample, but rather relate solely to the complete data, which can be analysed in this way.

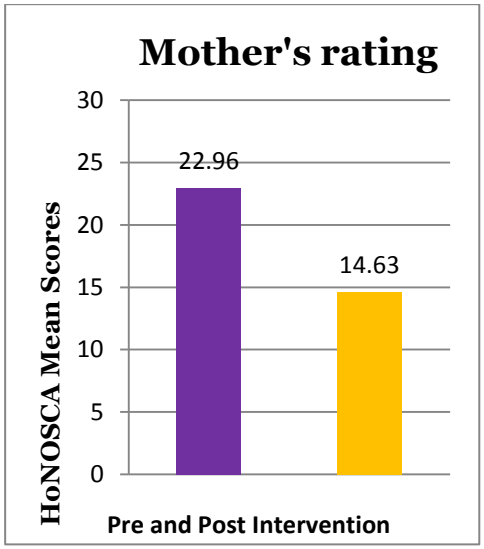
A significant decrease between total scores for the self-rated HoNOSCA was apparent at the post intervention time point ($t(30) = 3.02$; $p = <.01$), reflecting a medium effect size (Cohen's d: .58). There was no significant difference identified on clinician's rated HoNOSCA scores at the post intervention time point ($t(7) = 1.06$, $P = > .05$).

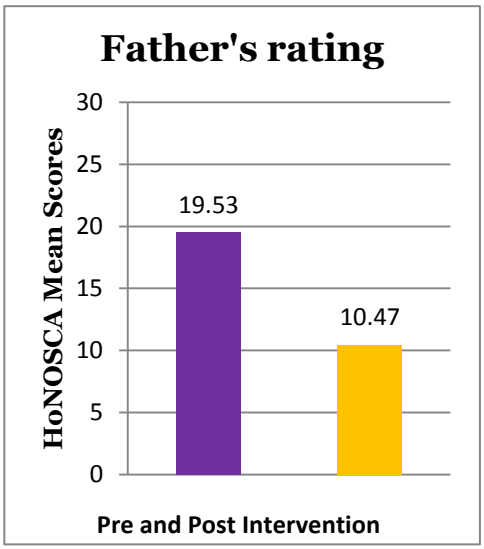
A significant decrease in total scores was also identified post intervention on mother's rated HoNOSCA (t (26) =4.95, p=<.001), which had a large effect size (Cohen's d: 1.00); and on father's rated HoNOSCA (t (14) = 4.01; p=<.01), which had a large effect size (Cohen's d: 1.35).

Graphs: Health of the Nation Outcome Scales for Children and Adolescents sub-scales









4.15.5. Summary

Willow Grove outcomes were captured using the Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA). Significant improvements were identified post intervention on the self-rated HoNOSCA, medium effect size and on mother and father rated HoNOSCA, both large

effect sizes. There was no significant differences identified post intervention on the Clinician rated HoNOSCA.

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. Hence, the absence of correlation between the self-rated and clinician rated scores in 2015 were not unforeseen.

It is of note that in 2015, the response rates on the HoNOSCA were low and as such these results should be interpreted with caution.

The clinical team have noted that completion of the HoNOSCA may not be a priority for the adolescent prior to their discharge and they also recognised that often only one parent will collect an adolescent from the unit, which means that both parents discharge data is not being captured.

The MDT are actively considering ways that data collection at discharge could be improved. Hence, it is anticipated that response rates will improve in 2016 and that it will be possible to conduct further analysis on the data to identify the breakdown of the pertinent presenting problems.

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 2016.

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 was developed and is distributed to service users who attend the Dean Clinics, Inpatient, and Day Programme services. This report outlines the views of a portion of Dean Clinic, Inpatient, and Day Programme service users from January to December 2015. The results of the service user satisfaction survey are collated for the first six months of each year and for each full year, to provide management and the board of governors' valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

5.1.2 Survey design

The report is structured to reflect the design of the survey, whereby responses of each survey question 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. Subsequent adaptations were made to include topics which appear to be 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 subsequently adapted from the Inpatient survey and tailored to collect data regarding the respective services.

One of the priorities of this project was that all service users would be made aware that participation was voluntary and anonymous. Collected data was managed using the SPSS statistical package, and descriptive graphs were created using Excel.

5.1.3 Data collection

The three surveys for the Dean Clinics, Inpatient, and Day Programmes were continually distributed from January to December 2015, in order to gather information about service users' journey through St Patrick's Mental Health Services, thus engaging a system in which service users can offer feedback and take an active role in the provision of their care. The employment of the Service User's Satisfaction Survey is part of a larger quality improvement process undertaken by St Patrick's Mental Health Services. Data collection across SPMHS is continually facilitated as a key strategic objective to improve services.

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, and those whom Dean Clinic administration staff felt may have been too unwell to complete the questionnaire.

Inpatient Adult Services

All service users discharged between January and December 2015 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge or by post following discharge.

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 it in person, or by post, to St Patrick's Mental Health Services.

5.1.4. Findings

5.1.4.1. Dean Clinic (Community Services)

***Percentage of surveys received from Dean Clinics*:**

Dean Clinic	n	%
St Patrick's	18	51.4
Sandyford	6	17.1
Capel Street	0	0
Donaghmede	1	2.9
Galway	3	8.6
Lucan Adolescent	0	0
Cork	6	17.1
Lucan Adult	1	2.9
No Answer	0	0
Total	35	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	5	14.3
<2 weeks	2	5.7
<1 month	13	37.1
<2 months	3	8.6
>2 months	4	11.4
>4 months	2	5.7
No Answer	6	17.1
Total	35	100

Were you seen at your appointment time?

34.3% of respondents reported being seen on time, 14.3% of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic and 25.7% of respondents reported a half hour wait for their appointment on arrival to the clinic. Cumulatively 78.8% of respondents were seen within half an hour of their appointment time.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	12	34.3
Seen within 15 minutes	5	14.3
Seen within a half hour	9	25.7
Seen within hour	5	14.3
Seen within over 2 hours	2	5.7
No Answer	2	5.7
Total	35	100

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?	34	97.1	1	2.9	0	0	0	0
Did a member of the clinic staff explain clearly what would be happening?	30	85.7	4	11.4	0	0	1	2.9
Were you told about the services available to you to assist you in looking after your mental health?	25	71.4	4	11.4	3	8.6	3	8.6

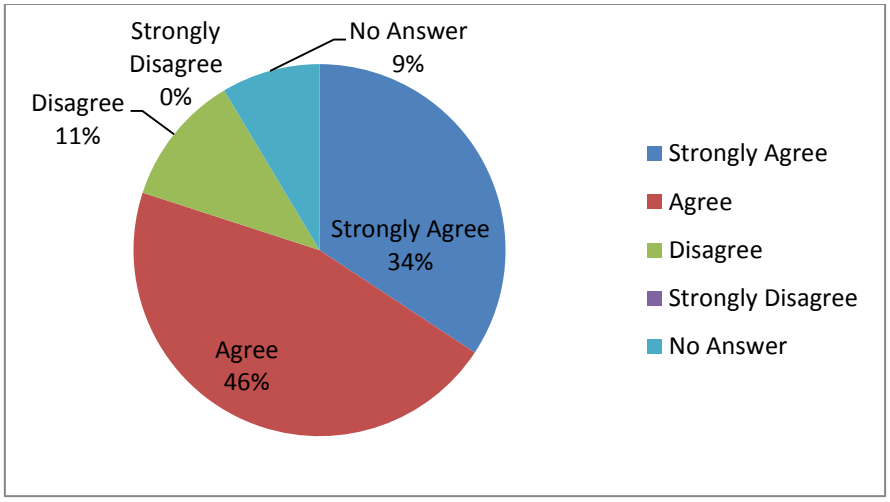
Tell us about your experience of care and treatment at the clinic following assessment

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	29	82.9	1	2.9	1	2.9	0	0	4	11.4
Treated with dignity & respect	32	92.4	2	5.7	0	0	0	0	1	2.9
Confidentiality was protected	28	80	2	5.7	0	0	1	2.9	4	11.4
Privacy was respected	30	85.7	1	2.9	0	0	1	2.9	3	8.6
Staff were courteous										
Felt included in decisions about my treatment	28	80	2	5.7	0	0	0	0	5	14.3
Trusted my doctor/therapist/nurse	30	85.7	1	2.9	0	0	0	0	4	11.4
Appointments were flexible	22	62.9	5	14.3	1	2.9	0	0	7	20

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



How would you rate the Dean Clinic facilities?

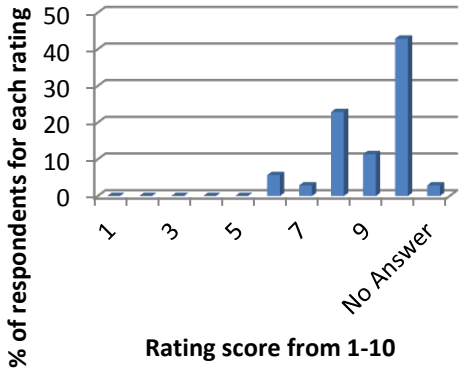
Respondents were asked to rate Dean Clinic facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Dean Clinic facilities, with all means above 8. Furthermore the standard deviation was below 2 across all four areas

showing small variation between responses, i.e. the majority of respondents responded favourably and similarly (see Table below).

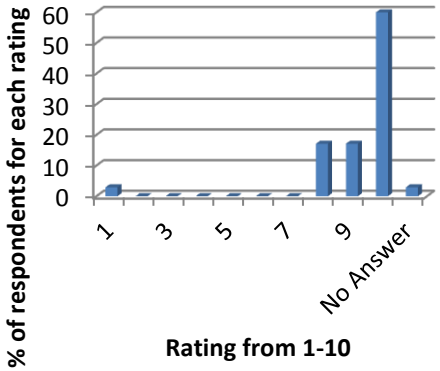
Respondents' scores of Dean Clinic facilities

Rate the following in relation to the Clinic…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	34	8.65	1.52
Cleanliness of Clinic	34	9.21	1.65
Calmness of environment	33	9.18	1.21
Welcome environment	33	8.79	1.65

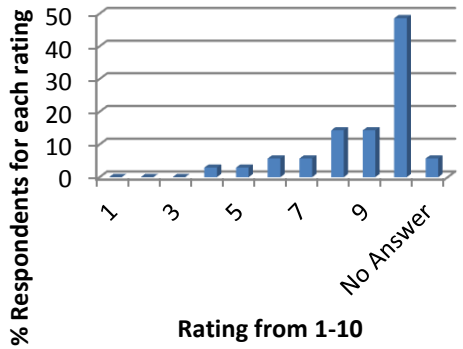
Clinic's decor/furniture



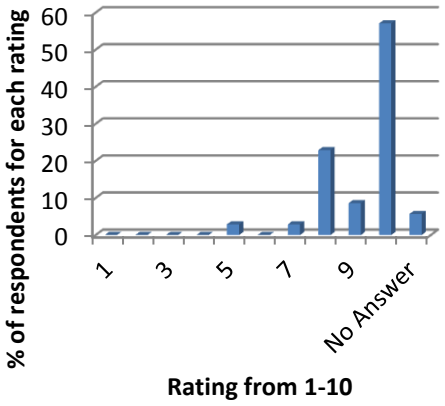
Cleanliness of the clinic



How welcoming was the clinic environment



How calm was the clinic 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=35; SD=1.5). Respondents also indicated a high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.7 (N=35; SD=1.5).

Table: *Respondents' ratings of: a) Care & Treatment b) The Overall Dean Clinic*

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	%	n	%
1	0	0	0	0
2	0	0	0	0
3	0	0	0	0
4	0	0	1	2.9
5	3	8.6	1	2.9
6	0	0	0	0
7	2	5.7	4	11.4
8	8	22.9	7	20
9	7	20	7	20
10	15	42.9	15	42.9
No Answer	0	0	0	0
1-5	3	8.6	2	5.7
6-10	32	91.4	33	94.3
Total	35	100	35	100

Table: *Respondents' ratings of: a) Care & Treatment b) The Overall Dean Clinic*

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	35	8.7	1.5
Overall, the Dean Clinic	35	8.7	1.5

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:

- "Very pleased that my GP referred me here. It is the right place for me to be".
- "I felt I was able to contact my psychiatrist on the same day via telephone if necessary". This greatly enhanced my feeling of security at the dean clinic.
- "I felt very well looked after and was assured I would get well".
- "Follow up was appreciated".
- "(Consultant) and team were an invaluble part of my recovery. Their patience and understanding was second to none. I don't think I would be alive today if I had not found Dean Clinic Cork".

Comments to learn from include:

- "I think the clinic is more beneficial if you live in or near Dublin. Community based services are poor, though this is understandable"
- "Sometimes phones can be unanswered for prolonged periods but understandable given high volume. More resources for receptionist".
- "More information needed to be given about aftercare".
- "It is very tiring and had to wait for over an hour for the Consultant, especially as I travel a long distance".
- "I understood my mother would be seeing (Consultant) but was told on arrival it would be a Registrar. This visit is a huge drama for my mother who would not have made the journey to have a consultation with any one other than (Consultant)".

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

- "I have always found that the receptionists are really helpful and friendly".
- "I was treated with respect and dignity".
- "Worked appointments around my finanical situation".
- "Overall my entire care at Dean Clinic was a very positive experience".

- “This is the first time I attended any kind of therapy. I found (Senior Psychologist) and team extremely encourging and calming and gave me some encourgement for the future”.
- “Felt listened to and great understanding of my situation for the first time”.
- “(Consultant) was extremely polite and understanding as too were the rest of his team”.

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

Comments to learn from include:

- “better time management”.
- “Run the appointment system on time. It seems like several people are booked for the same slot”.
- “I would really appreciate having routine reviews via skype or other internet-based contacts. Avoid long expensive car journeys”.
- “It would be helpful if continued (affordable) psychological therapy was available from the Deans clinic after group therapy programmes come to an end as finding a good psychologist outside of St Patricks services is difficult (plus St Pats have your files and know your history.) ”.
- “Create more clinics local to patients. Many had travelled long distances”.

Positive Comments:

- “No improvements necessary”.
- “Can‘t think of any improvements fantastic facility”.

5.1.4.2 Adult Inpatient Services

Demographics

Service users discharged between January and December 2015 from adult inpatient services were given the opportunity to return the satisfaction survey prior to discharge or by post following discharge. 2996 discharges were processed in 2015, with a total of 399 (13.3%) surveys being returned to St Patrick's Adult Inpatient services. The response rate relates to the number of discharges, rather than the number of people discharged. When the number of individual people discharged (1911) is considered then the response rate increases to 21%. SPMHS is actively working on methods to improve response rates for 2016.

Table: *Number of adult inpatient surveys returned and discharges in 2015*

Month	Surveys Returned	Discharges
January	31	207
February	34	230
March	52	226
April	39	244
May	30	268
June	50	286
July	19	271
August	5	236
September	21	246
October	26	272
November	41	221
December	51	289
Total	399	2996

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 '1-2 weeks' (25.1%), and between '4-7 days' (24.3%), (see table below). 18.3% waited <1 day.

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

Waiting Time	n	%
<1 day	73	18.3
1-3 days	78	19.5
4-7 days	97	24.3
1-2 weeks	100	25.1
3-4 weeks	34	8.5
Don't know	9	2.3
No answer	8	2
Total	399	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, with 65.9% of respondents endorsing this time period (see table below).

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

Waiting Time	n	%
<1 hr	263	65.9
1-2 hrs	79	19.8
2-3 hrs	24	6.0
3-4 hrs	10	2.5
>4 hrs	8	2.0
Don't know	5	1.3
No answer	10	2.5
Total	399	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 hrs' (32.8%) and ''2-3 hrs' (22.1%) (see table below).

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

Waiting Time	n	%
<1 hr	86	21.6
1-2 hrs	131	32.8
2-3 hrs	88	22.1
3-4 hrs	40	10.0
>4 hrs	35	8.8
Don't know	8	2.0
No answer	11	2.8
Total	399	100.0

"Tell us about your experience of admission."

Table: *Respondents' opinions 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?	303	75.9	57	14.3	29	7.3	10	2.5
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	297	74.4	51	12.8	38	9.5	13	3.3
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	314	78.7	53	13.3	25	6.3	7	1.8
Were you given written information about the Hospital and the services provided?	233	58.4	125	31.3	34	8.5	7	1.8

"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	332	83.2	16	4.0	10	2.5	21	5.3	20	5.0
I was involved in the development of my care plan	237	59.4	51	12.8	56	14	27	6.8	28	7.0
I was offered a copy of my care plan	176	44.1	37	9.3	119	29.8	28	7.0	39	9.8
I was involved in the review of my care plan	205	51.4	53	13.3	73	18.3	29	7.3	39	9.8
There was a focus on recovery in the care and treatment offered	290	72.7	35	8.8	19	4.8	19	4.8	36	9.0
My care plan is key to my recovery	273	68.4	49	12.3	25	6.3	22	5.5	30	7.5

Service users' perceptions regarding their understanding, involvement and engagement in their care plan has been a significant focus for the organisation over recent years. The concept of a care plan isn't familiar for many service users, particularly those being admitted for the first time. There has been on-going work at multidisciplinary team level to inform service users' and facilitate their involvement and engagement in their care planning process. Education and information regarding care planning, key working, recovery focus and multidisciplinary teams has also been on-going on an organisational level through a regular morning lecture and information booklets provided to all service users' on inpatient admission. This on-going focus has produced positive results, for example, as can be seen above 83.2% reported that they understood what a care plan is (76.6% in 2014) and 59.4% reported that they were involved in the development of their care plan (53.4% in 2014).

"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	312	78.2	2530	7.5	38	9.5	1	0.3	18	4.5
Registrar	272	68.2	51	12.8	46	11.5	5	1.3	25	6.3
Key Worker	198	49.6	58	14.5	85	21.3	8	2.0	50	12.5
Nursing Staff	312	78.2	22	5.5	25	6.3	3	0.8	37	9.3
Psychologist	136	34.1	40	10	73	18.3	30	7.5	120	30.1
Occupational Therapist	170	42.6	58	14.5	53	13.3	21	5.3	97	24.3
Social Worker	117	29.3	52	13	68	17	39	9.8	123	30.8
Pharmacist	107	26.8	72	18	64	21.116	36	9	120	30.1
Other	99	24.8	42	10.5	52	13	34	8.5	172	43.1

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

Waiting Time	n	%
<1 week	95	23.8
1-2 weeks	50	12.5
2-3 weeks	23	5.8
>3 weeks	56	14
Not on programme	82	20.6
No Answer	93	23.3
Total	399	100.0

There was a positive increase from last year's report in the number of people who stated they waited less than one week to attend a programme, 23.8% in 2015 from 12.7% in 2014.

Tell us about your care…

Table: *Respondents' experiences 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	268	67.2	71	17.8	17	4.3	5	1.3	38	9.5
Treated with dignity and respect	271	67.9	78	19.5	13	3.3	4	1.0	33	8.3
Protected my confidentiality	328281	70.4	79	19.8	9	2.3	0	0	30	7.5
Respected my privacy	283	70.9	78	19.5	6	1.5	1	0.3	31	7.8
Were courteous	279	69.9	71	17.8	8	2.0	3	0.8	38	9.5
Felt included when my team discussed medical issues at my beside / in my room	244	61.2	84	21.1	20	5.0	9	2.3	42	10.5
Respected me as an individual	271	67.9	79	19.8	9	2.3	6	1.5	34	8.5

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?	340	85.2	25	6.3	2	0.5	32	8
Do you think you were given enough notice of your discharge from hospital?	339	85	28	7.0	1	0.3	31	7.8
Do you have a discharge plan?	327	82	29	7.3	24	6.0	19	4.8
Do you know what to do in the event of a further mental health crisis?	306	76.7	46	11.5	7	1.8	40	10

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?	345	86.5	43	10.8	2	0.5	9	2.3
Did you attend any of the activities in the evenings and at weekends?	260	65.2	113	28.3	3	0.8	23	5.8
Was there a range of activities that you could get involved in?	345	86.5	32	8	6	1.5	16	4
At the weekend were there enough activities available for you?	143	35.8	199	49.9	22	5.5	35	8.8

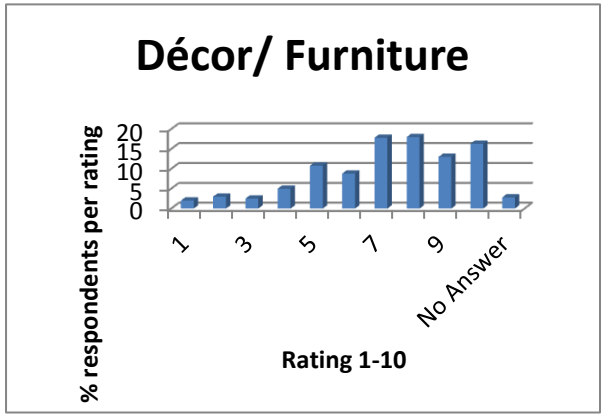
The majority of respondents felt that there was a range of activities they could get involved in (86.5%). However, 49.9% indicated that there were not enough activities available in the hospital at weekends.

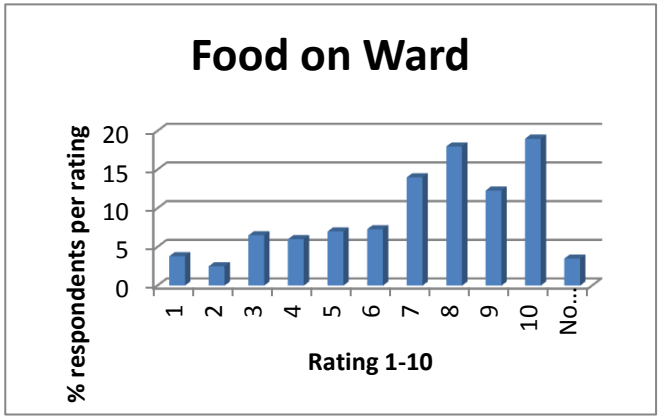
Tell us about your experience of hospital facilities…

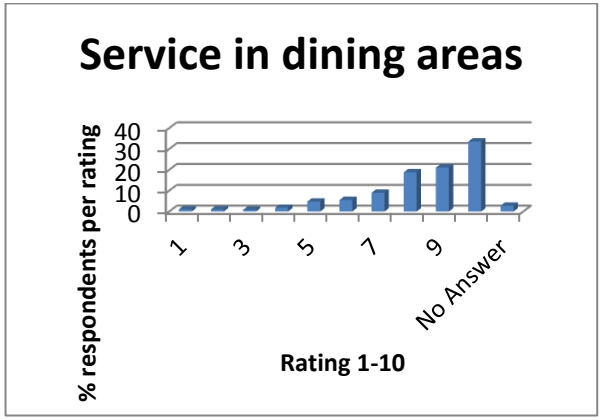
A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with most means above 8. In particular, the cleanliness of the ward (8.7) and Communal areas (8.5) received high scores as well. The standard deviation across most areas was close to 2 indicating that there was significant variation in responses.

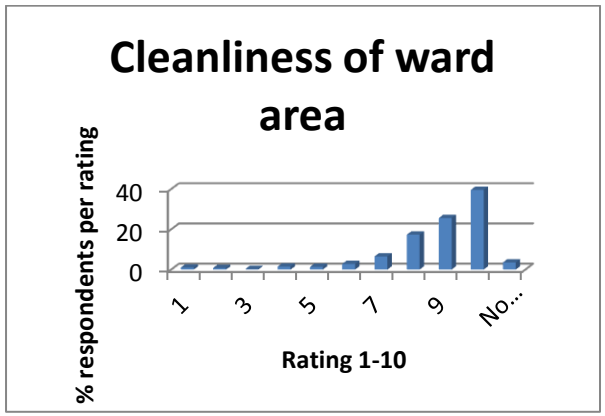
Table: *Respondents' scores of Hospital facilities*

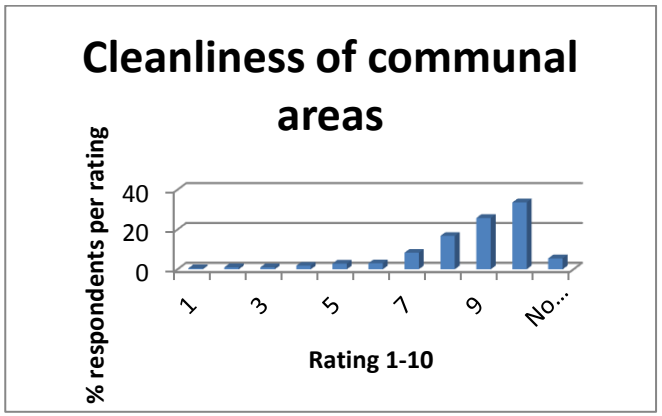
Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	388	7.1	2.3
Food on Ward	385	7	2.6
Service in ward dining areas	388	8.3	1.9
Cleanliness of ward areas	385	8.7	1.7
Cleanliness of Communal areas	377	8.5	1.8
Hospital Facilities	364	8.1	2.0
Garden Spaces	384	8.3	1.9

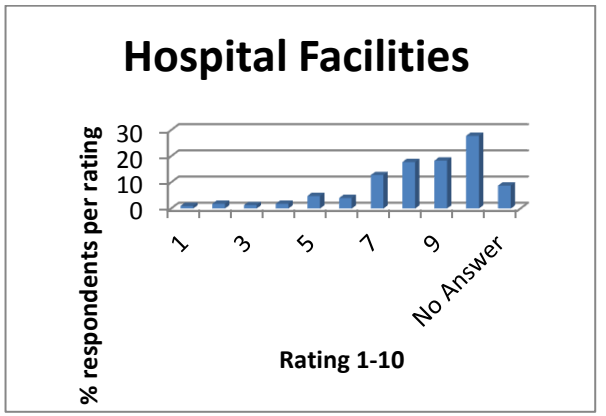

Décor/ Furniture
% respondents per rating
20
15
10
5
0
1
3
5
7
9
No Answer
Rating 1-10

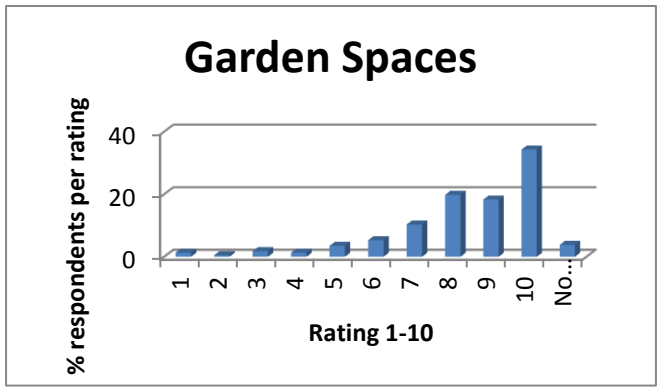

Food on Ward
% respondents per rating
20
15
10
5
0
1
2
3
4
5
6
7
8
9
10
No...
Rating 1-10


Service in dining areas
% respondents per rating
40
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


Cleanliness of ward area
% respondents per rating
40
20
0
1
3
5
7
9
No...
Rating 1-10


Cleanliness of communal areas
% respondents per rating
40
20
0
1
3
5
7
9
No...
Rating 1-10


Hospital Facilities
% respondents per rating
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


Garden Spaces
% respondents per rating
40
20
0
1
2
3
4
5
6
7
8
9
10
No...
Rating 1-10

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 disclose to 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 (80.5%) and towards their own mental health difficulties (82%) and felt that they would share with others that they received support from St Patrick's (74.4%).

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	%
Are your views regarding mental illness in general more positive than they were?	321	80.5	27	6.8	29	7.3	22	5.5
Are your views regarding your own mental illness more positive than they were?	327	82	29	7.3	24	6	19	4.8
Will you tell people that you have stayed in St Patrick's?	297	74.4	51	12.8	35	8.8	16	4

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 8.5 (N=381; SD=1.9). Respondents also demonstrated a high level of satisfaction with the Hospital overall, rating the Hospital on a scale of 1 to 10, with a mean of 8.7 (N=389; SD=1.6).

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	9	2.3	3	.8
2	2	.5	1	.3
3	4	1	4	1
4	3	.8	1	.3
5	9	2.3	5	1.3
6	15	3.8	15	3.8
7	39	9.8	41	10.3
8	72	18	83	20.8
9	82	20.6	73	18.3
10	146	36.6	163	40.9
No Answer	18	4.5	10	2.5
1-5	27	6.8	14	3.5
6-10	354	88.7	434	94
Total	399	100.0	399	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	381	8.5	1.9
The Hospital	389	8.7	1.6

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 service 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:

- "Had never been in hospital before, was terified but it was pleasant for me. Got support through the helpline before I went in and that helped alot."
- "I arrived at the hospital to get my blood work done. I mentioned to the nurse that I wasn't feeling well, I was feeling very low. The nurse arranged for me to be assessed and was subsequently admitted. I was very grateful for this quick turn around."
- "I felt very safe in the hospital."
- "Generally positive and there are a good selection of programmes available."
- "I found my stay completely changed my perception and attitude to mental health and mental illness for the better. I feel very positive now."

Comments to learn from include:

- "Restaurant prices are high."
- "Did not meet my key worker for 2 weeks. He did not know he was my key worker I had to tell him after I got confirmation from the nurses. "
- "I am on a restricted diet and I felt it was not well catered for. "
- "I think it should be emphasised in lectures/programmes that some recovery /self help techniques may or may not be suitable depending on stage of illness."
- "At the weekend the hospital can be very quiet, maybe put some films on in places like the lecture hall. "

Q: Was there anything particularly good about your care?

- "I found the craftroom was helpful and relaxing."
- "The staff. During my stay I did not meet a single staff member who was not caring. Thoughtful, helpful, and understanding".
- "The culture within the hospital with the care team was patient focussed which was very comforting."

- “Communication between MDT members was excellent. Empathy and compassion from MDT was second to none. Socialising with other patients was helpful for my recovery - sense of belonging that you are not alone. ”
- “As outlined in this survey, I found everthing in St Patrick's to be very positive. I felt respected as an individual and as a person and that my treatment and recovery was important to the professional team involved.”
- “ Twilight programme and art therapy. ”
- “Cleaning and kitchen staff have been extremely kind and caring. They brighten up your day.”
- “ Lots of programmes lectures and extra cirricular activities to keep my busy. Learned lots about myself and how to change my mental state and prioritise my life and future habits.”
- “Family meetings.”
- “Gluten free diet was always available.”

Q: What could we improve?

- “More activities in evenings and weekends.”
- “Longer gym opening times; art room open more, very little to do at weekends.”
- “Chairs in Delany need to be upholstered. A bit more time to eat meals - rushed.”
- “The smoking areas could be extended and made more accommodating. Like an outdoor patio area if possible.”
- “More leisure facilities for young patients such as pool, table tennis that we're not allowed to use.”
- “Ward coffee machines.”
- “Follow up consultative meeting every 6 months, more support units nationally.”
- “Better and bigger shop.”
- “Waiting lists for programmes, maybe more dean clinics in rural areas, involvement of GP in future care plans.”
- “Quality of food was very poor - should be as least as good as Ridgeways cafe.”
- “An ATM would be very helpful.”

- “Improve showers.”
- “Dispensing of medication.”
- “Stop the cleaners waking people up so early in the morning.”

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	90	10
February	81	16
March	93	9
April	138	42
May	114	30
June	85	21
July	147	33
August	58	21
September	127	41
October	69	33
November	74	22
December	55	13
Total	1131	292

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Mindfulness	100	34.2
Recovery	65	22.3
Anxiety	5	1.7
Depression	19	6.5
St Edmundsbury	26	8.9
Alcohol Step Down	0	0
Bipolar	13	4.5

Living Through Distress	0	0
Other	30	10.3
Eating Disorder	5	1.7
Radical Openness	11	3.8
Young adult	0	0
Pathways to Wellness	1	0.3
No answer	17	5.8

The "Other" programmes included in the table above, include; Compassion Focused Therapy, Self-Esteem, Roles in Transition and Living with Psychosis.

89% of respondents reported living in Leinster.

Province	n	%
Connaught	10	3.4
Leinster	260	89
Munster	7	2.4
Ulster	4	1.4
Don't want to say	1	.3
Missing	10	3.4
Total	292	100

The majority of respondents had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. 39.4% had experienced an in-patient stay and 41.4% had attended as an outpatient at the Dean Clinic.

Service	n	%
In-patient stay	115	39.4
Dean Clinic	121	41.4
In-patient day programme	6	2.1
Other day programme	14	4.8
Not applicable	18	6.2
Associate Dean consultation	8	2.7
No answer	10	3.4

Service User Responses

The service users' perceptions of the time they waited for communication from a member of the programme staff, following their referral.

'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	23	7.9
1-3 days	70	24
4-7 days	72	24.7
1-2 weeks	61	20.9
2-4 weeks	29	9.9
More than 4 weeks	19	6.5
No answer provided	18	6.2

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?	224	76.7	24	8.2	31	10.6	13	4.5
When you came to hospital did a member of Day Services explain clearly what would be happening?	243	83.2	14	4.8	26	8.9	9	3.1
When you commenced the programme did a member of staff explain the timetable?	266	91.1	7	2.4	10	3.4	9	3.1
Were you given a written copy of the timetable and other relevant information?	256	87.7	10	3.4	18	6.2	8	2.7

Respondents also generally reported an informed ending to the programme, with 97.5% of valid responses 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 that they had received information regarding the organisation'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?	278	95.2	5	1.7	2	.7	7	2.4
Did the programme meet all your expectations?	239	81.8	31	10.6	11	3.8	11	3.8
Have you been given details of the hospital's support and information service?	248	84.9	22	7.5	9	3.1	13	4.5
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	256	87.7	18	6.2	9	3.1	9	3.1

The Service User Satisfaction Questionnaire also asks for service users' experiences of stigma after having attended St Patrick's.

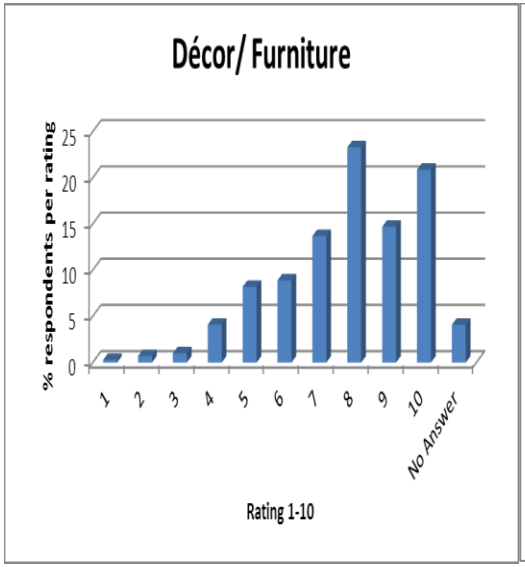
Tell us about your experience of stigma following your attendance at St Patrick's.

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?	258	88.4	11	3.8	11	3.8	12	4.1
Do you feel that your views regarding your own mental health difficulty are more positive than	258	88.4	16	5.5	7	2.4	11	3.8

they were?								
Will you tell people that you have attended St Patrick's	194	66.4	43	14.7	39	13.4	16	5.5

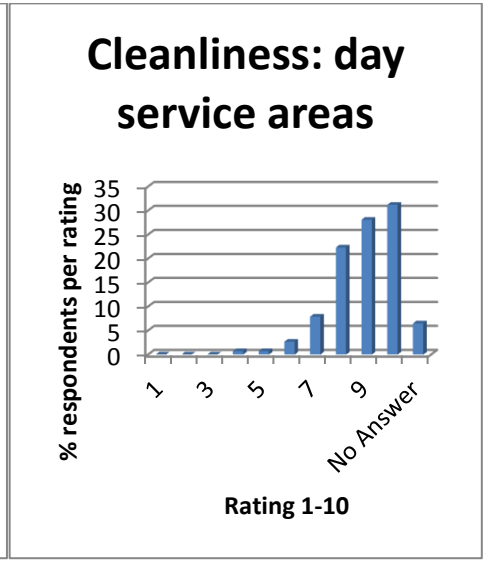
How would you rate the Day Services Facilities?

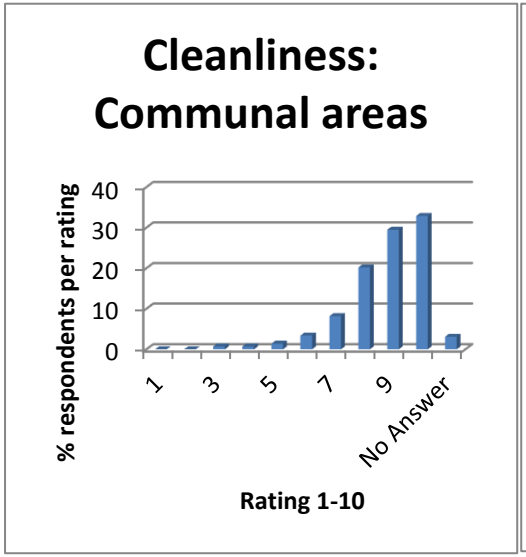
Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of one to ten. For each of the facilities, the most endorsed score was a score of 10. (Please see the following graphical depictions).

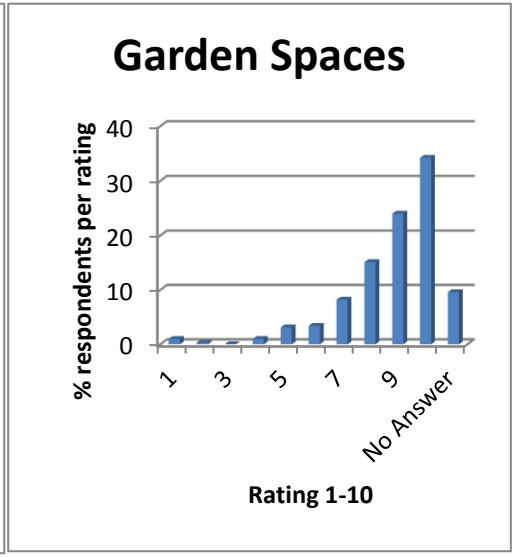

Décor/ Furniture
% respondents per rating
0
5
10
15
20
25
1
2
3
4
5
6
7
8
9
10
No Answer
Rating 1-10


Food/ restaurant
% respondents per rating
0
5
10
15
20
25
1
3
5
7
9
No Answer
Rating 1-10


Parking
% respondents per rating
0
5
10
15
20
25
30
1
3
5
7
9
No Answer
Rating 1-10


Cleanliness: day service areas
% respondents per rating
0
5
10
15
20
25
30
35
1
3
5
7
9
No Answer
Rating 1-10


Cleanliness: Communal areas
% respondents per rating
0
10
20
30
40
1
3
5
7
9
No Answer
Rating 1-10


Garden Spaces
% respondents per rating
0
10
20
30
40
1
3
5
7
9
No Answer
Rating 1-10

Respondents were also asked to rate their care and treatment, and St Patrick's Mental Health Day Services overall, on a scale of 1 to 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	0	0
2	0	0
3	1	.3
4	0	0
5	7	2.4
6	8	2.7
7	18	6.2
8	75	25.7
9	58	19.9
10	110	37.9
No answer	15	5.1
1-5	8	2.7
6-10	284	92.2

92.2% rated their care and treatment between 6 and 10.

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

Score	n	%
1	0	0
2	0	0
3	1	.3
4	2	.7
5	5	1.7
6	12	4.1
7	24	8.2
8	65	22.3
9	59	20.2
10	113	38.7
No answer	11	3.8
1-5	8	2.7
6-10	274	93.5

93.5% rated the St Patrick's Mental Health Day Services overall, between 6 and 10.

Further Service User Views

Lastly respondents were invited to give open-ended feedback to three questions. Not all respondents answered 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 had no experience of group so learned a lot - I was unaware of low self esteem - very engaging work - hard but worthwhile - always treated with respect"
- "I would like to stay engaged to hospital as long as I can . Support and general feeling of involvement"
- "I felt it was beneficial for me"
- "It has helped me greatly/ i was told by (consultant) that I had many vulnerablities but was given the confidence and tools to... describe them to come to terms with them"
- "Once I arrived I was given assurance and a sympathetic view which was appropriate"
- "All very good day service"
- "I enjoyed the programme and I have learned many tools to help me"
- "I always feel that St Ed's is a sanctuary from everything going on"
- "As a person who had problems since early seventies, the programmes that are in place now are much more enlightened and forward looking than when I started my journey in 1972"
- "I was very anxious coming into Eds, On leaving I felt much better and was able to cope with my anxiety"
- "The friendliness of all staff was noticeable, not just the carers i.e. maintenance people. it seems they were all told to be courteous towards patients"
- "I was very happy with all aspects of my day programme"

- “The mindfulness programme gave me tools and insight into what I can change in relation to my own mental health and that I can accept some aspects of my life that I cannot change”.
- “The facilitators were very supportive and excellent, the programme has been very helpful. I had no previous experiences of the service. I would like to know more about public lectures”.
- “Day services has made my life easier and I am very glad I came to the ACT programme”.
- “I found the attitude of staff on the WRAP programme to be encourging. I have felt really listened to as an individual. By being treated this way it has helped me to see myself in a less judgemental way. WRAP has been very beneficial”.

Comments to learn from include:

- “Day could be more compact- theres a lot of breaks”
- “Course was drawn out, could have been shorter”
- “Overall my experience was good but there are a few things I think that need to be improved such as the waiting lists to get onto programmes is far too long, especially when you leave the hospital and don‘t have much other help and you are vulnerable. I also think the nurses need to be more caring”
- “I think my time in St Patrick's has been a rollercoaster experience. I people I have met have got me through alot. I don't have many good things to say about my team but it made me stronger as a person knowing I had to fight for everything was tough when I was unwell”
- “Initial interview was poor, no allowance made for mental state! ”
- “Strong emphasis on medication. I believe more emphasis should be place on 'Talk Therapy'. I stayed in hospital for 4-5 weeks with no access to a psychologist. ”
- “The quality of faciliation was variable from fair to excellent”.
- “Lack of communication amongst team/staff members. Following my finishing the programme I felt a little bit isolated and follow-up could have been better”.

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

- "All aspects were very good".
- "Yes both tutors were excellent Mindfulness and CBT, work well together - follow up available, liked being met by friendly staff at upstairs counter".
- "Lovely friendly staff, very understanding and helpful, before I started WRAP I had call from team to see what support I had over christmas I found this very caring and helpful".
- "The comfort of the facility, the staff in healthcare, the staff in canteen and food, access to a lovely big garden, the gallery exhibitions made my stay more enjoyable".
- "The programme was welcoming and the facilitators were inclusive. the facilitator were interested in ones wellbeing".
- "Really positive things include: the support of everyone involved. feeling of safety, feeling of hope".
- "A facilitator would ring you if you did not attend the group one day to make sure everything was O.K. The notes handed out every week were helpful".
- "The course facilitators were excellent they also were able to advise me on further treatment".
- "Mindfulness team in St Pats are excellent and very encourging".
- "I found the group sessions most beneficial as they helped me see that other people have also had similar experiences and that I am not alone. I also found it beneficial to receive information on other support services within the hospital".
- "The team are excellent, supportive and caring. I felt comfortable, fully respected. .....(*illegible word*) the team group WRAP should be an example to all teams in the hospital, including MDT teams giving .....(*illegible word*) how mental health care should be provided".
- "I think (psychologist) and his team are fabalous psychologists and treated everyone equally respectfully as I now have skills to cope for the future".

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

- " More information given to in-patients. Information available as to what programmes are available".
- "After care meetings maybe 1 month after rather then 6 weeks - 2 months. From the depression recovery course a booklet of the notes at the end would be good".
- "Offer more courses even from those without adequate healthcare cover".
- "The texts reminders should be implemented from the start".
- "More follow up with each patient".
- "Provide follow up of sessions - 6 mnths - 1 yr down the road - same team
- "I did the WRAP programme and found the day was a bit too long/ One hour for lunch was too long".
- "Maybe include your partner more. I think they need to learn more about the illness, its recovery and what to do , not to do to prevent a relapse".
- "It would be great if some courses were scheduled outside of working to avoid stigma and ramifications at work".
- "Invite the patients family members to a review of the outcomes at the end of the program".
- "Would love to have a 'top up', maybe a couple of hours every month for a year- to maintain wellness and stay connected to support system. Would like a more professionnal mindfulness CD".
- "An evening once a month to do mindfulness would be great".

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2015

Willow Grove is the inpatient adolescent unit of St Patrick's Mental Health Services (previously described in this document). The unit has an associated outpatient Dean Clinic located in Lucan, Co Dublin, which also offers assessment and treatment services for adolescents.

The multi-disciplinary team are committed to on-going quality improvement. 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 2015.

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

Parents and young people were asked to complete this measure on the day of discharge. 44 young people and 62 parents/carers completed the questionnaire. Response rates were 52% and 74% respectively.

In 2015, a shortened questionnaire was introduced for the first time, which was given to young people and their parents on the day of discharge. This was in an attempt to increase the response rate to this survey, which may account for the increase in available data compared to 2014.

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 preceded 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

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 was directed to the young person or to their parent/carer. For example; *'your experience of the care and treatment you received'* compared to *'your experience of the care and treatment your child received'*.

Overall the young people and the parents who answered the survey appeared pleased or very pleased with the service. The majority of median responses for young people were a 4 'Good' (76.5%), followed by 5 'Very good' (5.9%) and 3 'Average' (5.9%). For the parents/carers, the most common response across questions was 4 'Happy (79.4%), followed by 5 'Very happy' (14.9%).

The least positive answers given by service users were in relation to information about the service and meals provided, where parents/ caregivers rated these more favourably. Service users rated 5 ‘very happy’ on items including cleanliness of the unit, safety of the unit and access to educational support, while parents/ caregivers rated 5 ‘very happy’ on the overall environment, cleanliness of the unit, the safety of the unit, access to key workers/allocated nurse, opportunity to attend discharge review meeting.

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

Please tell us how satisfied you were with aspects of our service	Median rating	
	Young person	Parent/ Carer
Experience of accessing the service	4	4
Information received prior to admission	3·5	4
Information provided by St Patricks website	3	4
The process of assessment and admission	4	4
The information given on admission	4	4
The environment and facilities	4	5
The overall atmosphere (or feel) of the unit	4	4
The cleanliness/ appearance of the unit	5	5
The meals provided	3	4
Visiting arrangements	4	4
Safety arrangements on the unit	4·5	5
Experience of care and treatment	4	4
Access to group therapy	4	4
Access to individual therapy	4	4
Access to leisure activities and outings	4	4
Access to a range of professionals	4	4
Access to key workers/allocated nurse	4	5
Access to educational support	5	4
Access to an independent advocacy group	4	4
Your level of contact with the treatment team	4	4
Information received (parent) on treatment plan	4	4
Your involvement (young person)/ collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4	4
How you felt you were listened to/ respected	4	4
Confidentiality of service	4	4
Opportunity to attend discharge planning meeting	4	5
Your preparation for discharge	4	N/A
Weekend/midweek therapeutic leave arrangements	4	4·5
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	4	4
Provision of family support	4	4
Opportunity to attend parents support group	N/A	4
Opportunity to attend Positive Parenting Course	N/A	4
Was your/ your child's stay helpful in addressing mental health difficulty?	4	4

Further Service User Views

The Willow Grove Service User satisfaction survey 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 provided by both young people and their parents/caregivers.

Q: What did you like best about the unit?

Young people:

- "The Patients. nurses".
- "The young people and staff and having my own room".
- "The other young people. The staff were helpful".
- "The young people and access to help or key workers to talk to"
- "The young people, structure and routine".
- "The young people and group therapy".
- "Knowing somebody was there for me when I felt low".
- "Activities on site, eg walks. Time spent with young people".
- "The vibe that it wasn't treated as a hospital".
- "The support that is always there for you. The nurses always dropped everything to talk to you or help you".
- "Young people and the safety".

Parents/ caregivers:

- "Allowed my child a safe, pleasant positive approach to addressing his mental health difficulties and accessing a range of treatments and therapies among adolescents of his own age".
- "The therapies were excellent for our son's needs. I like the fact that it was intensive for his duration here".
- "The physical layout is bright, modern aand cheerful. My daughter seemed to develop a good rapport with all of the professionals involved in her care. I got the feeling they knew what they were doing and had a definite plan etc, which gave me confidence".

- “Happy that my child was socialising and getting daily support”.
- “How friendly everyone was, how friendly staff and patients were to my daughter”
- “Opportunity to get help from a broad range of specialists”
- “I like the facilities and the diversity of discipline available to the children”.

Q: What did you dislike about the unit?

Young people

- “Nothing really, it's a pretty good place”.
- “They don’t treat you with respect and assume you are doing something wrong”.
- “Not knowing how long my stay was”.
- “Some staff were rude and mean to myself and others”.
- “The restriction and lack of sense of freedom to even go out to the courts”.
- “The lack of individual therapy nearly the whole programme was done in groups and I would have preferred less group sessions”.
- “I disliked how easy it was to hide items in my room. They don't check properly during enviromentals”.

Parents/ caregivers

- “Nothing really, Keep the good work up”.
- “Some staff here very helpful, other staff were not so helpful. I felt I had to ask for information - no clear pathway or support to help me as a parent to deal with issues”.
- “Nothing other than we didn't have access to family support until 4 weeks after admission. When we did get access it was very helpful”.
- “Possibly the fact that it is a "locked" ward and my child didn‘t pose a safety /flight risk. Can be difficult to attend all their meetings and balance home/work life”.
- “Not much, perhaps for us trying to fit in all the meetings during the day. Found this difficult as work committments”.

- “I would have liked more access to the therapists to give us a better idea if possible of why the disorder occurred and what changes in home life if any would be beneficial”.
- “Lack of communication between staff. To much change in arrangements-re home visits or school, also different opinions from staff on progress, confusing for parents and for patient also”.
- “Not enough individual therapy. Sometimes felt no understanding that others in the family, so difficult to attend all demands made by therapist or hospital”.

Is there anything you would change about the unit?

Young people

- “The food”.
- “Money distribution. Respect for patients”.
- “Go outside more”.
- “Would prefer to be treated as an individual”.
- “If cameras could be put out on the courts, so no nurses are needed , have more fun. Creative things could be done”.
- “Slightly less group work and a bit more individual therapy”.
- “more one to one therapy”.
- “Short Visiting hours”.
- The “no phone” rule.

Parent/ caregiver

- “More access to sport/physical therapy, for those who enjoy the outdoors. More planning with adolescents/parents for successful weekend leave”.
- “I think from my experience that the clinic were doing very well. Not much change needed”.
- “Daughters presence at all meetings sometimes prevented parents being able to ask any questions or seek guidance about how to address specific aspects of childs behaviour or issues arising during treatment. Overall highly satisfied and much better than I could have anticipated”.

- “The communication between team workers and parents was unreliable at times”.
- “Proper feedback on diagnosis and more help for parents on how to cope”.
- “Information regarding/relevant to patients diagnosis appears not to be a priority”.
- “The not taking into account the fact that some families live so far away and the strain of that”.
- “Support groups should be starting at 7pm”.
- “Keyworkers seem to change all the time. I spoke to a different member of staff nearly everytime we returned to Willow after therapeutic leave. I know some of this is due to shift work but I feel a bit impersonal at times”.
- “Alot of confusion about what needed to be done and who's responsibilty / duty of care etc - Clear guidelines on immediate care in the event of an incident”.

SECTION 6

Conclusions

6.1. Conclusions

1. The 2015 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, 2013 and 2014. 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. Clinical outcomes data was added for the Living through Psychosis Programme in 2015. Work was also commenced in 2015 to establish further additional services for the outcome measures in 2016.

3. Clinical and non-clinical staff are once again to be commended for contributions in further establishing routine outcome measurement within services and programmes in 2015. Work will continue in 2016 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.

4. 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. In 2016 there will be the additional option for service users to complete satisfaction surveys online, but hard copies will remain just as acccessible for those who prefer.

5. All clinical programmes involved in publishing their outcomes in the 2015 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 2016 outcomes measurement process.

6. 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. The scope of audit across the organisation was further strengthened in 2015, consistent with the requirements of the Mental Health Commission's Judgement Support Framework.

7. Report Strengths: Few if any other services in Ireland has provided the same level of insight into service accessibility, efficacy of clinical programmes/services and service user satisfaction. The report also demonstrates the organisations willingness and ability to reflect on results and use results to define ways to improve practice. For example, the improvements in this year's results for inpatient service users' perceptions regarding their involvement in the care planning process support the team based and organisation wide efforts to increase service user involvement and engagement with their care planning process. The broad range of measures regarding clinical outcomes, service accessibility and service user satisfaction provide valuable information for the organisation regarding the commissioning and improvement of services.

8. Report Challenges: Not all services within the organisation are reporting clinical outcomes in this report yet, but we are expanding each year. We are not able to benchmark the results of this report as no other organisation similar to SPMHS produces a comparable report. In order to best capture the efficacy of clinical programmes and services, there have been changes in the outcome measures used, which can undermine direct comparisons to previous reports. The report's clinical outcome results cannot be solely attributed to the programme being measured and are not produced to the standard of randomised control trials.

SECTION 7

References

7.1. References

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