St Patrick's
Mental Health Services

Outcomes Report 2013

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

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SECTION 1

Introduction

1. Introduction

The 2013 Outcomes Report is the third report of its type, produced by St Patrick's Mental Health Services (SPMHS), which attempts to collate, analyse and synthesise information relating to the organisation's outcomes with respect to its clinical care pathways, clinical governance processes, clinical programmes and service user satisfaction rates. The purpose of this report is to continue to promote an organisational culture of excellence and quality through engagement in continual service evaluation in relation to efficacy, effectiveness and quality. By routinely measuring and publishing outcomes of the services we provide, we strive to understand what we do well and what we need to continue to improve.

The 2013 Report is divided into 6 Sections. This Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPMHS are structured and were accessed in 2013. This includes how services are accessed through the hospital's three distinct care pathways. SPMHS provides a community and outpatient care pathway through its Dean Clinic Community Mental Health Clinics while the Wellness & Recovery Centre provides day-patient care pathways. Finally, SPMHS's three approved centres provide our inpatient care pathway. These include St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

Section 3 summarises the measures and outcomes of the organisation's Clinical Governance processes. Section 4 provides an analysis of clinical outcomes for a range of clinical programmes and services, a number of which have been added or enhanced since the 2012 Outcomes Report. This information provides practice-based evidence of interventions and programmes delivered to service users during 2013. These outcomes are not generated from research protocols but rather reflect the use and measurement of evidence-based mental health practice across SPMHS.

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

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

SECTION 2

Measures of SPMHS Access.

2. St Patrick's Mental Health Services: Care Pathways (2013)

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our services are accessed through three distinct but integrated care pathways. These include our community care pathway accessed through our Dean Clinic network of community mental health clinics, our day-patient care pathway accessed through our Wellness and Recovery Centre and our in-patient care pathway accessed through our three approved centres. This Section provides information about how our services were accessed through these pathways in 2013.

2.1. Dean Clinic Pathway (2013)

SPMHS's strategy, Mental Health Matters (2008-2013), committed the organisation to the development of community mental health clinics. Over the past five years, a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the organisation. SPMHS operates a total of seven Dean Clinics. Free of charge multi-disciplinary mental health assessments continue to be offered through the Dean Clinic network to improve access to service users. A further Dean development took place in 2013 with the expansion of our community network now including a number of Associate Dean Clinics, where new assessments are carried out on behalf of SPMHS.

2.1.1. Dean Clinic Referrals Volumes (2013)

Seven Dean Clinics have been established to date and provide multi-disciplinary mental health assessment and treatment for those who can best be supported and helped within a community setting and for those leaving the hospital's in-patient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community Mental Health Services, Day Services and Inpatient Care. The Dean Clinics encourage early involvement with mental health services which enhances outcomes. In 2013, there was a total of 1,889 Dean Clinic referrals received from General Practitioners. This compares to a total of 1,759 for the same period in 2012 representing an increase of 9% in referrals made in 2013.

2.1.2. Dean Clinic Referral Source by County (2013)

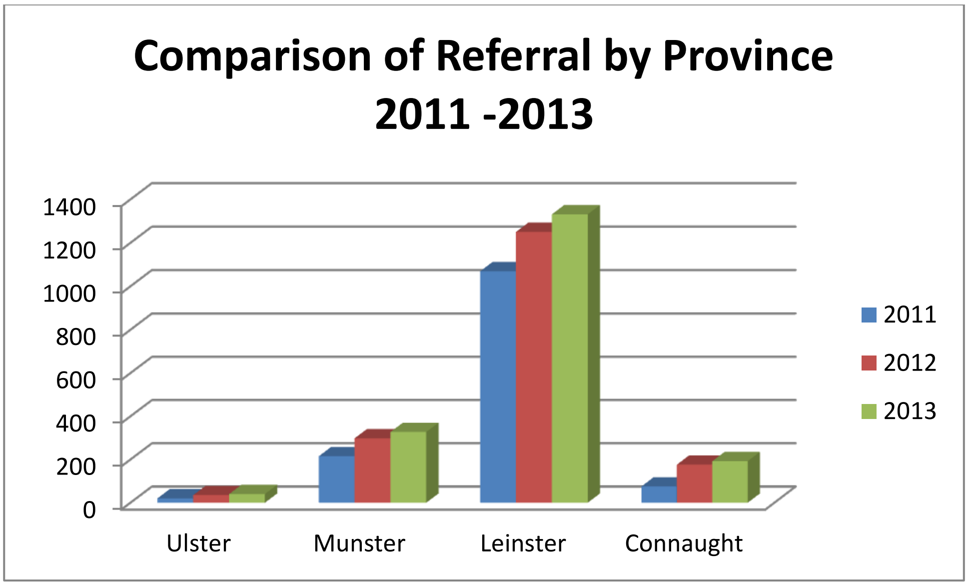
The following table illustrates the geographical spread of Dean Clinic Referrals by county for 2011 to 2013 in ranked order of frequency by county . The highest referral volumes continued to be from Dublin in 2013 with 841 referrals.

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

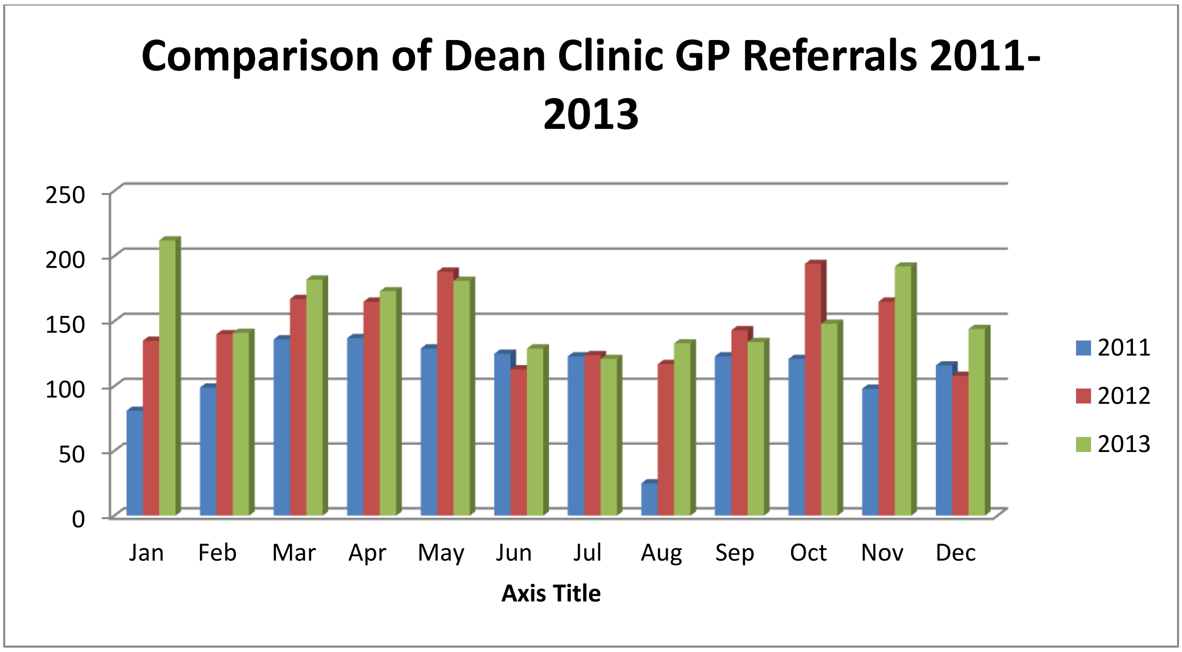
2.1.3. Dean Clinic Referral Source by Province (2013)

The Table below summarises the percentage of Dean Clinic referrals by Province for 2011 to 2013. The proportion of Dean Clinic referrals from Connaught continue to show greatest increase at 4% when comparing 2011 to 2013. Similarly, the proportion of referrals from Leinster remained the same at 71% of total referrals. The 2013 Leinster figure remained 6% less than 2011 percentage.

	2011		2012		2013	
Province	**No**	**%**	**No**	**%**	**No**	**%**
Ulster	20	1%	35	2%	40	2%
Munster	215	16%	298	17%	327	17%
Leinster	1069	77%	1250	71%	1331	71%
Connaught	75	6%	176	10%	192	10%
Totals	**1376**	**100%**	**1759**	**100%**	**1890**	**100%**



The following table summarises the Dean Clinics monthly referral rates for 2011 to 2013. Demand for Dean Clinic services peaked in January 2013 with the lowest referral rate in July 2013.



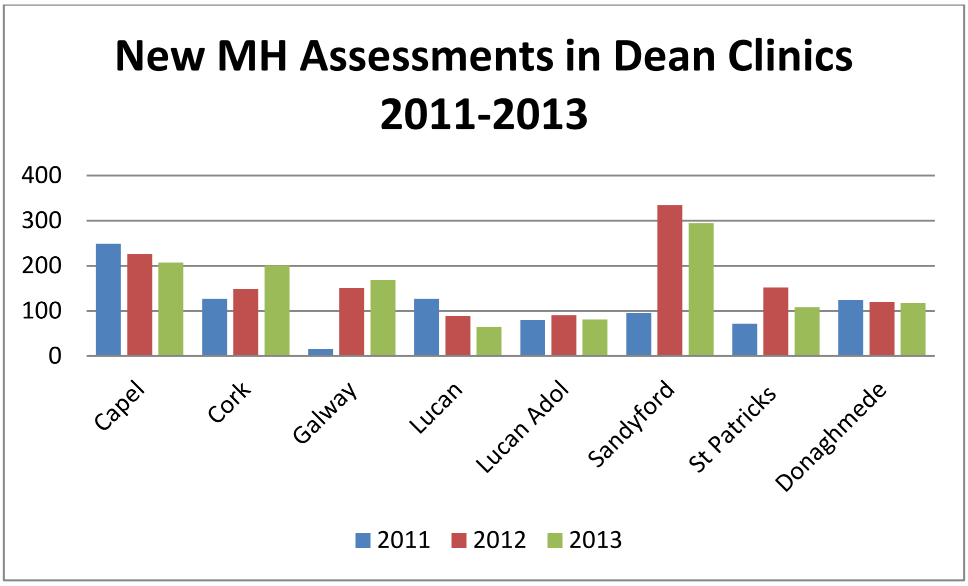
2.1.4. Dean Clinic Activities (2009-2013).

The table below summarises the number of mental health assessments provided to new referrals across Dean Clinics over the last five year period. A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Psychiatrist and another member of the multidisciplinary team. An individual care plan is agreed with the referred persons' 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 pathway.

Year	Dean Clinic New Assessments
2009	395
2010	573
2011	924
2012	1398
2013	1422*
Totals	**4712**

*2013 New Assessments includes assessments carried out by Associate Dean Consultant Psychiatrist.

The figure below illustrates the number of new patient assessments carred out within each of SPMHS's 7 Dean Clinics Dean Sandyford delivered the largest number of assessments in 2013.

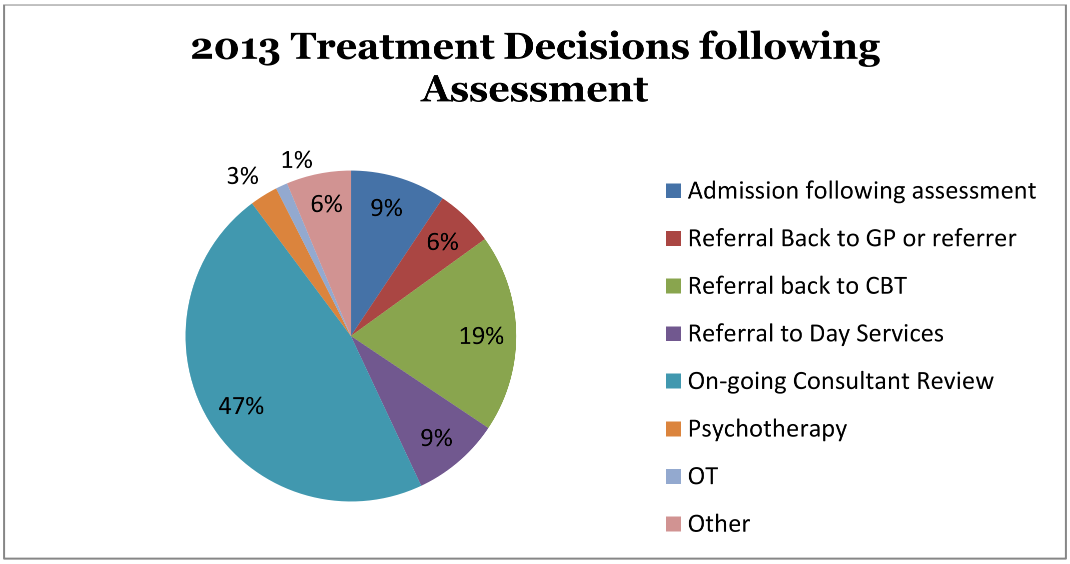


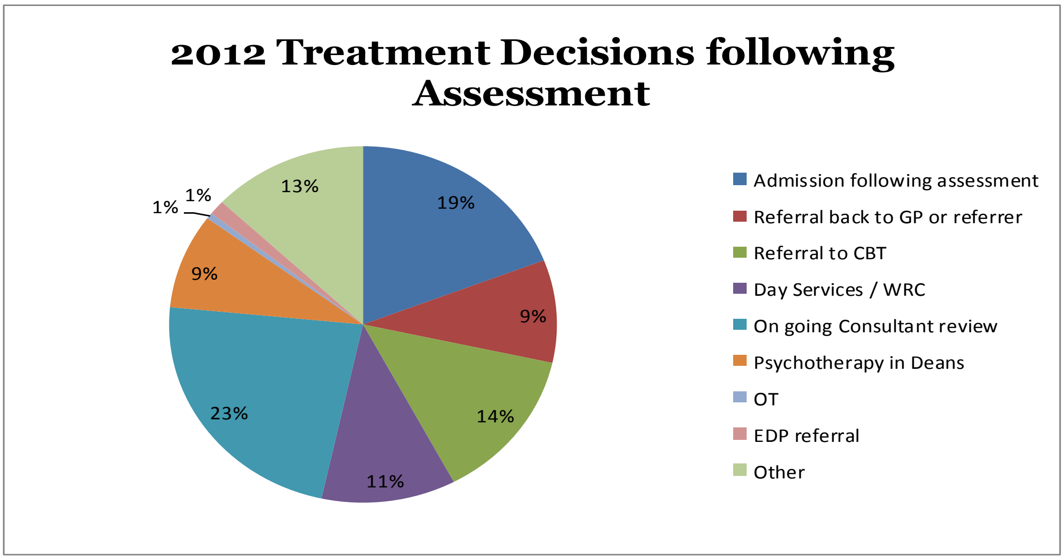
The following table summarises the total number of outpatient appointments or visits provided across Dean Clinics nationwide from 2009 to 2013.

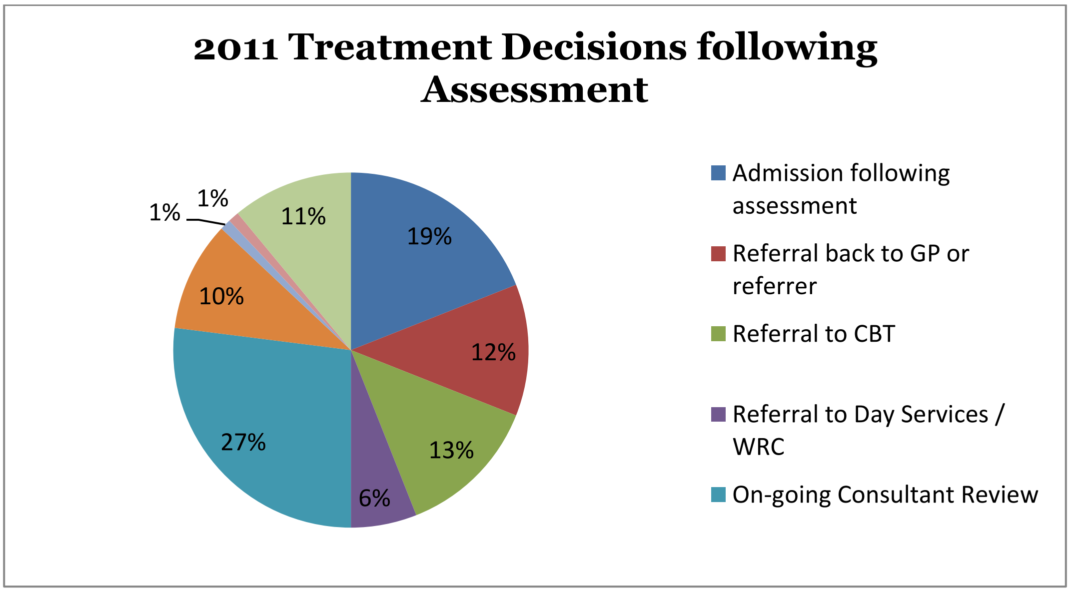
Year	Total No of Dean Clinic Appointments
2009	2,965
2010	5,220
2011	7,952
2012	12,177
2013	12,826
Totals	**41,140**

2.1.5. Dean Clinic: Outcome of Assessments (2013, 2012 & 2012)

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


2013 Treatment Decisions following Assessment
1%
3%
6%
9%
6%
19%
47%
9%
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
1%
1%
13%
19%
9%
9%
23%
14%
11%
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
1%
1%
11%
19%
10%
12%
27%
13%
6%
Admission following assessment
Referral back to GP or referrer
Referral to CBT
Referral to Day Services / WRC
On-going Consultant Review

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

Year	First Admission	Readmission	Total
2013	225	107	332
2012	180	123	303
2011	150	125	275
Total	**555**	**355**	**910**

2.2. SPMHS's Inpatient Care Pathway (2013).

SPMHS comprises three separate approved centres including St Patrick's University Hospital (SPUH) with 238 inpatients beds, St Edmundsbury Hospital (SEH) with 50 inpatient beds and Willow Grove Adolescent Unit (WGAU). In 2013, there were a total of 3,113 inpatient admissions across the organisation's three approved centres compared to 2,896 for 2012 and 2,887 for 2011.

2.2.1. SPMHS Inpatient Admission Rates (2013)

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 2013.

The table below shows inpatient admission numbers across the 3 approved centres for 2013 including the percentage rates for Male and Female admissions. In 2013, 62.9% of admissions across all three Approved Centres were female, compared to 61.6% in 2012.

No. of Admissions (% of Admissions) 2013

	SEH	SPUH	WGAU	Total
Female	361 (66.6%)	1,542 (61.7%)	54 (75.0%)	1,957 (62.9%)
Male	181 (33.4%)	957 (38.3%)	18 (25.0%)	1,156 (37.1%)
Total	**542 (100%)**	**2,499 (100%)**	**72 (100%)**	**3,113 (100%)**

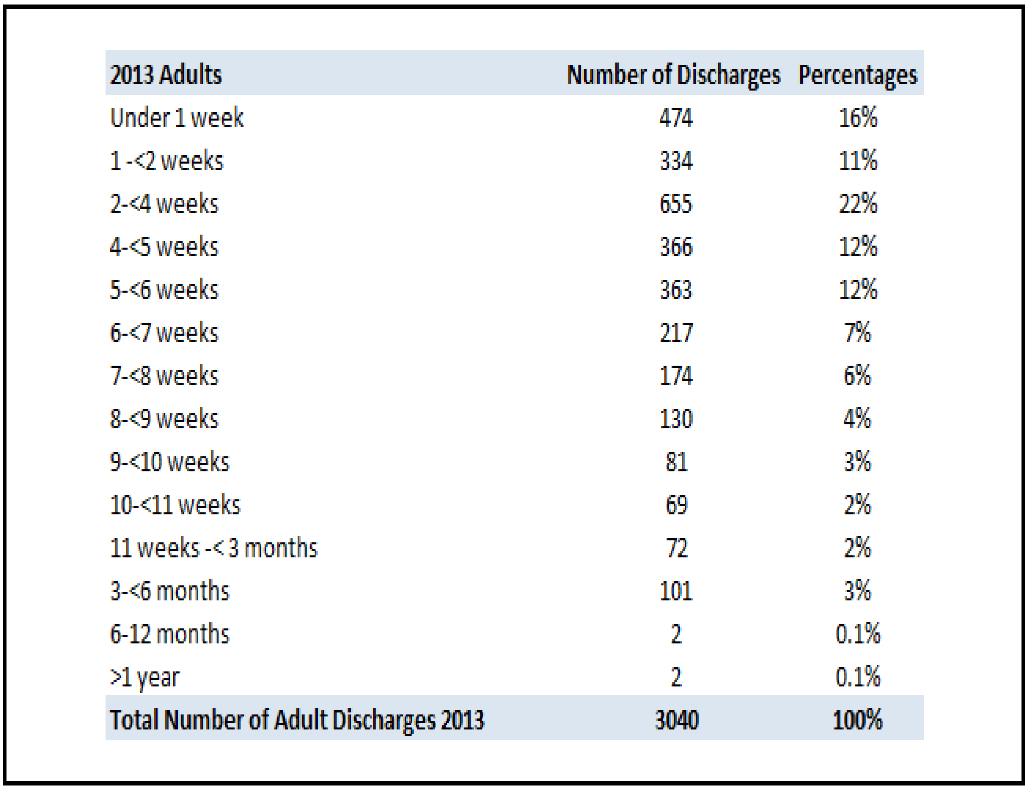
The table below shows the average age of service users admitted across the 3 Approved centres was 47.75 years in 2013. This compares to 47 years for both 2011 and 2012. The average age of adolescents admitted to WGAU (15.49) was also consistent with the previous two years (15). The average age of adults admitted to SEH was also consistent with 2011 and 2012 at 52 years. In addition, the average age of adults admitted to SPUH (47.71) for comparable with the previous two years at 48 years.

Average Age at Admission 2013				
	SEH	**SPUH**	**WGAU**	**Total**
Female	52.71	49.37	15.33	49.05
Male	51.22	45.04	15.94	45.55
Total	**52.21**	**47.71**	**15.49**	**47.75**

2.2.2. SPMHS Inpatient Length of Stay 2013

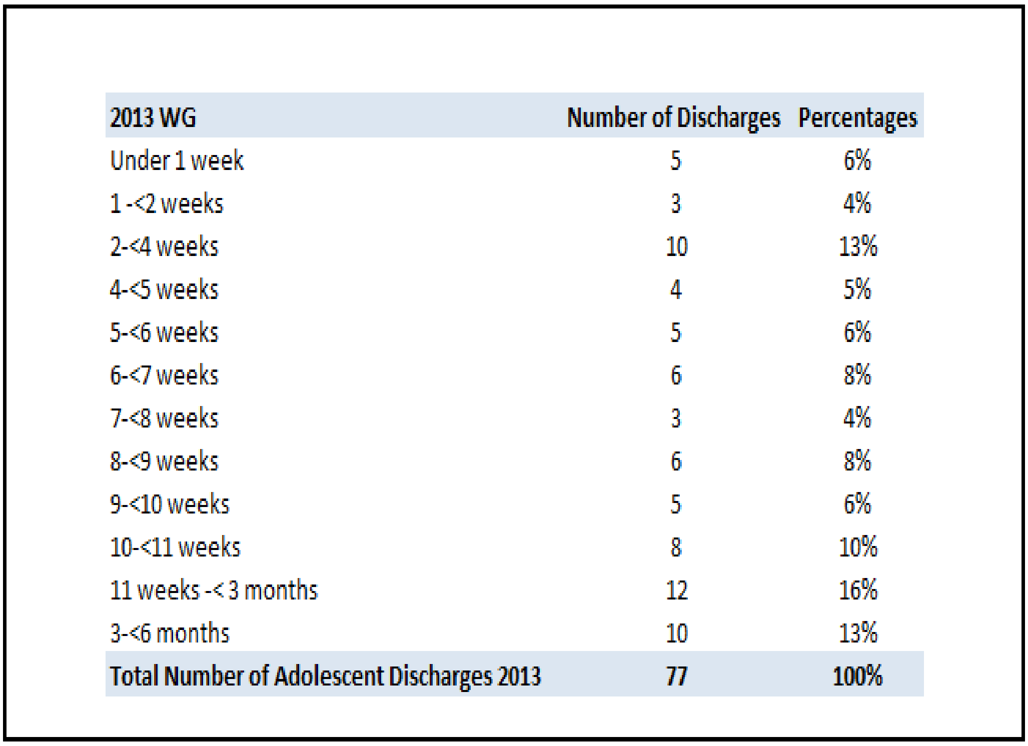
The following Tables present the 2013 average length of stay (ALOS) for adult inpatients (over 18 years of age) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis of inpatient length of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges across temporal categories from under 1 week up to 5 years. A number of additional temporal categories were used to evaluate SPMHS.

SPMHS Length of Stay (LOS) for Adults



2013 Adults	Number of Discharges	Percentages
Under 1 week	474	16%
1 -<2 weeks	334	11%
2-<4 weeks	655	22%
4-<5 weeks	366	12%
5-<6 weeks	363	12%
6-<7 weeks	217	7%
7-<8 weeks	174	6%
8-<9 weeks	130	4%
9-<10 weeks	81	3%
10-<11 weeks	69	2%
11 weeks -< 3 months	72	2%
3-<6 months	101	3%
6-12 months	2	0.1%
>1 year	2	0.1%
Total Number of Adult Discharges 2013	**3040**	**100%**

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



2013 WG	Number of Discharges	Percentages
Under 1 week	5	6%
1 -<2 weeks	3	4%
2-<4 weeks	10	13%
4-<5 weeks	4	5%
5-<6 weeks	5	6%
6-<7 weeks	6	8%
7-<8 weeks	3	4%
8-<9 weeks	6	8%
9-<10 weeks	5	6%
10-<11 weeks	8	10%
11 weeks -< 3 months	12	16%
3-<6 months	10	13%
Total Number of Adolescent Discharges 2013	**77**	**100%**

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpateints discharged in 2013)

The table below outlines the prevalence of diagnoses across SPMHS three Approved Centres during 2013 using the International Classification of Diseases 10th Revision (WHO 2010). The Primary ICD Code Diagnoses recorded upon admission and at the point of discharge are presented for all three of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Edmundsbury Hospital combined. The data presented was based on all inpatients discharged from SPMHS in 2013.

SPMHS Analysis of Inpatient Primary ICD Diagnoses

(For all inpatients discharged in 2013)

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

ICD Codes: Admission & Discharge	SPUH Admissions		SPUH Discharges		SEH Admissions		SEH Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
For All Service Users Discharged in 2013	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	43	1.7%	44	1.8%	1	0.2%	1	0.2%	44	1.4%	45	1.5%	0	0.0%	0	0.0%
F10-F19 Mental and behavioural disorders due to psychoactive substance use	399	15.9%	417	16.6%	29	5.4%	38	7.1%	428	14.1%	455	15.0%	0	0.0%	0	0.0%
F20-F29 Schizophrenia, schizotypal and delusional disorders	215	8.6%	214	8.5%	12	2.2%	13	2.4%	227	7.5%	227	7.5%	3	3.9%	3	3.9%
F30-F39 Mood [affective] disorders	1261	50.3%	1198	47.8%	395	73.9%	364	68.2%	1656	54.5%	1562	51.4%	45	58.4%	46	59.7%
F40-F48 Neurotic, stress-related and somatoform disorders	371	14.8%	374	14.9%	87	16.3%	101	18.9%	458	15.1%	475	15.6%	6	7.8%	9	11.7%
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	119	4.7%	115	4.6%	1	0.2%	2	0.4%	120	3.9%	117	3.8%	19	24.7%	18	23.4%
F60-F69 Disorders of adult personality and behaviour	93	3.7%	137	5.5%	9	1.7%	14	2.6%	102	3.4%	151	5.0%	0	0.0%	0	0.0%
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%	0	0.0%
F80-F89 Disorders of psychological development	1	0.0%	2	0.1%	0	0.0%	0	0.0%	1	0.0%	2	0.1%	4	5.2%	1	1.3%
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3	0.1%	4	0.2%	0	0.0%	1	0.2%	3	0.1%	5	0.2%	0	0.0%	0	0.0%
F99-F99 Unspecified mental disorder	1	0.0%	1	0.0%	0	0.0%	0	0.0%	1	0.0%	1	0.0%	0	0.0%	0	0.0%
Totals	2506	100.0%	2506	100.0%	534	100.0%	534	100.0%	3040	100.0%	3040	100.0%	77	100.0%	77	100.0%

2.3. SPMHS's Day-patient Pathway; Wellness & Recovery Centre (2013)

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 Clinic Referral Pathway. Clinical programmes are delivered by specialist multi-disciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports and include the following:

1. Anxiety Programmes
2. Bipolar Disorder Programmes
3. Depression Programme
4. Addictions Programme
5. Eating Disorder Programme
6. Men's Mental Health Programme
7. Mental Health Support Programme
8. Recovery Programme
9. Young Adult Programme
10. Psychosis Recovery Programme
11. Living through DistressProgramme
12. Radical Openness Programme
13. Enduring Depression & Anxiety Programme (SEH)

The data below provides a clear indication of the types of services required and provided by SPMHS. In 2013, the WRC received a total of 1,686 day programme referrals compared to a total of 1,594 for 2012. 664 of the day patient referrals for 2013 came from a Dean Clinic. This compares to a total or 585 day patient referrals from Dean Clinics in 2012.

2.3.1. Day-patient Referrals by Clinical Programme (2013)

This table below compares the total number of day patient referrals to each clinical programme for 2012 and 2013. In addition, day patient referrals received through the Dean Clinic Referral Pathway are also presented.

Day-Patient Referrals for Clinical Programmes

SPMHS Day Programmes	Total Day Patient Referrals 2012	Total Day Patient Referrals 2013	Total Day Patient Referrals from Dean Clinics 2012	Total Day Patient Referrals from Dean Clinics 2013
Links to Wellbeing	0	5	0	4
Living Through Psychosis	0	31	0	14
Pathways to Wellness	1	42	0	17
Remix Programme	9	0	5	0
Womens Support Programme	14	4	6	0
Psychosis Programme	18	17	4	7
Mens Mental Health	22	7	10	5
Eating Disorder Programme	31	60	4	15
Young Adult programme	40	41	24	21
Nurturing Hope & Resilience	43	13	27	12
Depression Programme	59	58	25	20
Bipolar Programme	103	89	20	13
Alcohol Stepdown	115	128	0	7
Living Through Distress	139	152	43	43
Radical Openness	142	140	48	55
Mindfulness	154	227	85	137
Anxiety Programme	185	192	89	107
St Edmundsbury	219	201	110	102
Recovery Programme	300	279	85	85
Total	**1594**	**1686**	**585**	**664**

2.3.2. Day-patient Referrals by Gender (2013)

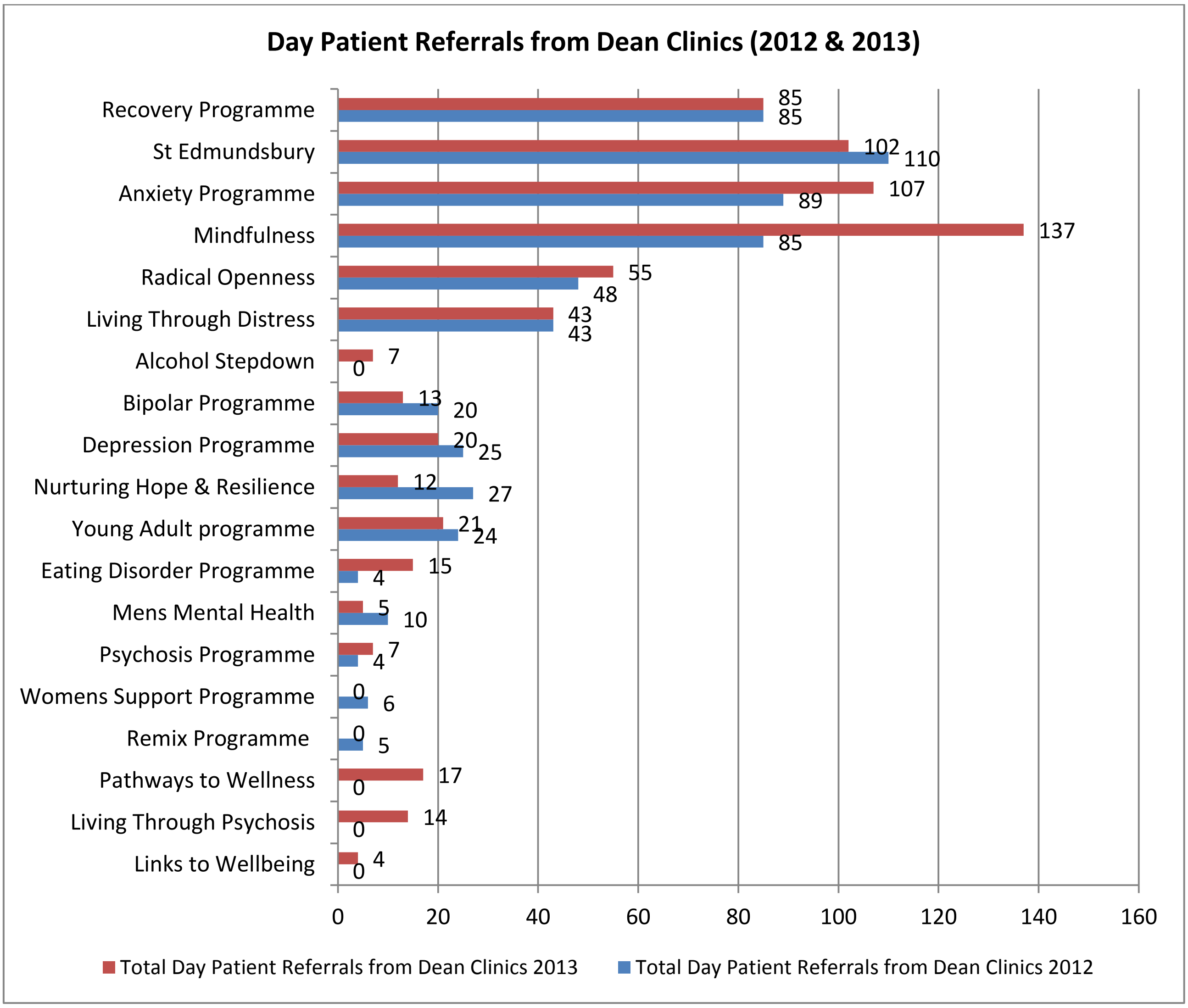
The tables below show male and female day-patient referral rates to all programmes during 2013. 33.6% of referrals to day programmes were male and 66.4% were female.

Day patient Referrals by Gender 2013

2013	Male	Female	Totals
Jan	54	76	130
Feb	39	58	97
Mar	46	101	147
Apr	53	112	165
May	60	126	186
Jun	46	89	135
Jul	50	126	176
Aug	43	98	141
Sep	51	96	147
Oct	42	101	143
Nov	44	63	107
Dec	38	74	112
Total	**566**	**1120**	**1686**

2.3.3. Day-patient Referrals from Dean Clinics (2013)

The table below shows the day-patient referrals to clinical programmes accessed through Dean Clinic Referral Pathway for 2012 & 2013. In 2013, a total of 664 day patient referrals were made from Dean Clinics, representing 39.4% of the total referrals (1686) to Day Programmes. This compares to a total of 585 day patient referrals from Dean Clinics in 2012 representing 36.7% of the total referrals to Day Programmes. Referrals to day programmes through Dean Clinic Referral Pathway increased by 2.7% from 2012 to 2013.



2.4. Section Summary

In 2013, service users received a range of clinical programmes and services accessed through structured and defined inpatient, day-patient and outpatients care pathways based on need, urgency and service user preference. Whilst measures of access do not define the quality or outcomes of programmes and services, they do provide information about how the organisation structures and resources its services. Overall, the number of referrals to all SPMHS pathways increased, indicating a sustained demand

SECTION 3

Measures of Clinical Governance

3. Clinical Governance Measures & Quality Management (2013)

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

3.1 Clinical Governance Measures Summary (2013)

Governance Measure	**2011**	**2012**	**2013**
Clinical Audits	**12**	**25**	**19**
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**606**	**608**	**635**
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.	**1374**	**1707**	**2098**
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.	**4**	**5**	**6**
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 illness. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	**62**	**94**	**107**
% Section 23's which progress to Involuntary admission (Section 24 - Form 13 Admissions) Following Section 23 an examination by the Responsible Consultant Psychiatrist and a second Consultant Psychiatrist the person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	**42% (26)**	**46% (43)**	**37 % (40)**
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.	**32**	**35**	**46**
% 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 illness following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	**72% (23)**	**86% (30)**	**76% (35)**
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**	**8**	**21**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**27**	**22**	**33**
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**
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**
Number of Tribunal's held	**61**	**72**	**96**
Mental Health Commission Reporting – Number of ECT Treatments 2012	**110**	**119**	**129**
Mental Health Commission Reporting – Number of Physical Restraint Episodes	**131**	**157**	**219**

We have refined the way that we collate and report on the data in the above table to ensure a more standardised approach.

3.2. Clinical Audits (2013)

This section summarises briefly the clinical audit activity for St. Patrick's Services in 2013. Clinical audit is an integral part of clinical governance and its purpose is to monitor and to improve the quality of care provided to service users and the resulting outcomes. This is accountable to the Hospital Clinical Governance Committee and ultimately to the Board of Governors.

3.2.1. Overview of Audit Activity

The table below demonstrates the breakdown of projects by type undertaken in 2013 including those facilitated by clinical staff at local level and those carried out throughout the organization led by the Hospital committees.

No.	Audit Title	Audit Lead	Status at year end
1.	**Electro Convulsive Therapy Booklet** To assess consistency and appropriateness of ECT documentation in accordance with the MHC guidelines.	ECT Committee	On-going
2.	**The Clinical Global Impression (CGI) score completion rates** To measure the CGI completion rate across SPMHS Approved Centres	Clinical Governance Committee	Baseline audit completed
3.	**Admission Nursing Assessment and Nursing Intervention Sheets** To strengthen the nursing process within the context of multidisciplinary service user centred & recovery focused care	Nursing Department	On-going
4.	**Key Worker System and Individual Care Planning process** To ensure compliance with the Mental Health Commission standards by ensuring that the key worker system is working effectively and an individual care plan is documented effectively	Clinical Governance Committee	On-going
5.	**Benzodiazepine and Hypnotic Usage Snapshot** The aim of this audit is to determine the percentage of in-patients prescribed benzodiazepines and night sedation (z-drugs) and feed back the findings to the multidisciplinary teams.	Clinical Governance Committee	On-going

No.	Audit Title	Audit Lead	Status at year end
6.	**Adherence to hospital protocol of the management of service users with more than one fall episode** To ensure that service users with more than one fall episode are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Baseline audit completed
7.	**Appropriateness and effectiveness of antibiotic prescribing practice** To increase the effectiveness of infection management and to ensure that antibiotics are prescribed appropriately.	Infection Control Committee	Re-audit completed
8.	**Infection Control Audits** These audits measure the implementation of policies and procedures relating to infection control.	Infection Control Committee	On-going
9.	**Comprehensive Discharge Summary** Determine if the comprehensive discharge summaries are currently sent within 3 working days of discharge, which is in compliance with the Mental Health Commission Code of Practice.	Clinical Governance Committee	Completed
10.	**Quality of Admission Psychiatric Assessment documentation** To assess the quality of the psychiatric admission assessment record completed by the non-consultant doctors	Clinical Governance Committee	Re-audit completed

No.	Audit Title	Audit Lead	Status at year end
11.	**PRN prescribing – Recording of a rationale for using when required prescriptions** To ensure that drugs on when required (PRN) basis are prescribed and administrated appropriately in accordance with Hospital policy.	Clinical Governance Committee	Completed
12.	**Prescribing anti-dementia drugs (audit facilitated by Prescribing Observatory for Mental Heath-UK)** To assess adherence to the best practice standards derived from NICE dementia clinical guideline (Dementia. CG42; 2012)	Multidisciplinary Teams	Baseline audit completed
13.	**Quality of history taking for service users diagnosed with Dependence Syndrome in the Temple Centre** To ensure that the ICD criteria for diagnosis of Dependence syndrome is documented and adhered to.	Multi-disciplinary Team Registrar	Completed
14.	**To measure and assess the quality of documentation and accountability in Section 23(1) initiation** The objective of this audit was to determine the level of documentation in relation to invocation of Section 23 (1) of the Mental Health Act 2001.	Multi-disciplinary Team Registrar	Baseline audit completed
15.	**A review of benzodiazepine and z-drug on a when required basis (PRN) prescribing levels** To determine compliance with Hospital Policy on PRN benzodiazepine and Z-	Multi-disciplinary Team Registrar	Completed

	hypnotic medications, and improve compliance levels.		
No.	**Audit Title**	**Audit Lead**	**Status at year end**
16.	**ICD-10 codes & corresponding history of presenting complaint** To compare the admission ICD – 10 diagnosis codes assigned by the admitting Registrars following assessment with service user history taking using ICD – 10 diagnostic criteria.	Multi-disciplinary Team Registrar	Work in progress
17.	**An audit of the effectiveness of text message reminders in improving adherence with lithium blood monitoring** To audit the effectiveness of a text message reminder service in improving compliance with the blood monitoring parameters of lithium therapy, in an out-patient psychiatric clinic	Multi-disciplinary Team Registrar	Completed
18.	**Risk of Venous Thromboembolism (VTE) in psychiatric patients and audit of current management** To assess the VTE risk of service users admitted to SPUH and to identify if current management of this risk meets the recommendations of the NICE guidelines.	Multi-disciplinary Team Registrar	Work in progress
19.	**Osteoporosis detection and management in service users diagnosed with anorexia nervosa** To audit the effectiveness of management of service users diagnosed with anorexia nervosa and osteoporosis	Multi-disciplinary Team Registrar	Work in progress

3.2.2. Key Audit Outcomes for 2013

- A comprehensive audit designed to assess the level of Key Working and effective care planning in the three Approved Centres was conducted in 2013. This audit was commissioned by the Clinical Governance Committee to assess if good care planning and key working practice was consistent throughout the year. The findings confirmed that good practice remained constant for that period. The Clinical Governance Committee is overseeing on-going quality improvement work to further strengthen the key-working and care planning process.
- Audit has demonstrated improvement in the time by which discharge summaries are completed and sent to GP's and in the efficiency of the whole process. The process improvements were made on foot of the results of a previous audit.
- Recommendations arising from an audit on appropriateness and effectiveness of antibiotic prescribing practice were implemented. These include improvements to the teaching programme for doctors and revisions to organisational policy to reflect the most up-date best practice guidelines.
- A Benzodiazepine and Hypnotic Usage Snap shot, indicated a continued gradual reduction in regular and PRN benzodiazepine and z-drug prescribing and appropriate adherence to prescribing guidelines. This data confirmed the positive effect of implemented recommendations arising from the audit on benzodiazepine and hypnotics prescribing on current prescribing practice.
- On-going audit of the nursing admission assessment process has enabled improvement of existing nursing interventions and development of new interventions.
- Junior doctors are required to participate in clinical audit projects as part of their training requirements. In 2013, seven approved projects were undertaken by registrars.

SECTION 4

Clinical Outcome Measures (2013)

4. Clinical Outcomes (2013)

The results presented in this Section summarise the findings from routine outcome measurement of St Patrick's Mental Health Services in 2013. Outcome measurement has been in place since 2011 and is a priority for the service, embedded within the context of clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2013 outcome measurement was expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing shift towards an organisational culture that recognises the value of routine outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important Considerations for Interpretation of Outcomes.

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

- The data reported in this chapter represent pre- and post- programme measurements
- Pre and post measurement is linked to the start and finish of programmes but other facets of care, other simultaneous interventions, medications etc. may also play a part (any effects cannot be solely attributable to clinical programme intervention).
- Where appropriate to the analysis of outcomes, paired sample t-tests were used to determine if, across the sample, post-scores are statistically significantly different from pre-scores. **Statistical significance** indicates the extent to which the difference from pre to post is due to chance or not. Typically the level of significance is 0.05 which means that there is only a 5% probability that the difference is due to chance and therefore it is likely that there is a difference. Statistical significance provides no information about the magnitude or clinical or practical importance of the difference. It is possible that a very small or unimportant effect can turn out to be statistically significant e.g. small changes on a depression measure can be statistically significant, but not clinically or practically meaningful.
- **Statistically non-significant findings** suggest that the change from pre- and post- is not big enough to be anything other than chance but does not necessarily mean that there is no effect. Non-significant findings may result from small sample size, issues to do with the sensitivity of the measure being used or the time point of the measurement. As such non-significant findings are not unimportant; rather they provide useful information and an invitation to investigate further.

- **Practical significance** indicates *how much* change there is. One indicator of practical significance is effect size. **Effect size** is a standardized measure of the magnitude of an effect. This means effect sizes can be compared across different studies that have measured different variables or used different scales of measurement. The most common measure of effect size is known as **Cohen's *d*.** For Cohen's *d* an effect size of:
    - 0.2 to 0.3 is considered a "small" effect
    - 0.5 a "medium" effect
    - 0.8 and upwards a "large" effect.

  As Cohen indicated '**The terms 'small,' 'medium,' and 'large'** are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation. In the face of this relativity, there is a certain risk inherent in offering conventional operational definitions for these terms for use in power analysis in as diverse a field of inquiry as behavioral science. This risk is nevertheless accepted in the belief that more is to be gained than lost by supplying a common conventional frame of reference which is recommended for use only when no better basis for estimating the ES index is available." (p. 25) (Cohen, 1988)
- **Clinical significance** refers to whether or not a treatment was effective enough to change a patient's diagnostic label. "For example, a treatment might significantly change depressive symptoms (statistical significance), the change could be a large decrease in depressive symptoms (practical significance- effect size), and 40% of the patients no longer met the diagnostic criteria for depression (clinical significance). It is very possible to have a treatment that yields a significant difference and medium or large effect sizes, but does not move a patient from dysfunctional to functional." ("Clinical Significance," 2013, para 7).

4.2. Clinical Global Impression and Children’s Global Impression Scales: Outcomes for Inpatient Care 2013

4.2.1. Objective

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

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

4.2.1.1. Background

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

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

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

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

4.2.1.2. Data Collection Strategy

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

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

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

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

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

4.2.2. Sample Description

		TOTAL SPUH and SEH	SPUH	SEH	WGAU
Sample size		398	239	159	64
Admissions	1st admission	35%	39%	28%	89%
	Re-admission	65%	61%	72%	11%
Average age ± standard deviation		49±16	46±17	53 ± 13	16 ± 1
Gender breakdown	Female	62%	61%	64%	77%
	Male	38%	39%	36%	23%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

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

The primary admission diagnosis was analysed. The percentage of treatment episodes in the sample with more than one admission ICD-10 diagnosis was 9% for adults (SPUH and SEH) and 22% for adolescent (WG).

		2011	2012	2013			
ICD-10 Admission Diagnosis Category		**TOTAL SPUH and SEH**	**TOTAL SPUH and SEH**	**TOTAL SPUH and SEH**	**SPUH**	**SEH**	**WGAU**
F30-F39	Mood disorders	59%	60%	58%	49%	72%	52%
F40-F48	Neurotic, stress-related and somatoform disorders	17%	15%	16%	15%	18%	8%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	13%	13%	16%	7%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	10%	7%	6%	8%	3%	5%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	0.5%	1%	4%	6%	0%	30%
F00-F09	Organic, including symptomatic, mental disorders	1.5%	1%	2%	3%	0%	0%
F60-F69	Disorders of adult personality and behaviour	0%	1%	2%	3%	1%	0%
F80-F89	Disorders of psychological development	0%	1%	0%	0%	0%	5%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0%	0%	0%	2%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *St. Patrick's University Hospital*

CGIS -Baseline measure of severity of illness		**2011**	**2012**	**2013**		
		TOTAL	**TOTAL**	**TOTAL**	**SPUH**	**SEH**
1	Normal, not at all ill	0%	0%	0%	0%	0%
2	Borderline mentally ill	2.5%	1%	0%	0%	0%
3	Mildly ill	8%	7%	8%	11%	3%
4	Moderately ill	24%	21%	20%	25%	13%
5	Markedly ill	26.5%	34%	33%	31%	38%
6	Severely ill	15%	18%	19%	11%	31%
7	Extremely ill	1%	2%	1%	1%	1%
	Not scored	23%	17%	19%	21%	16%

Table: *St. Edmundsbury Hospital*

CGIC – Final Global improvement or change score		**2011**	**2012**	**2013**		
		Total	**Total**	**Total**	**SPUH**	**SEH**
1	Very Much improved	14.5%	10%	11%	7%	16%
2	Much Improved	44.5%	44%	39%	39%	41%
3	Minimally Improved	20.5%	23%	16%	17%	15%
4	No Change	6.5%	7%	6%	9%	2%
5	Minimally Worse	0.5%	0%	0%	0%	0%
6	Much Worse	0%	0%	0%	0%	0%
7	Very Much Worse	0%	0%	0%	0%	0%
	Not scored	13.5%	15%	26%	27%	26%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		**2012**		**2013**	
		Baseline	**Final**	**Baseline**	**Final**
100-91	Superior functioning	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	0%
80-71	No more than a slight impairment in functioning	0%	0%	0%	2%
70-61	Some difficulty in a single area, but generally functioning pretty well	1%	23%	0%	19%
60-51	Variable functioning with sporadic difficulties	35%	53%	33%	63%
50-41	Moderate degree of interference in functioning	55%	16%	58%	9%
40-31	Major impairment to functioning in several areas	3%	3%	5%	2%
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	7%	5%	5%	6%
Mean ±SD		50±5	57±6	49±5	57±6
Median		50	58	50	57
Wilcoxon Signed Ranks Test:		Z=-6.584, p<.001		Z=-5.973, 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

	2011	2012	2013			2012	2013
	TOTAL SPUH and SEH	TOTAL SPUH and SEH	TOTAL SPUH and SEH	SPUH	SEH	WGAU	
Baseline Assessment Scale Score							
% of admission notes with recorded baseline scores	77%	83%	81% (↓)	79%	84%	93%	95% (↑)
% compliance with clinical audit standard 1	61%	64%	61% (↓)	57%	66%	N/A	N/A
Final Assessment Scale Score							
% of admission notes with recorded final scores	87%	85%	74% (↓)	73%	74%	95%	94% (↓)
% compliance with clinical audit standard no. 2	73%	73%	73% (↔)	73%	74%	N/A	N/A

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Services admissions in 2013.
2. Female to male ratio was 62% to 38% for adults and 77% to 23% for adolescents.
3. In comparison to the 2012 data there was a 9% increase in the number of service users who were re-admitted. In 2013 re-admissions accounted for 65% of adult service users.
4. 83% of WGAU admissions in 2013 were first admissions to a mental health service. This was 6% increase in the number of first admissions in comparison to the 2012 data.
5. In 2013 the breakdown of baseline clinical global improvement scores on admission shows that a majority of SPUH and SEH service users were markedly ill. A higher percentage of service users that were markedly or severely ill was noticed in 2012 and 2013 in comparison to the 2011 data.
6. More service users of St. Edmundsbury Hospital are scored as being very ill (31%) than service users of St. Patrick's University Hospital (12%) and this difference has increased by 5% in comparison to 2012.
7. Two adult service users of the entire sample worsened overall following in-patient treatment. These were admitted to Dean Swift ward which is a unit specializing in providing care to the most acutely ill service users.
8. The majority (58%) of WG service users were scored as having a moderate degree of interference in functioning on admission.
9. For WG service users there is a statistically significant improvement in level of functioning following in-patient treatment ($p<.001$). The median score on Children's Global Assessment Scale increased from pre-treatment (Median = 50) to post-treatment (Median=57).
10. There is a 7% increase in the percentage of adolescents for whom mental health improved following in-patient treatment in WG in comparison to the 2012 data.
11. The audit measure has been changed to include exceptional circumstances i.e. when a service user is discharged against medical advice or when a short admission occurs and the rating cannot be performed.
12. The audit shows a noticeable disimprovement in the completion rate of the baseline CGI score and the final CGI score in comparison to the audit for 2012. Out of three approved centres the highest completion rate was achieved by the WGAU.
13. 39% of the baseline CGI scores were recorded more than the target of 5 days following admission and 27% of final CGI scores were outside the targeted 5 days prior to discharge.

4.3. Acceptance & Commitment Therapy Programme, SEH

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 participants to identify and connect with their core personal values and integrate them into everyday action. ACT primarily aims to change people's relationship with anxiety and depression, and to increase value-led behavioural activation. As such, symptom reduction is a secondary gain, rather than a primary aim of this approach.

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

4.3.1. Descriptors

During 2013, 100 service users attending St Edmundsbury were referred to the ACT programme. Of the 100 participants, (76% female) both pre- and post-measures were available for 59 programme completers, representing 59%.

4.3.2. ACT Outcome Measures

The following programme measures were used:

- **Acceptance & Action Questionaire II**

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

- **Behavioural Activation for Depression Scale**

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

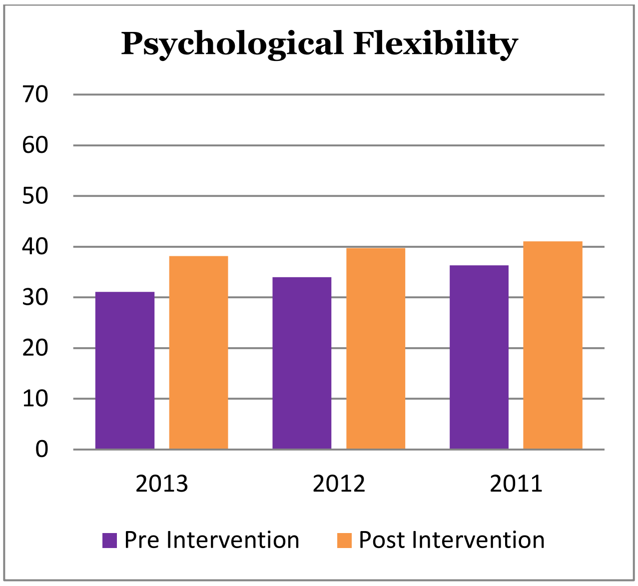
- **Five Facet Mindfulness Questionnaire**

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity- to inner experience, and non-judging of inner experience. The measure consists of 39 items which are responded to on a 5-point rating scale ranging from 1 “never or very rarely true” to 5 “very often or always true”. Scores range from 39 to 195 with higher scores suggesting higher levels of mindfulness. In a study of non-clinical samples participants who regularly practice mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practice mindfulness had a mean of 138.9 (*SD* = 19.2) (Lykins & Baer, 2009). The measure evidences good reliability (alpha co-efficient ranging from .72 to .92 for each facet) (Baer et al., 2006). Evidence for construct validity comes from analysis of data from samples with mindfulness meditation and no mindfulness meditation experience (Baer et al., 2006).

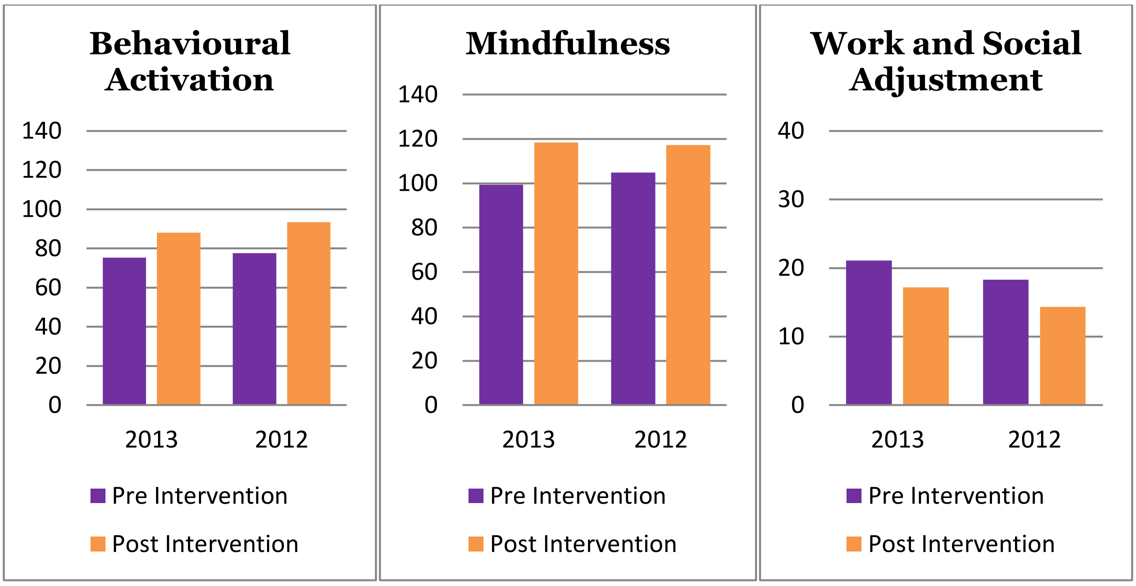
- ### Work and Social Adjustment Scale

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

4.3.3. Results



Total scores on the AAQ-II showed a statistically significant increase, *t* (56) = -4.52, *p* < .001, suggesting greater psychological flexibility post programme. The effect size *d* of .80 indicates a large effect. Pre and Post mean scores on the AAQ-II were similar to those reported in 2011 and 2012.



Mean post BADS scores increased significantly, from (*M* = 75.37, *SD* = 26.79) to (*M* = 88.13, *SD* = 27.55) indicating greater behavioural activation, t (53) = -3.04, *p* < .01, representing a medium effect size (*d* = .47). The percentage of programme completers with scores below 70 (the mean reported by Kanter et al. (2009) for a sample with elevated depressive symptoms) reduced from 35.5% to 25.5% at the post measurement time point.

Total FFMQ scores increased significantly, t (58) = -6.19, *p* < .001, from pre (*M* = 99.32, *SD* = 17.47) to post (*M* = 118.32, *SD* = 21.58) indicating greater levels of overall mindfulness. A large effect size was observed (Cohen's *d* = .97). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (56) = 3.87, *p* < .001, from 21.09 (SD = 8.13) to 17.17 (SD = 8.82), indicating less functional impairment. The effect size *d* of .46 suggests a medium effect. Both pre and post means are within the range suggesting significant functional impairment, but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 12.4% of programme completers had scores below 10 when they started the programme, while 20.7% had scores below 10 on completion of the programme.

These findings reflect the 2012 outcomes report that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

4.3.4. Summary

The four questionnaires currently in use appear to be good tools for capturing therapeutic targets/outcomes of the programme. Programme completers showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning. On the recommendations of the 2012 outcome report the same measures were continued to be utilised pre and post programme. This allowed for a comparison of the outcomes between 2012 and

2013. Mean scores for all measures pre and post programme in 2013 were very similar to those in 2012 particularly those indicated by the FFMQ.

Through discussions with the programme facilitators changes in data collection resulting from the 2013 analysis were considered, leading to the following decisions for future collection:

1. The same measures will continue to be used in 2014, allowing outcomes for 2012, 2013 and 2014 to be compared.
2. A planned recording and analysis of the five distinct subscales of the FFMQ, providing more clinically useful data about how participants are learning and utilising different aspects of mindfulness, will be implemented. This will also allow for comparisons with published research which tends to use subscale rather than total scale scores.
3. In addition to those measures currently in use, programme facilitators have added a measure of self-compassion for 2014 (Neff, 2003).

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 and ward based Nursing staff, and includes;

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

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

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

The programme includes the following elements:

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

Group based interventions

- **Addiction Counselling Groups:** These are part of the in-patient programme and involve 3 group therapy sessions, facilitated by a counsellor, where topics relevant to substance abuse/ dependence are discussed.

- **Women's Group:** This is a gender specific group, facilitated by a Counsellor, where women meet and discuss issues pertaining to females and addiction in a therapeutic environment.
- **Psycho-education lectures:** Weekly educational lectures are given on a weekly basis, designed both for in-patients and their families. People in recovery are also invited in to speak at these lectures. A weekly psycho-educational lecture is also offered to the 'Step-Down' programme.
- **Motivation for Change Group:** This group is facilitated by therapists. It is specifically for 'Goal setting' and 'Change planning', and is most relevant to patients who are embarking on periods of time outside the hospital.
- **Orientation Group:** This is where a number of recovering alcohol dependant people who have completed the Programme in the past chair a weekly meeting for in-patients, and host a question and answer session.
- **Recovery skills groups:** These groups teach and re-educate 'living skills' i.e. drink/drug refusal skill training, communication skills, recovery skills, relapse prevention etc.
- **Family Sessions/Meetings:** Providing support for the relatives of patients attending the Programme.

4.4.1. Alcohol and Chemical Dependency Programme Outcome Measures

- **Treatment Outcomes Profile**

  The Treatment Outcomes Profile (TOP: Marsden et al., 2008) is a 20 item drug treatment outcome monitoring tool which consists of four sections covering Substance Use, Injecting Risk Behaviour, Crime, and Health and Social Functioning over the past 28 days. In the first three sections participants are asked to record the number of days relevant behaviours (i.e. alcohol use, injecting etc.) occurred each week. In the fourth section of the tool three questions require subjective ratings of psychological health, physical health and quality of life on a scale of 0 "Poor" to 20 "Good". Recent analyses suggest that the psychological health question of the TOP is a valid measure of common mental disorders in the context of substance use (Delgadilo, Payne, Gilbody and Godfrey, 2013).

4.4.2. Results

Throughout 2013 the collection of pre and post measures on the Alcohol and Chemical Dependency Programme was inconsistent. Due to the small number of measures completed a full and accurate analysis of change could not be completed. On observing the inconsistent nature of data collection a series of meetings with the clinical team were arranged in October 2013. These meetings addressed concerns around the suitability of the TOP as an outcome measure for the current programme. The nature of the ACDP requires service users to attend the programme as inpatients during the initial 4 weeks, making it difficult for them to maintain access to alcohol or chemical substances. Therefore, it was felt by the clinical team that the four sections of the TOP, covering Substance Use, Injecting Risk Behaviour, Crime, and Health and Social Functioning over the past 28 days, did not give a full and accurate account of clinical change during the programme. A decision was made by the clinical team to implement an alternative measure, reflecting the changes observed by facilitators, the Leeds Dependence Questionnaire (LDQ; Raistrick et al, 1994).

4.4.3. Future Plans for 2014

Since concerns regarding the collection of measures were raised, the clinical team involved in the ACDP have agreed and implemented the use of a more suitable measure of change, the Leeds Dependence Questionnaire (LDQ; Raistrick et al, 1994).

The LDQ is a 10-item questionnaire completed by service users. The measure is designed to evaluate 10 markers of substance and/or alcohol dependence: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user’s day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Paton-Simpson & MacKinnon, 1999). Items are scored on a 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al, 1994).

The introduction and implementation of the LDQ will allow for a more clinically relevant reflection of change observed among service users completing the Alcohol and Chemical Dependency Programme (ACDP), which will be analysed and reported on in 2014 and future years.

4.5. Anxiety Disorders Programme

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

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

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

4.5.1. Anxiety Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2012. All service users attending the Anxiety Programme complete (or in the case of the CGI are rated on) the following measures, before starting the programme, after completing level one of the programme and again after completing level two (if they have attended this level). Participants either completed the Life Adjustment Scale or the Work and Social Adjustment Scale before starting the programme, and after completing level 1 and / or level 2 of the programme.

- **Beck Anxiety Inventory**

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

- **Beck Depression Inventory**

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

- **Clinical Global Impression Scale**

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

- **Fear Questionnaire**

  The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items including questions measuring the extent to which situations are avoided using a 9-point likert scale ranging from 0 "Would not avoid" to 8 "Always avoid". Four scores can be obtained from the Fear Questionnaire, including Main Phobia Level of Avoidance, Total Phobia Score, Global Phobia Rating and Associated Anxiety and Depression. For the purposes of this analysis Total Phobia Scores, ranging from 0 to 120 were 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).

- **Life Adjustment Scale**

  The Life Adjustment Scale (LAS) 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. Impairment in each domain is rated on a 9-point likert scale from 0 "Not at all" to 8 "Very severely". Total scores for the measure range from 0 to 40, with higher scores indicating a greater impairment in functioning. The LAS was introduced at the inception of the Anxiety Programme to address the absence of measures of functioning noted in various CBT for anxiety meta-analysis. Changes in functioning are seen as an important indicator of improvement (Stewart & Chambless, 2009; Butler, Chapman, Forman & Beck, 2006). Due to the fact that the LA is not a recognized evidence based measure and poorly referenced the Anxiety Programme staff decided to change it to the Work Life and Social adjustment scale (WSAS) – a very similar but more recent variant of the LA. The WSAS is commonly 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. 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 subclinical populations" (p. 463, Mundt, Marks, Shear & Greist, 2002).

- ### Work and Social Adjustment Scale

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

- **Yale Brown Obsessive Compulsive Scale**

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

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

- **Penn State Worry Questionnaire**

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

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

- **Liebowitz Social Anxiety Scale**

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

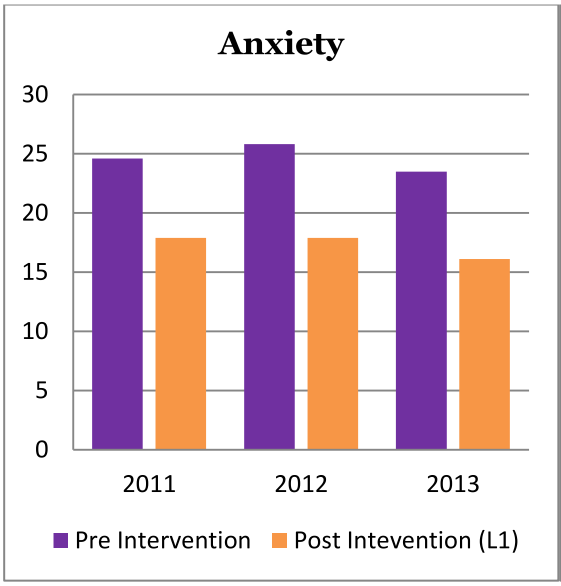
4.5.2. Descriptors

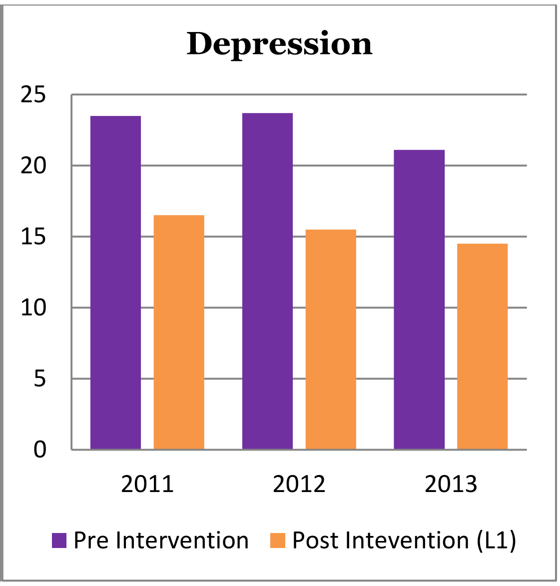
Data were available for one hundred and nineteen people, of which 67 (56.3%) were female and 52 male (43.7%). Programme attendees ranged in age from 18 to 85 with an average age of 38.68 (*SD* = 15.56). There were eight primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (42.0%), followed by Generalised Anxiety Disorder (17.6%), Social Phobia/Anxiety (16.8%), Agoraphobia (with/without panic) (7.6%), Panic Disorder (7.6%), Health Anxiety (5.9%), Specific Phobias (1.7%) and Post-Traumatic Stress Disorder (0.8%). The percentage of people with each diagnosis is represented in the table below, including figures for 2011 and 2012 for purposes of comparison.

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

4.5.3. Level 1 Results

Pre and post data were available for 106 – 119 people across all strands of the programme (depending on the measure) and 47 – 48 people with OCD specifically. Post data reflects data collected after Level 1 of the anxiety programme.





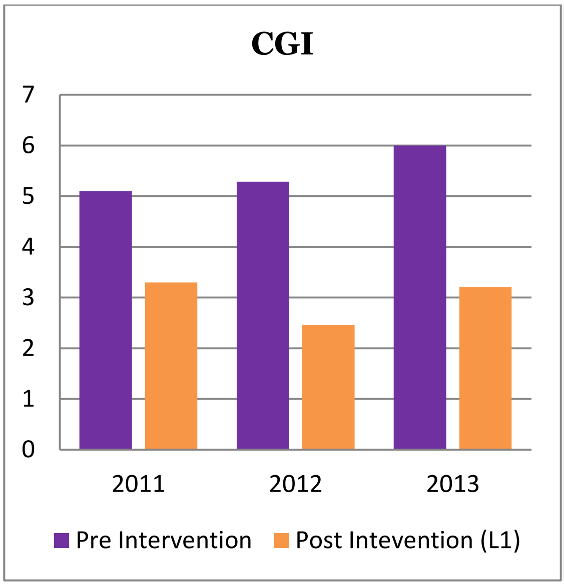
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that Anxiety Programme completers moved from the higher end of the moderate (*M* = 23.5, *SD* = 14.1) to the lower end of the moderate (*M* = 16.1, *SD*

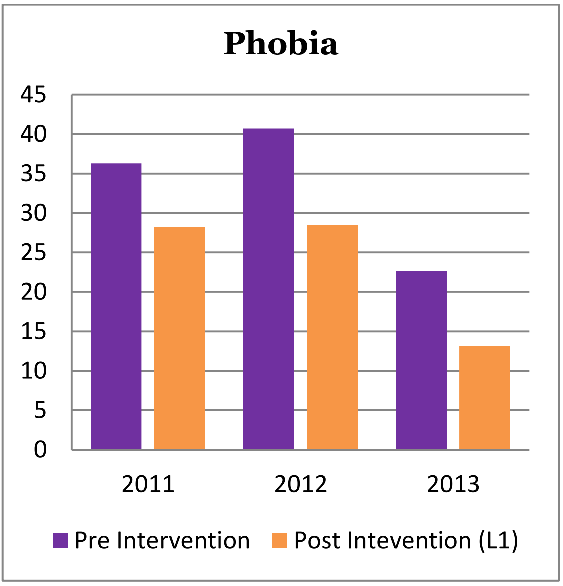
= 9.1) range on the measure. Changes were statistically significant, t(115) = 6.0, p<.001, and represent a medium effect (Cohen's *d* = 0.61). At the pre measurement time point, 39.5% had anxiety scores in the severe range, this dropped to 17.2% by the end of Level 1 (See the table below).

% in each category	**Anxiety (BAI)**		**Depression (BDI)**	
	PRE	**POST**	**PRE**	**POST**
Minimal	8.4	19.8	13.4	34.5
Mild	23.5	32.8	29.4	34.5
Moderate	27.7	30.2	32.8	23.3
Severe	39.5	17.2	24.4	7.8
Totals	**100**	**100**	**100**	**100**

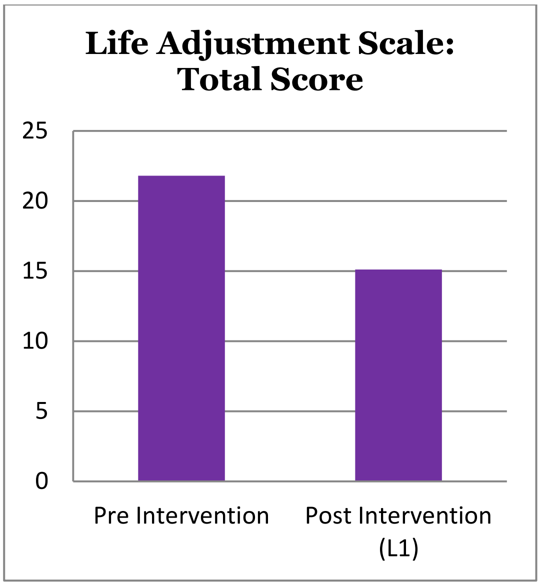
Average depression scores for Anxiety Programme completers (indicated on the graph above) were in the moderate range (*M* = 21.1, *SD* = 10.6) and showed a statistically significant drop to within the mild range (*M* = 14.5, *SD* = 9.8), t(115) = 7.0, *p* < .001, which represented a medium effect (Cohen's *d* = 0.62). While 24.4% were classified has having severe depression before the programme, 7.8% were classified as such by the end (See table above).

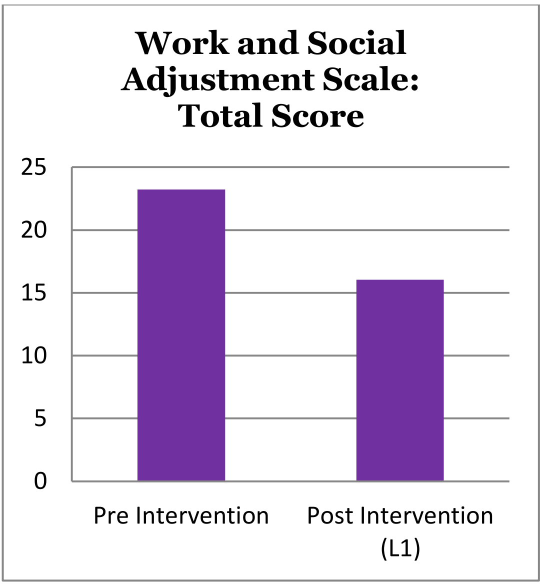
The mean pre programme Severity of Illness (measured using the CGI) was 5.2 (*SD* = 0.46) out of a possible 7 suggesting that people were *markedly ill* but were in the *much improved* category after completing level 1 of the programme.





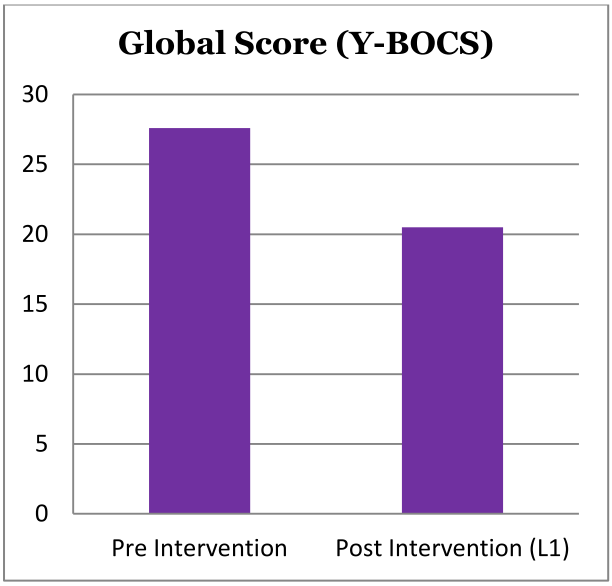
Total phobia scores showed a significant drop, *t* (115) = 5.4, *p* < .001, from a mean of 22.7 (*SD* = 20.7) to 13.2 (*SD* = 16.7) suggesting less phobia. The effect size *d* =0.50 indicates a large effect.



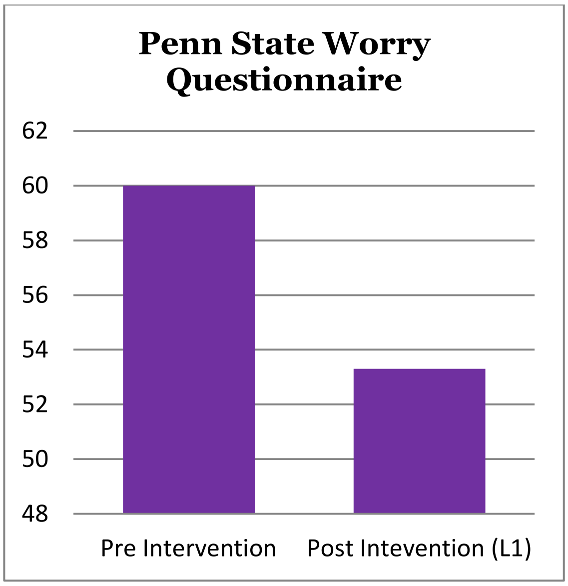


Of those who completed measures in 2013, 71 completed the Life Adjustment Scale while 47 completed the Work and Social Adjustment Scale. Statistically significant improvements were reported for overall impairment on the Life Adjustment Scale (LAS). Mean total LAS scores decreased from 21.8 (SD = 8.4) to 15.1 (SD = 8.7), indicating a large effect (Cohen's d = 0.81) on reducing impaired functioning t(69) = 5.9, p < .001.

Like the LAS significant improvements in impaired functioning is indicated by the Work and Social Adjustment Scale, t(43) = 5.0, p < .001, with Cohen's d representing a large effect (d = 0.88).

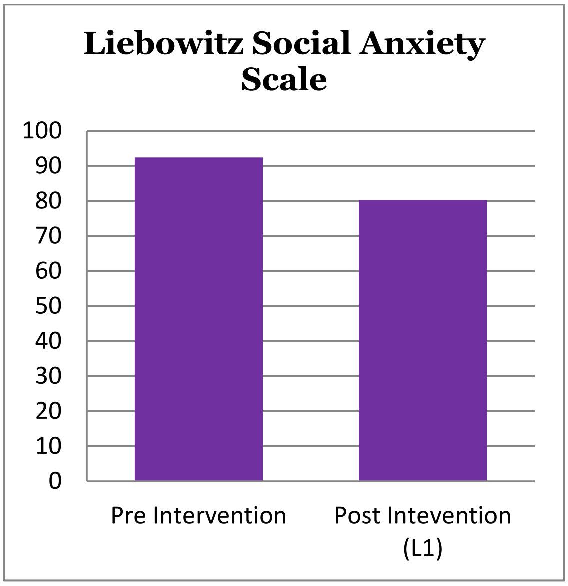


For those with OCD (48 individuals), global (Y-BOCS) scores dropped significantly from 27.6 (*SD* = 17.67) to 20.5 (*SD* = 14.41), *t* (47) = 5.71, *p* < .001, *d* = 0.40, indicating an overall reduction in the severity of OCD symptoms.



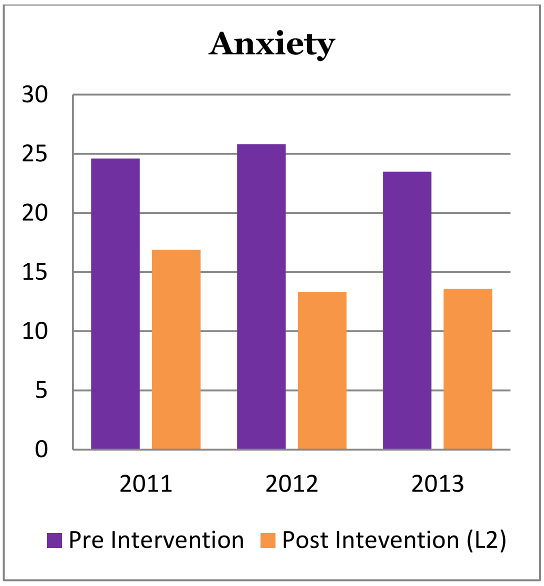
For those 22 participants with generalised anxiety disorders (GAD) scores on the PSWQ dropped significantly from 60.0 (SD = 12.19) to 53.3 (SD = 11.38), t (18) = 3.00, p < .01, d = 0.67. The percentage of completers (22 individuals) scoring above 60, indicating greater levels of social phobia, on the LSAS at the start of the programme reduced from 87.5 % to 72.7% after completing Level 2.

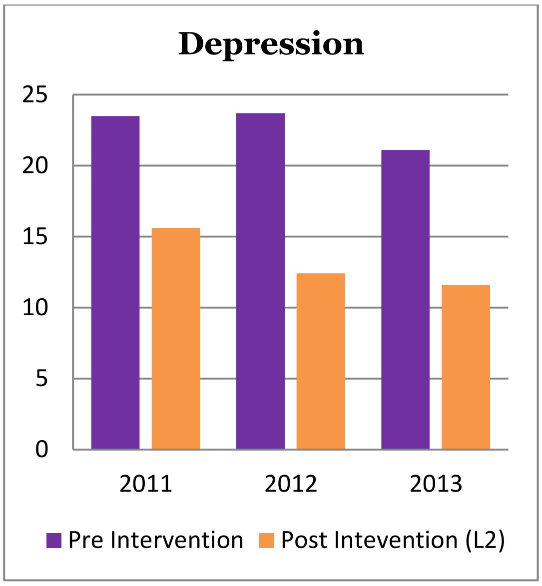
This decrease in levels of social phobia did not reach significance (see graph below).



4.5.4. Level 2 Results

Numbers were low (26 service users) for those who started Level 2 as only 3 cycles ran in 2013. Pre and post data were available for 6 – 18 people across all strands of the programme (depending on the measure) and 10 people with OCD specifically. Post data reflects data collected after Level 2 of the anxiety programme.



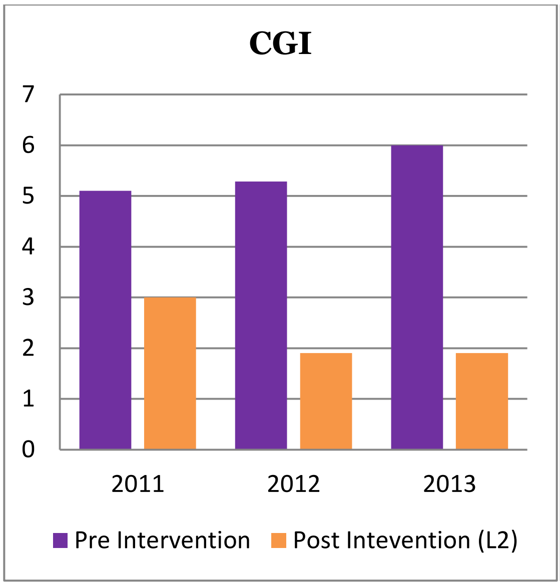


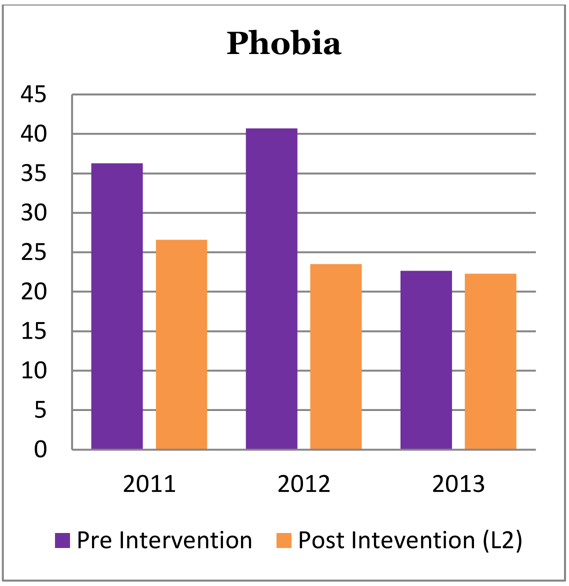
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that Anxiety Programme completers moved from the higher end of the moderate (*M* = 23.5, *SD* = 14.1) to the mild (*M* = 13.6, *SD* = 10.78) range on the measure. Changes were statistically significant, t(17) = 4.1, p<.001, and represents a large effect (Cohen's *d* = 0.90). At the pre measurement time point, 39.5% had anxiety scores in the severe range, this dropped to 11.1% by the end of Level 2 (See the table below).

% in each category	**Anxiety (BAI)**		**Depression (BDI)**	
	PRE	**POST**	**PRE**	**POST**
Minimal	8.4	33.3	13.4	38.9
Mild	23.5	33.3	29.4	55.6
Moderate	27.7	22.2	32.8	0.0
Severe	39.5	11.2	24.4	5.6
Totals	**100**	**100**	**100**	**100**

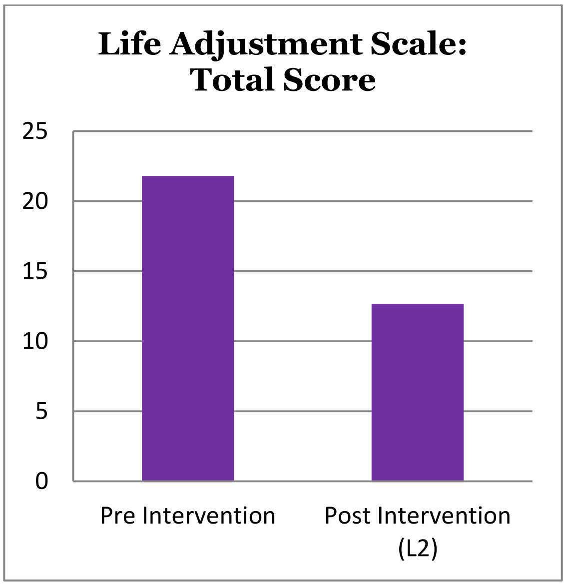
Average depression scores for Anxiety Programme completers (indicated on the graph above) were in the moderate range (*M* = 21.1, *SD* = 10.6) and showed a statistically significant drop to within the mild range (*M* = 11.6, *SD* = 8.63), t(17) = 4.0, *p* < .001, which represented a large effect (Cohen's *d* = 1.07). While 24.4% were classified has having severe depression before the programme, 5.6% were classified as such by the end of Level 2 (See table above).

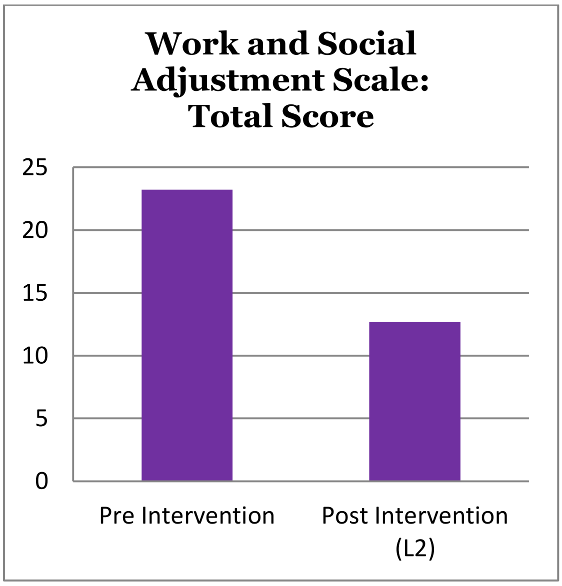
The mean pre programme Severity of Illness (measured using the CGI) was 5.2 (*SD* = 0.46) out of a possible 7 suggesting that people were *markedly ill* but were in the very *much improved* category after completing level 2 of the programme.



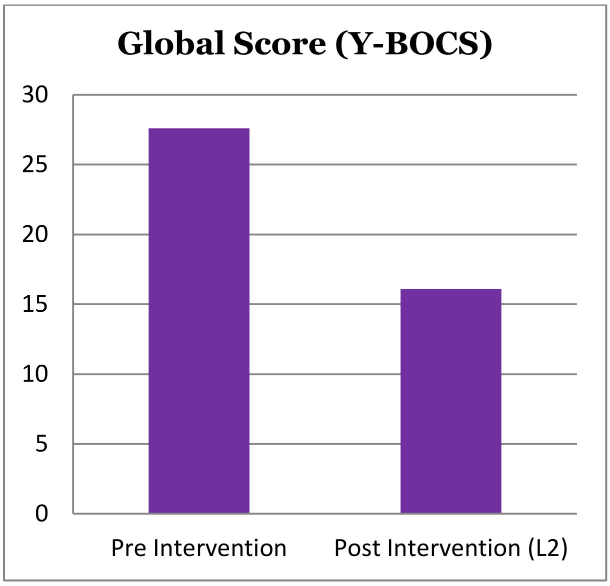


Total phobia scores did not show a significant drop from a mean of 22.7 (*SD* = 20.7) to 22.2 (*SD* = 20.0).





Of those who completed measures in 2013, 12 completed the Life Adjustment Scale while 6 completed the Work and Social Adjustment Scale. Statistically significant improvements were reported for impairment on the Life Adjustment Scale (LAS), t(11) = 2.53, $p < .05$, representing a large effect (Cohen's d = 0.80) on functioning. Like the LAS a significant improvement was reported for impairment on the Work and Social Adjustment Scale, t(4) = 3.25, $p < .05$, representing a large effect (Cohen's d = 1.85) on functioning. Effect sizes of 1.75 and 2.53, respectively, indicated large effects on functioning.



For those with OCD, global (Y-BOCS) scores dropped significantly from 26.1 (*SD* = 6.43) to 16.1 (*SD* = 3.76), *t* (9) = 5.10, *p* < .001, *d* = 1.90.

Due to a very small number of completers on the Penn State Worry Questionnaire and the Liebowitz Social Anxiety Scale analysis of these measures could not be undertaken.

4.5.5. Summary

Level 1: Outcomes for the 119 service users who completed Level 1 of the Anxiety Programme between January and December 2013 were positive, and suggest improvements in anxiety and depression symptoms, levels of phobia related avoidance, global OCD symptoms, pathological worry and impairment in functioning. All changes were statistically significant with small to large effect sizes.

Level 2: Numbers were low for those who started Level 2 as only 3 cycles ran in 2013. Outcomes for the service users who completed pre and post measures at Level 2 of the Anxiety Programme in 2013 were positive, and suggest improvements in anxiety and depression symptoms, global OCD symptoms, and impairment in functioning. All changes were statistically significant with small to large effect sizes.

Changes in mean scores for most measures were remarkably similar when 2011, 2012 and 2013 data, after both Level 1 and Level 2, are compared suggesting a degree of consistency over the last three years. Please note however that the data represents two different cohorts and different sample sizes.

With the successful pilot of two separate strands of the anxiety programme, the transdiagnostic group and the OCD specific group, it is recommended that a separate analysis of the OCD strand be completed in 2014. This will allow for data from the OCD strand in 2014 to be compared to the pilot analysis carried out in 2012, which found that those individuals who completed the OCD specific strand showed a greater improvement than those individuals diagnosed with OCD who completed the transdiagnostic strand of the programme.

4.6. Eating Disorder Programme

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

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

Following inpatient treatment, service users will usually attend day services. Often service users will attend daily for the first two weeks and subsequently reduce attendance, which is decided by the service user and treating MDT. The day programme runs Monday to Friday and offers a number of group interventions delivered by Nursing, Occupational Therapy and Psychology MDT members, including:

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

Following day services, outpatient care is offered in the Dean Clinic. Services offered at the Dean Clinic include Psychiatry, Nursing, and Dietician reviews, along with CBT sessions, in order to support service users in their recovery. Currently there is a monthly aftercare group held to support service users in goal setting and maintaining motivation. This service will be reviewed in June 2014 in order to improve the effectiveness of this group.

4.6.1. EDP Outcome Measures

The following measures are used as part of the outpatient assessment process at the Dean Clinic, Sandyford. Referrals to this service generally come from GPs who provide relevant medical and laboratory test results in advance of the appointment. The battery of measures below has been chosen to capture eating disorder severity and co morbidity, and to assess readiness for change.

- **Eating Disorder Examination – Questionnaire**

The Eating Disorder Examination Questionnaire (EDE-Q: Fairburn and Beglin, 1994) is a self report version of the Eating Disorder Examination (EDE: Fairburn and Cooper, 1993) which is considered to be the “gold standard” measure of eating disorder psychopathology (Guest, 2000). Respondents are asked to indicate the frequency of certain behaviours over the past 28 days as well as attitudinal aspects of eating-disorder psychopathology on a seven point rating scale. Twenty-seven items contribute to a Global score and four subscales including: Restraint, Eating Concern, Weight Concern, and Shape Concern. Items from each subscale are summed and averaged with the global score generated by summing and averaging the subscale scores (resulting scores range from 0 – 6 for each subscale and the global score). Higher scores suggest greater psychopathology. Evidence in support of the reliability and validity of the measure comes from a number of studies (e.g. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

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

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

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

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

- ### Beck Anxiety Inventory

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

- **Beck Depression Inventory**

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

- **Clinical Impairment Assessment**

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

- **University of Rhode Island Change Assessment Questionnaire**

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

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

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

4.6.2. Descriptive Statistics

Eighty-nine service users attended the EDP as an inpatient in 2013 and 48 attended as a day-patient. As there are multiple care pathways within the EDP, data was collected at four time points:

- At initial assessment in the Dean Clinic (time point 1)

- At commencement of inpatient services (time point 2)
- At inpatient discharge or upon beginning day patient care (time point 3)
- At discharge of day patient services (time point 4)

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

In order to maximise the use of collected data, descriptives are provided below for all service users who completed the outcome measures at each time point. Though not all this data could be used in the pre/post analysis, this offers some insight in participants' experiences at each time point. In total, one hundred and five services users completed an outcome measure at least once. Of this 94 (88.7%) were female. See the table below for the number of service users who completed outcome measurement at each time point.

Table: Number of service users with recorded data at each time point

Time points (TP)	Number of service users with data (N=105)
TP 1	63
TP 2	44
TP 3	35
TP4	20
T1 & T3	10
T1 & T4	6
T2 & T3	11
T2 & T4	2

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

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

Measure	Mean	SD	N
Beck Anxiety Inventory	22.45	11.96	65
Beck Depression Inventory	26.51	11.43	63
EDE-Q Global	3.79	1.53	57
EDE-Q Restraint	3.24	1.77	63
EDE-Q Eating Concern	3.58	1.56	63
EDE-Q Shape Concern	4.23	1.64	61
EDE-Q Weight Concern	4.03	1.7	63
Clinical Impairment Assessment	31.73	12.34	33
Motivation (URICA)	8.92	2.57	56

The scores at initial assessment suggest that on average, services users were experiencing moderate levels of anxiety and depression. However, looking closer at the scores on the BDI, 6.3% would be considered to be experiencing ‘normal ups and downs’, 15.9% experiencing ‘mild mood disturbances’, 12.7% experiencing borderline clinical depression, 22.2% experiencing ‘moderate depression’, 34.9% experiencing ‘severe depression’, and 7.9% experiencing ‘extreme depression’.

When looking at the scores on the BAI, though the mean falls within the moderate range, 9.2% reported experiencing ‘minimal anxiety’, 20% ‘mild anxiety’, 30.8% ‘moderate anxiety’, and 39.6% ‘severe anxiety’.

Previous research in the Netherlands using the EDE-Q has suggested that a ‘normal’ global score for adult women without an eating disorder would be on average 0.93, and 4.02 for someone experiencing an eating disorder (Aardoom et al., 2012). The average global score for service users at initial assessment was 3.79.

The average score for the CIA was 31.73, suggesting that service users’ eating disorders were having a high impact on the social, personal, and cognitive aspects of their lives. In their research, Bohn et al. (2008) found a mean score of 31.2 before treatment.

At the initial assessment, the average URICA score was 8.92 which falls within the contemplation stage. Looking at all individual scores, 26.9% fell within the pre-contemplation, 57.7% fell within the contemplation stage and 15.4% fell within the preparation and action stage. Average scores at this time point were similar to those reported in 2012.

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

Measure	Mean	SD	N
Beck Anxiety Inventory	24.79	12.78	43
Beck Depression Inventory	27.31	11.63	42
EDE-Q Global	3.89	1.43	37
EDE-Q Restraint	3.43	1.93	41
EDE-Q Eating Concern	3.81	1.49	40
EDE-Q Shape Concern	4.54	1.47	40
EDE-Q Weight Concern	4.17	1.43	40
Clinical Impairment Assessment	33.4	9.91	25
Motivation (URICA)	9.91	1.7	36

The scores upon entering inpatient care suggest that on average, services users were experiencing moderate levels of anxiety and depression. Based on the BDI scoring norms, 9.5% would be considered to be experiencing 'normal ups and downs', 14.3% experiencing 'mild mood disturbances', 7.1% experiencing borderline clinical depression, 31% experiencing 'moderate depression', 23.8% experiencing 'severe depression', and 14.3% experiencing 'extreme depression'.

When looking at the scores on the BAI, though the mean falls within the moderate range, 7% reported experiencing 'minimal anxiety', 18.6% report 'mild anxiety', 27.9% report 'moderate anxiety', and 46.7% report 'severe anxiety'. The mean EDE-Q Global score (3.89) is suggestive of eating difficulties. The mean CIA score (33.4) suggests that upon entering inpatient treatment, eating difficulties were likely having a strong negative impact on the social, personal, and cognitive aspects of service user's lives.

The average URICA score was 9.91, again falling within the contemplation stage. Looking closer at the scores, only 9.4% fell within the pre-contemplation stage, 75% in the contemplation stage, and 15.6% in the preparation and action taking stage.

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

Measure	**Mean**	**SD**	**N**
Beck Anxiety Inventory	19.31	13.17	36
Beck Depression Inventory	20.91	12.35	34
EDE-Q Global	2.82	1.62	35
EDE-Q Restraint	1.89	1.77	35
EDE-Q Eating Concern	2.37	1.55	36
EDE-Q Shape Concern	3.7	1.89	36
EDE-Q Weight Concern	3.23	1.8	36
Clinical Impairment Assessment	26.55	12.6	29
Motivation (URICA)	10.35	1.25	29

The scores upon finishing inpatient care, and/or beginning day patient services, suggest that on average services users were experiencing moderate levels of anxiety, and borderline clinical depression. Based on the BDI scoring norms, 23.5% would be considered to be experiencing 'normal ups and downs', 23.5% experiencing 'mild mood disturbances', 5.9% experiencing borderline clinical depression, 23.5% experiencing 'moderate depression', 14.7% experiencing 'severe depression', and 8.8% experiencing 'extreme depression'.

When looking at the scores on the BAI, though the mean falls within the moderate range, 28% reported experiencing 'minimal anxiety', 16.8% report 'mild anxiety', 25.2% report 'moderate anxiety', and 30.8% report 'severe anxiety'.

The EDE-Q Global mean score was 2.82, while the CIA was 26.55. Upon finishing inpatient care/ beginning day patient care the average URICA score was 10.35, suggestive of the contemplative stage. At this time point almost all respondents were in the contemplative stage (85.7%), with only 1 in the pre-contemplative stage (4.8%), and 2 in the preparation/action stage (9.5%).

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

Measure	**Mean**	**SD**	**N**
Beck Anxiety Inventory	14.95	9.59	20
Beck Depression Inventory	15.35	10.45	20
EDE-Q Global	2.37	1.35	21
EDE-Q Restraint	1.49	1.55	21
EDE-Q Eating Concern	2.24	1.44	21
EDE-Q Shape Concern	3.25	1.45	21
EDE-Q Weight Concern	2.49	1.42	21
Clinical Impairment Assessment	23.86	13.11	14
Motivation (URICA)	9.49	1.4	19

The scores upon discharge from day patient care suggest that on average, services users were experiencing mild levels of anxiety and depression. Eight percent would be considered to be experiencing 'normal ups and downs', 1.9% experiencing 'mild mood disturbances', 2.8% experiencing borderline clinical depression, 3.8% experiencing 'moderate depression', and only .9% experiencing 'severe' and 'extreme depression'.

When looking at the scores on the BAI 20% reported experiencing 'minimal anxiety', 35% report 'mild anxiety', 30% report 'moderate anxiety', and 15% report 'severe anxiety'.

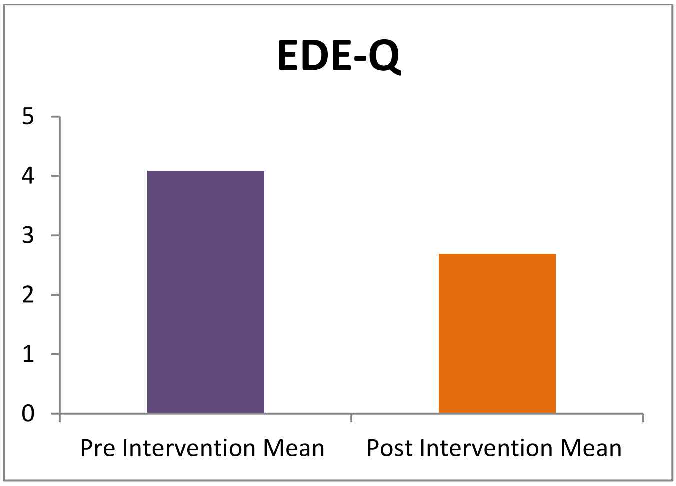
At discharge the average global EDE-Q score was 2.37, which appears lower than Aardoom et al.'s 2012 reported norm score (4.02) for those experiencing an eating disorder, and higher than the norm score for those not experiencing an eating disorder (0.93). The mean CIA score at discharge was 23.86. In one study, Bohn et al. (2008) found that at post-treatment the average CIA score was 8.22.

At discharge the average URICA score (9.49) again fell into the contemplation stage. The majority of respondents scored within this range (n=14; 82.4%), while two scored within the pre-contemplative stage (11.8%) and one within the preparation/action stage (5.9%).

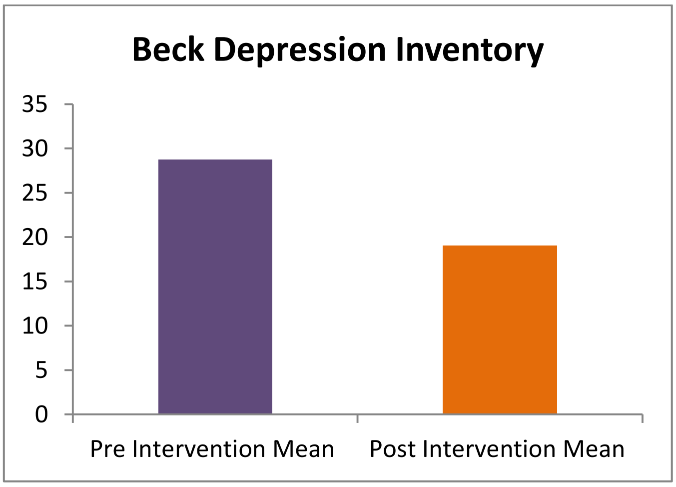
4.6.3. Results

Data from 34 service users at either time point one or two was compared with data collected at either time point time three or four. If data for a service user was available at more than two time points, the data points with the greatest distance between them were used. Data was collected from 105 service users in total and so this analysis represents findings for 32.4% of service users who attended EDP in 2013. Thus the sample is not representative of all those who received EDP treatment in 2013, but still offers important information for a sub-group of those who received care. Results from paired sample t-tests for each measure used can be seen in the table below.

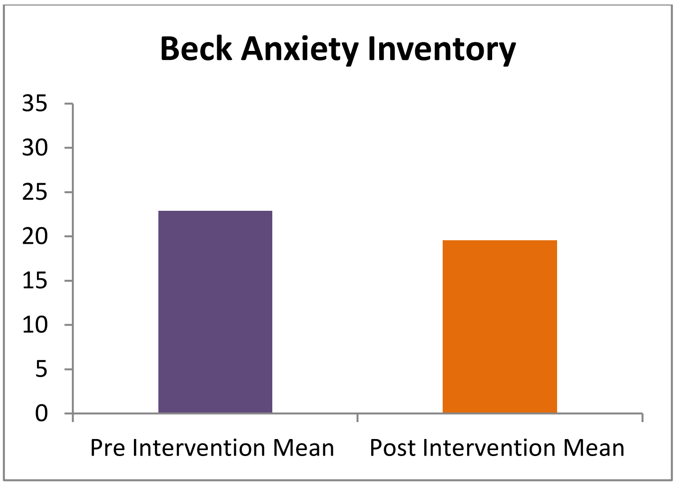
A highly significant improvement was seen in eating disorder symptomology after completing the programme, as reflected by a reduction of scores on the EDE-Q, showing a very large effect size (*d*=0.99). At pre intervention the average score was 4.08, in line with previous research. Post intervention the mean score was 2.69, which is still above previous recorded scores for the general population (M=0.93). However, the post intervention mean appears more similar to previous scores found for those who are obese (M=2.75), perhaps suggesting that while there was a very large reduction seen in eating disorder symptomology, some disordered eating remains for service users upon finishing the programme.



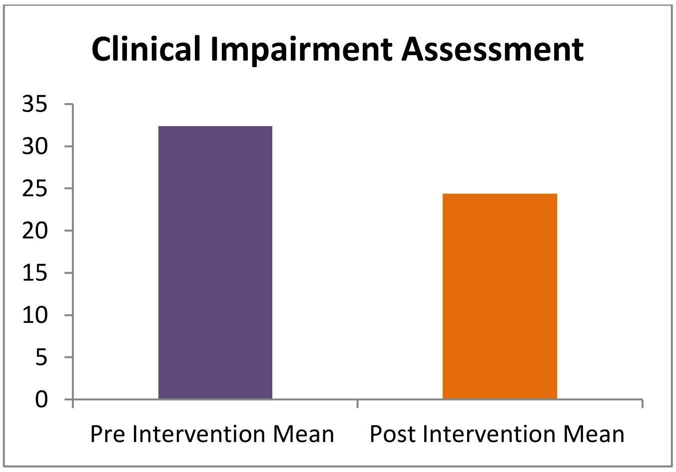
Scores on the BDI were also seen to reduce significantly, again showing a large effect size (*d*=0.85). Pre intervention the mean score on the BDI (28.76) fell within the 'moderate' range. At post intervention the mean score (19.06) fell within the 'borderline clinical' range.



No significant change was seen in scores on the BAI. This may suggest that anxiety levels neither increased nor decreased after treatment. A small effect size of 0.29 would support this interpretation. At both pre (M=22.86) and post (M=19.54) intervention the average scores fell within the 'moderate' range. There may be many variables that contribute to this finding, and we are unable to determine what they are in this report. However, some possible aspects to consider include the potential anxiety a service user may feel when being discharged from inpatient or day patient services, or the potential anxiety a service user may feel when disordered eating behaviours have been reduced, among others.



Scores on the CIA were not seen to reduce significantly, however, a moderate to large effect size was observed (0.66), suggesting some meaningful change in scores. At pre intervention the average score (M=32.37) was similar to previous research looking at the clinical impairment associated with eating disorders, before treatment (see Bohn et al. 2008). The average post intervention score (M=24.33), however, does appear to be greater than previously post intervention scores (M=8.22) reported in previous research. However, there could be many factors that contribute to this apparent difference in post-treatment scores, including for example, different service users, and treatment content and length, among others.



No significant change was seen in readiness for change. Cohen's d was -0.3, suggesting a small effect size. The average score at both pre (M=9.6) and post (M=10.12) intervention fall within the contemplation stage, suggesting that service users may have been in a position to get ready to make change, considering the pros and cons of their behaviours.

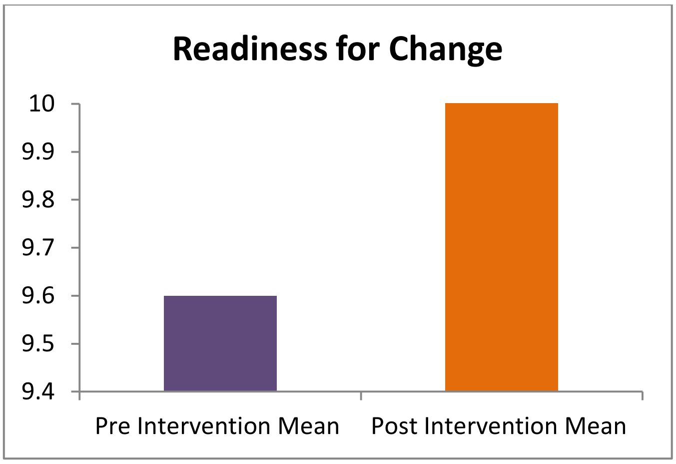


Table: *Results from paired samples t-tests for measures pre and post Eating Disorder Programme.*

Measures	**Pre Mean (SD)**	**Post Mean (SD)**	***t***	***df***	***p***	**Cohen's *d***
EDE-Q	4.08 (1.32)	2.69 (1.5)	6.18***	32	.000	0.99
BAI	22.86 (10.79)	19.54 (12.17)	1.85	34	.073	0.29
BDI	28.76 (10.28)	19.06 (12.44)	5.38***	32	.000	0.85
CIA	32.37 (10.18)	24.33 (13.79)	2.57	22	.018	0.66
URICA	9.6 (2.13)	10.12 (1.28)	-1.18	26	.247	-0.3

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

4.6.4. Summary

The assessment battery for the EDP is comprehensive and provides a useful profile of patients attending the service. However, the comprehensive nature of the measures may contribute to a difficulty in collecting data at all chosen time points, in turn contributing to less representative results and greater variation in the services being measured. It should be noted that from August 2013 to December 2013 there has been a higher rate of data collection, likely due to increased effort from EDP staff.

4.7. Living through Distress Programme

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

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

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

The programme (now in its seventh year) is run by the psychology department and is a six week programme involving three afternoon sessions per week. Eight skills are taught twice over this time period making the programme 16 sessions in all. Patients who attend the majority of the programme i.e. see at least eight skills are invited to attend Aftercare which runs once a month.

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

4.7.1. Living Through Distress Programme Outcome Measures

- **Deliberate Self-Harm Inventory**

The Deliberate Self Harm Inventory (DSHI; Gratz, 2001) measures the frequency, severity, duration and type of self-harm behaviour. Participant's frequency responses to the 17 items are summed to create a total frequency score. The DSHI has demonstrated good internal consistency ($\alpha = .82–.83$), test-retest reliability ($r = .92$), construct validity, and concurrent validity (Gratz, 2001). In a comprehensive evaluation of measures of self-harm, Latimer, Meade and Tennant (2013) found that along with 5 other measures, the DSHI demonstrated strong psychometric properties including reliability, external validity and clear uni-dimensional factor structure. In a sample of women who self-harm who participated in a research study frequency scores on the DSHI went from 18.58 ($SD = 26.63$) to 5 ($SD = 4.94$) following intervention (Gratz & Gunderson, 2006).

- **Difficulties in Emotion Regulation Scale**

The Difficulties in Emotion Regulation Scale (DERS; Gratz and Roemer, 2004) assesses emotion dys-regulation, comprising six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 “almost never” to 5 “almost always”. Total scale scores range from 36 to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability ($\alpha = .93$), construct and predictive validity, and test-retest reliability in the development study.

- **Distress Tolerance Scale**

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

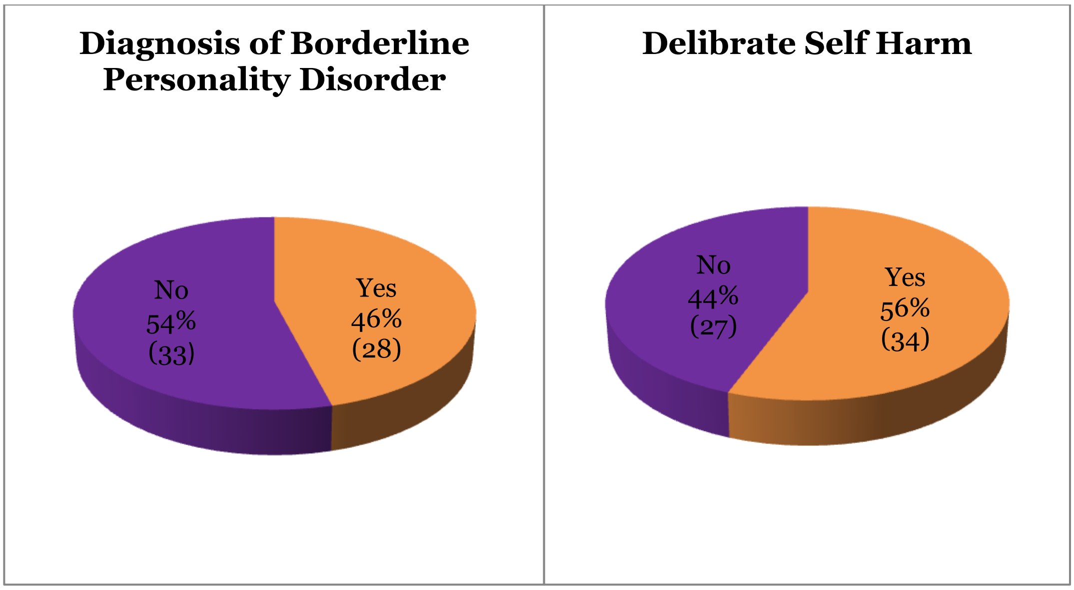
- **Five Facet Mindfulness Questionnaire – Short Form**

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

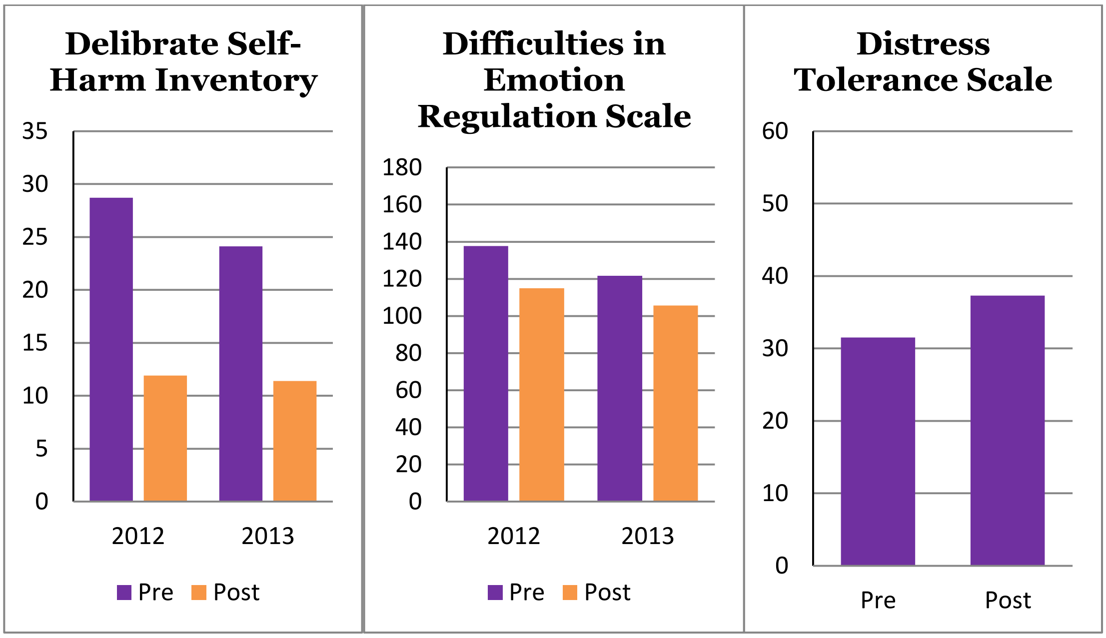
4.7.2. Descriptors

Baseline data were available for 61 participants, due to data corruption scores were not available for one cycle of the programme run in 2013. Pre and post data were available for 57 participants for the FFMQ (93.4%), 52 for DERS (85.2%) and 44 (72.1%) for the DTS, respectively.

Of the 61 group attendees, 80.3% were female. LTD attendees ranged in age from 19 to 65 years (*M* = 37, *SD* = 12.6). As indicated in the charts below, approximately 46% had a diagnosis of Borderline Personality Disorder and 56% of LTD attendees reported that they had engaged in self-harm behaviours.



4.7.3. Results

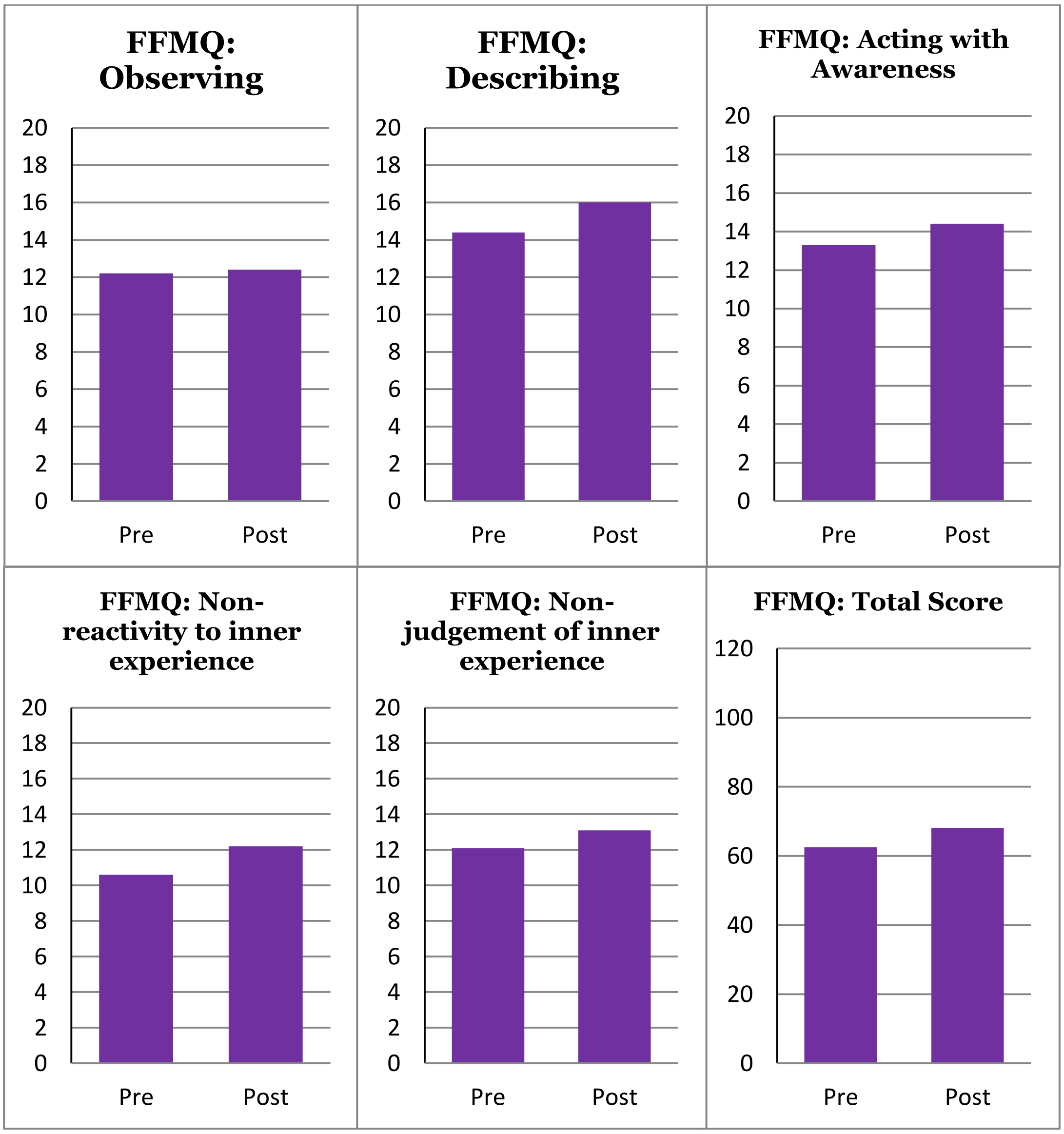


Note: Higher scores indicate more self-harm incidents, more difficulties regulating emotion and greater distress tolerance.

Significant gains were made across measures from pre to post programme participation. Participants on the programme showed statistically significant decreases in levels of self-harm from before (M = 24.14, SD = 48.8) to after (M = 11.39, SD = 30.9) completion of the programme, t (60) = 2.94, p < .005, reflecting a medium effect (d = .50).

Participants also experienced a decrease in difficulties regulating emotions moving from an average score of 121.7 (*SD* = 22.53) on the DERS pre to 105.6 (*SD* = 19.66) post completion of the programme, *t* (51) = 4.38, *p* < .001. This change represented a large effect (*d* = .76).

Participants also experienced a significant increase in distress tolerance moving from an average score of 31.5 (*SD* = 9.99) before the programme on the DTS to 37.3 (*SD* = 8.06) after completing the programme, *t* (43) = -3.12, *p* < .005, representing a medium effect (*d* = .64).



Statistically significant improvements were reported for levels of mindfulness in two of the five domains of the FFMQ, describing and non-reactivity to inner experience. Both t-test comparisons $p < .01$, with effect sizes d of .38 to .40, respectively, indicate medium effects on level of mindfulness.

Total levels of mindfulness also increased significantly from an average of 62.5 ($SD = 14.40$) at the start to 68.1 ($SD = 12.63$) at completion of the programme, $t(56) = -2.59$, $p = .012$, representing a medium effect ($d = .42$).

4.7.4. Summary

For those participants with pre and post data, significant improvements were observed in terms of self-harm, emotion regulation, and levels of overall mindfulness following engagement with LTD. Effect size calculations suggest small to large effects.

2013 saw the addition of a new outcome measure for a core therapeutic target of DBT, distress tolerance. Pre and post data showed significant improvements, with a medium effect size, in distress tolerance for those participants who completed LTD.

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

The programme will continue to provide 16 skill-group sessions, three times a week. Following these 16 sessions, each LTD group will receive an additional 4 skill-group sessions, once a week for 4 weeks. This will enable us to introduce additional skills that will help to address areas of need such as interpersonal effectiveness in more depth.

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

At this point, outcome measures for the programme will remain the same.

4.8. Mindfulness Programme (SEH)

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

4.8.1. 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 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 increased scores suggesting increased mindfulness. The measure has shown good reliability in previous research (alpha = .72 to .92 for each facet; Baer et al., 2006).

4.8.2. Descriptors

In 2013 pre and post data were available for 53 services users who completed the mindfulness programme in St Edmundsbury. Of this, 38 (71.7%) were female. No further descriptive data were available for service users in 2013, however, further information will be collected in 2014.

4.8.3. Results

A highly significant increase was seen in total scores on the FFMQ from pre intervention (M=109.35; SD=21.05) to post intervention (M=119.51; SD=20.3), t(52)=-3.61, *p*=.001, reflected by a medium effect size (*d*=0.49). These results would suggest that service users, who completed the programme and the outcome measure, reported a meaningful increase in their tendency to be mindful in daily life. Data was not available to look at the scores on each sub-scale in 2013, however, this will carried out in the 2014 report.

4.8.4. Summary

Outcomes for the mindfulness programme in St Edmundsbury are being reported for the first time in 2013. Results suggest that the programme is successful in helping service users to cultivate an ability to be more mindful in daily life. Plans to expand on next year's outcome data collection and reporting include: 1) collecting greater demographic information in order to better understand whose data is being reported on, 2) completing a closer analysis on individual sub-scales in order to identify whether the programme appears to be equally helpful in contributing to change, across the five facets of mindfulness, and 3) to include outcome data for the mindfulness programmes run in St Patrick's Mental Health Services.

4.9. Radical Openness Programme

The Radical Openness (RO) Programme is a Dialectical Behaviour Therapy (DBT) informed therapeutic skills group, delivered by the Clinical Psychology Department. The programme focuses on the development of skills including emotion regulation, mindfulness, interpersonal effectiveness, and compassion. 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 in order to cope with difficult situations in their lives.

Through learning and practicing Radical Openness skills, the group aims to offer participants flexibility in: 1) experiencing and expressing emotion, 2) developing more fulfilling relationships, and 3) being more open to what life can offer. The group is trans-diagnostic, however, the theory behind it suggests that for some, these experiences of behavioural over-control, rigidity, and emotional constriction can underpin 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.

4.9.1. Radical Openness Programme Outcome Measures

- **Acceptance and Action Questionnaire - II**

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

- **Brief symptom Inventory**

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

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

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

- **Emotion Control Questionnaire-2; Emotional Intelligence Scale**

The Emotion Control Questionnaire-2 (ECQ-2: Roger & Najarian, 1989) consists of 56 true or false items which measure a respondent's tendency to inhibit the expression of emotional responses. The original measure has four subscales, however, for the purpose of outcome measurement, only the 'Emotional inhibition' (the tendency to inhibit experienced emotion) scale has been used (See Roger, de la Banda, Lee and Olason, 2001). Scores can range from 0 to 28, with higher scores indicating greater emotional inhibition. The emotional inhibition subscale is reported to have good internal consistency (Chronbach's alphas=.86) and good test-retest reliability (Cronbach's alpha=.80 over a 7 week period).

- **Ego Under Control Scale**

The Ego-Under Control Scale (Letzring, Block, & Funder, 2005) is a 37-item measure of ego-control, designed to assess the expression or inhibition of impulses. Higher scores are suggestive of under-control and impulsivity, and lower scores are indicative of over-control and inhibition. Letzring et al. (2005) have suggested the measure is reliable (alpha=0.63) and shows validity, through correlation with personality characteristics consistent with theoretical conceptualisations.

- **Personal Need for Structure Scale**

  The Personal Need for Structure Scale (PNS; Neuberg & Newsom, 1993; Thompson, Naccarato, Parker, & Moskowitz, 2001) is an 11-item measure, scored on a 6-point likert scale, which aims to measure over-control through assessing preference for structure and clarity, and discomfort caused by ambiguity. A greater need for structure suggests an individual may struggle to be flexible in unexpected situations. The PNS is constructed of two subscales, 'desire for structure' (DFS; desire to be in a well-defined environment) and 'response to lack of structure' (RLS; reactions to unstructured environments). The subscales have been found to be reliable with reported alpha values ranging from 0.62 to 0.78 for the 'desire for structure' subscale and alpha values of 0.69 to 0.82 for the 'response to lack of structure' subscale.

- **The Social Safeness and Pleasure Scale**

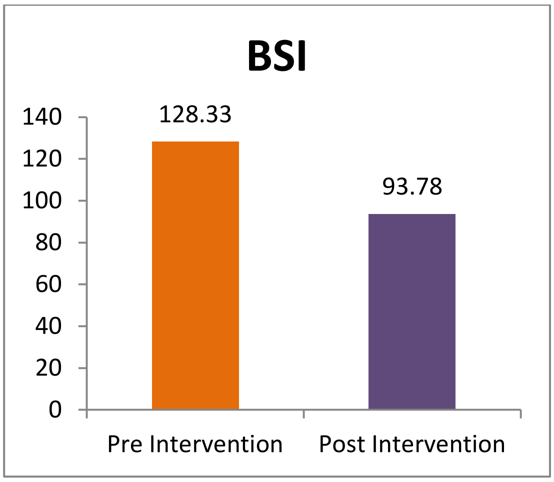
  The Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009) aims to measure service users' feelings of safety, warmth, acceptance, and belonging within their social world. The measure is a brief 11-item, 5 point likert scale, with responses ranging from 0 'Almost never' to 4 'Almost all the time'.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

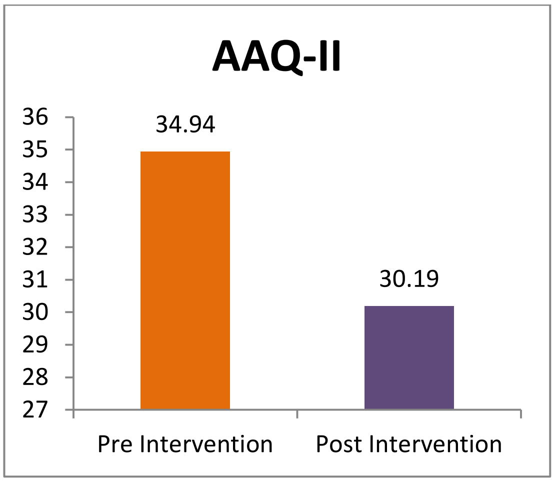
4.9.2. Descriptors

Pre and post data were available for 61 participants in 2013, representing 88.5% of those who completed the RO programme. Twenty-four participants were male (44.4%) and 30 were female (55.6%), and ranged in age from 18 to 66 years (M=44.3; SD=13.4).

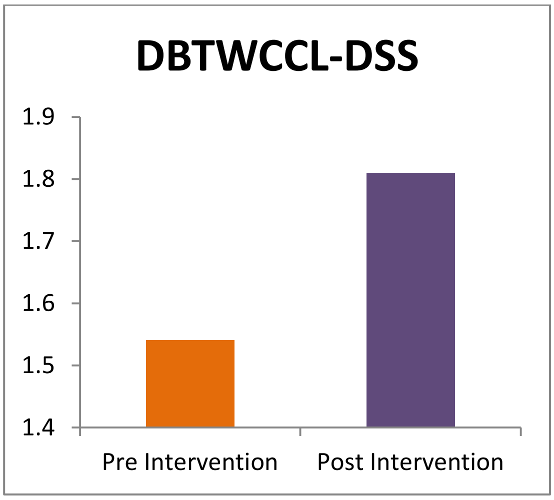
4.9.3. Results

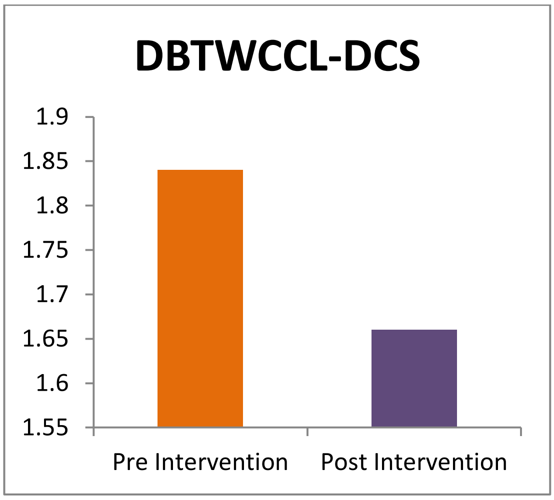
A highly significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in scores on the BSI, reflecting a very large effect size (*d*=.98). A significant change was also observed on the AAQ-II, reflecting a medium to large effect (*d*=.58), suggesting that after the programme participants were less avoidant of their emotions and more able to accept and acknowledge their emotional experiences.





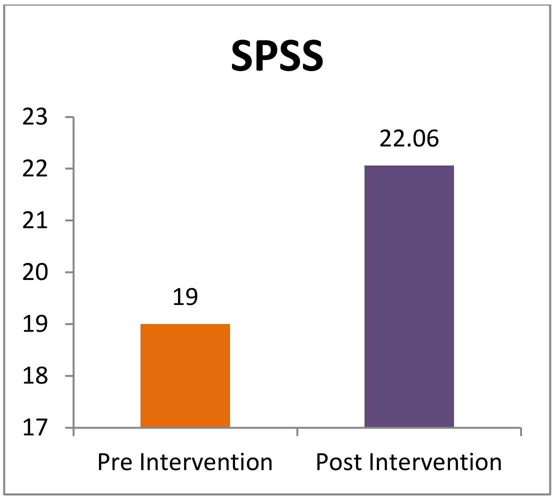
Participants were also found to be using significantly more of the DBT skills/ways of coping after completing the programme. This was reflected by a significant increase in the DBT-WCCL Skills Use Subscale, and a medium to large effect size (*d*=-.6). A non-significant change was observed on the DBT-WCCL Dysfunctional Coping Scale, suggesting that though there was a large change in beginning to use the skills taught in group, there was less change seen in participants letting go of less helpful ways of coping. However, a medium effect (*d*=.44) was observed, which may suggest that there was some meaningful reduction in unhelpful coping, but that other factors, such as small sample size and an adjusted alpha value, may have contributed to a non-significant finding.





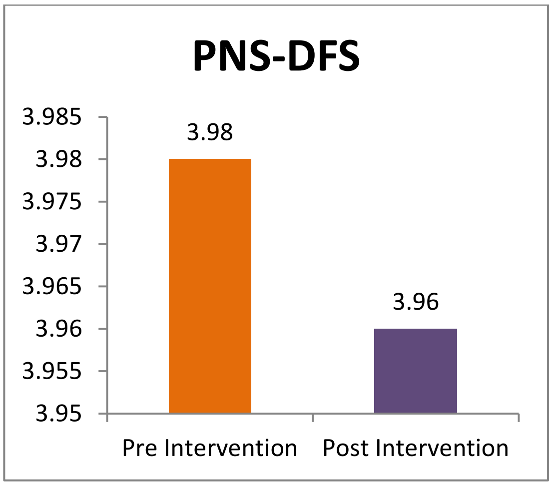
No significant change was observed for scores on the ECQ-EI subscale, reflected by a very small effect size (d=-.13). These findings would suggest that after completing the group participants showed similar levels of emotional inhibition, i.e. the desire and/or tendency to inhibit emotional responses rather than sharing them with others.

The EUCS showed poor reliability post intervention (alpha=.585) suggesting that this is not be a reliable measure of emotional control in this instance, and inferences regarding the outcomes of the programme cannot be made from this scale.



Though the mean scores increased from pre to post intervention, there was no significant change in participant's scores on the SSPS, reflected by a small effect size (*d*=-.22), suggesting little increase in general feelings of safeness, belonging, and acceptance in a social context after completing the group.

No significant changes were observed for the PNS subscales, Desire for Structure and Response to Lack of Structure, reflected by very small effect sizes (*d*=0.02 and *d*=0.07, respectively). These findings would suggest that after completing the group participants showed a similar need for structure. It may be that participants experienced no change in these areas post intervention, or there may be other factors which contributed to this finding. For example, the PNS showed a reduction in alpha value post intervention which may suggest the scale was less reliable at measuring need for structure in this instance. See the table below for all test statistics.



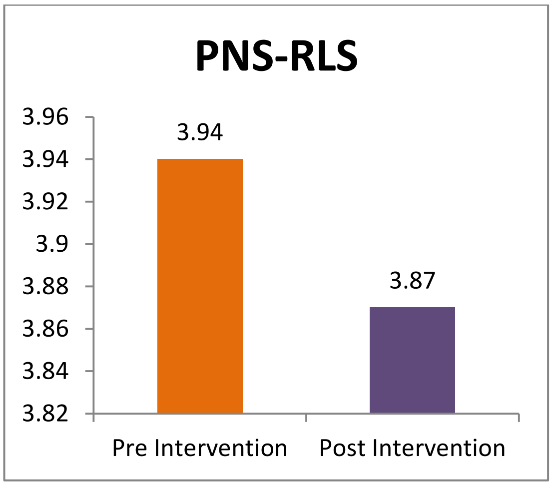


Table: *Results from paired samples t-tests for measures pre and post Radical Openness intervention.*

Scale	**Pre Mean (SD)**	**Post Mean (SD)**	***t***	***df***	***p***	**Cohen's *d***	**Pre & Post α**
BSI	**128.33** **(31.93)**	**93.78** **(38.59)**	**5.96****	**53**	**.000**	**.99**	**.950** **.959**
SSPS	19.0 (11.4)	22.06 (10.75)	-2.18	50	.034	-.22	.944 .955
PNS-DFS	3.98 (1.07)	3.96 (.79)	.122	47	.904	0.02	.846
PNS-RLS	3.94 (1.13)	3.87 (.84)	.375	47	.709	0.07	.659
AAQ	**34.94** **(7.99)**	**30.19** **(8.37)**	**3.76****	**47**	**.000**	**.58**	**.857** **.858**
EUCS	88.91 (13.63)	83.19 (19.57)	2.44	46	.018	.41	.737 .585
ECQ-EI	21.08 (5.31)	21.6 (4.84)	-1.13	47	.264	-.13	.898 .922
DBTWCCL-DSS	**1.54** **(.5)**	**1.81** **(.39)**	**-3.57****	**39**	**.001**	**-.6**	.897
DBTWCCL-DCS	1.84 (.36)	1.66 (.46)	2.58	41	.014	.44	.818

A Bonferroni correction was applied to account for multiple tests and thus significance is shown at $p<.006$=* and $p<.001$=**. BSI=Brief Symptom Inventory, SSPS=Social Safeness and Pleasure Scale, PNS-DFS=Personal Need for Structure-Desire for Structure, PNS-RLS=Personal Need for Structure-Response to Lack of Structure, AAQ=Acceptance and Action Questionnaire 2, EUCS=Ego Under-control Scale, ECQ-EI=Emotional Control-Emotional Inhibition, DBTWCCL-DSS=DBT Ways of Coping Checklist-DBT Skills Subscale, DBTWCCL-DCS=DBT Ways of Coping Checklist-Dysfunctional Coping Scale

4.9.4. Summary

The Radical Openness programme offers skills and new ways of coping to those who have been doing their best to cope using an emotionally over-controlled style. This is a targeted approach for service users who are often underserved in mental health care. This year a new battery of assessments were used in order to better capture change that may occur during the programme. In 2012 attendees showed significant decreases in hopelessness, self-judgement, over-identification with thoughts and feelings, and experiential avoidance, coupled with an increase in mindfulness. In 2013 participants were found to show a significant decrease in mental ill-health symptoms and in emotional avoidance. A significant increase was also seen in the use of DBT coping skills. RO aims to support and improve participants' mental health through three key areas: 1) emotional avoidance and inhibition, 2) flexibility and openness to life, and 3) relationships and intimacy. A large improvement in mental health was seen, along with an improvement in emotional avoidance (i.e. avoiding the internal experience of emotion) and helpful coping skills. However, little improvement was indicated in the areas of emotional inhibition (i.e. not expressing emotion to others), flexibility and openness to life, and relationships and intimacy. As discussed above this may be due to a lack of available reliable and valid measurement choices rather than no meaningful change in these areas. However, it may also be that participants are not experiencing large changes in their preferences and personalities, but rather that with the support of Radical Openness skills, they are now more open to experiencing emotion and have the tools that can help in managing difficult life situations.

4.10. 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.

4.10.1. Psychosis Programme Outcome Measures

- **Recovery Assessment Scale**

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

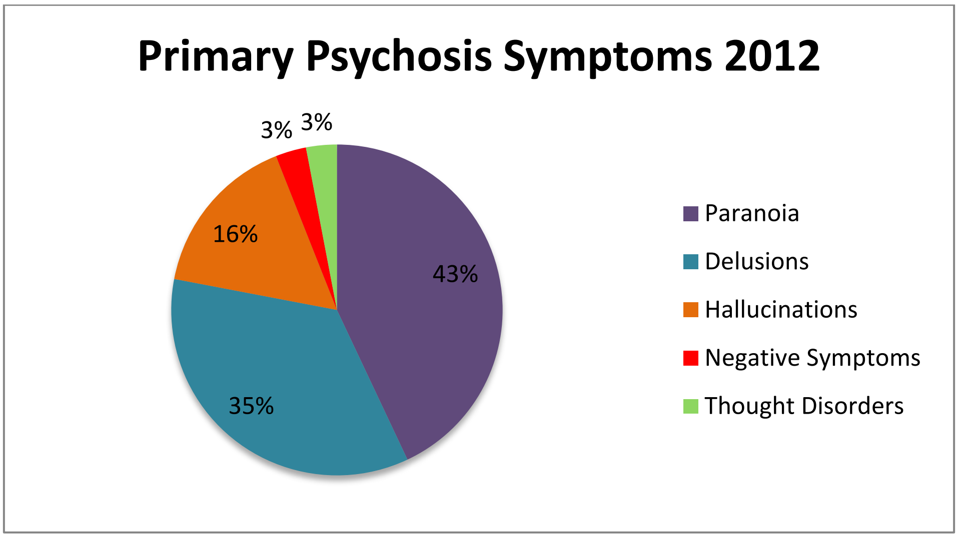
- **Drug Attitude Inventory**

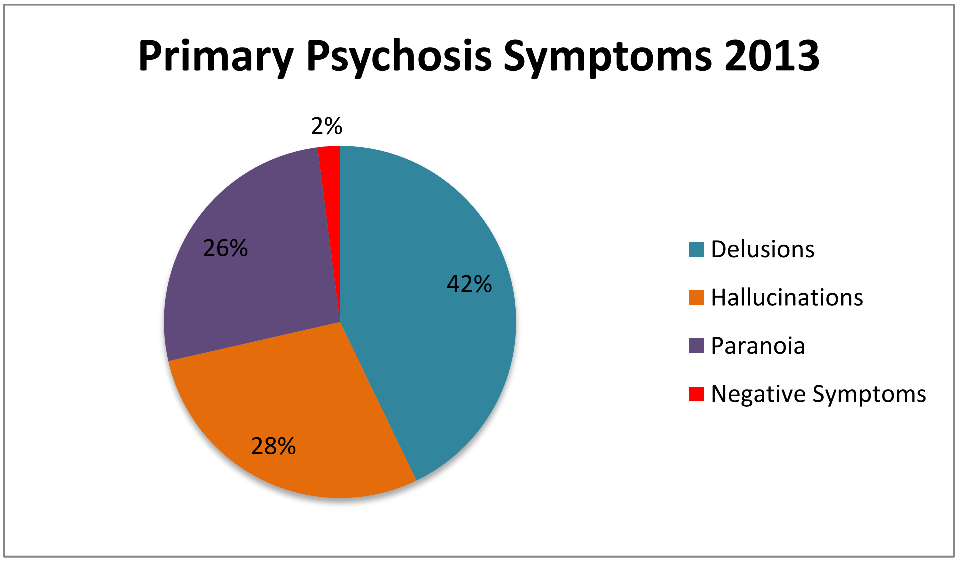
  The Drug Attitude Inventory (DAI: Hogan, Awad & Eastwood, 1983) is a 30 item questionnaire to measure service users' attitudes towards psychotropic treatment. Each statement has true or false response options. Scores range from 0-30 with higher scores indicating more positive views about medication. The measure has been shown to have good reliability (alpha=0.93) and test-retest reliability (alpha=0.82; Hogan et al., 1983).

4.10.2. Descriptors

In 2013 pre and post RAS scores were available for 58 participants, and pre and post DAI scores were available for 58 participants. The average age of psychosis programme participants was 36.65 years (ranging from 18 to 77 years) and 61.4% were male (n=35). Seventy-seven percent were single, 19.3% married, 3.6% separated or divorced. Similar proportions were employed (35.1%) and unemployed (36.8%), 14% were students, 5.3% were retired and a further 5.3% worked in the home. A third had attained a third level degree, compared to almost half in 2012. Twenty-two percent had completed the leaving certificate, 12% had a non-degree third level qualification, with the remaining 10% having left school before the leaving certificate. The majority lived with family (67.4%) followed by living alone (28.3%). One percent were homeless, living with friends, or cohabiting. The majority of service users reported their ethnicity as white Irish (96.7%). Comparing 2012 to 2013, services users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment. Without using statistical methods to determine the magnitude of the difference, it does appear that less services users in 2013 had completed a college degree.

There also appeared to be some differences in the primary psychosis experience reported for service users in 2012 and 2013. It is not clear whether this may reflect differences in service users' experiences, or differences in clinicians' judgement, as they were clinician rated. In 2013 the primary reported symptoms were delusions, followed by hallucinations, and paranoia. In 2012 the same three experiences were most reported, however, the order was: paranoia, delusions, and hallucinations. See the figures below for reported primary psychosis symptoms in 2012 and 2013. Attendance data were available for 45 participants and indicated that the average number of days attended was 4.9 days (SD=3.5) in 2013 compared to 7.9 (*SD* = 4.7) days in 2012. Attendances ranged from 1 to 19 days in 2012 and 1 to 21 days in 2013. Participants are permitted to attend multiple cycles of the programme.





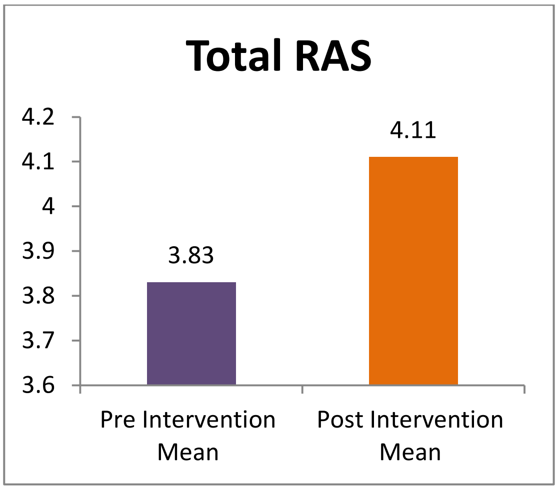
4.10.3. Results

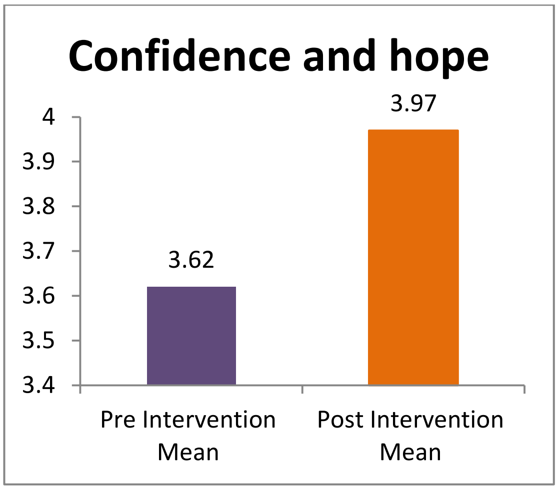
A significant improvement was seen in total scores for the RAS, and a medium to large effect size. Looking closer at the scores on the sub-scales of the RAS, highly significant improvements were seen for users on the ‘Confidence and hope’, ‘Willingness to ask for help’, and ‘Goal and success orientation’ sub-scales, all of which showed a medium to large effect size. A significant improvement was also seen on the ‘No domination by symptoms’ sub-scale, showing a small to medium effect. The change in scores observed for the ‘Ability to rely on others’ sub-scale was not significant and the effect size was small, suggesting that there may have been little meaningful change in relation to service users becoming more able to rely on others after treatment. See the table below for test statistics, and figures for differences in pre and post intervention means.

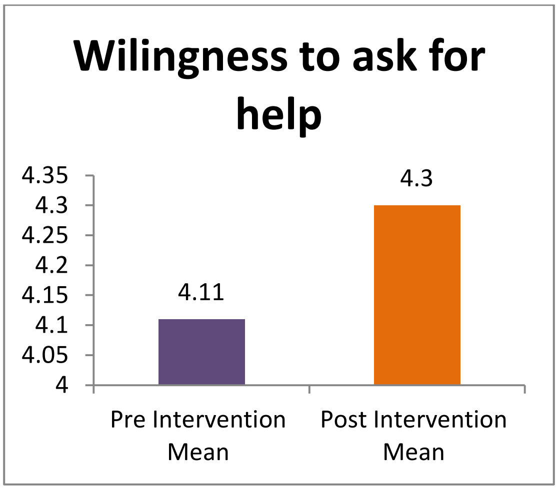
Table: *Results from paired samples t-tests for the RAS pre and post Psychosis Recovery Programme.*

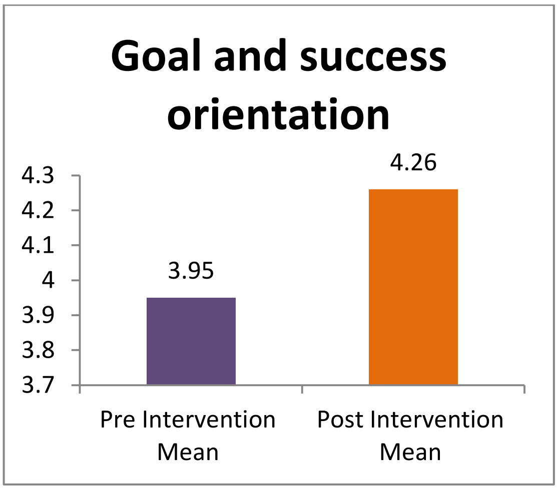
RAS	**Pre Mean (SD)**	**Post Mean (SD)**	***t***	***df***	***p***	**Cohen's *d***
Total	3.8 (.59)	4.08 (.5)	-4.97**	58	.000	-0.51
Confidence and Hope	3.76 (.67)	4.13 (.55)	-4.89**	50	.000	-0.6
Willingness to ask for Help	3.65 (.76)	3.99 (.57)	-4.35**	53	.000	-0.5
Goal and Success Orientation	3.95 (.64)	4.26 (.58)	-5.13**	55	.000	-0.51
Ability to Rely on Others	3.98 (.62)	4.14 (.51)	-2.49	51	.016	-0.28
No Domination by Symptoms	3.7 (.82)	3.99 (.65)	-3.35**	51	.002	-0.39

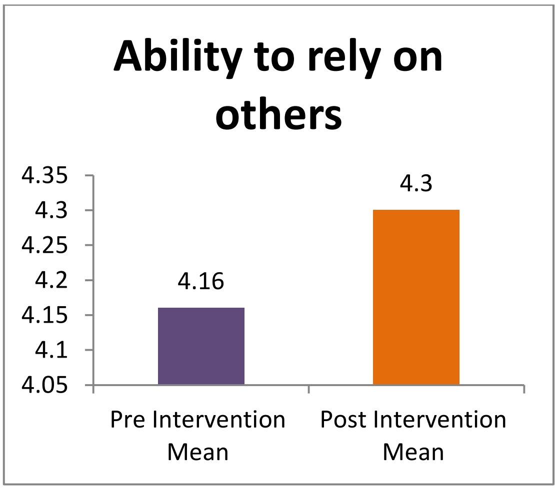
A Bonferroni correction was applied to account for multiple tests, and thus significance was set at .007, and is indicated as: p<.007=* and p<.001=**. RAS = Recovery Assessment Scale.

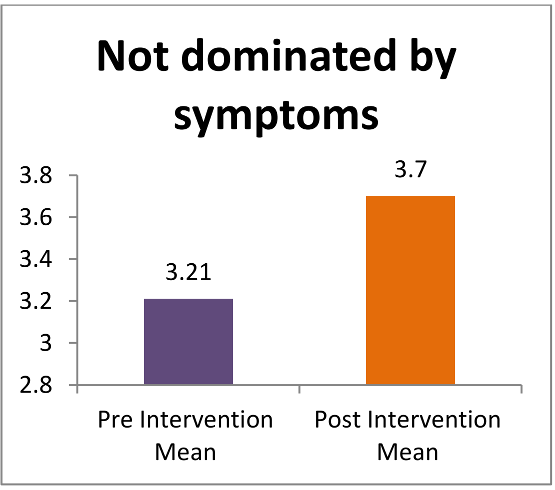





Wilingness to ask for help


Goal and success orientation


Ability to rely on others


Not dominated by symptoms

A highly significant increase in scores was seen for the DAI, from pre intervention (M=21.03; SD=6.58) to post intervention (M=24.36; SD=4.49) on the DAI, $t(58)=-5.96$, $p=.000$, reflecting a medium to large effect size ($d=-0.59$), suggesting there service users who completed the measures reported more positive views towards medication after completing the programme.

These findings are similar to last year's findings. In both years, average scores on the RAS and DAI were seen to increase significantly post intervention, suggesting the Psychosis Recovery Programme is helpful in supporting service users' recovery and in encouraging more positive views towards medication.

4.10.4. Summary

Outcomes for the psychosis programme were captured and quantified for the first time in 2012 and have continued to suggest benefits for service users in both 2012 and 2013. The 2012 Outcomes Report noted some difficulties in data collection, however, in 2013 the number of service users who completed the outcome measures both pre and post intervention has increased by 20 people (this figure is variable according to which measure is being considered). A greater number of pre intervention data appear to be available for service users, thus it may be considered how further data can be collected at the post intervention point. A valid and reliable 10 item short form of the DAI has been developed (see Nielsen, Lindstrom, Nielsen and Levander, 2012) which may help to facilitate completion of post measures by programme attendees, and may be considered for routine data collection in January 2015.

4.11. Wellness and Recovery Programme

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

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

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

4.11.1. Wellness and Recovery Programme Outcome Measure

- **Recovery Assessment Scale**

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. The RAS is a 41-item survey rated on a 7-point scale from 1 "Strongly Disagree" to 7 "Strongly Agree". Twenty four of these items make up five sub-scales: Personal Confidence and Hope, Willingness to ask for Help, Ability to Rely on Others, Not dominated by Symptoms and Goal and Success Orientation. The RAS was found to have good test-retest reliability (*r* = 0.88) along with good internal consistency (Cronbach's alpha = 0.93) (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999). Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

4.11.2. Descriptors

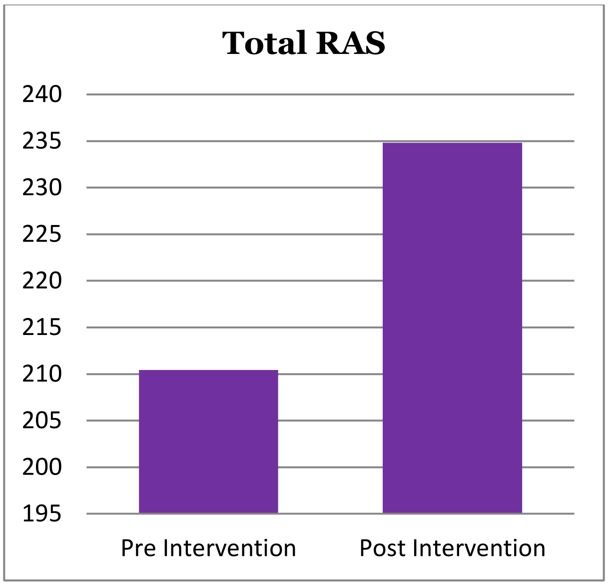
One hundred and twenty-one people took part in the Recovery Programme in 2013. The average age of recovery programme participants was 46.12 years and 66.9% were female. Pre and post data were available for 94 participants (78.5%).

4.11.3. Results

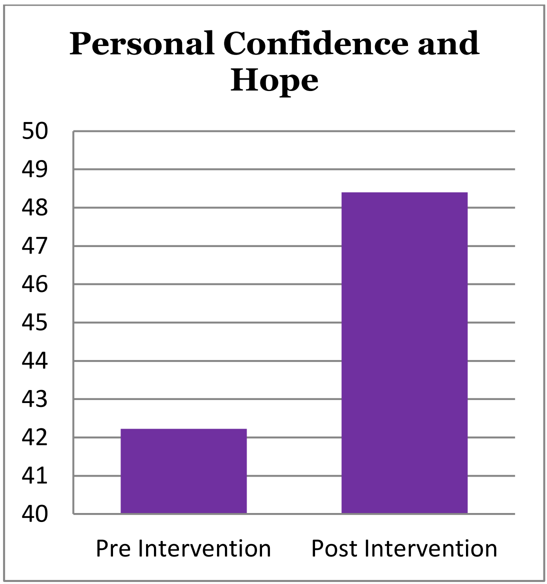
Total RAS scores increased from pre-measurement (M = 210.4, SD = 30.66) to post-measurement (M = 234.8, SD = 29.57) on the Recovery Assessment Scale indicating greater overall recovery. This increase was statistically significant, t (93) = -8.49, $p < .001$, and represented a large effect (d = 0.85).

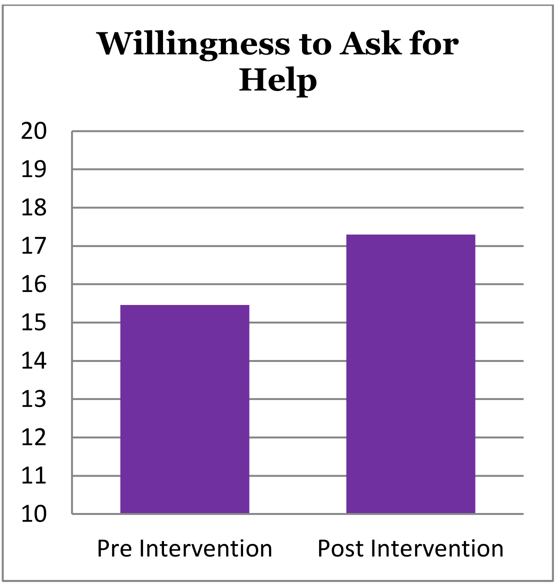
There are five sub-scales within the RAS and the figures below show pre and post scores on the total and each of the five subscales including: Personal Confidence and Hope, Willingness to ask for Help, Ability to rely on others, not dominated by Symptoms and Goal and Success Orientation. Mean scores,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

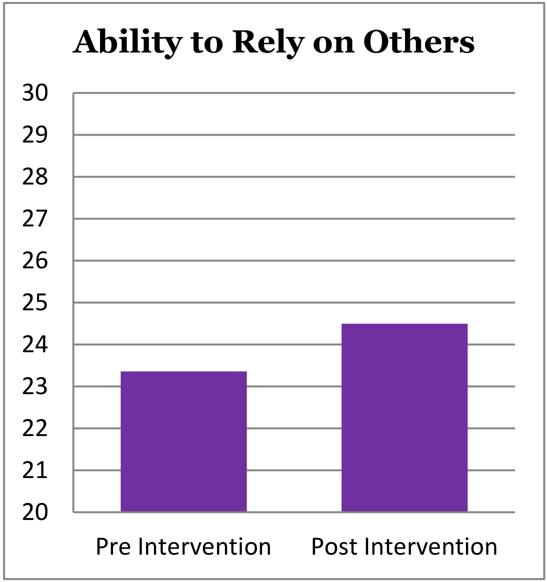
	Pre *Mean*	**Post *Mean***	***t***	***df***	***p***	***D***
Personal confidence &	42.22 (9.38)	48.40 (9.08)	-7.99	93	<.001	0.67
Willingness To Ask For Help	15.46 (3.77)	17.30 (3.12)	-4.77	93	<.001	0.53
Ability To Rely On Others	23.36 (3.12)	24.50 (3.03)	-3.67	93	<.001	0.37
Not Dominated By	12.68 (4.04)	15.20 (3.78)	-6.45	93	<.001	0.64
Goal and Success Orientation	26.70 (8.14)	29.47 (4.42)	-3.38	93	<.001	0.42

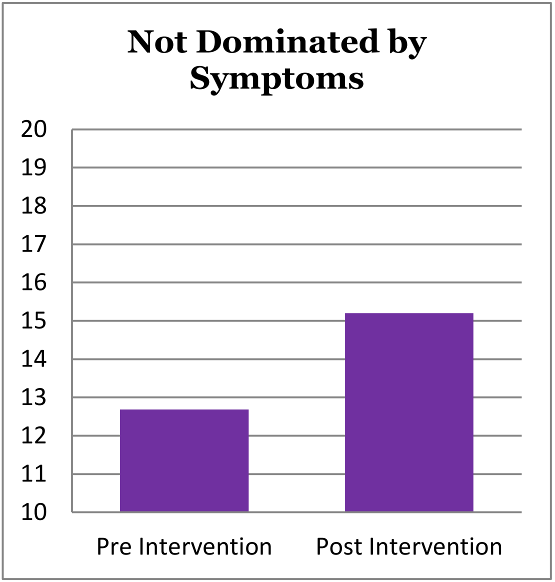


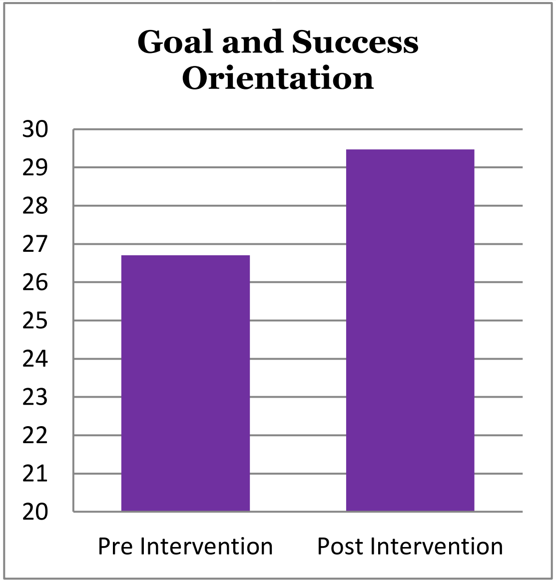
Scores on each of the subscales improved significantly, p<0.01, from pre to post-measurement (see the following graphs). Medium effect sizes were evident for all 5 subscales, Personal Confidence and Hope, Willingness to Ask for Help, Ability to Rely on Others, Not dominated by Symptoms and Goal and Success Orientation (*d* = .67, .53, .37, .64 and .42 respectively).



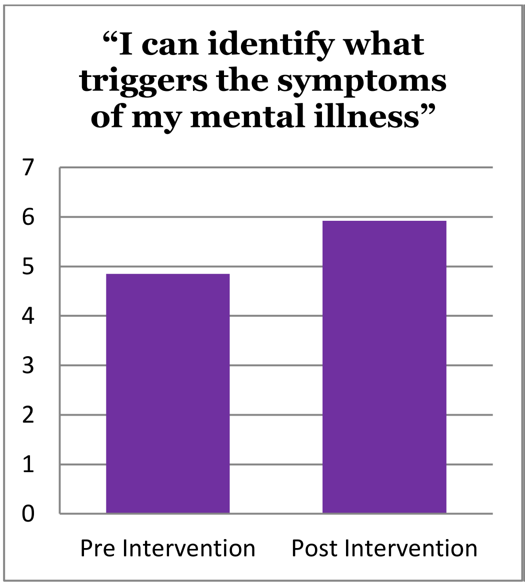


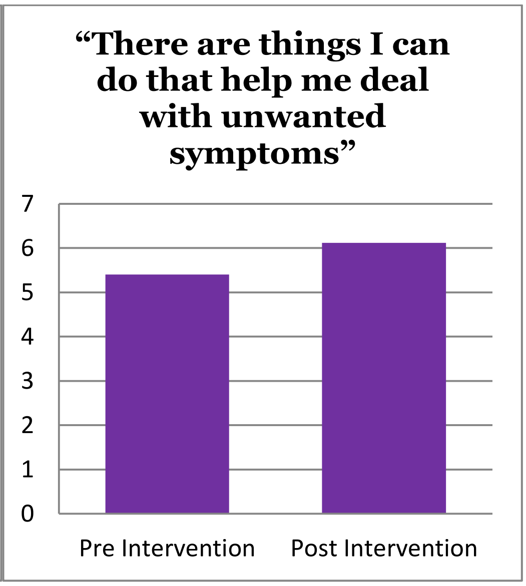




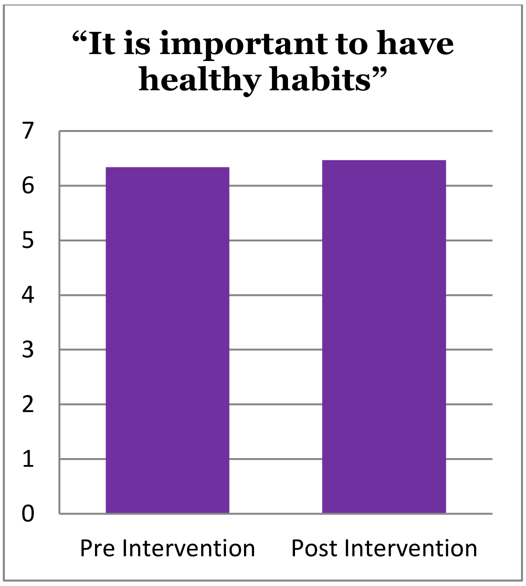


From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 "I can identify what triggers the symptoms of my mental illness”, item 13 “There are things I can do that help me deal with unwanted symptoms” and item 41 “It is important to have healthy habits”. Scores on two of the items improved significantly, $p < 0.01$, from pre to post-measurement (see the following graphs). These two items 9 and 13 evidenced large effect sizes .90 and .92, respectively.





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



4.11.4. Summary

Improvements in systems for data capture and completion have resulted in an increase in the number of participants completing the RAS at the beginning and end of each programme compared to 2011 (50.8% in 2011, 81.7% in 2012 and 78.5% in 2013). 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 programme completers showed significant improvements over all 5 subscales of the RAS, Personal Confidence and Hope, Willingness to Ask for Help, Ability to Rely on Others, Not dominated by Symptoms and Goal and Success Orientation. In addition two of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements pre to post measurement.

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 July to December 2013.

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.

5.1.3 Data collection

The three surveys were continually distributed from July to December 2013, in order to gather information about service users' journey through Inpatient, Dean, or Day 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 a part of a larger quality improvement process undertaken by St Patrick's Mental Health Services.

Data collection across SPMHS is now established for 2014 and will be continually facilitated as key strategic objective to continually 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

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

Day Programme Services

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

In carrying out this project, the aim was that all service users would be made aware that participation was voluntary and anonymous. Collected data was managed using SPSS statistical package, and descriptive graphs were created using Excel. Statistical comparative analysis was not undertaken given the lack of research design. As the response rate was low, and no existing reliable and valid measures were used, statistical analysis would not be helpful in understanding the present data.

5.1.4. Findings

5.1.4.1. Dean Clinic

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

Dean Clinic	n	%
St Patrick's	77	52.4
Sandyford	28	19.0
Chapel Street	17	11.6
Donaghmede	10	6.8
Galway	8	5.4
Lucan Adolescent	3	2.0
Cork	2	1.4
Lucan Adult	2	1.4
No Answer	0	0.0
Total	147	100.0

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	23	16.2
<2 weeks	23	16.2
<1 month	38	26.8
<2 months	16	11.3
>2 months	13	9.2
>4 months	7	4.9
No Answer	22	15.5
Total	142	100.0

Were you seen at your appointment time?

From table 9, most respondents reported being seen either on time (26.8%) or within 15 minutes (24.6%) of arriving at the Dean Clinic. On the other hand only 28.2% of respondents waited over half an hour for their appointment on arrival between July and December.

R*espondents who endorsed each waiting time frame*

Waiting Time	n	%
Seen on time	38	26.8
Seen within 15 minutes	35	24.6
Seen within a half hour	25	17.6
Seen within hour	24	16.9
Seen within over 2 hours	16	11.3
No Answer	4	2.8
Total	142	100.0

Tell us about your experience of assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

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

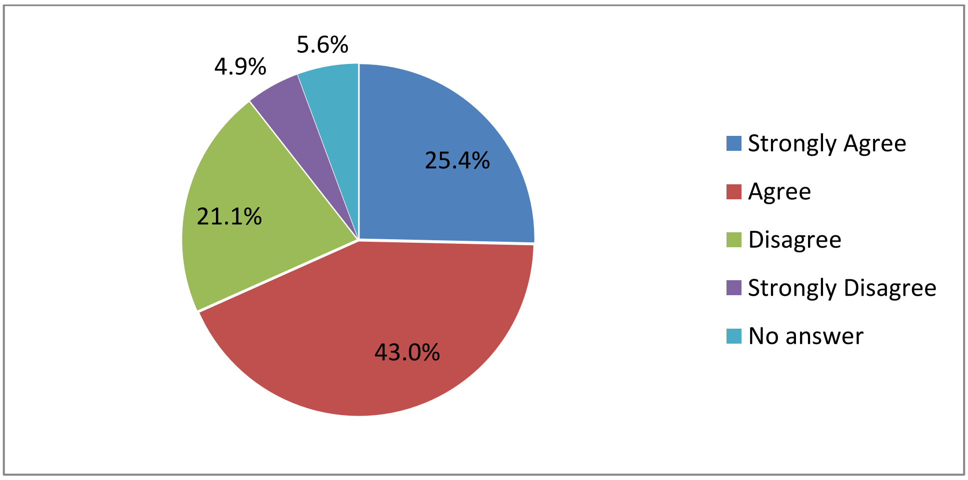
Tell us about your experience of care and treatment at the clinic following assessment

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

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	131	92.3	4	2.8	2	1.4	0	0.0	5	3.5
Treated with dignity & respect	129	90.8	5	3.5	1	0.7	0	0.0	7	4.9
Confidentiality was protected	128	90.1	4	2.8	1	0.7	1	0.7	8	5.6
Privacy was respected	131	92.3	3	2.1	0	0.0	0	0.0	8	5.6
Staff were courteous	131	92.3	4	2.8	1	0.7	0	0.0	6	4.2
Felt included in decisions about my treatment	114	80.3	12	8.5	6	4.2	1	0.7	9	6.3
Trusted my doctor/therapist/nurse	121	85.2	15	10.6	1	0.7	0	0.0	5	3.5
Appointments were flexible	110	77.5	13	9.2	8	5.6	1	0.7	10	7.0

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



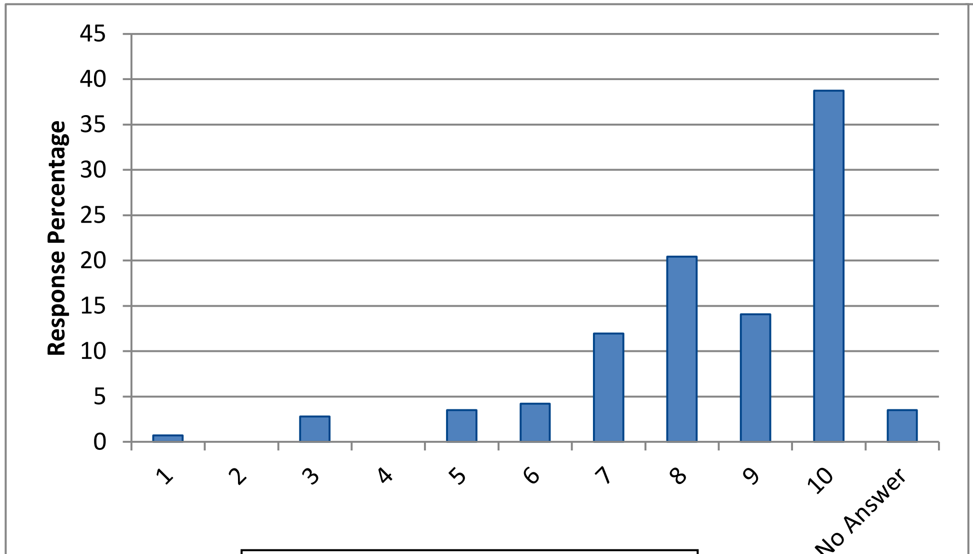
How would you rate the Dean Clinic facilities?

A series of questions asked respondents 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

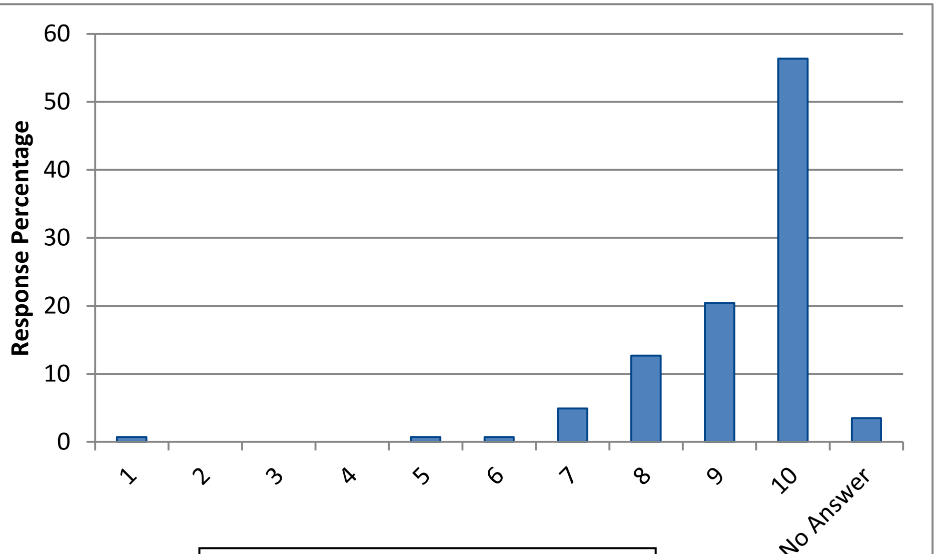
8. In particular, the cleanliness of Dean Clinics and the environment being calm received high scores, with means scores 9 or above. Furthermore the standard deviation was below 2 in across all four areas showing small variation between responses, i.e. the majority of respondents responded favourably and similarly (see Table below).

Respondents' scores of Dean Clinic facilities

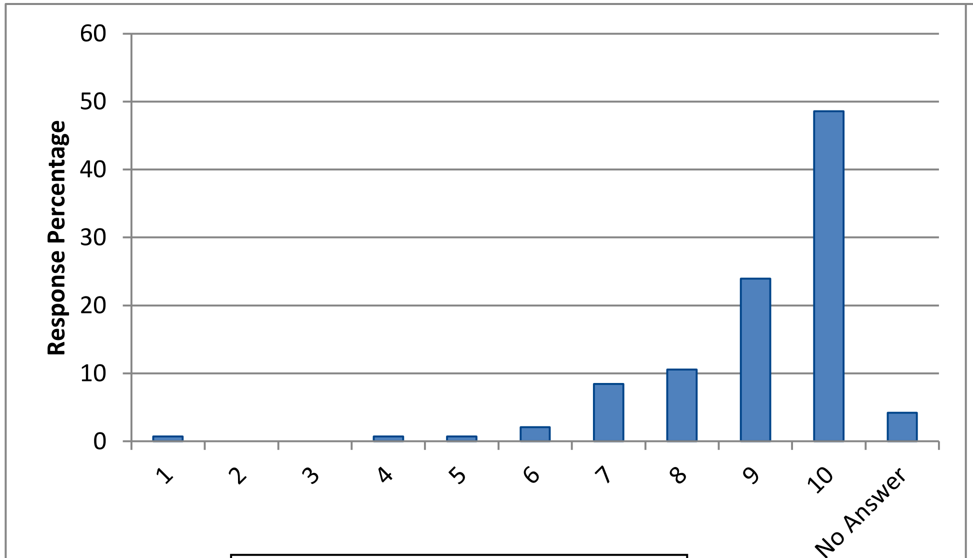
Rate the following in relation to the Clinic…	N	Mean (µ)	Standard Deviation (∂)
Décor/Furniture	137	8.4	1.8
Cleanliness of Clinic	137	9.2	1.2
The environment was calm	136	9.0	1.4



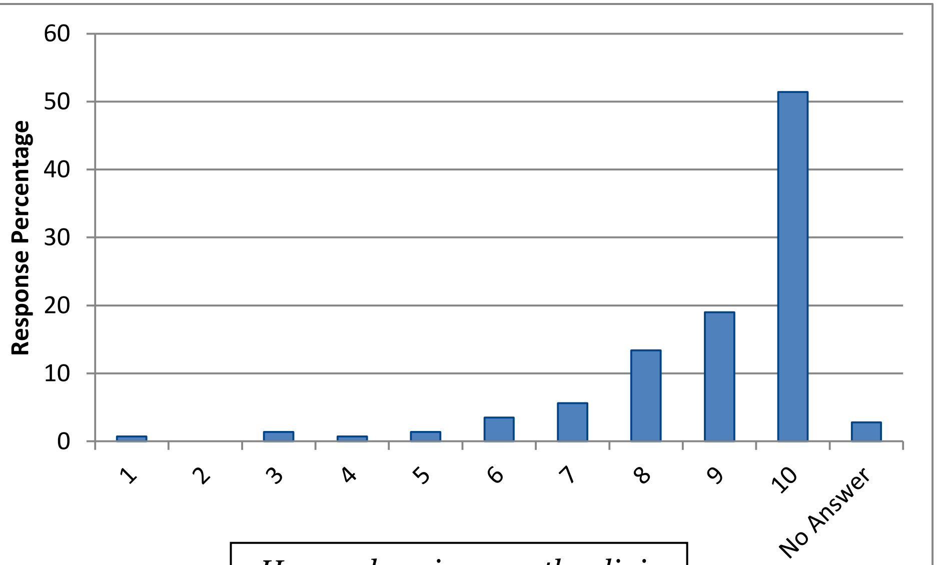
Clinic’s decor/furniture



Cleanliness of the clinic



How calm was the clinic environment



How welcoming 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 July and December demonstrated a high level of satisfaction with the care they received. Rating their care and treatment at the Dean Clinic on a scale of 1 to 10, with a mean of 8.7 (N=139; SD=1.8). Respondents also demonstrated a high level of satisfaction with the overall Dean Clinic service. Rating the Dean Clinic on a scale of 1 to 10, with a mean also of 8.7 (N=139; SD=1.7).

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

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	**%**	**n**	**%**
1	3	2.1	2	1.4
2	0	0.0	1	0.7
3	0	0.0	0	0.0
4	1	0.7	1	0.7
5	2	1.4	3	2.1
6	9	6.3	6	4.2
7	10	7.0	8	5.6
8	25	17.6	35	24.6
9	26	18.3	22	15.5
10	63	44.4	61	43.0
No Answer	3	2.1	3	2.1
1-5	6	4.2	7	4.9
6-10	124	87.3	126	88.7
Total	142	100.0	142	100.0

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

How would you rate...?	**N**	**Mean (µ)**	**Standard Deviation (∂)**
Your care and treatment at the Dean Clinic	139	8.7	1.8
Overall, the Dean Clinic	139	8.7	1.7

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:

- I felt in control of my own life and in particular my treatment. I had a fear of being directed by others without consent/choice but it was totally unfounded.
- Without attending the Dean Clinic to be assessed and treated I would have been lost. With the help of the team of psychologists, the therapists I got an accurate diagnosis and subsequent treatment as an inpatient. The aftercare has been great and I am so grateful for all the on-going support.
- When I thought there was no way out there was, I was treated by a pure professional that went beyond the limits of her job, i.e. polite helpful and well mannered.
- My experience in the Dean Clinic has been very positive. Every member of staff has been welcoming and helpful. I feel there is an enormous sense of care between doctors/nurses in relation to their patients.

Comments to learn from include:

- I think occupational therapy is essential in recovery and not available.
- Try to keep apt times. I understand it can be hard at times.
- Sometimes had to wait a very long time between appointments so it was difficult to make progress with treatment.
- Cost is major thing & probably prevents me from visiting clinic as often as I need to & therefore impacts negatively on my mental health.
- I don't like the location of the Dean Clinic in Capel Street, Dublin. I don't feel safe walking to or from the building to my bus stop on the Quays.
- Parking awkward.

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

- The staff and consultant were excellent.
- Never rushed. Friendly staff.
- Caring people, truly dedication to their job.

- The consultant was lovely, felt he really listened to me- I went to see him re depression. When I first met him, the relief I felt to know he confirmed it was depression I was suffering from and that I would get better.
- I was treated at all times with the utmost respect and had good communication with staff/registrar.
- Doctors, nurses and other staff treated me with dignity, courtesy and friendliness.
- My counsellor, xxx was incredible, as is xxx at the moment. xxx has helped me link the different skills I have learnt together.
- I attended a back to college programme which was very good. Sometimes appointments can be very helpful, other times they seem like a waste of time.
- My recovery was good.
- Given plenty of time at appointment, not rushed in any way.
- Provided urgent appointment.
- The range of professionals available and consistence with nurse and regular appointments with consultant.
- Staff welcoming but not intrusive. Flexibility around time of appointment. very accommodating.

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

Comments to learn from include:

- More detailed consultation with reg.
- A system whereby one could connect with people who have recovered.
- Maybe to have aftercare on other days of the week as Tuesdays doesn't always suit everyone. Make it easier to get an appointment.
- More support services for the family.
- Varying levels of prices dependent on time spent/level of care needed.
- There were so many positive in the clinic, yet when I started to attend the clinic I was a student, so the fees were quite high. Luckily my parents were able to help me out but it would be nice to see a slight decrease in the fees. But overall the service is of a very high standard.
- Reduce rates a small bit.

Positive Comments:

- Just keep doing what they are doing.
- Just to continue the same high level of service.
- For me I see no need to change anything about the service.
- All the staff are most helpful. It does not need any improvement they are kind and approachable. Very human, very important.
- I am very happy with the services and have no suggestions. I am full of praise for the service and will always be grateful for it.

5.1.4.2 Inpatient services

Demographics

Service users discharged between July and December 2013 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge or by post following discharge. 162 were returned to St Patrick's Hospital. Previous research has suggested that a response rate of under 50% may be indicative of a response bias and thus findings should be considered with caution. SPMHS is actively working on methods to improve response rates.

Table: *Number of surveys distributed and returned between July and December*

Month	Surveys Returned
July	38
August	15
September	44
October	31
November	19
December	15
Total	162

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 'less than a day' (30.9%), and 'one to three days' (34.0%) between July and December (see table below).

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

Waiting Time	n	%
<1 day	50	30.9
1-3 days	55	34.0
4-7 days	20	12.3
1-2 weeks	19	11.7
3-4 weeks	11	6.8
Don't know	5	3.1
No answer	2	1.2
Total	162	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' (66.7%) between July and December (see table below).

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

Waiting Time	n	%
<1 hr	108	66.7
1-2 hrs	32	19.8
2-3 hrs	11	6.8
3-4 hrs	2	1.2
>4 hrs	4	2.5
Don't know	3	1.9
No answer	2	1.2
Total	162	100.0

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

The most endorsed waiting time frames reported by respondents were '1-2 hours' (33.3%) and 'less than 1 hour' (27.2%) between July and December (see table below).

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

Waiting Time	n	%
<1 hr	44	27.2
1-2 hrs	54	33.3
2-3 hrs	36	22.2
3-4 hrs	11	6.8
>4 hrs	9	5.6
Don't know	5	3.1
No answer	3	1.9
Total	162	100.0

Tell us about your experience of admission

Table: *Respondents' opinions between July and December 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?	132	81.5	18	11.1	10	6.2	2	1.2
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	120	74.1	22	13.6	16	9.9	4	2.5
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	121	74.7	30	18.5	7	4.3	4	2.5
Were you given written information about the Hospital and the services provided?	95	58.6	53	32.7	10	6.2	4	2.5

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	135	83.3	9	5.6	6	3.7	6	3.7	6	3.7
Involved in the development of my care plan	97	59.9	25	15.4	25	15.4	9	5.6	6	3.7
Offered a copy of my care plan	67	41.4	9	5.6	53	32.7	21	13.0	12	7.4
Involved in the review of my care plan	77	47.5	17	10.5	42	25.9	14	8.6	12	7.4
Focus was on recovery in the care and treatment offered	118	72.8	12	7.4	12	7.4	10	6.2	10	6.2
Care plan is key to recovery	109	67.3	21	13.0	14	8.6	7	4.3	11	6.8

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	120	74.1	12	7.4	23	14.2	2	1.2	5	3.1
Registrar	105	64.8	27	16.7	16	9.9	5	3.1	9	5.6
Key Worker	88	54.3	22	13.6	32	19.8	5	3.1	15	9.3
Nursing Staff	125	77.2	10	6.2	12	7.4	0	0.0	15	9.3
Psychologist	66	40.7	23	14.2	33	20.4	11	6.8	29	17.9
Occupational Therapist	51	31.5	16	9.9	41	25.3	11	6.8	43	26.5
Social Worker	43	26.5	25	15.4	35	21.6	13	8.0	46	28.4
Pharmacist	26	16.0	26	16.0	43	26.5	19	11.7	48	29.6
Other	32	19.8	19	11.7	29	17.9	17	10.5	65	40.1

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

Waiting Time	**n**	**%**
<1 week	33	19.9
1-2 weeks	22	13.3
2-3 weeks	17	10.2
>3 weeks	12	7.2
Not on programme	44	26.5
No Answer	38	22.9
Total	166	100.0

Tell us about your care…

Table: *Respondents experience of care and treatment at the Clinic following assessment*

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	106	65.4	36	22.2	6	3.7	1	0.6	13	8.0
Treated with dignity and respect	114	70.4	29	17.9	5	3.1	3	1.9	11	6.8
Protected my confidentiality	111	68.5	33	20.4	1	0.6	1	0.6	16	9.9
Respected my privacy	99	61.1	39	24.1	2	1.2	1	0.6	21	13.0
Were courteous	112	69.1	31	19.1	4	2.5	1	0.6	14	8.6
Felt included when my team discussed medical issues at my beside / in my room	100	61.7	36	22.2	7	4.3	4	2.5	15	9.3
Respected me as an individual	99	61.1	37	22.8	7	4.3	1	0.6	18	11.1

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?	122	75.3	22	13.6	7	4.3	11	6.8
Do you think you were given enough notice of your discharge from hospital?	139	85.8	12	7.4	2	1.2	9	5.6
Do you have a discharge plan?	99	61.1	39	24.1	8	4.9	16	9.9
Do you know what to do in the event of a further mental health crisis?	120	74.1	26	16.0	5	3.1	11	6.8

Tell us about your experience of hospital activities…

Tell us about your experience of hospital activities	Yes		No		Don't Know		No Answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Did you attend any of the activities during the day?	140	86.4	15	9.3	3	1.9	4	2.5
Did you attend any of the activities in the evenings and at weekends?	103	63.6	51	31.5	3	1.9	5	3.1
Was there a range of activities that you could get involved in?	135	83.3	19	11.7	5	3.1	3	1.9
At the weekend were there enough activities available for you?	56	34.6	80	49.4	15	9.3	11	6.8

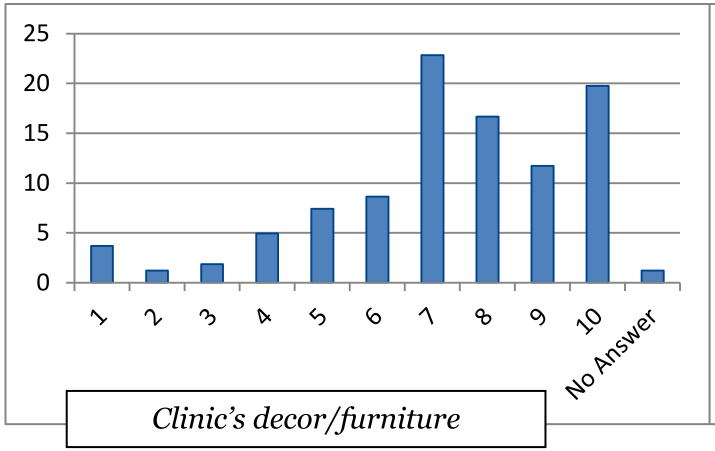
The majority of respondents felt that there was a range of activities they could get involved in (83.3%). On the other hand, at the weekends the majority of respondents' indicated that there were not enough activities available (49.4%) in the hospital.

Tell us about your experience of hospital facilities…

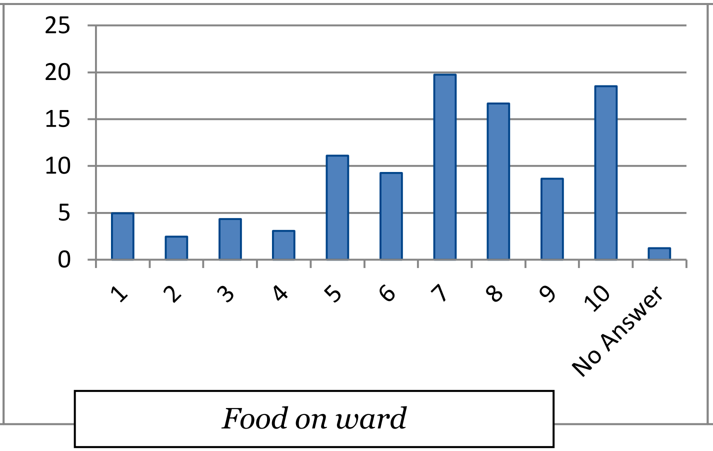
A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with all means above 6. In particular, the Garden Spaces and the cleanliness of the ward and Communal areas received high scores, with means scores 8.3 or above. On the other hand the standard deviation across all areas was above 2 showing significant variation between responses. Therefore average results should be considered with caution.

Table: *Respondents' scores of Hospital facilities*

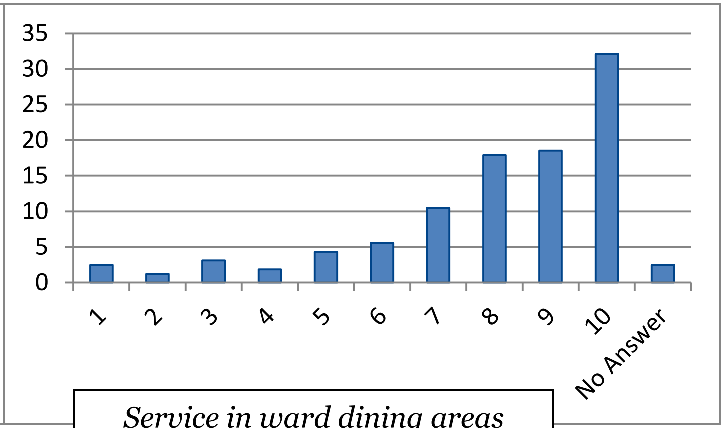
Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	160	7.2	2.3
Food on Ward	160	6.9	2.5
Service in ward dining areas	158	8.0	2.2
Cleanliness of ward areas	159	8.4	2.0
Cleanliness of Communal areas	149	8.3	2.1
Hospital Facilities	150	7.8	2.1
Garden Spaces	152	8.5	2.0



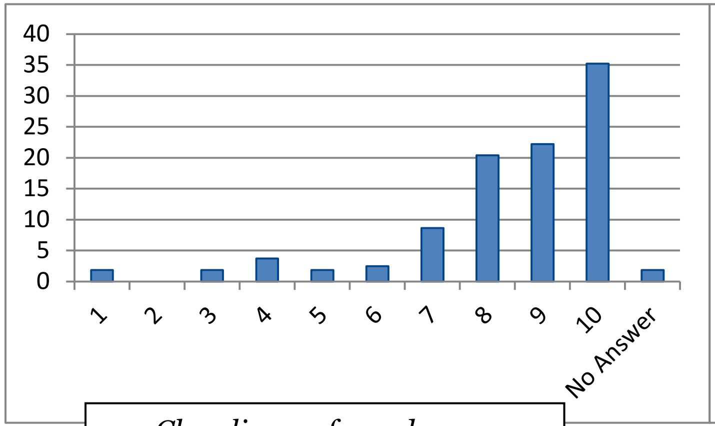
Clinic's decor/furniture



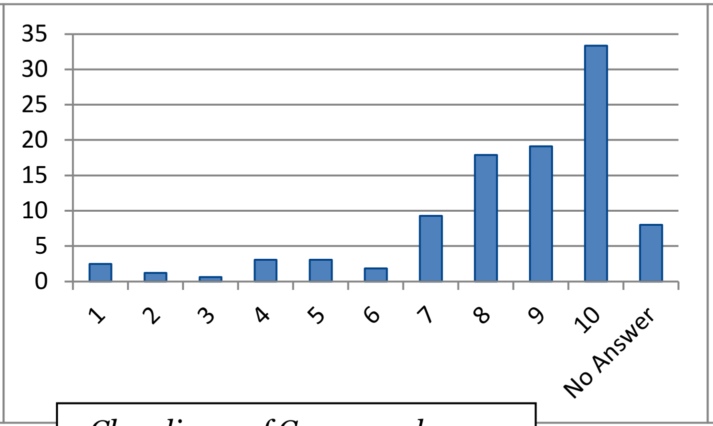
Food on ward



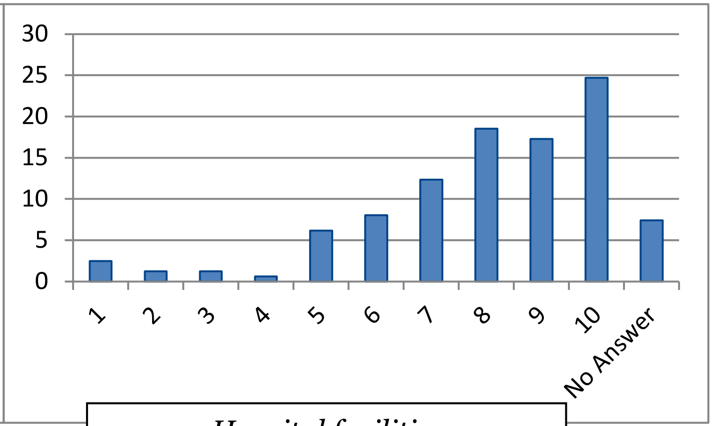
Service in ward dining areas



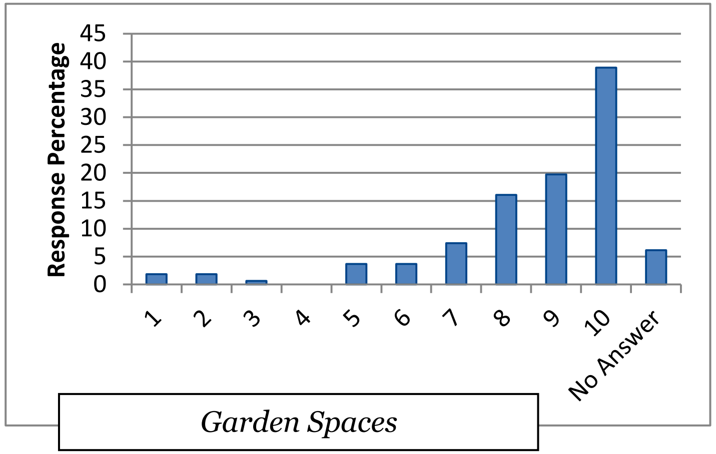
Cleanliness of ward areas



Cleanliness of Communal areas



Hospital facilities



Garden Spaces

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

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would share with others that they received support from St Patrick's. The majority of responders felt they had more positive views towards mental health difficulties in general (72.8%) and their own experience of mental health difficulties (74.7%) and felt that they would share with others that they received support from St Patrick's (65.4%).

Table: *Experiences of stigma*

Tell us about your views and perceptions regarding mental illness following your stay...	Yes		No		Don't Know		No Answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
In general are they more positive than they were?	118	72.8	20	12.3	16	9.9	8	4.94
Regarding your own mental illness are they more positive than they were?	121	74.7	22	13.6	13	8.0	6	3.70
Will you tell people that you have stayed in St Patrick's?	106	65.4	25	15.4	23	14.2	8	4.94

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 8.3 (N=162; SD=2.0). Respondents also demonstrated a high level of satisfaction with the Hospital overall (refer to table 19). Rating the Hospital on a scale of 1 to 10, with a mean of 8.5 (N=158; SD=1.7).

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	3	1.9	2	1.2
2	1	0.6	1	0.6
3	4	2.5	1	0.6
4	4	2.5	2	1.2
5	5	3.1	5	3.1
6	2	1.2	3	1.9
7	15	9.3	12	7.4
8	35	21.6	42	25.9
9	32	19.8	34	21.0
10	61	37.7	56	34.6
No Answer	0	0.0	4	2.5
1-5	17	10.5	11	6.8
6-10	145	89.5	147	90.7
Total	162	100.0	162	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	162	8.3	2.0
The Hospital	158	8.5	1.7

Further Service User Views

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

- Always 24hours service of support day and night very reassuring to me.
- The lectures were a great resource and felt like I had ownership in my recovery due to availability of information, MDT consultations & regular genuine checking of how I was feeling.

- Nursing staff are the most warm, welcoming, and pleasant people I have met. Excellent treatment.
- Nursing care very good.
- Glad I came and my confidence progressed with the unfolding of my program. Big breakthrough for me was 3rd week.
- The environment is very friendly and I never felt like I was in a hospital during my time here.
- I'd gladly endorse its good reputation for its staff and programmes.
- Totally different experience to what I expected, I wasn't sure what to expect but I never thought it would be of such benefit to me.
- St Eds is a great place to be when one is not feeling well, anxious & depressed.

Comments to learn from include:

- I felt in no man's land for the 1st few days - not really knowing what I should be doing.
- Not enough time from psychiatrist - This is a concern. Complaint/Feedback from patients - Also the Psychiatrist doesn't seem to listen - and not friendly - doesn't explain - she is clinical & cool - needs to improve manner.
- Gym needs to be open for full day, 2) Rushed out of dining area at food times although good opportunity for talking to other patients
- More activities at weekends.
- I felt there was not a big push by the nursing staff to get me involved in or even tell me about the various activities in the hospital e.g. pottery, PC room, music room etc.

Q: Was there anything particularly good about your care?

- I couldn't get over how kind courteous, supportive, and non-judgemental from the consultants, team, key workers, nurses and domestic staff were to me personally.
- The attention and care nursing staff and registrar gave me. The registrar was very supportive and seemed to make my interest and welfare her total responsibility.
- The O.T. facilities were excellent. xxx was brilliant with them.

- I could not fault the nurses, doctors, or food staff. In my room especially the cleaning lady, xxx, was very good and friendly to me.
- Dr xxx saved my life; she was so kind and helpful.
- The supportive environment was very helpful in my recovery. The nursing staff were very approachable and supportive.
- The nurses are excellent. (There was a large volume of positive comments regarding nursing staff)
- The welcome on admission by xxx & xxx was excellent.
- Staff were always helpful and courteous, always gave of their time.
- The MDT interest and attentiveness & Follow up.
- The extra activities, pottery, mediation etc. is very good.
- Emphasis on fact that I was involved in solutions. Good aftercare plan.
- Having the knowledge that everybody else is in the same position and if you have good days or bad they understand.
- Dietary requirements met.

Q: What could we improve?

- More emphasis in encouraging patients to value their own experiences.
- Including the patient in the wads of paper writing that goes on.
- Maybe more discussion could be focused on the event of re-admission should it prove necessary.
- More time from psychiatrists - more talk from her i.e. explaining what they think of your condition and giving their views on the way forward to.
- Longer gym opening hours and more activities in the evenings and weekends particularly.
- Wi-Fi all over the hospital. TV points in bedrooms. More weekend activity/evening classes.
- More activities.
- More time for leisure activities esp. at the weekend. People need time out from the "heavy stuff!"
- A salad bar at dinner time too.

- Single rooms for all as v. hard to sleep on a bay and rest is what you really need when first admitted.
- I thought everything was excellent.
- Overall I can't fault my stay at the hospital.

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	Response Rate (%)
July	128	61	50.0
August	109	40	54.8
September	120	42	54.5
October	91	40	44.4
November	113	15	13.3
December	59	50	84.7
Total	620	248	40

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Mindfulness	97	25.9
Recovery	68	18.1
Anxiety	54	14.4
Depression	36	9.6
St Edmundsbury	30	8.0
Alcohol Step Down	18	4.8
Bipolar	16	4.3
Living Through Distress	14	3.7
Other	13	3.5
Eating Disorder	11	2.9
Radical Openness	11	2.9
Young adult	5	1.3
Pathways to Wellness	1	0.3
Therapeutic and Lifestyle for Men	1	0.3
No answer	0	0.0

Over three quarters of respondents reported living in Leinster (82.3%).

Provence	n	%
Leinster	204	82.3
Munster	23	9.3
Connaught	7	2.8
No answer	7	2.8
Ulster	4	1.6
Don't Want to Say	3	1.2

The majority of participants had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. Under half had experienced an in-patient stay, and 20% had attended as an outpatient at the Dean Clinic.

Service	n	%
In-patient stay	151	40.8
Dean Clinic	79	21.4
In-patient day programme	62	16.8
Other day programme	50	13.5
Not applicable	20	5.4
Associate Dean consultation	8	2.2
No answer	0	0

Service User Responses

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

Wait time	n	%
Less than 1 day	19	7.7
1-3 days	51	20.6
4-7 days	61	24.6
1-2 weeks	43	17.3
2-4 weeks	43	17.3
More than 4 weeks	25	10.1
No answer	6	2.4

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 above 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?	182	73.4	40	16.1	23	9.3	3	1.2
When you came to hospital did a member of Day Services explain clearly what would be happening?	202	81.5	29	11.7	15	6	2	0.8
When you commenced the programme did a member of staff explain the timetable?	223	89.9	19	7.7	2	0.8	4	1.6
Were you given a written copy of the timetable and other relevant information?	204	82.3	34	13.7	6	2.4	4	1.6

Respondents also generally reported an informed ending to the programme, with over 80% agreeing that they knew when the programme was to end, feeling that the programme met their expectations, and feeling that they know what to do in the event of a further mental health crisis. A quarter reported not receiving information regarding the hospital’s support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme.

	Yes		No		Don’t know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Did you know in advance when the programme was due to end?	238	96	6	2.4	0	0	4	1.6
Did the programme meet all your expectations?	199	80.2	34	13.7	11	4.4	4	1.6
Have you been given details of the hospital’s support and information service?	166	67.2	63	25.5	10	4	8	3.2
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	202	81.5	32	12.9	5	2	9	3.6

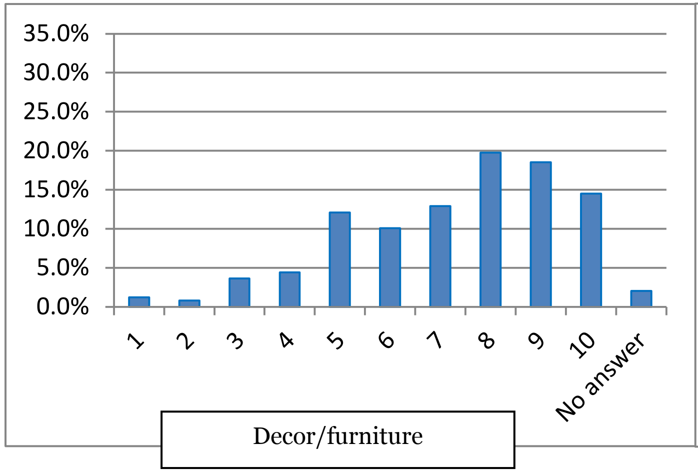
The Service User Satisfaction Questionnaire is also interested in service users’ experiences of stigma after having attended St Patrick’s.

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

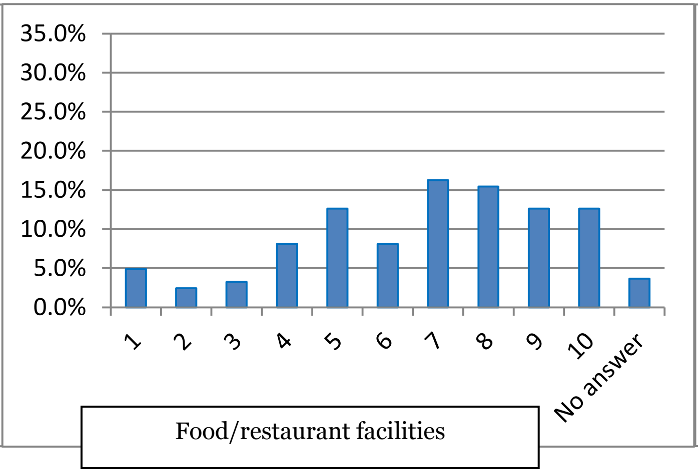
As you are prepared to leave the programme…	Yes		No		Don't know		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Do you feel that your views regarding mental ill-health in general are more positive than they were?	228	91.9	13	5.2	6	2.4	1	0.4
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	222	89.5	17	6.9	8	3.2	1	0.4
Will you tell people that you have attended St Patrick's	156	62.9	57	23	33	13.3	2	0.8

How would you rate the Day Services Facilities?

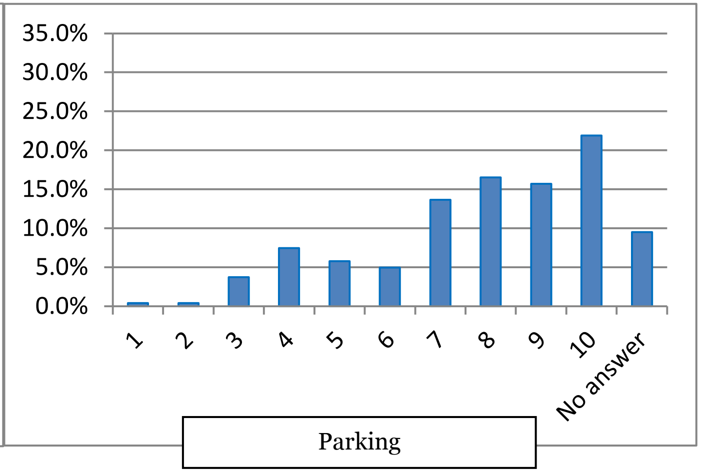
Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of one to ten. The highest scoring facilities were the garden space, cleanliness of day service and community areas, and parking, all with a most endorsed score of 10. These were followed by hospital facilities (e.g. shop), and decor/furniture, with a most endorsed score of 8. Food/restaurant facilities had a most endorsed score of 7.



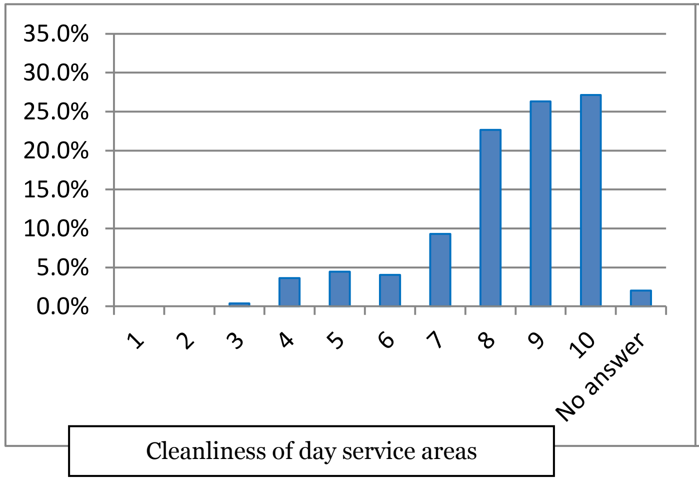
Decor/furniture



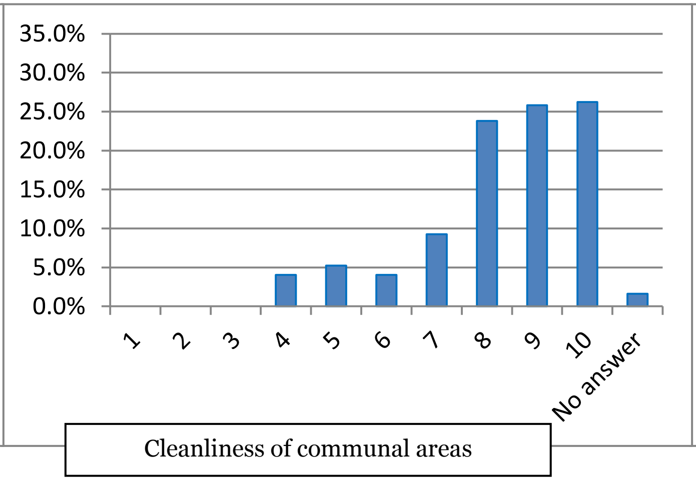
Food/restaurant facilities



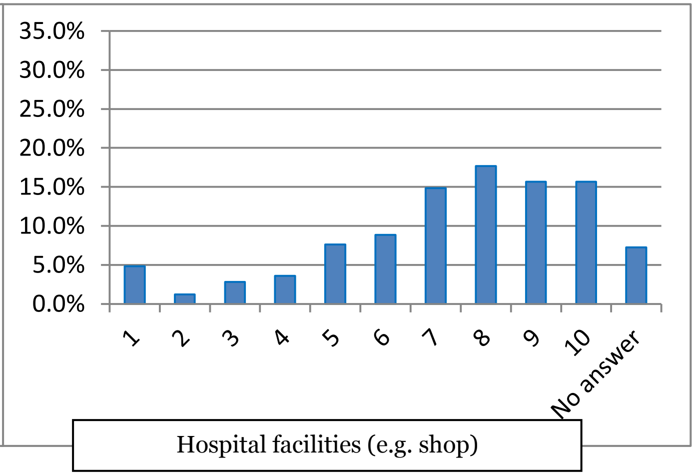
Parking



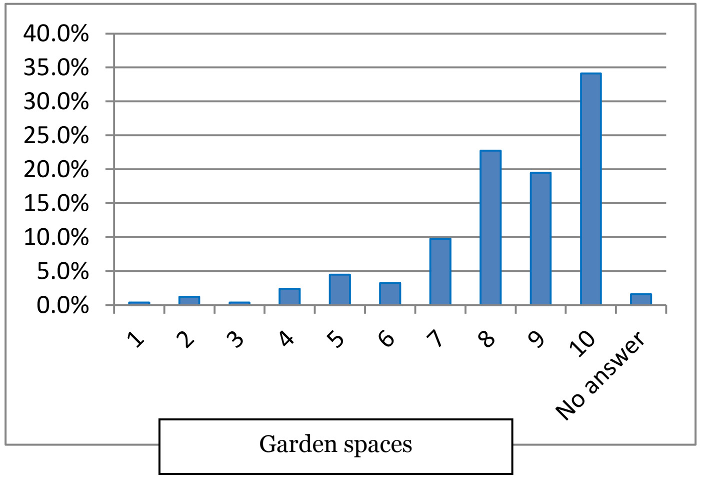
Cleanliness of day service areas



Cleanliness of communal areas



Hospital facilities (e.g. shop)



Garden spaces

Respondents were also asked to rate their care and treatment, and the hospital, overall, on a scale of 1 to 10. Over 90% rated their care and treatment and the hospital in general, between 6 and 10.

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

Score	n	%
1	1	0.4
2	1	0.4
3	4	1.6
4	3	1.2
5	8	3.2
6	9	3.6
7	24	9.7
8	53	21.4
9	58	23.4
10	85	34.3
No answer	2	0.8
1-5	17	6.9
6-10	229	93.1

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

Score	n	%
1	1	0.4
2	2	0.8
3	2	0.8
4	4	1.6
5	9	3.7
6	13	5.3
7	21	8.6
8	62	25.3
9	49	20.0
10	76	31.0
No answer	6	2.4
1-5	18	7.5
6-10	221	92.5

Further Service User Views

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

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

- 'The standard of care that I have received has been excellent'

- ‘I felt very comfortable and at ease overall during my visit here and would feel very happy to have to return or to recommend it’
- ‘This has been life changing experience and my only regret is not having done this before’
- ‘Excellent programme. Enable silver cloud to be an ongoing support service and not only for 12 months.’
- ‘I found the WRAP and depression program extremely helpful in my recovery and would highly recommend them. I also enjoyed the various activities that are held’
- ‘I attended the psychosis program -XXXX and his team were excellent. From such a small thing like the social group (which really helped me) to CBT with XXXXX which was excellent - her mindfulness sessions where fantastic too’
- ‘I have done 2 programmes Mindfulness and ACT. I have a better understanding of my mental health. I am hoping I will be able to use the information to have good mental health’
- ‘My team were fantastic and the day services were also great. The staff were so friendly.’
- ‘All the staff at St Edmundsbury were supportive and attentive. I never felt that I was bothering then or that they didn't have time for me.’
- ‘I felt that the staff are very eager to listen & to respond accordingly’
- ‘The staff were very approachable and communication was good’
- ‘I feel after attend St Patrick's I am more capable of dealing with my mental health’
- ‘I have found this programme to be life changing. It pulled together many threads that I have been working on for a while.’
- ‘It was a very positive experience for me and I have a much great knowledge about my illness & how to manage it due to the bipolar programme.’
- ‘I am anxious about not having a follow on programme perhaps once/twice a month’
- ‘Should have a more structured follow-up for those finishing the programme’
- ‘Very glad to have been given the opportunity to do this course - I would love some form of support eg weekly/monthly groups - to maintain good practice in life’
- ‘Liked the programme ACT. Need time to absorb all information & aids given. A lot to take in in one course. Great feedback given by facilitators.’
- ‘More consultations with consultant/registrar/key worker. More communication when I've been discharged. I'd like to see a 1 day/couple of days review courses offered to patients after 1 year then 2 years etc’

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

- ‘Felt really listened to by staff’
- ‘Well trained and respectful team members. They made me feel safe and comfortable’
- ‘My team worked with me and my family very well’
- ‘The care and help by the counsellors and others was just incredible. They really go out of their way to help.’
- ‘I was impressed that the admin staff for the day programmes remembered my name each week.’

- ‘The course was particularly good and clever and I found them very interesting’
- ‘Yes the facilitator for OCD groups was excellent’
- ‘The Bipolar programme was very well organised and informative’
- ‘Facilitator was caring and gave me time out to think.’
- ‘Focus on recovery- V practical and do-able.’
- ‘My attendance marked a turning point in dealing with things!’
- ‘Taught me that you are not alone and you are not a failure.’
- ‘Yes, I feel that I have been given and shown how to use Mindfulness as a way to help me with all the anxiety that I have.’
- ‘Meeting other people who were the same as me & totally accepting of me - helped me feel better before St Pats I felt v. isolated’
- ‘The social worker on my team was just amazing I think without her I may have taken my own life she made me feel so much better about myself. She also ensured that I would have other supports in place when I went home.’
- ‘St Pats: Clinical Psychologist – excellent’
- ‘Key worker brilliant with ongoing issue I had feeling stronger and able to cope with it.’
- ‘I felt the level of cleanliness throughout the hospital is very good. The standard of food served in the hospital is excellent.’
- ‘CBT treatment and also group work led by facilitators was fantastic.’
- ‘Group sessions with dedicated clinician. Range of therapists and different approaches.

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

- ‘The key worker concept didn't really seem to work in my case’
- ‘St Pats: Communication. Be aware that although you may communicate patients in early stages may not be able to be receptive.’
- ‘Include family members more in the history & treatment of the patient.’
- ‘ ‘I cannot think of anything, except to say provide more information to GPs that such a service exists. It has been life-changing for me. I have hope again.’
- ‘More exposure work. More hours per week. more or any information about aftercare services’
- ‘Nothing really as I found everything very valuable. Maybe introduce a refresher course every so often or extend the course as it takes a few weeks to get into this course’
- ‘Couldn't have been looked after better’
- ‘Class times - for people who work full time, difficult to travel to St Eds in rush hour traffic. Mindfulness classes were very long - 3.5 hours maybe extend course to 9 weeks’
- ‘the programme should be longer. I believe that mental health should be part of the school curriculum as mental health is much bigger than talked about and is still far too taboo’

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2013

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

The unit opened in April 2010 and aims to provide evidence based treatment in a safe, comfortable and young person friendly environment. The multi-disciplinary team are committed to on-going quality improvement. Young people's views were taken on board in the design and development of the unit and the team continue to work collaboratively with young people and their parents/carers. The Willow Grove Service User Satisfaction Survey is one aspect of the collaborative approach taken by the unit. This report presents the responses the survey which was distributed to young people and parents/carers following an inpatient stay in the Willow Grove Adolescent Unit in 2013.

5.2.1. Methodology

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

5.2.1.1. Respondents

This questionnaire was distributed to 52 parents and young people on discharge from the unit. Nine young people and 15 parents/carers completed the questionnaire. Response rates were 17.3% and 28.8% respectively. Given that the completion rate was below 50% these results should be interpreted while considering this as it likely that the sample is not representative of those who attended the unit in 2013. Therefore these results may reflect a more positive or negative view, than the opinion of the majority of users.

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

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

In order to improve completion rates and to collect data from a wider range of service users, consideration is being given to distributing a brief survey on the day of discharge, and posting the more comprehensive version at 1 month post discharge.

5.2.1.2. Survey Design

The questionnaire asked young people a set of questions which gather information on their experiences of access to services, the environment and facilities, the therapeutic services offered, the ability of the service to help young people and parents manage mental health difficulties, discharge preparation, professionalism of staff, and confidentiality and rights. Both questionnaires also included qualitative questions which asked young people and their parents what they liked, disliked, and would like to change about the service.

The questionnaires asked parents and young people to rate a number of statements precede by the statement, ‘What is your overall feeling about…’. Answers ranged from 0 ‘Very unhappy’ to 5 ‘Very happy’. The young person’s questionnaire also included a 5 point likert scale ranging from 0 ‘Very poor’ to 5 ‘Very good’, printed with corresponding smiley faces to help young people to understand the response options.

5.2.2. Results

5.2.2.1. Quantitative Responses

The median response (i.e. the most common response) for each question is listed in the table below. Overall the young people and the parents who answered the survey appear pleased or very pleased with the service. The majority of median responses for young people were a 4 'Good' (75.9%), followed by 5 'Very good' (17.2%) and 3 'Average' (6.9%). For the parents/carers, the most common response across questions was also 4 'Happy' (51.7%), followed by 5 'Very happy' (41.3%) and 3 'Mixed' (6.9%).

The least positive answers were in relation to cost of service according to both young people and parents, in relation to the service helping the young person to improve relationships outside of the family according to the young person themselves, and the length of time between discharge and follow-up appointment according to the parent/carer. Items for which both young people and carer's had a median rating of 5 included the manner of professionals, professionals keeping the time of appointments, confidentiality and respect of the young person's rights, and the explanation of treatment given.

Table: *Median responses to Willow Grove Service User Satisfaction Questionnaire 2013*

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

5.2.2.2 Qualitative Responses

Young people and parents/carers were also invited to answer three open-ended questions. See below for a selection of responses to each question. Please note this does not include all responses from service users.

Q: The things I liked about my experience (Young person)

- Trust the staff, knowing staff where always there to help, making friends through groups and outings
- I met good people, staff were nice, activities really good
- Young people were very supportive, staff were caring
- Meeting other young people suffering with the same issues
- I didn't feel alone, people understood me, gave me hope that things could get better

Q: The things I liked about my experience (Parent/carer)

- Doctors and staff worked well together to help the needs of young person
- Excellent level of care. Plenty of staff available. Very supportive and non judgemental. Extremely friendly, caring and enthusiastic about their work.
- Empathy of all concerned. Professionalism of all staff. Close knit teamwork of all concerned. Reassurance afforded. Human aspect of dealing with patient and parents.
- Helpful staff. Well run facility. Family therapy.
- This service has completely changed my child, he has grown in confidence and is trying his best to be a young adult thanks to a very dedicated and wonderful staff team.
- the team were very good and answered all questions regarding treatment etc very well and inspired confidence that my daughter was receiving the best possible care at willow grove.
- Teacher was excellent. The sense of relief that she would be cared for in an appropriate facility. Support at time of crisis. Professional staff; very impressed with doctors nurses. Teacher, kitchen staff. The layout of the unit- lovely rooms, all nicely appointed and equipped. some very caring staff. X and X were excellent overall

Q: The things I disliked about my experience (Young person)

- Being away from home
- Some of the programme was boring and unhelpfull such as advocacy and art squad, better system in place

- Some of the nursing staff could have been more supportive and understanding, the food.
- Felt as if I had cabin fever-not a lot of time out, the days are very long.

Q: The things I disliked about my experience (Parent/carer)

- parents group (not relevant)
- Feel we should have been given more skills and knowledge on managing our child’s illness. Had a very good session on the day of discharge but should have been 1-2 more of these meetings.
- Only the travel in and out of the city.
- Our child having to be transferred off the unit on the day she turned 18.
- Absolutely no faults or dislikes in any aspect of the service.

Q: The things I would like to change (Young person)

- Nothing
- Better system in place for giving medication, certain nurses more sensitive to patients issues, important
- More structured activities in the evenings, need for young people to be more distracted in the evening
- More gym time, beds aren't very comfy.

Q: The things I would like to change (Parent/carer)

- A follow up phone call to see if treatment plan or new services were received.
- Overall we were very happy with the service but waiting time of over 3 months for a bed was extremely difficult.
- Nothing you have a great staff team.
- There is nothing I would change, only if there were more beds to help other families in need of help.
- Psychology: should give parents some time. Some aspects may be better discussed without child being present initially. Rooms are really lovely but mattresses are rock hard. Perhaps a latex on top of existing mattress. Medication checks prior to administration.
- The time frame, because of the health insurance cover of 100 days, sometimes maybe more time would be helpful.
- I would have liked if there were some more effort to reconcile me and …(my child) ie for her to come out with me or stay here the odd time. This only happened near the end-because my ex was away.

SECTION 6

Conclusions

6.1. Conclusions

1. The 2013 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 2011 and 2012. Service evaluation, outcome measurement, clinical audit and service user satisfaction surveys continue to be used routinely in the context of improving the quality of service delivery.

2. Demand for SPMHS services in 2013 increased across all of its three distinct but integrated community, inpatient and day service pathways.

3. Clinical outcomes data was added for the Mindfulness Programme in St Edmundsbury and level 2 of the Anxiety Programme in 2013. Work was also commenced in 2013 to establish outcome measures in 2014 for the Addictions, Dual Diagnosis, Mindfulness (in SPUH) and Depression Programmes.

4. Clinical and non-clinical staff are once again to be commended for contributions in further establishing routine outcome measurement within services and programmes in 2013. In 2014 options will be explored to make data entry more efficient, with a view to incorporating outcome measurement into the plans for an electronic health record in the coming years.

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

6. All clinical programmes involved in publishing their outcomes in the 2013 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 2014 outcomes measurement process.

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

SECTION 7

References

7.1. References

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