St Patrick's
Mental Health Services

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Outcomes Report 2012

Annual Review of SPMHS's Service Outcomes.

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SECTION 1

Introduction

1. Introduction

The 2012 Outcomes Report is the second 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 2012 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 2012. 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 since the 2011 Outcomes Report. This information provides practice-based evidence of interventions and programmes delivered to service users during 2012. 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 (2012)

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our mental health services are accessed through three distinct but integrated care pathways. These include our out-patient 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 2012.

2.1. Dean Clinic Pathway (2012)

SPMHS's strategy, Mental Health Matters (2008-2013), has 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 hospital. 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.

2.1.1. Dean Clinic Referrals Volumes (2012)

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. Capacity of each of the clinics per week is based on current staffing levels and budgeted sessions per week at January 2012.

In 2012, there was a total of 1,759 Dean Clinic referrals received from General Practitioners. This compares to a total of 1,376 for the same period in 2011 representing an increase of 28%.

2.1.2. Dean Clinic Referral Source by County (2012)

The following table illustrates the geographical spread of Dean Clinic Referrals by county for 2011 and 2012 in ranked order of frequency by county for 2012. The highest referral volumes continued to be from Dublin in 2012.

Dean Clinic Referral Numbers by County (2011 -2012)

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

2.1.3. Dean Clinic Referral Source by Province (2012)

The Table below summarises the percentage of Dean Clinic referrals by Province in for 2011 and 2012. The proportionate of Dean Clinic referrals from Connaught increased by 4% when compared to 2011. Similarly, the proportion of referrals form Leinster decreased by 6% when compared to 2011.

Dean Clinic Referral Source - Provincial Distribution

Province	2011		2012	
	No	%	No	%
Ulster	20	10%	37	20%
Munster	215	16%	303	17%
Leinster	1069	77%	1241	71%
Connaught	75	6%	178	10%
Totals	**1379**	**100%**	**1759**	**100%**

Dean Clinic Referral Source - Provincial Distribution

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

The following table summarises the Dean Clinics monthly referral rates for 2012 compared to 2011. Demand for Dean Clinic services peaked in October 2012 compared to April in 2011.

2.1.4. Dean Clinic Activities (2009-2012).

The table below summarises the number of mental health assessments provided to new referrals across Dean Clinics over the last four 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 person following assessment which may involve follow-on outpatient therapy, a referral to a day-patient programme, admission 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.

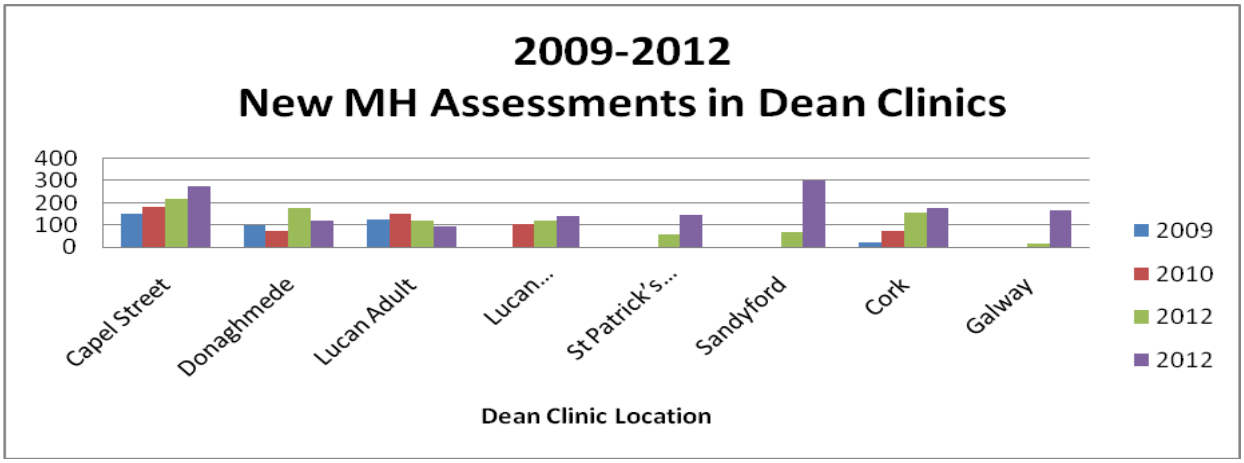
Dean Clinic Total New Patient Assessments 2009 - 2012

Year	Total No of Dean Clinic Appointments
2009	395
2010	573
2011	924
2012	1,398
Grand Total	3,290

Dean Clinic Total New Patient Assessments 2009 - 2012

Year	Total Dean Clinic Appointments
2009	395
2010	573
2011	924
2012	1,398
Grand Total	3,290

The figure below illustrates the number of new patient assessments carred out within each of SPMHS's 7 Dean Clinic. Dean Sandyford delivered the largest number of assessments in 2012.



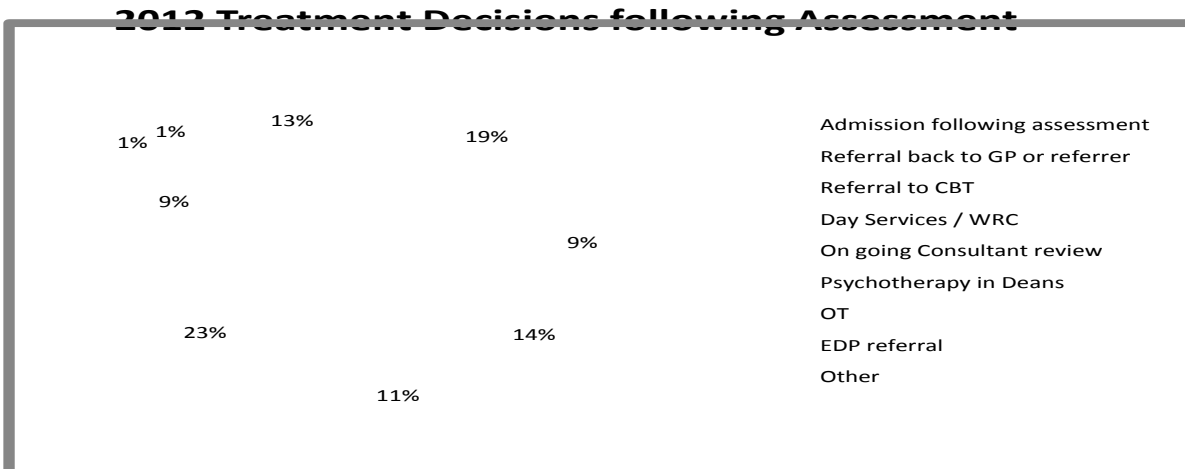
The following table summarises the total number of outpatient appointments provided across Dean Clinics nationwide from 2009 to 2012.

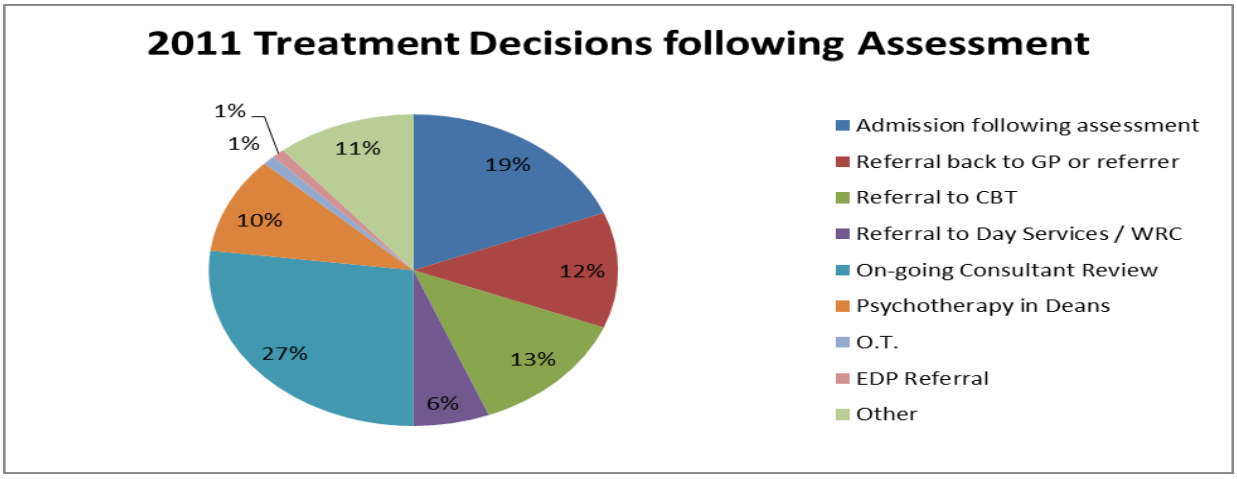
Dean Clinic Total Appointments delivered 2009 - 2012

Year	Total No of Dean Clinic Appointments
2009	2,965
2010	5,220
2011	7,952
2012	12,177
Grand Total	**28,314**

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

The two charts below summarise the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics in 2012 compared to 2011. Of note referrals to Day Services (11%) increased significantly on 2012 when compared to 2011 (6%). Referrals back to GPs (9%) and Consultant Review (23%) following initial assessment decreased when compared to 2011.





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

Admissions following Dean Clinic Assessment

Year	First Admission	Readmission	Total
2012	244	168	412
2011	150	125	275
Grand Total	**394**	**293**	**687**

2.2. SPMHS's Inpatient Care Pathway (2012).

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 2012, there were a total of 2,896 inpatient admissions across the organisation's three approved centres compared to 2.887 for 2011 and 2,888 for 2010.

2.2.1. SPMHS Inpatient Admission Rates (2012)

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 2012 compared to 2011.

The tables below present inpatient admission numbers across the 3 approved centres for 2011 and 2012 including the percentage rates for Male and Female admissions. In 2012, 61.6% of admissions across all three Approved Centres were female with 38.4% were male. This compares to 2011 gender ratio of admission of 60% female and 40% male for 2011.

2012 No. of Admission by Gender and Approved Centre								
	SEH	**%**	**SPUH**	**%**	**WGAU**	**%**	**Total**	**%**
Female	356	69.8%	1,361	59.2%	68	78.2%	1,785	61.6%
Male	154	30.2%	938	40.8%	19	21.8%	1,111	38.4%
Total	**510**	**100%**	**2,299**	**100%**	**87**	**100%**	**2,896**	**100%**

2011 No. of Admission by Gender and Approved Centre								
	SEH	%	**SPUH**	%	**WGAU**	%	**Total**	%
Female	**328**	67%	**1,352**	58%	**53**	68%	**1,733**	60%
Male	**161**	33%	**969**	42%	**25**	32%	**1,155**	40%
Total	**489**	**100%**	**2,321**	**100%**	**78**	**100%**	**2,888**	**100%**

The Tables below show the average age of service user admitted across the 3 Approved centres was 47 years for both 2011 and 2012. The average age of adolescents admitted to WGAU was consistent for 2011 and 2012 at 15 years. The average age of adults admitted to SEH was also consistent for 2011 and 2012 at 52 years. In addition, the average age of adults admitted to SPUH for both years was consistent at 48 years.

2012 Average Age at Admission				
	SEH	**SPUH**	**WGAU**	**Total**
Female	52.94	49.39	15.96	48.83
Male	47.92	46.11	15.47	45.83
Total	**51.42**	**48.05**	**15.85**	**47.68**

2011 Average Age at Admission				
	SEH	**SPUH**	**WGAU**	**Total**
Female	53.21	49.31	15.81	49.02
Male	50.62	46.22	15.60	46.17
Total	**52.36**	**48.02**	**15.74**	**47.88**

2.2.2. SPMHS Inpatient Length of Stay (2011 & 2012)

The Tables below present the 2012 average length of stay (ALOS) for adults 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 cateorgies were used to evaluate SPMHS including

SPMHS Length of Stay (LOS) for Adults

LOS Category	2011			2012		
	No of Discharges	Actual %	Cumulative %	No of Discharges	Actual %	Cumulative %
Under 1 week	355	13%	13%	340	12%	12%
1- <2 weeks	324	11%	24%	337	12%	24%
2 - <4 weeks	639	23%	47%	589	22%	46%
4 - <5 weeks	359	13%	60%	320	12%	58%
5 - <6 weeks	296	10%	70%	333	12%	70%
6 - <7 weeks	218	8%	78%	227	8%	78%
7 - <8 weeks	181	6%	84%	153	6%	84%
8 - <9 weeks	115	4%	88%	105	4%	88%
9 - <10 weeks	85	3%	91%	81	3%	91%
10 - <11 weeks	71	3%	94%	63	2%	93%
11 - <3 months	104	4%	98%	83	3%	96%
3 - <6 months	75	2%	100%	101	4%	100%
6 -12 months	5	0%	100%	6	0%	100%
Total Numbers of Adult Discharges	**2827**	**100%**		**2738**	**100%**	

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

LOS Category	2011			2012		
	No of Discharges	Actual %	Cumulative %	No of Discharges	Actual %	Cumulative %
Under 1 week	9	11%	11%	11	14%	14%
1- <2 weeks	8	11%	22%	10	12%	26%
2 - <4 weeks	13	16%	38%	12	15%	41%
4 - <5 weeks	5	6%	45%	5	6%	47%
5 - <6 weeks	4	5%	50%	5	6%	53%
6 - <7 weeks	2	3%	52%	5	6%	59%
7 - <8 weeks	5	6%	59%	2	2%	62%
8 - <9 weeks	5	6%	65%	6	7%	69%
9 - <10 weeks	5	6%	71%	3	4%	73%
10 - <11 weeks	8	10%	81%	4	5%	78%
11 - <3 months	9	11%	93%	12	15%	92%
3 - <6 months	6	8%	100%	6	7%	100%
6 -12 months	0	0%	100%	0	0%	100%
Total Numbers of Adolescent Discharges	**79**	**100%**		**81**	**100.0%**	**100%**

2.2.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (2012)

The tables below outline the prevalence of diagnoses across SPMHS three Approved Centres during 2012 using the International Classification of Diseases 10th Revision (WHO 2010) The Primary ICD Code Diagnoses recorded upon admission were compared to the Primary ICD Code Diagnosis recorded at the point of service user's discharge. The following tables summarise the ICD Code percentage distribution for SPUH, SEH and WGAU based on the number of service users admitted to these Approved Centres. The first table summarises ICD Code Percentage distribution for SPUH in 2012.

S.P.U.H 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis: Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Disorders of adult personality and behaviour (F60-F69)	Disorders of psychological development (F80-F89)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Organic, including symptomatic, mental disorders (F00-F09)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Unspecified mental disorder (F99-F99)	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	No ICD Code
Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	93%			2%	3%	3%					
Disorders of adult personality and behaviour (F60-F69)	3%	76%	3%	3%	6%	6%	3%				
Disorders of psychological development (F80-F89)			100%								
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		1%		87%	9%	2%		1%			
Mood disorders (F30-F39)	1%	2%	0%	4%	83%	7%	1%	3%	0%		
Neurotic, stress-related and somatoform disorders (F40-F48)		2%	0%	2%	16%	78%	1%	0%			0%
Organic, including symptomatic, mental disorders (F00-F09)					4%	11%	85%				
Schizophrenia, schizotypal and delusional disorders (F20-F29)				2%	10%	5%	1%	81%			
Unspecified mental disorder (F99-F99)									100%		
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)										100%	
No ICD Code					50%		50%				

The Table below summarises the Primary ICD code Diagnosis distribution for service users admitted to SPUH using the actual number of service users.

S.P.U.H 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis: Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Disorders of adult personality and behaviour (F60-F69)	Disorders of psychological development (F80-F89)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Organic, including symptomatic, mental disorders (F00-F09)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Unspecified mental disorder (F99-F99)	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	No ICD Code
Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	99			2	3	3					
Disorders of adult personality and behaviour (F60-F69)	1	25	1	1	2	2	1				
Disorders of psychological development (F80-F89)			6								
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		4		324	32	8		4			
Mood disorders (F30-F39)	8	20	1	42	930	75	16	29	1		
Neurotic, stress-related and somatoform disorders (F40-F48)		7	1	8	57	270	2	1			1
Organic, including symptomatic, mental disorders (F00-F09)					1	3	23				
Schizophrenia, schizotypal and delusional disorders (F20-F29)				4	21	10	3	165			
Unspecified mental disorder (F99-F99)									5		
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)										1	
No ICD Code					1		1				

The Table below summarises the percentage distribution of Primary ICD code Diagnosis for service users admitted to SEH in 2012.

S.E.H. 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis							
	Disorders of adult personality and behaviour (F60-F69)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Disorders of psychological development (F80-F89)	Organic, including symptomatic, mental disorders (F00-F09)
Disorders of adult personality and behaviour (F60-F69)	75%		25%				
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		83%	14%	3%			
Mood disorders (F30-F39)	1%	2%	91%	5%	1%		1%
Neurotic, stress-related and somatoform disorders (F40-F48)		1%	33%	65%	1%		
Schizophrenia, schizotypal and delusional disorders (F20-F29)			12%		82%	6%	

admitted to SEH, represented by the actual number of service users admitted.

S.E.H. 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis: Disorders of adult personality and behaviour (F60-F69)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Disorders of psychological development (F80-F89)	Organic, including symptomatic, mental disorders (F00-F09)
Disorders of adult personality and behaviour (F60-F69)	3		1				
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		30	5	1			
Mood disorders (F30-F39)	4	8	339	19	2		2
Neurotic, stress-related and somatoform disorders (F40-F48)		1	27	53	1		
Schizophrenia, schizotypal and delusional disorders (F20-F29)			2		14	1	

The Table below summarises the Primary ICD code Diagnosis combined percentage distribution for Adults admitted to SPUH and SEH in 2012.

Adults Only 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis: Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Disorders of adult personality and behaviour (F60-F69)	Disorders of psychological development (F80-F89)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Organic, including symptomatic, mental disorders (F00-F09)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Unspecified mental disorder (F99-F99)	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	No ICD Code
Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	93%			2%	3%	3%					
Disorders of adult personality and behaviour (F60-F69)	3%	76%	3%	3%	8%	5%	3%				
Disorders of psychological development (F80-F89)			100%								
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		1%		87%	9%	2%		1%			
Mood disorders (F30-F39)	1%	2%	0%	3%	85%	6%	1%	2%	0%		
Neurotic, stress-related and somatoform disorders (F40-F48)		2%	0%	2%	20%	75%	0%	0%			0%
Organic, including symptomatic, mental disorders (F00-F09)					4%	11%	85%				
Schizophrenia, schizotypal and delusional disorders (F20-F29)			0%	2%	10%	5%	1%	81%			
Unspecified mental disorder (F99-F99)									100%		
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)										100%	
No ICD Code					50%		50%				

The Table below summarises Primary ICD Diagnoses distribution for the combined adult cohort admitted to SPUH and SEH in 2012 based on actual numbers of service users admitted.

Adults Only 2012

Primary ICD Admission Diagnosis	Primary ICD Discharge Diagnosis: Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Disorders of adult personality and behaviour (F60-F69)	Disorders of psychological development (F80-F89)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Organic, including symptomatic, mental disorders (F00-F09)	Schizophrenia, schizotypal and delusional disorders (F20-F29)	Unspecified mental disorder (F99-F99)	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)	No ICD Code
Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	99			2	3	3					
Disorders of adult personality and behaviour (F60-F69)	1	28	1	1	3	2	1				
Disorders of psychological development (F80-F89)			6								
Mental and behavioural disorders due to psychoactive substance use (F10-F19)		4		354	37	9		4			
Mood disorders (F30-F39)	8	24	1	50	1269	94	18	31	1		
Neurotic, stress-related and somatoform disorders (F40-F48)		7	1	9	84	323	2	2			1
Organic, including symptomatic, mental disorders (F00-F09)					1	3	23				
Schizophrenia, schizotypal and delusional disorders (F20-F29)			1	4	23	10	3	179			
Unspecified mental disorder (F99-F99)									5		
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)										1	
No ICD Code					1		1				

The Table below summarises the Primary ICD Diagnosis percentage distribution for under service users less than 18 years of age admitted to Willow Grove Adolescent Unit (WGAU)

W.G.A.U. 2012

		Primary ICD Discharge Diagnosis				
		Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Disorders of adult personality and behaviour (F60-F69)	Schizophrenia, schizotypal and delusional disorders (F20-F29)
Primary ICD Admission Diagnosis	Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	88%		8%		4%
	Mood disorders (F30-F39)	7%	84%	5%		5%
	Neurotic, stress-related and somatoform disorders (F40-F48)		25%	50%	8%	17%

The Table below summarises the Primary ICD Diagnosis distribution for service users less than 18 years of age admitted to Willow Grove Adolescent Unit (WGAU) based on actual numbers.

W.G.A.U. 2012						
		Primary ICD Discharge Diagnosis				
		Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	Mood disorders (F30-F39)	Neurotic, stress-related and somatoform disorders (F40-F48)	Disorders of adult personality and behaviour (F60-F69)	Schizophrenia, schizotypal and delusional disorders (F20-F29)
Primary ICD Admission Diagnosis	Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)	23		2		1
	Mood disorders (F30-F39)	3	36	2		2
	Neurotic, stress-related and somatoform disorders (F40-F48)		3	6	1	2

2.3. SPMHS's Day-patient Pathway; Wellness & Recovery Centre (2012)

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 2012, the WRC received a total of 1,594 day programme referrals compared to a total of 1,418 for 2011. 585 of the day patient referrals for 2012 came from a Dean Clinic. This compares to a total or 339 day patient referrals from Dean Clinics in 2011.

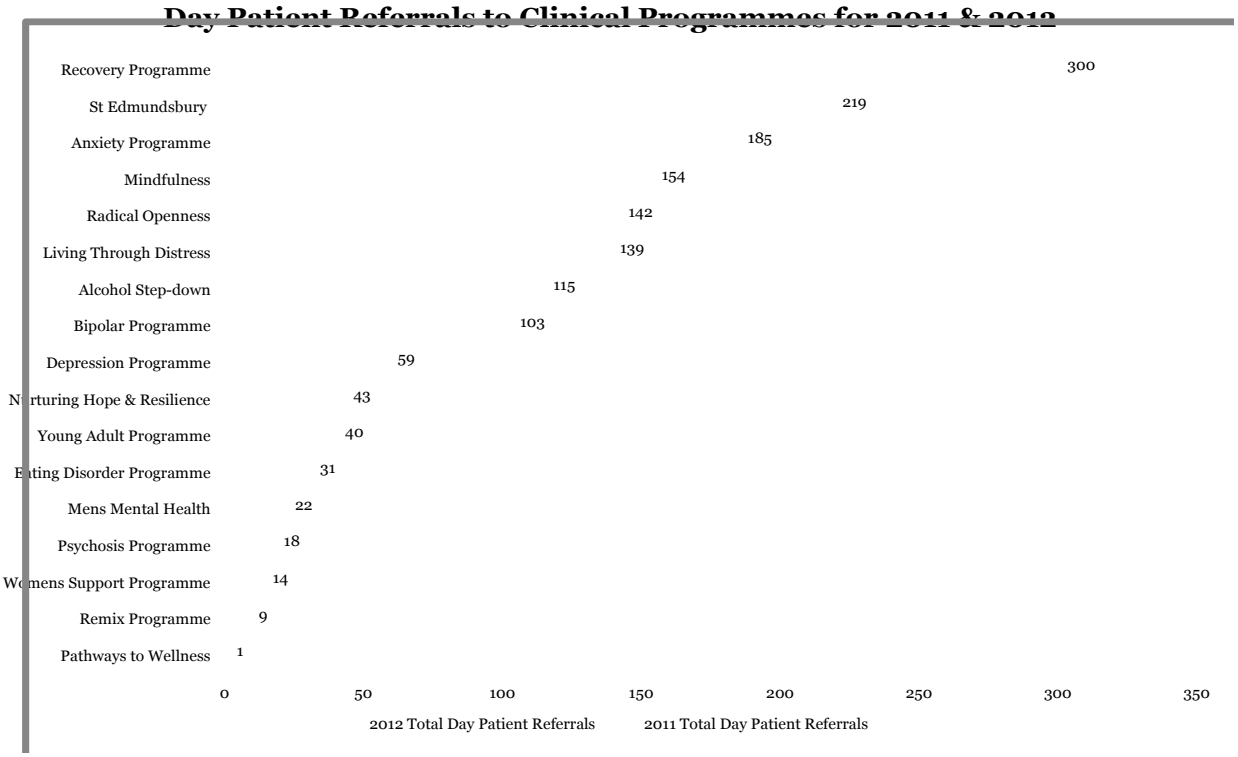
2.3.1. Day-patient Referrals by Clinical Programme (2012)

This table below compares the total number of day patient referrals to each clinical programme for 2011 and 2012. In addition, day patient referrals received through the Dean Clinic Referral Pathway are also presented.

Day Patient Referrals for Clinical Programmes 2012

SPMHS Day Programmes	Total Day Patient Referrals 2011	Total Day Patient Referrals 2012	Total Day Patient Referrals from Dean Clinics 2011	Total Day Patient Referrals from Dean Clinics 2012
Pathways to Wellness	0	1	0	0
Remix Programme	0	9	0	5
Womens Support Programme	16	14	2	6
Psychosis Programme	27	18	11	4
Mens Mental Health	39	22	8	10
Eating Disorder Programme	23	31	1	4
Young Adult Programme	30	40	16	24
Nurturing Hope & Resilience	21	43	5	27
Depression Programme	75	59	28	25
Bipolar Programme	122	103	12	20
Alcohol Step-down	104	115	2	0
Living Through Distress	230	139	75	43
Radical Openness	16	142	7	48
Mindfulness	84	154	26	85
Anxiety Programme	144	185	67	89
St Edmundsbury	212	219	25	110
Recovery Programme	275	300	54	85
Total	**1418**	**1594**	**339**	**585**

* Nurturing Hope & Resilence Programme 2011 Referral figures were not included in 2011 Outcomes Report

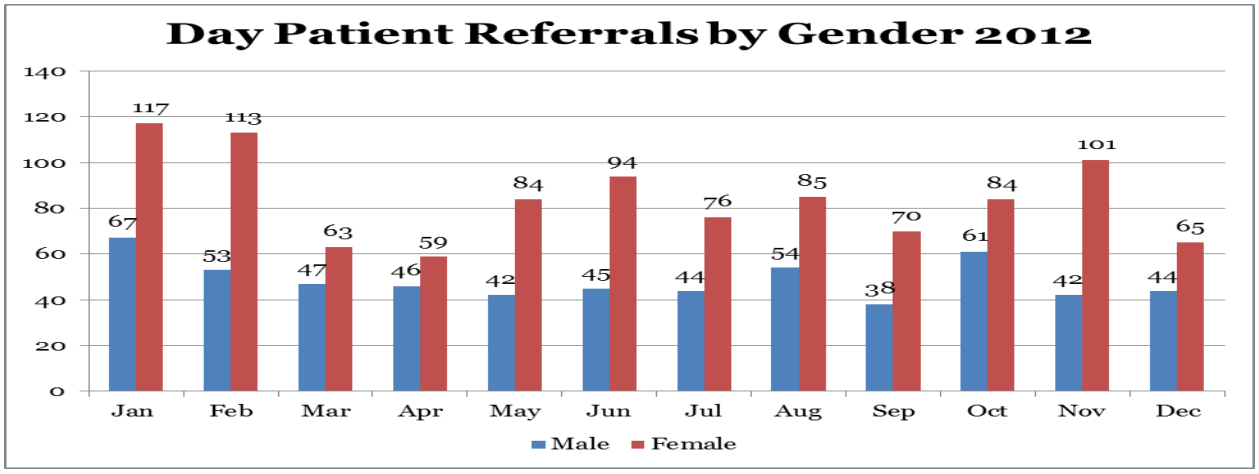


2.3.2. 2012 Day-patient Referrals by Gender

The tables below show male and female day-patient referral rates to all programmes during 2012. 36.6% of referrals to day programmes were male and 63.4% were female.

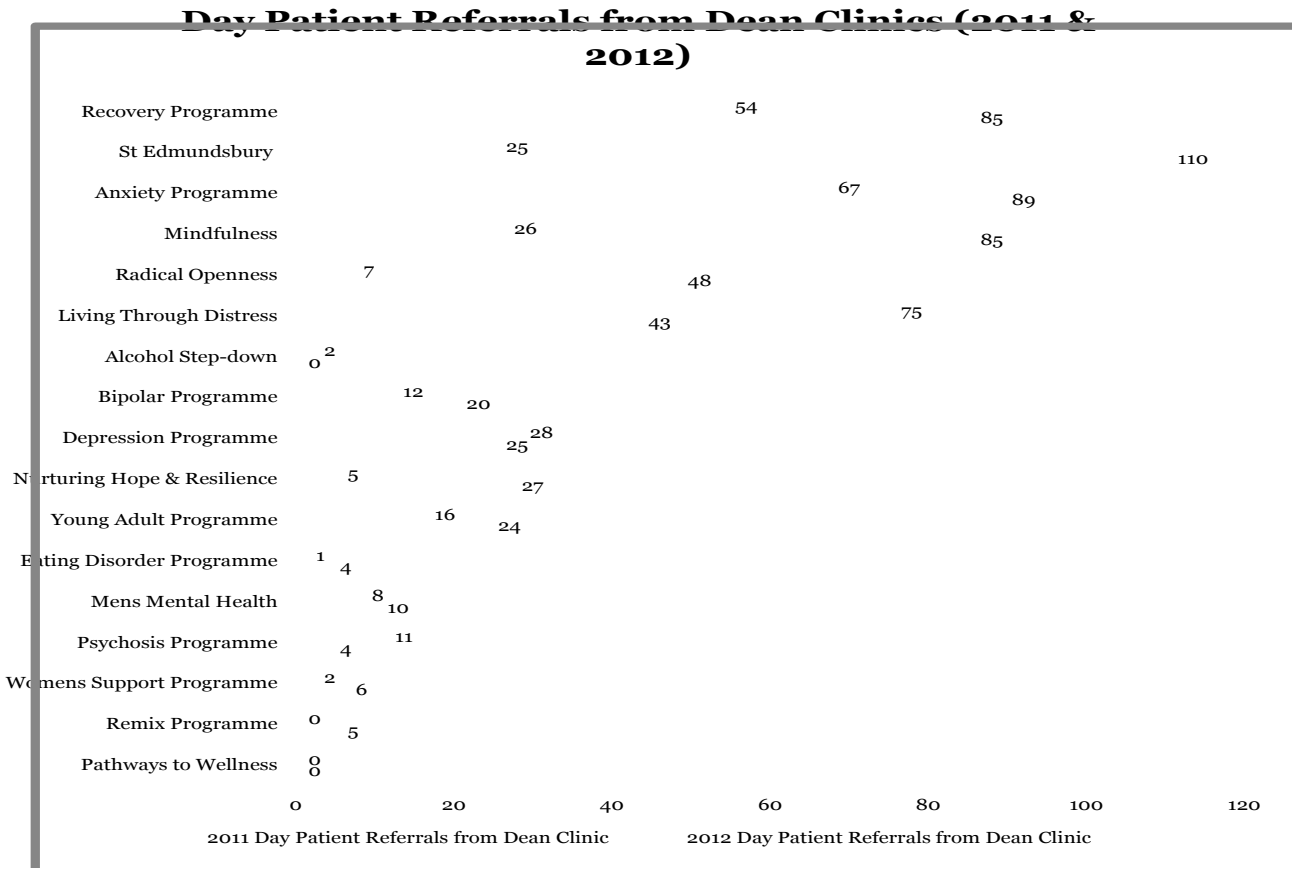
Day patient Referrals by Gender 2012

2012	Male	Female	Totals
Jan	67	117	184
Feb	53	113	166
Mar	47	63	110
Apr	46	59	105
May	42	84	126
Jun	45	94	139
Jul	44	76	120
Aug	54	85	139
Sep	38	70	108
Oct	61	84	145
Nov	42	101	143
Dec	44	65	109
	583	**1011**	**1594**



2.3.3. Day-patient Referrals from Dean Clinics (2012)

The table below shows the day-patient referrals to clinical programmes accessed through Dean Clinic Referral Pathway for 2011 & 2012. In 2012, a total of 585 day patient referrals were made from a Dean Clinic, representing 36.7% of the total referrals (1594) to Day Programmes. This compares to a total of 339 day patient referrals from Dean Clinics in 2011 representing 23.9% of the total referrals to Day Programmes. Referrals to day programmes through Dean Clinic Referral Pathway increased by 12.8% from 2011 to 2012.



2.4. Section Summary.

In 2012, 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 2012

3. Clinical Governance Measures & Quality Management (2012)

SPMHS aspires to provide its 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 Quality Framework.

3.1. Clinical Governance Measures Summary (2012)

The following table provides a summary of the clinical governance measures for 2012.

Governance Measure	2011	2012
Clinical Audits	**12**	**25**
Number of Complaints Total including all complaints, comments and suggestions received and processed in 2012	**606**	**608**
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**
Root Cause Analyses commenced in 2012 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**
Number of Section 23s 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 of 24 hours for assessment.	**51**	**91**
% Section 23s 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.	**39% (20)**	**44% (40)**
Number of Section 14s 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.	**31**	**36**
% of Section 14s 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.	**74% (23)**	**86% (31)**
FORM 10 Admissions Where a 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**	**9**
Assisted Admissions	**27**	**22**
Number of Section 60 – Medication Reviews 2012 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**
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**
Number of Tribunal's held	**61**	**72**
Mental Health Commission Reporting – Number of ECT Treatments 2012	**110**	**119**
Mental Health Commission Reporting – Number of Physical Restraint Episodes	**131**	**157**

3.2. Clinical Audit Summary (2012)

This section summarises briefly the clinical audit activity for SPMHS in 2012. 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. The Clinical Audit Process is overseen and managed by the organisation's Clinical Governance Committee and all audits are reviewed by the Quality Governance Sub-Committee of SPMHS Board of Governors.

The number of clinical audits and service review projects was greater in 2012 than that completed in 2011. There is noticeable enthusiasm and active involvement among staff for the monitoring and continuous improvement of the quality of services provided to our service users.

3.2.1. Overview of audit activity 2012

The table below demonstrates the breakdown of projects by type undertaken in 2012. These include those facilitated by staff at local clinical level and those applied across the entire organization.

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 the 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.	***ICD-10 Diagnostic Codes*** *To standardize the usage of ICD-10 codes in recording of diagnoses*	Clinical Governance Committee	Completed
6.	***Photographic identification of residents–providing safe medicine administration*** *To ensure that the MHC standard and Hospital policy on identification of a resident is being followed.*	Clinical Governance Committee	On-going

No.	Audit Title	Audit Lead	Status at year end
7.	***Generic Prescribing*** *To measure and assess the level of compliance with hospital policy requiring medications to be prescribed using approved generic names.*	Clinical Governance Committee	Baseline audit completed
8.	***Appropriateness and effectiveness of antibiotic prescribing practice*** *To measure the effectiveness of infection management and to ensure that antibiotics are prescribed appropriately.*	Infection Control Committee	Re-audit completed
9.	***Infection Control Audits*** *To measure the implementation of policies and procedures relating to infection control.*	Infection Control Committee	On-going
10.	***European Point Prevalence Survey on hospital acquired infection and antimicrobial usage*** *To measure the overall prevalence of antimicrobial prescribing and types of antimicrobial prescribed and compliance with local policy.*	Infection Control Committee	Completed
11.	***Report of accurate, timely and efficient use of the medical record tracking system for medical files*** *To examine how accurately medical records are tracked on the patient administrative system.*	Clinical Governance Committee	Baseline audit completed

No.	Audit Title	Audit Lead	Status at year end
12.	***The Quality of the Admission Psychiatric Assessment documentation*** *To assess the quality of the psychiatric admission assessment record completed by non-consultant hospital doctors*	Clinical Governance Committee	Re-audit completed
13.	***Compliance with Child Protection and Welfare Practice*** *To ensure information is being collected and reported at admission to identify concerns in relation to Child Protection and Welfare*	Social Work Department: Designated Person for Child Protection and Welfare	Re-audit completed
14.	***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.*	MDT Registrar	Completed
15.	***Benefits of ECG screening in new admission to a psychiatric hospital*** *To measure adherence to guidelines for performing ECG's on new admissions to SEH who meet the criteria for baseline ECGs.*	MDT Registrar	Work in progress
16.	***Evaluation of medical risk assessment guidelines used in in-patient eating disorder programmes*** *To measure documented risk assessment compliance against gold standards used for Eating Disorders Medical Risk protocol*	MDT Registrar	Completed

No.	Audit Title	Audit Lead	Status at year end
17.	***Prescribing patterns of high dose and combination antipsychotics on adult psychiatric wards*** *To assess compliance with hospital policy on high dose and combination antipsychotic prescribing.*	MDT Registrar	Completed
18.	***To audit the Children's Global Assessment Scale (CGAS)*** *To measure CGAS completion rates and analyse the level of change pre and post in-patient treatment*	MDT Registrar	Completed
19.	**Audit of the Health of the Nation *outcome scale for children and adolescents (HoNOSCA)*** *To measure HoNOSCA completion rates and analyse the level of change pre and post in-patient treatment.*	MDT Registrar	Work in progress
20.	***ICD-10 codes & corresponding history of presenting complaint*** *To compare the admission ICD-10 diagnoses codes assigned by the admitting Registrars following assessment and service user history taking against ICD-10 diagnostic criteria.*	MDT Registrar	Work in progress
21.	***To measure and assess the quality of documentation and accountability in section 23(1) initiation and to evaluate the characteristics of service users detained under this section*** *To improve and standardise the documentation requirements of SPUH and SEH at the immediate point of the initiation stage.*	MDT Registrar	Work in progress

No.	Audit Title	Audit Lead	Status at year end
22.	***An audit of the effectiveness of text message reminders in improving adherence with lithium blood monitoring*** *To measure adherence with lithium blood monitoring where text message service is used.*	MDT Registrar	Work in progress
23.	***Assessment of Attitudes to and Knowledge of ECT and Intervention to Improve Mental Health Professionals' Knowledge and Attitudes*** *To measure MH professionals attitude to and knowledge of ECT Intervention*	MDT Registrar	Work in progress
24.	***Assessing and Improving The Security of Electronic Files and Access within St Patrick's University Hospital.*** *To assess and improve the level of Registrars' in training knowledge regarding password creation and maintenance.*	MDT Registrar	Work in progress
25.	**Clozapine and Gastrointestinal Hypo-motility** *To improve the care of patients taking Clozapine, with respect to monitoring and treatment of the side-effect of constipation.*	MDT Registrar	Work in progress

3.2.2. Key Audit Outcomes for 2012.

The Outcomes of Audits are reviewed by the Clinical Governance Committee (CGC) and where the need for change is necessary, the implementation of these changes is overseen by the C.G.C. The paragraghs below describe improvements to clinical practice introduced in 2012.

- The implementation of recommendations arising from an audit of lithium treatment. These included the development of a hospital protocol and care pathway for lithium treatment, the development of a lithium therapy booklet providing user friendly information for those prescribed lithium and logbook for recording blood tests and health checks.

- The implementation of recommendations arising from the audit on benzodiazepine and hypnotics prescribing. These included the development of hospital protocols and patient information leaflets on sleep hygiene and anxiety management;

- The introduction of a quality improvement initiative on the admission nursing assessment and the nursing intervention sheets has strengthened the nursing process within the context of the multidisciplinary teams, service user centred and recovery focused care. This initiative has also fostered more consistent use of evidence based practice for nursing led interventions.

- Junior doctors are required to participate in clinical audit projects as part of their training requirements. In order to facilitate their participation a Postgraduate Audit Training Committee has been established. In 2012, eleven projects (Items 14 to 25 of the table above) were approved by the committee. The completed audits were presented at two of the Hospital's weekly academic meetings and at national conferences also.

- The Nursing Audit Sub-committee was set up to support the nursing process within the context of the multidisciplinary service user centred and recovery focussed care and to satisfy compliance with An Bord Altránais and the Mental Health Commission requirements and guidelines.

- A European-wide hospital point prevalence survey was carried out in May 2012. In Ireland this project was coordinated by the Health Protection Surveillance Centre (HPSC) and 50 Irish acute hospitals collected data for 9030 patients. SPUH was the only hospital specialising in Mental Health Care from Ireland to take part in this survey.

SECTION 4
Clinical Outcomes Measures 2012

4. Clinical Outcomes (2012)

The results presented in this Section summarise the output of a programme of routine outcome measurement in St Patrick's Mental Health Services in 2012. This programme has been in place since 2011 and is embedded within the context of routine clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. 2012 saw the expansion of routine outcome measurement to new clinical programmes and improvements in 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. Clinic Global Impression (CGI) and Children's Global Impresssions Scales - 2012 Inpatient Outcomes.

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. Background

The Clinical Global Impressions Scale (CGI) is a clinician rated mental health assessment tool used to establish the severity of illness (CGIS) at point of assessment and global improvement or change (CGIC) scored following care, treatment or intervention. The CGIS is rated on a 7-point scale, with the severity of illness scale rated from 1 (normal) through to 7 (most severely ill). CGIC scores range from 1 (very much improved) through to 7 (very much worse).

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.

4.2.2. 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. The cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases across each admission ward.

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 anonymized 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.

4.2.3. Sample description

		TOTAL SPUH and SEH	SPUH	SEH	WGAU
Sample size		402	237	165	75
Re-admissions	1st admission	44%	47%	39%	83%
	Re-admission	56%	53%	61%	17%
Average age ± standard deviation		49±17	47±17	52 ± 16	16 ± 1
Gender breakdown	Female	60%	54%	68%	79%
	Male	40%	46%	32%	21%

4.2.4. ICD-10 Admission Diagnosis Breakdown

The primary admission diagnosis was analysed.

ICD-10 Admission Diagnosis Category		2011	2012			
		TOTAL SPUH and SEH	TOTAL SPUH and SEH	SPUH	SEH	WGAU
F30-F39	Mood disorders	59%	60%	45%	80%	53%
F40-F48	Neurotic, stress-related and somatoform disorders	16%	15%	19%	10%	13%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	13%	19%	5%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	10%	7%	10%	4%	0%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	0.5%	1%	3%	0%	34%
F00-F09	Organic, including symptomatic, mental disorders	1.5%	1%	2%	0%	0%
F60-F69	Disorders of adult personality and behaviour	0%	1%	1%	1%	0%
F80-F89	Disorders of psychological development	0%	1%	1%	0%	0%

4.2.5. Breakdown of baseline and final assessment scales score

St. Patrick's University Hospital and St. Edmundsbury Hospital

CGIS -Baseline measure of severity of illness		2011	2012		
		TOTAL	TOTAL	SPUH	SEH
1	Normal, not at all ill	0%	0%	0%	0%
2	Borderline mentally ill	2.5%	1%	2%	0%
3	Mildly ill	8%	7%	10%	2%
4	Moderately ill	24%	21%	28%	12%
5	Markedly ill	26.5%	34%	27%	45%
6	Severely ill	15%	18%	12%	27%
7	Extremely ill	1%	2%	2%	1%
	Not scored	23%	17%	19%	13%

CGIC – Final Global improvement or change score		2011	2012		
		Total	Total	SPUH	SEH
1	Very Much improved	14.5%	10%	11%	10%
2	Much Improved	44.5%	44%	35%	56%
3	Minimally Improved	20.5%	23%	25%	21%
4	No Change	6.5%	7%	8%	6%
5	Minimally Worse	0.5%	0%	0%	1%
6	Much Worse	0%	0%	0%	0%
7	Very Much Worse	0%	0%	0%	0%
	Not scored	13.5%	15%	20%	6%

Willow Grove Adolescent Unit

Children's Global Assessment Scale		Baseline	Final
100-91	Superior functioning	0%	0%
90-81	Good functioning	0%	0%
80-71	No more than a slight impairment in functioning	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	1%	23%
60-51	Variable functioning with sporadic difficulties	35%	53%
50-41	Moderate degree of interference in functioning	55%	16%
40-31	Major impairment to functioning in several areas	3%	3%
30-21	Unable to function in almost all areas	0%	0%
20-11	Needs considerable supervision	0%	0%
10-1	Needs constant supervision	0%	0%
	Not scored	7%	5%
Mean ±SD		50±5	57±6
Median		50	58
Wilcoxon Signed Ranks Test: Z=-6.584, p<.001 *Statistical methods have been used to analyse the change in level of functioning in adolescent population following in-patient treatment. The non-parametric Wilcoxon Signed Rank Statistic designed for use with repeated measures was applied. It revealed a statistically significant increase in the median score on Children's Global Assessment Scale (Z = -6.584, p<.001) from the median score of 50 pre-treatment to the median score of 58 post-treatment."*			

In order to simplify the report and the analysis both scales have been converted into a three level scales in the following way:

- **The CGIS rate** from 1 to 3 were converted into “normal to mildly ill”, the rates 4 and 5 – “moderately ill” and the rates 6 and 7 – “very ill”;
- **The CGIC rates** 1 and 2 were transformed into “overall improved”, the rates 3 and 4 – “ no change” and the rates from 5 to 7 – “overall worsened”;
- **The initial CGAS rates** from 1 to 40 were converted into “very ill”, the rates from 41 to 70 – “moderately ill” and the rates from 71 to 100 – “normal to mildly ill”.

4.2.6. Service User Improvement Rates per Treatment Centre

The following tables summarises the improvement rates from initial baseline score to final adult improvement rates for SEH and SPUH Approved Centres.

Approved Centre	Sample size, n	Baseline measure of severity of illness				Final measure of improvement rate			
		Normal to mildly ill	Moderately ill	Very ill	Not scored	Overall improved	No change	Overall worsened	Not scored
SPUH	237	12% (28)	55% (130)	14% (33)	19% (46)	47% (110)	33% (78)	0% (1)	20% (48)
SEH	165	2% (3)	57% (94)	28% (47)	13% (21)	65% (108)	27% (45)	1% (1)	7% (11)
WGAU	75	0% (0)	90% (68)	3% (2)	7% (5)	76% (57)	10% (8)	7% (5)	7% (5)

4.2.7. Data correlation per diagnosis – *breakdown of data per admission primary diagnosis.*

The Table below summarises CGI data per admission diagnosis for St. Patrick's University Hospital, n=237

ICD-10 Admission Diagnosis Category		Baseline measure of severity of illness				Final measure of improvement rate			
		Normal to mildly ill	Moderately ill	Very ill	Not scored	Overall improved	No change	Overall worsened	Not scored
F00-F09	Organic, including symptomatic, mental disorders		75% (3)	25% (1)			75% (3)		25% (1)
F10-F19	Mental and behavioural disorders due to psychoactive substance use	25% (11)	34% (15)	5% (2)	36% (16)	32% (14)	39% (17)	2% (1)	27% (12)
F20-F29	Schizophrenia, schizotypal and delusional disorders	4% (1)	58% (14)	21% (5)	17% (4)	46% (11)	29% (7)		25% (6)
F30-F39	Mood disorders	6% (6)	60% (64)	15% (16)	20% (21)	56% (60)	28% (30)		16% (17)
F40-F48	Neurotic, stress-related and somatoform disorders	15% (7)	63% (29)	13% (6)	9% (4)	43% (20)	35% (16)		22% (10)
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	17% (1)	17% (1)	50% (3)	17% (1)	50% (3)	33% (2)		17% (1)
F60-F69	Disorders of adult personality and behaviour	50% (1)	50% (1)			50% (1)	50% (1)		
F80-F89	Disorders of psychological development	33% (1)	67% (2)			33% (1)	67% (2)		
F99	Unspecified mental disorder		100% (1)						100% (1)

The Table below summarises CGI data per admission diagnosis for SEH n=165

ICD-10 Admission Diagnosis Category		Baseline measure of severity of illness				Final measure of improvement rate			
		Normal to mildly ill	Moderately ill	Very ill	Not scored	Overall improved	No change	Overall worsened	Not scored
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13% (1)	13% (1)	62% (5)	13% (1)	75% (6)	25% (2)		
F20-F29	Schizophrenia, schizotypal and delusional disorders		33% (2)	67% (4)		83% (5)	17% (1)		
F30-F39	Mood disorders	2% (2)	57% (75)	28% (37)	14% (19)	66% (88)	25% (34)	1% (1)	8% (10)
F40-F48	Neurotic, stress-related and somatoform disorders		94% (15)		6% (1)	50% (8)	44% (7)		6% (1)
F60-F69	Disorders of adult personality and behaviour		50% (1)	50% (1)		50% (1)	50% (1)		

The Table below summarises CGAS data per admission diagnosis for WGAU, n=75

ICD-10 Admission Diagnosis Category		Baseline measure of severity of illness				Final measure of improvement rate			
		Normal to mildly ill	Moderately ill	Very ill	Not scored	Overall improved	No change	Overall worsened	Not scored
F30-F39	Mood disorders		93% (37)	3% (1)	5% (2)	70% (28)	18% (7)	8% (3)	5% (2)
F40-F48	Neurotic, stress-related and somatoform disorders		90% (9)		10% (1)	80% (8)		10% (1)	10% (1)
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors		88% (22)	4% (1)	8% (2)	88% (22)	4% (1)		8% (2)

4.2.8. Audit of Completion Rates for baseline and final CGI scores

The following Clinical Audit Standards were applied when evaluating CGI and CGAS completion rates.

1. Baseline score is taken no more than 5 days following admission, Exception: None, Target level of performance: 100%

2. Final CGI score is taken no more than 5 days prior to discharge, Exception: None, Target level of performance: 100%

Results

	2011	**2012**			
	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%	87%	93%
% compliance with clinical audit standard 1	61%	64% (↑)	62%	68%	N/A
Final Assessment Scale Score					
% of admission notes with recorded final scores	87%	85% (↓)	80%	94%	95%
% compliance with clinical audit standard no. 2	73%	73% (↔)	69%	79%	N/A

4.2.9. Summary of Key Findings

1. The Female to Male ratio for total sample was 60% and 40% respectively for adults and 79% to 21% for adolescents.

2. Re-admissions accounted for 56% of SPUH and SEH service users while for 83% of WG service users it was a first admission to a mental health service.

3. The breakdown of baseline CGI scores on admission shows that a majority of SPUH and SEH service users were moderately or markedly ill. In comparison to 2011 data there was noticeable increase in the number of service users markedly and severely ill and a decrease in admissions scored with moderate illness.

4. Overall Improvement in mental health was achieved for 54% of adult service users. This is less than the sample of 59% of adult service users who received inpatient treatment in 2011. Only 2 adults service users mental health worsened in the sample.

5. For Adolescents, there was a statiscally significant improvement in level of functionig following inpatient treatment ($p < .001$). The median score on the Children's Global assessment Scale increased from pre-treatment (Median = 50) to post treatment (Median = 58).

6. The Audit shows a noticeable improvement in the completion rate of the baseline CGI score and a decrease in the completion rate of final CGI score in comparison to the audit for 2011. Out of three approved centres the highest completion rate was achieved by the WGAU.

7. 36% 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.

8. This Audit measure did not include an exceptional circumstances e.g. when a service user is discharged against medical advice or when a short admission occurs and the rating cannot be performed. Incorporating these exceptions into the clinical audit standard could lead to increase of the calculated completion and compliance rates.

4.3. Acceptance & Commitment Therapy Programme, (ACT) SEH.

Acceptance and Commitment Therapy (ACT) is an evidence-based psychotherapy (for example in the US the National Registry of Evidence-based Programs and Practices [NREPP]) 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 to anxiety and depression and increase values-based 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 participant's to integrate ACT processes into their daily lives. The essential aim of this programme is to help people connect to what matters most to them and develop skills to help overcome what gets in the way of living a values-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 2012, 138 service users attending St Edmundsbury were referred to the ACT programme. Of the 138 participants, (72.5% female) both pre- and post-measures were available for 106 programme completers, representing 76.8%.

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 Behavioral Activation for Depression Scale (BADS: Kanter, Mulick, Busch, Berlin & Martell, 2007) measures behaviors 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, 2008). The measure has good internal consistency (Cronbach's α ranging from .76 - .87), adequate test-retest reliability (Cronbach's α ranging from .60 - .76), good construct and predictive validity (Kanter et al., 2007)

- **Five Facet Mindfulness Questionnaire**

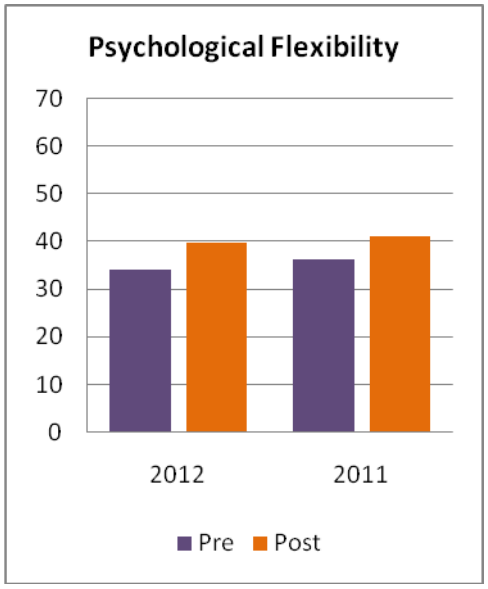
  The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity- to inner experience, and non-judging of inner 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, 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.

4.3.3 Results



Total scores on the AAQ-II showed a statistically significant increase, t (105) = -5.18, p < .001, suggesting greater psychological flexibility post programme. The effect size d of .58 indicates a medium effect. Pre and Post mean scores on the AAQ-II were similar to those reported in 2011.

Mean post BADS scores increased significantly, suggesting greater behavioural activation, from pre (M = 77.5, SD = 24.60) to post (M = 93.4, SD = 26.89), t (104) = -5.47, p < .001, representing a medium effect size (d = 0.62). The percentage of programme completers with scores below 70 (the mean reported by Kanter et al.

(2008) for a sample with elevated depressive symptoms) reduced from 40.7% to 15.9% at the post measurement time point.

Total FFMQ scores increased significantly, t (104) = -5.00, $p < .001$. From pre (M = 104.8, SD = 21.48) to post (M = 117.2, SD = 22.11) indicating greater levels of overall mindfulness. A medium effect size was observed (Cohen's d = .57). 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 (105) = 5.27, $p < .001$, from 18.3 (SD = 7.73) to 14.3 (SD = 7.68), indicating less functional impairment. The effect size d of .51 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 14% of programme completers had scores below 10 when they started the programme, while 38% had scores below 10 on completion of the programme.

4.3.4 Summary

Data collection systems and processes have improved over the past year. As a result of this improvement, data for a much larger proportion of ACT programme completers were captured in 2012 (76.8%) than 2011 (23%).

On the basis of findings from 2011, three new measures were introduced in 2012 which were felt to better reflect therapeutic targets of the programme. Programme completers showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning. The AAQ (psychological flexibility) was the only measure used both in 2011 and 2012. Mean scores for the AAQ pre and post programme were very similar to those reported for 2011.

The questionnaires currently in use appear to be good tools for capturing therapeutic targets/outcomes of the programme. In addition to those currently in used, the

programme facilitators plan to add a measure of compassion for 2013 (Neff, 2003). Two recommendations emerge from the 2012 analysis. Firstly, the same measures should continue to be used in 2013, allowing outcomes for 2012 and 2013 to be compared. Secondly, recording and analysis of the five distinct subscales of the FFMQ, rather than the total scale score alone, might provide more clinically useful data about how participants are learning and utilising different aspects of mindfulness. Using the FFMQ subscales will also allow for comparisons with published research which tends to use subscale rather than total scale scores.

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 psychiatrist, 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.

The group based programme includes;

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.

Concerned Persons Group: This group provides support for the relatives of patients attending the Programme.

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-educational Lectures: There are educational lectures 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. Also a psycho-educational lecture is offered to the 'Step-Down' programme on a weekly basis.

Motivation for Change Group: Facilitated by therapists. Specific 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.

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

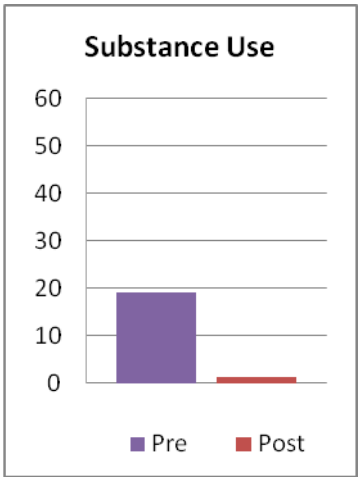
28 days. In the first three sections participants are asked to record the number of days relevant behaviours (i.e. alcohol use, injecting etc.) occurred each week. In the fourth section of the tool three questions require subjective ratings of psychological health, physical health and quality of life 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). For the purposes of this report, only sections one and four of the measure were used providing a Substance Use score and Health and Social Functioning score (comprising the questions about psychological and physical health status and quality of life).

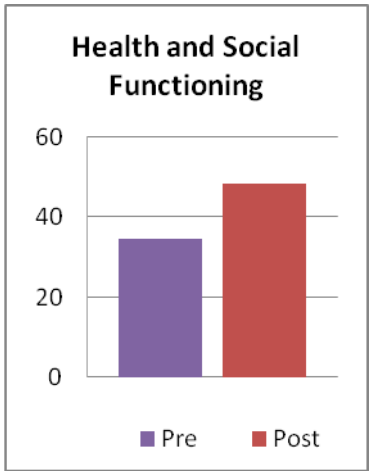
4.4.2. Descriptors

Pre and post data were available for 94 programme participants.

4.4.3. Results

Changes in Substance Use and Health and Social Functioning were significant with large effect sizes (see graphs on the next page). Substance Use scores dropped from an average of 19.12 (*SD* = 12.16) to 1.20 (*SD* = 6.44), t (93) = 15.13, $p < .001$, d = 1.76. For 92.6% of programme completers Substance Use Scores post intervention had dropped to 0. Health and Social Functioning scores increased significantly from an average of 34.66 (*SD* = 15.05) to 48.37 (*SD* = 10.74), t (93) = -10.23, $p < .001$, d = *-1.02,* suggesting improvements in psychological and physical health and quality of life.





4.4.4. Summary

2012 is the first year for which outcome data is available and initial results suggests improvements in participants. While this is a good start, the clinical team having reviewed this measure, have concluded that it is not ideally suited to the service at SPUH and other options are being considered. The possibility of using individual subscales rather than a total Health and Social Functioning score is also being considered. Future reports will also include a profile of the types of substances used by those attending the programme.

4.5. Anxiety Disorders Programme

The Anxiety Disorders Programme was established in 2005 to provide 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 5-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).

- **Beck Anxiety Inventory**

  The Beck Anxiety Inventory (BAI: Beck & Steer, 1990) 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, 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. 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).

- **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 (Cabeda et al, 2010; 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 (Wyatt, 1998). 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”.

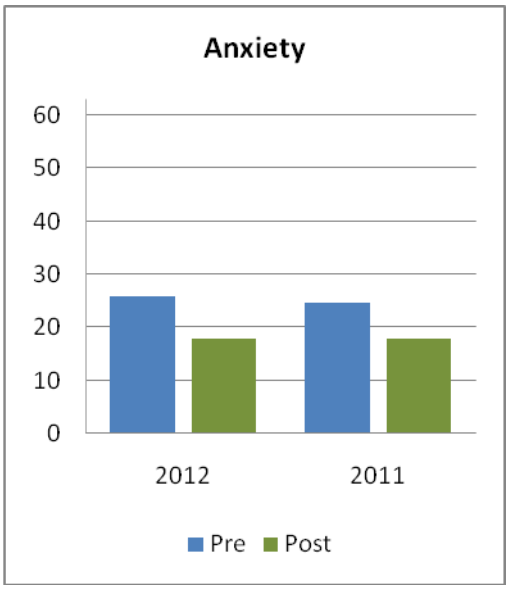
4.5.2. Descriptors

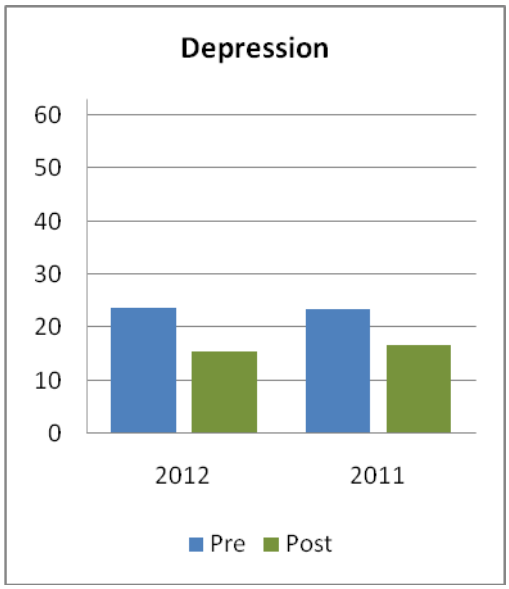
Data were available for one hundred and fifty nine people, of which 91 (57.2%) were female and 68 male (42.8%). Programme attendees ranged in age from 19 to 71 with an average age of 39.07 (*SD* = 13.58). There were seven primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (35%), followed by Generalised Anxiety Disorder (19.1%), Social Phobia/Anxiety (16.6%), Agoraphobia (with/without panic) (10.8%), Panic Disorder (14%), Health Anxiety (2.5%) and Specific Phobias (1.9%). The percentage of people with each diagnosis is represented in the table below, including figures for 2011 for purposes of comparison.

	2011		**2012**	
	N	**%**	**N**	**%**
Obsessive Compulsive disorder	48	37.5	55	35
Generalised Anxiety Disorder	24	18.8	30	19.1
Social Phobia/Anxiety	25	19.5	26	16.6
Panic Disorder	13	10.2	22	14
Agorophobia	14	10.9	17	10.8
Health Anxiety	3	2.3	4	2.5
Specific Phobia	-	-	3	1.9
Habit and Impulsive Disorders	1	0.8	-	-

4.5.3. Results

Pre and post data were available for 156 – 158 people across all strands of the programme (depending on the measure) and 50 – 56 people with OCD specifically. Post data reflects data collected after Level 1 of the anxiety programme.



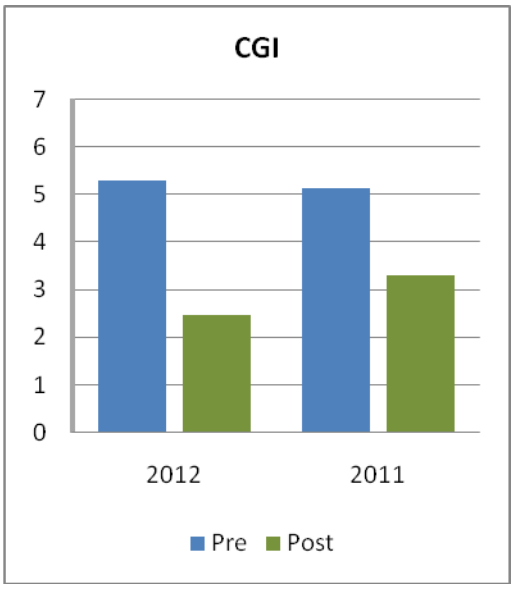


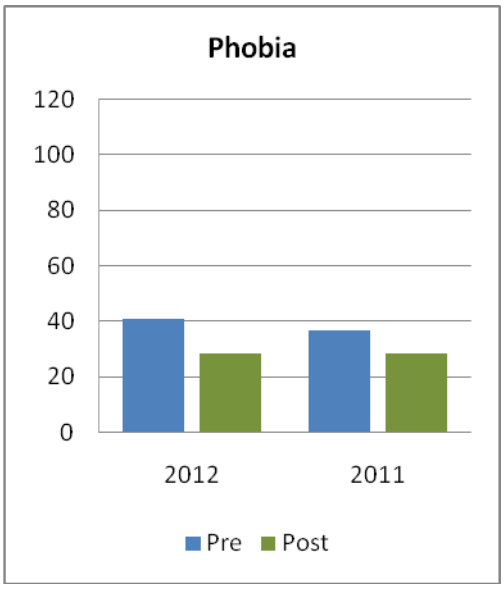
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that Anxiety Programme completers moved from the lower end of the severe (*M* = 25.8, *SD* = 12.1) to the lower end of the moderate (*M* = 17.9, *SD* = 10.5) range on the measure. Changes were statistically significant, t(157) = 9.7, p<.001, and represent a medium effect (Cohen's *d* = 0.69). At the pre measurement time point, 50.3% had anxiety scores in the severe range, this dropped to 24.7% by the end of Level 1 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	**POST**	**PRE**	**POST**
Minimal	6.3	18.4	10.8	33.3
Mild	15.7	31.6	23.6	30.8
Moderate	27.7	25.3	36.0	28.2
Severe	50.3	24.7	29.6	7.7
Totals	**100**	**100**	**100**	**100**

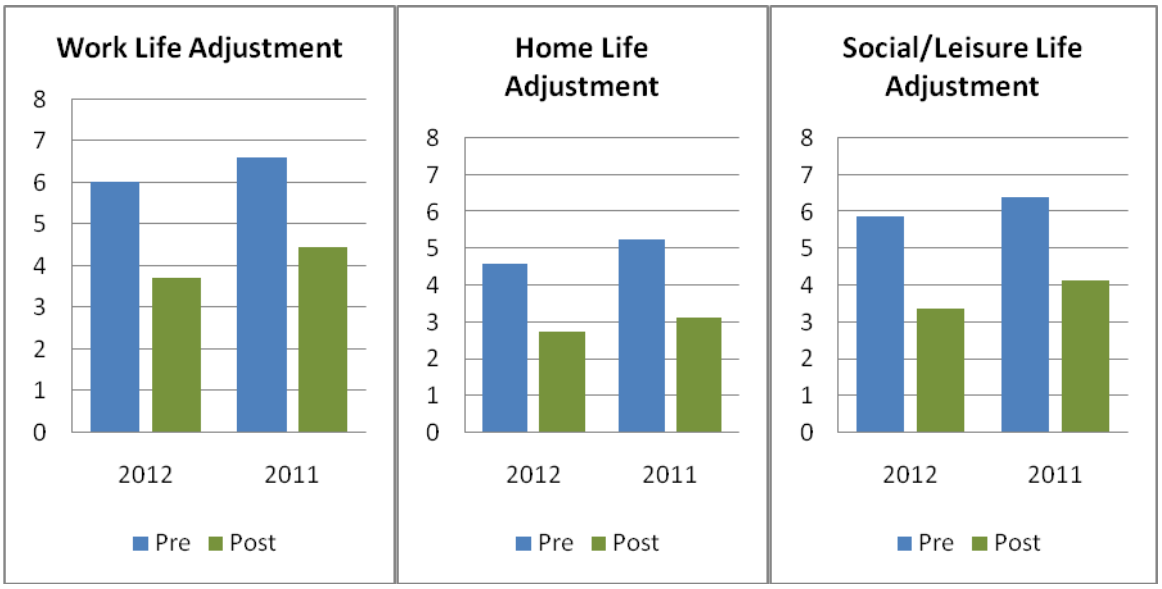
Average depression scores for Anxiety Programme completers (indicated on the graph above) were in the moderate range (*M* = 23.7, *SD* = 11.19) and showed a statistically significant drop to within the mild range (*M* = 15.5, *SD* = 10.5), I(155) = 11.4, *p* < .001, which represented a medium (approaching large) effect (Cohen's *d* = 0.76). While 29.6% were classified has having severe depression before the programme, 7.7% were classified as such by the end (See table above).

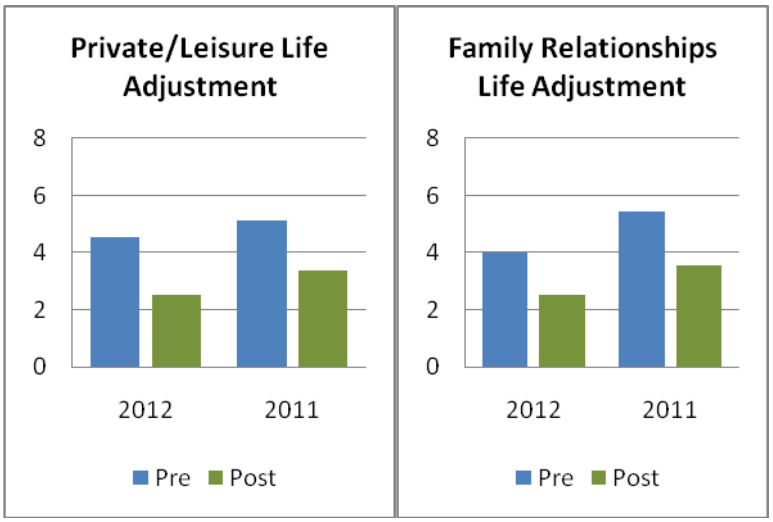
The mean pre programme Severity of Illness (measured using the CGI) was 5.3 (*SD* = 0.68) out of a possible 7 suggesting that people were *markedly ill* but were in the *much improved* category after completing level 1 of the programme.



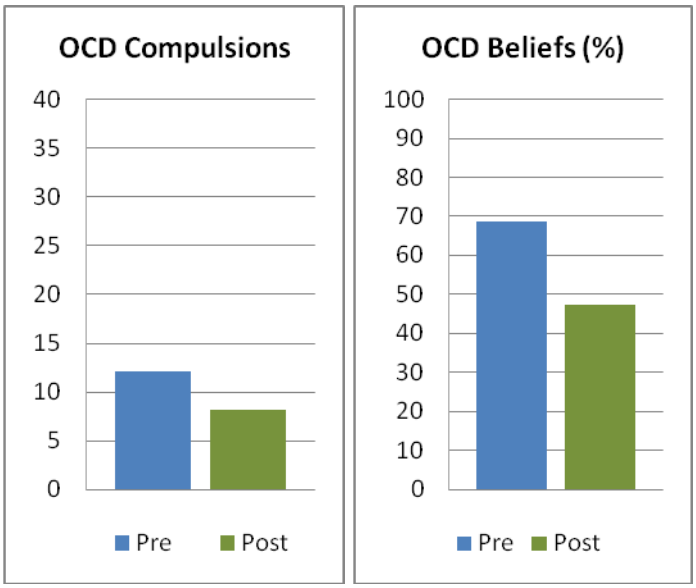


Total phobia scores showed a significant drop, t (156) = 8.7, p < .001, from a mean of 40.8 (*SD* = 22.87) to 28.5 (*SD* = 15.85) suggesting less phobia. The effect size d =.69 indicates a medium effect.





Statistically significant improvements were reported for impairment across all five domains of the Life Adjustment Scale. For all t-test comparisons $p<.001$ and effect sizes d ranged from .61 to 1.18 indicating medium (home and family) to large effects (work, social/leisure and private leisure) on functioning.



For those with OCD, Compulsions (Y-BOCS) scores dropped significantly from 12.1 (SD = 4.79) to 8.2 (SD = 3.97), t (56) =5.71, p < .001, d = 0.89. Scores on the Beliefs scale also dropped significantly from 68.7% (SD = 28.14) to 47.5% (SD =27.85), t (50) = 4.82, p < .001, d = 0.77.

4.5.4. Summary

Outcomes for the 159 service users who completed Level I of the Anxiety Programme between January and December 2012 were positive, and suggest improvements in anxiety and depression symptoms, levels of phobia related avoidance, OCD compulsions and obsessions and impairment across five domains of functioning. All changes were statistically significant with medium to large effect sizes. Changes in mean scores for most measures were remarkably similar when 2011 and 2012 data are compared suggesting a degree of consistency over the last two years. Please note however that the data represent two different cohorts and different sample sizes.

4.6. Eating Disorders Programme (EDP)

The Eating Disorders Programme 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 3 stages. Following assessment at Dean Clinics the first (inpatient) stage includes;

- 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

Following inpatient treatment, Stage 2 or day treatment commences which typically lasts for 8 weeks. Once the person has successfully completed day treatment, they progress to outpatient follow up. In addition there is a monthly aftercare peer support group.

The following summary provides information pertaining to service users who were assessed at Dean Clinics providing a foundation for future routine outcomes measurement and analysis.

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 ED severity, co morbidity and to assess readiness to change.

- **Beck Anxiety Inventory**

The Beck Anxiety Inventory (BAI: Beck & Steer, 1990) 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).

- **Brief Disability Questionnaire**

  The Brief Disability Questionnaire (BDQ: See Von Korff, Ustun, Ormel, Kaplan & Simon, 1996) assesses physical and social disability. Eleven items are responded to on a three-point scale from 0 "No, not at all" to 2 "Yes, moderately or definitely" and scores can range from 0 to 22 with higher scores suggesting more disability. Two additional questions ask about the total number of days in the last few weeks that the respondent has been unable to carry out usual activities and number of days in bed all or most of the day. For the purposes of this analysis the two additional questions were not used. Von Korff et al (1996) report good internal consistency (Cronbach's alpha ranging from 0.83 to 0.94) and evidence of concurrent validity in the form of significant moderate correlations with related validated measures.

- **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, & Touryz, 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, 2005).

	Binge Eating Disorder Sample (n = 52) 1	Control group of UK Schoolgirls (n = 808) 2	Anorexia Nervosa Sample at Time 1 (n = 28) 3	Anorexia Nervosa Sample at Time 2 (n = 28) 3
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.*

- **Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form**

The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF: Endicott, Nee, Harrison & Blumenthal, 1993) asks respondents to rate their satisfcation with a range of life domains (e.g. physical health, mood, work etc.) on a five-point scale from 1 "Very Poor" to 5 "Very Good". Items are summed to yield a total raw score and converted to a percentage using a formula. Higher percentages indicate better enjoyment and satisfaction with life domains. In a sample of psychiatric inpatients scores on the Q-LES-Q predicted length of hospital stay even after symptoms of depression and anxiety were taken into account (Hope, Page & Hooke, 2009). For the aforementioned sample, the average score at admission was 32.29% (SD = 16.13). Good reliability (Cronbach's Alpha = 0.89 - 0.95) and construct validity have been reported for this measure (Rapaport, 2005; Ritsner et al., 2002).

- **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. Descriptors

Data were available for 104 service users attending the Eating Disorder Service in 2012. Of these, initial Dean Clinic baseline assessment data were available for 72 people. Many programme attendees had outcome data for a single time point, however, pre and post programme analyses could not be conducted due to incomplete data capture and small sample sizes. However, baseline data for those 72 patients who had initial assessments at the Dean Clinic are described below.

4.6.3. Results

The table below shows the mean scores and standard deviations for each of the measures administered at initial assessment.

Measure	Mean	Standard Deviation	N
Beck Anxiety Inventory	20.3	11.9	71
Beck Depression Inventory	26.1	11.9	71
Brief Disability Questionnaire	9.4	7.1	69
EDE-Q Global	3.8	1.7	72
EDE-Q – Restraint	3.6	2.0	43
EDE-Q – Eating Concern	3.2	1.8	43
EDE-Q – Shape Concern	4.3	1.7	43
EDE-Q – Weight Concern	3.8	1.8	42
Motivation - URICA	9.0	2.5	69
Q-LES-Q-SF	42.1	17.9	69

Using norms provided by Beck inventory developers, average scores for depression (BDI) and anxiety (BAI) can be interpreted as falling within the moderate range in this sample. In terms of anxiety it is worth noting that approximately one third of those in the sample had scores within the severe range, one third were in the moderate range, 26.8% in the mild anxiety category and 12.7% were classified as having minimal anxiety. In terms of depression, 39% of the sample had scores in the severe range, approximately one third in the moderate range, 24% in the mild category and 6% had scores suggesting minimal depression. For each of the EDE-Q subscales average scores for this sample were much higher than a control group (Carter et al., 2001) and other clinical samples (Passi et al., 2003; Wilfley et al., 1997) for the restraint and weight concern subscales. Some research has cast doubts about the utility of the EDE-Q subscales and in a recent study of 935 females with eating disorder, Aardoom, et al (2012) reported a mean global score of 4.02 (SD = 1.28) across eating disorders which is slightly higher than the average in this sample

The average readiness to change score (URICA) in this sample can be interpreted as indicating that respondents were in the contemplation stage who have a desire to change certain behaviours but may be quite ambivalent about change. Approximately half of the sample had scores falling within this range. One third of this sample had scores below 8 which represents the pre-contemplation category - people in this stage

are not thinking about or intending to change problem behaviour. While 17% of the sample were in the preparation or action stages with plans to make changes.

	URICA	BAI	BDI	Q-LES-Q SF	EDE-Q Global	EDE-Q Restraint	EDE-Q Eating Concern	EDE-Q Shape Concern	EDE-Q Weight Concern
BDQ	-.09	**.51****	**.53****	**.41****	.30	.06	**.45***	.23	.19
URICA		0.1	0.9	.14	0.5	-.06	.13	-.04	-.13
BAI			**.73****	**.50****	**.61****	**.41****	**.60****	**.62****	**.52****
BDI				**.60****	**.71****	**.44***	**.60****	**.55****	**.54****
Q-LES-Q-SF					**-.36***	-.32	-.38	**-.43***	-.35
EDE-Q Global						**.89****	**.87****	**.96****	**.92****
EDE-Q Restraint							**.67****	**.78****	**.77****
EDE-Q Eating Concern								**.81****	**.69****
EDE-Q Shape Concern									**.90****

** $p < .001$ * $p < 0.01$

The table above shows correlations among measures at baseline. While correlations are useful for establishing relationships among measures, no causal inferences can be made from this data. Strong positive correlations can be seen between EDE-Q scores and Depression (BDI) and Anxiety (BAI) scores indicating that higher levels of eating disorder psychopathology are associated with higher levels of depression and anxiety. It is worth noting that in this sample URICA readiness to change scores are not significantly correlated with any of the other measures included. It will be interesting to explore the extent to which URICA scores predict response to treatment in future.

The two measures of quality of life and functioning, Q-LES-Q-SF and BDQ, show moderate overlap. Higher physical and social disability as measured by the BDQ was associated with lower life enjoyment and satisfaction across life domains as measured

by the Q-LES-Q-SF. Both measures were significantly associated with measures of anxiety and depression. The Q-LES-Q-SF but not the BDQ was significantly correlated with the EDE-Q overall (global) score and the EDE-Q Shape Concern subscale in particular, suggesting that greater eating disorder psychopathology and higher levels of concern about shape was associated with lower life satisfaction. The BDQ was significantly associated with the eating concern subscale of the EDE-Q only highlighting a relationship between disabilities and eating concern.

4.6.4. Summary

The assessment battery for the EDP is comprehensive and provides a useful profile of patients attending the service. Measures and data capture continue to be reviewed and consideration is being given to use of a shorter form of the URICA (12, 24 and 28 item versions exist) and other ways of limiting response burden. In 2013 the BDQ and Q-LES-Q-SF will be replaced by a single measure of eating disorder quality of life – the Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008). The CIA captures functional impairment resulting from eating disorder and has three subscales relating to personal, social and cognitive domains.

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 (1993a) proposed that emotional dysregulation underlies much maladaptive coping behaviour. Research suggests that behaviours such as deliberate self harm (DSH) may function as emotion regulation strategies (Chapman et al., 2006).

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

as effective evidence based interventions for DSH behaviours, emotional under-control difficulties and Borderline Personality Disorder.

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

The programme (now in its sixth 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 have 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 (α = .93), construct and predictive validity, and test-retest reliability in the development study.

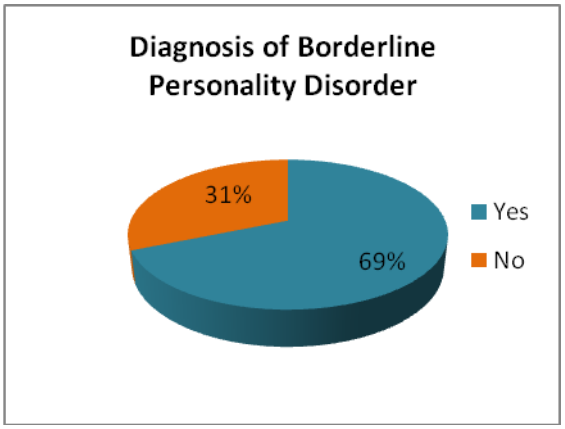
- **Five Facet Mindfulness Questionnaire – Short Form**

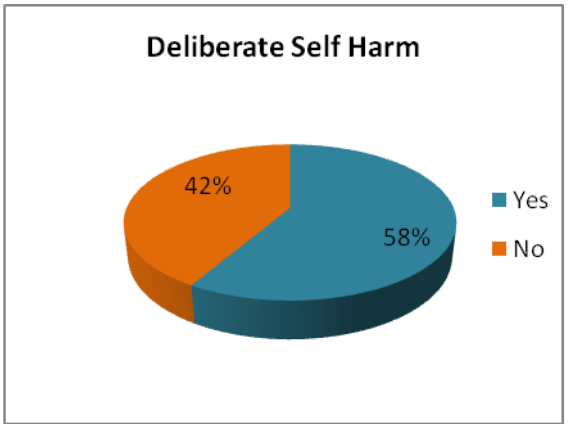
  The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietmeyer & Toney, 2006) assesses the tendency to be mindful in daily life, including five particular facets of mindfulness: observing, describing, acting with awareness, non-reactivity- to inner experience, and non-judgement of 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 80 participants. Pre and post data were available for 24 participants for deliberate self-harm and DERS (30%) and 18 (22.5%) LTD participants for the FFMQ respectively[1].

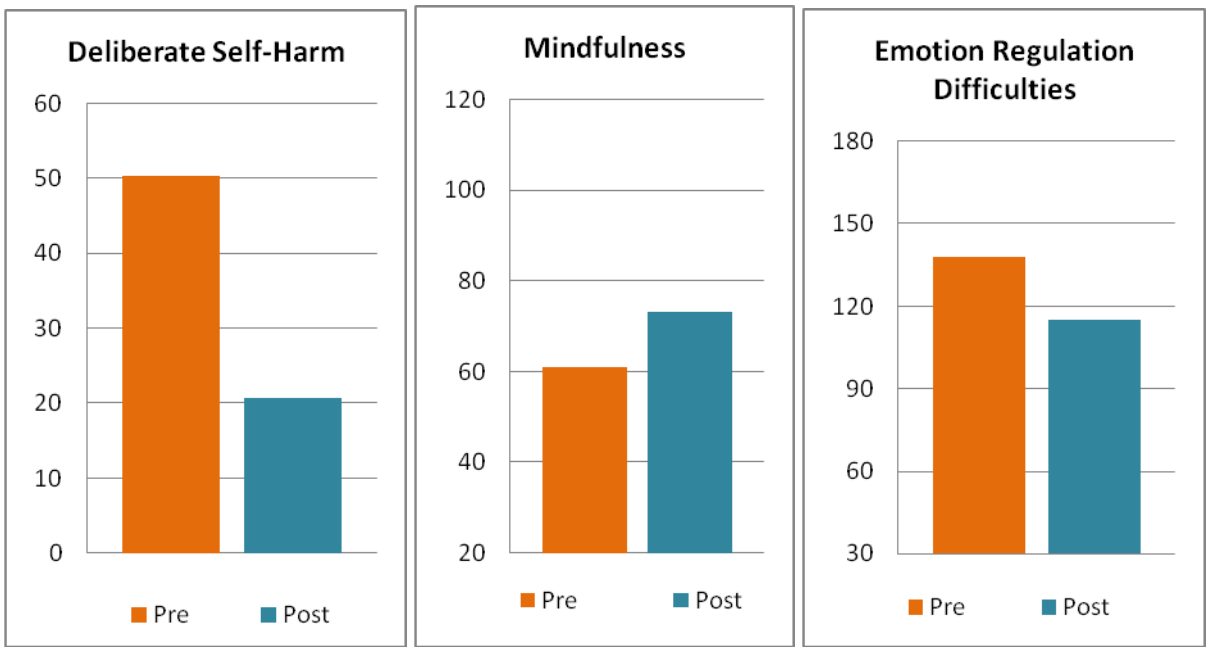
Of the 80 group attendees, 71.3% were female. LTD attendees ranged in age from 18 to 78 years (M = 34, SD = 14.4). As indicated in the graphs below, approximately 69% had a diagnosis of Borderline Personality Disorder and 58% of LTD attendees had engaged in self-harm behaviours in the previous six weeks.





[1] The DERS and FFMQ were only introduced as outcome measures in June 2012 which accounts for the small response rate. Although similar numbers of responses were available in relation to deliberate self-harm and DERS and FFMQ – these numbers do not reflect that same participants (though there is some overlap).

4.7.3. Results



Note: Higher scores indicate more self-harm incidents, greater levels of mindfulness and more difficulties regulating emotion.

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 = 50.25, SD = 71.6) to after (M = 20.7, SD = 40.5) completion of the programme, t (23) = -2.15, p = .042, reflecting a medium effect (d = 0.50).

Levels of mindfulness increased significantly from an average of 60.9 (SD = 12.47) at the start to 73.2 (SD = 10.7) at completion of the programme, t (17) = -4.15, p = .001, representing a large effect (d = 1.0).

Participants also experienced a decrease in difficulties regulating emotions moving from an average score of 137.7 (SD = 21.6) on the DERS pre to 115.0 (SD = 20.6) post completion of the programme, t (23) = 5.17, p < .001. This change represented a large effect (d = 1.1)

4.7.4. Summary

For those participants with pre and post data, significant improvements were observed in terms of self-harm, levels of overall mindfulness and emotion regulation following engagement with LTD. Effect size calculations suggest medium to large effects. While these findings are encouraging, it should be noted that variability in effect sizes increases as sample sizes decrease – increasing the likelihood of a somewhat inflated effect size. Furthermore response bias cannot be ruled out given that post data were available for less than 30% of participants.

2012 saw the addition of two new outcome measures for LTD with intentions to add a measure of distress tolerance in 2013 given that this is a core therapeutic target of DBT. Clinicians on the programme report observing changes in attendees on a broader array of maladaptive behaviours than self-harm alone and measures to capture these changes are also being considered.

4.8. Radical Openness Programme

The Radical Openness (RO) Programme was introduced in SPUH at the end of 2011 and is delivered by the Clinical Psychology Department. Like Living through Distress (LTD), RO is a Dialectical Behaviour Therapy (DBT) informed group-based intervention. The programme shares with LTD a focus on developing skills including emotion regulation, mindfulness and interpersonal effectiveness. However, while LTD is tailored for difficulties resulting from emotional under-control, RO focuses on emotional over-control. The programme is based on an adaptation of DBT for emotional over-control, developed by Lynch (Lynch, Morse, Mendelson, and Robins, 2003; Lynch et al., 2007; Lynch and Cheavens, 2008). This development recognises that for some people behavioural over-control, cognitive and behavioural rigidity and emotional constriction underpin difficulties including recurrent depression, obsessive-compulsive personality disorder, and certain eating disorders, for example. RO focuses on increasing flexibility, openness to new experiences and authentic experience and expression of emotion using a combination of acceptance and change skills.

RO is a nine week programme run over two afternoons a week (18 sessions in total). Those who complete the programme are invited to attend monthly Aftercare sessions which build on the skills learned.

The data presented below reflects the first year of the programme - including pre and post data for the first group which started at the end of 2011. Since RO began at SPUH the programme, assessment tools and outcome measures have evolved – some have been used consistently throughout and some dropped in favour of more suitable/preferred measures.

4.8.1. Radical Openness Programme Outcome Measures

- **Acceptance and Action Questionnaire - II**

  The Acceptance and Action Questionnaire (AAQ II: Bond et al., 2011) measures experiential avoidance, or the tendency to avoid unwanted internal experiences (the opposite of this is acceptance/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 in this instance indicating greater psychological inflexibility/more 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).

- **Beck Hopelessness Scale**

  The Beck Hopelessness Scale (BHS: Beck, Weissman, Lester, & Trexler, 1974) captures the extent of negative attitudes/pessimism about the future. Hopelessness is thought to underlie a variety of mental health disorders. The BHS contains 20 true or false statements about the immediate and long range future. Total scores can range from 0 to 20 with higher scores suggesting greater hopelessness. Cut-off scores should be employed cautiously as guidelines for interpretation with 0 to 3 defined as minimal, 4 to 8 mild, 9 to 14 moderate and above 14 severe. The BHS has demonstrated good internal consistency (Kuder-Richardson reliabilities ranging from .82 to .92) and reasonable test-retest reliability at one week (.66 - .69). The measure is well

established with evidence of concurrent, discriminate, construct and predictive validity from multiple studies (Beck and Steer, 1988).

- **Emotion Control Questionnaire-2**

  The Emotion Control Questionnaire-2 (ECQ-2: Roger & Najarian, 1987) consists of 56 true or false items which capture emotional control/inhibition which is defined as the tendency to inhibit the expression of emotional responses. The original measure has four subscales, however, two subscales have been found to be less robust and as such only two subscales - 'Rehearsal' (the degree of rumination over emotionally upsetting events) and 'Emotional inhibition' (the tendency to inhibit experienced emotion) - are used (See Roger, de la Banda, Lee and Olason, 2001). Scores can range from 0 to 14 for each subscale, with higher scores indicating greater emotional inhibition or more rumination. The rumination and emotional inhibition subscales are reported to have good internal consistency (alphas .77 and .86) and good test-retest reliability (alphas .79 to .80 over a 7 week period).

- **Self-Compassion Scale**

  The Self Compassion Scale (SCS: Neff, 2003) is a 26 item questionnaire consisting of six subscales: self-kindness, self-judgement, common humanity, isolation, mindfulness and over-identification. Items are rated on a 5 point likert scale from 1 "Strongly Disagree" to 5 "Strongly Agree". Scores for each subscale range from 1 to 5 and 1 to 30 for the overall scale. Neff reports good test-retest reliabilities (alphas for the subscales ranging between .80 and .93) and internal consistency (alphas ranging from .75 to .81 for subscales and .92 for the total scale score). An exploration of the scale's validity found that self-compassion was distinct from self-esteem and a measure of social desirability. Self-compassion was also found to be positively correlated with a sense of social connectedness and life satisfaction and negatively correlated with self-criticism, anxiety, depression and neurotic perfectionism. In a sample of undergraduate students means and standard deviations (in parentheses) were as follows: Self-Kindness 3.05 (0.75), Self-Judgement 3.14 (0.79), Common Humanity 2.99 (0.79), Isolation 3.01 (0.92), Mindfulness 3.39 (0.76) and Over-identification 3.05 (0.96).

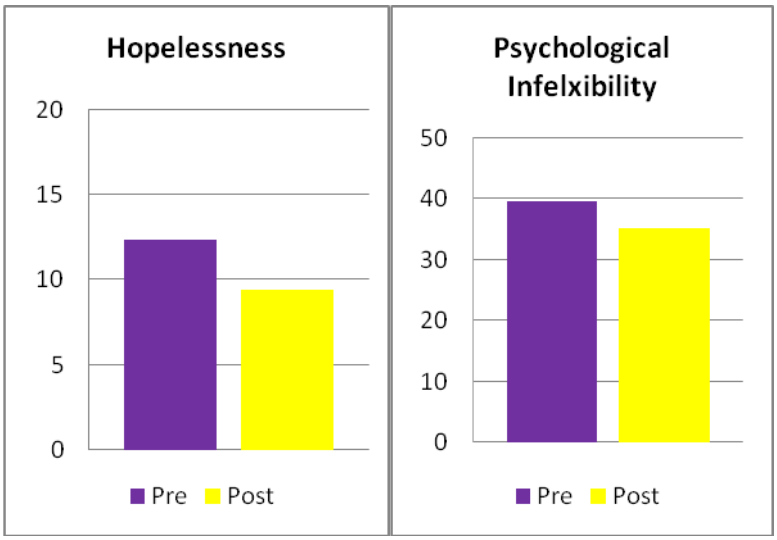
4.8.2. Descriptors.

Baseline data were available for 79 programme attendees. Of these, both pre and post data were available for 66 (BHS) and 62 (ECQ-2) people for the two measures administered consistently throughout the year representing 83.5% and 78.5% of the sample respectively. The SCS was administered for three groups resulting in pre and post data on this measure for 36 people, while the AAQ-II was administered for two groups providing pre and post data for 21 and 22 participants respectively.

Forty-eight RO participants (60.8%) were male and 31 female (39.2%) ranging in age from 22 to 65 (M = 41.54, SD = 10.25).

4.8.3. Results

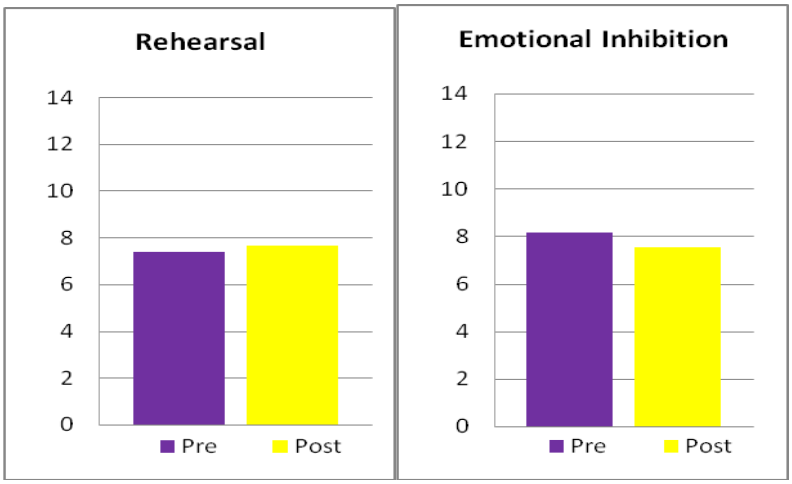
The BHS was administered to all RO participants in 2012 and pre - post data are presented in the graph below. Average hopelessness scores were in the moderate range for RO participants at baseline and showed statistically significant decreases, suggesting improvement, from before (M = 12.38, SD = 5.42) to after (M = 9.39, SD = 6.58) completion of the programme, t (65) = 3.94, p < .001. This change reflected a medium effect (d = .49).



For two of the cycles of RO in 2012, the AAQ-II was included in the assessment battery measuring experiential avoidance. Experiential avoidance decreased significantly from pre (M = 39.62, SD = 5.43) to post (M = 35.62, SD = 1.88), t (20) = 2.37, p = .028, reflecting a medium effect (d = .59).

Scores on the ECQ-2 rehearsal and emotional inhibition subscales did not change significantly over the course of the programme. Rehearsal scores capture the

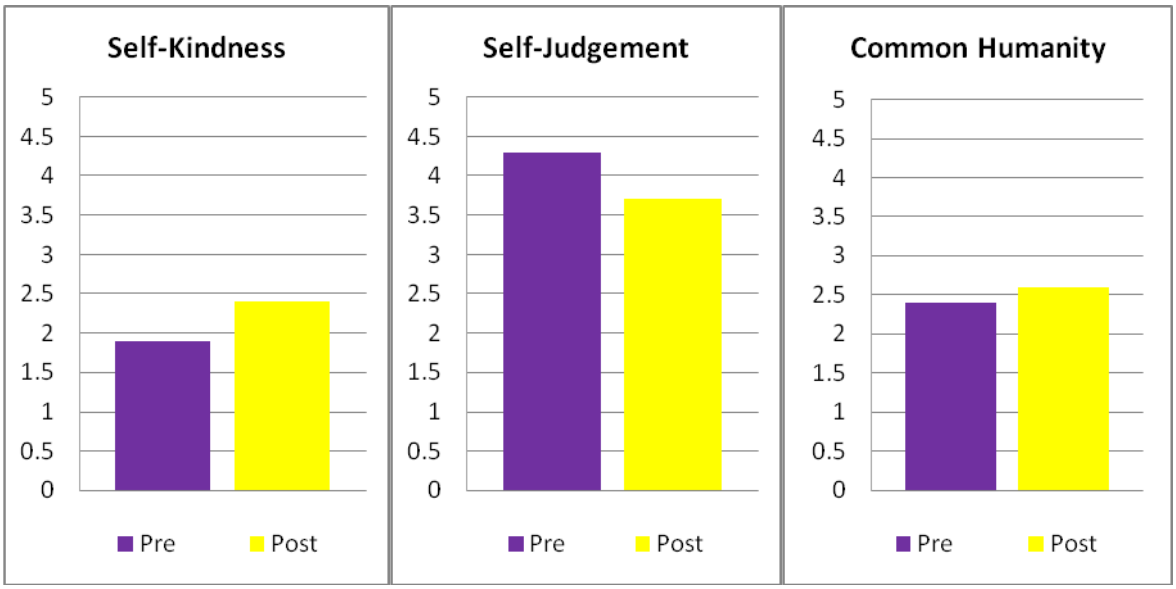
tendency to ruminate and were similar at both time points; M = 7.39 (SD = 3.55) before and M = 7.68 (SD = 3.67) after completing the programme, t (61) = -.72, p >.05. Emotional inhibition scores, the tendency to exhibit high levels of emotional control, were also quite similar at both times points; M = 8.16 (SD = 4.05) before and M = 7.52 (SD = 3.97) after completing the programme, t (61) = 1.67, p >.05.

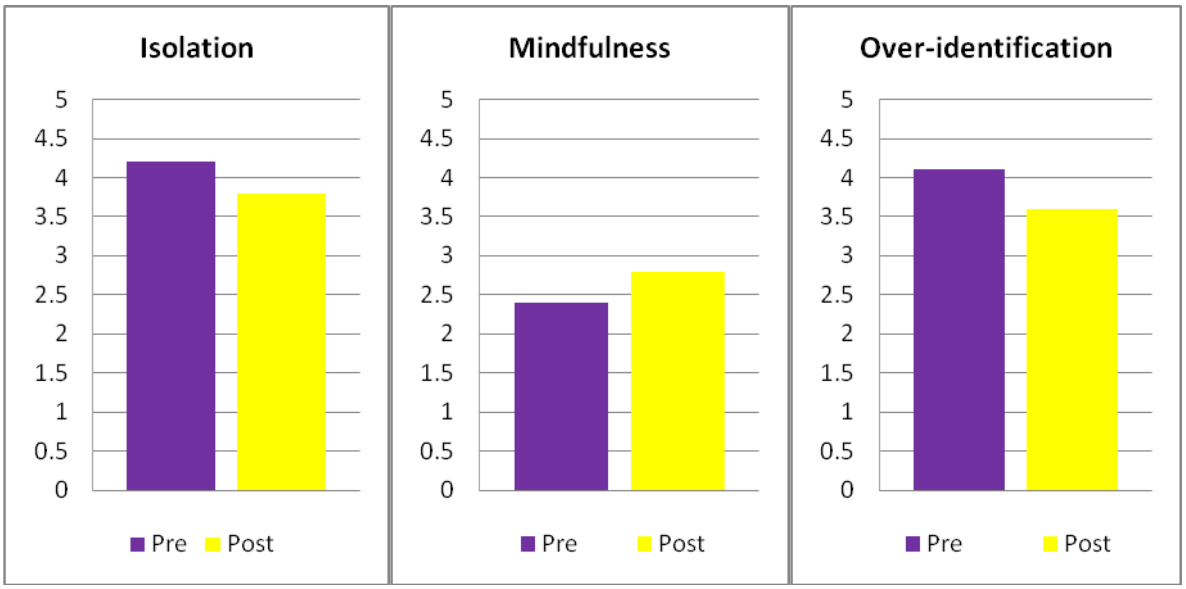


For the first three cycles of the RO programme the SCS was administered before and after the programme as a measure of self-compassion consisting of six facets/subscales: Self-Kindness, Self-Judgement, Common Humanity, Isolation, Mindfulness and Over-identification. Pre and post scores for each subscale are shown in the graphs on the next page. Scores on the mindfulness subscale increased significantly following RO, while levels of self-judgement and over-identification with thoughts and emotions decreased significantly. Means standard deviations, t, p values and effect sizes are shown in the table below. Where changes were statistically significant effect sizes (d) were medium for mindfulness and large for self-judgement and over-identification. It is worth noting that over-identification involves narrowly focusing on and ruminating about negative emotions. The finding that this changed significantly stands in contrast to the absence of significant changes on the ECQ-2 Rehearsal subscale which captures a similar process. This discrepancy may reflect differences in properties of the measures used including differences in sensitivity to change.

	Pre *Mean (SD)*	Post *Mean (SD)*	*t*	*df*	*p*	*d*
Self-Kindness	1.93 (0.78)	2.42 (0.99)	-2.56	35	.015	-0.54
Self-Judgement	**4.34** **(0.57)**	**3.74** **(0.87)**	**3.71**	**35**	**.001**	**.080**
Common Humanity	2.40 (1.04)	2.59 (.0.93)	-1.02	35	.316	-0.20
Isolation	4.19 (0.74)	3.76 (0.79)	2.63	35	.013	0.56
Mindfulness	**2.44** **(0.81)**	**2.83** **(0.66)**	**-2.90**	**35**	**.006**	**-0.51**
Over identification	**4.10** **(0.50)**	**3.60** **(0.78)**	**3.61**	**35**	**.001**	**0.76**

**Standard deviations (SD) are in parentheses. Statistically significant changes from pre to post are indicated in bold. A more stringent criteria for statistical significance were used here (based on Bonferroni Correction) in order to account for multiple comparisons.*





4.8.4. Summary

The RO programme provides an innovative and targeted approach for a previously underserved group of people. RO is now in its second year at SPUH and data to date suggests statistically significant and promising changes in core therapeutic targets. In particular programme attendees showed significant decreases in hopelessness, self-judgement, over-identification with thoughts and feelings, and experiential avoidance, and increases in mindfulness. Based on these findings and as part of on-going refinement of the programme and relevant measures, a new assessment battery will be implemented for 2013.

4.9. 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 are anxious to avoid coming in to hospital but again need formal and structured support to do so.

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.

4.9.1. 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 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. For the purposes of the analysis that follows, scores have been recalculated to range from 0 to 5 to facilitate comparison across subscales. 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).

4.9.2. Descriptors

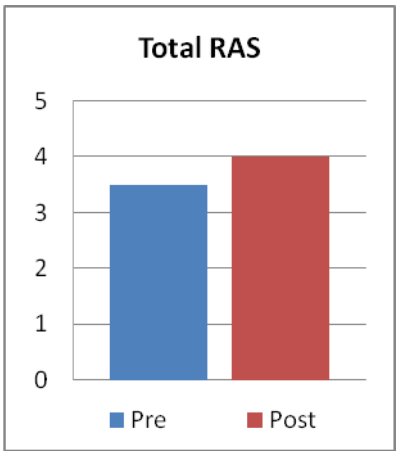
One hundred and four people took part in the Recovery Programme in 2012. The average age of recovery programme participants was 47.07 years and 59.6% were female. Pre and post data were available for 85 participants (81.7%).

4.9.3. Results

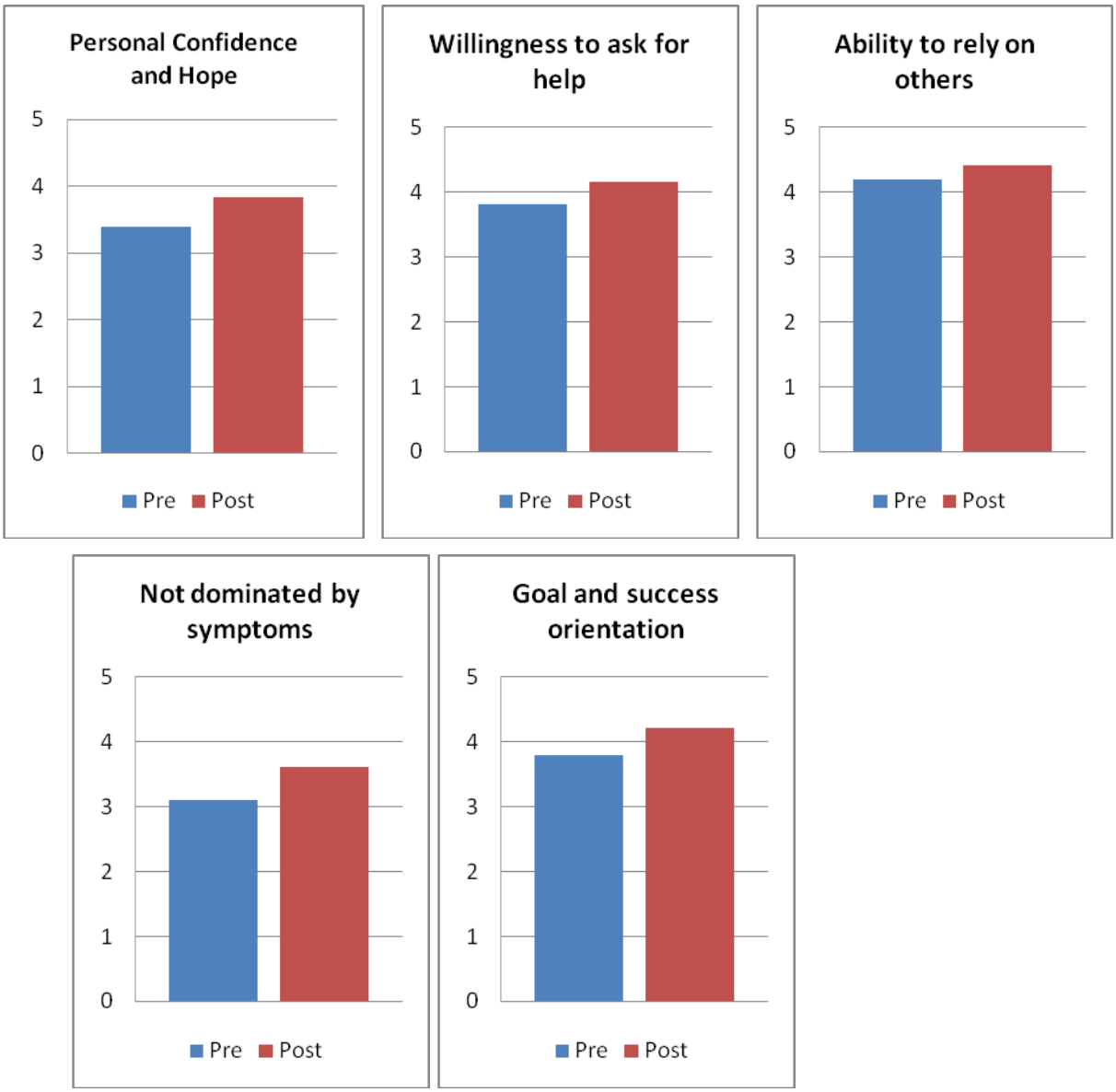
Total RAS scores increased from pre-measurement (M = 3.52, SD = 0.80) to post-measurement (M = 4.02, SD = 0.96) on the Recovery Assessment Scale indicating greater overall recovery. This increase was statistically significant, t (85) = -7.39, p < .001, and represented a medium effect (d = 0.55).

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 table below.

	Pre *Mean (SD)*	Post *Mean (SD)*	*t*	*df*	*p*	*D*
Personal confidence & Hope	3.39 (0.90)	3.84 (0.95)	-.72	85	<.001	0.55
Willingness To Ask For Help	3.82 (1.03)	4.16 (0.98)	-3.46	85	.001	0.49
Ability To Rely On Others	4.20 (0.89)	4.41 (0.92)	-3.39	85	.001	0.23
Not Dominated By Symptoms	3.11 (1.03)	3.62 (1.01)	-5.53	85	<.001	0.50
Goal and Success Orientation	3.80 (0.91)	4.21 (0.87)	-5.49	85	<.001	0.48



Scores on each of the subscales improved significantly from pre to post-measurement (see graphs on the next page). Effect sizes were small for the Willingness to Ask for Help and Ability to Rely on Others subscales (d = 0.34 and 0.23 respectively) and medium for Personal Confidence and Hope, Not dominated by Sypmtoms and Goal and Success Orientation (d = 0.49, 0.5 and 0.48 respectively).



4.9.4. 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 up to 81.7% in 2012). 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. Clinicians on the programme have also indicated that they experience the measure to have considerable face validity and generally reflect core targets of the programme. Alongside this measure consideration is also being given to other measures that might be used to capture recovery elements that are not measured by the RAS.

Improvements across the measure's subscales are promising; however, some changes are suggested for 2013. In particular, clinicians on the programme have reflected that certain individual items, which are not included in the subscale scores have high face validity and reflect elements of the programme that should be noted. For example, items such as "I can identify what triggers the symptoms of my mental illness", "There are things I can do that help me deal with unwanted symptoms" and "It is important to have healthy habits" capture specific therapeutic targets of the programme and may be worth examining individually. In 2013 the database will be structured so that item level, rather than manually calculated scale score data will be stored and analysed. In addition to allowing a more fine grained analysis of pre to post programme changes, the internal consistency (reliability) of the measure can be assessed in this sample and total and subscale raw scores (rather than scores out of 5) can be used allowing for comparisons with published research that uses the RAS.

4.10. Psychosis Recovery Programme

The psychosis recovery programme is an intensive three week programme catering for both in-patients and day patients. It aims to provide education around psychosis, recovery, and special cognitive behavioural therapy (CBT) skills to help participants cope with the distressing symptoms of psychosis. In particular, groups focus on recovery strategies, practical information about psychosis, social support, staying well, effective use of medication, cognitive behavioural therapy techniques, building resilience and occupational therapy.

The programme is delivered by members of a multi-disciplinary team 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. For the purposes of the analysis that follows, only total scale scores are used and have been recalculated to range from 0 to 5. 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).

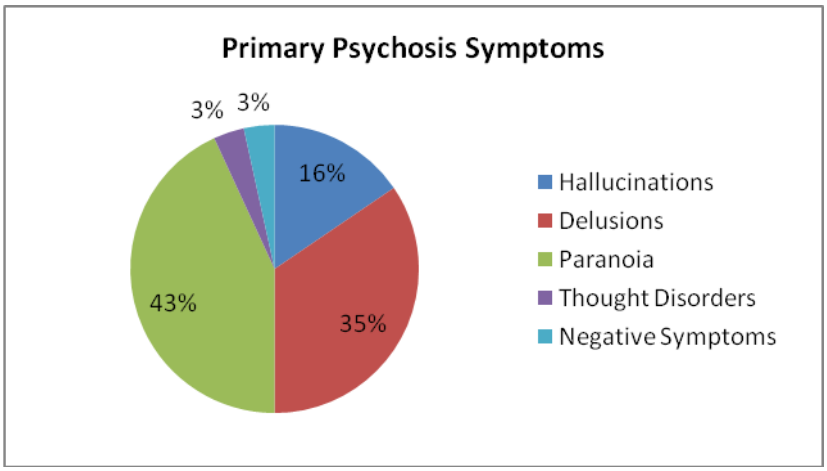
- **Drug Attitude Inventory**

  The Drug Attitude Inventory (DAI: Hogan, Awad & Eastwood, 1983) is a 30 item questionnaire to measure the subjective responses and attitudes of patients toward psychotropic treatment. Each statement has true or false response options. Scores range from 0-30 with higher scores indicating more positive views about medication. Categories addressed by the measure include: subjective positive, subjective negative, health and illness, physician control, prevention and harm. The measure has been shown to have good reliability (KR-20 values of 0.93) and test-retest reliability (0.82) (Hogan et al., 1983).

4.10.2. Descriptors

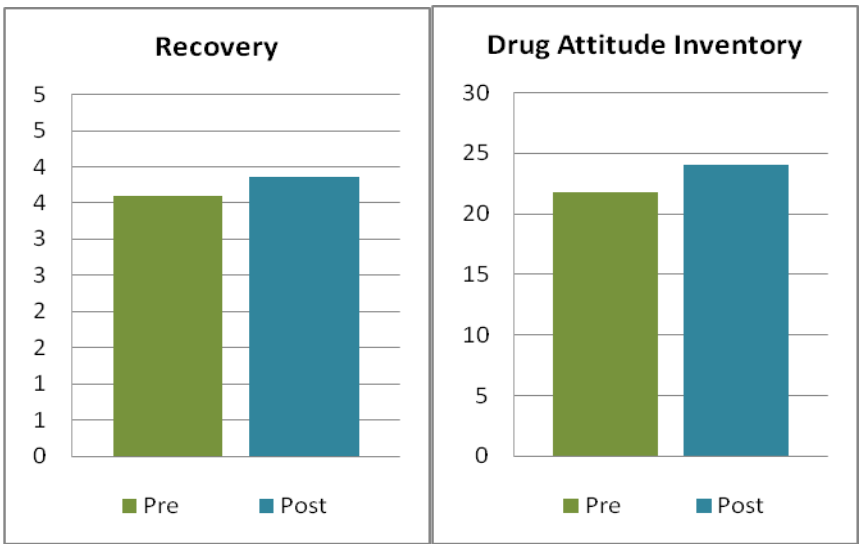
79 people took part in the Psychosis Programme in 2012. Pre and post RAS scores were available for 41 participants (51.9%) while pre and post DAI scores were available for 38 participants (48.1%). Of the 41 participants who had at least pre and post RAS scores the average age of psychosis programme participants was 36.41 years (ranging from 20 to 68 years) and 63.4% were male. Seventy-eight percent were single, 12.2% married, 4.9% co-habiting with a long-term partner and 4.8% separated or divorced.

Similar proportions were employed (41.5%) and unemployed (39%), 9.8% were in receipt of disability allowance, 4.9% were retired and a further 4.9% worked in the home. Nearly half of this group had third level education (47.5%), 42.5% had completed leaving certificate, with the remaining 10% having left school before the leaving certificate. For more than half of programme attendees, the primary psychosis symptom was paranoia, followed by (in order of decreasing frequency) delusions, hallucinations, thought disorder and negative symptoms. Attendance data were available for 32 participants and indicated that the average number of days attended was 7.9 (*SD* = 4.7) with attendances ranging from 1 to 21 days (participants are permitted to attend multiple cycles of the programme).



4.10.3. Results

Pre and post scores on the two outcome measures are shown in the graphs that follow. Participants on the programme showed statistically significant improvements in recovery from before (*M* = 3.6, *SD* = 0.8) to after (*M* = 3.9, *SD* = 0.6) completion of the programme, *t* (40) = -3.63, *p* = .001, reflecting a small to medium effect (*d* = 0.35).



Attitudes towards psychotropic treatment were also more positive at the end of the programme and increased from pre (M = 21.8, SD = 8.1) to post (M = 24, SD = 6.8). Changes reflect a statistically significant difference, t (38) = -2.33, p = .03, with a small effect size (d = 0.29).

4.10.4. Summary

Outcomes for the psychosis programme were captured and quantified for the first time in 2012 and suggest some benefits for participants in terms of recovery and attitudes to medication. A good start has been made in implementing routine data collection though some challenges emerged in this process. In particular, capturing post measures has proved to be difficult. Some obstacles include: service users being discharged before post measurement was possible, psychosis symptoms contributing to reluctance to complete the measures, and the length of the questionnaire pack. Since the development of the DAI-30, a valid and reliable 10 item short form of the measure has been developed (See Nielsen, Lindstrom, Nielsen and Levander, 2012) which may help to facilitate completion of measures by programme attendees and will be considered for routine data collection going forward.

Section 5

Service User Measures and Outcomes

5.1. 2012 Service User Satisfaction Survey (Inpatient Care)

St Patrick's Mental Health Service is committed to listening to and acting upon the views of those who use and engage with its services. An annual survey of the views of service users is carried out aimed at eliciting their opinions and views on their journey through the Hospital from admission, hospital stay to preparation for discharge. Participation in the survey was voluntary and all responses were treated as confidential with no individual identifiers to ensure anonymity.

5.1.1. Methodology

A paper survey adapted from the NICE Clinical Guidelines 2012 and the Mental Health Commission / Irish Society for Quality and Safety in Healthcare survey was designed. In addition, two questions on stigma and individual's perception of their views about their own mental health were included in the survey. A copy of the survey is included in Appendix 1. It was agreed that the appropriate time to deliver the survey was at the point of departure or as close to discharge as possible as service users would be able to reflect on their journey through the Hospital at this time.

The exit survey team were issued with the list of discharges from the Admissions CNM on a daily basis and each member of the team was assigned to a specific ward. The team member went to the ward and asked the service user who was due to be discharged to complete the survey. Participation was voluntary and confidential. The completed survey was placed in a sealed envelope for collation at a later date. The collated data was analysed using the SPSS Statistical management package and graphical representation of the results was also undertaken. A comparison with available data from the MHC/ISQSH survey was also provided.

5.1.2. Survey Sample

A total of 104 surveys were analysed which represent 26% of total discharges during the period of the survey. Below is a breakdown of the % discharges captured by ward.

Discharges Captured	
% of Total Discharges Captured	**26%**
% Kilroot Discharges	41%
% Vanessa Discharges	28%
% St. Edmundsbury Discharges	28%
% Delany Discharges	27%
% Grattan Discharges	25%
% Temple Discharges	20%
% Stella Discharges	17%
% DSW Captured	1%
% EDU Captured	0%

63% of the respondents were female and 37% were male.

The age range distribution of survey respondents is summarised in the table below. 46% of respondents were aged between 30 and 50 years with a further 31% aged between 51 and 70 years. 10% of respondents were under 30 years and 13% were greater than 71 years.

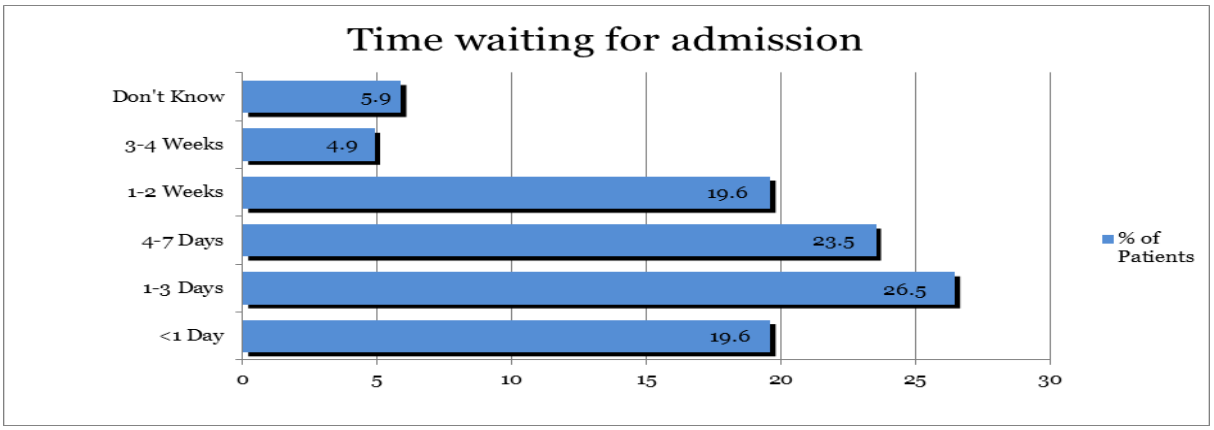
Age	%
Under 25	4
25-30	6
30-40	26
41-50	20
51-60	21
61-70	10
71-80	9
>80	4

5.1.3. Survey Results

The following results are based on an analysis of responses to all survey questions.

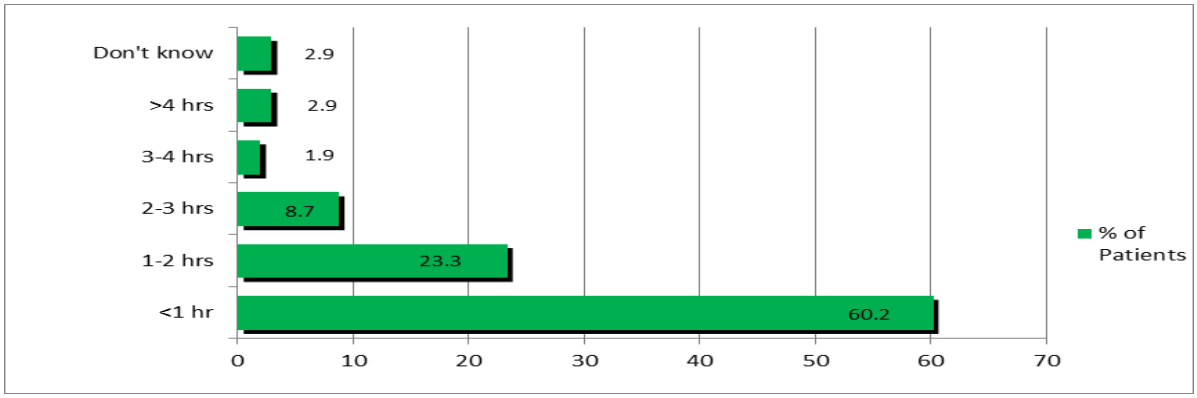
a) Assessment and Admission

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



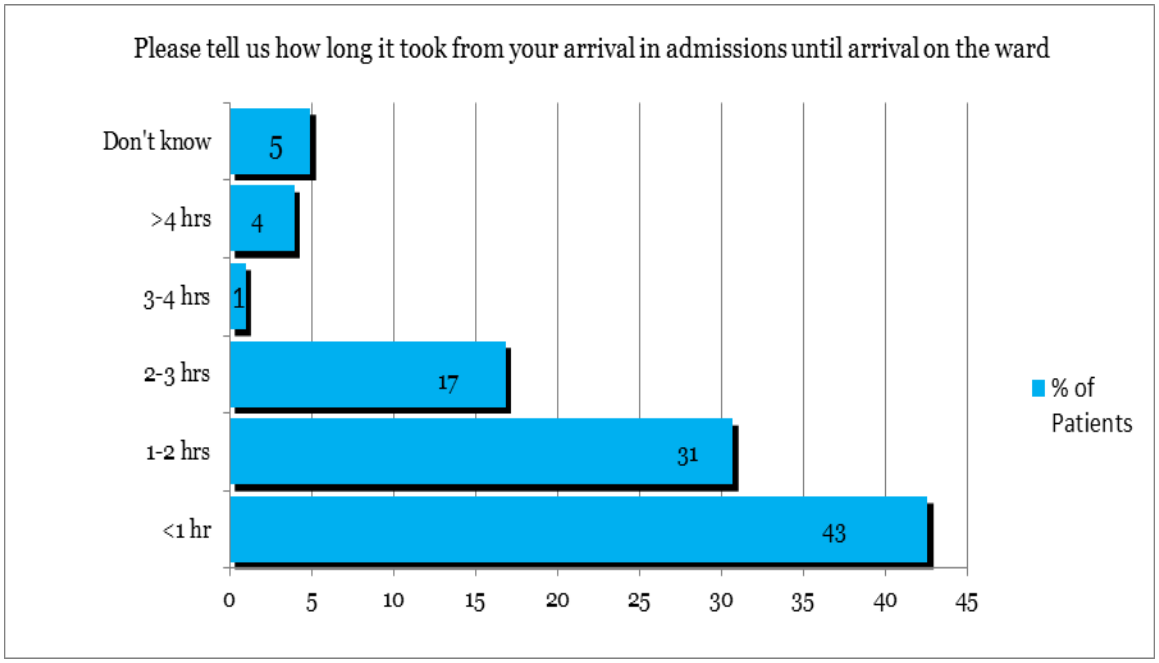
St Patrick's Mental Health Services operates a triage system for admissions where admissions are prioritised based on urgency, appropriateness of admission as an intervention and service user scheduling and preferences. Waiting times for admission may not always reflect bed availability in the Hospital. It is encouraging to note that the majority of participants had less than a week waiting time for admission to the Hospital.

- ***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?***



60% of respondents were seen within one hour of arrival at the Admissions and Assessment Unit. A further 23.3 % were seen between within one to two hours.

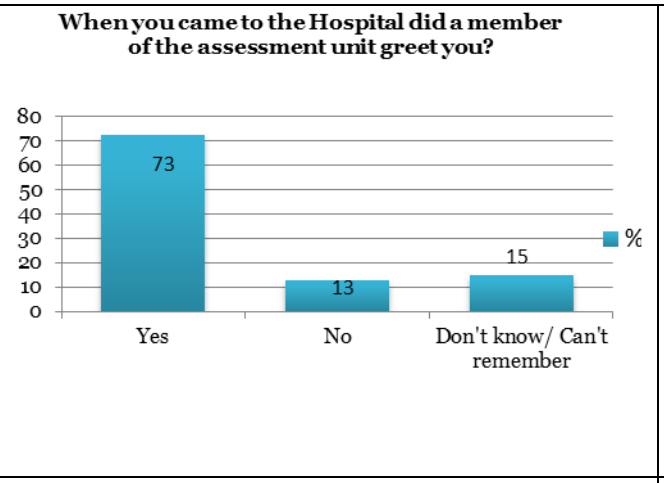
- ***Please tell us how long it took from your arrival in admissions until to your arrival on the ward?***

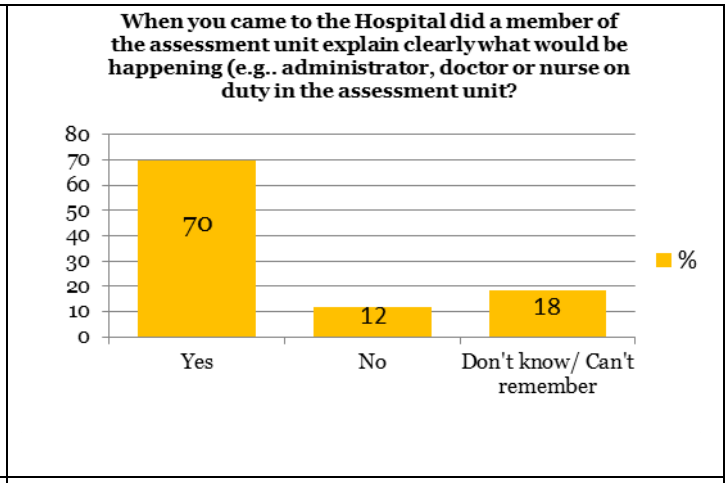


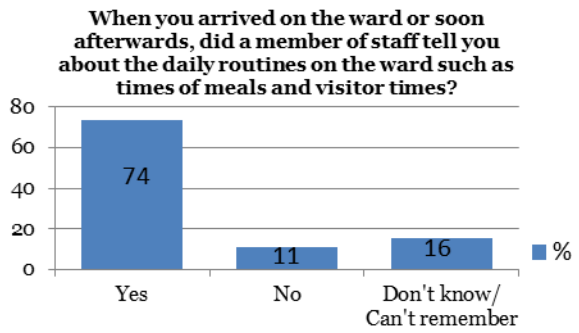
73.3% of respondents spent less than two hours in the assessment / admissions area, with 16.8% between 2 and 3 hours. 1% of respondents were between 3 and 4 hours and 4% spent longer than four hours in the assessment / admissions area.

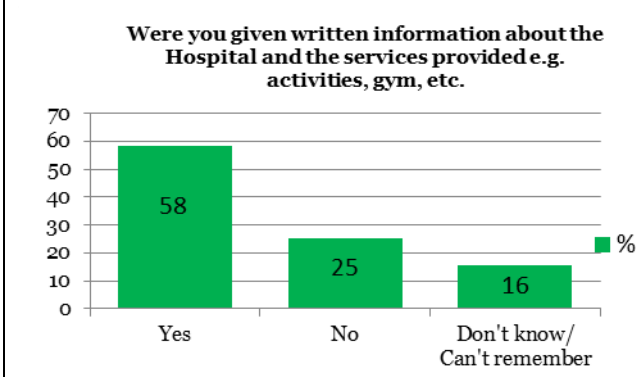
- ***Service Users were asked about their experience of being admitted.***

  Responses are summarises in Tables below.









73% of service users were met by a member of the assessment / admissions unit with 13% responding in the negative. 15% of respondents didn't know or could not remember and this may be reflective of their level of distress at the point of admission.

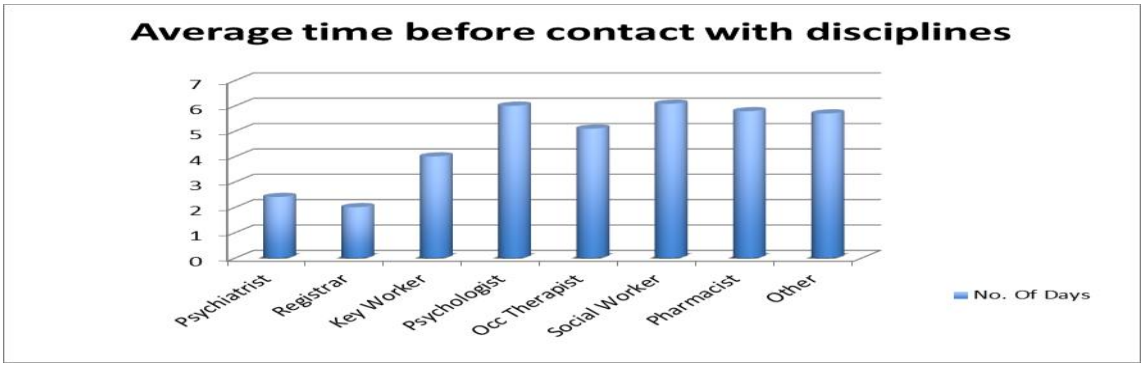
b) Contact with Disciplines

Participants in the exit survey were asked the following question;

"***During your stay can you recall how long you were in Hospital before you met the following people?"***

For purposes of clarity nursing was not included as nursing is the first point of contact that service users have during their admission and first days in the Hospital. The

admissions process is led by a Clinical Nurse Manager and when service users first go to their ward their welcome and induction to the Hospital is undertaken by ward based nursing staff.



A further analysis shows the breakdown of the waiting times and the % of people who did not meet disciplines during their in-patient stay.

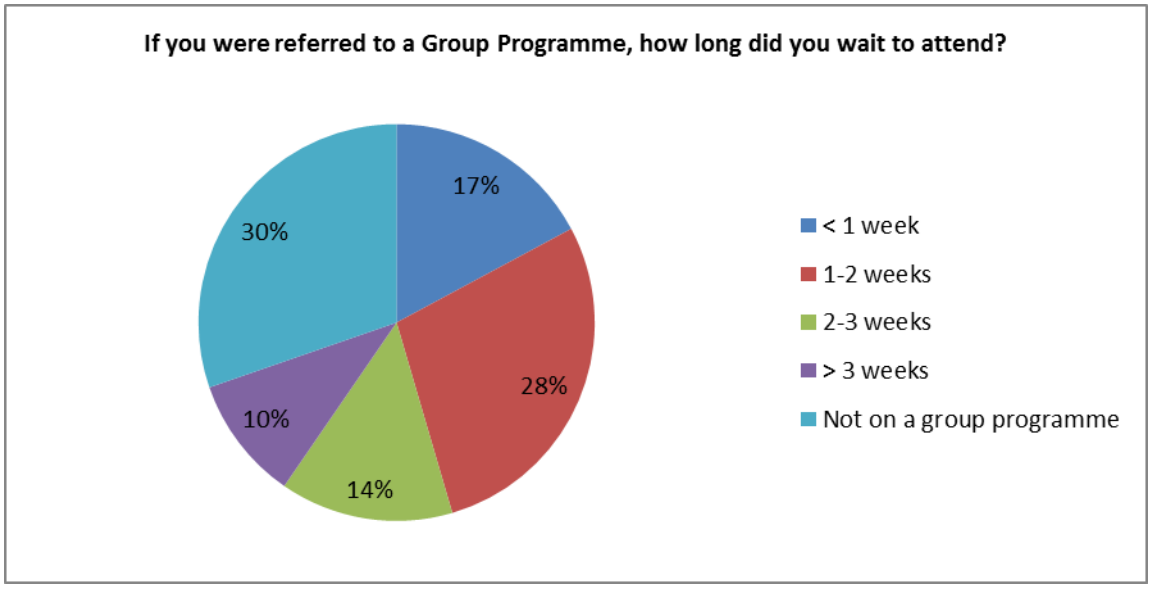
- ***During your stay can you recall how long you were in Hospital before you met the following people?***

	< 1 day	1-3 days	3-5 days	5-7 days	>1 week	>2 weeks	Did not meet
Psychiatrist	23.5%	41.2%	12.7%	17.6%	3.9%	1.0%	0%
Registrar	45.4%	25.8%	10.3%	13.4%	0.0%	0.0%	5.2%
Key Worker	10.1%	18.2%	10.1%	7.1%	13.1%	14.1%	27.3%
Psychologist	2.4%	6.2%	8.6%	22.3%	12.3%	8.6%	39.5%
Occ Therapist	1.2%	11.0%	9.8%	19.5%	12.2%	6.1%	40.2%
Social Worker	1.3%	3.9%	1.3%	11.7%	7.8%	9.1%	64.9%
Pharmacist	2.7%	9.5%	6.8%	6.8%	4.1%	2.7%	67.6%
Other e.g. counsellor	5.1%	10.2%	1.7%	5.1%	6.8%	13.6%	57.6%

c) Programme Attendance

Service users were asked about their perception of waiting times to attend programmes as this is an issue which is raised through feedback from service users.

"If you were referred to a programme can you tell us how long did you wait to attend?"

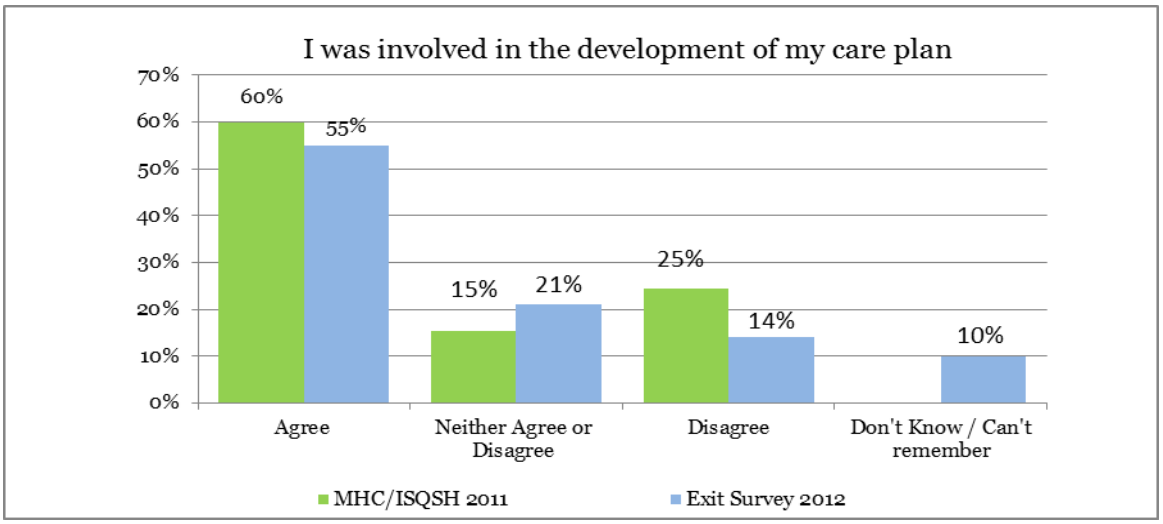


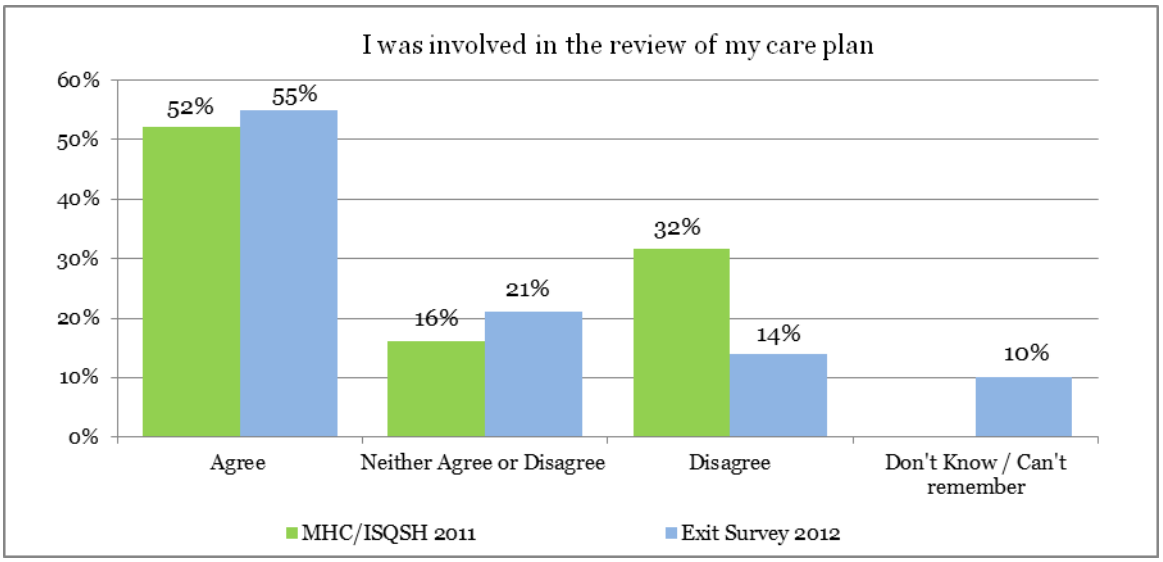
30.4% of the respondents stated they did not attend a group programme as their individualised care and treatment was provided by the multidisciplinary team. Of the remaining respondents, 17.4% were referred to a clinical programme within one week, 28.3% in 1-2 weeks, 14.1% in 2-3 weeks and 9.78% waited longer than three weeks to attend a programme. There are a number of clinical reasons why service users may have had waiting periods for attendance at programmes.

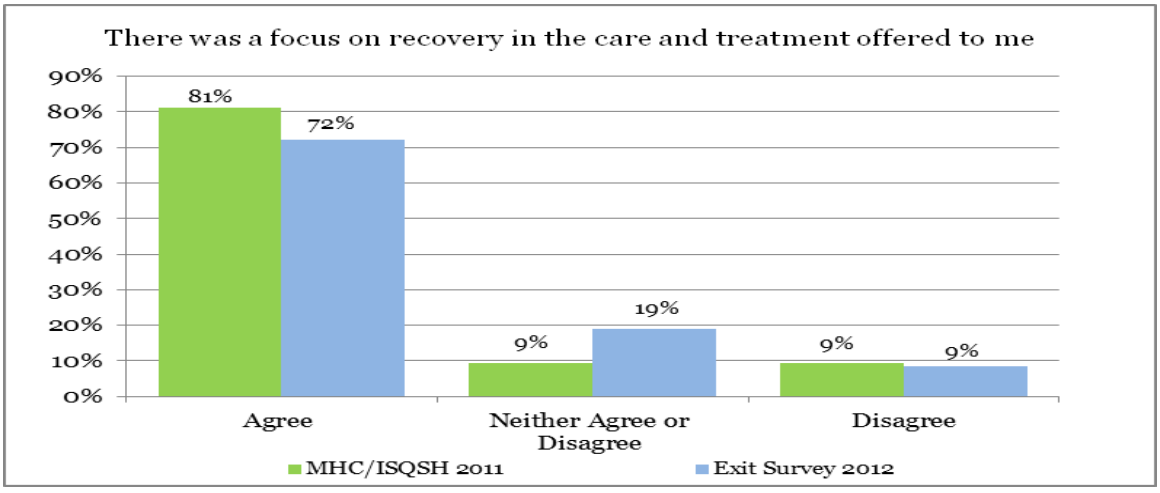
d) Care Planning

Individual care planning and individual care plans are a key component of the Mental Health Commission's Code of Practice for Admission, Transfer and Discharge To and From Approved Centres. Significant work has been undertaken in the SPMHS to ensure compliance with statutory requirements. A key principle of individual care planning is the service user's awareness of their individual care plan and the opportunity to be an active participant in its development. Participants in the survey were asked to agree or disagree with five statements in relation to their care planning. These questions had previously been used for the 2011 MHC/ISQSH survey (n=144)

and therefore provide a useful comparator on awareness of care planning as illustrated in the tables below.







e) Time with Mental Health Professionals

Participants were asked if they perceived they had been given sufficient time with members of their multidisciplinary team.

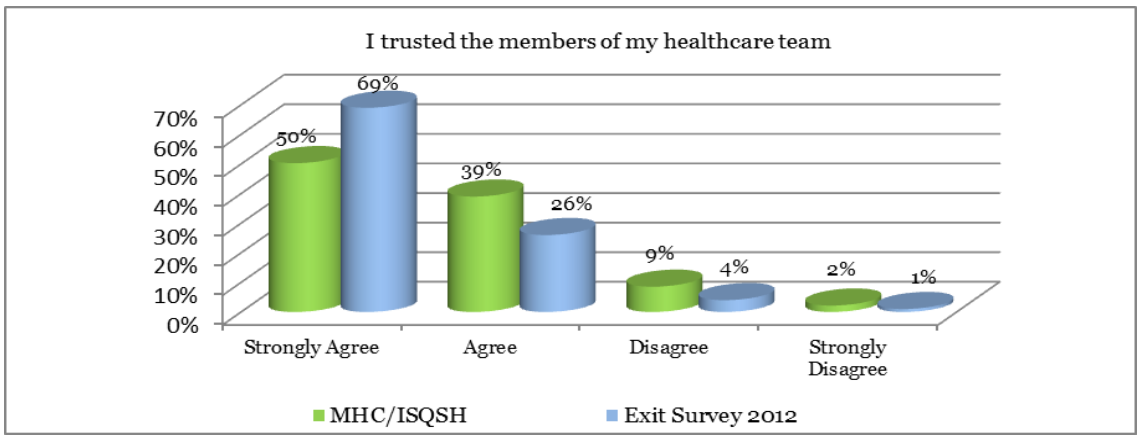
"During my stay in Hospital I was given enough time with the following health professionals:"

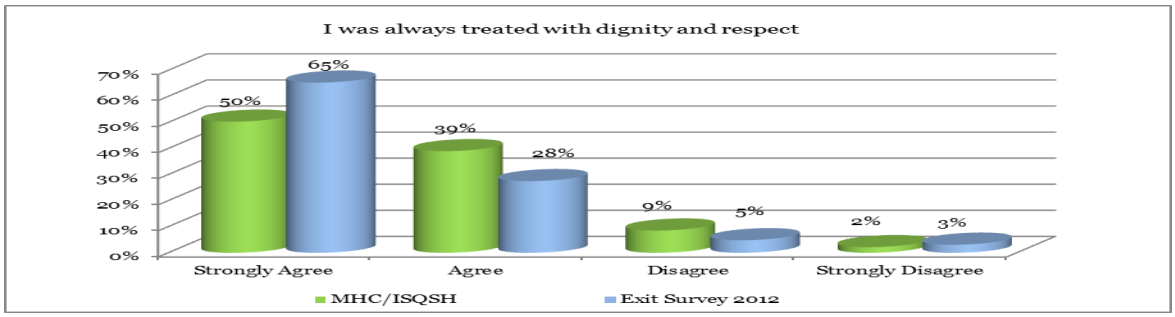
The responses are provided in the below.

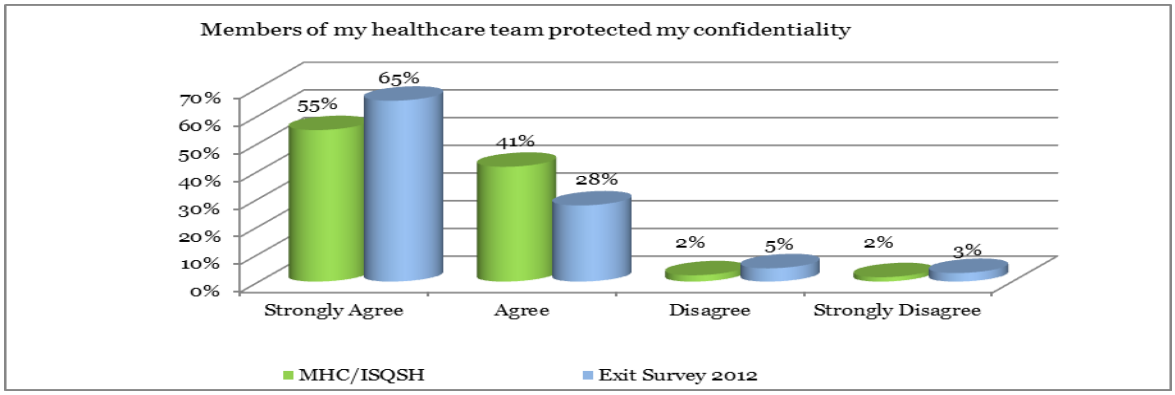
Health Professional	% Agree	% Disagree	% Neither agree or Disagree
Consultant Psychiatrist	62	23	15
Registrar	54	11	35
Key Worker	38	43	19
Nursing Staff	78	6	16
Occupational Therapist	51	17	32
Psychologist	48	22	30
Social Worker	33	21	46
Pharmacist	36	25	39

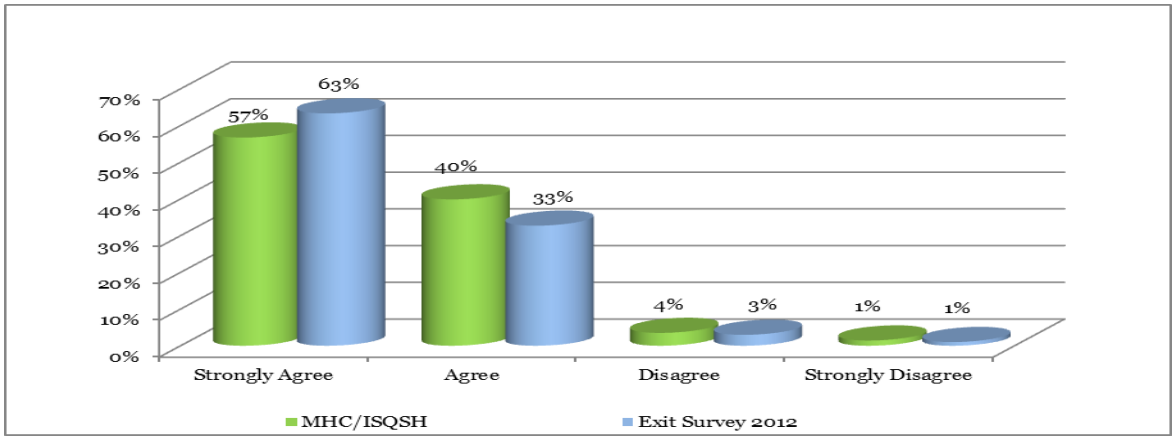
f) Relationship with Health Professionals – Dignity and Respect

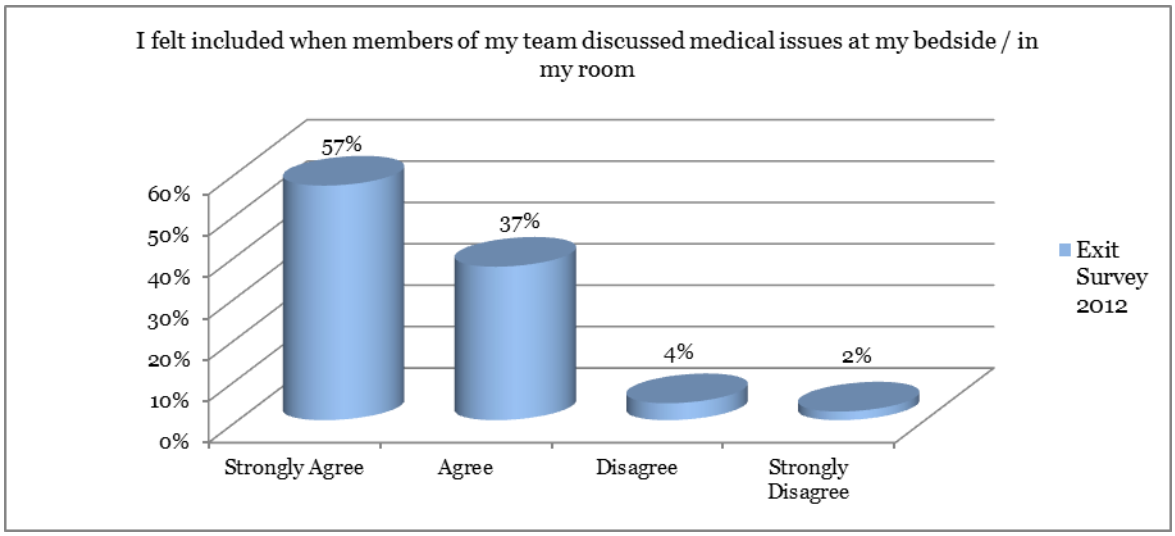
Service Users were also asked about their experience of dealing with members of their multidisciplinary team during their stay in Hospital.




I was always treated with dignity and respect
70%
60%
50%
40%
30%
20%
10%
0%
50%
65%
39%
28%
9%
5%
2%
3%
Strongly Agree
Agree
Disagree
Strongly Disagree
MHC/ISQSH
Exit Survey 2012

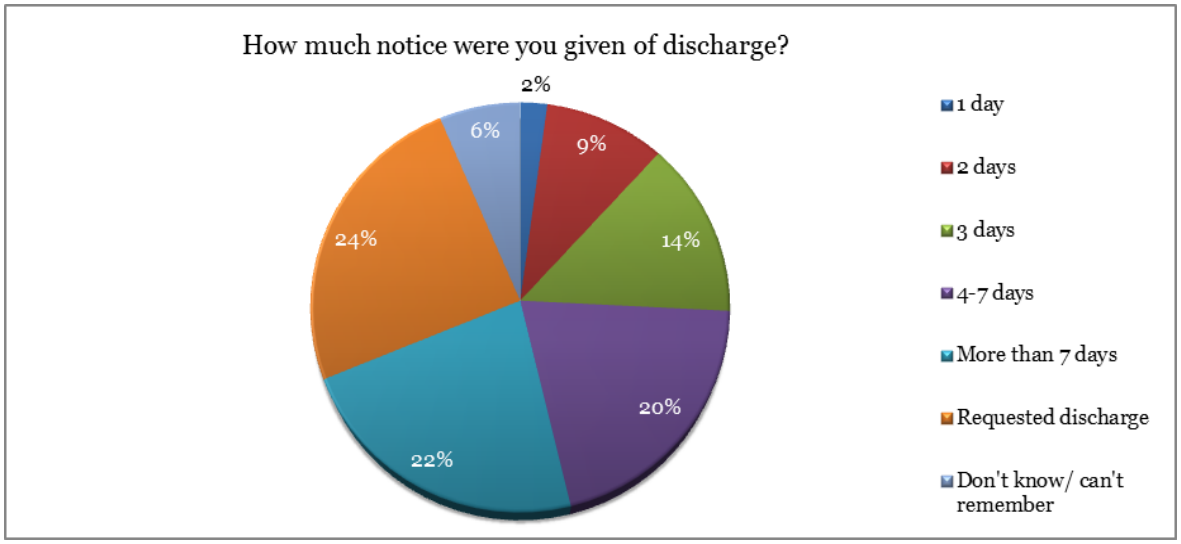

Members of my healthcare team protected my confidentiality
70%
60%
50%
40%
30%
20%
10%
0%
55%
65%
41%
28%
2%
5%
2%
3%
Strongly Agree
Agree
Disagree
Strongly Disagree
MHC/ISQSH
Exit Survey 2012

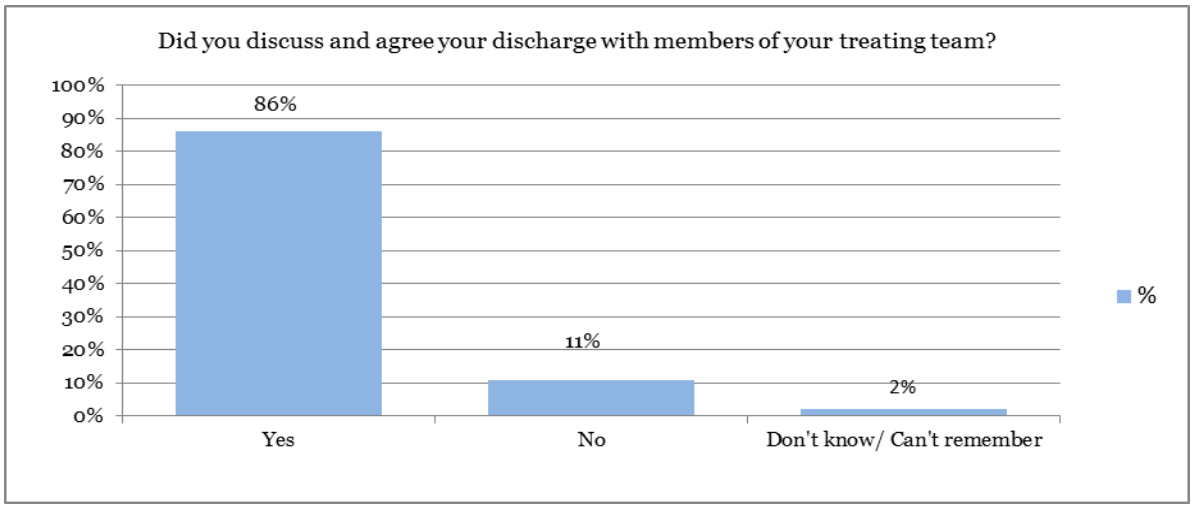

70%
60%
50%
40%
30%
20%
10%
0%
57%
63%
40%
33%
4%
3%
1%
1%
Strongly Agree
Agree
Disagree
Strongly Disagree
MHC/ISQSH
Exit Survey 2012

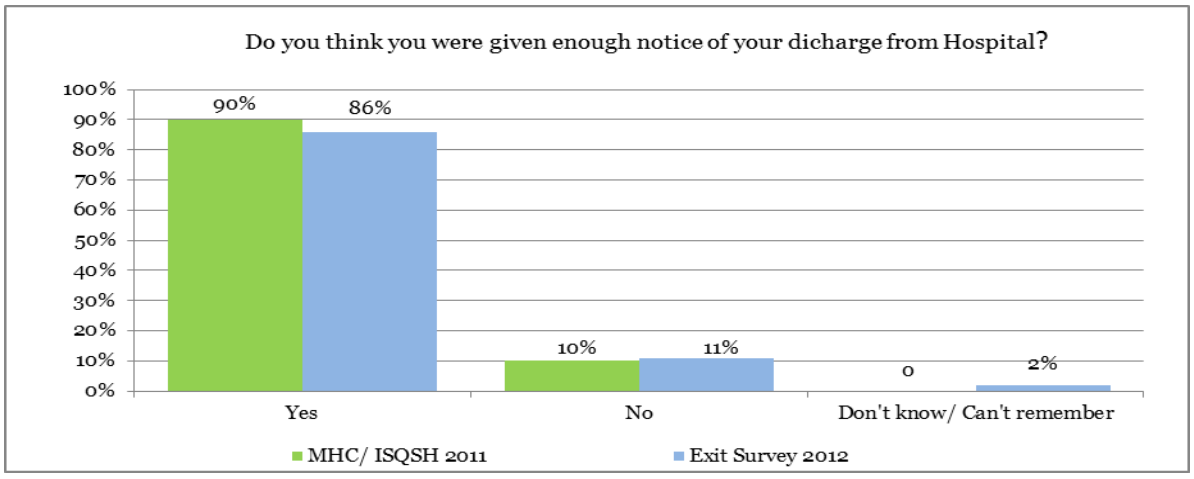

I felt included when members of my team discussed medical issues at my bedside / in my room
60%
50%
40%
30%
20%
10%
0%
57%
37%
4%
2%
Strongly Agree
Agree
Disagree
Strongly Disagree
Exit Survey 2012

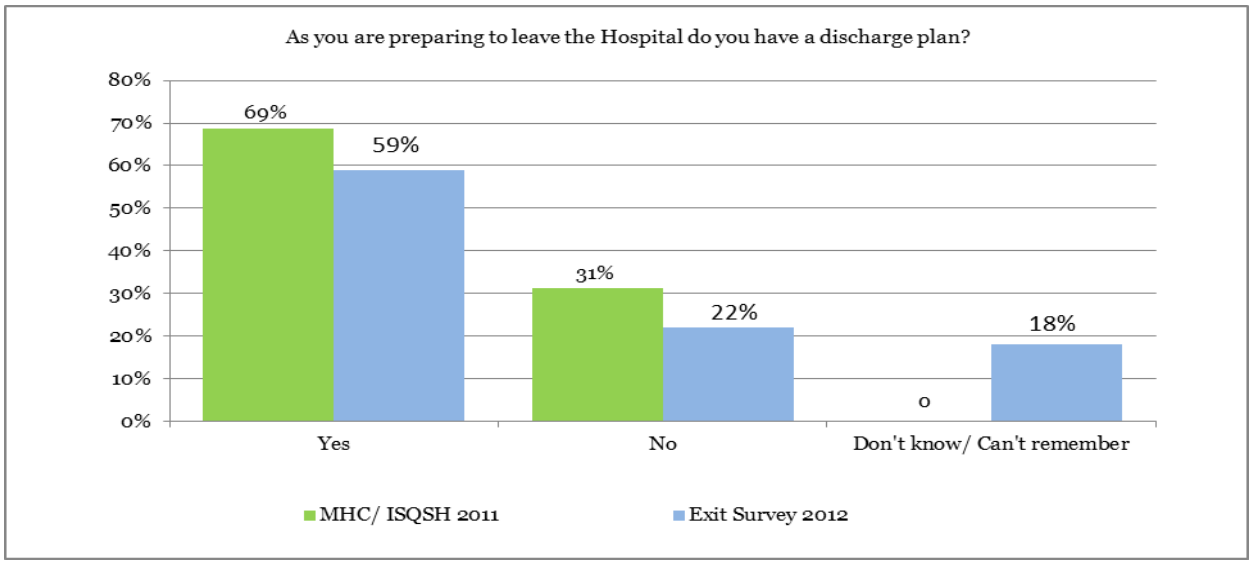
g) Discharge and Discharge Planning

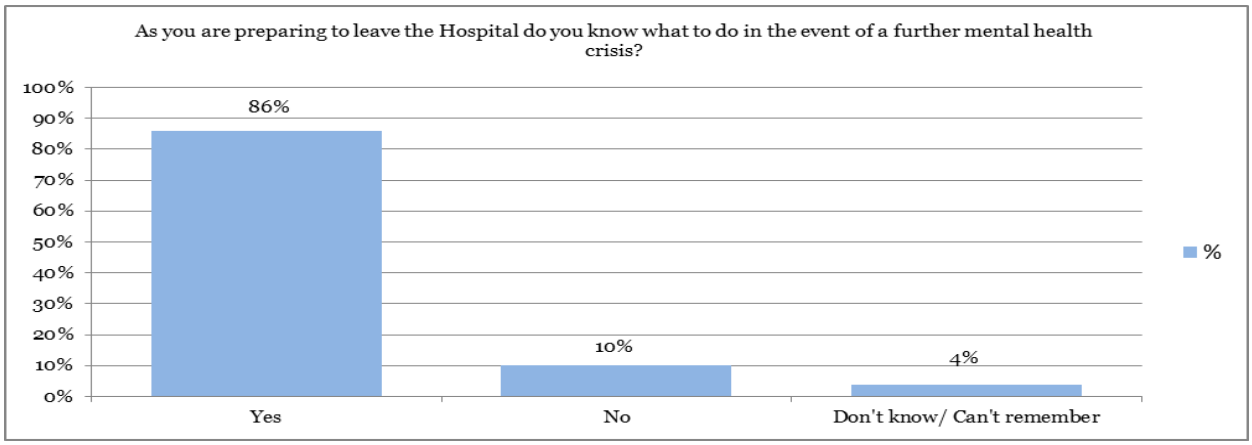
The survey asked service users about their experience of discharge from hospital. Responses are illustrated in the figures below.











h) Hospital Activities

Participants in the survey were asked for their views about their experience of therapeutic and recreational activities available to them during the day, in the evenings and at the weekends.

76% of participants **attended** activities **during the day**.

69% of participants **attended** activities in the **evenings and at weekends.**

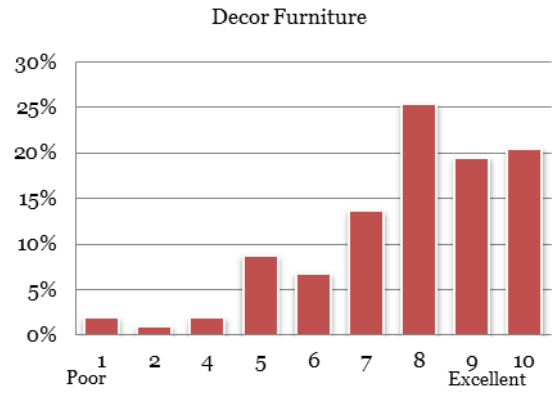
84% of participants felt the hospital provided a **range of activities** they could get involved in.

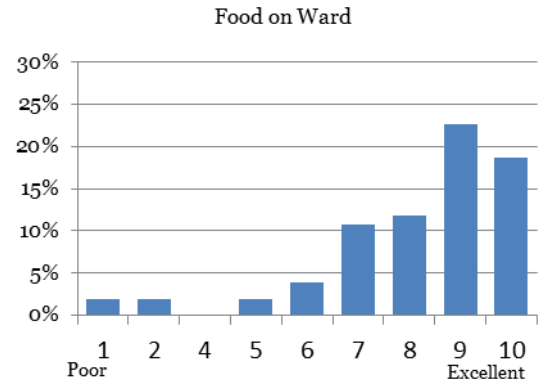
50% of participants felt there were **enough activities** available for them **at weekends**

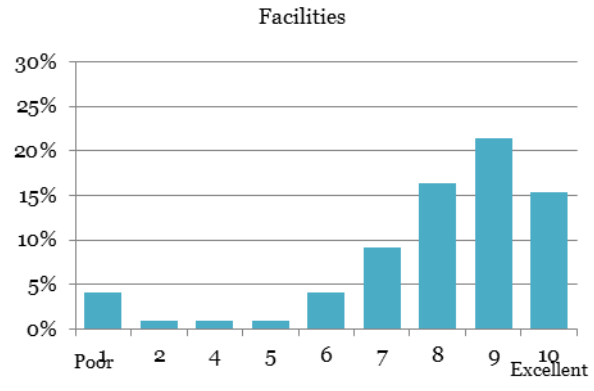
i) Hospital Facilities

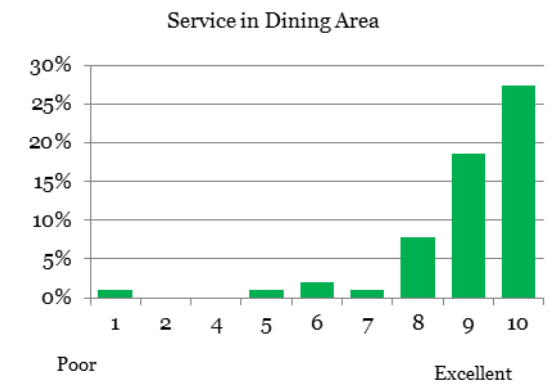
Service Users who participated in the survey were asked to rate general hospital facilities, food and the garden spaces. The average ratings and specific ratings are provided below with 1 being poor and 10 being excellent.

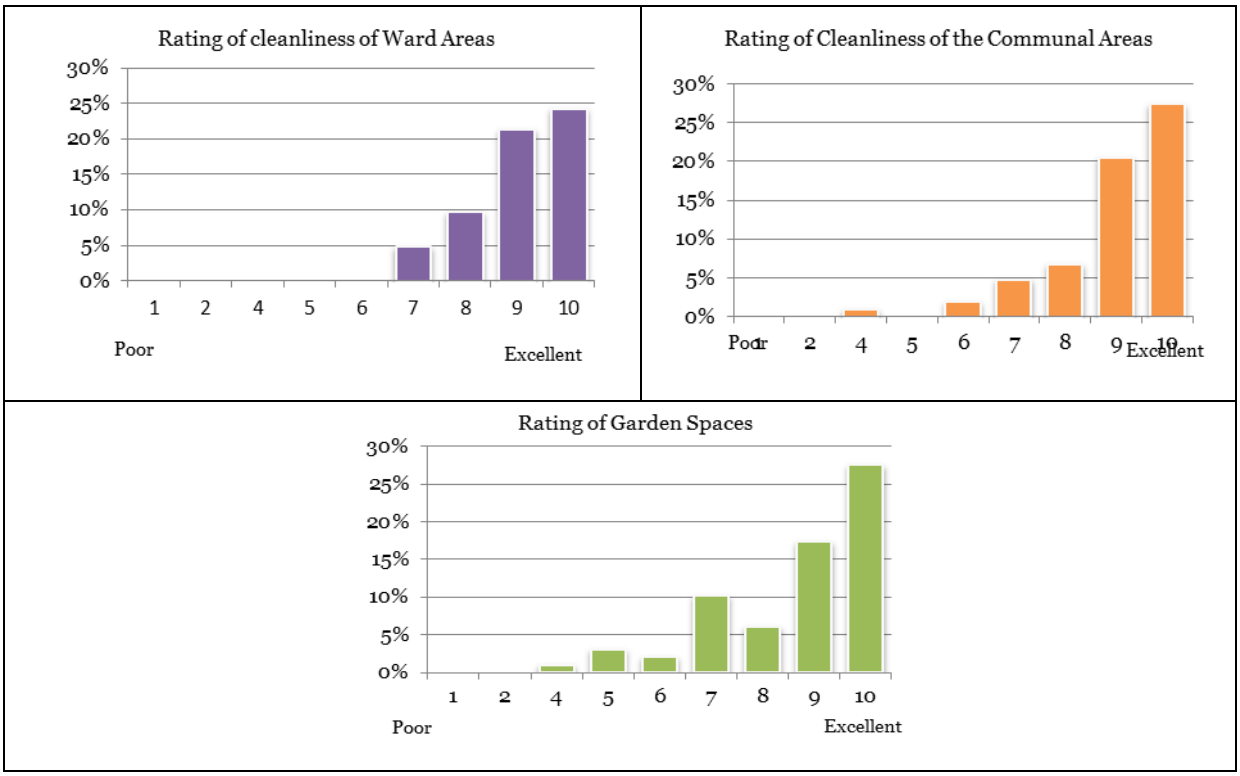
Item	Average Rating
Decor / Furniture	8
Food on Ward	8
Service in Dining Areas	9
Cleanliness of Wards	9
Cleanliness of communal areas	8
Hospital facilities	8
Garden Spaces	8









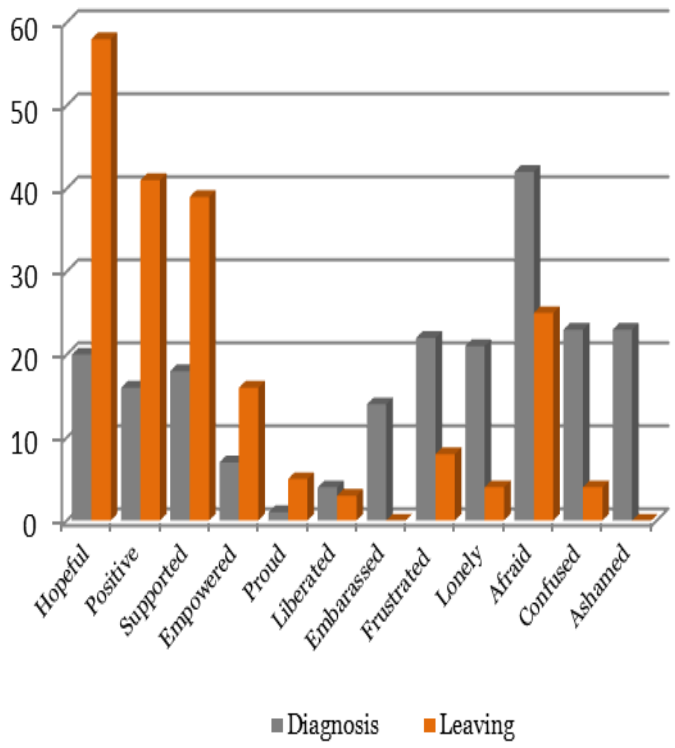


j) Attitude to Mental Health at Diagnosis and Discharge

Service users who participated in the study were asked to select a number of adjectives to describe their feelings at diagnosis and at discharge. The results are provided below. Service users were asked to tick three adjectives to describe their feelings at diagnosis and three to describe their feelings at discharge. The data below provides details of the number of each descriptor that was ticked and may not necessarily represent an individual's views. The question is also limited by the use of the term diagnosis as no time limit has been placed on when and individual may have been diagnosed with mental illness.

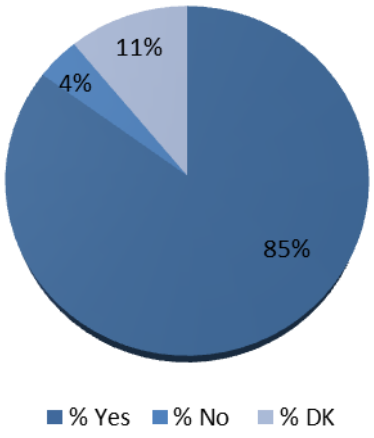
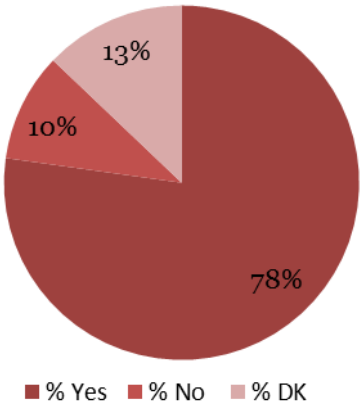
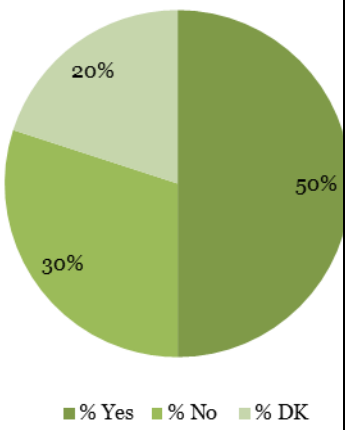
It is encouraging to note that at the point of discharge service users felt more hopeful, positive and supported. Feelings of loneliness, shame, confusion and fear had reduced from point of diagnosis to point of discharge.

Descriptor	Diagnosis	Leaving	Change
Hopeful	20	58	38
Positive	16	41	25
Supported	18	39	21
Empowered	7	16	9
Proud	1	5	4
Liberated	4	3	-1
Embarrassed	14	0	-14
Frustrated	22	8	-14
Lonely	21	4	-17
Afraid	42	25	-17
Confused	23	4	-19
Ashamed	23	0	-23



k) Service Users Perception of Stigma

St Patrick's Mental Health Services is committed to challenging the stigma experienced by those who attend out services and was interested in seeking their views on stigma. Service users were asked about their views and perceptions regarding mental illness in general, their own mental illness and whether or not they would tell people if they had attended the Hospital. The questions and results are detailed below.

Do you feel that your views and perceptions regarding mental illness in general are more positive than they were?	Do you feel that your views and perceptions regarding your own mental health difficulty are more positive than they were?	Will you tell people that you have stayed in St Patrick's?
		

85% of respondents stated that they had a more positive view and perception of mental illness in general and 78% had a more positive view regarding their own mental health difficulty. However, 10% had a more negative view and perception of their own mental health difficulty compared to 4% of mental illness in general.

50% of respondents stated that they would tell people that they had stayed in St Patrick's but 30% would not disclose their stay and 20% of respondents did not know if they would tell others about their stay in the Hospital.

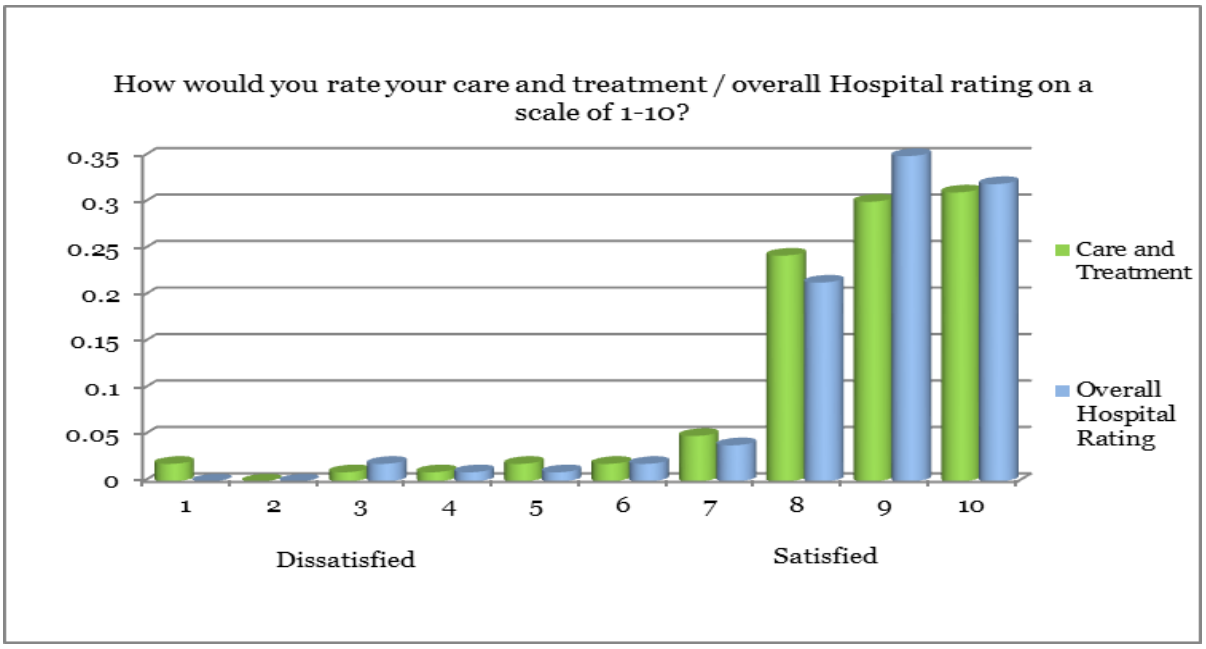
l) Overall View of the Hospital (2012)

Service users were asked to rate their experience of the hospital over all on a scale of 1 (poor) to 10 (excellent) in relation to both their care and treatment and the Hospital overall.

Overall, on a scale of 1-10 how would you rate your care and treatment in Hospital?

Overall on a scale of 1-10 how would you rate the Hospital overall?

The average score for each question was 9. The chart below provides a breakdown of the scores awarded by the participants in the exit survey.



This compares favourably to the 2011 ISQSH Service Users satisfaction survey results which showed an 84% satisfaction rate amongst service users.

- ***Qualitative Comments***

Service users were given an opportunity to provide qualitative feedback on their experience of being in Hospital which had not already been addressed through the survey.

General Qualitative Comments

"At all times I was met with courtesy and respect. I would be proud to tell family and patients of how I was treated at all times".

"I came to the hospital ashamed and frightened and broken in so many ways. I am leaving stronger and looking forward for the first time in a long time. Thank you so much."

"The dignity, care and good humour I experienced from all the staff allowed me to settle in and slowly recover my health and confidence".

"I wasn't alone and wasn't judged by anyone, only supported. Thank you"

"Overall the experience was very positive. I found the first couple of weeks very difficult but nursing staff were always very kind."

"When I came into Hospital I was very alone and at very low ebb in my own life. It was the best decision I ever made as it has helped me to address issues that had been lurking in the back of my mind for a very long time. I have been overwhelmed with the kindness of people; everyone has been great and really supported me."

"Staff excellent, in particular nursing staff. Catering and household staff always friendly. Good hospital and nice people."

"More work needs to be done regarding making admissions service user friendly. Meet and greet is definitely necessary and checking to see if the service user is literate. At no stage is a first admission to St Pats asked if they followed the care plan i.e. did they take the drugs as prescribed by a doctor / psychiatrist outside the St Pats network."

"One of the things I found most difficult was not having enough time to talk with the psychiatrist – always seemed to be rushed and I found it difficult to speak in front of so many people".

"St Patrick's is a nice hospital. Just a bit more communication re discharge date would help ease anxiety."

Was there anything particularly good about your care?

"The staff were very supportive, caring and understanding. At all times I was met with respect. It is a lovely environment; lectures are excellent and very informative."

"You have given me back my life. I can never thank you enough for that. I leave hospital ready to face the future stronger and better than ever. Thank you so much."

"I came to the Hospital ashamed and frightened broken in so many ways. I am leaving stronger and looking forward for the first time in a long time. Thank you so much."

"The garden, art, twilight programme. The nurses were very kind and helpful. The ward felt safe. The other patients were hugely supportive."

"All the nurses took time to sit and talk to me and were very helpful and very good at listening to me and guiding me about my future and making me feel safe and good about any issues / concerns I had. Also my doctors were amazing and made me feel very secure that I was getting the attention I needed"

"The staff were very supportive, caring and understanding. At all times I was met with respect. It is a lovely environment; lectures are excellent and very informative."

What could we improve?

"Maybe more to do at the weekend, better access to the gym would be good".

"I found that the nursing staff when you go to talk to them was very kind and helpful but I hated bothering them because they were always so busy."

"Overall the experience was very positive. I found the first couple of weeks very difficult but nursing staff were always very kind. "

"Please more time for nursing staff to talk to patients. An improved system when about to see your consultant. Queuing, queuing, queuing is a source of great anxiety. "

"Considerably increase the frequency of personal contact to at least once per day. Whole days without either and treatment or a one to one contact can't be conducive to improving health. "

"Allow patients as long as it takes to eat a meal, on one occasion I felt rushed by a member of nursing staff and was asked are you finished yet? I obviously was not. I appreciate that this nurse had other duties to attend to and I had been delayed coming for tea. I had let the nurse know I would be late. Is there a half hour allocation for meals? Mealtime is a very important part of the patient's day more could be done to make this relaxing experience. The new dining facilities I feel will help"

"I feel I needed far more time with the psychiatrist, radical openness programme not available until January 2013. I feel that the momentum is lost by waiting until January. Communication of activities needs to improve. I didn't know about OT kitchen until I met OT in my last week in Hospital. Don't know who my care (Key?) worker is. "

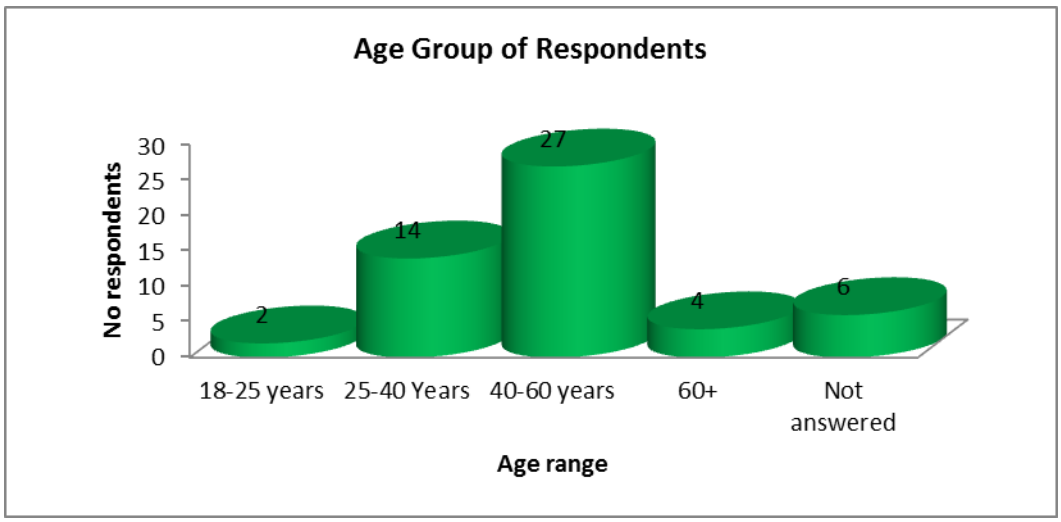
"I think all consultants should make appointments to meet their in-patients. Hoping to see your doctor on the corridor is not good enough. "

5.2. Dual Diagnosis Service User Feedback Survey 2012

Service users attending the Dual Diagnosis programme in St Patrick's Mental Health Services were asked for their views about the service in April 2012 as part of a wider review of the service. The purpose of the survey was to elicit service user views about the Dual Diagnosis Treatment Programme's (DDP) structure, content and delivery. This service user feedback was intended to focus the future development of the service. All service users who had participated in the DDP in the previous 12 months were eligible for participation and surveys were distributed to all attendees. 56 completed surveys were returned and were analysed using Microsoft Excel. The report below provides a summary of the results of this survey.

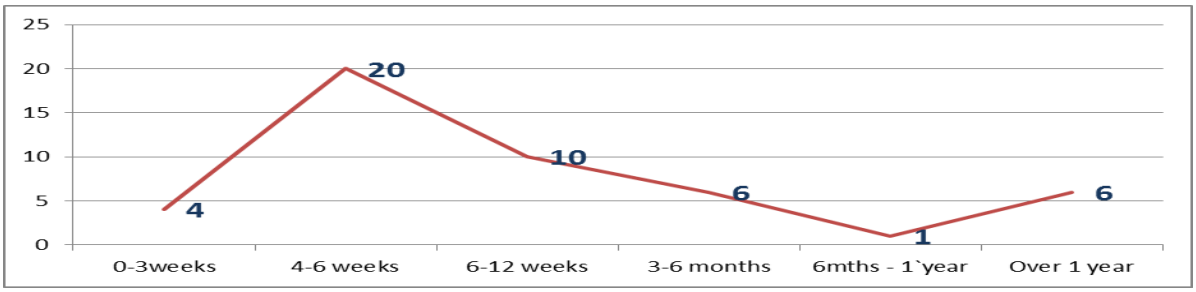
5.2.1. Results

a) Age Profile of Respondents:



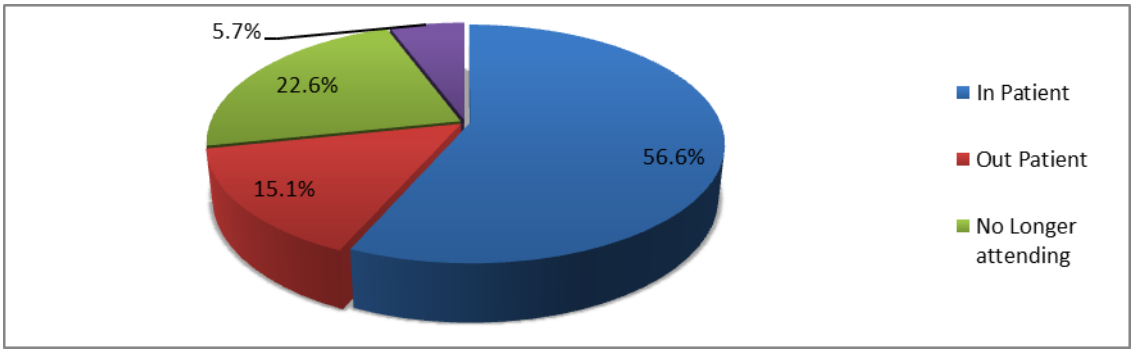
The majority of the respondents (n-27) were in the 40-60 years age range with the next highest grouping in the 18-25 years age range.

b) Length of time attending the Programme



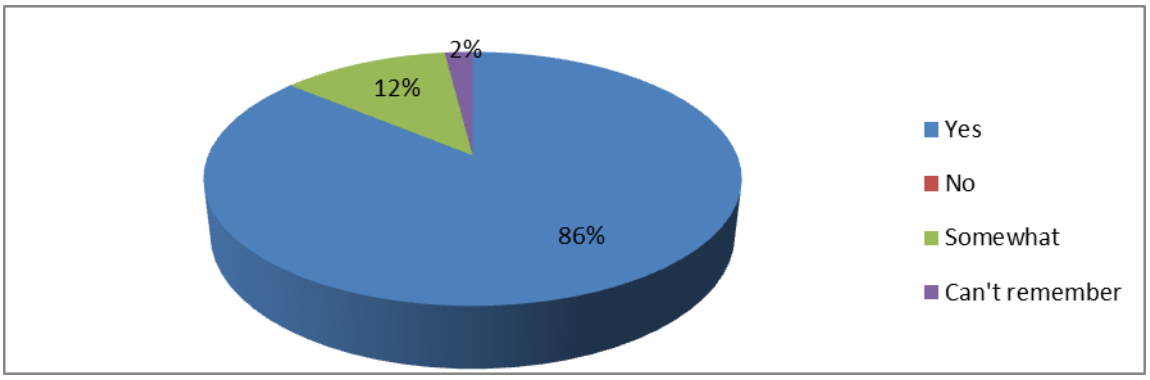
c) Current Status on Programme

Service users were asked to specify if they were currently attending the Dual Diagnosis programme or had attended in the past. The results showed that **56.6%** of those who responded were current in-patients and the remaining **37.7%** of service users were no longer attending (26.6%) or were attending as an out-patient (15.1%). **5.7%** of respondents did not provide an answer to the question.



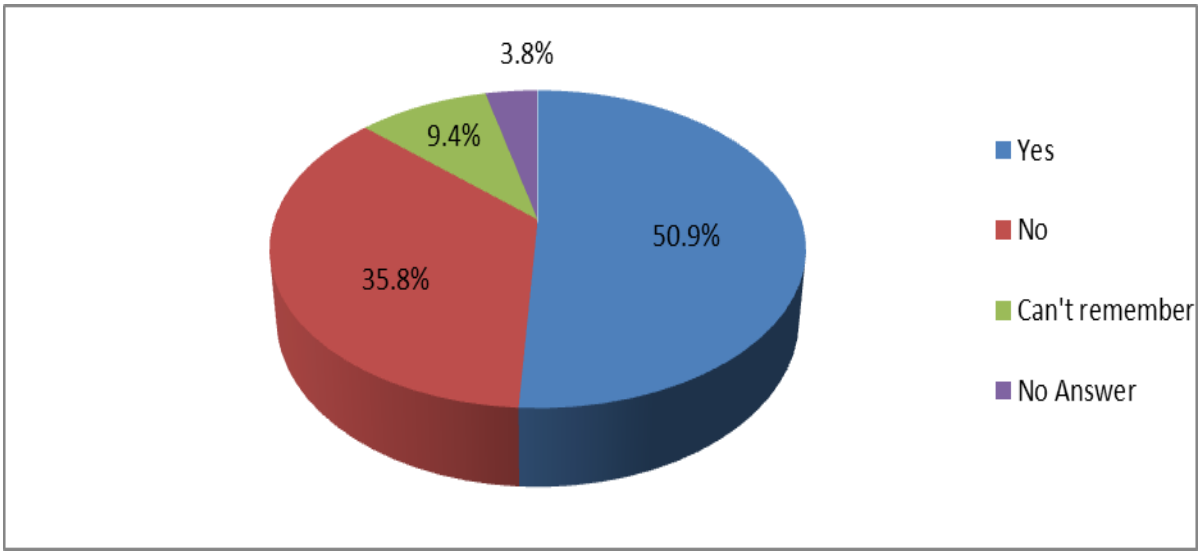
d) Understanding of Programme Aims

86% of respondents understood the aims of the Dual Diagnosis programme in relation to their recovery with 12% of respondents stating that they understood this somewhat. No respondents indicated that they did not understand the aims of the programme in relation to their recovery and 2% of respondents did not answer this question.



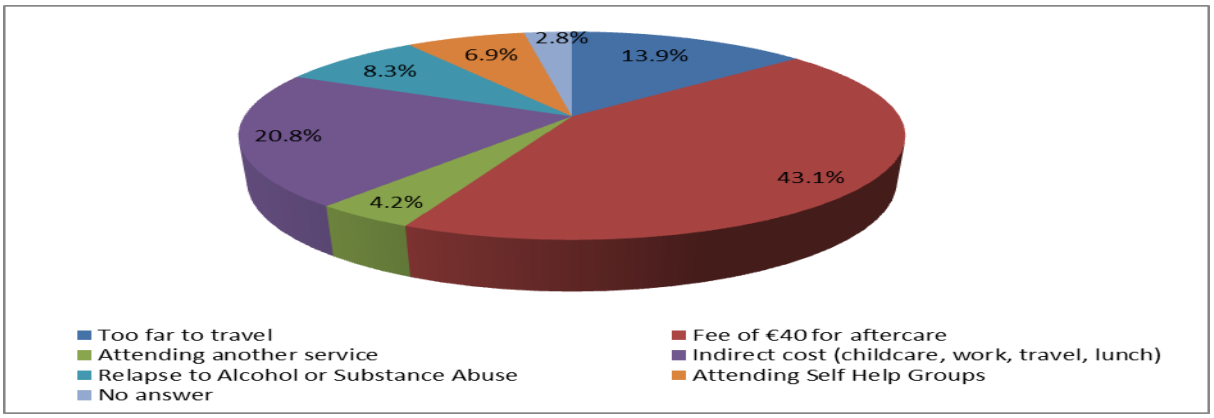
e) Programme Information

Attendees were asked if they felt they were given enough information about the content of the inpatient Dual Diagnosis programme and aftercare groups when you commenced attending the programme.



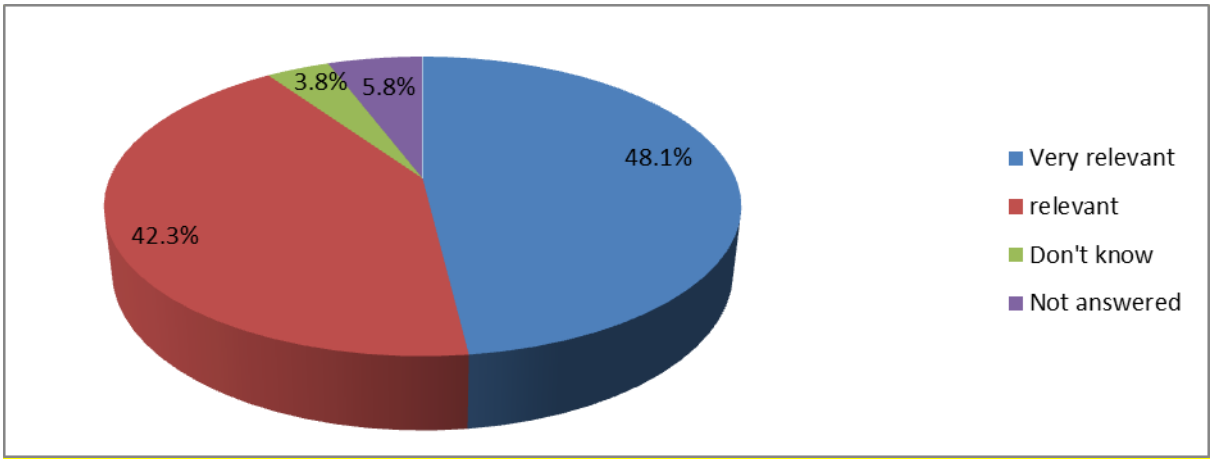
Just over half (50.9%) of service users had been given enough information about the Dual Diagnosis prior to commencing the programme.

f) Reasons for non-completion of DDP?



Service users who participated in the study were asked for the reasons why they did not attend the full dual diagnosis programme, in particular aftercare. 43.1% of respondents indicated that the fee of €40 for aftercare was a reason for their non-attendance with 20.8% indicating that indicated that indirect cost (the cost of childcare, work, travel and lunch). 13.9% of respondents found it too far to travel and 8.3% of service users reported relapse to alcohol or substance abuse. The remaining 13.9% of respondents indicated that they were attending self-help groups (6.9%); attending another service (4.2%) and 2.8% did not provide an answer to this question.

g) Was the content of the inpatient Dual Diagnosis programme relevant to your recovery?

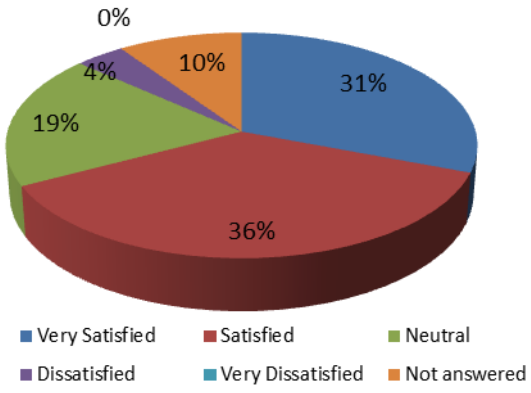


90.4% of respondents stated the content of the Dual Diagnosis programme was *relevant to their recovery: 48.1% responded that it was very relevant and 42.3% indicated that the content was relevant.*

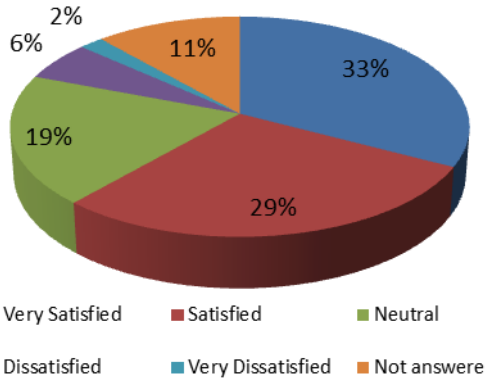
h) Satisfaction with Dual Diagnosis Programme elements.

Service Users were asked … "How satisfied were you with ……

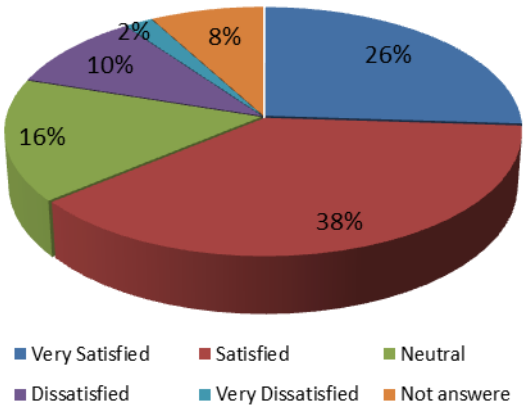
The information provided by the Dual Diagnosis Group



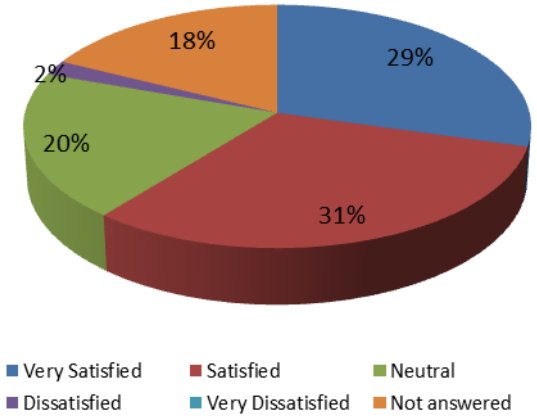
The relevance and usefulness of Relapse Prevention Group



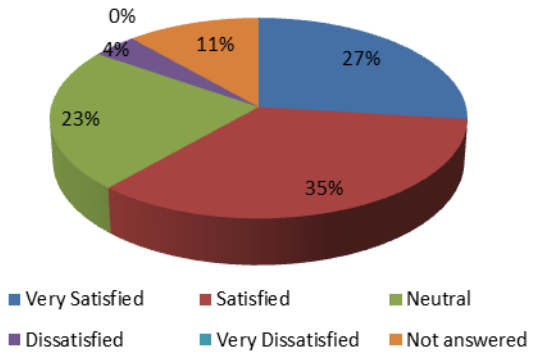
The relevance and usefulness of the Role Play Group



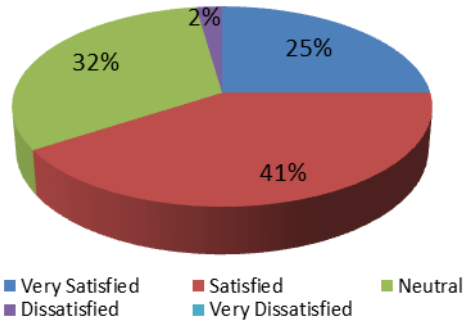
The role of the First Step Group in motivating you in your recovery?



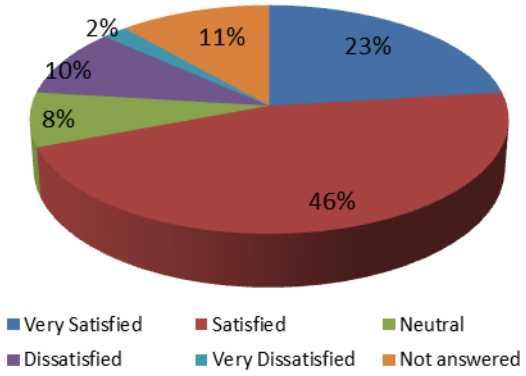
Your personal plan developed in the Recovery Plan Group



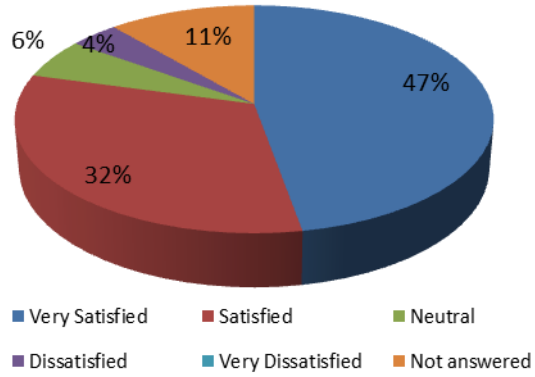
The goal setting group in maintaining your recovery during weekend leave



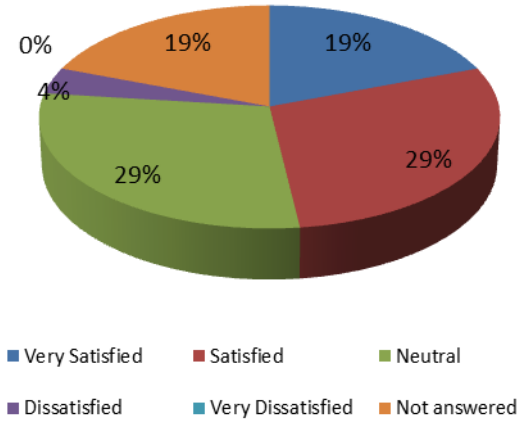
The information provided during lectures?



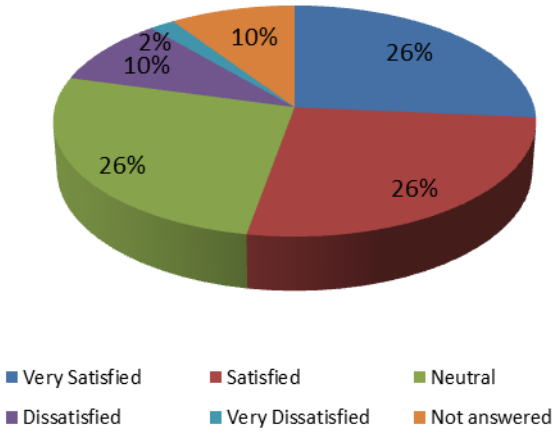
The accessibility and benefit of professional support from your counsellor?



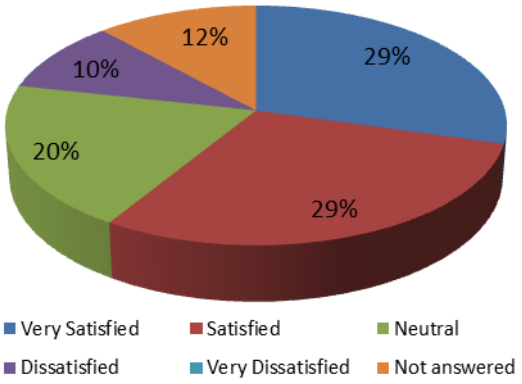
The relevance of your Aftercare group to your continued recovery after discharge



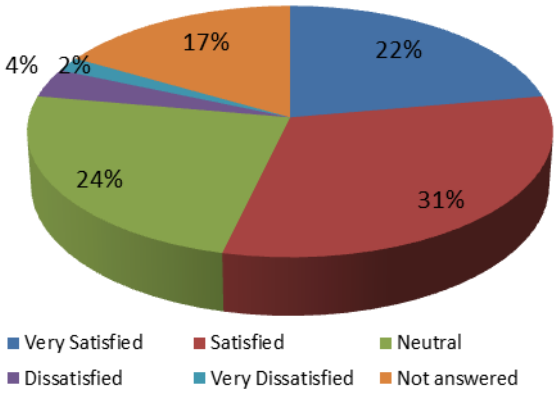
The support and education provided for family and concerned others regarding my treatment and recovery



The Temple Centre therapeutic environment and how it supported your recovery

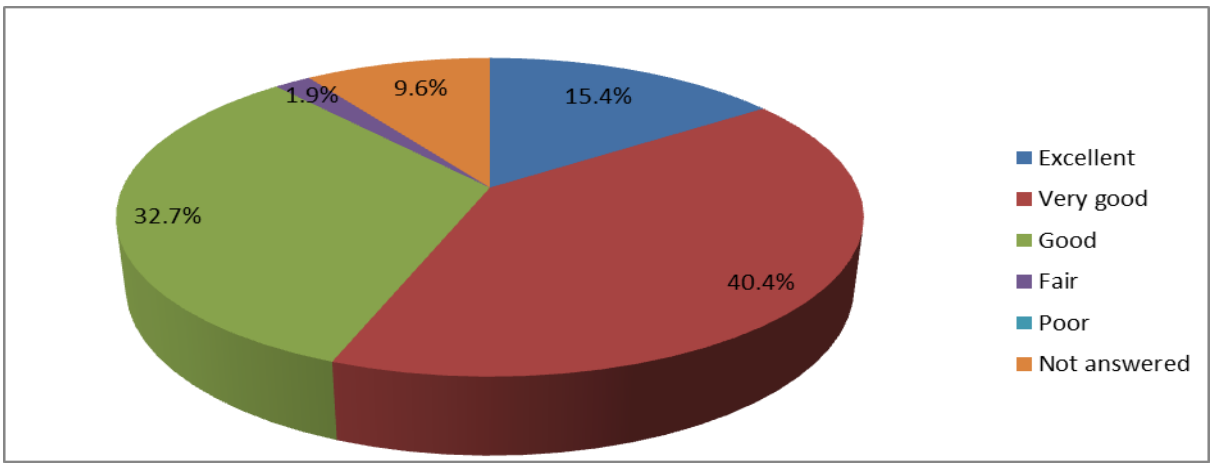


How Relapse is managed while as an inpatient and in Aftercare



i) Overall Rating of Dual Diagnosis Programme.

Service users were asked how would you rate the Dual Diagnosis Programme overall?



Service users were asked to rate the Dual Diagnosis programme overall. 15.4% of respondents rated the programme as Excellent with 40.4% of respondents stating that the programme was Very Good and a further 32.7% of respondents stating that the programme was good. 1.95% of respondents rated the programme as Fair.

j) Qualitative Comments

Service users who completed the survey were asked to comment on what was felt was particularly good about the service. A key theme of responses was the key role that staff played in the service user's recovery. The following comments are indicative of the responses.

"One to one counselling was highly rated."

"Excellent counselling service and support. Nursing staff were approachable and always available, the catering staff were a tonic and the food was great"

"I was pleased with the one to one work. I really got to know myself and have made huge changes in my life. Written work is excellent as it gets it all out – you have time to think and reflect between appointments".

k) Service users were asked to comment on areas that they felt could be improved in the service.

Three key themes emerged in the qualitative comments in response to this question.

(1) Information provision before commencing the programme / aftercare.

Provided below are the indicative comments related to information provision

> *"Aftercare was landed on me just before discharge. I wasn't well informed, (the other patients were talking). I felt that I had no choice on that day I went…"*
>
> *"The content of the programme was never explained and it was only through talking with other patients that I found out I had to present my first step".*
>
> *"Excellent written in-patient programme but no information about aftercare in any detail."*
>
> *"More information on joining the programme. I was admitted to another ward and then to the Dual Diagnosis Programme but I was never briefed on the details of the programme or what is expected of me.*

(2) Additional Mental Health input required

A number of service users that there was too much emphasis on addiction and insufficient focus on other mental health conditions within the programme of care and treatment provided by the Hospital.

> *"A much more evenly balanced or even a predominantly biased approach to other diagnoses other than alcohol. Very little attention given to depression other than with my counsellor."*
>
> *"Very little focus on mental health: include some aspects of other programmes instead of keeping them separate".*
>
> *"Groups good, lectures good, I felt the programme focussed on addiction to the detriment of mood disorders".*

"More emphasis on resolving depression, anxiety bipolar etc. Far more emphasis is placed on dealing with drink/ drug abuse than in trying to treat the underlying condition."

(3) More skills training and involvement of family members.

Service users were then asked for suggested programme and service improvements. The following suggestions were put forward by service users who completed the survey.

"Lots more group work and discussion focusing on sharing of experiences. This can be done through discussion or role play for those who feel comfortable doing so. I also think that the care plan should be used to aid recovery. I went to the trouble of completing it and never saw or discussed it once I handed it in."

"More work either in group or individually regarding triggers for behaviours and recognising emotions within oneself would be beneficial."

"Just some literature describing the programme, especially for family and friends".

"A named nurse/ nurses who would meet with their named patient daily even for a few minutes to offer support, advice and feedback."

"Lots more group work, structured counselling sessions as not to interfere with group work. Care planning with a key worker in the first few days before the commencement of the programme with clear goals and responsibilities for tasks agreed by all the patients."

"More exploration of feelings/ emotions and effects of behaviour"

"More involvement of children in education and support as family members"

- ***Summary and Overall Conclusions***

The Dual Diagnosis programme Survey highlighted a number of key areas for improvement across service provision. The views of service users indicated that information provision was central to recovery and the continued value placed of one to one counselling. This survey has provided the basis for Dual Diagnosis Programme development as part of an on-going review and improvement of the service.

5.3. Willow Grove Adolescent Unit Service User Survey 2012

Willow Grove is an inpatient general adolescent unit which provides treatment for a range of mental illnesses for young people aged 13 to 17 years of age. In addition, the unit has an outpatient service which operates from the Dean Clinic Community Clinic in Lucan, Co Dublin, where assessments and treatment are offered. The Inpatient Unit opened in April 2010 and it aims to provide an excellent standard of evidence based treatment in a safe, comfortable and young person friendly environment. The multi-disciplinary team are committed to on-going quality improvement and believe that service users are vital in informing us about the service they receive and are best placed to suggest areas for improvement. Young people's views were taken on board in the design and development of the unit and we continue to work collaboratively with young people and parents and be informed by them. This report summarises key findings from a service satisfaction survey which was given to young people and parents following an inpatient stay in Willow Grove Adolescent Unit.

5.3.1. Service User Satisfaction Survey Objectives

1. To determine parent and young person's satisfaction with service.
2. To determine areas for quality improvement.
3. To determine what we are doing well.
4. To assist in service design, development and delivery.

5.3.2. Methodology

Willow Grove is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (Q.N.I.C.) which is a network of similar units which conducts 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 questionnaire used for young service users of Willow Grove was one recommended by Q.N.I.C and was an adapted version of a standard Child and Adolescent Mental Health Service (CAMHS) inpatient satisfaction questionnaire, taken from COSI-CAPs study. This questionnaire was issued to parents and young people attending the Dean Clinic (who had been inpatient in Willow Grove) and to parents and young people on discharge from the Unit. 28 questionnaires were

distributed between June and October 2012. 14 parents and 15 young people completed questionnaires.

5.3.3. Questionnaire Focus.

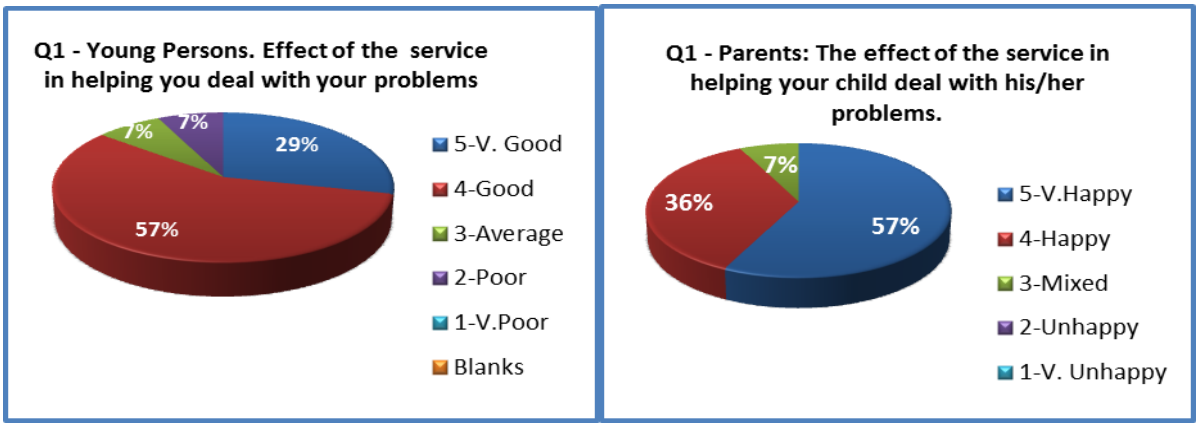
The questionnaire gathered feedback on a wide range of issues including, Access to service, Environment and facilities, therapeutic services offered, the effect of the service in helping young people and parents deal with mental health problems and prevent relapse, discharge preparation, professionalism of staff, confidentiality and rights. Both questionnaires asked what parents and young people liked and disliked about the service and what they would like to change.

The questionnaire was printed in a booklet form and began with the question,
"What is your overall feeling about.....?"
Parents were asked to express their overall feeling from Very Happy, Happy, Mixed, and Unhappy to Very Unhappy and each response was numbered from 1-5. The young person's questionnaire used a similar format and questions and used Smiley Faces in the ratings. There were 40 questions in total and the main findings from the survey are outlined below.

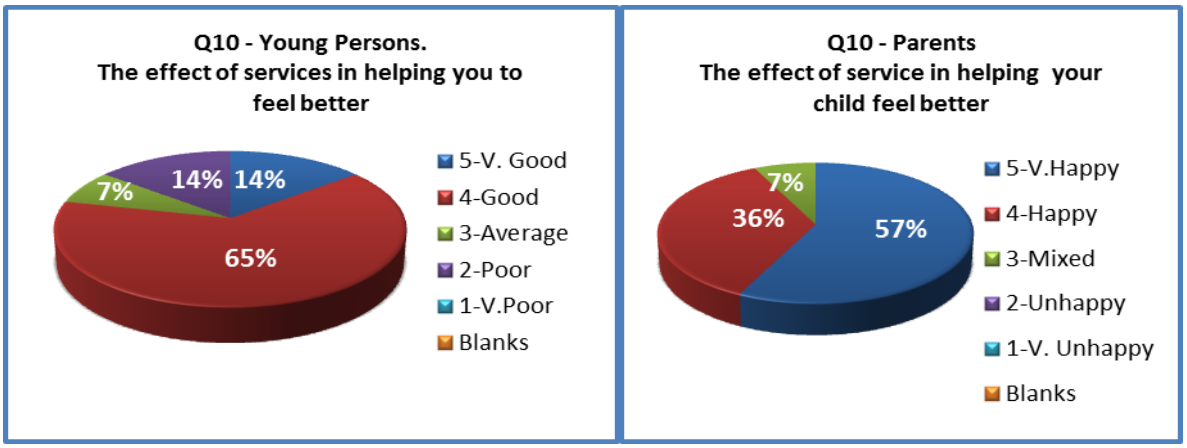
5.3.4. Survey Results

- ***Effectiveness of the Service.***

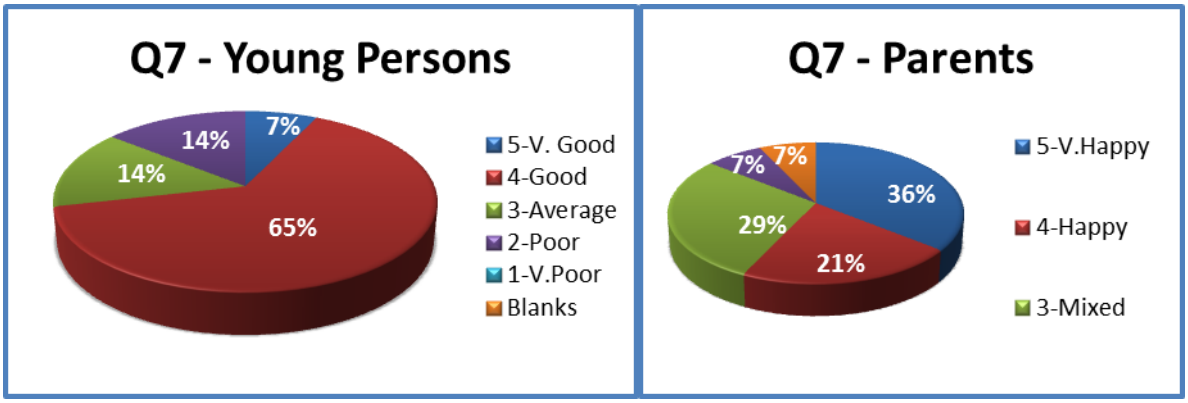
Overall both parents and young people reported that the service was effective in helping young people to cope with their problems. They also expressed satisfaction with the variety of services available.



Both parents and young people felt that the service offered helped them to feel better.



72% of young people rated the effectiveness of the service in helping to prevent the return of problems as being good and very good. 36% of parents were very happy with the effect of the services in helping to prevent the return of their child's problems and 21% were very happy (Question 7).



Parents and young people identified that the service was effective in the following ways.

- ***Improving knowledge and understanding of problems. (Young Person)***

  93% of Young People rated the service as good /v good in this area

  100% of Parents stated they were happy/v. Happy with this aspect of service.

- **Helping relationship between YP and family/carers**

  86% of Young People rated the service as good/v. good in this area

  93% of Parents stated they were happy/v.happy with this aspect of service.

- ***Helping family/carers understand YP problems.***

  71% of Young People rated the service as good/v. good in this area

  86% of Parents stated they were happy/v. happy with this aspect of service.

- ***Establishing good relationships outside your family***

  86% of Young People rated the service as good/v. good in this area

  86% of Parents stated they were happy/v. happy with this aspect of service.

- ***Effectiveness of service in helping your family or carer deals with your problems?***

  71% of Young People rated the service as good/v. good in this area

  79% of Parents stated they were happy/v. happy with this aspect of service.

- ***Qualitative comments about effectiveness of service***

  "Treatment appropriate for illness, excellent and rare service"

  "Helped me to understand reasons what made me sick"

  "Lack of support and advice for parents at times"

- ***The Multidisciplinary Team at Willow Grove.***

A high level of satisfaction was noted by respondents about the multi-disciplinary team.

79% -100% of parents and Young People rated professional manner of staff as good /very good.

100% parents and Young People were happy/very happy with continuity of care.

100% Parents were Happy (71%) or Very Happy (29%) with the professional's ability to listen to and understand their worries about their child.

64% of Young People were happy with professional's ability to listen to and understand the worries their family / carers had about them.

Qualitative Comments about the Multidisciplinary Team at Willow Grove.

"Most of the nurses were all very friendly and helpful; they made me feel comfortable to talk to them"

"patient learnt new skills-self esteem, problem solving and confidence. Admitted as timid and frightened - discharged as confident, secure and happy"

"Staff supportive and friendly,"

"MDT approach, excellent professionalism, excellent care, extracurricular activities"

"Sometimes I felt that there was a lack of communication between different staff and also some family members. The lack of continuity caused some problems and tensions"

- ***Confidentiality and Respect for Rights.***

  86% of Parents stated they were Very happy and **14%** were Happy

  50% of People rated the service as Very Good and **43%** Good at this aspect of the service.

- ***Cost Of Service***

57% of parents had mixed views about the costs associated with treatment. A number of Parents comments related cost of car park fees and the cost of travel. As WGAU is a national service some families have to travel long distances to visit their loved ones. It is also an expectation of the service that Parents will participate in the treatment process and are required to attend review and family meetings with members of the multidisciplinary team which for some families may mean traveling long distances.

- ***The Environment***

86% of Parents were Very Happy with the appearance and comfort level of the rooms and 71% of Young People rated this as very good/good. Overall feedback about the environment of the Unit was very positive, however some young people wanted more outside time and sports.

- ***Qualitative Comments about the Unit Environment.***

  "The unit is nice and modern. The atmosphere is good and I felt like it was a safe and relaxed environment".

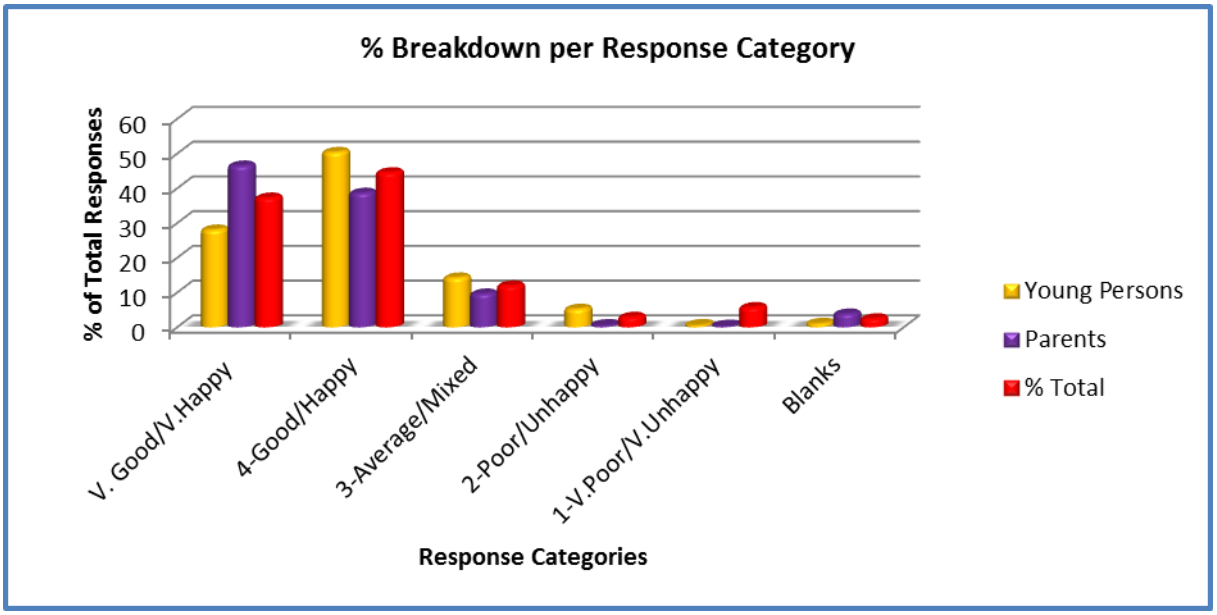
  "Lack of sports" "Not enough freedom"

  "Suitable building - bright, comfortable, non threatening" "felt my child was safe"

  "The safety and security of being in a supportive environment with people of my own age, trying to cope with similar problems. The sense of community and structure."

Overall the responses from both Parents and Young People were overwhelmingly positive. However there are some areas cited which could be improved. More advice and support for parents was requested by some respondents. In addition, more input on discharge planning and help with transitioning from the unit to home was requested.

The following figure represents the breakdown of responses from both sets of respondents.



Section 6.

Conclusions

7. CONCLUSIONS

1. The 2012 SPMHS Outcomes report builds on the organisation's 2011 published Outcomes report. It 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. Service evaluation, outcome measurement, clinical audit and service user satisfaction surveys continue to be used routinely in the context of everyday delivery of our service deliver.

2. Demand for SPMHS in 2012 incresased across all of its 3 distinct but integrated outpatient, inpatient and daypatient pathways.

3. Clinical outcomes data for 3 further clinical programmes were added in the 2012 report, including the Addictions Service, the Psychosis Recovery Programme and the Radical Openness Programme. While the Anxiety Management, Recovery, Eating Disorder, ACT and Living through Distress Programmes produced the second year of outcomes data for this report.

4. The capture of clinical outcomes data continued to be highly manualised within the organisation. Systems to routinise outcomes data capture have bedded in further in 2012. Clinical and non-clinical staff are once again to be commended for contributions in establishment outcome measurement within services and programmes.

5. Service user satisfaction continued to be monitored in 2012 and survey results indicated service user experience of SPMHS inpatient care continued to be overall positive.

6. All clinical programmes involved in publishing their outcomes in the 2012 Report continued to review the clinical utility and psychometric robustness of measures used and where appropriate measures were changed or added.

7. On foot of the 2011 Report findings, Registrars audit activity was included in the 2012 report under the Clinical Goverance Section. Registrars as part of the training carry out audits and applied research within the organisation which is of value to the organisations committment to the a continuous quality improvement programme.

Section 7.

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