St Patrick's
Mental Health Services

Outcomes Report 2018

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

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SECTION 1

Introduction

1. Introduction

This report presents outcomes relating to clinical care, clinical governance processes, clinical programmes and service user experiences, within St Patrick's Mental Health Services (SPMHS). It is the eighth year that an Outcomes Report has been produced by SPMHS and is central to the organisation's promotion of excellence in mental health care. By measuring and publishing outcomes of the services we provide, we continually strive to understand what we do well and what we need to do to continue to improve. Wherever possible, validated tools are utilised throughout this report and the choice of clinical outcome measures used is constantly under review to ensure we are attaining the best possible standards of service delivery.

Leading healthcare providers around the world capture outcome measures related to care and treatment and make the results publicly available in order to enable service users, referrers and commissioners to make informed choices about what services they choose. Transparency informs staff of the outcomes of services they provide and advances a culture of accountability for the services being delivered. It prompts debate about what care and treatment should be provided and crucially how best to measure their efficacy. The approach of sharing treatment outcome results has also been used by the Mental Health Commission in Ireland (Mental Health Commission, 2012).

The 2018 Outcomes Report is divided into 7 sections. Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPMHS services are structured and how community clinics, day-patient and inpatient services were accessed in 2018. SPMHS provides community care through its Dean Clinic Community Mental Health Clinics and day-patient services through its Wellness & Recovery Centre. It provides inpatient care through its three approved centres, St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

Section 3 summarises the measures and outcomes of the organisation's Clinical Governance processes. Section 4 provides an analysis of clinical outcomes for a range of clinical programmes and services. This information

provides practice-based evidence of the efficacy of interventions and programmes delivered to service users during 2017, reflecting the use and measurement of evidence-based mental health practice across SPMHS.

SPMHS considers service user participation and consultation to be an essential and integral aspect of clinical service development. Section 5 summarises the outcomes from a number of service user experience 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.

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

Section 7 provides a reference list.

SECTION 2

Service Accessibility

2. St Patrick's Mental Health Services

SPMHS is the largest independent not-for-profit mental health service provider in Ireland. Our services are accessed in a number of ways. These include community care accessed through our Dean Clinic network of community mental health clinics; day-patient care accessed through our Wellness and Recovery Centre; and our in-patient care accessed through three approved centres. In addition, free of charge Prompt Assessment of Needs (PAON) was introduced in December 2017, through the Referral and Assessment service aimed to improve access for service users. The PAON service is delivered through technology (e.g. telephone / FaceTime) which ensures that the assessment is delivered at a time that suits the service user in their own home, greatly increasing accessibility. This section provides information about how services were accessed through these services in 2018.

2.1. Prompt Assessment of Needs (PAON)

SPMHS made improvements to the way referrals are assessed, in order to improve speed of access. This was in response to feedback from service users and referrers about the waiting times to access initial outpatient assessment in the Dean Clinics. Any referrals received for Dean Clinic assessment are transferred into the new Referral and Assessment service and receive a free-of-charge assessment by an experienced mental health nurse. This allows for more prompt and efficient mental health assessments and onward referral to the most appropriate service.

Service users can access this assessment from their own home, without the need to travel to a clinic. A range of communications technologies including telephone and audiovisual technologies such as 'Skype' or 'FaceTime' are used to provide the assessment. The choice of communication with the Referral and Assessment service is based on the preference of the service user.

2.1.1. Outcomes of the PAON Assessments 2018

The table below provides the number and percentages of adult PAONs completed and the outcome of each PAON in 2018. These results identify the immediate outcome of the PAON.

	Number	%
Dean Clinic Referral	942	86.3%
Discharge*	76	8.2%
Inpatient Admission Referral	60	5.5%
Total	**1,078**	**100%**

*Discharge includes service users who declined any further services following PAON and service users for whom there was not an appropriate service to offer.

2.2 Community Based Services (Dean Clinics)

The SPMHS strategy, *Changing Minds, Changing Lives* (2018-2022), reinforces the organisation's commitment to the development of community-based mental health clinics. Since 2009, a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the organisation. SPMHS operates a total of seven Adult Dean Clinics and two Adolescent Clinics. In 2018, three Dublin-based clinics consolidated into the clinic at St Patricks University Hospital. In addition, free of charge Prompt Assessment of Needs (PAON) was introduced through the Referral and Assessment service aimed at improving access for service users. The PAON service is delivered through technology e.g. telephone / FaceTime which ensures that the assessment is delivered at a time that suits the service user in their own home, greatly increasing accessibility of the service.

Adult Dean Clinic Services

2.2.1. Dean Clinic Referrals Volume

The five Adult Dean Clinics provide multi-disciplinary mental health assessments and treatment for those who can best be supported and helped

within a community-based setting and provision of continued care for those leaving the hospital's in-patient services and day-patient services. The Dean Clinics seek to provide a seamless link between Primary Care, Community-based Mental Health Services, Day Services and Inpatient Care. The clinics encourage and facilitate early intervention which improves outcomes. In 2018, there was a total of 1,615 Adult Dean Clinic referrals received. This compares with 1,923 in 2017, representing a decrease of 16% (decrease of 308 referrals). However, referrers are now more likely to send referrals that are appropriate to the services provided by SPMHS, due to the increasing awareness among GP's of the services provided by SPMHS. In addition, a new centralised referral and assessment process introduced in December 2017 has had a positive impact in directing referrals to the most appropriate service at the point of receipt.

2.2.2. Dean Clinic Referral Source by Province

The following table illustrates the geographical spread of Dean Clinic Referrals by Province from 2014 to 2018. The highest referral volumes continued to be from Leinster in 2018 with 1112 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2014	1503	287	214	43	0
2015	1494	427	257	58	0
2016*	1320	444	243	45	16
2017*	1251	333	299	40	0
2018*	**1112**	**276**	**193**	**34**	**0**

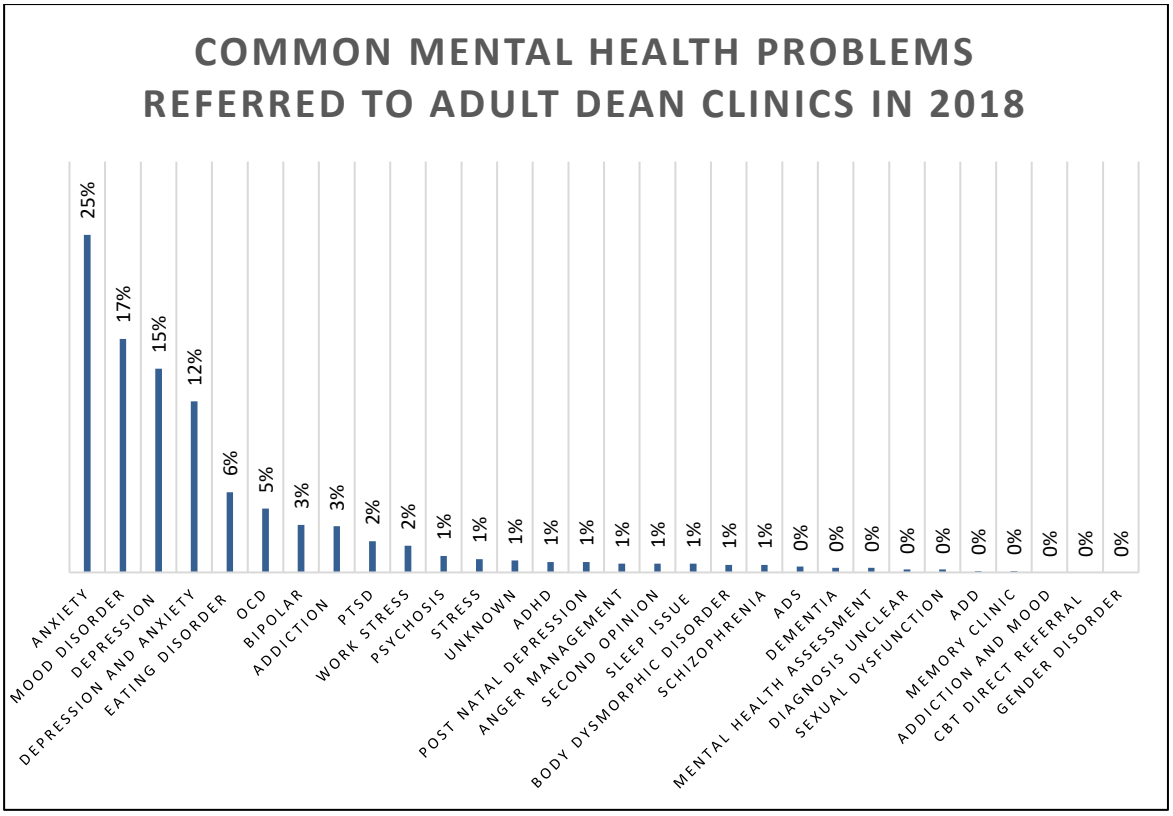
*This refers to Adult Services only. Adolescent Services are reported separately from 2016.

2.2.3. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic Adult referrals for 2018 was 60% female to 40% male.

2.2.4. Dean Clinic Referrals by Reason for Referral

The chart below documents the Common Mental Health Problems that people were referred for to the Dean Clinics throughout 2018 and shows Depression, Anxiety, Mood Disorders and Eating Disorders as the most common reasons for referral.



2.2.5. Dean Clinic Activities (2010-2018)

The following table summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2010. Not all referrals resulted in an assessment, there are several reasons for this. In some cases, a decision is made not to progress with an assessment as the service user is already under the care of another service. Others do not attend their appointments and other service users have a more immediate need and are assessed for possible urgent admission to inpatient care. In 2018 62.7% of referrals were assessed in comparison to 58.7% in 2017 – the increase of 4% of referrals assessed despite the 16% decrease in referrals is a direct result of an improved assessment process of referrals sent to the Dean clinics.

Year	No. of Referrals	No. of Assessments
2010	692	573
2011	1376	924
2012	1759	1,398
2013	1889	1,422*
2014	2047	1,287*
2015	2236	1,461*
2016	2068**	1,204**
2017	1923**	1,128**
2018	1615**	1012**

* From 2013 onwards, New Assessments include Assessments carried out by Associate Dean Consultant Psychiatrists.
** Excludes Adolescent Assessments from 2016, now reported separately.

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

The following table summarises the total number of outpatient appointments or visits provided across Dean Clinics nationwide from 2010 to 2018.
Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager II Reviews, Clinical Nurse Specialist reviews, Nurse Reviews, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology and Psychotherapy. There was an 11% increase in Dean Clinic appointments attended in 2018.

Year	Total No of Dean Clinic Appointments
2010	5,220
2011	7,952
2012	12,177
2013	12,826*
2014	13,541*
2015	16,142*
2016	15,017**
2017	14,465**
2018	15,801**

*Includes Associate Dean Assessment and Adolescent appointments from 2013
** Excludes Adolescent Appointments from 2016, now reported separately.

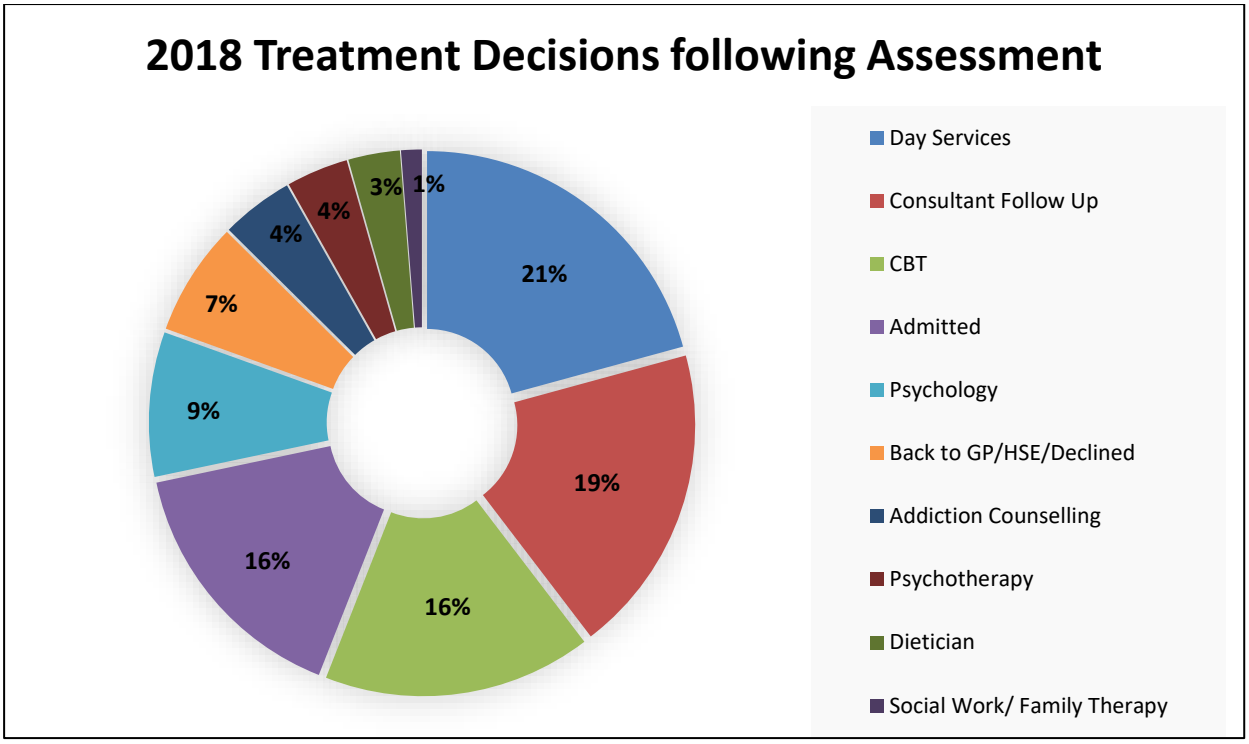
The table below summarises the number of first time inpatient admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2018.

Year	First Admission
2011	150
2012	180
2013	225
2014	202
2015	235
2016	132*
2017	182*
2018	184*

*Excludes Adolescent Admissions from 2016

2.2.6 Dean Clinic: Outcome of Assessments

The two charts below summarise and compare the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics for 2017 and 2018.



Adolescent Dean Clinic Services

2.2.7 Adolescent Dean Clinic Referral Volume

The Adolescent Dean Clinics are based in Dublin and Cork. In 2018, there were a total of 606 referrals received for the Adolescent Service - a slight reduction of 1.3% from 2017. The introduction of the centralised Adolescent Prompt Assessment of Needs (PAON's) in 2018 streamlined referral management. 200 Adolescent PAON's were performed in 2018.

2.2.8 Dean Clinics Referral Source by Province

The following table illustrates the geographical spread of Adolescent Dean Clinic Referrals by Province from 2016. The highest referral volume is from Leinster.

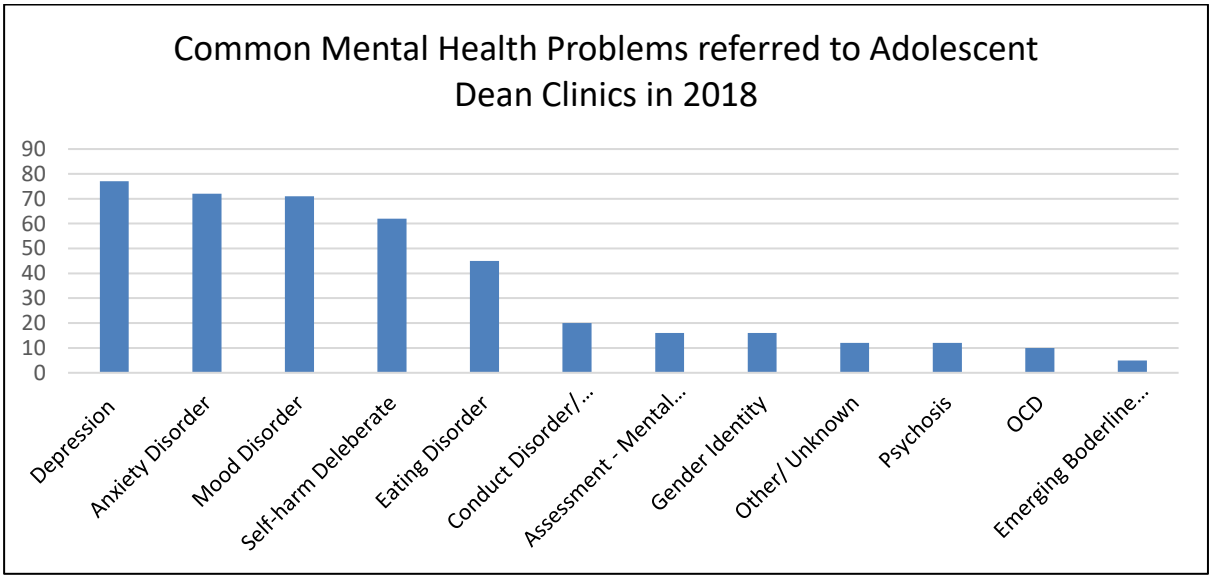
Year	Leinster	Munster	Connaught	Ulster	Other
2016	311	231	39	8	4
2017	343	232	23	16	0
2018	358	143	20	14	0

2.2.9 Dean Clinic Referrals by Gender

The Gender ratio of Dean Clinic Adolescent referrals for 2018 was 64% female to 36% male.

2.2.10 Common Mental Health Problems referred to Adolescent Dean Clinics

The chart below documents a sample of the Common Mental Health Problems referred to the Adolescent Dean Clinics throughout 2018. Depression, Anxiety Disorders, Mood Disorders and Deliberate Self -harm were the primary reasons for referral.



2.2.11 Dean Clinic Activities

The table below summarises the number of Adolescent referrals and mental health assessments provided across the Adolescent Dean Clinics in 2018. Not all referrals result in an assessment due to: service user already under the care of another service; non-attendance of assessment appointments; decline of the assessment offered and / or may be referred for an admission assessment. In addition, service users may have been referred to several services and opted to take a local service. Parental consent is required prior to Adolescent assessments taking place.

Year	No. Of Referrals	No. Of Assessments
2016	593	201
2017	614	106
2018	606	130

The 18.5% increase in the Adolescent Dean Clinic assessments is attributed to additional clinical resources being made available and the positive impact the PAON's had on the referral screening process. The mental health assessment involves a comprehensive evaluation of the young persons' mental state carried out by members of the multidisciplinary team. An individual care plan is agreed with the referred young person and family following assessment. This may involve follow-on community-based therapy, a referral to a day-patient programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the young person to make a full recovery through the most appropriate treatment and care. The adolescent team provide family psycho-education to assist families in supporting the adolescents' recovery.

The 2018 total number of Adolescent Dean clinic appointments provided by the Adolescent Dean Clinics nationwide – summarized in the table below - demonstrates an increase of 19.6%. This noticeable increase is attributed to the improved clinic structures enabled by the electronic eSwift clinic booking system and additional clinical resources being made available.

Appointments include Assessments, Consultant Reviews, Clinical Nurse Manager Reviews, Nurse Practitioner appointments, Medication Reviews, Cognitive Behavioural Therapy, Occupational Therapy, Social Work, Psychology, Psychotherapy, Dietician service.

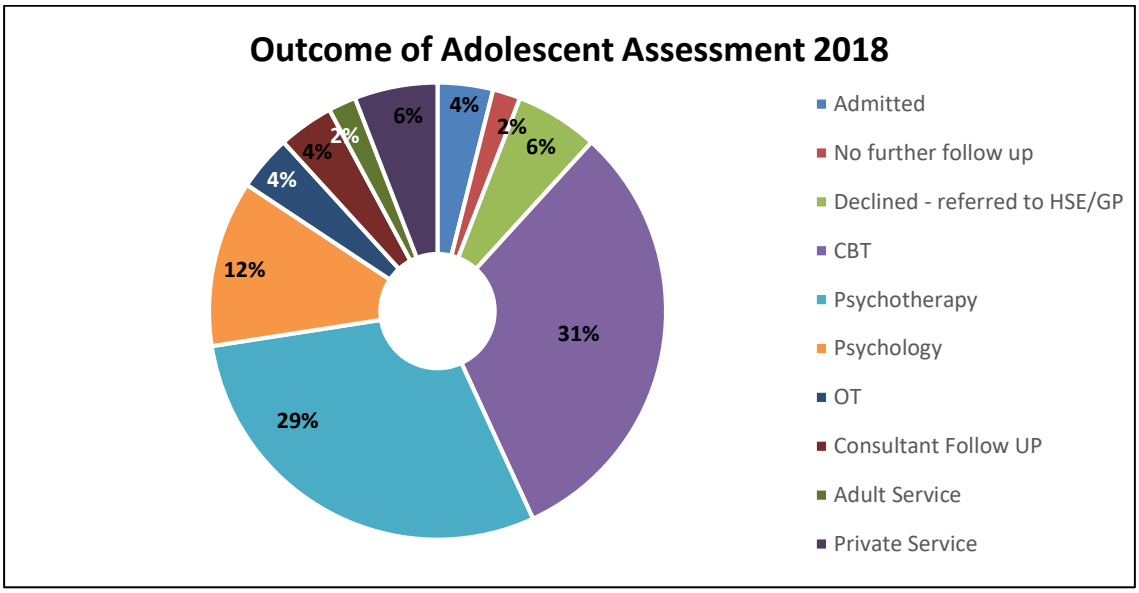
Year	Total No. Of Dean Clinic Adolescent Appointments
2016	1,944
2017	1,658
2018	1,983

The total number of admissions to Willow Grove Adolescent Unit in 2017 was 85. The total number of admissions to Willow Grove Adolescent Unit in 2018 was 81. The table below summarises the number of first time inpatient admissions to Willow Grove following an Adolescent Dean Clinic assessment from 2016.

Year	First Admission
2016	68
2017	76
2018	76

2.2.12 Dean Clinic: Outcome of Assessments

The chart below summarises the treatment decisions recorded from a sample of individual care plans following initial assessment in Adolescent Dean Clinics in 2018.



2.3. SPMHS's Inpatient Care

SPMHS comprises of 3 separate approved centres; St Patrick's University Hospital (SPUH) with 241 inpatients beds, St Edmundsbury Hospital (SEH) with 52 inpatient beds, and Willow Grove Adolescent Unit (WGAU) with 14 inpatient beds. In 2018, there were a total of 3,041 inpatient admissions across the organisation's 3 approved centres (2,953 adult admissions and 88 adolescent admissions), compared to a total of 2,934 for 2017.

2.3.1. SPMHS Inpatient Admission Rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the 3 SPMHS approved centres; SPUH, SEH and WGAU for 2018.

The following table shows inpatient admission numbers and the percentage rates for Male and Female admissions. In 2018, 61.9% of admissions across all 3 Approved Centres were female, compared to 60.6% in 2017 and 62.4% in 2016.

No. of Admissions (% of Admissions) 2018				
	SEH	**SPUH**	**WGAU**	**Total**
Female	368 (69.8%)	1457 (60.1%)	56 (63.6%)	1881 (61.9%)
Male	159 (30.2%)	969 (39.9%)	32 (36.4%)	1,160 (38.1%)
Total	**527 (100%)**	**2,426 (100%)**	**88 (100%)**	**3,041 (100%)**

The table below shows the average age of service users admitted across the 3 Approved centres was 49.14 years in 2018. This compares to a figure of 48.58 years in 2017. The average age of adolescents admitted to WGAU was 16.17 years in 2018 as compared with 15.49 years in 2017. The average age of adults admitted to SEH was 55.36 years in 2018 & 55.51 years in 2017. Finally, the average age of adults admitted to SPUH was 49.66 years in 2018 compared with 49 years in 2017.

Average Age at Admission 2017					
	SEH	SPUH	Total Adult	WGAU	Total
Female	55.84	50.75	51.65	16.07	50.13
Male	54.33	48.10	48.88	16.34	47.62
Total	55.36	49.66	50.55	16.17	49.14

2.3.2. SPMHS Inpatient Length of Stay 2018

The following Tables present the 2018 average length of stay (LOS) for adult inpatients (18 years of age and over) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis and presentation of inpatient length of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2018 Adults	Number of Discharges	Percentage
Under 1 week	529	18%
1 -<2 weeks	295	10%
2-<4 weeks	529	18%
4-<5 weeks	314	11%
5-<6 weeks	311	11%
6-<7 weeks	254	9%
7-<8 weeks	204	7%
8-<9 weeks	170	6%
9-<10 weeks	36	1%
10-<11 weeks	63	2%
11 weeks -< 3 months	101	3%
3-<6 months	129	4%
6 + months	5	0.2%
Total Number of Adult Discharges 2018	2940	100.00%

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

2018 WG	Number of Discharges	Percentage
Under 1 week	3	3%
1 -<2 weeks	4	5%
2-<4 weeks	10	11%
4-<5 weeks	8	9%
5-<6 weeks	6	7%
6-<7 weeks	16	18%
7-<8 weeks	9	10%
8-<9 weeks	8	9%
9-<10 weeks	8	9%
10-<11 weeks	1	1%
11-<12 weeks	1	1%
3-<6 months	13	15%
Total Number of Adolescent Discharges 2018	87	100%

2.3.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpatients discharged in 2018)

The following table outlines the prevalence of diagnoses across SPMHS 3 Approved Centres during 2018 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded on admission and at the point of discharge are presented for all 3 of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Edmundsbury Hospital combined. The data presented is based on all inpatients discharged from SPMHS in 2018.

SPMHS Analysis of Inpatient Primary ICD Diagnoses

(For all inpatients discharged in 2018)

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

ICD Codes: Admission & Discharge **For All Service Users Discharged in 2018**	SPUH Admissions		SPUH Discharges		SEH Admissions		SEH Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	42	1.7	48	2.0	5	0.9	6	1.1	47	1.6	54	1.8	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	424	17.6	436	18.1	27	5.1	23	4.4	451	15.3	459	15.6	0	0.0	0	0.0
F20-F29 Schizophrenia, schizotypal and delusional disorders	191	7.9	195	8.1	24	4.5	23	4.4	215	7.3	218	7.4	3	3.4	3	3.4
F30-F39 Mood [affective] disorders	1185	49.1	1160	48.1	341	64.6	330	62.5	1526	51.9	1490	50.7	43	49.4	37	42.5
F40-F48 Neurotic, stress-related and somatoform disorders	305	12.6	300	12.4	108	20.5	119	22.5	413	14.0	419	14.3	16	18.4	19	21.8
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	84	3.5	83	3.4	2	0.4	1	0.2	86	2.9	84	2.9	17	19.5	16	18.4
F60-F69 Disorders of adult personality and behaviour	172	7.1	183	7.6	21	4.0	25	4.7	193	6.6	208	7.1	0	0.0	1	1.1
F70-F79 Mental retardation	0	0.0	1.0	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	0	0.0
F80-F89 Disorders of psychological development	4	0.2	3	0.1	0	0.0	1	0.2	4	0.1	4	0.1	2	2.3	3	3.4
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	3	0.1	2	0.1	0	0.0	0	0.0	3	0.1	2	0.1	6	6.9	8	9.2
F99-F99 Unspecified	2	0.1	1	0.0	0	0.0	0	0.0	2	0.1	1	0.0	0	0.0	0	0.0
Totals	2412	100	2412	100	528	100	528	100	2940	100	2940	100	87	100	87	100

2.4 SPMHS's Day-patient: Wellness & Recovery Centre

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

1. Anxiety Programmes
2. Bipolar Disorder Programmes
3. Depression Programme
4. Addictions Programme
5. Eating Disorders Programme
6. Mental Health Support Programme (Pathways to Wellness)
7. Recovery Programme
8. Young Adult Programme
9. Psychosis Recovery Programme
10. Living Through Distress Programme
11. Radical Openness Programme
12. Compassion Focused Therapy
13. Living Through Psychosis
14. Mindfulness Based Stress Reduction
15. Psychology Skills Older Adults (SAGE)
16. Psychology Skills Adolescents
17. Compassion Focused Therapy for eating Disorders
18. Schema Group Therapy
19. Access to Recovery

The table below in section 2.4.1 provides information on the types of services accessed by service users. In 2018, the WRC received a total of 2,296 referrals compared to a total of 2,096 for 2017, a year on year increase of 9.5%. Of the day programme referrals for 2018, 465 were received from Dean Clinics. This compares to a total of 460 day-programme referrals received from Dean Clinics in 2017.

2.4.1. Day-Patient Referrals by Clinical Programme

The following table compares the total number of day programme referrals to each clinical programme for 2017 and 2018. In addition, day programme referrals received from the Dean Clinics are presented.

SPMHS Day Programmes	Total Day Patient Referrals from Dean Clinics 2017	Total Day Patient Referrals from Dean Clinics 2018	Total Day Patient Referrals 2017	Total Day Patient Referrals 2018
St.Edmundsbury Day Services: Acceptance & Commitment Therapy, Mood Management, Roles in Transition, Radical Openness	82	123	354	369
Depression Programme	47	30	272	178
Recovery Programme	32	23	200	142
Anxiety Programme	89	89	194	223
Access to Recovery	32	80	160	223
Alcohol Stepdown	0	0	139	286
Compassion Focused Therapy	25	19	118	135
Living Through Distress	17	14	104	154
Radical Openness	14	9	84	121
Mindfulness	36	0	78	0
Pathways to Wellness	7	11	74	100
Psychology Skills for Older Adults	13	5	62	62
Living Through Psychosis	7	13	61	45
Eating Disorder Programme	13	7	60	23
Bipolar Programme	24	10	49	78
CFT Eating Disorders	10	18	35	59
Schema Therapy	1	1	17	17
Psychology Skills for Adolescents	9	8	12	12
Young Adult Programme	1	3	12	49
Driving Assessments	0	0	8	4
Psychosis Programme	1	0	3	0
Total	**460**	**465**	**2096**	**2296**

2.4.2. Day-patient Referrals by Gender

Of all referrals to day services in 2018, 1,525 (66.42%) were female and 772 (33.58%) were male. This compares to 1,317 (62.8%) female and 779 (37.2%) male in 2017. These gender ratios were comparable with inpatient admission gender ratios, in 2017 and 2018.

2.4.3 Day-patient Referrals from Dean Clinics

In 2018 a total of 465 day-patient referrals were received from Dean Clinics representing 20% of the total referrals to Day Programmes.
In 2017, a total of 460 day-patient referrals were made from Dean Clinics, representing 22% of the total referrals to Day Programmes.

2.4.4. Day-patient Attendances for Clinical Programmes 2017-2018

In 2018, of the 2,296 referrals to a day programme, 1,375 day-patients commenced day programmes. This compares to 2096 referrals and 1,329 commencing a programme, in 2017. These registrations represented a total of 15,638 (2018) and 14,150 (2017) half day attendances respectively. Therefore in 2017 each registered day service user attended on average 10.64 half days while in 2018 each registered day service user attended on average 11.37 half days.

Not all service users referred to Day Programmes commence a programme. This is due to a variety of reasons including; personal circumstances (work, family, travel) or the programme that the service user was referred to was established as not clinically appropriate following assessment by the programme clinicians. Similarly, Service Users occasionally withdraw from programmes after commencement due to; relapse of Mental Health difficulties, inpatient admission, personal circumstances (work, family, travel) or not feeling the programme meets their needs or expectations.

Day Patient Attendances at Clinical Programmes

SPMHS Day Programmes	Total Day Patient Registrations 2017	Total Day Patient Registrations 2018	Total Day Patient Attendances 2017	Total Day Patient Attendances 2018
Depression Programme	137	126	1616	1516
Access to Recovery	124	96	1558	1563
Eating Disorder	48	32	1290	1566
Recovery Programme	79	97	1135	1450
Anxiety Programme	86	116	1032	1287
Alcohol Stepdown	141	168	1030	1242
Radical Openness	73	42	922	771
Living Through Distress	64	92	769	1348
Pathways to Wellness	43	68	742	1174
Acceptance Commitment Therapy	130	187	660	822
Compassion Focus Therapy	41	44	458	778
Psychology Skills Older Adults (Sage)	30	35	346	303
Schema Therapy	15	20	335	228
CFT Eating Disorders	22	16	307	300
Living Through Psychosis	44	42	291	200
Mindfulness St Patricks	36	0	280	0
Mindfulness St Eds	45	40	233	277
Healthy Self Esteem	24	24	230	144
Bipolar Programme	39	65	185	238
Psychology Skills Adolescents	11	12	173	168
Radical Openness St Eds	12	10	142	103
Mood Management	26	6	116	26
Roles in Transition	28	27	90	85
Young Adult programme	3	3	34	34
Psychosis Programme	7	3	29	11
Driving Assessments	5	4	7	4
	1329	**1375**	**14150**	**15638**

SECTION 3

Clinical Governance

3. Clinical Governance & Quality Management

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

The following table provides a summary of key clinical governance measures, between 2013 and 2018.

3.1 Clinical Governance Measures Summary

Governance Measure	2013	2014	2015	2016	2017	2018
Clinical Audits	19	10	16	26	20	16
Number of Complaints Total including all complaints, comments, and suggestions received and processed throughout the entire year.	635	627	666	860	818	782
Number of Incidents An event or circumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	2098	2227	2423	2601	2594	2352
Root Cause Analyses & Focused Reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	6	11	9	3	8	4
Number of Section 23's – Involuntary detention of a voluntary service user A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the Approved Centre (SPUH) - where the person indicates an intention to discharge from the Approved Centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	107	107	92	84	73	63
% Section 23's which progress to Involuntary admission (Section 24 - Form 13 Admissions) Following Section 23 an examination by the Responsible Consultant Psychiatrist and a second Consultant Psychiatrist the person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	37 % (40)	43% (46)	44% (41)	48% (41)	47% (34)	62% (39)
Number of Section 14's – Involuntary Admissions An involuntary admission that occurs as a result of an application from a spouse or relative, a member of An Garda Síochána, an Authorised Officer or a member of the public and a recommendation from a GP (the person is admitted as involuntary). A person subject to such an admission may decide to remain voluntarily.	46	52	39	60	61	77
% of Section 14's which progress to Involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	76% (35)	80% (42)	87% (34)	88% (53)	90% (55)	91% (70)
Number of Section 20/21 - Transfers Where an involuntary patient is transferred to an approved centre under *Section 20 or 21* of the Mental Health Act 2001, the clinical director of the centre from which he or she has been transferred shall, as soon as possible, give notice in writing of the transfer to the MHC on Statutory Form 10.	21	13	19	18	47	15
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	33	37	18	15	20	51
Number of Section 60 – Medication Reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of 3 months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	15	11	10	4	12	18
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.	6	2	2	0	3	6
Number of Tribunals held	96	91	63	72	86	104
Mental Health Commission Reporting – Number of ECT Programme's (Signed off) in 2018	129	143	103	142	132	166
Mental Health Commission Reporting – Number of Physical Restraint Episodes (SPUH + WGAU)	219	129	178	174	204	151

3.2. Clinical Audits

This section summarises briefly the clinical audit activity for St. Patrick's Mental Health Services in 2018. Clinical audit is an integral part of clinical governance. Its main purpose is to improve the quality of care provided to service users and the resulting outcomes. The clinical audit process is a cycle which involves measurement of the quality of care and services against agreed and proven standards for high quality and taking action to bring practice in line with these standards. A complete clinical audit cycle involves re-measurement of previously audited practice to confirm improvements and make further improvements if needed.

3.2.1. Overview of Clinical Audit Activity

The following table demonstrates the breakdown of projects by type undertaken in 2018 including those facilitated by clinical staff at local level and those carried out throughout the organization led by various committees.

No.	Audit Title	Audit Lead	Status at year end
1.	**The Clinical Global Impression (CGI) and Children's Global assessment Scale (CGAS) level of change of change pre and post inpatient treatment** To measure the CGI /CGAS outcomes for service users pre and post admission.	Clinical Governance Committee	Yearly audit completed
2.	**Individual Care Plan Key Worker System** To ensure the highest quality of care coordination through ensuring compliance with the Mental Health Commission standards and local policies at St. Patrick's University Hospital, St. Edmundsbury Hospital and Willow Grove Adolescent Unit.	Clinical Governance Committee	Routine quarterly audits completed
3.	**Audits of compliance with the Regulations for approved centres** To ensure the highest quality of clinical governance through ensuring compliance with the Mental Health Commission guidelines and rules of practice.	Departmental Audits	Baseline audits and re-audits completed in 2018.
4.	**ECT Processes** To assess consistency and appropriateness of the ECT documentation in accordance with the MHC guidelines.	Clinical Governance Committee	Re-audit completed in 2018.
5.	**Adherence to the organisations protocol on falls risk prevention interventions** To ensure that service users identified as medium or high risk of fall or with fall episode are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Re-audit completed.
6.	**Infection Control Audits** These audits measure the implementation of policies and procedures relating to infection control.	Infection Control Committee	These are yearly routine audits. Audits scheduled for 2018 were completed.
7.	**Nursing Metrics:** To compare fundamental aspects of nursing practice with standards as outlined by NMBI, the MHC and best practice.	Nursing Department	This is a monthly routine audit.

No.	Audit Title	Audit Lead	Status at year end
8.	**Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from the NICE Guideline on Violence and aggression: short-term management in mental health, health and community settings - NICE NG10 (2015).	Clinical Governance Committee	Re-audit completed.
9.	**Prescribing valproate for bipolar disorder** To ensure that the Valproate prescribing practice in SPMHS is in line with the local policy and the conditions of the national pregnancy prevention programme designated to women of childbearing potential if prescribed Sodium Valproate.	Clinical Governance Committee	Baseline and re-audit completed
10.	**Use of Pregnancy Tests on Female Patients of Childbearing Potential on Admission to the General Adult and Eating Disorder Services of St. Patrick's University Hospital** To ensure that pregnancy tests are being carried out on adult patients on admission according to hospital policy, and to change practice where necessary to improve implementation of the policy.	Multidisciplinary Team	A full audit cycle completed
11.	**Social Work Screening Tool Assessment Audit** To ensure social work involvement directed towards improving parenting and ensuring child welfare in the context of mental illness.	Social Work Department	Re-audit completed
12.	**Medical assessment and monitoring of adolescent with anorexia nervosa** A medical monitoring protocol was initiated in Willow Grove in 2016 to ensure gold standard monitoring of young people on the AN programme. The objective of this re-audit is to monitor the current level of compliance.	Multidisciplinary Team	A full audit cycle completed

* The Prescribing Observatory for Mental Health (POMH-UK) runs national quality improvement programmes designed to the UK specialist mental health services

No.	Audit Title	Audit Lead	Status at year end
13.	**The early recognition of sepsis in a standalone psychiatric hospital** To ensure the accuracy of tympanic temperature measurement as part of the routine vital observations of inpatients in a psychiatric hospital against the normal accepted distribution of tympanic temperature values	Multidisciplinary Team	A full audit cycle completed
14.	**Assessment of completion of a detailed formulation (based on Padesky model and Beck's longitudinal model) upon service user's completion of step B of the Depression Programme** Review adherence to the gold standard guidelines outlined in the local policy which states that all teams whose SUs have completed the depression recovery service will have a report generated to include an initial formulation (based on the Padesky model) and a more detailed formulation (based on the Beck's longitudinal model) on completion of level B.	Multidisciplinary Team	Re-audit completed
15.	**Pre-lithium commencement therapy treatments checks** To ensure that Lithium therapy is efficacious and monitored effectively.	Multidisciplinary Team	Re-audit cycle completed.
16.	**Audit of Individual Care Planning** To ensure our current care planning process is effective and that the current standards of practice are in accordance with the Mental Health Act, 2001.	Multidisciplinary Team	A full audit cycle completed

3.2.2. Key Audit Outcomes for 2018

- A Clinical Audit Programme for audits of compliance with Regulations for approved centres is ongoing and all clinical and non-clinical Departments are actively involved. The 2018 MHC inspection process confirmed that SPMHS met all monitoring and audit requirements.

- Clinical audit activity among junior doctors remains high and it is facilitated by the Postgraduate Training Audit Committee. Ongoing training and support is provided to doctors in training. Completed audits were presented at the SPMHS audit prize competition and at national conferences also.

- A routine audit designed to assess level of Key Working and effective care planning in the three Approved Centres were conducted in 2018. The audit findings confirmed that good practice remained constant for that period. Ongoing quality improvement work is being undertaken to further strengthen key-working and care planning processes.

- SPMHS took part in the POMH-UK rapid tranquillisation re-audit that looked at prescribing patterns for the management of an episode of acutely-disturbed behaviour.

- Sodium Valproate is a widely-used mood stabilising medication and one of a number of medications that are associated with serious teratogenic effects. Analysis of data collected on the use of Sodium Valproate in SPMHS showed that a small number of female in-patients of child-bearing potential were prescribed this drug. SPMHS are committed to ensure safety in cases where a woman of child bearing potential is prescribed a medication with teratogenic effect. For this reason and to improve continuous monitoring, a protocol for pregnancy testing on admission was introduced in December 2017 and updated in August 2018 to include pregnancy testing in line with national pregnancy guidelines.

SECTION 4

Clinical Outcomes

4. Clinical Outcomes

Clinical outcome measurement has been in place in St Patrick's Mental Health Services since 2011 and is a priority for the service, embedded within clinical practice. The processes which underpin clinical outcome measurement continue to be refined and informed by the realities and challenges of clinical practice. In 2018 outcome measurement expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing evolution towards an organisational culture that recognises the value of integrated outcome measurement in informing practice and service development. A strong desire among all our clinicians for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important Considerations for Interpretation of Outcomes.

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

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

out to be statistically significant e.g. small changes on a depression measure can be statistically significant, but not clinically or practically meaningful.

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

  > 0.3 is considered a "small" effect
  > 0.5 a "medium" effect
  > 0.8 and upwards a "large" effect.

As Cohen indicated '**The terms 'small,' 'medium' and 'large'** are relative, not only to each other, but to the area of behavioural science or even more particularly to the specific content and research method being employed in any given investigation. In the face of this relativity, there is a certain risk inherent in offering conventional operational definitions for these terms for use in power analysis in as diverse a field of inquiry as behavioural science. This risk is nevertheless accepted in the belief that more is to be gained than lost by supplying a common conventional frame of reference which is recommended for use only when no better basis for estimating the ES index is available." (p. 25) (Cohen, 1988).

- **Clinical significance** refers to whether or not a treatment was effective enough to change whether or not a patient met the criteria for a clinical diagnosis at the end of treatment. It is possible for a treatment to produce

a significant difference and medium to large effect sizes but not to demonstrate a positive change in the service user's level of functioning.

4.2. Clinical Global Impression and Children's Global Impression Scales: Outcomes for Inpatient Care 2018

4.2.1. Objective

The objective is to measure the efficacy of inpatient treatment, by comparing the severity of illness scores completed at the point of inpatient admission and the final score prior to discharge. These scores are completed by clinicians using the Clinical Global Impressions (CGI) in case of adults and the Clinical Global Assessment Scale in the case of adolescents.

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

4.2.1.1. Background

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

The CGIS asks a clinician the question: "Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?" which is rated on the following seven-point scale: 1=normal, not at

all ill; 2=borderline mentally ill; 3=mildly ill; 4=moderately ill; 5=markedly ill; 6=severely ill; 7=among the most extremely ill patients.

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

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

4.2.1.2. Data Collection Strategy

This report used data extracted from the Health Electronic Record (eSwift) which provided details on the St. Patrick's University Hospital (SPUH) and l Edmundsbury Hospital (SEH) Hospital admissions and admissions to the Willow Grove Adolescent Unit (WGAU).

A random sample was chosen from admissions to SPUH and SEH. The chosen sample size was minimum of 320 cases. Then the cases were randomly selected by employing stratified and quasi random sampling strategies. This ensured appropriate representation of cases for each ward within the services.

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

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

- Service user age and gender,
- Admission ICD code (primary and additional),
- Date of admission,
- Admission ward,
- Re-admission rate,

- Date of discharge,
- Baseline assessment scale score (CGIS or CGAS respectively)– recorded on the Individual Care Plan on or before the first MDT meeting,
- Date recorded against the baseline score,
- Final assessment scale score (CGIC or CGAS respectively)– recorded on the MDT meeting care plan review document,
- Date recorded against the final score.

4.2.2. Sample Description

		TOTAL ADULT SERVICE	WGAU
Sample size		321	78
Admissions	1st admission	30%	87%
	Re-admission	70%	13%
Average age ± standard deviation		52±17	16±1
Gender breakdown	Female	61%	60%
	Male	39%	40%

4.2.2.1. ICD-10 Admission Diagnosis Breakdown

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

		TOTAL ADULT SERVICE			WGAU		
ICD-10 Admission Diagnosis Category		**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
F30-F39	Mood disorders	53%	58%	50%	39%	39%	33%
F40-F48	Neurotic, stress-related and somatoform disorders	15%	13%	13%	24%	21%	18%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	17%	14%	17%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	7%	8%	5%	1%	1%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	2%	1%	4%	26%	30%	21%
F00-F09	Organic, including symptomatic, mental disorders	0%	1%	2%	1%	0%	0%
F60-F69	Disorders of adult personality and behaviour	4%	5%	7%	1%	4%	1%
F80-F89	Disorders of psychological development	0%	0.3%	0.3%	0%	2%	4%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	0%	3%	2%	22%

4.2.3. Breakdown of Baseline and Final Assessment Scale Scores

Table: *Total adult service*

CGIS - Baseline measure of severity of illness		2016	2017	2018
		TOTAL	TOTAL	TOTAL
1	Normal, not at all ill	0%	0%	0%
2	Borderline mentally ill	0%	1%	1%
3	Mildly ill	10%	9%	9%
4	Moderately ill	30%	40%	43%
5	Markedly ill	30%	32%	27%
6	Severely ill	15%	9%	9%
7	Extremely ill	2%	1%	1%
	Not scored	13%	8%	9%

Table: *Total adult service*

CGIC – Final Global improvement or change score		2016	2017	2018
		Total	Total	Total
1	Very Much improved	13%	15%	8%
2	Much Improved	37%	45%	42%
3	Minimally Improved	15%	15%	19%
4	No Change	5%	5%	7%
5	Minimally Worse	0%	0%	1%
6	Much Worse	0%	0%	0%
7	Very Much Worse	0%	0%	0%
	Not scored	31%	20%	24%

Table: *Willow Grove Adolescent Unit*

Children's Global Assessment Scale		2016		2017		2018	
		Baseline	Final	Baseline	Final	Baseline	Final
100-91	Superior functioning	0%	0%	0%	0%	0%	0%
90-81	Good functioning	0%	0%	0%	0%	0%	0%
80-71	No more than a slight impairment in functioning	0%	0%	0%	0%	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	45%	0%	26%	0%	21%
60-51	Variable functioning with sporadic difficulties	24%	38%	7%	68%	0%	62%
50-41	Moderate degree of interference in functioning	61%	8%	56%	2%	41%	13%
40-31	Major impairment to functioning in several areas	12%	4%	36%	2%	46%	3%
30-21	Unable to function in almost all areas	4%	0%	1%	1%	13%	0%
20-11	Needs considerable supervision	0%	0%	0%	0%	0%	0%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	0%	5%	0%	0%	0%	3%
Mean ±SD		45±7	59±7	41±6	57±6	38±6	56±6
Median		45	59	42	58	39	58
Wilcoxon Signed Ranks Test:		Z=-5.485, p<.001		Z=-7.841, p<.001		Z=-7.525, p<.001	

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

4.2.4.1. Clinical Audit Standards

Audit Standard No. 1: Baseline score is taken within at least 7 days following admission;

Exception: Short admission;

Target level of performance: 100%.

Audit Standard No. 2: Final score is taken within at least 7 days prior to discharge;

Exception: Short admission, unplanned discharge;

Target level of performance: 100%

4.2.4.2. Results

	TOTAL ADULT SERVICE			WGAU		
	2016	2017	2018	2016	2017	2018
Baseline Assessment Scale Score						
% of admission notes with recorded baseline scores	87%	92%	91%	100%	100%	100%
% compliance with clinical audit standard No. 1	84%	85%	87%	99%	100%	100%
Final Assessment Scale Score						
% of admission notes with recorded final scores	69%	80%	76%	95%	100%	100%
% compliance with clinical audit standard No. 2	83%	85%	86%	95%	100%	100%

4.2.5. Summary of Findings

1. A sample was chosen out of a dataset of St. Patrick's Mental Health Services discharges for 2018.

2. A female to male ratio was 1.6:1 for adults and WGAU 1.5:1 for adolescents. There were 7% increase in the percentage of male young people receiving care in WGAU in comparison to the 2017 data.

3. Among the adults, there was a 9% decrease in the percentage of service users who were admitted for the first time, in comparison to 2017. In the 2018 sample, 1st admissions accounted for 30% of adult service users. An increase was observed in the percentage of service users who were admitted for the

first time in 2016 and 2017. In 2018 this percentage was the same as reported in 2015.

4. 2018 analysis of the primary ICD-10 codes showed for the adults' population the most frequent reasons for admission were mood disorders followed by behavioural disorders due to psychoactive substance use and neurotic, stress related, somatoform disorders.

5. In 2018 43% of SPUH and SEH service users were moderately ill. Another 27% were markedly ill. 9% were severely ill. 1% of service users was extremely ill on admission. The breakdown of baseline clinical global improvement scores on admission shows no major changes in the levels of severity of illness on admission in comparison to 2017 data.

6. Based on a sample of 245 (total cases with discharge CGI score documented) 91% of the sample were rated with an overall improvement (1 - very much improved (11%), 2 - much improved (56%) and 3 - minimally improved (24%)). This percentage of sample rated with an overall improvement is 3% lower than the one observed between 2014 and 2017. There was 8% decrease of service users who very much improved following the in-patient treatment and 6% increase in the percentage of service users who minimally improved.

7. 2018 analysis of the primary ICD-10 codes showed that for the adolescent population the most frequent reasons for admission were mood disorders. There was an increase from 2% to 22% of adolescent with admission diagnosis of behavioural and emotional disorders (F90-F98).

8. There was a substantial increase in the percentage of service users who were severely ill on admission in comparison to 2017 data. In 2018 46% of Willow Grove Adolescent Unit service users were scored as having a major degree of impairment in functioning on admission and another 13% was unable to function.

9. The overall improvement rate for Willow Grove Adolescent Unit was 96%. One adolescent had same level of functioning and no one dis-improved following in-patient care.

10. The audit shows no major changes in recording the baseline and final assessment scales scores in adult and adolescent population. The Willow Grove Adolescent Unit remains fully compliant with the standards.

4.3. Acceptance & Commitment Therapy Programme

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

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

4.3.1. Descriptors

In 2018, data were available for a sample of 81 participants. Both pre and post measures were available for 56 of those completing the programme, representing 69.13% of the sample.

4.3.2. ACT Outcome Measures

The following programme measures were used:

• Acceptance & Action Questionaire II

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

• Behavioural Activation for Depression Scale

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

• Five Facet Mindfulness Questionnaire

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

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

- **Work and Social Adjustment Scale**

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

- **The Self-Compassion Scale**

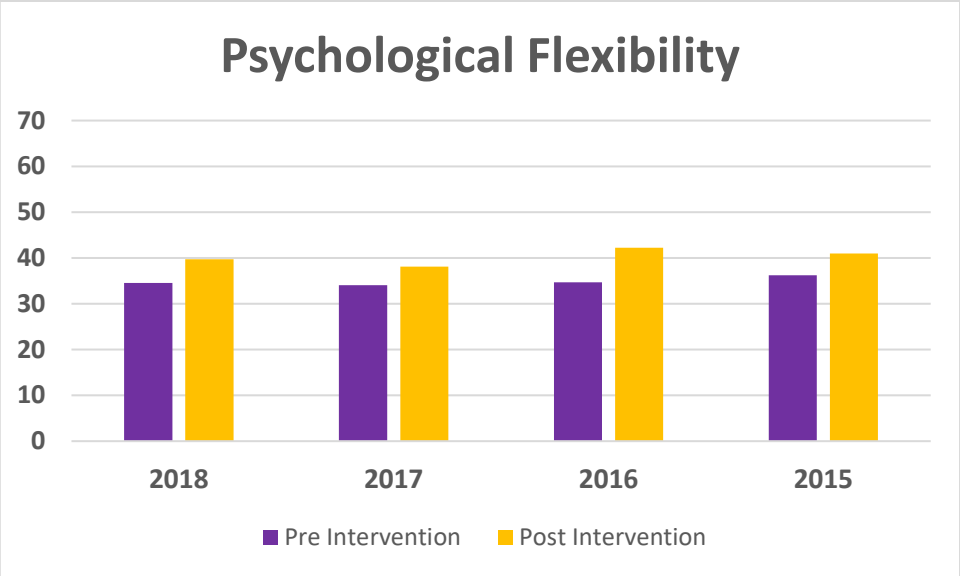
The Self-Compassion Scale (SCS) is a twenty-six item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-

Identification" with thoughts. Each item is rated on a 5-point Likert scale, from 1 Almost Never to 5 Almost Always.

4.3.3. Results

Acceptance & Action Questionnaire-II

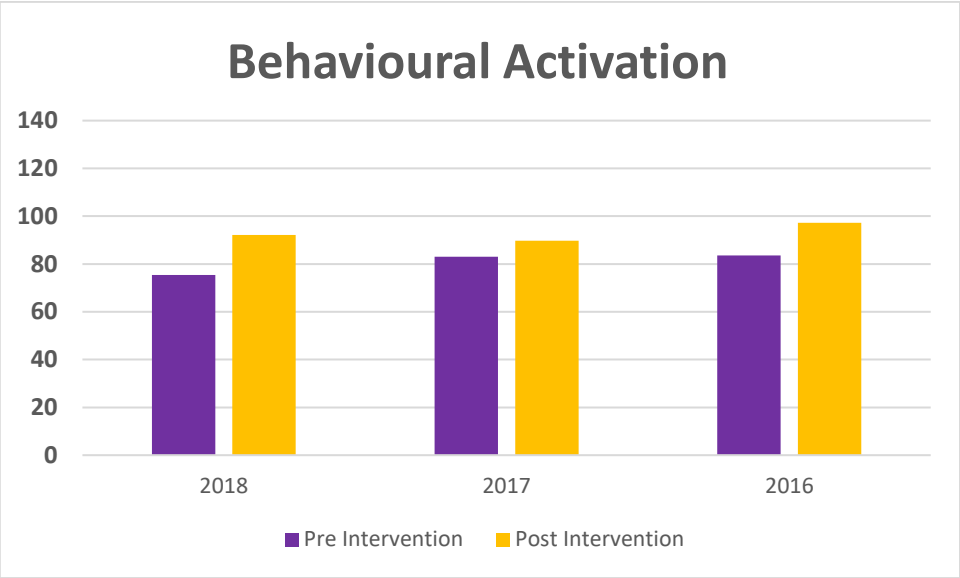
Graph: Psychological Flexibility as measured by the AAQ-II



Total scores on the AAQ-II showed a statistically significant increase, t (40) = 3.28, p < .002, which indicates greater psychological flexibility post programme. An effect size (*d)* of .48, indicates a small effect size. Pre and Post mean scores on the AAQ-II were similar to those reported in previous years.

Behavioural Activation for Depression Scale (BADS)

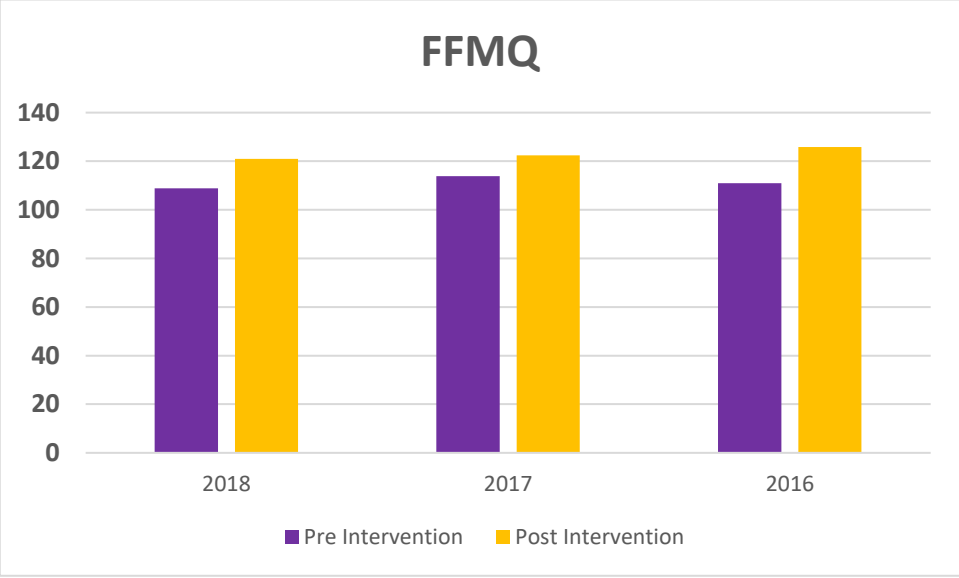
Graph: Behavioural Activation as measured by the BADS



Mean BADS scores increased significantly from (M = 75.4, SD =26.5) to (M = 92.1, SD = 28.1) indicating greater behavioural activation, t (55) = 4.38, p < .000, representing a medium effect size (d = 0.61). The percentage of those completing the programme with scores below 70 (the mean reported by Kanter et al. (2009) for a sample with elevated depressive symptoms) reduced from 46.42% to 19.64% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

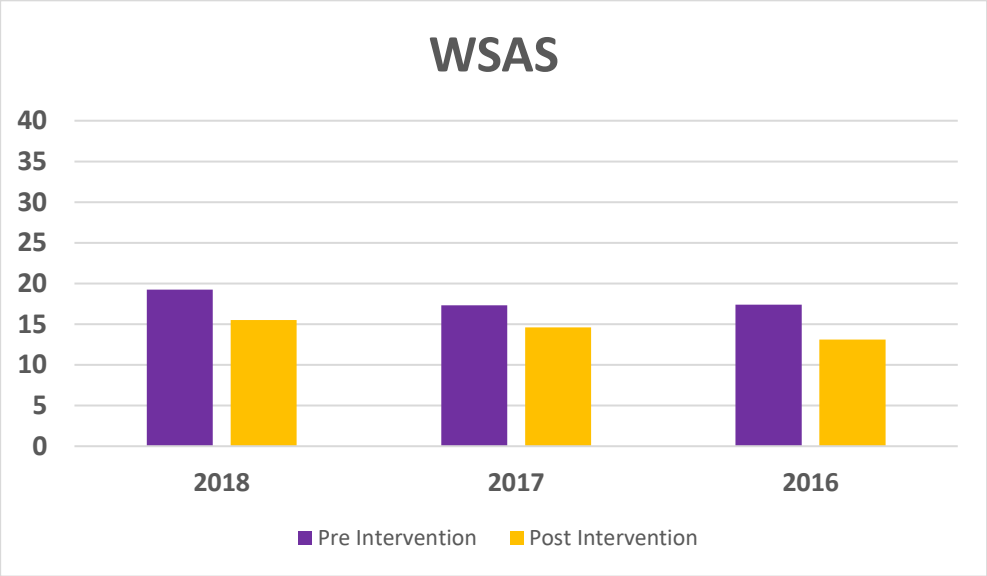
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (56) = 4.19, p < .000, from pre (M = 108.8, SD = 18.24) to post (M =121.0, SD = 23.36) indicating greater levels of overall mindfulness, with a medium effect size observed (Cohen's d =.58). Mindfulness is defined in this context as; observing, describing, acting with awareness, non-reactivity to inner experience, and non-judging of inner experience.

Work and Social Adjustment Scale (WSAS)

Graph: Total Work and Social Adjustment Scale Scores



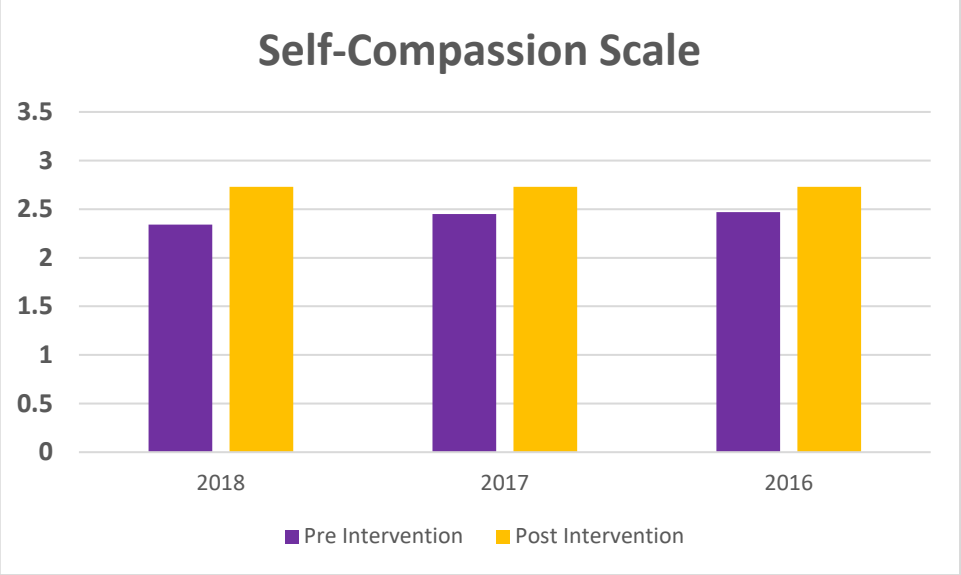
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (55) = 3.50, p <.001, from 19.23 (SD = 7.4) to 15.52 (SD =8.2), indicating less functional impairment. The effect size of Cohen's d =.47 indicates a small effect.

The scores on both pre and post means are within the range which indicates significant functional impairment, but post scores are closer to 10 (scores below which are associated with sub-clinical samples). In this sample 8.9% of those who completed the programme had scores below 10 when they started the programme, while 23.2%% had scores below 10 on completion of the programme.

These findings are in line with the 2017, 2016, and 2015 outcomes reports that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

Self-Compassion Scale

Graph: Total scores on Self-Compassion Scale



Total SCS scores increased significantly, t (55) = 3.98, $p < .000$, from pre (M = 2.34, SD = .6) to post (M = 2.73, SD = .7) indicating higher overall levels of self-compassion post intervention. A medium effect size was observed (Cohen's d = .59). Self-compassion is measured in six domains; Self-Kindness, Self-Judgement, Humanity, Isolation, Mindfulness and identification or "Over-Identification" with thoughts.

4.3.4. Summary

People who completed the programme showed significant gains in mindfulness, psychological flexibility/acceptance, behavioural activation and functioning as measured by the available psychometrics. Comparisons show consistent results across 2018, 2017, 2016 and 2015. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of mindfulness. This also allows for the potential comparison with published research.

4.4. Alcohol and Chemical Dependency Programme.

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

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

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

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

4.4.1. Alcohol and Chemical Dependency Programme Outcome Measures

• Leeds Dependency Questionnaire (LDQ)

The Leeds Dependence Questionnaire (LDQ; Raistrick et al., 1994) is a 10-item questionnaire, designed to screen psychological dependence to a variety of different substances. The LDQ was designed to be sensitive to change over time and to range from mild to severe dependence (Raistirck et al.,1994).

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence, the 10 items map on to the ICD-10 and DSM-IV criteria for substance dependence which include: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Kelly, Magill, Slaymaker & Kahler, 2010).

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

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

4.4.2. Descriptors

Data were collected for 87 participants. Of those that completed the programme, 43.7% of participants were male and 56.3% were female.

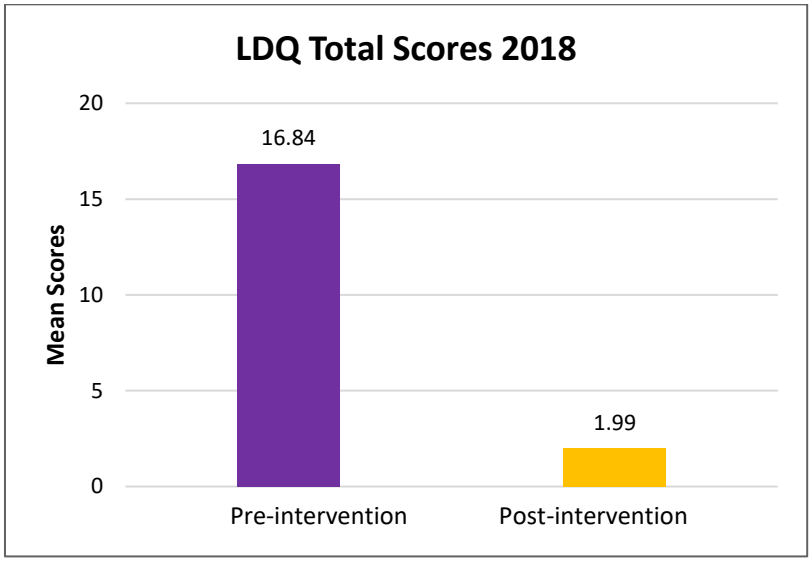
4.4.3 Results

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post programme participation. Following completion of the programme, a Wilcoxon Signed Rank Test

revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, z= -8.06, p<.001, with a large effect size (r= -.61). The mean score on the total LDQ scores decreased from pre-programme to post-programme, as depicted in the graph below.

Leeds Dependency Questionnaire (LDQ)

Graph: Total scores on Leeds Dependency Questionnaire



4.4.4 Summary

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

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

It is recognised that it can be challenging to collect psychometric data from individuals with substance use difficulties. According to Tober et al. (2000), service users with substance difficulties can find it difficult to commit to completing follow-up measures for many reasons including motivation, difficulties with attendance and convenience of appointment times given.

These results suggest that the introduction of the LDQ as a measure to evaluate this programme has been successful and will continue to be used as the primary outcome measure in 2019. Response rates have improved since post measures are being conducted as part of the discharge plan and it is hoped to improve them further as, anecdotally, it has been noted that there may be scope to identify those who relapse and return to the programme as these service users are not being represented in the data. Discussions around this will continue in 2019 with the aim of collecting data from these service users.

4.5. Anxiety Disorders Programme

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

The programme is structured into two levels. Level 1 is a 5-week programme and includes group-based psycho-education and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based therapy, through behaviour workshops, which aid experiential goal work, fine tune therapeutic goals and identify possible obstacles, in order to address an individual's specific anxiety difficulties (Anderson & Rees, 2007).

Service users with more complex clinical presentations of anxiety are referred to Level 2 of the programme, a closed group which builds on therapeutic work carried out during Level 1. Level 2 provides a structured 8-week programme which is also based on a CBT approach focusing on shifting core beliefs, emotional processing and regulation, and increased exposure work. Service users typically attend Level 2 following discharge from hospital as an inpatient.

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

4.5.1. Anxiety Programme Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2018. All service users attending the Anxiety Programme complete (or are rated on) the following measures, before starting the programme, after completing level one of the programme and again after completing level two (if they have attended this level).

- **Beck Anxiety Inventory**

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

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck, Steer, & Brown, 1996) is a 21-item questionnaire developed to measure the intensity, severity, and depth of depression symptoms in patients with psychiatric diagnoses. Individual questions on the BDI assess mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess physical symptoms. Scores range from 0 – 63, where higher scores indicate, increased depressive symptoms. Scores can be interpreted in four qualitative categories: minimal depression (0-9), mild depression (10-18), moderate depression (19-29) and severe depression (30-63).

- **Fear Questionnaire**

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

- **Yale Brown Obsessive Compulsive Scale**

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

Obsessions and compulsions are each assessed on a 5-point scale ranging from 0 "no symptoms" to 4 "severe symptoms" measuring the following: time spent engaging with obsessions and / or compulsions, the level of distress, the ability to resist and level of control over obsessions and compulsions. Scores are rated across five levels: Sub-clinical: 0 – 7; Mild: 8 – 14; Moderate: 16 – 23; Severe: 24 – 31; Extreme: 32 – 40. Taylor (1995, p. 289) states that: "When breadth of measurement, reliability, validity, and sensitivity to treatment effects are considered together, the YBOCS appears to be the best available measure for treatment outcome research".

- **Penn State Worry Questionnaire**

The Penn State Worry Questionnaire (PSWQ: Meyer, Miller, Metzger, & Borkovec, 1990) is designed to capture the generality, excessiveness, and

uncontrollability of pathological worry. The PSWQ allows clinicians to identify individuals with Generalised Anxiety Disorder (GAD) who present for treatment for anxiety disorders (Fresco et al, 2003).

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

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

The Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009), aims to measure service users' feelings of safety, warmth, acceptance, and belonging within their social world. The measure is a brief 11-item, 5-point Likert scale, with responses ranging from 0 'Almost never' to 4 'Almost all the time'. Previous research has suggested that this scale's psychometric reliability is good (alpha=.92; Gilbert et al., 2009). This instrument was administered at time points, pre and post level 2.

- **Social Phobia Inventory (SPIN)**

The Social Phobia Inventory (SPIN; Connors et al., 2000) is a 17-item questionnaire developed by the Psychiatry and Behavioural Sciences Department at Duke University**.** The Social Phobia Inventory (SPIN) provides a patient-rated assessment of the three clinically important symptom domains of social phobia (Fear, Avoidance and Physiological Symptoms), with the practical advantages of brevity, simplicity and ease of scoring. The SPIN demonstrates solid psychometric properties, can be used as a valid measure of severity of social phobia symptoms, and is sensitive to the reduction in symptoms over time.

- **The Agoraphobia Scale**

The Agoraphobia scale (Bandelow, 1995) consists of 20 items depicting various typical agoraphobic situations, which are rated for anxiety/discomfort (0-4)

and avoidance (0-2). The Agoraphobia Scale has high internal consistency. Regarding concurrent validity it correlates significantly with other self-reported measures of agoraphobia (Mobility Inventory and Fear Questionnaire). This instrument was administered at time points, pre and post level 1.

4.5.2. Descriptors

Data were collected for 122 people who completed the programme in 2018, of which 59 (48.4%) were female and 63 were male (51.6%). Programme attendees ranged in age from 18 to 70 with an average age of 42 years (*SD* = 14.18). 57.4% of participants were in employment, 4.1% were working from home, 9.8% were unemployed, 12.3% were students, and 8.2% were retired, with the remaining percentage selecting "Disability" or "Supported training employment". 44.3% of programme attendees were single, 37.7% were married, 3.2% were separated or divorced, 9.0% were in a long-term relationship and cohabiting, and 5.7% were in a relationship. 51.6% of participants had achieved a 3rd level degree, 18.0% had a non-degree 3rd level education, 23.8% had completed their Leaving Certificate and 6.6% left school before their leaving certificate. Post data were collected after Level 1 and Level 2 of the anxiety programme.

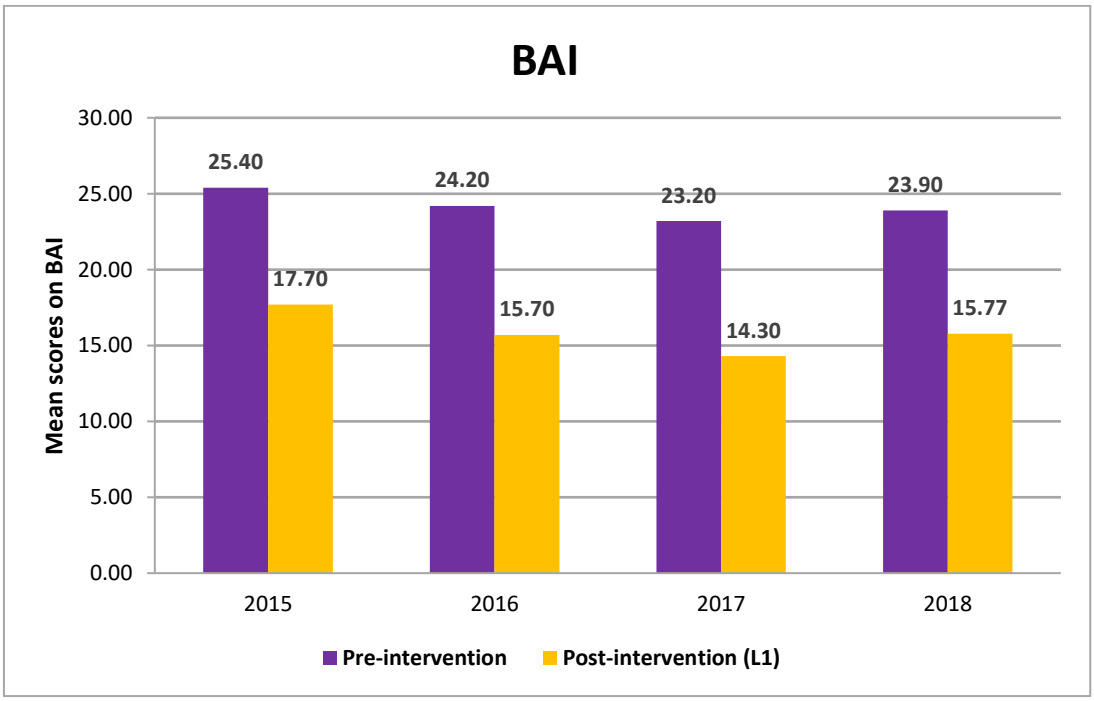
There were seven primary anxiety diagnoses represented within this group. Obsessive Compulsive Disorder accounted for the largest subgroup (42.6%), followed by Social Phobia/Anxiety (20.5%), Generalised Anxiety Disorder (18.0%), Agoraphobia (with/without panic) and Panic Disorder (11.5%), and Specific Phobia and Health Anxiety (6.5%). The following table shows the percentage of people with each diagnosis over the past three years.

	2016		2017		2018	
	N	%	N	%	N	%
Obsessive	29	40.3	40	48.8	52	42.6
Generalised	13	18.1	9	11.0	22	18.0
Social	16	22.2	14	17.1	25	20.5
Panic Disorder	7	9.7	6	7.3	6	4.9
Agorophobia	2	2.8	9	11.0	8	6.7
Health Anxiety	3	4.1	2	2.4	7	5.7
Specific Phobia	2	2.8	2	2.4	1	.8
Habit and Impulse Disorder	-	-			1	.8
Total	72	100	82	100	122	100

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores



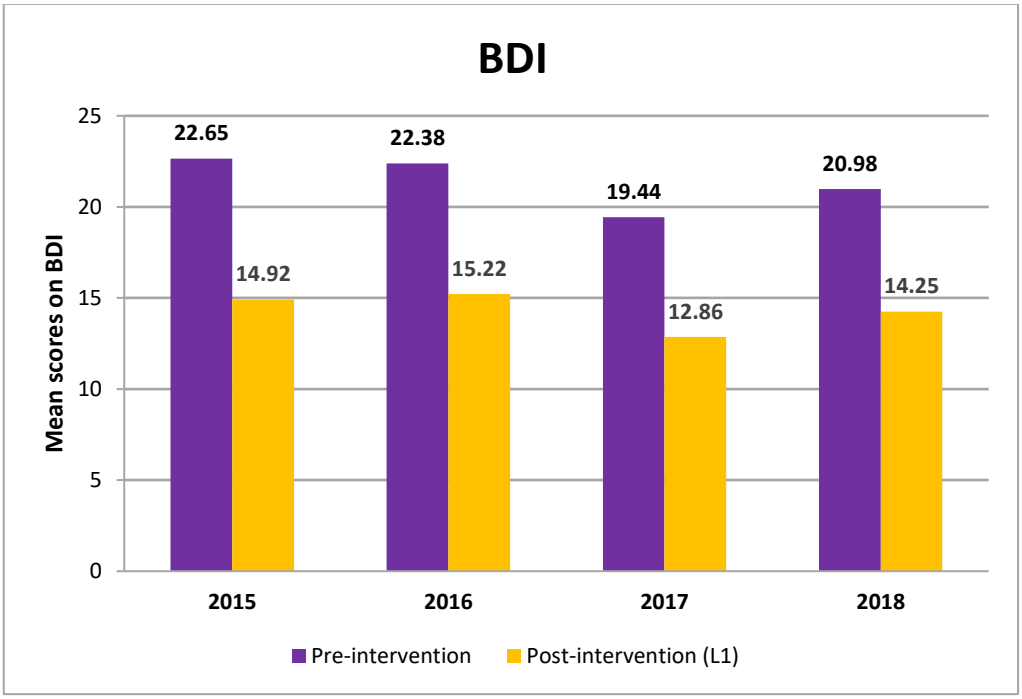
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved from the higher end of the moderate (M = 23.86, SD = 11.34) to the higher end of mild (M = 15.78,

SD = 10.52) range on the measure. Changes were statistically significant, z = -7.52, p < .001, and reflect a medium effect size (*r* = -.48). At the pre measurement time point, 76.23% had anxiety scores in the severe and moderate ranges, this dropped to 45.9% by the end of Level 1. See the table below for how these scores redistributed into the other categories.

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	9.8	23.8	6.6	34.5
Mild	14.9	30.5	22.9	26.3
Moderate	29.5	31.2	39.3	23.8
Severe	45.8	14.5	31.2	15.4
Totals	**100**	**100**	**100**	**100**

Beck Depression Inventory (BDI)

Graph: Beck Depression Inventory Scores

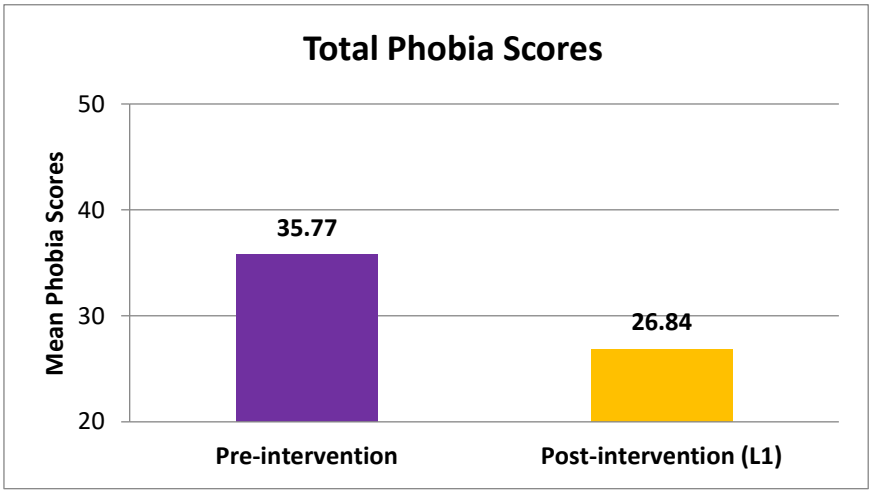


Mean scores on the Beck Depression Inventory were in the moderate range pre-intervention (*M* = 20.98, *SD* = 9.1) and a Wilcoxon Signed Rank test revealed a statistically significant drop to within the mild range post-intervention, (*M* = 14.25, SD = 10.27), *z* = -7.49, *p* < .001, which represented a medium effect size (*r* = -.48). While 60.5% were classified has having

moderate and severe depression before the programme, 39.2% were classified as such by the end (See the table above).

The Fear Questionnaire

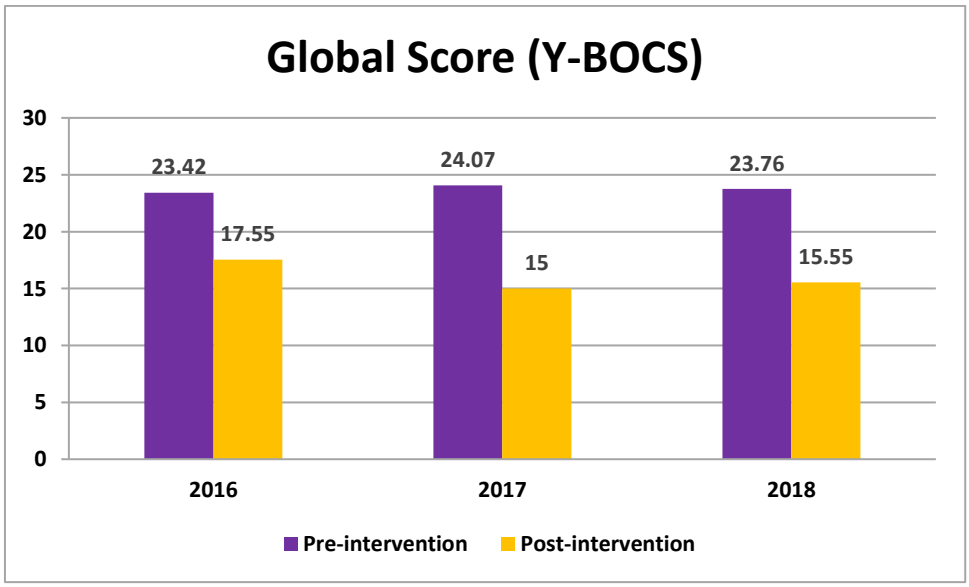
Graph: Fear Questionnaire Total Phobia Scores



A Wilcoxon Signed Rank test revealed a statistically significant difference between pre and post level 1 Total Phobia scores, $z = -6.29$, $p < .001$. The mean phobia score decreased from 35.77 (SD = 21.53) to 26.84 (SD = 18.51) and represented a medium effect size (r = -.40).

The Yale Brown Obsessive Compulsive Scale

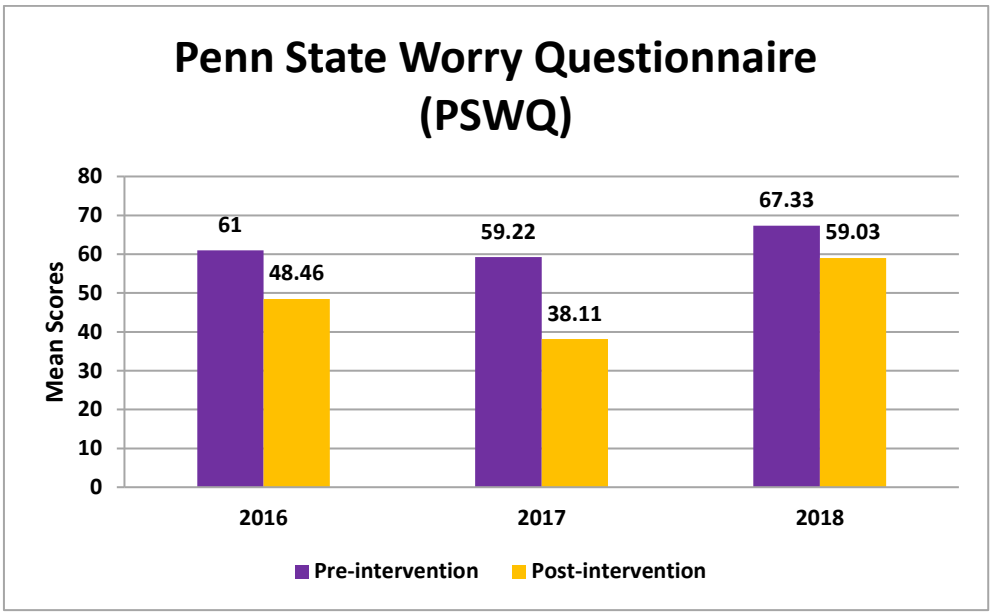
Graph: Yale Brown Obsessive Compulsive Scale



For those with OCD (n = 52), global (Y-BOCS) scores dropped significantly from 23.76 (*SD* = 7.16) to 15.55 (*SD* = 6.87), *t* (50) = 9.02, *p* <.001, (Cohen's *d* = 1.26), indicating an overall reduction in the severity of OCD symptoms with a large effect size.

Penn State Worry Questionnaire (PSWQ)

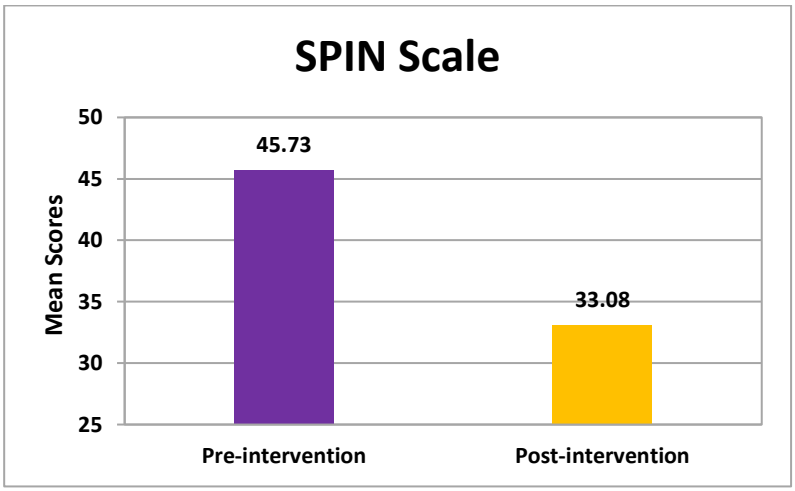
Graph: Penn State Worry Questionnaire



Participants' scores on the Penn State Worry Questionnaire dropped significantly from 67.33 (SD = 10.50) to 59.03 (SD = 10.94), z = -4.34, p < .000, which reflects a large effect size (r = -.60).

Social Phobia Inventory (SPIN)

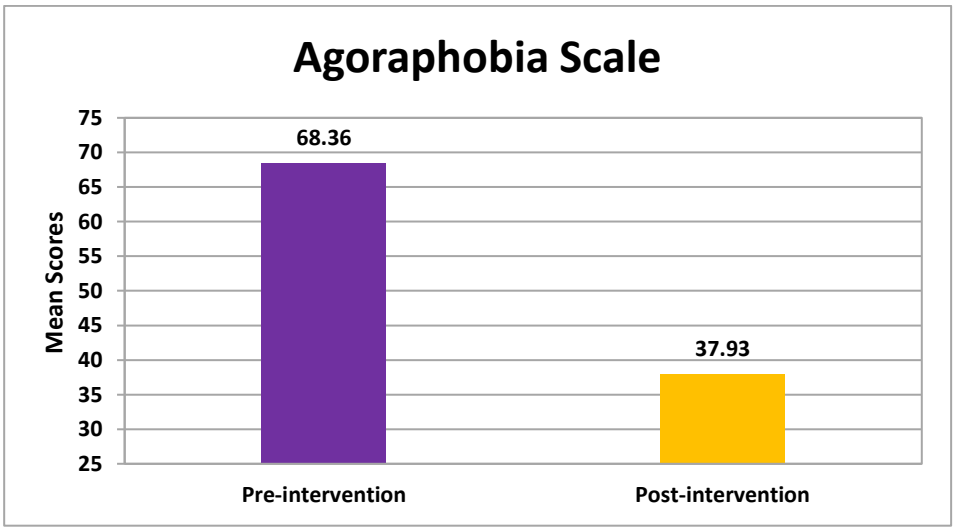
Graph: SPIN Scale



A statistically significant reduction in SPIN scores were observed, t (25) = 5.15, p<.001, from pre intervention (M = 45.73, SD = 10.57) to post level 1 intervention (M = 33.08, SD = 13.69), reflecting a large effect size (Cohen's *d* = 1.01).

The Agoraphobia Scale

Graph: The Agoraphobia Scale

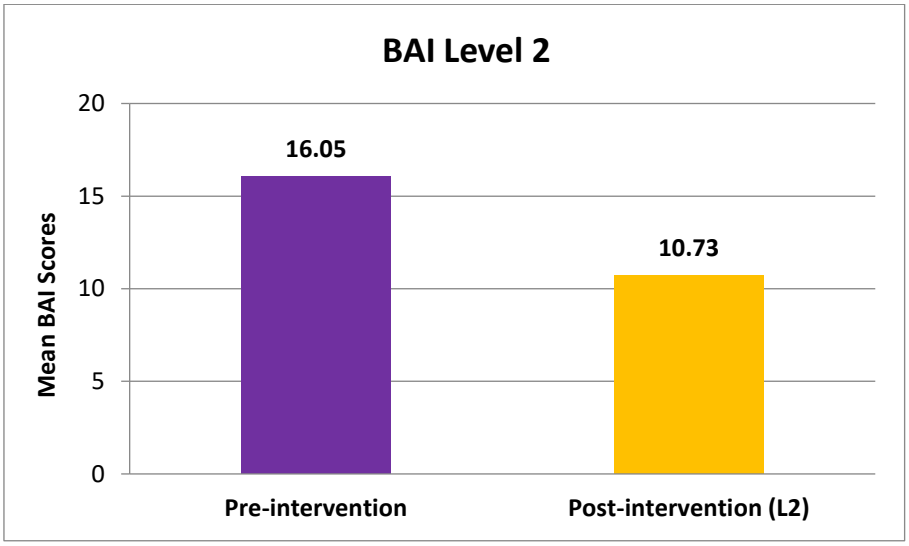


A statistically significant reduction in mean scores on the Agoraphobia Scale was observed, t (13) = 5.56, p < .001, from pre intervention (M = 68.36, SD = 16.41) to post level 1 intervention (M = 37.93, SD = 20.29), reflecting a large effect size (Cohen's *d* = 1.49).

4.5.4. Level 2 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Total Scores

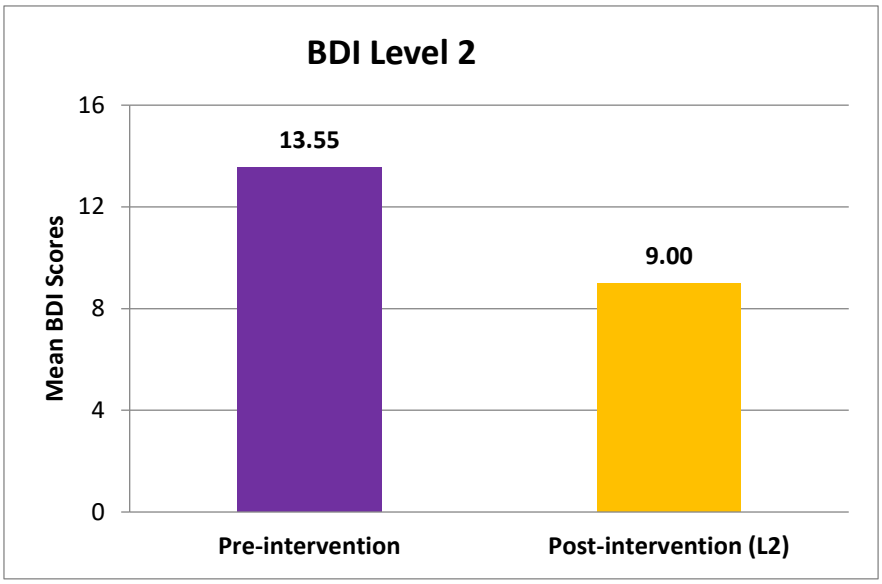


Pre and post level 2 scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programmes mean score decreased from M = 16.05 (SD = 8.79) pre intervention to M = 10.73 (SD = 6.5) post intervention. Changes were statistically significant, z = -2.98, p < .005, and reflect a medium effect size (r = -.45). At the pre measurement time point, 70.4% had anxiety scores in the severe and moderate ranges, this dropped to 39.1% by the end of Level 2 (See the table below).

% in each category	Anxiety (BAI)		Depression (BDI)	
	PRE	POST	PRE	POST
Minimal	6.4%	34.4%	22.6%	49.9%
Mild	22.9%	26.3%	27.3%	31.7%
Moderate	39.3%	23.7%	49.9%	18.3%
Severe	31.3%	15.5%	0%	0%
Totals	**100**	**100**	**100**	**100**

Beck Depression Inventory (BDI)

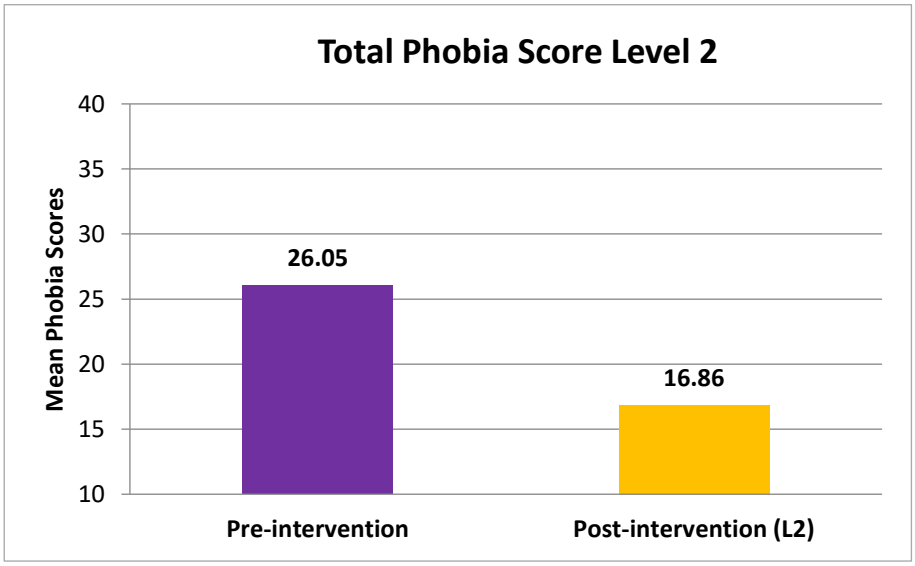
Graph: Beck Depression Inventory Total Scores



Average depression scores for those who completed the level 2 programme (indicated on the graph above) were in the mild range pre-intervention (M = 13.55, SD = 7.31) and and showed a statistically significant drop to the lower mild range post-intervention, (M = 9.00, SD = 6.13), t (21) = 4.33, p < .001, which represented a large effect size (d =.92).

The Fear Questionnaire

Graph: The Fear Questionnaire

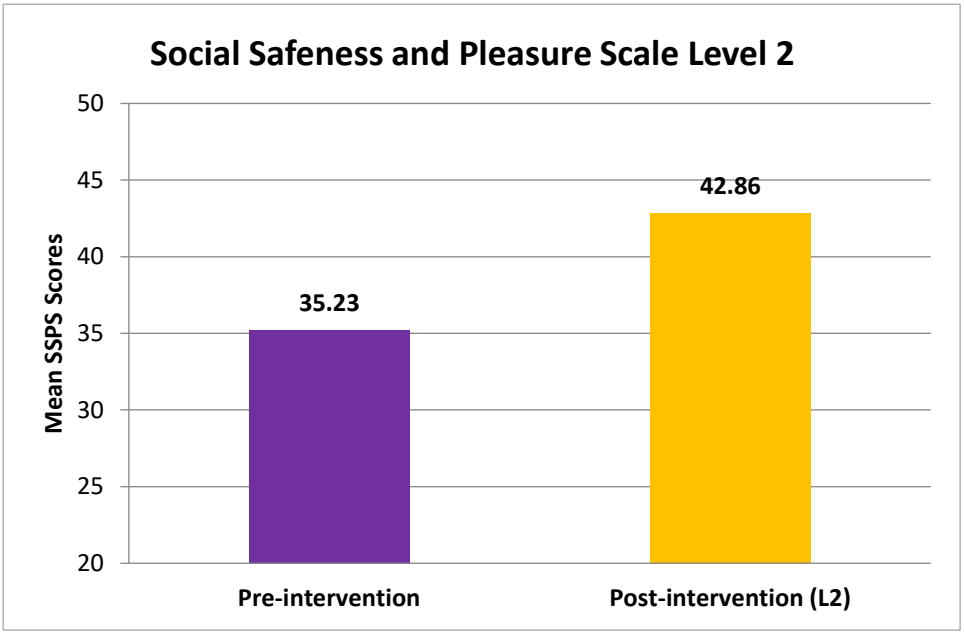


Total Phobia Scores dropped from a mean of 26.05 (*SD* = 15.63) to 16.86 (*SD* = 13.04) post level 2. This reduction was statistically significant, $z = -3.22$, $p < .001$ with a medium effect size; ($r = .49$).

The Social Safeness and Pleasure Scale

Participant's scores on the Social Safeness and Pleasure Scale changed from a mean of 35.23 (SD = 6.82) pre level 2 intervention to 42.86 (SD = 5.64) post intervention. This increase was statistically significant t (21) = -7.22, $p < .001$, with a large effect size; ($d = -1.54$).

Graph: The Social Safeness and Pleasure Scale



4.5.5. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2018 suggested significant reductions in anxiety and depression symptoms, OCD symptoms, and reductions in pathological worrying and social anxiety. The majority of effect sizes observed were within the large range as shown on the table below.

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

Instrument	Effect Size
BAI	-.48 (r)
BDI	-.48 (r)
Fear Questionnaire	-.40 (r)
Y-BOCS (Global Score)	1.26 (Cohen's *d*)
Penn State Worry Questionnaire	-.60 (r)
Social Phobia Inventory	1.01 (Cohen's *d*)
Agoraphobia Scale	1.49 (Cohen's *d*)

Note: 'Cohen's d' or 'r' is reported depending on parametric or non-parametric test

Level 2: Outcomes for the service users who completed pre and post measures at Level 2 of the anxiety programme in 2018 suggested further decreases in anxiety and depression symptoms. These reductions were also statistically significant with the majority of effect sizes also observed within the medium and large ranges.

Changes in scores for most measures have been consistently positive across the data since 2011, following both Level 1 and Level 2.

4.6. Compassion Focused Therapy

CFT was developed by Professor Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Leaviss & Uttley, 2014). Compassion Focused Therapy (CFT) draws on evolutionary psychology, neuroscience, attachment theory, cognitive behaviour therapy and mindfulness and compassion practices. CFT recognises the importance of being able to engage with our own suffering in a compassionate way and helps people to respond to distress and challenging emotions (Kolts, 2016).

Research has demonstrated the importance of self-compassion for psychological functioning (Neff & Germer, 2017). Jazaeiri et al. (2012) identified compassion as a predictor of psychological health and wellbeing and found that it was associated with fewer negative feelings and stress as well as more positive feelings and greater social connectedness. A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful

intervention for clients experiencing high shame and criticism. Research has found that CFT is associated with reductions in depression, anxiety, shame, and self-criticism and increased ability to self soothe in response to emotional distress (Lucre & Corten, 2012). Research conducted on the CFT group in St. Patrick's demonstrated that group CFT was effective in reducing symptoms of mental ill health for service users who attended the group. These improvements were associated with improvements in self-criticism and fears of self-compassion (Cuppage, Baird, Gibson, Booth & Hevey, 2017). Research was also recently carried out at St. Patricks to investigate subjective bodily changes associated with attending a trans-diagnostic CFT group (Mernagh, et al. 2017). Results suggest that service users who attended a CFT group developed an increase in mind-body attunement. That is, they became more trusting of their bodies as a source of important information about their emotions and were more readily able to self-regulate their emotions by becoming aware of physical sensations in the body.

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

4.6.1. Compassion Focused Therapy Outcome Measures

The following section presents a summary of the routine clinical outcome measures used by the Compassion Focused Therapy Programme in 2018.

All service users attending the CFT Programme are invited to complete the following measures, before starting the programme and again after completion. These measures have been selected because studies have shown them to be reliable and valid (Lovibond & Lovibond, 1995; Gilbert et al., 2011; Gilbert et al, 2015), in other words, they provide a good measure of the intended outcome of the CFT programme.

- **Depression Anxiety and Stress Scales**

The Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995) is a 21 item Likert scale that measures the three related states of depression, anxiety and stress. Each item is rated on a 4 - point scale from 0 ("Did not apply to me at all") to 4 ("Applied to me very much or most of the time"). Higher scores are indicative of greater psychological difficulty. This

measure was introduced in April 2017 and has replaced the Brief Symptom Inventory.

- **Fears of Compassion**

The Fears of Compassion Scale (FCS; Gilbert, McEwan, Matos & Rivis, 2011) consists of three sub-scales measuring; *Fear of compassion for self* (e.g. "I fear that if I am too compassionate towards myself, bad things will happen"), *Fear of compassion from others* (e.g. "I try to keep my distance from others even if I know they are kind) and *Fear of compassion for others* (e.g. "Being too compassionate makes people soft and easy to take advantage of"). The scale consists of 38 items in total, each rated on a five point scale from 0 ("Don't agree at all") to 4 ("Completely agree"). Higher scores are indicative of greater fears of self-compassion.

- **Compassionate Engagement and Action Scales**

The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring *compassion to the self*, *compassion to the other* and *compassion experienced from the other* (Gilbert et al., 2015). Each scale consists of 13 items, which generate an engagement (i.e. motivation to care for well-being, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and nonjudgmental) and an action sub scale (i.e. directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10-point Likert scale (*1 =never* to *10 = always*). High scores indicate high compassion. This measure was introduced in April 2017.

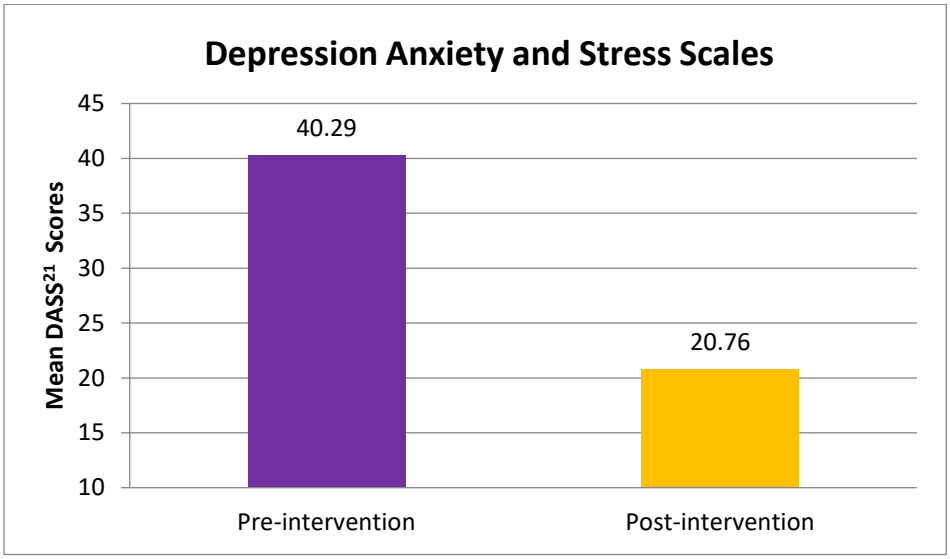
4.6.2. Descriptors

There were pre and post data available for 35 participants who completed the programme either at St Patrick's University Hospital or at St Edmundsbury Hospital in 2018. Of these 35 service users, 64.7% were female and 35.3% were male, compared to 14% male attendance in 2017. Programme attendees ranged in age from 20 to 71 years with an average age of 42.88 years. Data for those who started a cycle in 2018 but finish in 2019 will be included in next year's report.

4.6.3. Results

Depression Anxiety and Stress Scales (DASS)

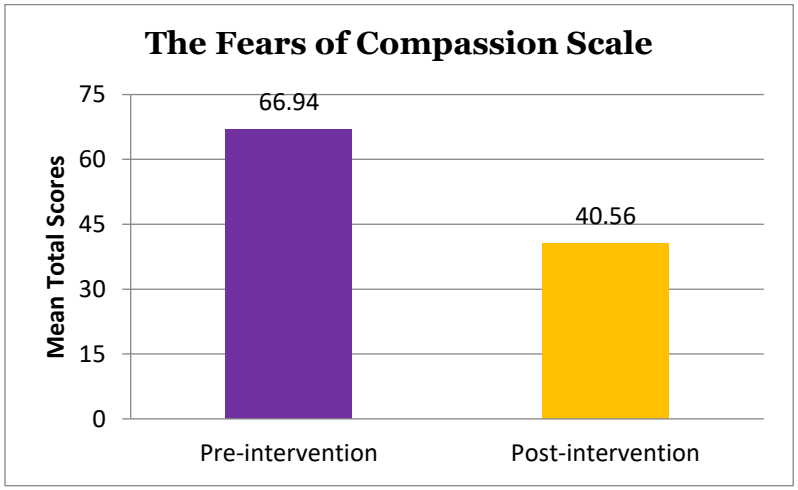
Graph: Depression Anxiety and Stress Scores



A significant decrease in psychological difficulty as measured by the Depression Anxiety and Stress (DASS[21]) Inventory was observed in service users who completed the Compassion Focused Therapy programme in 2018, where t (16) = 2.87, p<.05. A large effect size was observed (*d* = .70).

4.6.3.2 The Fears of Compassion Scale

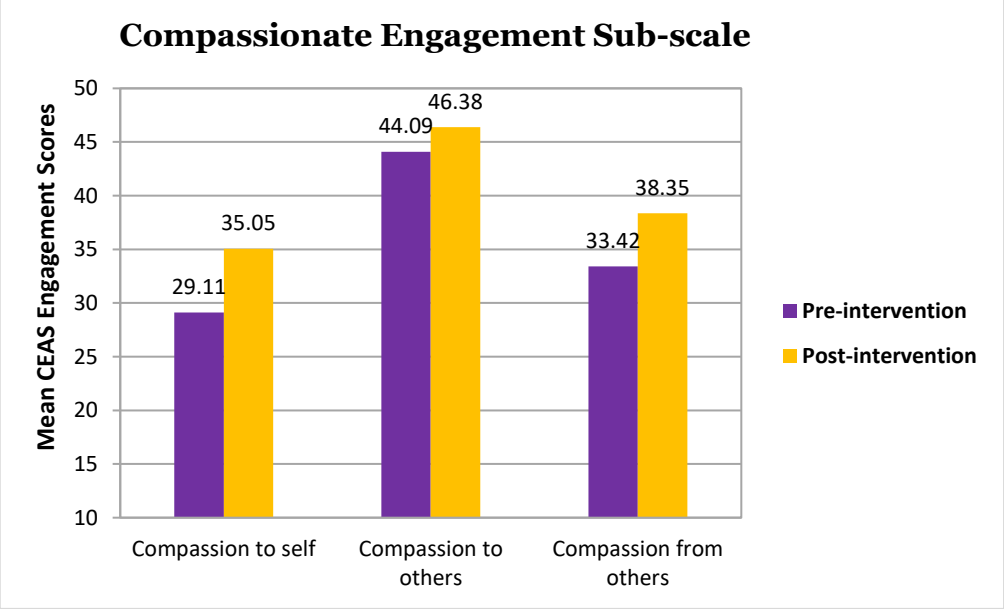
Graph: The Fears of Compassion Scale

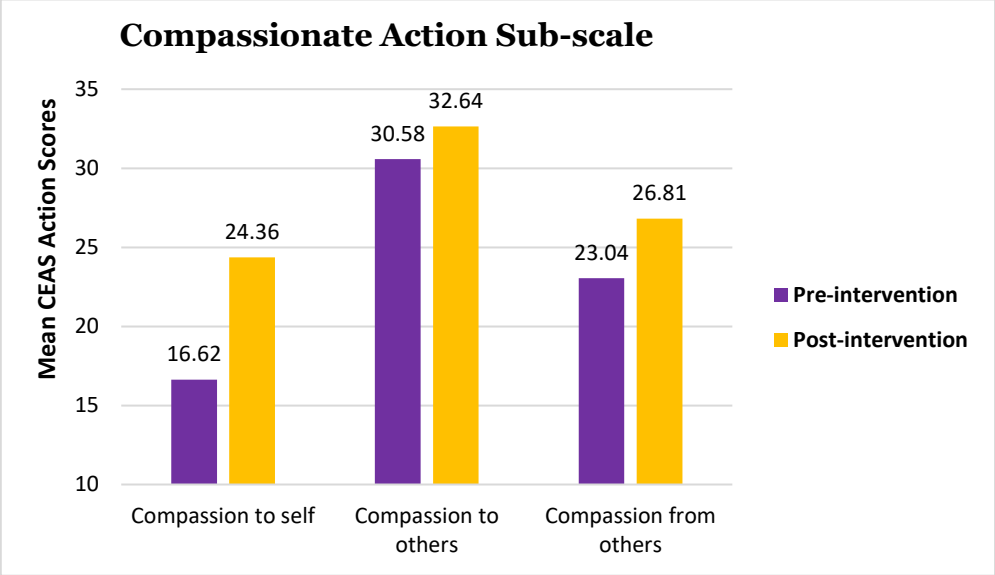


A statistically significant reduction in total Fears of compassion (expressing kindness and compassion towards self, expressing compassion for others, and

responding to compassion from others) was found for those attending the programme in 2018; $t(15) = 3.61$, $p<.01$, with a large effect size ($r = .90$). These findings suggest that fears of developing and having compassion decreased from pre to post programme participation.

4.6.3.2 Compassionate Engagement and Action Scale





Significant increases were observed from pre- to post- intervention on the Compassionate to Self Scale overall; $t(18) = -3.75$, $p< .01$, with a large effect size ($d = .86$) and on the Compassion From Others Scale; $t(16) = -2.43$, $p<.05$, with a medium effect size ($d = -.59$). There was no significant difference observed from pre- to post intervention on the Compassion to Others Scale; $t(17) = 1.67$, $p = .11$. These findings suggest that on completion of the

programme, service users compassion for themselves and openness to receiving compassion from others increased. The lack of significant difference in compassion towards others would be consistent with the findings that many service users who enter this programme tend to show compassion to others before considering their own needs (Mernagh et al., 2017).

4.6.4. Summary

The Compassion Focused Therapy programme started in SPMHS in 2014. Since it began 21 cycles of the group have been facilitated. The programme has received considerable interest within the hospital.

Anecdotal feedback from clients who attended these groups has been largely positive, with clients reporting noticeable improvements in their lives. This feedback has been supported statistically by the findings of this report; specifically, by the reduction of symptoms of psychological distress as measured by the DASS-21 following completion of the group.

Fears of self-compassion were found to significantly decrease while service user self-perceptions of their ability to feel safe in and draw on their relationships for support significantly increased following completion of the group.

The CFT group delivery format is currently under review in an effort to ensure a high-quality service that meets service user's needs.

4.7. Depression Recovery Programme

The Depression Recovery Service is a comprehensive multidisciplinary assessment, treatment and aftercare service for those experiencing depression. In line with international best practice guidelines for depression, the Depression Recovery Service aims to deliver treatment in an accessible and flexible way. It also aims to provide follow up care and support for those who require it. The Depression Recovery Service offers a group- based stepped care approach using an ABC model.

There are currently three programmes offered within the service:

Level A - Activating Recovery - An initial three-week psycho-educational programme open to service users currently in hospital or attending from home on a day basis.

Level B - Building Recovery - A 10-week cognitive behaviour therapy (CBT) skills-based programme open to day-patients only.

Level C - Maintaining Recovery - A stepdown group for those who have completed Level B - Building Recovery. This programme runs for four half days over a six-month period.

The Depression Recovery Service offers a group-based stepped level treatment programme in line with international best practice guidelines.

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

Level B (Building Recovery – a psychotherapy group) is a ten-week programme. For the first five weeks the programme aims to introduce the concepts of CBT (Cognitive Behavioural Therapy), Compassion Focused Therapy and Mindfulness. Workshops have been designed as a means of exploring the thought mood connection, the development of the Vicious Cycle of Depression and how to unravel it. The following five weeks introduce the concepts of compassion focused therapy and focus on compassionate resilience, building on concepts introduced in week one to five. It assists a person to develop a deeper psychotherapeutic understanding of the impact of depression on their life or factors that may have increased their vulnerability to depression.

4.7.1. Depression Recovery Programme Outcome Measures

- **Beck Depression Inventory**

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

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

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

4.7.2. Descriptors

Paired data were collected for 126 participants who completed the programme in 2018. Of the 126 service users, 77 were female (61.1%) and 49 were male (38.9%).

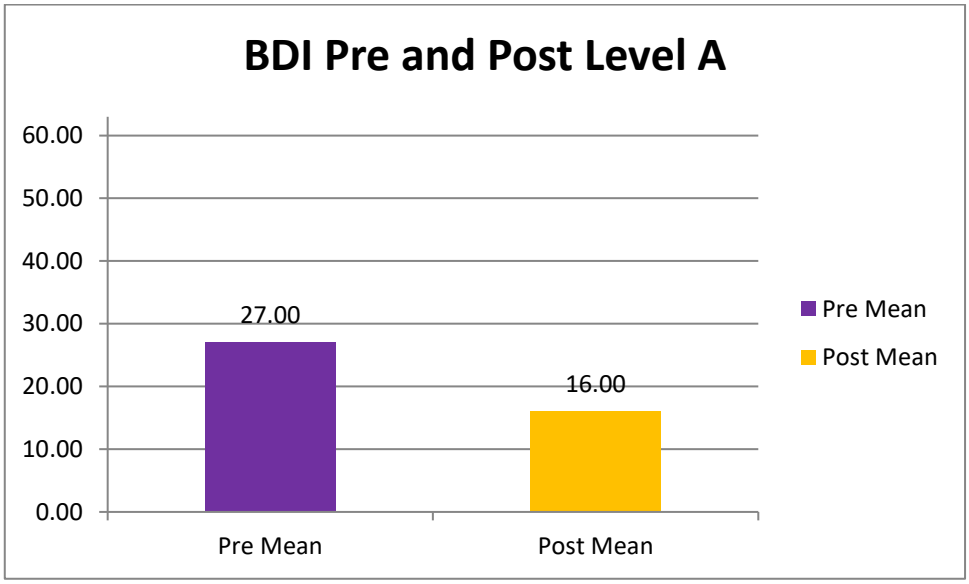
4.7.3. Results

Pre Level A and Post Level A

Beck Depression Inventory (BDI)

Comparison of service user scores on the BDI from pre and post level A indicated that on average service users moved from the moderate range (*Md* = 27) to the mild range (*Md* = 16) on the measure (see graph below). A Wilcoxin Signed Rank test revealed that the reduction was statistically significant, z= -8.19, p = .000, with a large effect size (Cohen's *r* = 0.51). This indicates a significant decrease in depressive symptoms post intervention.

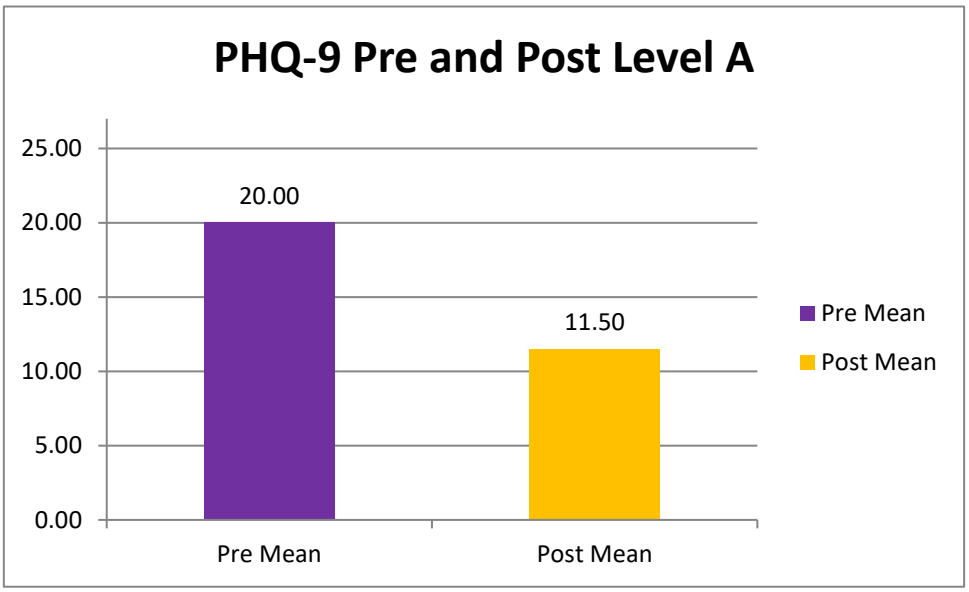
Graph: Beck Depression Inventory Total Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of service user scores on the PHQ-9, pre and post Level A indicated that, on average, those who completed rated themselves in the severe range (*Md* = 20) prior to the intervention and in the moderate range (*Md* = 11.5) following intervention. This reduction in mean scores is statistically significant, A Wilcoxin Signed Rank test revealed z= -8.5, p = .000, with a large effect size (Cohen's *r* = 0.53).

Graph: Patient Health Questionnaire-9 Scores



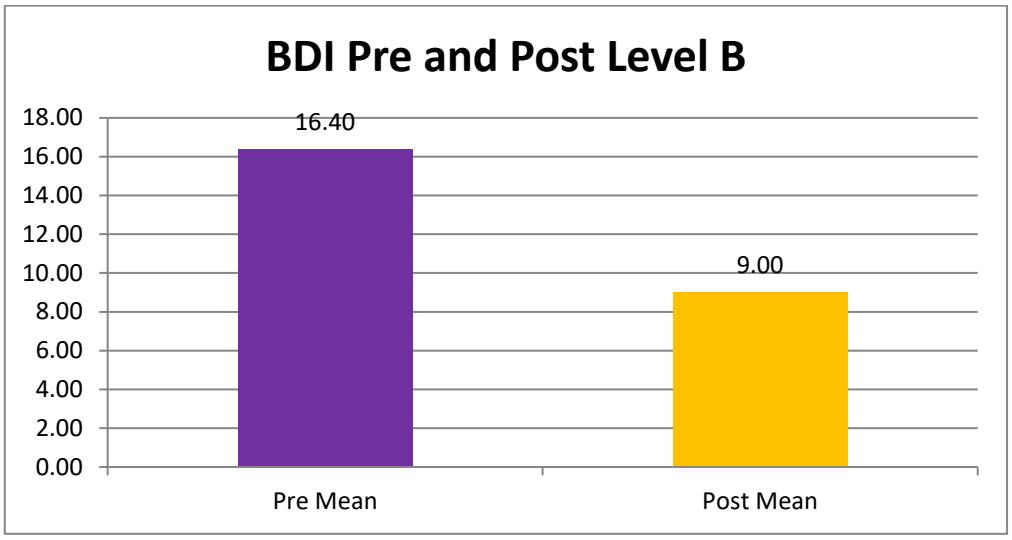
Pre Level B and Post Level B

Prior to 2016, data was analysed from pre Level A to post Level B. However feedback from the clinical team in 2016 highlighted that the time between completing level A to commencing level B can vary significantly. There can be lengthy gaps in commencing level B due to the service user's choice and personnel circumstances, such as fitting around work, family commitments or study. As a result it was decided to analyse the data from pre level B to post level B instead.

Beck Depression Inventory (BDI)

Pre and post scores on the Beck Depression Inventory (see graph below) demonstrate that the average score for people who completed Level B of the Depression Programme moved from the mild range pre Level B (M = 16.4) to the minimal range (*M* = 9.0). This reduction in the mean score is statistically significant, t(22) = 4.5 p < .000, with a large effect size (Cohen's *d* = 0.9).

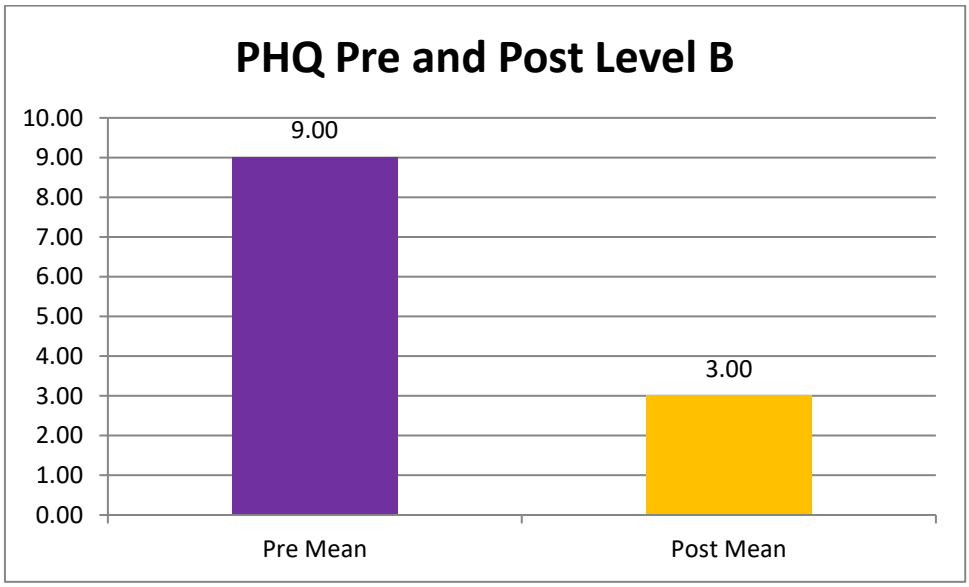
Graph: Beck Depression Inventory Scores



Patient Health Questionnaire-9 (PHQ-9)

Comparison of patient scores on the PHQ-9, indicated that, on average, those who completed Level B rated themselves in the mild range (*Md* = 9.0) prior to Level B and moved to the non-clinical range (*Md* = 3.0) following Level B. This reduction in mean scores is statistically significant, A Wilcoxin Signed Rank test revealed z= -3.5, p = .001, with a large effect size (Cohen's *r* = 0.52).

Graph: Patient Health Questionnaire-9 Scores



4.7.4. Summary

This is the fourth year the depression programme has been included in the SPMHS outcomes report. Two well established outcome measures were used to investigate the programme's effectiveness at reducing symptoms of depression. Both measures showed significant reductions in service users' mean scores following completion of the programme.

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

4.8. Dual Diagnosis Programme

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

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

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

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

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

The programme includes the following elements:

- **Individual multi-disciplinary assessment:** This facilitates the development of an individual treatment care plan for each client.
- ***Psycho-education lectures:*** A number of lectures are delivered weekly with a focus on providing education on substance misuse and recovery, as well as approaches for managing mental health issues e.g. CBT, and Mindfulness. There is also a weekly family and patient lecture, facilitated by Addiction Counsellors, providing information on substance misuse and recovery to clients and their families.
- ***Goal setting and change plan*****:** This group is facilitated by therapists and encourages participants to put plans and structure in place for time spent outside of the hospital.
- ***Mental health groups:*** This is a psycho-educational group focussing on Mental Health related topics such as Depression, Anxiety and Recovery.
- ***Role play groups:*** This group aims to allow clients to actively practice drink/drug refusal skills, to learn how to communicate about mental health, and to manage relapse in mood and substance misuse. The group creates opportunities to role play real life scenarios that may have been relevant to the client or may be relavant in the future.
- ***Recovery plan:*** This group facilitates and supports clients in developing and presenting an individual recovery plan. It covers topics such as Professional Monitoring, Community Support groups, Daily

inventories, Triggers, Physical care, problem solving, Relaxation, spiritual care, Balance Living, family/friends, work balance etc.

- ***Reflection group:*** This group provides a safe place to support clients through the process of change; an opportunity to reflect on the extent of dependence on substances and mental health difficulties.
- ***Relapse prevention and management groups:*** This group focuses on developing successful relapse prevention and management strategies.

4.8.1. Dual Diagnosis Outcome Measures

Leeds Dependency Questionnaire (LDQ)

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

The measure is designed to evaluate 10 markers of substance and/or alcohol dependence, the 10 items map on to the ICD-10 and DSM-IV criteria for substance dependence which include: pre-occupation with the substance, the primacy of activities associated with the substance over other activities, the perceived compulsion to continue using the substance, the way in which the user's day is planned around procuring and using the substance, attempts to maximise the effect of the substance, the narrowing of the substance use repertoire, the perceived need to continue using the substance in order to maintain effect, the primacy of the pharmacological effect of the substance over any of its other attributes, the maintenance of the substance induced state, and the belief that the substance has become essential to the user's existence (Kelly, Magill, Slaymaker & Kahler, 2010).

Items are scored on a 4-point scale from 0 "Never" to 3 "Nearly Always" with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and

opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

4.8.2. Descriptors

Data were collected for 78 participants, of which, 55.8% were male and 44.2% were female.

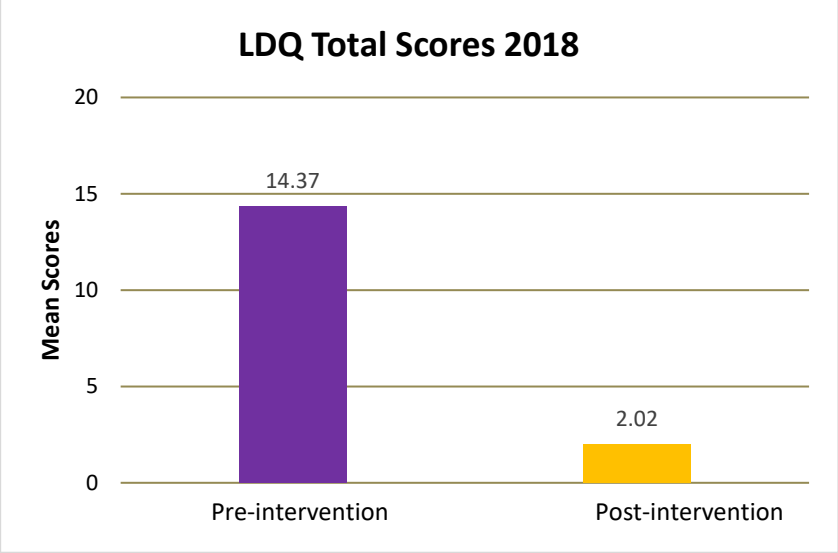
4.8.3. Results

Leeds Dependency Questionnaire

A Wilcoxin Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, z=-7.54, p<.001, with a large effect size (r=-.60).

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

Graph: Leeds Dependency Questionnaire Scores



4.8.4. Summary

Following completion of the Dual Diagnosis programme, significant and large reductions in psychological markers of alcohol/substance dependency were observed. These results suggest that the introduction of the LDQ as a measure to evaluate this programme was been successful and its use will continue in 2019.

These findings support previous studies and literature which regard the LDQ as a suitable tool for the evaluation of interventions for adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000) and psychiatric difficulties (Ford, 2003). It is recognised that it can be challenging to collect psychometric data from individuals with substance use difficulties. According to Tober et al. (2000), service users with substance difficulties can find it difficult to commit to completing follow-up measures for many reasons including motivation, difficulties with attendance and convenience of appointment times given.

Response rates have improved since post measures are being conducted as part of the discharge plan and it is hoped to improve them further as, anecetodally, it has been noted that there may be scope to identify those who relapse and return to the programme as these service users are not being represented in the data. Discussions around this will continue in 2019 with the aim of collecting data from these service users.

4.9. Eating Disorder Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the needs of people with Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. The objective of the programme is to address the physical, psychological and social issues arising as a result of an eating disorder in an attempt to resolve and overcome many of the struggles associated with it. The programme is a multidisciplinary programme with an emphasis on a cognitive behaviour therapy (CBT) treatment model which is applied throughout inpatient, day patient and outpatient treatment stages, as needed by the patient. The programme is structured into three stages. Following a Prompt Assessment of Needs by the Referral & Assessment Service, a service users is

assessed at the Dean Clinic. The typical care pathway then involves inpatient care, day care, and follow-up outpatient care. Inpatient care consists of a variety of interventions including:

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

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

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

Following day services, outpatient care is offered in the Dean Clinic. Services offered at the Dean Clinic include Psychiatry, Nursing, and Dietician reviews, along with Cognitive Behavioural Therapy for eating disorders (CBT-E), the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) and the Specialist Supportive Clinical Management (SSCM), in order to support service users in their recovery.

4.9.1. EDP Outcome Measures

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

- **Eating Disorder Examination – Questionnaire**

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

Twenty-seven items contribute to a Global score and four subscales including: Restraint, Eating Concern, Weight Concern, and Shape Concern. Items from each subscale are summed and averaged with the global score generated by summing and averaging the subscale scores (resulting scores range from 0 – 6 for each subscale and the global score). Higher scores suggest greater psychopathology. Evidence in support of the reliability and validity of the measure comes from a number of studies (e.g. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce & Crowther, 1999). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al., 1997; Carter et al., 2001, and Passi et al., 2003 as cited in Garety et al., 2005).

- **State Self Esteem Scale (SSES)**

The State Self Esteem Scale is a 20-item scale that measures a participant's self-esteem at a given point in time. The 20 items are subdivided into 3

components of self-esteem: (1) performance self-esteem, social self-esteem, and appearance self-esteem. All items are answered using a 5-point scale (1= not at all, 2= a little bit, 3= somewhat, 4= very much, 5= extremely).

Higher scores indicate higher levels of self esteem.

4.9.2. Descriptors

Data were collected for a total of 26 service users attending the EDP as an inpatient in 2018 and 12 attending as a day-patient.

As there may be multiple entry points to the programme data was collected at 4 points

1. Inpatient admission
2. Inpatient Discharge
3. Daypatient Admission
4. Daypatient discharge

Due to these multiple timepoints data was grouped and analysed according to inpatient and day-patient categories. Results are presented in two separate sections as follows.

1. Inpatient outcomes: Time point 1 – inpatient admission, Time point 2 – inpatient discharge
   and
2. Daypatient outcomes: Time point 1 – daypatient admission, Time point 2 – daypatient discharge

4.9.3. Results

Inpatient Results

Eating Disorders Examination Questionnaire (EDE-Q)

A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed. The total score on the EDE-Q showed decreased symptomatology between inpatient admission (*Md*=4.8) and inpatient discharge (m = 2.7) A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= 3.07, p = .002, with a large effect size (Cohen's *r* = 0.54).

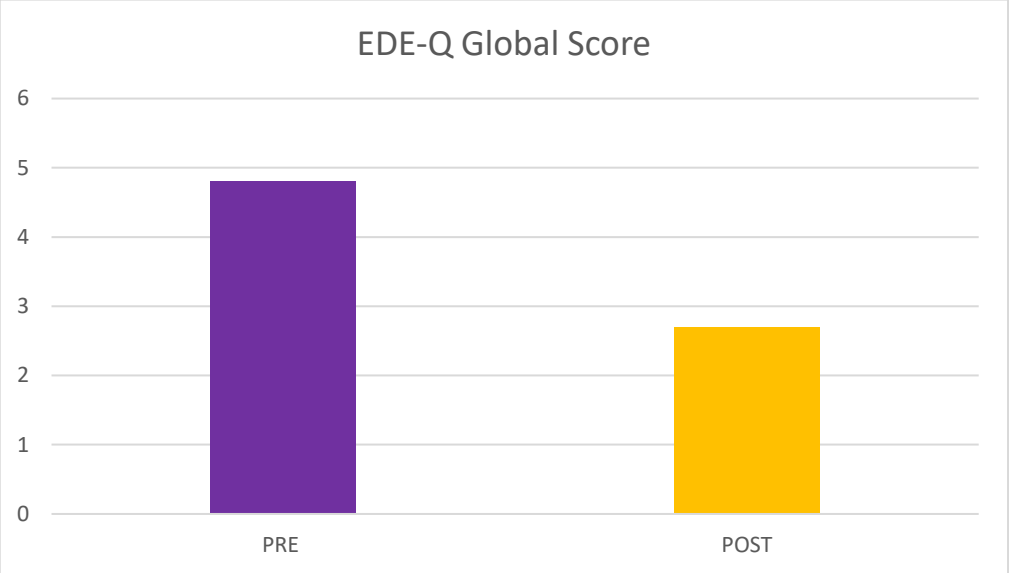
All subscales of the EDE-Q showed decreases in symptomatology by time point 2 (inpatient discharge).

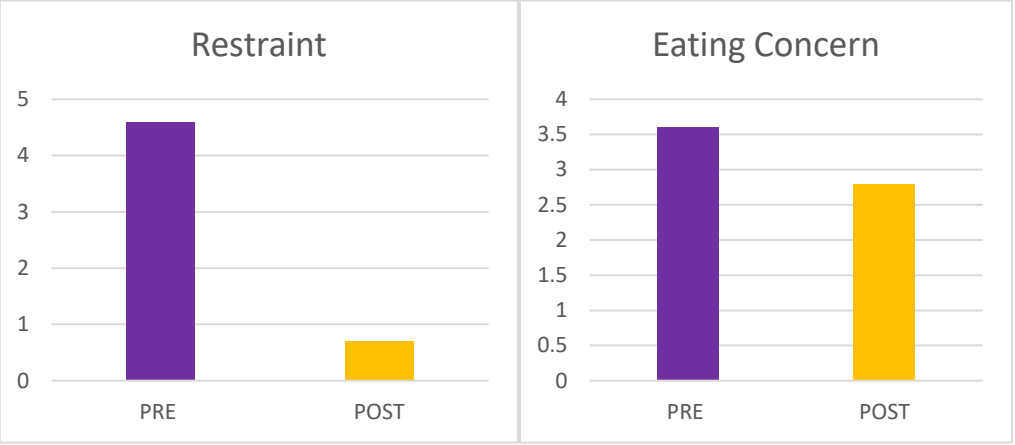
Of these, two subscales, restraint and weight concern, showed statistically significant change.

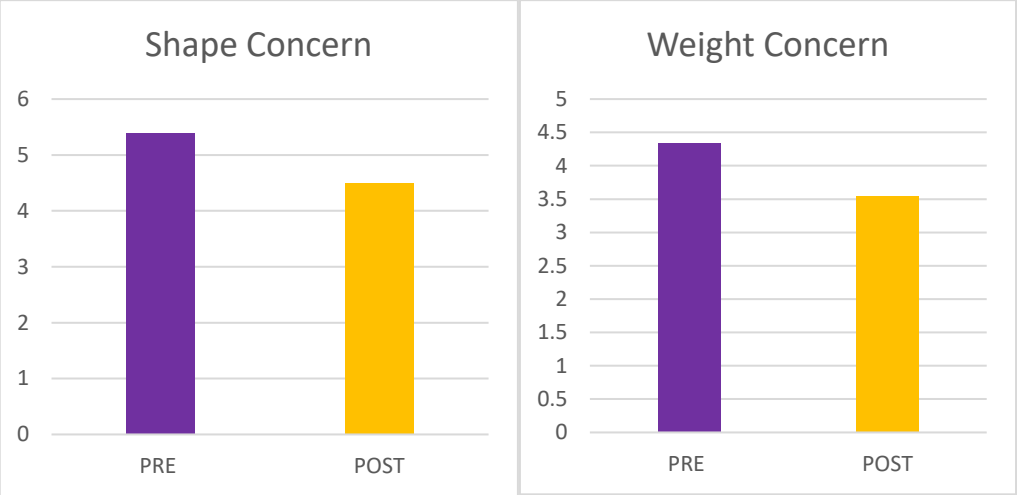
Symptomatology on the restraint subscale decreased from (*Md*= 4.6) to (M=0.7). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= 3.2, p = .001, with a medium effect size (Cohen's *r* = 0.48).

Symptomatology on the weight concern subscale decreased from (M = 4.34) to (M = 3.5). Paired sample t-tests indicated that this was a statistically significant change, whereby t(14) – 2.3, p < .05, reflecting a small to medium effect size (d = 0.47).

The failure to observe statistical differences in some of the subscales may be due to many factors and it is not possible to determine these in this report.







State Self Esteem Scale (SSES)

On the SSES, patients with measures at both timepoints showed increased overall self-esteem as well as increases across the 3 subscales (Performance Self Esteem, Appearance Self Esteem and Social Self Esteem. At time 2 (inpatient discharge) mean score across all scales had increased suggesting improvements across all domains.

The total score on the SESS showed an increase between inpatient admission (M=45) and inpatient discharge (M=55). A paired sample t-test indicated that this was a statistically significant change, whereby $t(14) = 2.4$, $p < .05$, reflecting a medium effect size ($d = 0.60$)

While the results indicate increased average means across all domains, only the subscales Performance Self Esteem and Appearance Self Esteem were statistically significant.

Performance self-esteem increased from pre-intervention (M=18) to post intervention (M=22). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(14) = 2.5$, $p < .05$, reflecting a large effect size ($d = 0.70$)

Appearance Self Esteem increased from pre-intervention (Md =8.5) to post intervention (Md = 15). A Wilcoxin Signed Rank test indicated this was a statistically significant change, $z = 2.3$, $p = .05$, with a medium effect size (Cohen's $r = 0.39$).

Daypatient Results

Eating Disorders Examination Questionnaire (EDE-Q)

A reduction of scores on the EDE-Q, measuring eating disorder symptomatology was observed on all subscales for the day-patient data. The

total score on the EDE-Q showed decreased symptomatology between day-patient admission (M = 4.2) and day-patient discharge (M = 2.2). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(6) = 4.2$, $p < .05$, reflecting a large effect size ($d = 1.23$)

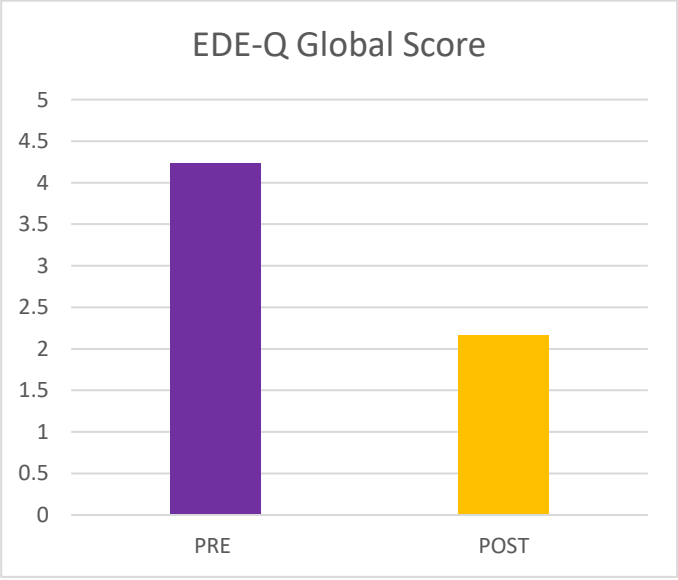
Similarly, all subscales of the EDE-Q showed statistically significant decreases in symptomatology at time point two for day-patients.

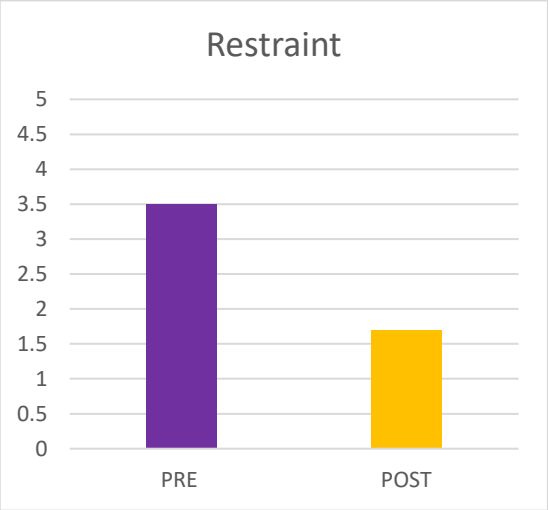
Symptomatology for the restraint subscale decreased from day patient admission (M= 3.5) to day patient discharge (M= 1.7). Paired sample t-tests indicated that this was statistically significant, $t(6) = 2.5$, $p < .05$. This had a large effect size ($d = 0.9$).

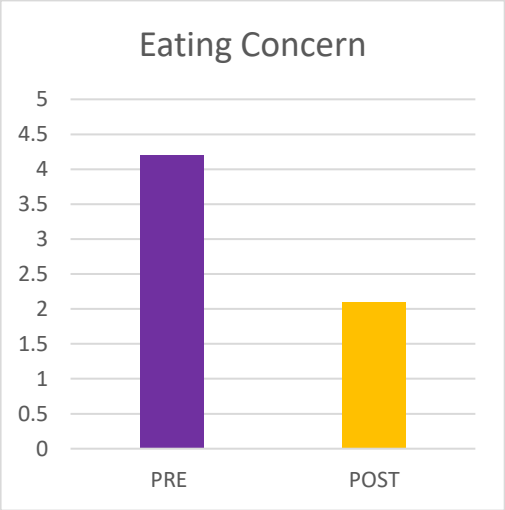
Symptomatology on the eating concern subscale decreased from (M= 4.2) to (M= 2.1). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(6) = 5.6$, $p < .001$, reflecting a large effect size ($d = 1.19$).

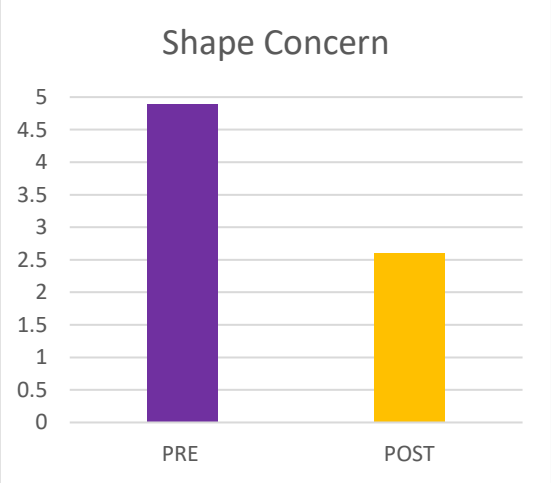
Symptomatology on the shape concern subscale decreased from (M= 4.8) to (M= 2.6). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(6) = 4.4$, $p < .005$, reflecting a large effect size ($d = 1.49$).

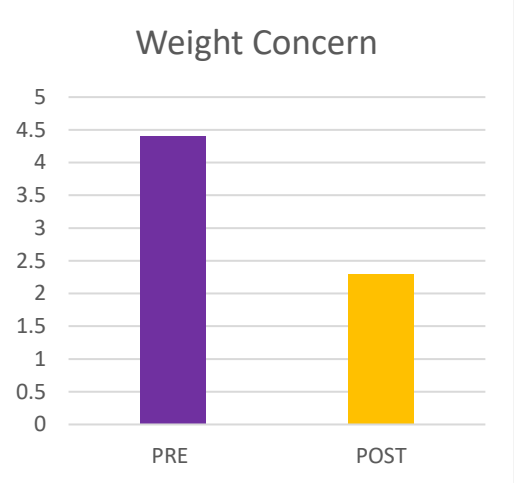
Symptomatology for the weight concern subscale decreased from day patient admission (M= 4.4) to day patient discharge (M= 2.3). Paired sample t-tests indicated that this was statistically significant, $t(6) = 3.5$, $p < .05$. This had a large effect size ($d = 1.29$).











State Self Esteem Scale (SSES)

On the SSES patients with measures at both timepoints showed increased overall self-esteem as well as increases across the 3 subscales (Performance Self Esteem, Appearance Self Esteem and Social Self Esteem. At time two (day-patient discharge) mean score across all scales had increased suggesting improvements across all domains.

The total score on the SESS showed an increase between day-patient admission (*Md*=44.5) and day-patient discharge (M=72.0). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= 2.3, p = .05, with a large effect size (Cohen's *r* = 0.89).

While the results indicate increased average means across all domains, only the subscales Performance Self Esteem and Social Self Esteem were statistically significant.

Performance self-esteem increased from pre-intervention (*Md*=19) to post intervention (*Md*=72). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= 2.39, p = .05, with a large effect size (Cohen's *r* = 0.91).

Social self-esteem increased from pre-intervention (*Md*=12) to post intervention (*Md*=25). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= 2.37, p = .05, with a large effect size (Cohen's *r* = 0.89).

4.9.4. Summary

The findings presented provide insight into the effectiveness of the programme. Results provide evidence to suggest that, on average, those

attending both as inpatients and daypatients on the EDP experienced a significant reduction in eating disorder symptomology as measured by the Eating Disorder examination questionnaire (EDE-Q), as well as significant improvements in self-esteem across a range of domains as measured by the state self-esteem questionnaire (SSES). This is indicative of the aims of the programme and reflects promising service user outcomes on completion of the Eating Disorders Programme.

4.10. Living Through Distress Programme

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

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

Skills which aid patients to regulate their emotions are at the core of LTD. LTD focuses on both change and acceptance skills. The content is informed by Linehan's skills-based group intervention and has been modified to meet the needs of the organisation, based on clinical research on the efficacy of the group.

In August 2019 the Level 1 programme moved from taking place three days per week for 6 weeks, to two days per week for 8 weeks. This change has not impacted the number of skills being taught.

The Level 1 sessions focus on teaching mindfulness, distress tolerance and introducing emotion regulation skills. Following these 16 sessions, the programme has introduced a 16-week Level 2 intervention for those who complete Level 1. Level 2 is exclusively a day patient programme and is focused on building "*a life worth living"* and facilitating patients in generalising their use of skills beyond the hospital setting. These 16 sessions aim to address emotion regulation and interpersonal effectiveness in more depth.

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

4.10.1. Living Through Distress Programme Outcome Measures

- **Difficulties in Emotion Regulation Scale**

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) assesses emotion dysregulation. It comprises six domains: non-acceptance of emotions, inability to engage in goal directed behaviours when distressed, impulse control, emotional awareness, emotion regulation strategies, and emotional clarity. The measure consists of 36 items scored on a 5-point scale from 1 "almost never" to 5 "almost always". Total scale scores range from 36

to 180 with higher scores indicating greater difficulties regulating emotion. Gratz and Roemer (2004) reported good internal reliability (α = .93), construct and predictive validity, and test-retest reliability in an article which described the development of this scale.

- **Distress Tolerance Scale**

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

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

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

4.10.2. Descriptors

Data were collected for 48 participants who completed the Level 1 "getting in control" of the programme in 2018. Of those who had pre and post data, 89.6% were female and 10.4% were male. LTD attendees ranged in age from 19 to 58 years, with an average age of 31.25 (*SD* = 11.96). Their highest level of educational attainment ranged from Junior Certificate (4.2%), to Leaving Certificate (29.2%), to non-degree 3rd level qualification (18.8%), to 3rd level degree (18.8%) to postgraduate qualification (27.1%). 2.1% chose other. Those who attended the group's current employment status was also recorded. 10.4% worked in the home, 4.2% were in part-time employment, 37.5% were in full-

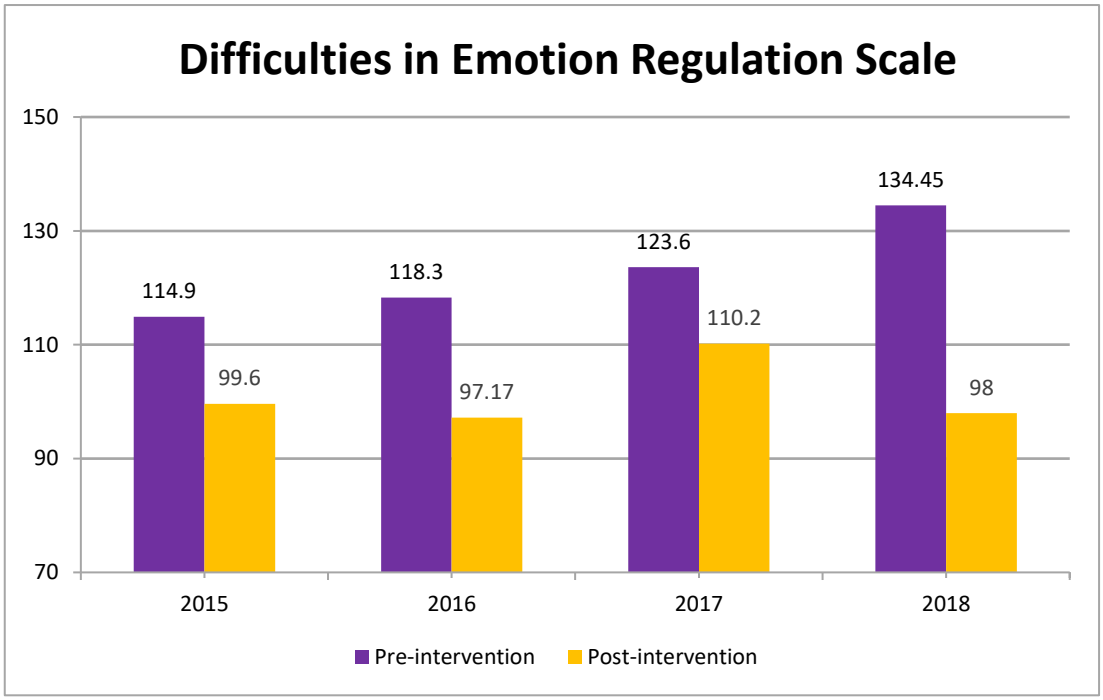
time employment, 22.9% were unemployed, 2.1% were retired, 16.7% were students and 6.2% chose other.

4.10.3. Results

Difficulties in Emotion Regulation Scale

Significant gains were made on the Difficulties in Emotion Regulation Scale (DERS) from pre to post intervention. Participants experienced a decrease in difficulties regulating emotions moving from an average score of 134.45 (*SD* = 22.43) on the DERS pre to 98.00 (*SD* = 28.14) post completion of the programme, $z = -4.14$, $p < .001$. This change represented a medium effect size ($r = -.53$). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

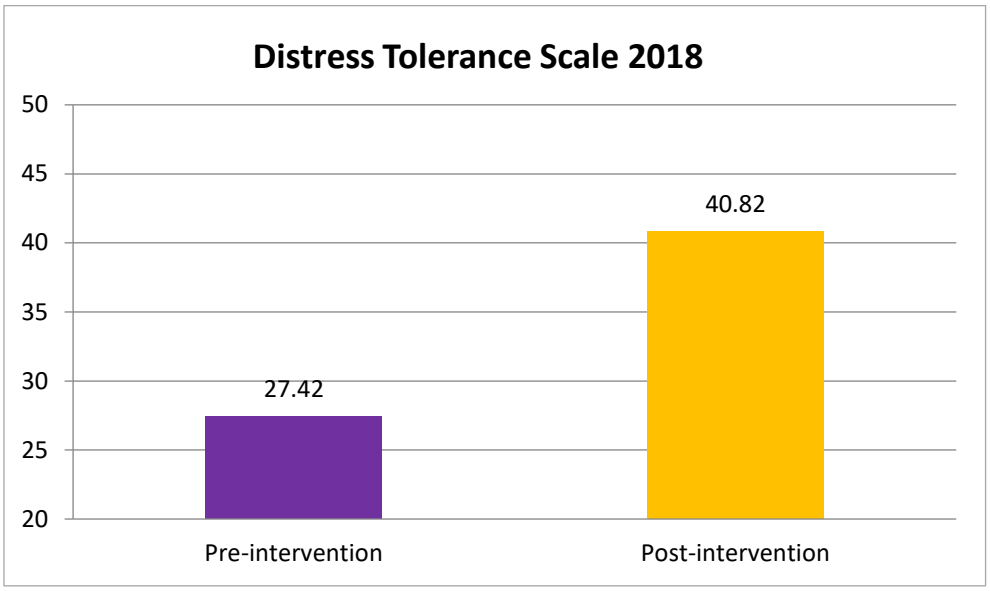


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 27.42 (*SD* = 9.88) before the programme on the DTS to 40.82 (*SD* = 13.08) after completing the programme, $z = -4.58$, $p < .001$, representing a medium effect size (r = -.48).

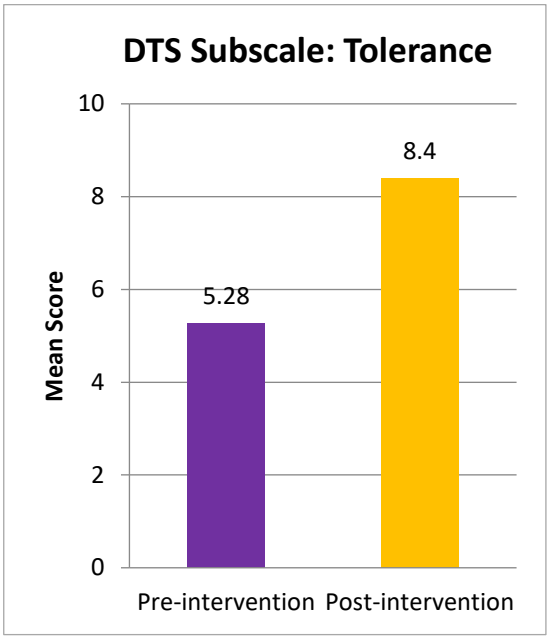
Graph: Distress Tolerance Scale Total Scores

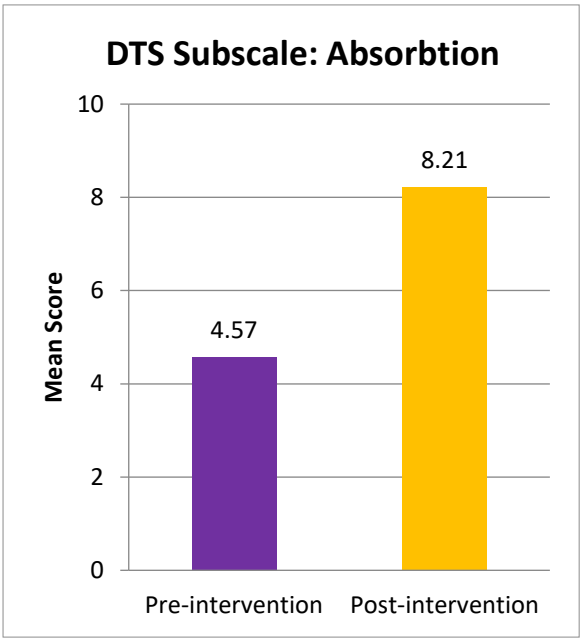


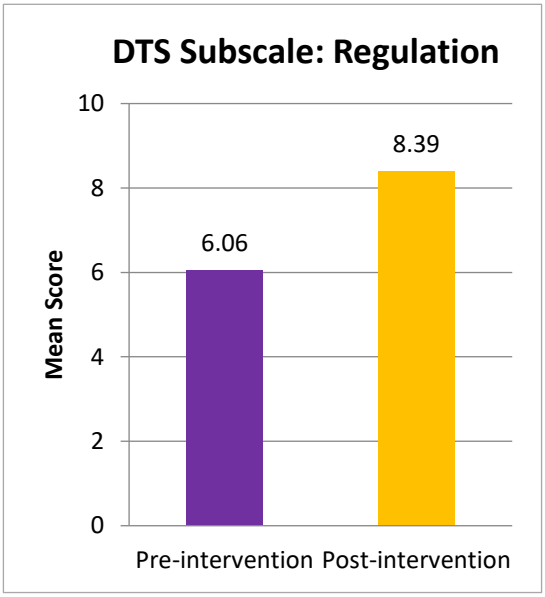
Note: Higher scores indicate increased ability to tolerate distress

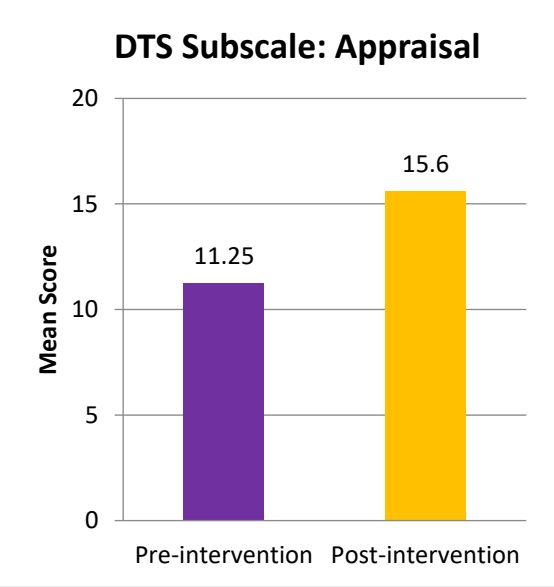
The DTS comprises of 4 subscales assessing tolerance, absorption, appraisal and regulation. There were statistically significant differences identified between pre and post intervention on all subscales; tolerance, absorption, regulation and appraisal. These results indicate that participants' distress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

Graph: Distress Tolerance Scale Sub-scales





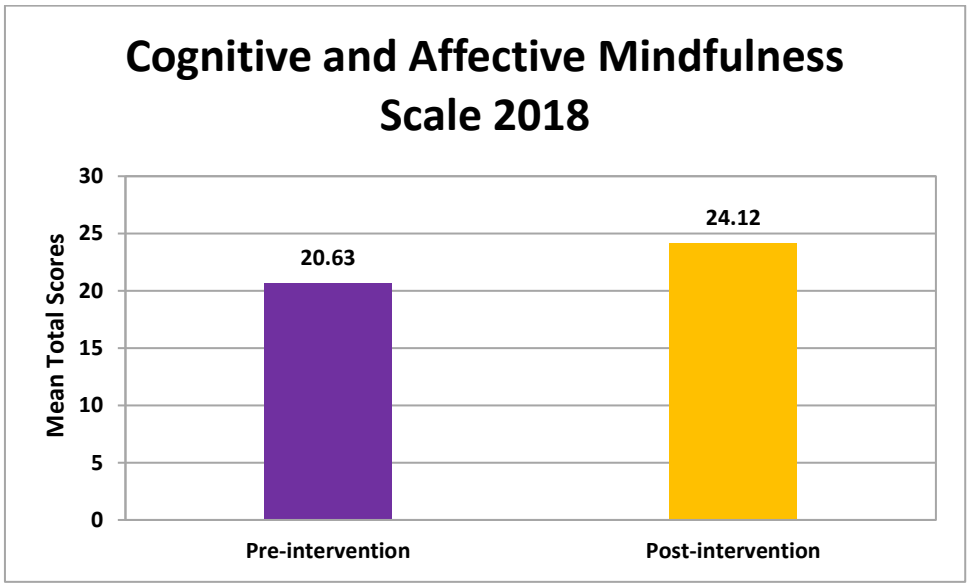




Cognitive and Affective Mindfulness Scale

Participants also had greater mindful qualities post intervention moving from a mean score of 20.63 (*SD* = 2.99) before the programme on the CAMS-R to 24.12 (*SD* = 4.27) after completing the programme. This was a statically significant change; t (42) = -5.46, p < .001, representing a large effect size (d = .83).

Graph: Cognitive and Affective Mindfulness Scale Total Scores



4.10.4. Summary

For those participants completed the programme, significant improvements were observed in increased mindfulness, improved distress tolerance, and increases in emotion regulation. Effect size calculations showed medium and large effect sizes, respectively.

4.11. Living through Psychosis Programme

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

LTP has been developed in line with established models of cognitive behavioural therapy for psychosis which promotes normalising and coping with both positive and negative symptoms. These models have been enhanced by incorporating skills that focus on emotion regulation. Given that each

patient is impacted uniquely by psychosis a formulation-based approach further informs the content of the programme.

The programme provides teaching on eight skills which have been found to be important factors to better cope with symptoms. Additionally, the programme provides a safe environment where the personal impact of psychosis can be explored. Following these eight sessions, each LTP group member is offered a level 2 intervention. This is a longer intervention and combines well established models of cognitive behavioural therapy with an emerging evidence base of Compassion Focused Therapy.

4.11.1 Living Through Psychosis Programme Outcome Measures

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

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

- **The Southampton Mindfulness Questionnaire (SMQ)**

The Southampton Mindfulness Questionnaire (SMQ; (Chadwick, Hember, Symes, Peters, Kuipers, & Dagnan, 2007) assesses awareness of distressing thoughts and images defined as a concept consisting of four related constructs: awareness of cognitions as mental events in wider context, allowing attention to remain with difficult conditions, accepting such difficult thoughts and oneself without judging, and letting difficult cognitions pass without reactions such as rumination. The measure consists of 16 items and is measured on a 7-point Likert scale, from 0 ‘strongly disagree’ to 6 ‘strongly agree’. Total scale scores range from 0 to 96.

The SMQ was included in a study by Baer et al. (2006) exploring the psychometric properties of five mindfulness questionnaires. The SMQ was internally reliable (a=.85) and significantly positively correlated with mindfulness measures, as well as with measures of emotional experience, self-compassion, psychological symptoms, and dissociation.

4.11.2. Descriptors

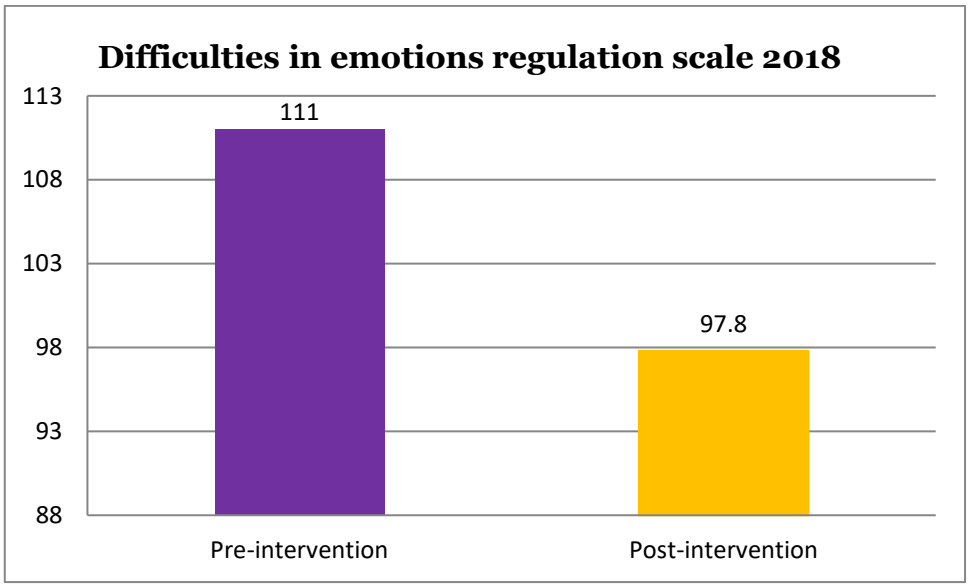
Data were collected for 12 participants who completed the programme in 2018, with an equal number of males and females. Programme attendees ranged in age from 20 to 66 years with a mean age of 36.75 (SD=14.01).

4.11.3. Level 1 Results

Difficulties in Emotion Regulation Scale

Participants experienced a decrease in difficulties regulating emotions moving from an average score of 111.00 (*SD* = 25.44) on the DERS to 97.80 (*SD* = 19.08) post completion of the programme. This change was found to be statistically significant, *t* (9) =2.33, p= .04. See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

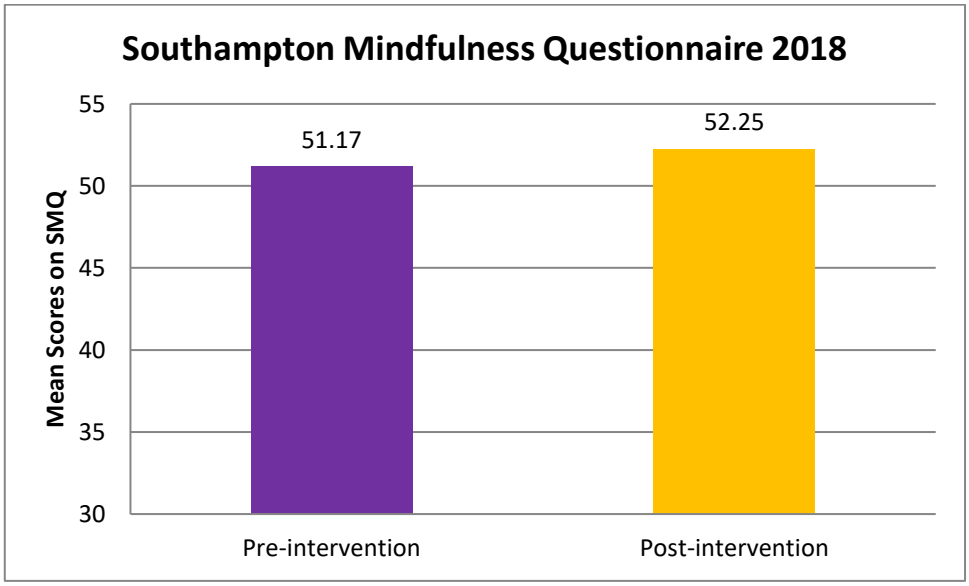


Note: Higher scores indicate greater difficulties with emotion regulation

Southampton Mindfulness Questionnaire (SMQ)

In terms of the degree to which individuals mindfully responded to distressing thoughts and images; there was an increase from an average score of 51.17 (SD = 8.26) to 52.25 (SD = 11.12) on the SMQ from pre- to post intervention. However, there was no statistically significant change identified t (11) = -.45, p= .66.

The Southampton Mindfulness Questionnaire (SMQ)



4.11.4. Summary

The Living Through Psychosis programme continues to promote a service that engages the patient actively in their recovery. The programme draws on current research findings to determine key areas to target in psychological recovery. The findings presented above demonstrate that skills such as emotion regulation can be learnt during recovery from psychosis and that it can lead to improvements in many factors related to positive recovery. The programme continues to aim towards being a central part of care planning for each person in this cohort.

4.12. Mindfulness Programme

The mindfulness programme provides eight weekly group training sessions in mindful awareness in St Edmundsbury Hospital. The course is offered in the afternoon and evening in order to accommodate service users. The group is facilitated by staff trained with Level One teacher training in Mindfulness from

Bangor University, Wales. The programme aims to introduce service users to the practice of mindfulness for stress reduction, through group discussion and experiential practices. The programme aims to help service users develop the ability to pay attention to the moment and to be more aware of thoughts, feelings and sensations, in a non-judgemental way. Developing and practicing this non-judgemental awareness has been found to reduce psychological distress and prevent relapse of some mental ill-health experiences (see Piet & Hougaard, 2011).

4.12.1. Mindfulness Programme Outcome Measures

- **Five Facet Mindfulness Questionnaire**

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

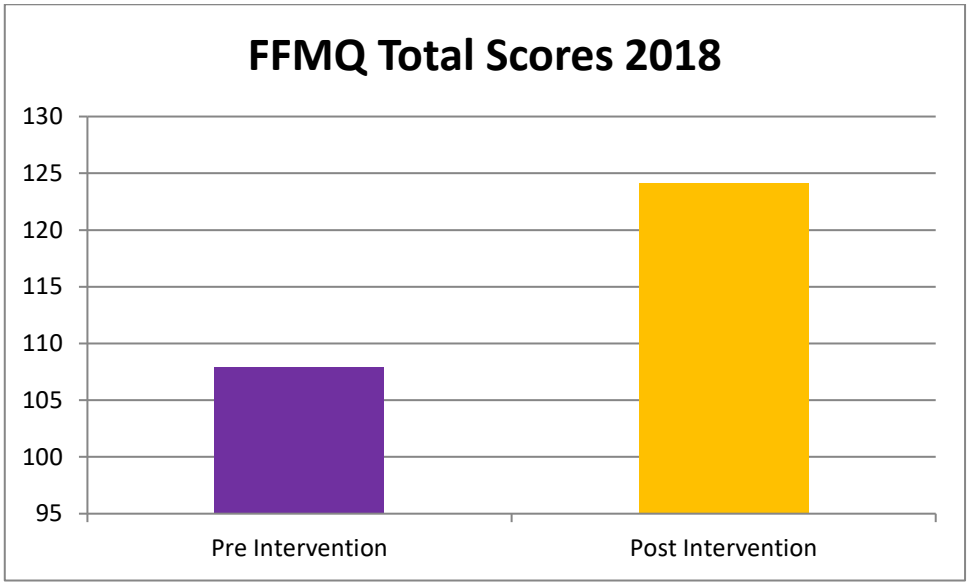
4.12.2. Descriptors

Data were collected for 41 participants, 17 males (41.5%) and 24 females (58.5%). Pre and post data were available for 17 participants. Participant's ages ranged from 21 to 70 years old (mean = 45 years).

4.12.3. Results

Five Fact Mindfulness Scale (FFMQ)

Graph: Five Facet Mindfulness Scale Total Scores



Analysis revealed a significant increase in total scores on the FFMQ from pre intervention (M=107.9; SD=16.40) to post intervention (M=124.1; SD=25.41). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (15) = 2.56, p<.05, with a medium effect size (Cohen's *d* = 0.75). These results suggest that, on average, service users who completed the outcome measure showed an increase in their tendency to be mindful in daily life.

Statistically significant increases were reported on all subscales except for the "describing" and "non-reactivity to inner experience" domains. A medium effect size for the "observing" (Cohen's *d* =0.71), the "acting with awareness" (Cohen's *d* =0.74), and the "non-judgement of inner experience" domains (Cohen's *d* = 0.65).

Table: FFMQ Mean scores by subscales, t values and effect size

FFMQ	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*P value*	*Cohen's d*
Observe	23.7 (4.3)	27.4 (6.2)	2.6	16	.019	0.71
Describe	27.7 (5.5)	28.2 (6.6)	0.3	16	.735	
Awareness	18.1 (5.8)	22.7 (6.5)	2.6	15	.021	0.74
Non-Judgement	20.5 (6.6)	25.3 (5.4)	2.5	15	.025	0.65
Non-Reactivity	18.3 (5.4)	21.1 (4.5)	2.1	16	.057	

4.12.4. Summary

In line with the 2017 report, results for 2018 suggest that the programme continues to be successful in helping service users develop their capacity for mindfulness in daily life. The analysis revealed significant change with a medium effect size apparent for changes on the measure overall. Medium effect sizes were reported for all significant subscales.

4.13. Psychology Skills Group for Adolescents

Due to the limited numbers in the Psychology Skills Group for Adolescents the outcome measures from when the group began in 2015 to 2018 are analysed together so that the data from these measures can provide us with meaningful feedback in relation to the effectiveness of the group.

The Psychology Skills Group is a psychological group therapy that aims to provide young people who are experiencing a range of mental health difficulties with new ways of coping. The group is centred on learning a mixture of skills from Dialectical Behavioural Therapy for adolescents and Group Radical Openness. The group runs for one afternoon per week for 20 weeks. The structure of the group features five modules each containing four sessions.

4.13.1. Descriptors

Data were collected for 35 young people who took part in the Psychology skills group. The average age of young people attending was 16 years.

4.13.2 Psychology Skills for Adolescents Measures

Child Behaviour Checklist (CBCL)

The CBCL is a measure which is completed by parents or caregivers to provide an indication of behavioural and emotional problems experienced by young people aged 6-18 years. It consists of 113 questions, scored on a three-point Likert scale (0=absent, 1= occurs sometimes, 2=occurs often). The measure consists of a number of sub-scales, categorised as anxious/depressed, withdrawn/depressed, somatic complaints, thought problems, attention problems, rule-breaking behaviour and aggressive behaviour. These sub-scales are grouped into two composite scales, which assess internalising behaviours and externalising behaviours. Achenbach and Rescorla (2000) found that the measure has excellent test-retest reliability and internal consistency.

Difficulties in Emotion Regulation Scale (DERS)

The Difficulties in Emotion Regulation Scale (DERS; Gratz &Roemer, 2004) assesses emotion dysregulation, 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.

DBT Ways of Coping Checklist (DBTWCCL)

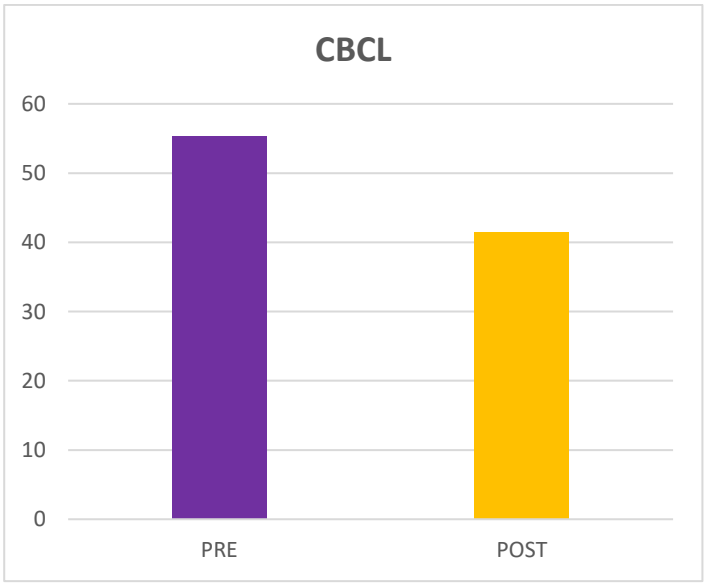
Participants completed this measure pre and post intervention. The DBTWCCL measures DBT skills use. It comprises two sub-scales, one which assesses coping using DBT skills, the DBT Skills Subscale (DSS), and one which assesses coping using dysfunctional means, the Dysfunctional Coping Subscale (DCS). The measure consists of 59 items scored on a 4-point scale, from 0

"never used" to 3 "regularly used". Higher scores indicate on the DSS indicate greater use of DBT skills, while higher scores on the DCS indicate higher levels of unhelpful coping behaviours. Neacsiu, Rizvi, Vitaliano, Lynch and Linehan (2010) found that the measure has excellent test-retest reliability, internal consistency and content validity.

4.13.3 Results

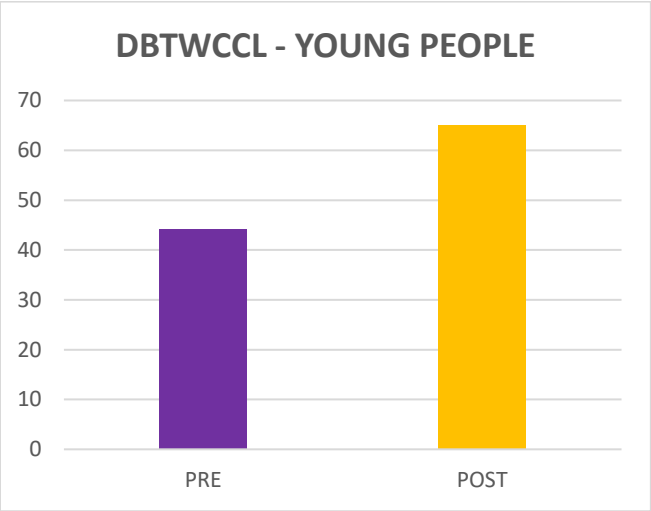
Child Behaviour Checklist (CBCL)

This measure is completed by caregivers only. Total problem scores on the CBCL as completed by the young person's caregivers decreased from pre-intervention (M = 55.34) to post intervention (M = 41.45). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(28) = 2.5$, $p < .05$, reflecting a medium effect size ($d = 0.5$).



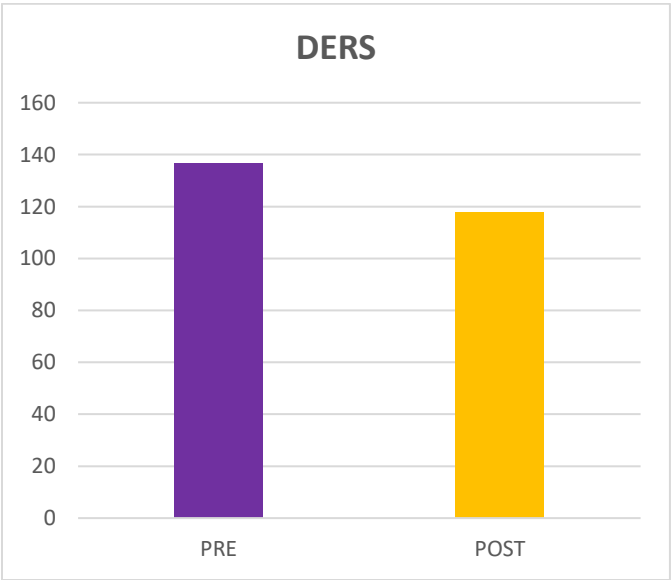
DBT Ways of Coping Checklist (DBTWCCL)

For young people, total DBT skill use increased from pre-intervention (M=44.21) to post intervention (M=65.00). Paired sample t-tests indicated that this was a statistically significant change, whereby t(13) = 4.8, p < .000, reflecting a large effect size (d = 1.1).



Difficulties in Emotion Regulation Scale (DERS)

Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=136.7) to post intervention (M=117.7). Paired sample t-tests indicated that this was a statistically significant change, whereby t(13) = 2.8, p < .05, reflecting a large effect size (d = 0.9).



4.13.4. Summary

The psychology skills group for adolescents aims to teach young people new skills for regulating emotions, fostering healthy relationships and managing distressing situations.

The findings presented provide a meaningful insight into the effectiveness of the programme. The results indicate that by attending the group, young people developed an increased capacity to tolerate distress and to manage difficult emotions. Young people who completed the group also evidenced an increase in the use of DBT skills when coping. Parents and caregivers reported a decrease in young peoples' externalising behaviours, such as physical aggression and rule-breaking, and a decrease in internalising behaviours, such as low mood and anxiety.

4.14. Radical Openness Programme

The Radical Openness (RO) Programme is a therapeutic group delivered by the Psychology Department. The programme is based on an adaptation of DBT for "emotional overcontrol", developed by Tom Lynch (Lynch, 2018; Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007; Lynch & Cheavens, 2008). The programme is for individuals who have developed an overcontrolled style of coping. This includes inhibiting emotional experience and expression, maintaining aloof and distant relationships, and having rigid cognitions and behaviours.

The Radical Openness programme aims to enhance participants' ability to 1) experience and express emotion 2) develop more fulfilling relationships and 3) be more open to what life can offer. The group is underpinned by a model that suggests that behavioural overcontrol, psychological rigidity, and emotional constriction can underlie difficulties such as recurrent depression, obsessive-compulsive characteristics and restrictive eating difficulties. Radical Openness is offered over a five-month period, twice a week for eleven weeks and then once a week for four weeks.

4.14.1. Radical Openness Programme Outcome Measures

Brief symptom Inventory

The Brief Symptom Inventory (BSI; Derogatis, 1993) is a 53-item measure of symptoms that cause service users to experience psychological distress within the previous week. Psychometric evaluations (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004) have shown that the BSI is a reliable and valid measure. It has good test-retest reliability and internal consistency, and it shows high convergence with comparable scales on the SCL-90-R and MMPI. Service users rate each symptom on a scale of 0 'Not at all' to 4 'Extremely'. The Global Severity Index score, which is used in this report, is the best indicator of current distress levels.

The Social Connectedness Scale-Revised

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

Distress Tolerance Scale

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

4.14.2. Descriptors

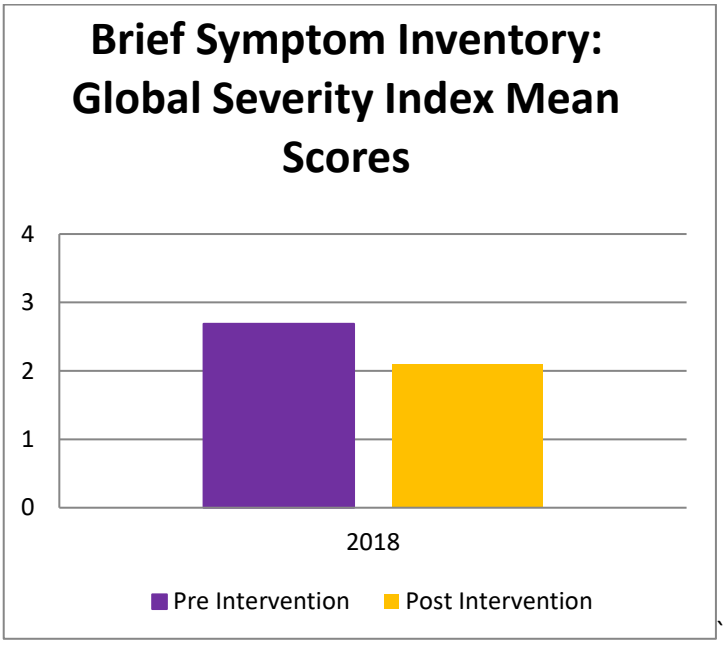
Data were collected for 27 participants in 2018. 51.6% of participants were female and 48.4% were male and they ranged in age from 19 to 71 years (M=39.6; SD=14.5).

4.14.3. Results

Brief Symptom Inventory

A significant reduction in service users' psychological distress was observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale on the Brief Symptom Inventory (BSI), whereby t(25)= 4.53, p<.001, reflecting a large effect size (*d*= .83).

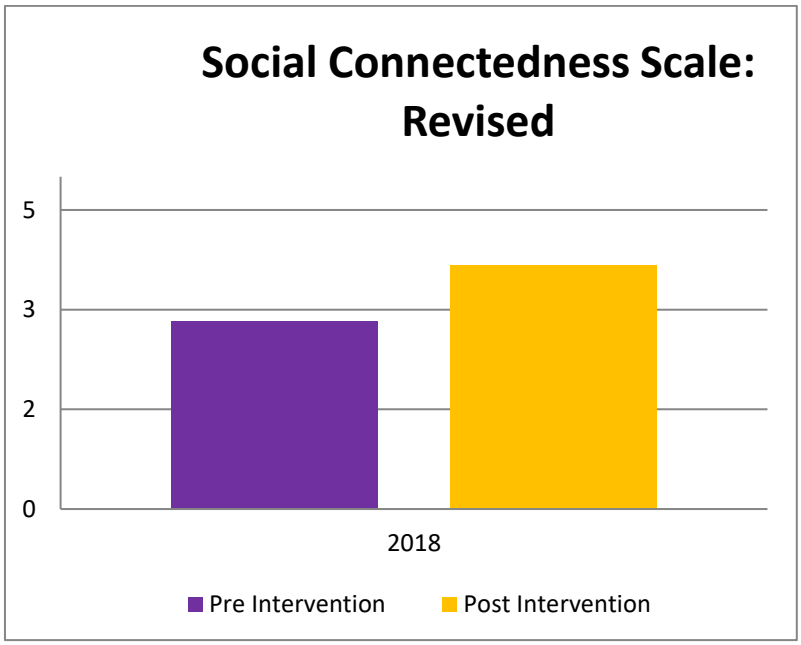
Graph: Brief Symptom Inventory Global Severity Index



Social Connectedness Scale: Revised

A significant change was also observed on the SCS-R, whereby t (25) = 6.84, p< .001, reflecting a large effect size (Cohen's *d*=0.88), suggesting that after the programme participants felt more connected to their social world.

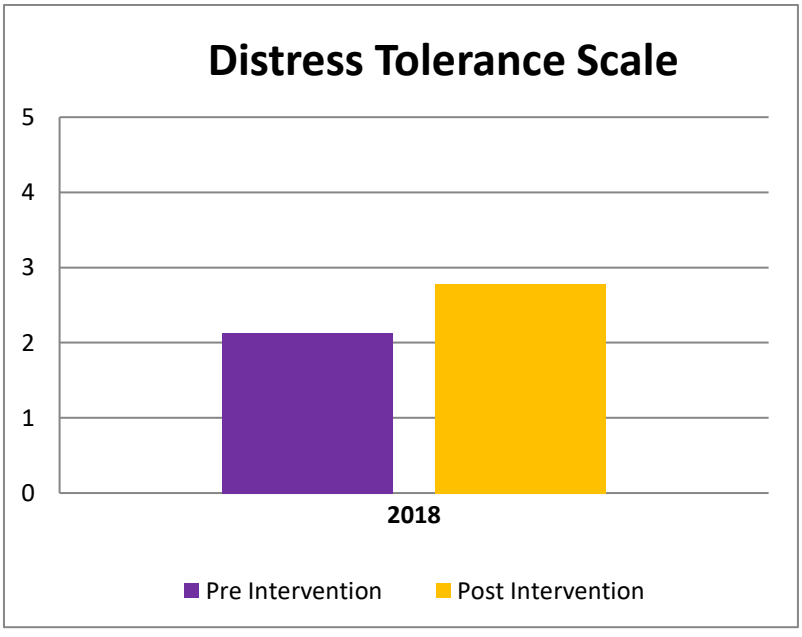
Graph: Social Connectedness Scale: Revised



Distress Tolerance Scale

A significant change was also observed on the DTS, whereby t (24) = 3.62, p< .001, reflecting a large effect size (Cohen's *d*=0.85), suggesting that after the programme participants were better able to tolerate their distress.

Graph: Social Connectedness Scale: Revised



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

Scale	Pre Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
BSI	2.69 (0.8)	2.10 (0.7)	4.53	25	.001	0.83
SCS-R	2.82 (1.2)	3.66 (1.1)	6.84	25	.001	0.88
DTS	2.13 (0.8)	2.78 (0.8)	3.62	24	.001	0.85

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

4.14.4. Summary

The Radical Openness group therapy programme helps individuals develop a better understanding of their emotional and behavioural overcontrol and new ways of coping that are less costly in their lives. This is a targeted approach for service users who are often underserved in mental health care. In 2018 service users who completed Radical Openness showed reductions in psychological distress as measured by mental ill health symptoms as well as emotional avoidance (i.e. avoiding the internal experience of emotion) and increases in social connectedness. These findings were consistent with previous years.

Service users who have completed the programme report better insight into their overcontrol and the impact this can have in their lives. This is supported by the significant improvements in ability to tolerate distress and in social connectedness as found in this report.

4.15. Psychosis Recovery Programme

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

building resilience, and occupational therapy. The programme is delivered by members of a multi-disciplinary team (MDT) which includes a Consultant Psychiatrist, Clinical Nurse Specialist, Clinical Psychologist, Occupational Therapist, and a Pharmacist.

4.15.1. Psychosis Programme Outcome Measures

- **Recovery Assessment Scale**

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

- **Drug Attitude Inventory**

The Drug Attitude Inventory (DAI: Hogan, Awad & Eastwood, 1983) is commonly used to measure service users' attitudes towards psychotropic treatment. A valid and reliable 10 item brief version of the DAI has been developed (see Nielsen, Lindstrom, Nielsen and Levander, 2012) and was used in data collection for the psychosis programme from January 2015. The DAI-10 scoring ranges from -10 to 10. Whereby a total score of >0, indicates a positive attitude toward psychiatric medications. DAI-30 and DAI-10 were homogenous (r=0.82 and 0.72, respectively) with good test–retest reliability (0.79). The correlation between the DAI versions was high (0.94).

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

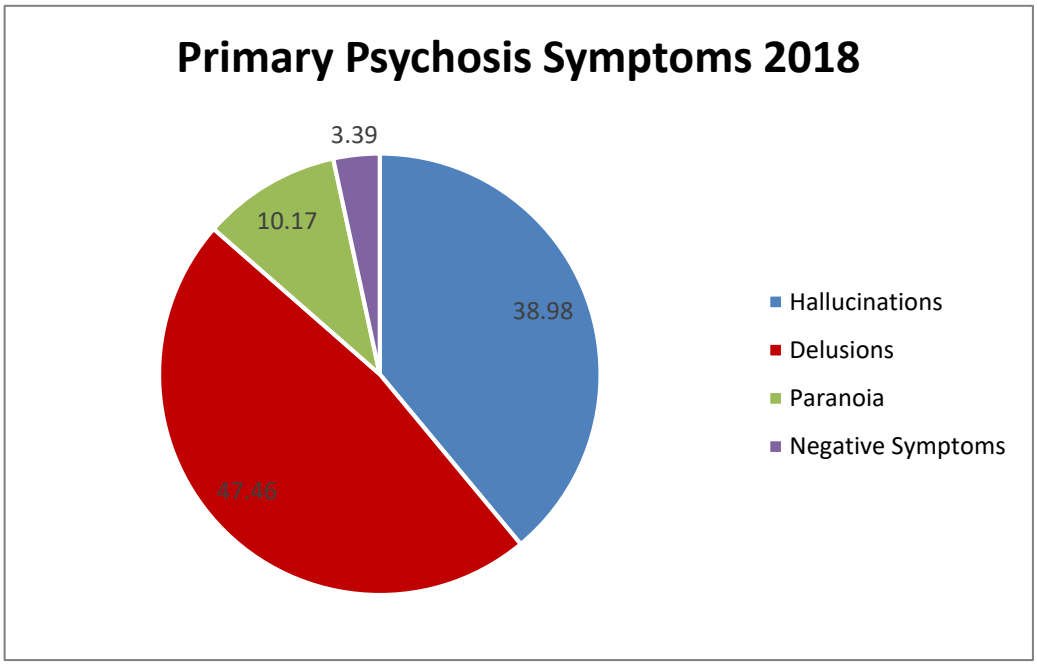
4.15.2. Descriptors

In 2018 completed pre and post RAS and DAI scores were collected for 21 participants. The average age of psychosis programme participants was 37.47 years (ranging from 18-74 years) with a slightly lower number of females (n=8) than males (n=13). 74.6% were single, 20.6% married, and 3.2% were separated or divorced while 1.6% were cohabiting with a partner. 40.9% were in employment, 22.7% were unemployed, 13.6% were students, 15.2% were receiving disability allowance, and a further 7.5% were either in part-time employment or retired. 32.3% had attained a third level degree, 40% had completed the leaving certificate, with 9.2% having a non-degree third level qualification. The remaining 18.4% had left school before the leaving certificate. The majority lived with family (63.6%) followed by living alone (27.3%). 6% were living with friends or cohabiting and 3% were homeless. The majority of service users reported their ethnicity as white Irish (95.5%). Comparing 2017 to 2018, services users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

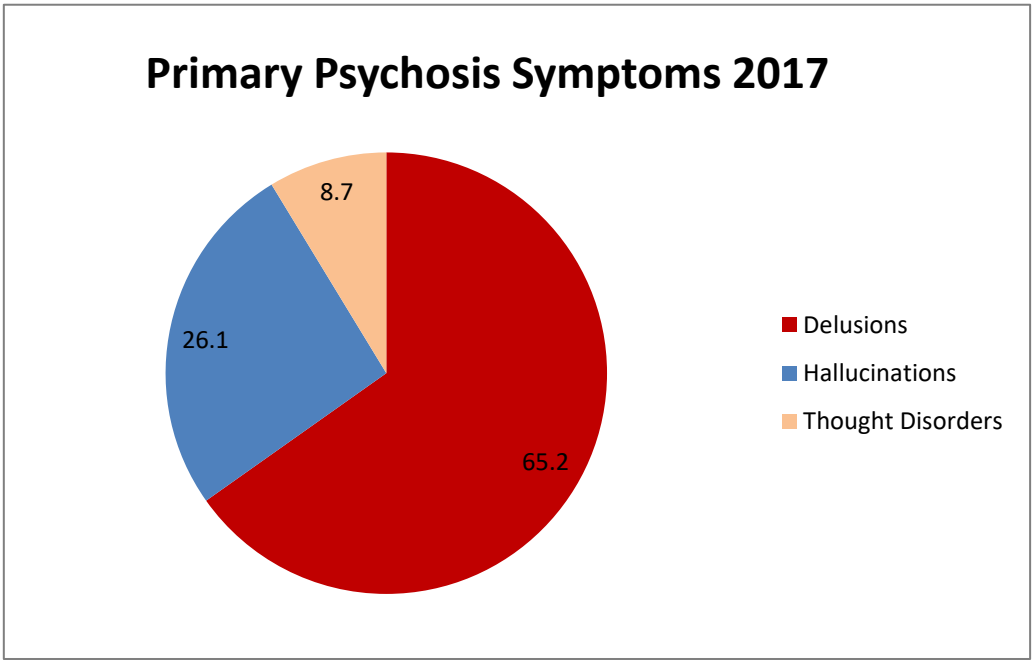
There were similar trends identified in the primary psychosis experience reported for service users in 2017 and 2018. In 2017 the primary reported symptoms were delusions (65.2%), followed by hallucinations (26.1%), and thought disorders (8.7%). In 2018, the primary reported symptoms were delusions (47.5%), followed by hallucinations (39%), paranoia (10.2%) and negative symptoms (3.4%) See the figures below for reported primary psychosis symptoms in 2017 and 2018. The average attendance at sessions per client in 2018 was 10.63. Participants are permitted to attend multiple cycles of the programme.

4.15.3. Results

Graph: Primary Psychosis Symptoms 2018



Graph: Primary Psychosis Symptoms 2017



Recovery Assessment Scale

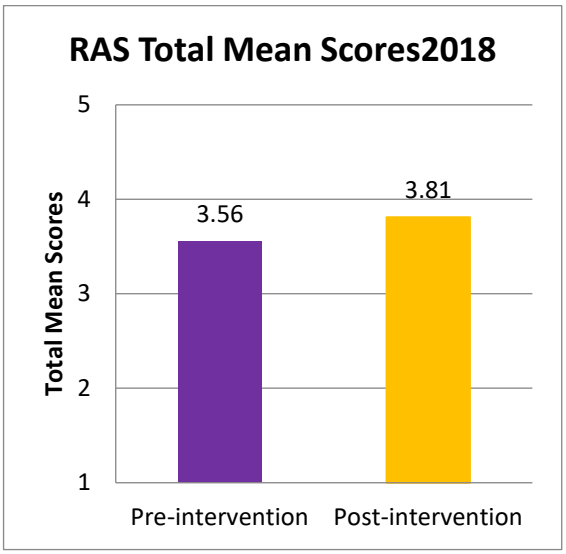
A Wilcoxon Signed Rank test identified a statistically significant difference in mean total scores for the RAS from pre- intervention (M=3.56; SD=.49) to post intervention (M=3.81; SD=.58), z=-2.13, p=<.05 with a small effect size (*r*=-

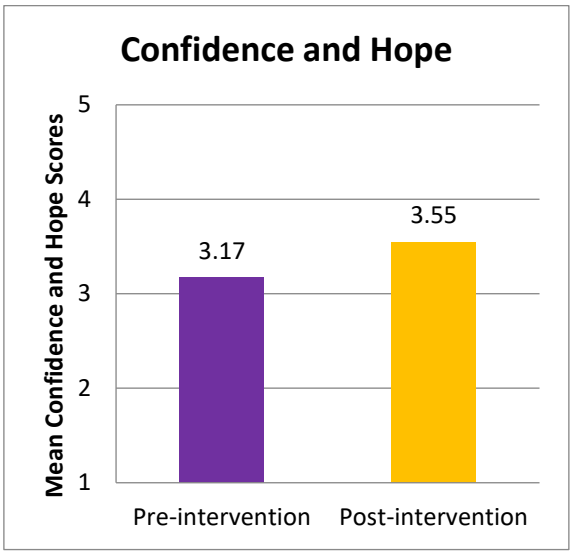
0.33). This indicates that service users experienced an increase in coping ability and quality life following completion of the programme. Looking at the RAS sub-scale scores, significantly higher scores were identified post intervention for users on the 'Confidence and hope' subscale, z=-2.2, p<.05, the 'Goal and success orientation' subscale, z=-2.6, p<.05 and the 'No domination by symptoms' subscale, z=-2.47, p<.05. The difference between pre- and post- intervention means on the 'Ability to rely on others' and 'Willingness to ask for help' subscales were not statistically significant. See the table below for test statistics and figures for differences in pre- and post-intervention means and graphs on the following page for visual representations.

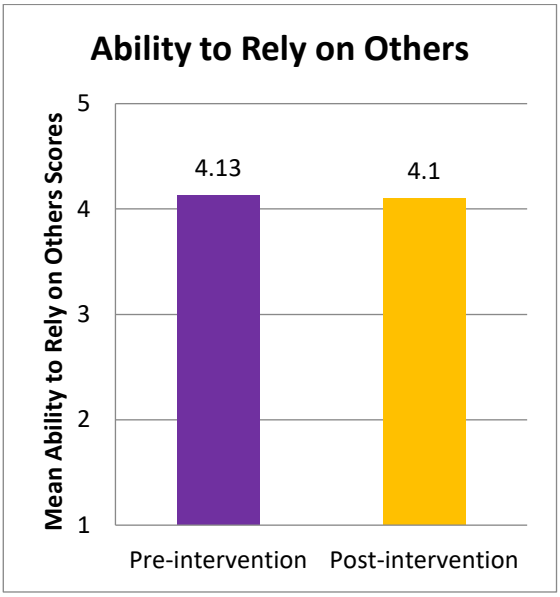
RAS	**Pre Mean**	**Post Mean**	***z***	***p***	***r***
Mean Total	3.56 (.49)	3.81 (.58)	-2.13	.03	-0.33
Confidence and Hope	3.17 (.71)	3.55 (.79)	-2.2	.03	-0.34
Willingness to ask for Help	3.93 (.65)	4.03 (.44)	-.39	.69	-0.06
Goal/ Success Orientation	3.77 (.65)	4.07 (.53)	-2.6	.01	-0.39
Ability to Rely on Others	4.13 (.61)	4.10 (.61)	-.27	.79	-0.37
No Domination by Symptoms	2.81 (1.07) (.95)	3.35 (1.00)	-2.47	.01	-0.04

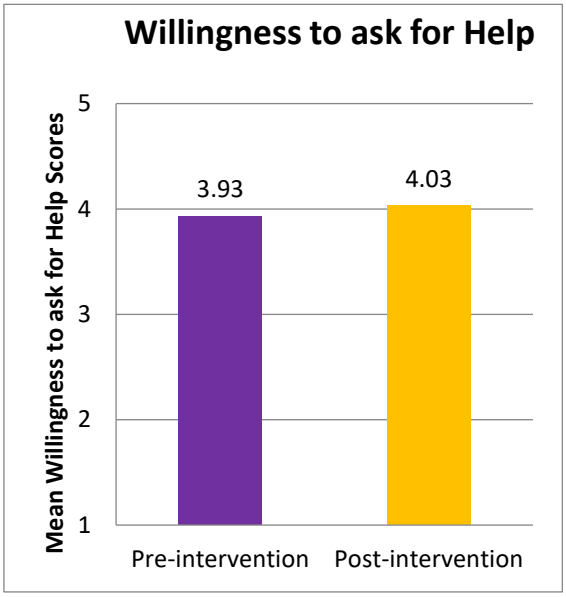
Table: *Results from Wilcoxon Signed Rank tests for the RAS pre and post scores*

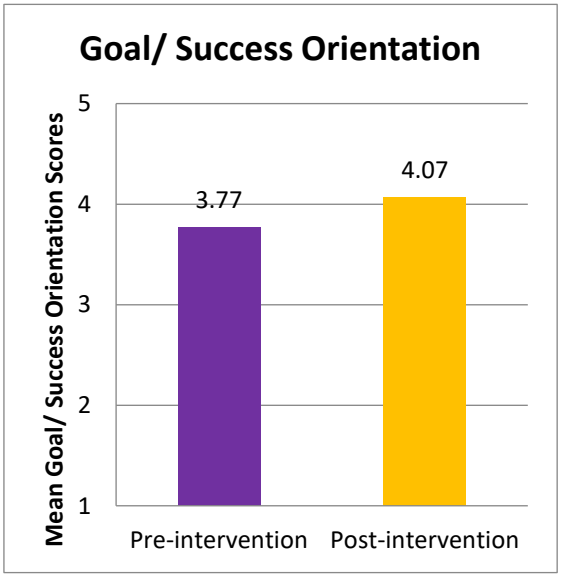
Graphs: Recovery Assessment Scale sub-scales

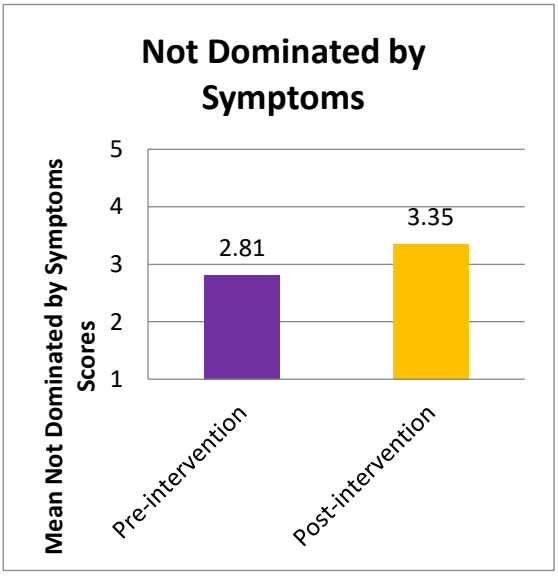






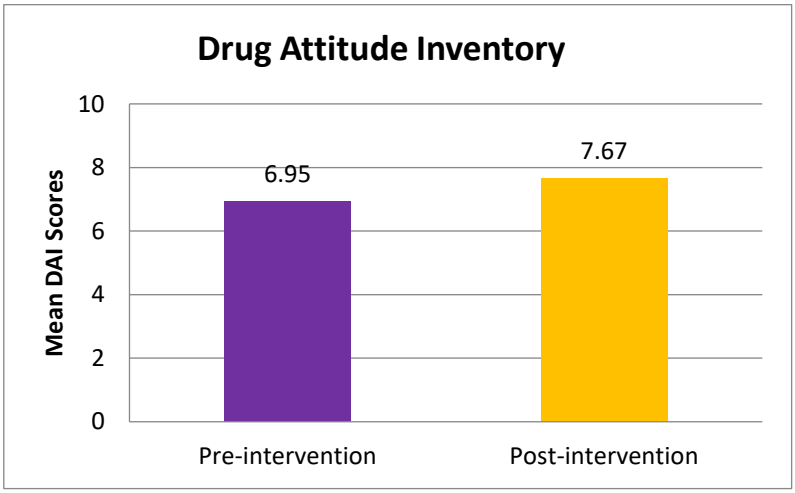






A Wilcoxin Signed Rank test identified an increase in mean scores on the DAI-10 from pre- intervention (M=6.95 SD=2.13) to post intervention (M=7.67; SD=1.77), however this was not statistically significant; z=-1.7, p=.09 (*r*= -0.27). The mean scores indicate that some service users who completed the measures reported more positive views towards medication after completing the programme, though this is not statistically significant.

Graph: Drug Attitude Inventory mean scores



4.15.4. Summary

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

Programme staff explained that their client's inability to complete the measures accurately at the pre time point due to the acute nature of their illness has resulted in significant amount of lost data. It is important to note that questionnaires were distributed to 66 service users who attended the programme therefore the results outlined above may not be indicative of all views of those attending the psychosis programme. Programme staff will be proactive in encouraging completion of measures accurately in order to increase response rates in 2019.

4.16. 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 St Patrick's Mental Health Services (SPMHS) is delivered through the Wellness and Recovery Centre for day-patients.

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

The programme is group based and focuses on accessing good health care, managing medications, self-monitoring their mental health using their WRAP; using wellness tools and lifestyle; keeping a strong support system; participating in peer support; managing stigma and building self-esteem. The option of attending monthly aftercare meetings are available to all participants for a period of 12 months after completion of the programme. The programme is delivered by four mental health nurses and two part-time social workers with sessional input from a pharmacist, a service user who is drawn from a panel of experts by experience, consumer council and carer representatives.

4.16.1. Recovery Programme Outcome Measures

• Recovery Assessment Scale

The Recovery Assessment Scale (RAS: Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) assesses service user empowerment, coping ability, and quality of life. Scale scores have been found to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms

suggesting discriminant validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

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

4.16.2. Descriptors

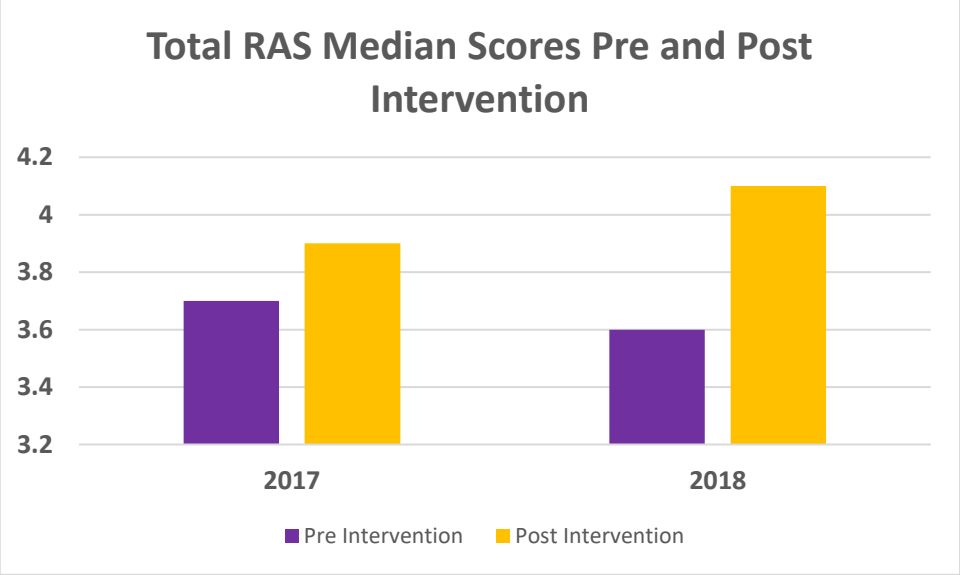
Data were collected for 21 participants who attended in 2018. The average age of participants was 53 years and 61.9% were female.

4.16.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre-measurement (*Md* = 3.6) to post measurement (*Md* = 4.1) indicating greater overall recovery. A Wilcoxin Signed Rank Test revealed this increase was not statistically significant, $z = 1.59$, $p > 0.05$.

Graph: Recovery Assessment Scale: Median Scores



The figures below show pre and post scores on each of the five subscales: 'Personal Confidence and Hope', 'Willingness to ask for Help', 'Ability to rely on others', 'Not dominated by Symptoms' and 'Goal and Success Orientation'.

A series of t-tests and Wilcoxin Signed rank tests were run in order to compare pre and post scores, mean and median scores, standard deviations, z values, *p* values and effect sizes for each of the subscales. Significant change was seen across all subscales as can be seen in the tables below.

Table 1: Mean scores on RAS (t-tests)

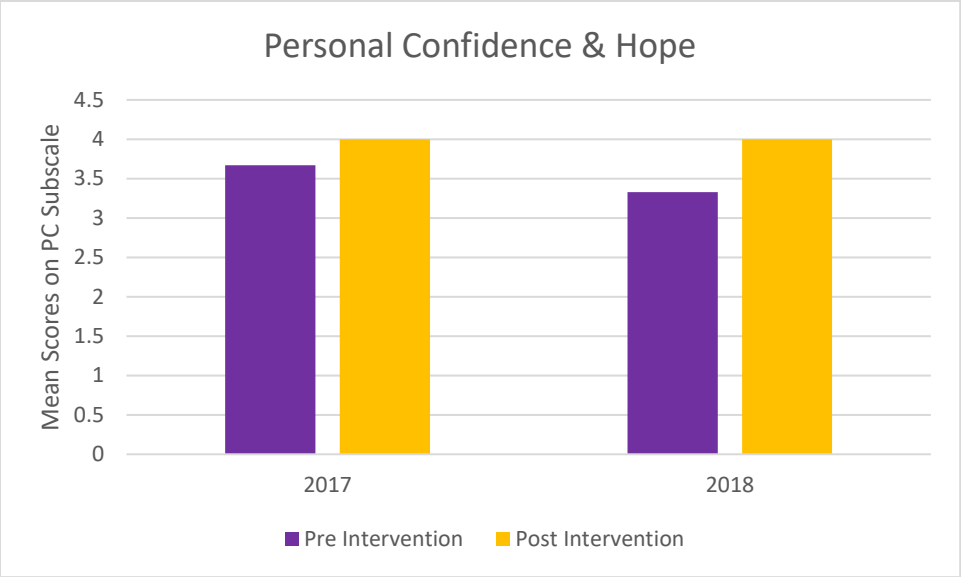
RAS	**Pre** ***Mean (SD)***	**Post** ***Mean (SD)***	***T value***	***P***	***Cohen's d***
Willingness To Ask For Help	3.27 (0.7)	3.78 (1.3)	2.7	.014	0.52

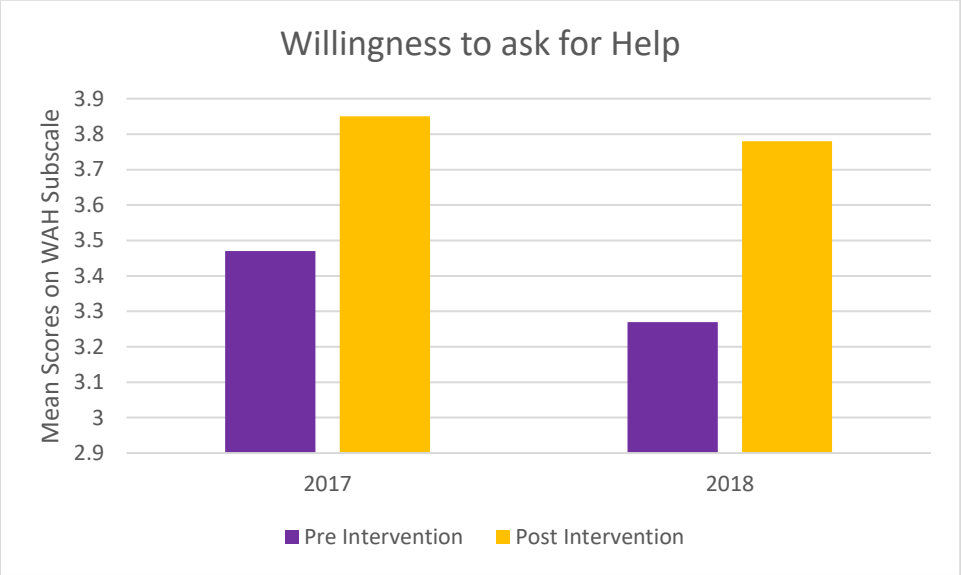
Table 2: Median scores on RAS (Wilcoxin Signed rank tests)

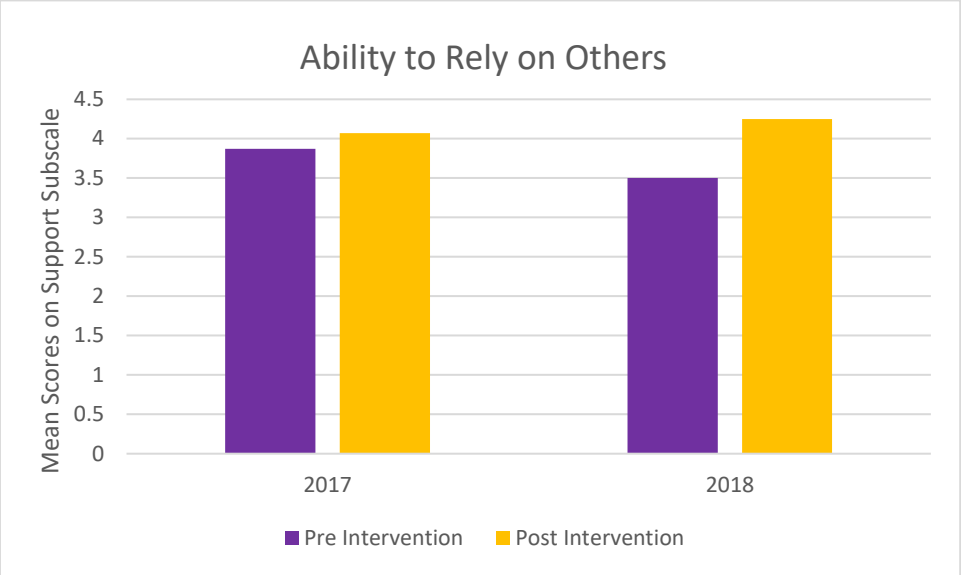
RAS	**Pre** ***Median***	**Post** ***Median***	***Z value***	***P***	***Cohen's r***
Personal confidence	3.33	4.00	2.65	.008	0.4
Ability To Rely On Others	3.50	4.25	2.14	.033	0.4
Not Dominated By Symptoms	3.33	4.00	2.96	.003	0.5
Goal and Success Orientation	3.60	4.20	2.98	.003	0.5

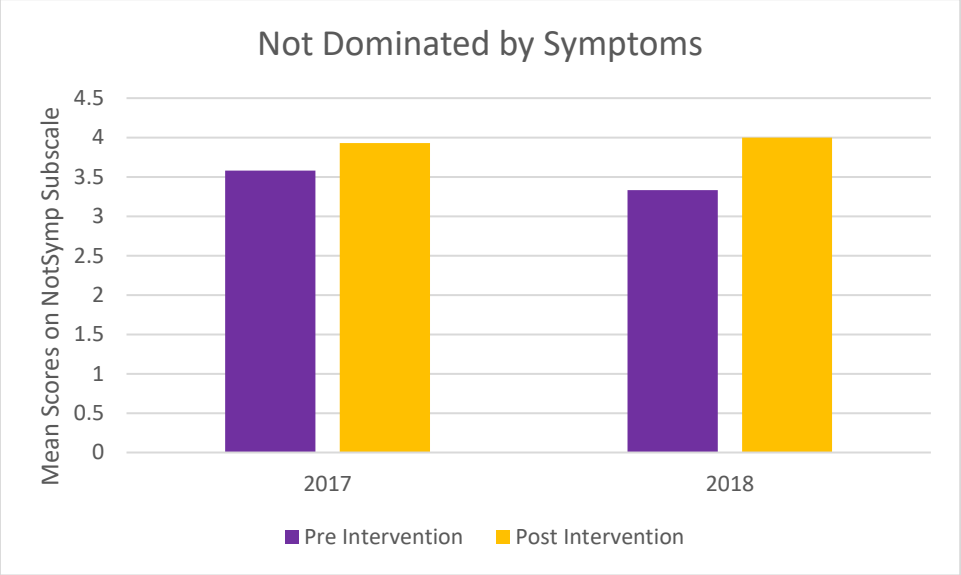
Scores on each of the 5 subscales improved significantly from pre to post measurement (see the graphs below).

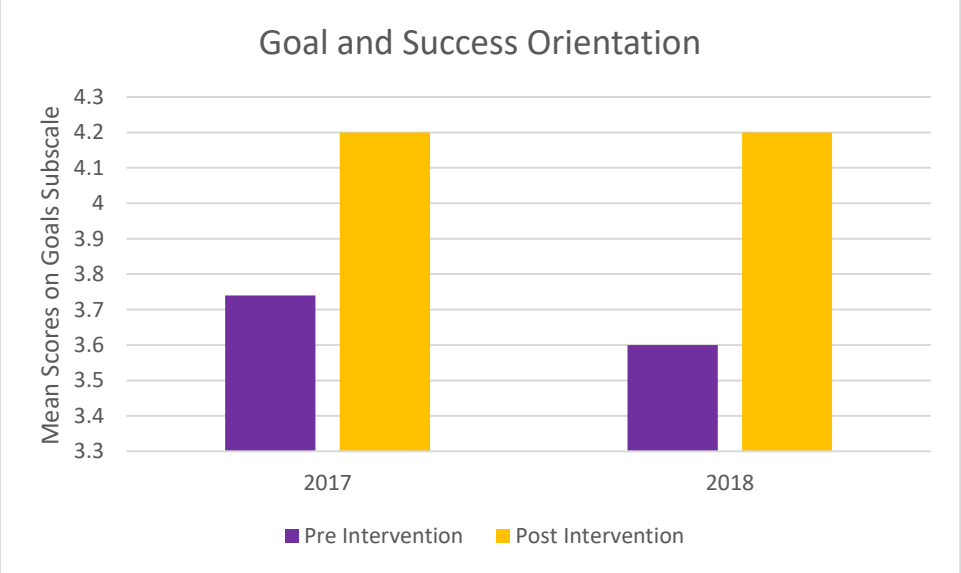
Graphs: Recovery Assessment Scale sub-scale






Ability to Rely on Others
Mean Scores on Support Subscale
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2017
2018
Pre Intervention
Post Intervention

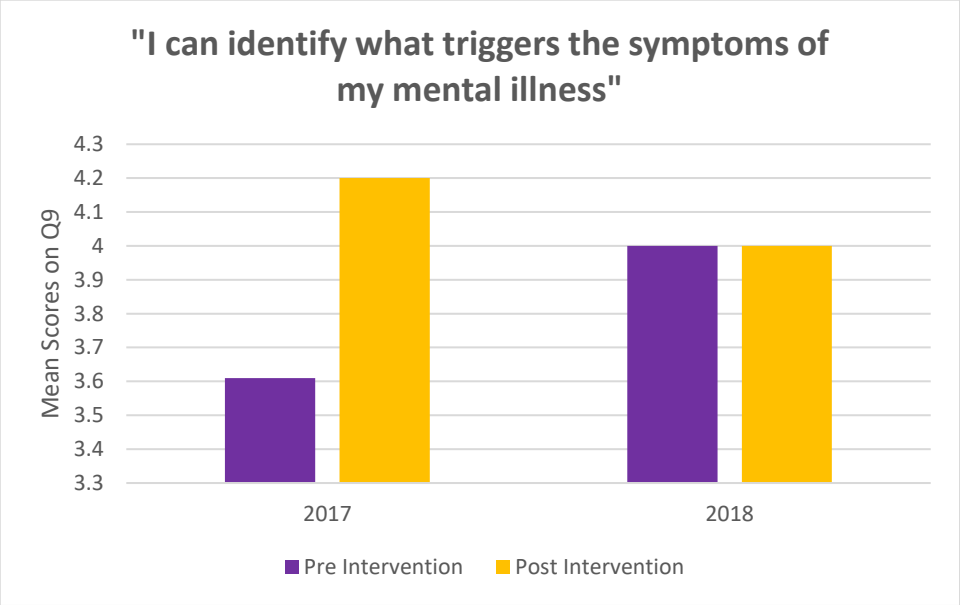

Not Dominated by Symptoms
Mean Scores on NotSymp Subscale
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2017
2018
Pre Intervention
Post Intervention

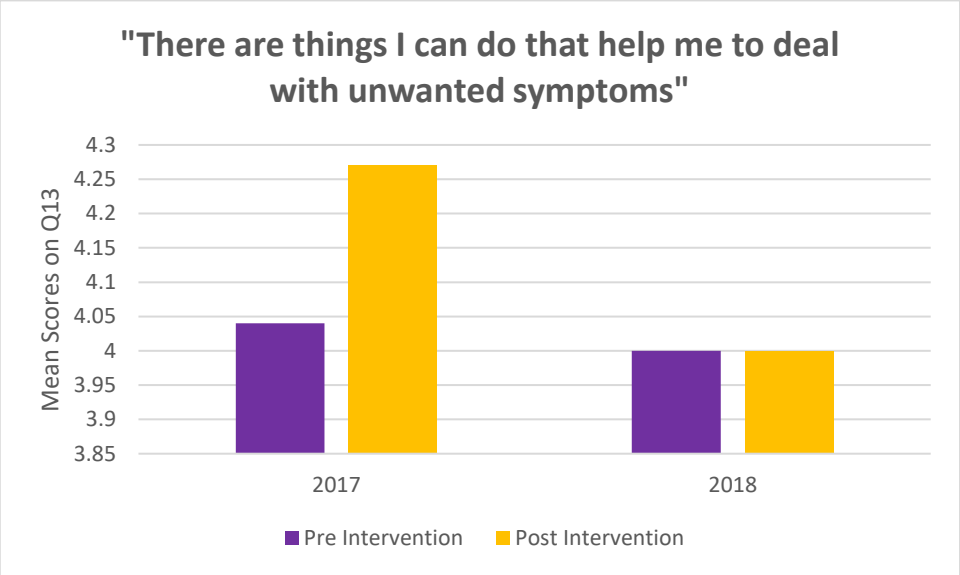

Goal and Success Orientation
Mean Scores on Goals Subscale
4.3
4.2
4.1
4
3.9
3.8
3.7
3.6
3.5
3.4
3.3
2017
2018
Pre Intervention
Post Intervention

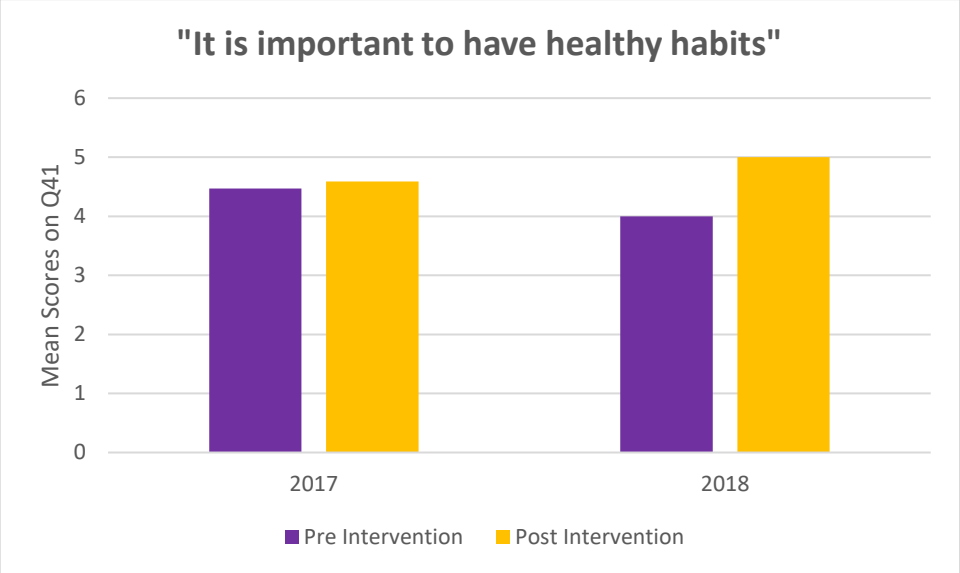
From clinician reflection it was recommended in the 2012 report to examine certain individual items not included in the subscale scores that reflect elements of the programme. These included item 9 “I can identify what triggers the symptoms of my mental illness”, item 13 “There are things I can do that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

A series of Wilcoxin Signed Rank tests were run, and scores improved significantly, p <0.05, from pre to post measurement (see the following graphs) for item 41. Item 9 and item 13 both showed improved scores at post measurement however these were not statistically significant P >0.05. Item 41 showed a medium effect size, r = 0.31, while both item 9 and 13 evidenced small effect sizes, r = 0.27 and r = 0.24, respectively.

Graph: Recovery Assessment Scale Questions 9, 13, 41







4.16.4. Summary

The findings presented provide insight into the effectiveness of the programme. Careful consideration has been given to the retention of the RAS as the primary outcome measure for the Recovery Programme. While there is no "gold standard" measure of recovery, the RAS has strong support for its psychometric properties. The RAS was found to meet a number of criteria set out by Burgess, Pirkis, Coombs and Rosen (2010), in their assessment of existing recovery measures including; measuring domains related to personal recovery, is brief, takes a service user perspective, is suitable for routine use, has been scientifically scrutinised, and demonstrates sound psychometric properties.

In summary, those who completed the programme showed significant improvements on each of the 5 subscales. While significant change was not observed on the total RAS scale, this could be due to the smaller sample size relative to previous years. Improvements made demonstrated small to medium effect sizes. In addition, one of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements at post intervention, with a medium effect size.

4.17. Sage Older Adults Psychology Skills Group

SAGE is a psychological therapy group for older adults who are experiencing difficulties with anxiety and /or depression and are interested in applying a psychological approach to their difficulties. The group is adapted from psychological theories about emotional regulation and emotional over-control (Linehan, 1993; Lynch et al, 2016), and how these can underpin certain recurrent mental health problems. The format is skills based, with eight skills taught twice over 16 sessions, which address problems of emotional regulation, interpersonal aloofness, emotional loneliness, and cognitive and behavioural rigidity.

4.17.1. Sage Outcome Measures

Difficulties in Emotion Regulation Scale

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

Depression, Anxiety and Stress Scale

The 21-item Depression, Anxiety and Stress Scale (DASS) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. Each item comprises a statement and four short response options to reflect severity and scored from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*). In order to yield equivalent scores to the full DASS 42, the total score of each scale is multiplied by two (Lovibond & Lovibond, 1995) and ranges from 0 to 42. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items. The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

4.17.2. Descriptors

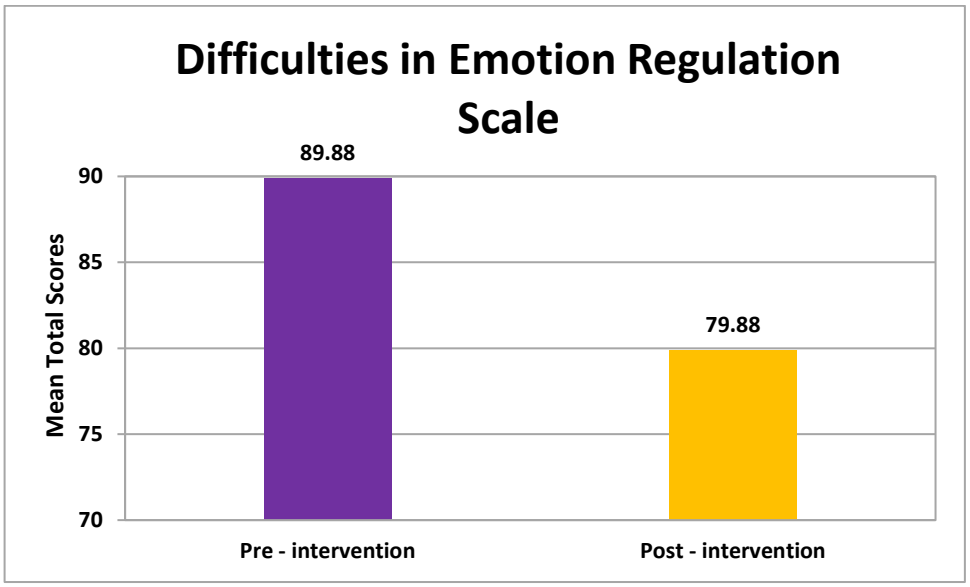
Data were collected for 15 participants in 2018, of whom 9 (60%) were female and 6 (40%) were male. Programme attendees ranged in age from 65 to 84 with a mean age of 73.73 (SD = 6.05). People attended an average of 13.73 sessions.

4.17.3. Results

Difficulties in Emotion Regulation Scale

Complete data for the DERS was available for 8 service users only, therefore the results may not be representative of the experience of all service users who returned the measures. A decrease in difficulties regulating emotions was observed, moving from a mean score of 85.88 (SD = 14.92) to 79.88 (SD = 17.07) post completion of the programme, though this was not statistically significant; t (7) = 1.26, p > .05. This change, though not significant, reflected a small to medium effect size (Cohen's d = .45). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

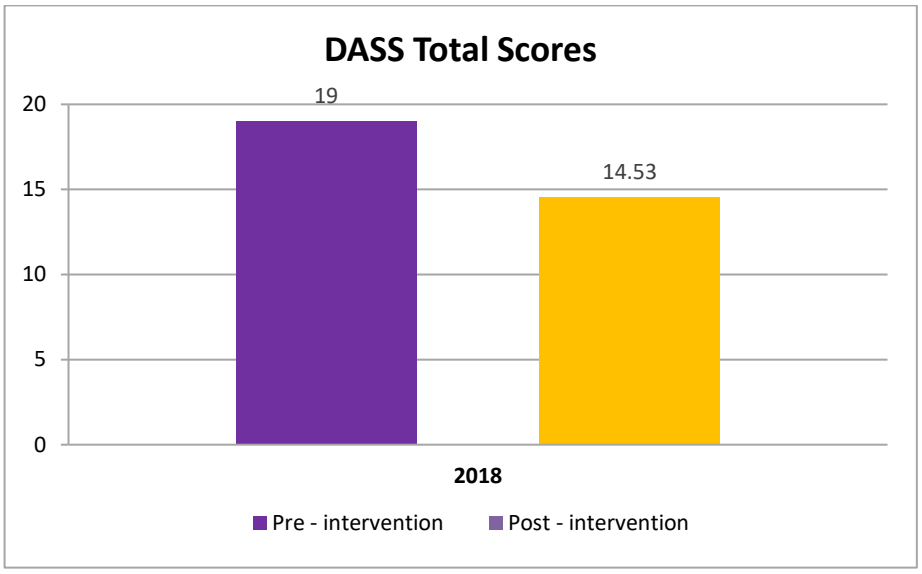


Note: Higher scores indicate greater difficulties with emotion regulation

Depression, Anxiety and Stress Scale (DASS)

Scores on the DASS scales decreased from a mean of 19.00 (SD = 9.36) to a mean of 14.53 (SD = 11.67) post completion of the study. However, this improvement was not statistically significant, t (14) = 1.93, p = .07.

Graph: Depression, Anxiety and Stress Scale (Total)



There are three subscales within the DASS and the figures below show pre and post scores on each of these subscales including: "Depression", "Anxiety", and "Stress". Following a series of Wilcoxon Signed Rank Tests, mean scores, z values, *p* values and effect sizes (*r*) for the subscales are shown in the following table.

Table: DASS Subscale Scores 2018

DASS	Pre *Mean*	Post *Mean*	z	*p*	*r*
Depression	7.36	5.29	-2.28	.02	-0.43
Anxiety	4.71	4.36	-.46	.67	-0.09
Stress	7.08	4.92	-1.81	.08	-0.35

There was a significant decrease in scores on the depression subscale from pre to post intervention from a mean of 7.36 to a mean of 5.29; z = -2.28, $p < .05$ with a small effect size (r= -0.43). Scores on the Anxiety and Stress subscales did not show significant improvements from pre to post measurement.

4.17.4. Summary

Improvements were observed in group member's ability to regulate their emotions as indicated by their pre and post mean scores on the DERS; however

this was not statistically significant. Significant reductions were evident in a self-reported measure of depression, as indicated by patients scores on the DASS. The smaller sample size may have impacted the power to detect meaningful differences and it is important to hold this in mind when interpreting the results.

Anecdotally, group members have found that the group "(gave me) a new vocabulary to describe feelings, emotions, states of mind, etc.". A group member noted that they now "know(ing) if I am feeling down it is only temporary once I do the mindfulness". Other group members stated that "it was interesting to find that I shared some problems with other people" and that they have "a newfound confidence and an acceptance of all that has changed in my life".

Due to difficulties statistically with the sample size, new outcome measures have been adopted starting with a cycle which began in November 2018. The Depression, Anxiety and Stress Scale has been retained, and three new measures have been introduced; the Acceptance and Action Questionnaire-II (Bond et al, 2011), the Personal Need for Structure Scale (Neuberg & Newsom, 1993) and the Social Connectedness Scale-Revised (Lee & Robins, 1995). We look forward to analysing data from these measures going forward.

In addition, a piece of qualitative research examining change processes within the programme will begin in 2019. The research will be carried out by a psychologist undergoing further clinical training on the Doctoral Programme in Clinical Psychology in Trinity College Dublin in conjunction with the Sage programme team and the Department of Psychology in SPMHS.

4.18. Willow Grove Adolescent Unit

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

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

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

- Mood Disorders
- Anxiety Disorders
- Psychosis
- Eating Disorders

Our Treatment Approach

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

4.18.1 Willow Grove Outcome Measures

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

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) was developed as an outcome measure for children and adolescents (3-18 years) engaging with mental health services (Gowers, Levine, Bailey-Rogers, Shore & Burhouse, 2002). This measure provides a global assessment of the behaviour, impairments, symptoms and social functioning of children and adolescents with mental health problems. Studies such as Garralda et al. (2000) have found the validity and inter-rater reliability of the HoNOSCA to be satisfactory. Lesinskiene, Senina & Ranceva (2007)

investigated the use of the HoNOSCA in an inpatient child psychiatric unit and found satisfactory inter-rater reliability amongst multi-disciplinary team members. The measure has been regarded as suitable for use as a routine measure in mental health services and is used internationally.

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

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

4.18.2. Descriptors

Data were collected for 61 patients who were admitted in 2018. Of those, 24 (39.3%) were male and 37 (60.7%) were female. The age ranged from 14-19 years, with a mean of 16.94 (SD=1.3).

4.18.3 Results

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

Table 1: Paired Samples T Test

	Pre	Post	*t*	*df*	p	*d*
Client Rated	23.87 (8.54)	15.42 (9.25)	7.24	54	.000	.98

Table 2: Wilcoxon Signed Rank Test

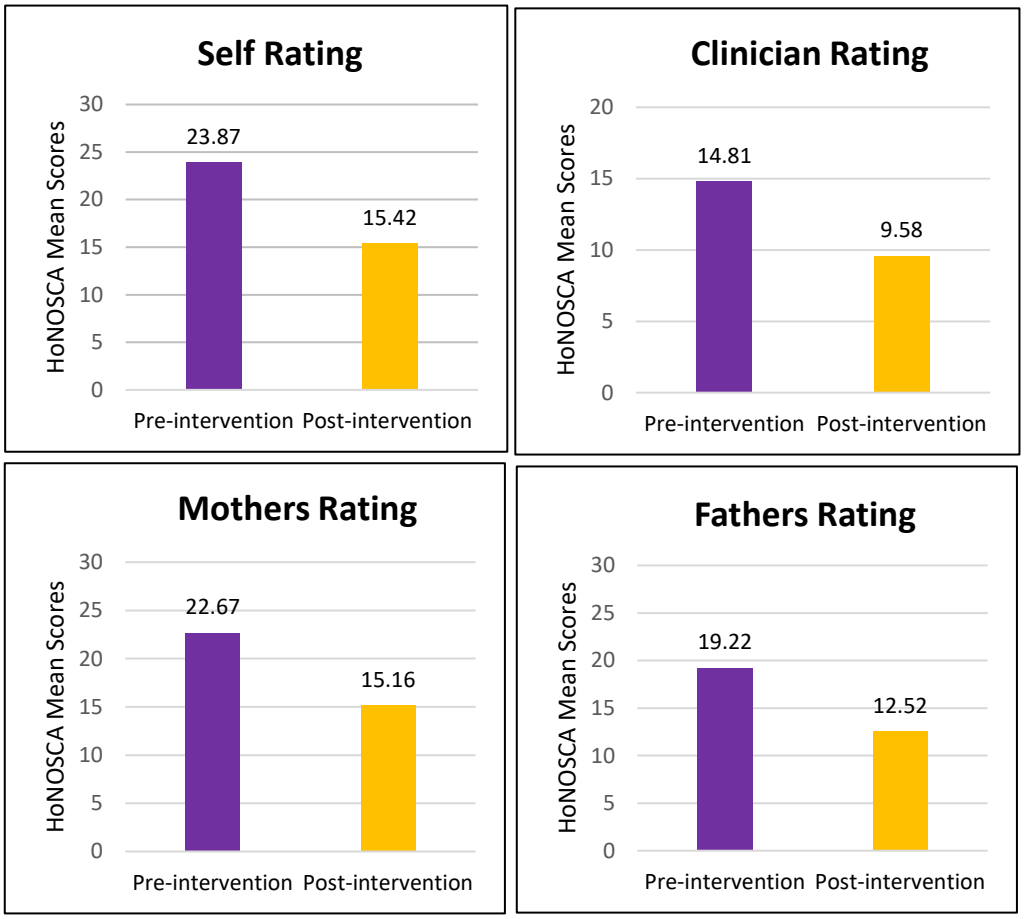
	Pre	Post	*z*	p	*r*
Clinician Rated	14.81 (6.52)	9.58 (5.17)	-6.07	.000	-.60
Mother Rated	22.67 (8.61)	15.16 (8.67)	-4.80	.000	-.52
Father Rated	19.22 (9.03)	12.52 (8.91)	-3.78	.000	-.51

In order for the analysis to be run, each participant had to have a pre and a post score on the measure. Hence, the completion rates reported are for 55 patients and are not representative of all the data in the sample, but rather relate solely to the complete data, which can be analysed in this way.

A significant decrease between total scores for the self-rated HoNOSCA was apparent at the post intervention time point ($t(54) = 7.24$ $p = <.001$), reflecting a large effect size (Cohen's d: .98). A Wilcoxon Signed Rank test also revealed a statistically significant decrease in Clinician's rated HoNOSCA scores at the post intervention time point ($z = -6.07$, $p < .001$), with a large effect size ($r = -.60$)

A significant decrease in total scores was also identified post intervention on mother's rated HoNOSCA ($z = -4.8$, $p < .001$), which had a large effect size ($r = -.52$); and on father's rated HoNOSCA ($z = -3.78$, $p < .001$), which had a large effect size ($r = -.51$).

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



4.18.4. Summary

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

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

The MDT is actively considering ways that data collection at discharge could be improved. It is of note that the response rates on the HoNOSCA in 2018 were higher than 2017, and rates in 2017 were higher than 2016. It is anticipated that response rates will continue to improve in 2019 and that it will

be possible to conduct further analysis on the data to identify the breakdown of the pertinent presenting problems.

The measure has been commended in the literature for its ease of access for adolescents (Levine, Bailey-Rogers, Shore & Burhouse, 2002) and clinicians (Jaffa, 2000). It is expected to continue to serve as the primary outcome measure for 2018.

SECTION 5

Measures of Service User Satisfaction

5.1 Service User Satisfaction Questionnaires

5.1.1 Introduction

St Patrick's Mental Health Service is committed to listening to and acting upon the views of those who use and engage with its service. In order to enhance communication between service users and providers, a Service User Satisfaction Survey was developed and is distributed to service users who attend the Dean Clinics, Inpatient, and Day Programme services. This report outlines the views of a portion of Dean Clinic, Inpatient, and Day Programme service users from January to December 2018. The results of the service user satisfaction survey are collated for the first six months of each year and for each full year, to provide management and the board of governors with valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

5.1.2 Survey design

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

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

5.1.3 Data collection

The three surveys for the Dean Clinics, Inpatient, and Day Programmes were continually distributed from January to December 2018, in order to gather information about service users' journey through St Patrick's Mental Health Services, thus engaging a system in which service users can offer feedback and take an active role in the provision of their care. Since March 2016, the Service User Satisfaction Surveys for the Dean Clinics, Inpatient and Day Programmes are also available online, in order to increase accessibility. The employment of the Service User's Satisfaction Survey is part of a larger quality improvement process undertaken by St Patrick's Mental Health Services. Data collection across SPMHS is continually facilitated as a key strategic objective to improve services.

Dean Clinics

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

Inpatient Adult Services

All service users discharged between January and December 2018 from inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online.

Day Programme Services

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

5.1.4.1. Dean Clinic (Community Based Services)

SPMHS are currently considering ways to improve the response rate for the service user experience surveys within our Dean Clinic services. The current content and structure of the survey is being reviewed as well as the processes around how and when we request completion from service users.

Percentage of surveys received from Dean Clinics:

Dean Clinic	n	%
St Patrick's	8	33.3
Sandyford	3	12.5
Capel Street	8	33.3
Donaghmede	0	0
Galway	1	4.2
Lucan Adolescent	0	0
Cork	1	4.2
Lucan Adult	3	12.5
No Answer	0	0
Total	24	100

Service User Responses

How long did you wait for a first appointment?

Percentage of respondents who endorsed each first appointment waiting time frame

1st Appt. Waiting Time	n	%
<1 week	5	20.9
<2 weeks	3	12.5
<1 month	2	8.3
<2 months	2	8.3
>2 months	4	16.7
>4 months	6	25.0
No Answer	2	8.3
Total	24	100

Were you seen at your appointment time?

33.3 % of respondents reported being seen on time, 20.9 % of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic and

8.3% of respondents reported a half hour wait for their appointment on arrival to the clinic. Cumulatively 62.5% of respondents were seen within half an hour of their appointment time. 25.0% of respondents reported a delay in over 2 hours to being seen by a clinician.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	8	33.3
Seen within 15 minutes	5	20.9
Seen within a half hour	2	8.3
Seen within an hour	2	8.3
Seen within over 2 hours	6	25.0
No Answer	1	4.2
Total	24	100

Tell us about your experience of assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

Experience of assessment/therapy/review?	Yes		No		Don't Know		No Answer	
	n	%	N	%	n	%	n	%
Did a member of the clinic staff greet you?	21	87.5	3	12.5	0	0	0	0
Did a member of the clinic staff explain clearly what would be happening?	15	62.5	8	33.3	0	0	1	4.2
Were you told about the services available to you to assist you in looking after your mental health?	10	41.6	12	50.0	1	4.2	1	4.2

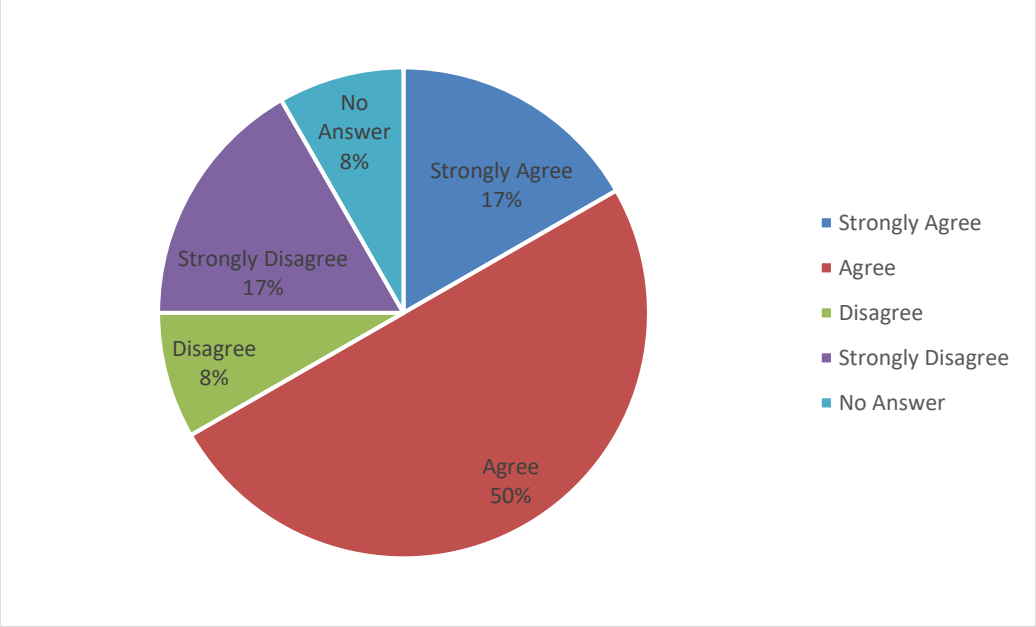
Tell us about your experience of care and treatment at the clinic following assessment

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

Respondents experience of care and treatment at the Clinic following assessment

Experience of Care & Treatment following your assessment?	Agree		Neither Agree or Disagree		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Treated as an individual	17	70.8	4	16.7	3	12.5	0	0	0	0
Treated with dignity & respect	20	83.3	1	4.2	3	12.5	0	0	0	0
Confidentiality was protected	19	79.1	1	4.2	3	12.5	0	0	1	4.2
Privacy was respected	19	79.1	1	4.2	4	16.7	0	0	0	0
Staff were courteous	19	79.1	1	4.2	3	12.5	1	4.2	0	0
Felt included in decisions about my treatment	18	75.0	0	0	6	25.0	0	0	0	0
Trusted my doctor/therapist/nurse	17	70.8	1	4.2	4	16.7	2	8.3	0	0
Appointments were flexible	15	62.4	4	16.7	4	16.7	1	4.2	0	0

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



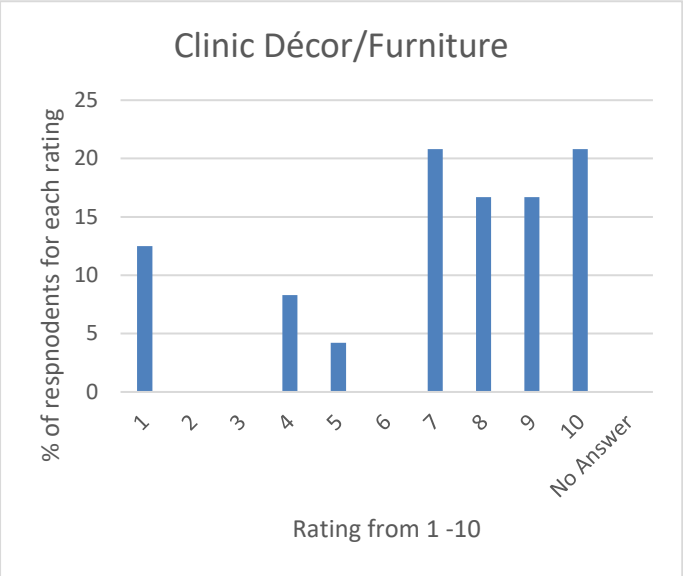
How would you rate the Dean Clinic facilities?

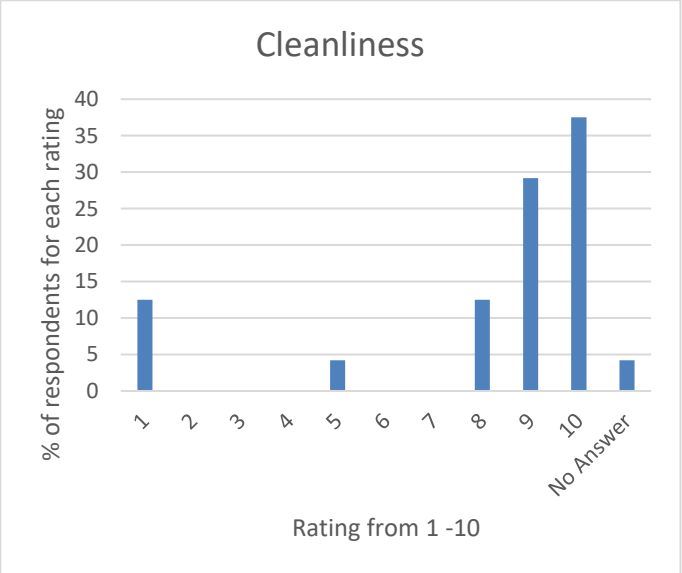
Respondents were asked to rate Dean Clinic facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that

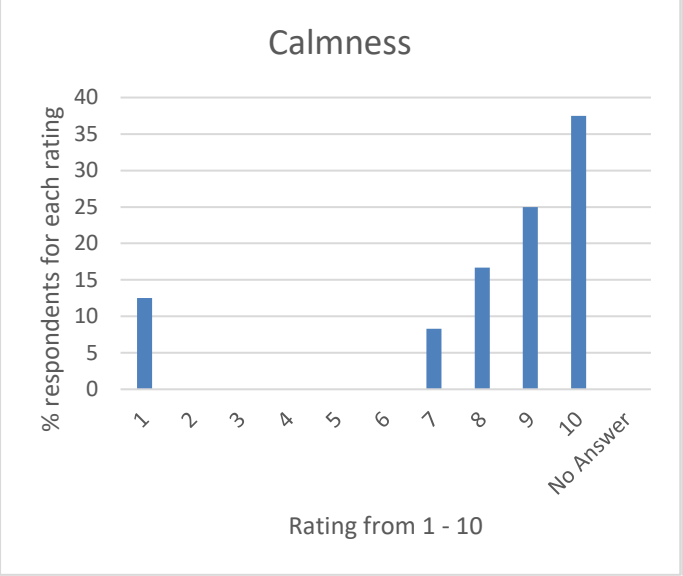
respondents held positive opinions of the Dean Clinic facilities, with all means ranging close to a rating of 7.5. Furthermore, the standard deviation was below 4 across all four areas showing small variation between responses.

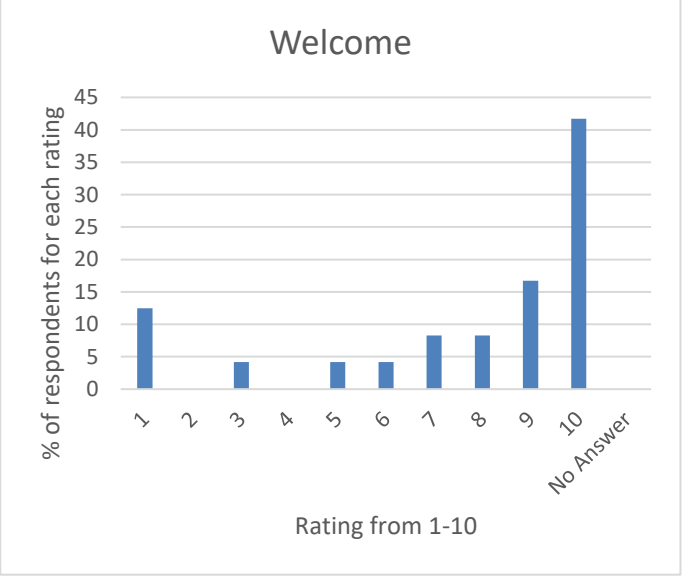
Respondents' scores of Dean Clinic facilities

Rate the following in relation to the Clinic...	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	24	7.04	2.9
Cleanliness of Clinic	23	8.04	3.0
Calmness of environment	24	8.04	2.8
Welcome environment	24	7.63	3.1









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

Service users who completed and returned the Service User Satisfaction Survey between January and December demonstrated a relatively high level of satisfaction with the care they received. Service users rated their care and treatment at the Dean Clinic on a scale of 1 to 10; showing a mean score of 7.3 (N=24; SD=3.3). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 7.1 (N=24; SD=3.2).

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

How would you rate...?	Your care & treatment		The Dean Clinic overall	
	n	%	n	%
1	4	16.6	4	16.6
2	0	0	0	0
3	0	0	0	0
4	1	4.2	1	4.2
5	1	4.2	1	4.2
6	0	0	1	4.2
7	3	12.5	1	4.2
8	3	12.5	5	20.8
9	3	12.5	5	20.8
10	9	37.5	6	25.0
No Answer	0	0	0	0
1-5	6	25	6	25
6-10	18	75	18	75
Total	24	100	24	100

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

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	24	7.3	3.3
Overall, the Dean Clinic	24	7.1	3.2

Further Service User Views

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

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

Positive Comments include:

- *I always feel comfortable and actually look forward to seeing my consultant. She is always kind and helpful to me.*
- *Being greeted by the receptionist at the clinic in Cork always brightened my day.*
- *The regular progress check ups gave me the confidence to get back to myself after a long battle with depression and anxiety.*
- *The staff for the most part are doing a very good job.*

Comments to learn from include:

- *I had to wait 4 months in between appointments.*
- *I found it almost impossible to find a parking space.*
- *Telephone is not always answered.*

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

- *I know my consultant is extremely busy, but she makes me feel like I'm her only patient. She knows me and everything about me, and always helps.*
- *The team were extremely reassuring, welcoming and professional especially as I was attending for the first time and was nervous.*
- *I was really treated like a person. I felt I could open up, talk, and even joke lightly.*
- *If I needed a quick or emergency appointment, I always got it quickly.*
- *Overall very reassuring. Very courteous and kind.*

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

- *More parking spaces needed.*

- *Less waiting times for appointments.*
- *Better signage for clinics for cars and taxis.*
- *Rooms in the clinic are too cold sometimes – there should be heating in the clinic.*
- *I think punctuality needs to be worked on with more frequent appointments.*
- *It would be good if they had a free library of relevant mental health books.*

5.1.4.2 Adult Inpatient Services

Demographics

Service users discharged between January and December 2018 from adult inpatient services were given the opportunity to return the satisfaction survey prior to discharge, by post following discharge or to complete the survey online. 2940 discharges were processed in 2018, with a total of 221 (7.5%) surveys being returned to St Patrick's Adult Inpatient services.

Table: *Number of adult inpatient surveys returned and discharges in 2018*

Month	Surveys Returned	Discharges
January	11	182
February	18	203
March	15	221
April	19	220
May	19	248
June	25	230
July	40	240
August	18	272
September	24	219
October	24	277
November	4	322
December	4	306
Total	221	2940

Service User Responses

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

The most common waiting time frames reported by respondents were between '1 – 3 days (22.6%), and '4 - 7 days' (21.3%), (see table below).

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

Waiting Time	n	%
<1 day	31	14.0
1-3 days	50	22.6
4-7 days	47	21.3
1-2 weeks	47	21.3
3-4 weeks	32	14.5
Don't know	12	5.4
No answer	2	0.9
Total	221	100.0

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

The most common waiting time frame reported by respondents was less than 1 hour, with 67.4% of respondents reporting this time period (see table below).

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

Waiting Time	n	%
<1 hr	149	67.4
1-2 hrs	42	19.0
2-3 hrs	13	5.9
3-4 hrs	3	1.4
>4 hrs	4	1.8
Don't know	6	2.7
No answer	4	1.8
Total	221	100.0

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

The most common waiting time frames reported by respondents were '1-2 hrs' (36.7%) and ''2-3 hrs' (20.8%) (see table below).

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

Waiting Time	n	%
<1 hr	44	19.9
1-2 hrs	81	36.7
2-3 hrs	46	20.8
3-4 hrs	23	10.4
>4 hrs	18	8.1
Don't know	6	2.1
No answer	3	1.4
Total	221	100.0

"Tell us about your experience of admission."

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

Tell us about your experience of admission.	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
When you came to the Hospital did a member of the assessment unit greet you?	184	83.2	22	10.0	12	5.4	3	1.4
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	170	76.9	27	12.2	20	9.1	4	1.8
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	168	76.0	39	17.7	12	5.4	2	0.9
Were you given written information about the Hospital and the services provided?	142	64.3	58	26.2	15	6.8	6	2.7

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

In relation to your care plan…	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
I understand what a care plan is	169	76.5	18	8.2	12	5.4	10	4.5	12	5.4
I was involved in the development of my care plan	108	48.9	41	18.6	38	17.2	16	7.2	18	8.1
I was offered a copy of my care plan	131	59.3	18	8.1	43	19.5	15	6.8	14	6.3
I was involved in the review of my care plan	113	51.1	34	15.4	36	16.3	17	7.7	21	9.5
There was a focus on recovery in the care and treatment offered	158	71.5	20	9.1	17	7.7	8	3.6	18	8.1
My care plan is key to my recovery	118	53.4	47	21.3	32	14.5	11	5.0	13	5.8

Service users' perceptions regarding their understanding, involvement and engagement in their care plan has been a significant focus for the organisation over recent years. The concept of a care plan isn't familiar for many service users, particularly those being admitted for the first time. There has been on-going work at multidisciplinary team level to inform service users and facilitate their involvement and engagement in their care planning process. Education and information regarding care planning, key working, recovery focus and multidisciplinary teams has also been on-going on an organisational level through a regular morning lecture and information booklets provided to all service user's on inpatient admission. This on-going focus has produced positive results, for example, as can be seen above 76.5% reported that they understood what a care plan is and 71.5% reported that they felt there was a focus on recovery in their care and treatment.

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

	Agree		Neither		Disagree		Don't know		No answer	
	n	%	n	%	n	%	n	%	n	%
Consultant Psychiatrist	156	70.6	22	10.0	35	15.8	3	1.3	5	2.3
Registrar	136	61.5	33	14.9	26	11.8	8	3.6	18	8.2
Key Worker	116	52.5	29	13.1	45	20.4	11	5.0	20	9.0
Nursing Staff	177	80.1	11	5.0	16	7.2	1	0.5	16	7.2
Psychologist	66	29.9	29	11.3	67	30.3	18	8.1	45	20.4
Occupational Therapist	98	44.3	26	11.8	45	20.4	14	6.3	38	17.2
Social Worker	61	27.6	33	14.9	47	21.3	23	10.4	57	25.8
Pharmacist	48	21.7	44	19.9	52	23.5	26	11.8	51	23.1
Other	43	19.4	24	10.9	46	20.8	22	10.0	86	38.9

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

Waiting Time	n	%
<1 week	33	14.9
1-2 weeks	27	12.2
2-3 weeks	22	10.0
>3 weeks	39	17.7
Not on programme	25	11.3
No Answer	75	33.9
Total	221	100.0

Tell us about your care…

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

Experience of the team that worked with you	Strongly Agree		Agree		Disagree		Strongly Disagree		No answer	
	n	%	n	%	n	%	n	%	n	%
Trusted the team members	144	65.2	49	22.2	6	2.7	4	1.8	18	8.1
Treated with dignity and respect	148	67.0	41	18.5	12	5.4	5	2.3	15	6.8
Protected my confidentiality	155	70.1	40	18.1	3	1.4	3	1.4	20	9.0
Respected my privacy	148	67.0	45	20.4	5	2.2	3	1.4	20	9.0
Were courteous	153	69.2	39	17.6	11	5.0	1	0.5	17	7.7
Felt included when my team discussed medical issues at my beside / in my room	133	60.2	47	21.2	15	6.8	3	1.4	23	10.4
Respected me as an individual	148	67.0	43	19.5	8	3.6	5	2.2	17	7.7

Tell us about your experience of discharge…

Table: *Respondents' perceived involvement in discharge*

Experience of Discharge from Hospital	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you discuss and agree your discharge with your treating team?	186	84.2	20	9.0	6	2.7	9	4.1
Do you think you were given enough notice of your discharge from hospital?	191	86.4	13	5.9	5	2.3	12	5.4
Do you have a discharge plan?	130	58.8	57	25.8	19	8.6	15	6.8
Do you know what to do in the event of a further mental health crisis?	161	72.9	40	18.1	6	2.7	14	6.3

Tell us about your experience of hospital activities…

Tell us about your experience of hospital activities	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Did you attend any of the activities during the day?	186	84.2	16	7.2	2	0.9	17	7.7
Did you attend any of the activities in the evenings and at weekends?	152	68.8	51	23.0	3	1.4	15	6.8
Was there a range of activities that you could get involved in?	180	81.4	21	9.5	5	2.3	15	6.8
At the weekend were there enough activities available for you?	92	41.6	96	43.4	13	5.9	20	9.1

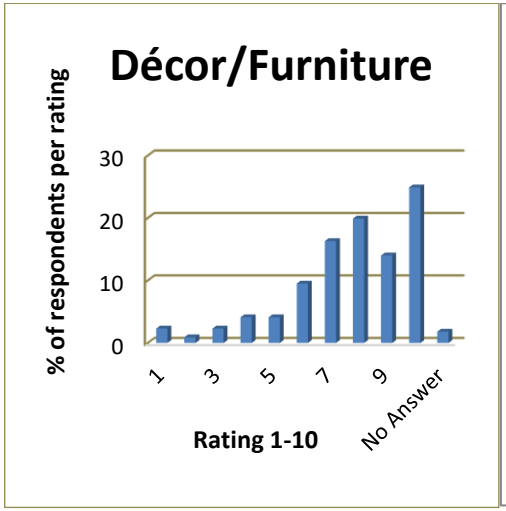
The majority of respondents felt that there was a range of activities they could get involved in (81.4%). However, 41.6% indicated that there were not enough activities available in the hospital at weekends.

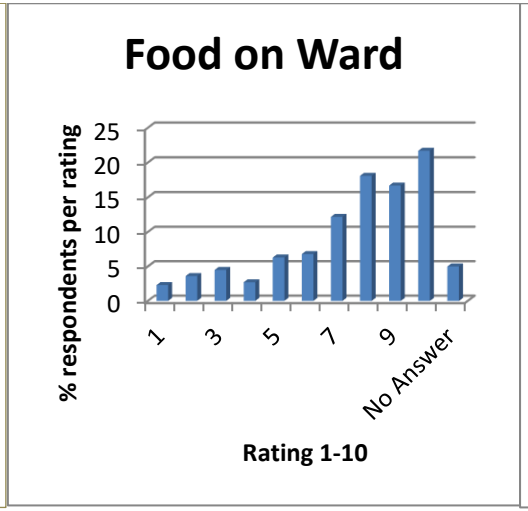
Tell us about your experience of hospital facilities…

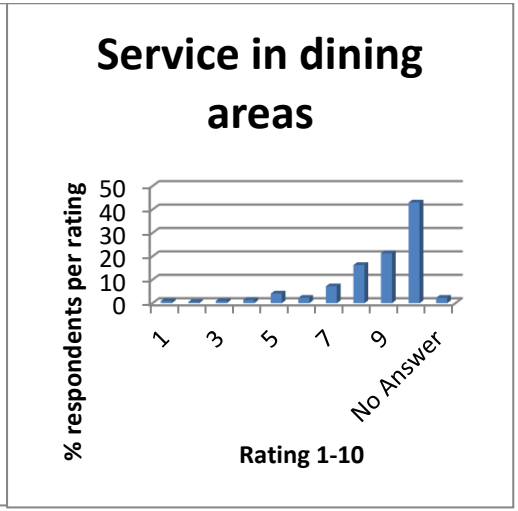
A series of questions asked respondents to rate Hospital facilities on a scale of 1 (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the Hospital facilities, with all means above 7. In particular, the service in ward dining areas (8.66) and Cleanliness of ward areas (8.76) received high scores as well. The standard deviation across most areas was close to 2 indicating that there was significant variation in responses.

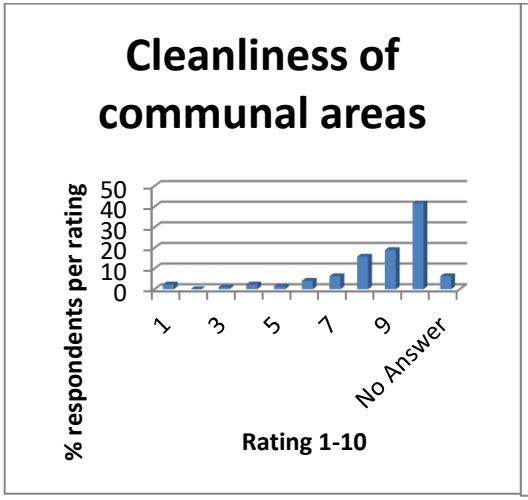
Table: *Respondents' scores of Hospital facilities*

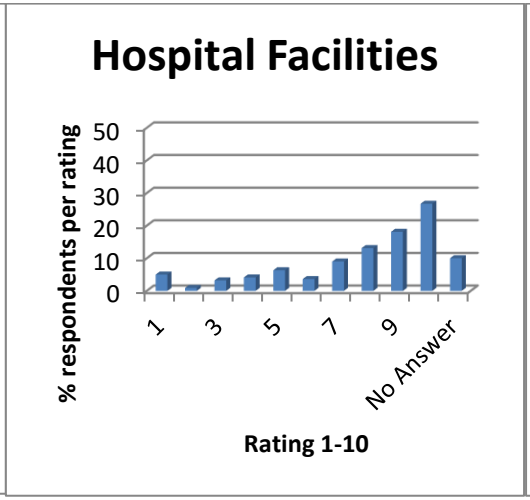
Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/Furniture	217	7.67	2.2
Food on Ward	210	7.41	2.5
Service in ward dining areas	216	8.66	1.8
Cleanliness of ward areas	213	8.76	1.9
Cleanliness of Communal areas	207	8.58	2.0
Hospital Facilities	199	7.60	2.6
Garden Spaces	205	8.55	1.9

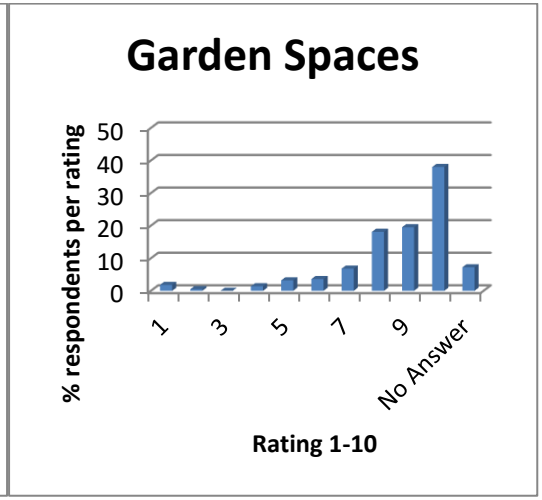

Décor/Furniture
% of respondents per rating
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


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


Service in dining areas
% respondents per rating
50
40
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


Cleanliness of communal areas
% respondents per rating
50
40
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


Hospital Facilities
% respondents per rating
50
40
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10


Garden Spaces
% respondents per rating
50
40
30
20
10
0
1
3
5
7
9
No Answer
Rating 1-10

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

Respondents were asked to reflect on their opinions towards mental health difficulties and whether they would disclose to others that they received support from St Patrick's. The majority of respondents felt they had more positive views towards mental health difficulties in general (76.9%) and towards their own mental health difficulties (77.4%) and felt that they would share with others that they received support from St Patrick's (67.4%).

Table: *Experiences of stigma*

Tell us about your views and perceptions regarding mental illness following your stay…	Yes		No		Don't Know		No Answer	
	n	%	n	%	n	%	n	%
Are your views regarding mental illness in general more positive than they were?	170	76.9	26	11.8	19	8.6	6	2.7
Are your views regarding your own mental illness more positive than they were?	171	77.4	31	14.0	8	3.6	11	5.0
Will you tell people that you have stayed in St Patrick's?	149	67.4	40	18.1	25	11.3	7	3.2

Overall views of St Patrick's Mental Health Services

Service users who completed and returned the Service User Satisfaction Survey demonstrated a high level of satisfaction with the care they received, rating their care and treatment in Hospital on a scale of 1 to 10, with a mean of 8.3 (N=219; SD=2.1). Respondents also demonstrated a high level of satisfaction with the Hospital overall, rating the Hospital on a scale of 1 to 10, with a mean of 8.6 (N=215; SD=8.6).

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

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	%	n	%
1	4	1.8	3	1.4
2	3	1.3	0	0
3	3	1.3	2	0.9
4	5	2.3	3	1.4
5	11	5.0	5	2.2
6	9	4.1	9	4.1
7	15	6.8	12	5.4
8	41	18.5	49	22.2
9	47	21.3	42	19.0
10	81	36.7	90	40.7
No Answer	2	0.9	6	2.7
1-5	26	11.7	13	5.9
6-10	193	87.4	202	91.4
Total	221	100.0	221	100.0

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

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	219	8.3	2.1
The Hospital	215	8.6	1.7

Further Service User Views

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

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

Positive Comments include:

- *Everything about my care and time in the hospital made me feel very safe and secure and, in my opinion, could not have been better.*
- *I was treated with the utmost respect by all staff members.*
- *I was very happy overall with my experience. The time the nurses took to talk was very valuable and really contributed to the positive experience.*
- *From arrival to discharge, I felt I was treated with dignity and respect at all times. The hospital felt like a safe place of restfulness during a difficult time in my life.*
- *Thanks to all staff in ward including nursing team, catering, and cleaning team. Each were always eager to assist and approachable at all times.*

Comments to learn from include:

- *The care plan wasn't mentioned until I asked for it 3 weeks into my stay.*
- *Some of the food options for dinner were quite bland. Maybe different varieties?*
- *Not enough room for people in the activity room.*
- *I did not like when meds were distributed during meal times, as we were having our meals.*
- *Going through your bags I know has to be done for safety reasons. I think a leaflet or link to the website to prepare you would be good as I felt awkward with this procedure.*

Q: Was there anything particularly good about your care?

- *Nursing staff and doctors were very professional.*
- *The care, kindness, and compassion shown to patients from every nurse was exceptional. I cannot speak highly enough of them and the positive impact they had on my recovery.*
- *Everything and everyone were excellent.*
- *Great list of activities to get myself motivated on the road to recovery.*
- *Staff were very attentive.*

- *My consultant was excellent. He treated me wtih respect, listened to me, and explained every part of my care and medication. I always felt he was listening to me and felt I was important.*
- *The pottery room was excellent.*
- *I got great care and enjoyed food, gym, and other activities.*
- *Nurses were very attentive and caring.*
- *Nursing staff were warm and attentive. Helped me find solutions and maintained a stigma free environment. Encouragement was offered without pressure and attitudes were always friendly and positive.*
- *Every member of the staff could not have been nicer. They always had a smile and asked me how they could help me. Everyone was treated with respect.*
- *The hospital wasn't a scary place. I benefitted from the rest it offered me. I came out with a better understanding of myself..*
- *The staff were amazing and the food was great.*
- *The way my MDT worked together and care of nursing staff.*
- *My psychologist was warm, caring, and very helpful.*
- *Yes, it was the attitude taken by the whole team. You did not feel people were just doing a job, you felt that they genuinely wanted to look after you. Kindness, respect, intuition, grace, and compassion are just some of the qualities portrayed.*

Q: What could we improve?

- *Think the food could be improved.*
- *Gym hours times could be expanded so as not to clash with programmes when most people are unavailable.*
- *Involvement of family in my care plan and discharge.*
- *The garden area is very dull and lifeless, could do with a revamp.*
- *More activities at weekend.*
- *Wait to see a psychologist was very long.*
- *More emphasis on my care plan could have been provided and explained.*
- *Bank machine/ATM.*
- *The rooms in relation to decor and furniture are rather dated and could do with a facelift.*

5.1.4.3 Day Services

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

Day Services Service User Satisfaction Survey Response Rate

Month	Surveys Distributed	Surveys Returned
January	129	6
February	74	9
March	109	11
April	137	2
May	124	8
June	79	0
July	94	4
August	123	11
September	69	15
October	116	11
November	194	20
December	162	5
Total	**1341**	102

The total number of surveys returned in 2018 was 102, but some respondents attended multiple programmes at different times, therefore the percentage of those attending programmes is of the total responses to this question (n=133). A number of changes have been made regarding the circulation and collection of surveys in 2019, in order to improve the response rate. One of these changes is the inclusion of a question within the day services consent form, regarding permission to allow SPMHS to send a survey following discharge from the service. This was required in order to comply with data protection rules.

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Recovery	15	11.3
Mindfulness	27	20.3
Other	48	36.1
Depression	10	7.5
St Edmundsbury	15	11.3
Bipolar	3	2.3
Eating Disorder	1	.7
No answer	0	0
Anxiety	7	5.3
Radical Openness	1	.7
Living Through Distress	1	.7
Alcohol Step Down	0	0
Young adult	2	1.5
Pathways to Wellness	3	2.3

The "Other" programmes included in the table above, include; Compassion Focused Therapy, Acceptance and Commitment Therapy, Cognitive Behaviour Therapy, healthy self-esteem and WRAP.

Almost 90% of respondents reported living in Leinster.

Province	n	%
Leinster	90	88.2%
Connaught	3	2.9%
Munster	4	3.9%
Ulster	2	2.0%
Don't want to say	1	1.0%
Missing	2	2.0%
Total	102	100%

The majority of respondents had previous experiences attending St Patrick's Mental Health Services before attending a Day Programme. Similar to above therefore, the number of total responses provided for this question is 153 and percentages reflect this total. 30.1% had experienced an in-patient stay (down from 43.2% in 2017). 24.8% had attended as an outpatient at the Dean Clinic (down from 42.0% in 2017).

Service	n	%
Dean Clinic	38	24.8%
In-patient stay	46	30.1%
In-patient day programme	17	11.1%
Other day programme	29	18.9%
Not applicable	12	7.8%
Associate Dean consultation	5	3.3%
No answer	6	3.9%

Service User Responses

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

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

Wait time	n	%
Less than 1 day	15	14.7%
1-3 days	23	22.5%
4-7 days	31	30.4%
1-2 weeks	16	15.7%
2-4 weeks	7	6.9%
More than 4 weeks	6	5.9%
No answer provided	4	3.9%
Total	102	100

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

Tell us about your experience of starting a programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
When you came to the hospital did a member of Day Services greet you?	92	90.2%	5	4.9%	5	4.9%	0	0%
When you came to hospital did a member of Day Services explain clearly what would be happening?	93	91.2%	3	2.9%	4	3.9%	2	2.0%
When you commenced the programme did a member of staff explain the timetable?	95	93.2%	3	2.9%	3	2.9%	1	1.0%
Were you given a written copy of the timetable and other relevant information?	84	82.3%	11	10.8%	6	5.9%	1	1.0%

Respondents also generally reported an informed ending to the programme, with 96.1% agreeing that they knew when the programme was to end. Over 90% of respondents felt that the programme met their expectations and just under 90% felt that they know what to do in the event of a further mental health crisis. The majority of respondents (91.2%) reported that that they had received information regarding the organisation's support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme.

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Did you know in advance when the programme was due to end?	98	96.1%	0	0%	2	2.0%	2	2.0%
Did the programme meet all your expectations?	93	91.2%	6	5.9%	2	2.0%	1	1.0%
Have you been given details of the hospital's support and information service?	93	91.2%	5	4.9%	1	1.0%	3	2.9%
As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	91	89.2%	2	2.0%	6	5.9%	3	2.9%

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

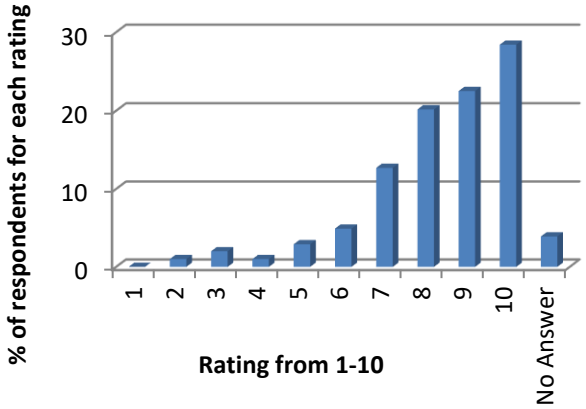
Tell us about your experience of stigma following your attendance at St Patrick's.

As you are prepared to leave the programme...	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Do you feel that your views regarding mental ill-health in general are more positive than they were?	85	83.3%	6	5.9%	8	7.8%	3	2.9%
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	88	86.3%	4	3.9%	8	7.8%	2	2.0%
Will you tell people that you have attended St Patrick's	63	61.8%	16	15.7%	21	20.6%	2	2.0%

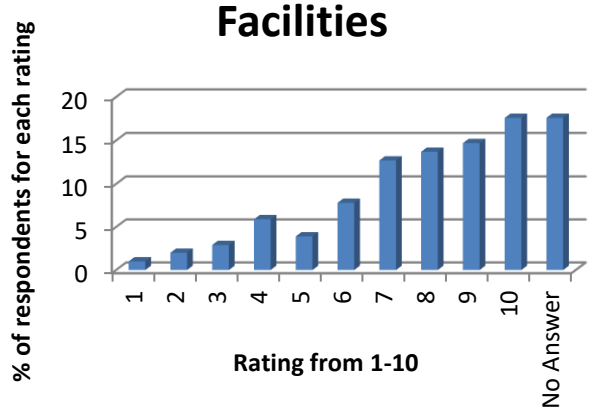
How would you rate the Day Services Facilities?

Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of one to ten. For each of the facilities, the most endorsed scores were 8, 9 and 10. (Please see the following graphical depictions).

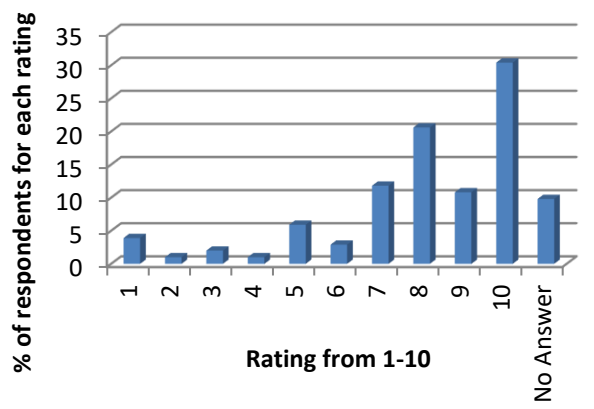
Decor/ Furniture



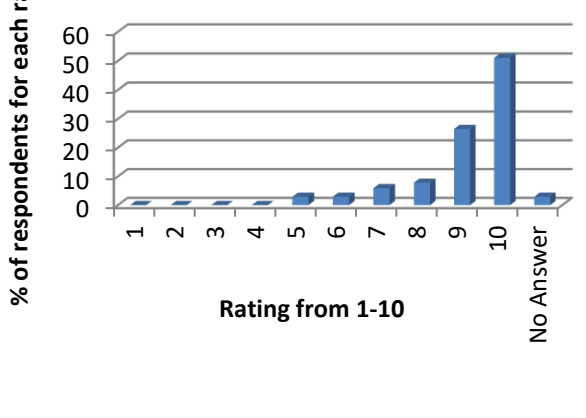
Food/ Restaurant Facilities



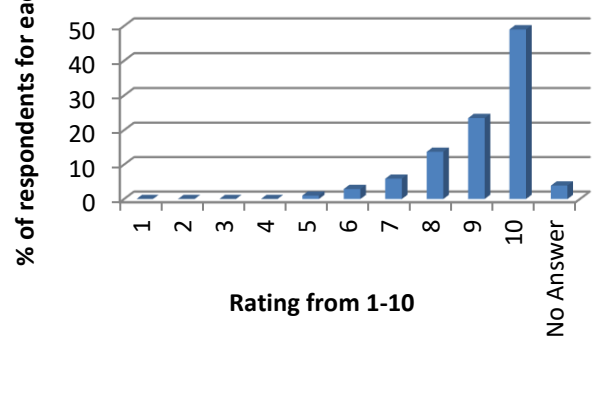
Parking



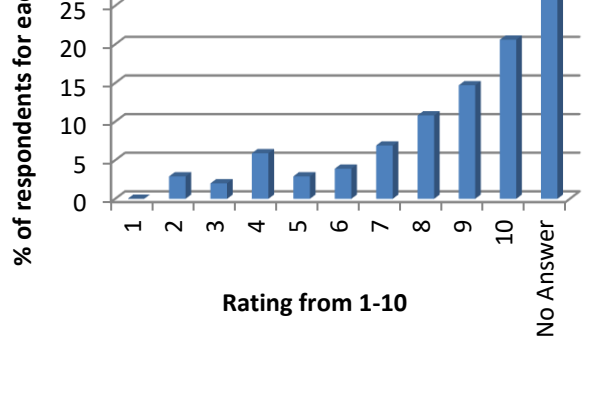
Cleanliness of day service areas



Cleanliness of communial areas



Hospital Facilities



Respondents were also asked to rate their care and treatment, and St Patrick's Mental Health Day Services overall, on a scale of 1 to 10.

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

Score	n	%
1	0	0%
2	1	1.0%
3	0	0%
4	0	0%
5	1	1.0%
6	7	6.9%
7	4	3.9%
8	15	14.6%
9	19	18.6%
10	53	52.0%
No answer	2	2.0%
1-5	2	2.0%
6-10	98	96%

96% rated their care and treatment between 6 and 10.

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

Score	n	%
1	0	0%
2	1	1.0%
3	0	0%
4	0	0%
5	2	2.0%
6	5	4.9%
7	3	2.9%
8	19	18.6%
9	17	16.7%
10	52	51.0%
No answer	3	2.9%
1-5	3	2.9%
6-10	96	94.1%

94.1% rated the St Patrick's Mental Health Day Services overall, between 6 and 10.

Further Service User Views

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

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

Positive comments include:

- *"Every staff member is so empathetic and kind and compassionate."*
- *"I came to St. Pat's wanting to learn how to deal with negative thoughts and situations and that's exactly what I learned to do"*
- *"I got a lot from the course. I liked the continuity of building each week on the last. There was a calmness, no rushing, nice pace of learning and practicing"*
- *"Brilliant staff. Excellent programmes and support offered"*
- *"Very supportive atmosphere, good support and interaction with the group"*
- *"I felt I got the right tools to deal with my mental health issues. I do believe I have a more positive, better outlook on life in this moment in time due to my time in St. Ed's"*
- *"The staff are very kind, and when I was struggling that was noticed and I was able to have a chat with someone before I went home"*
- *"The care and support shown by staff and faciltators was excellent"*
- *"The course was very well delivered, staff were extremely informative and kind"*
- *"I feel supported and safe to focus on difficulties that overwhelm me outside the hospital"*
- *"People were very friendly. Ladies giving the course were very friendly and helpful"*
- *"I was made feel really comfortable and at ease"*
- *"My experience was of a very welcoming one, no judgments, understanding"*
- *"My wife has noticed that I have become more tolerant and patient"*

- *"I have found it incredibly beneficial and am sad the WRAP programme is over! I am really looking forward to attending the Connections Cafe"*
- *"I enjoyed my experience at Day services. I felt very welcome from the moment I walked in the door to the moment I left. Day services at times felt like a safe haven for me."*
- *"I found it hugely helpful in accepting and learning how to deal with my own experiences of depression. It normalised it and it was helpful to have it dealt with so matter of factly - like any other illness. Talking and listening to others in the group was also a great help"*
- *"My overall experience was very positive. I am very happy that I took the step to attend a programme here as I was quite reluctant at first. It was great to meet new poeple who may struggle with the same issues that I have"*

Comments to learn from include:

- *"Difficult to get clarity in relation to insurance/payment for course"*
- *"St Ed's day services would benefit from access to another toilet"*
- *"It is difficult to commute from afar - is there a Munster region group?"*
- *"ACT would benefit from being a few weeks longer"*
- *"I felt that I was waiting too long to meet with the consultant initially. I also felt the wait for CBT and Mindfulness programme was longer than I expected"*
- *"I would like to be told that I'm charged for everything that I attend in St Patrick's by the insurance company and how many days I have left so that I'm properly covered"*

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

- *"Care of all the facilitators"*
- *"It was all so good I trusted and felt safe"*
- *"Facilitators are very professional and Knowledgeable"*

- *"I was amazed with how negative events from my past were used to help change the way I feel about myself"*
- *"I was glad to be given some one-to-one time with the facilitators when it was needed"*
- *"Yes as a person, I feel very good about the way I can deal with situations and I'm very proud of myself, and can't thank Julie enough"*
- *"The course and personnel generated hope in me and was a very positive experience. WRAP was excellent. Finally, the atmosphere of support is fantastic. Thank you."*
- *"I was made feel welcome and the staff in WRAP and Access to Recovery could not have been more helpful and supportive"*
- *"Nurses are the most precious support I found in St. Patrick's. Person from OT was very well prepared and able to engage the group and uplift us. The empathy and understanding they showed with every one of us was priceless"*
- *"The course was run very well. I enjoy everything the staff have done"*
- *"Program has given me better tools and skills to help me deal with my negative thoughts and behaviours. The group sessions were very helpful as I learned from other attendees."*
- *"Feeling of security/safety to talk within the group"*
- *"Excellent caring staff"*
- *"Yes it was great to feel you fit in with people on programme and you're not on your own"*
- *"It gave me time for myself and to be around people that understood what I am going through"*
- *"Never any judgment, always someone to listen"*
- *"The people giving the course were informative and I sensed that they are genuinely caring people, wishing us to recover"*
- *"That you linked in with other services once you're finished programme"*
- *"Access to all facilitators, treated extremely well by staff"*
- *"If you had any practices outside the course, they were extremely helpful"*
- *"The dignity and respect shown by staff"*

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

- *"More time in the art class"*
- *"Group activities outside of work day, mindfulness before crisis plan"*
- *"My only problem was time off work. It's good that the aftercare is on in the evening. Although I prefer coming in the day maybe an option to come for courses in the evening also."*
- *"Part of me feels that more might have been noticed, challenged, if there had been a second person to quietly observe when the other interacts with patients.*
- *"Waited too long to start CBT. The MDT doesn't meet the patient all together as a team"*
- *"Voucher for lunch should include drink/sparkling water"*
- *"There needs to be an improvement in car spaces provided at St Ed's. There is no place to buy sandwiches or snacks at St Ed's. It would be great if that option was provided. One could order in the morning a snack or sandwich for lunch"*
- *"Parking"*
- *"The group can be hard to time manage as some people talk more than others meaning you don't get the same time/help as others"*
- *"Extended time. Also have more information for partners and friends, family and supporters - what it entails. My family thought they would have met with the team before I left hospital as an inpatient, and that did not happen"*
- *"Too reliant on health cover. Too many assumptions made to continue onto next programme"*
- *"It would be helpful to have new sets of value cards (ACT) - current set are very well used!"*
- *"I found that the environment in St Ed's is more caring than in St Patrick's.*
- *"In St Ed's, it is critical that more car park space is provided. Desperate congestion every Wednesday evening due to AA meetings etc."*
- *"Please offer a drop-in service to mindfulness courses in St Ed's/ many mindfulness courses on offer outside the hospital are just not the same superior quality as those run by the hospital"*
- *"ACT programme needs to be 2-3 sessions longer. Feel the programme could benefit hugely with being 12 sessions. Feel I was only beginning to both*

understand and benefit from process by week 6 by which time programme was almost coming to a close. Attended all 8 sessions"

- *"I attended the ACT 8-week course - for the 2nd time. It would really benefit by an extension to a 10-week programme. A few new sets of value cards would be great"*
- *"Be told of the cost before the programme"*
- *"The intro programme to mindfulness is good. It would be great if there was an ongoing monthly evening part to it. An aftercare for once a month for x period"*
- *"I believe there should be a monthly class of mindfulness to follow on from the course ending."*
- *"I would create a monthly/weekly class mindfulness for each patient to attend optional if it was available for past/present patients"*
- *"I did the mindfulness which was excellent. it would be really useful if there was a follow up session, perhaps 3-6 months after the course. Also, it would be helpful if more of the courses were held at evening time to facilitate people at work."*

5.2. Willow Grove Adolescent Unit Service User Satisfaction Survey 2018

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

The multi-disciplinary team are committed to on-going quality improvement. This report presents the responses from the survey which was distributed to young people and parents/carers following an inpatient stay in the Willow Grove Adolescent Unit in 2018.

5.2.1. Methodology

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

5.2.1.1. Respondents

Parents and young people were asked to complete this measure on the day of discharge. 56 young people and 55 parents/carers completed the questionnaire. Response rates for service users were 64.4%. As surveys were anonymous and some service users may have only one parent/carer, this response rate could not be calculated. The number of surveys returned by young people and parents/carers were down 18.4% and 38.2% respectively in 2018 compared with the previous year.

5.2.1.2. Survey Design

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

The questionnaires asked parents and young people to rate a number of statements preceded by the statement, 'What is your overall feeling about…', answers ranged from 1 'Very unhappy' to 5 'Very happy'. The young person's questionnaire also included a 5-point Likert scale ranging from 1 'Very poor' to 5 'Very good', printed with corresponding smiley faces to help young people to understand the response options.

5.2.2. Results

Quantitative Responses

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

Overall the young people and the parents who answered the survey appeared pleased or very pleased with the service. The majority of median responses for young people were a 4 'Happy' (59.4%), followed by 5 'Very happy' (37.5%; up from 6.25% in 2017) and 3 'Mixed' (3.1%). For the parents/carers, the most common response across questions was 5 'Very happy' (66.7%), followed by 4 'Happy' (27.3%) and 3 'Mixed' (6.1%).

The least positive answer given by service users was in relation to meals provided, whereas parents/ caregivers rated this more favourably. Service users rated 5 'Very happy' on items including experience accessing the service, overall atmosphere of the unit, safety of the unit and confidentiality of the service, while parents/ caregivers rated 5 'Very happy' on information given on admission, the safety and atmosphere of the unit, and access to professionals. Both service users and parents/ care givers rated 5 'Very happy' for experience of care and treatment.

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

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

Further Service User Views

The Willow Grove Service User satisfaction survey respondents were invited to answer three open-ended qualitative questions in order to identify any points of interest not contained within the closed statements, and to give further voice to the users' experiences. Not all respondents answered these questions. Please find below a sample of answers provided by both young people and their parents/caregivers.

Q: What did you like best about the unit?

Young people:

- *"The learning"*
- *" The young people and nurses"*
- *" The environment and young people"*
- *" Atmosphere"*
- *" Other young people"*
- *" people/ other patients/ nurses"*
- *"The coping skills"*
- *" The staff were very helpful"*
- *" The nurses and the young people, also the structure"*
- *" The community aspect of the unit"*
- *"The environment, young people, staff are so nice , good vibes"*

Parents/ caregivers:

- *"Keyworking between parents and daughter and continuous support to both parents while in and out of the unit has been exceptional"*
- *"My child felt cared for and that encouraged him to start recovery process"*
- *"Friendly atmosphere, warm and caring staff"*
- *"Friendly staff and safe area"*

- *"Family atmosphere, excellent care, private rooms, and compassionate nature of the unit. Outbound activities were excellent and Sean was a great help to[son]"*
- *"Openness of the staff when talking to them"*
- *"They discussed everything with the young person first"*
- *"Very professional in everything they do. I felt my child was very safe whilst attending the facility"*
- *"Quick reaction on any point brought up by parents"*
- *"Positivity, listening, respectful of the young person"*

Q: What did you dislike about the unit?

Young people

- *"Leave time"*
- *"Locked doors"*
- *"When people were having a bad day and it became contagious"*
- *"The fact that it doesn't help or promote talking about why you don't want to go to groups"*
- *"Not a strong routine / showers too hot"*
- *"Dictator-style leadership"*
- *"Restrictions with leave and group participation"*
- *"Forcefulness, doors to rooms closed until 5 when sometimes I need to be by myself, a light having to be on in the relaxation room"*
- *"Feelings of people judging you behind your back"*
- *"The way people on the ED programme can't go to groups and go on leave"*
- *"Doctors ignoring my feedback"*
- *"Sometimes it felt like I wasn't being listened to"*

Parents/ caregivers

- *"Everyone always seemed too busy, would have liked more access to doctor; also felt they should have had less access to junk food in the bedroom"*

- *"Little bit dark in unit"*
- *"Thought the bedroom as always very cold"*
- *"The 1/2 hours night check - too much"*
- *"I didn't like that she was constantly checked on at night, but I understand the need for it. but it did interfere with her sleep"*
- *"Would suggest more opportunity for games/sport. but I'm sure health and safety come into it too"*
- *"I did find it difficult to understand exactly what was planned in terms of treatment and follow up care after discharge"*
- *"Sometimes continuity of care is compromised. I understand that it's done for holidays/ staff turnover"*
- *"I found it hard to know what was happening next. Information was only when I asked for it"*
- *"The distance from home"*
- *"Nothing"*

Is there anything you would change about the unit?

Young people

- *"The noise"*
- *"Groups shouldn't be forced upon the young people and should be seen as an option"*
- *"Change/update the no physical contact rule"*
- *"I thought having more than one individual session a week would greatly benefit myself and others"*
- *"Get a pool table on the unit"*
- *"The way we are woken up"*
- *"Meet with therapist twice a week"*
- *"Bedtime"*
- *"More computers and access to them are needed"*
- *"Better food choices"*
- *"TV in multipurpose rooms"*
- *"Therapeutic pets and hugs when one is sad"*

Parents/ caregivers

- *"Earlier conversations about discharge plans. More clarity about services available or lack of availability to help us with future plans. Still feel we could know a lot more. I hoped given so many others had been through the unit that there would have been more options/ a better roadmap"*
- *"Should there be consideration about a phone end of contact with the children on discharge? The discharged feels sudden for him"*
- *"More light and colour outside bedrooms"*
- *"The evening visiting times were restrictive during the week if you are travelling, perhaps one day per week they could be 4-6. Understand however it's difficult to schedule with therapy etc"*
- *"Maybe healthier vegetarian food like tofu…but did not see the menu"*
- *"More communication between parent and staff. Especially 1st 3 weeks. Felt I didn't really know what was going on"*
- *"More information for parents re recovery or sessions with parents about this would really help. Overall very happy with the care and support my daughter received from all team members"*
- *"I would have benefitted from receiving more information in writing as then I could read it again. When there is a lot of new terminology and jargon, it can be hard to follow and remember"*
- *"Step down services are missing for our requirements"*
- *"Written feedback from the team would be helpful with regards to treatment and education. Joint family therapy groups to support parents in helping their child"*
- *"Inclusion of sibling with family therapy"*
- *"It is a tough job - you are all amazing. Thank you so much"*

SECTION 6

Conclusions

6.1. Conclusions

1. The SPMHS 8th Outcomes Report builds on the previous reports. Service evaluation, outcome measurement, clinical audit and service user experience surveys are now being used routinely in the context of improving the quality of service delivery. The annual outcomes report has also provided positive feedback to the staff who deliver the outcomes driven services within SPMHS. Recruitment and ongoing education/training is underpinned by a service user centred philosophy and the attainment of positive outcomes. The skills, talents and commitment of staff, are reflected in the positive outcomes within this report

2. Service user experience survey results indicate the service user experience of SPMHS services continued to be positive.

3. The clinical staff delivering the programmes and services continue to identify the appropriate validated clinical outcome measures and utilise them as a routine part of clinical service delivery. Clinical outcome measurement is now an established practice within SPMHS, with clinical staff driving ways to expand or improve the way outcomes are measured and utilised to maintain and improve services.

4. The scope of audit across the organisation was further strengthened in 2018, consistent with the requirements of the Mental Health Commission's 2018 revisions to the Judgement Support Framework. Clinical audit is utilised within SPMHS as part of robust clinical governance processes, in order to deliver continuously improving services.

5. Strengths: SPMHS continues to lead by example in providing such a detailed insight into service accessibility, efficacy of clinical programmes and service user satisfaction. Reporting this breadth of routinely collected clinical outcomes, demonstrates a willingness to constantly re-evaluate the efficacy of our clinical programmes/services, in an open and transparent way. Well established in this report, is a detailed service user satisfaction survey encompassing all service delivery within SPMHS, reinforcing the organisation's commitment for service user centred care and treatment.

6. Challenges: We continue in our efforts to expand the number of services included within the SPMHS outcomes report, but as yet we do not have all areas of service delivery included. Efforts to benchmark the results of this report remain very difficult, as no other organisation within Ireland produces a comparable report. In order to best capture the efficacy of clinical programmes and services, there have been changes in the outcome measures used, which can create difficulties when comparing results to previous reports. The report's clinical outcome results cannot be solely attributed to the service or intervention being measured and are not developed to the standard of randomised control trials. The relatively low

service user experience survey response rate remains a significant challenge for SPMHS. The current content and structure of the survey is being reviewed as well as the processes around how and when completion by service users is requested.

SECTION 7

References

7.1 References

- Achenback, T.M., & Rescorla, L.A. (2000) Manual for the ASEBA Preschool forms and profiles. Burlington, VT: University of Vermont Department of Psychiatry.
- Anderson, R.A., & Rees, C.S. (2007). Group versus individual cognitive-behavioral treatment for obsessive-compulsive disorder: a controlled trial. *Behaviour Research and Therapy, 45*(1), 123-37.
- Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27-45.
- Bandelow, B. (1995). Assessing the efficacy of treatments for panic disorder and agoraphobia: II. The Panic and Agoraphobia Scale. *International Clinical Psychopharmacology, 10*(2), 73-81.
- Beaumont P.J.V., Kopec-Schrader E.M., Talbot P., Toyouz S.W.: Measuring the specific psychopathology of eating disordered patients. *Psychiatry, 27,* 506–511, 1993.
- Beck, A.T. & Steer, R.A. (1993). *Beck Hopelessness Scale, Manual.* San Antonio, Tx: Pearson.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI–II, Beck Depression Inventory: Manual* (2nd ed.). Boston: Harcourt Brace.
- Bergomi, C., Tschacher, W., Kupper, Z. (2012). Mindfulness: First Steps Towards the Development of a Comprehensive Mindfulness Scale. *Mindfulness 4*(1), 18-32
- Bilenberg, N. (2003). Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA): Results of a Danish field trial. *European Child & Adolescent Psychiatry, 12*, 298-302.
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionniare - II: A revised measure of psychological flexibility and experiential avoidance. *Behavior Therapy*.
- Burgess, P., Pirkis, J., Coombs, T., & Rosen, A. (2010). Review of recovery measures. *Australian mental health outcomes and classification network, 1*, 1-78.
- Butler, A.C., Chapman, J.E., Forman, E.M., & Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical Psychology Review, 26*(1), 17-31.

- Chadwick, P., Hember, M., Symes, J., Peters, E., Kuipers, E., & Dagnan, D. (2008). Responding mindfully to unpleasant thoughts and images: reliability and validity of the Southampton mindfulness questionnaire (SMQ). *British Journal of Clinical Psychology*, *47*(4), 451-455.
- Chapman, A. L. (2006). Acceptance and mindfulness in behavior therapy: A comparison of Dialectical Behavior Therapy and Acceptance and Commitment Therapy. *International Journal of Behavioral Consultation and Therapy*, *2*(3), 308.
- Cohen, J. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.) Hillsdale, NJ Erlbaum.
- Connor, K., Davidson, J., Churchill, L., Sherwood, A., Weisler, R., & Foa, E. (2000). Psychometric properties of the Social Phobia Inventory (SPIN): New self-rating scale. *British Journal of Psychiatry, 176(4),* 379-386. doi:10.1192/bjp.176.4.379
- Cooper, Z., Cooper, P. J., & Fairburn, C. G. (1989). The validity of the eating disorder examination and its subscales. The British Journal of Psychiatry, 154(6), 807-812.
- Corrigan, P.W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community mental health journal*, *35(3),* 231-239.
- Cuppage, J; Baird, K; Gibson, J; Booth, R; & Heavy (2017) Compassion focused therapy: Exploring the effectiveness with a transdiagnostic group and potential processes of change. British Journal of clinical psychology. *57(2).*
- Derogatis, LR. (1993). *Brief Symptom Inventory: Administration, scoring and procedures manual (4th ed.). Minneapolis, MN: NCS, Pearson Inc.*
- Derogatis, L.R., & Fitzpatrick, M. (2004). The SCL-90-R, the Brief Symptom Inventory (BSI), and the BSI-18. In L.R. Derogatis, M.M. Fitzpatrick, & E. Mark (Ed). *The use of psychological testing for treatment planning and outcomes assessment: Volume 3: Instruments for adults (3rd ed.),* (pp. 1-41). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.
- Derogatis, L.R., & Melisaratos, N. (1983). The Brief Symptom Inventory: an introductory report. *Psychological medicine*, *3*, 595-605.

- Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International journal of eating disorders, 16(4),* 363-370.
- Fairburn, C. G., Wilson, G. T., & Schleimer, K. (1994). *Binge eating: Nature, assessment, and treatment* (pp. 317-360). New York: Guilford Press.
- Feldman G, Harley R, Kerrigan M, Jacobo M, Fava M. (2009). Change in emotional processing during a dialectical behavior therapy based skills group for major depressive disorder. *Behaviour Research and Therapy, 47*(4), 316–321.
- Ford, P. (2003). An evaluation of the Dartmouth Assessment of Lifestyle Inventory and the Leeds Dependence Questionnaire for use among detained psychiatric populations. *Addiction, 98(1),* 111-118.
- Fresco, D.M., Mennin, D.S., Heimberg, R.G., & Turk, C.L. (2003). Using the Penn State Worry Questionnaire to identify individuals with generalised anxiety disorder: a receiver operating characteristic analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 34*(3-4), 283-291.
- Garety, P.A., Freeman, D., Jolley, S., Dunn, G., Bebbington, P.E., Fowler, D.G., Kuipers, E., & Dudley, R. (2005). Reasoning, emotions, and delusional conviction in psychosis. *Journal of abnormal psychology*, *114*(3), 373.
- Garralda, M.E., Yates, P. & Higginson, I. (2000). Child and adolescent mental health service use: HoNOSCA as an outcome measure. *British Journal of Psychiatry,* 177, 428-431.
- Gibson, J. (2011). Outcomes and mechanisms of change in living through distress: A dialectical behaviour therapy-informed skills group for individuals with deliberate self-harm. Unpublished doctoral dissertation, Trinity College, Dublin.
- Gideon N, Hawkes N, Mond J, Saunders R, Tchanturia K, Serpell L (2016) Development and Psychometric Validation of the EDE-QS, a 12 Item Short Form of the Eating Disorder Examination Questionnaire (EDE-Q). PLoS ONE 11(5)
- Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). The recovery assessment scale. In R.O. Ralph & K.A. Kidder (Eds.), *Can we measure recovery? A compendium of recovery and recovery related-related instruments*. (pp. 7–8). Cambridge, MA: Human Services Research Institute.
- Gilbert, P., Catarino, F., Duarte, C., Matos, M., Kolts, R., Stubbs, J., ... & Basran, J. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care*, *4*(1), 4.

- Gilbert, P., McEwan, K., Matos, M. & Rivis, A. (2011). Fears of compassion: Development of a self-report measure. *Psychology & Psychotherapy: Theory, Research and Practice, 84*(3), 239-255.
- Gilbert, P., McEwan, K., Mitra, R., Richter, A., Franks, L., Mills, A., Bellew, R. & Gale, C. (2009). An exploration of different types of positive affect in students and patients with bipolar disorder. *Clinical Neuropsychiatry*, 6135-143.
- Goodman, W.K., Price, L.H., Rasmussen, S.A., Mazure, C., Fleischmann, R.L., Hill, C.L., Heninger, G.R., & Charney, D.S. (1989). The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Archives of General Psychiatry, 46*(11), 1006-11.
- Gowers, S., Levine, W., Bailey-Rogers, S., Shore, A. & Burhouse, E. (2002). Use of a routine, self-report outcome measure (HoNOSCA-SR) in two adolescent mental health services. *British Journal of Psychiatry, 180,* 266-269.
- Gratz, K.L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Pschopathology and Behavioural Assessment, 26(1),* 41-54.
- Guest, T. (2000). Using the Eating Disorder Examination in the assessment of bulimia and anorexia: Issues of reliability and validity. *Social Work in Health Care, 31(4),* 71-83.
- Higgins JPT, Green S (editors). *Cochrane Handbook for Systematic Reviews of Interventions* Version 5.0.2 [updated September 2009]. The Cochrane Collaboration, 2009. Available from www.cochrane-handbook.org.
- Hofmann, S.G., & Smits, J.A.J. (2008). Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry, 69(4),* 621-632.
- Hogan, T.P, Awad, A.G., & Eastwood, M.R. (1983). A self-report scale predictive of drug compliance in schizophrenics: Reliability and discriminative ability. *Psychological Medicine, 13,* 177-183.
- Jaffa, T. (2000). HoNOSCA: Is the enthusiasm justified? *Child Psychology and Psychiatry, 5(3),* 130.
- Jazaeiri, H., McGonigal, K, Jinpa, T., Doty, J.R., Gross, J. & Goldin, P.R. (2012). A randomised control trial of compassion focusd therapy: Effects on mindfulness, affect and emotion regulation. Retrieved http://ccare.stanford.edu/wp-content/uploads/2013/07/Jazaieri-et-al.-2013.pdf.
- Kanter, J. W., Mulick, P. S., Busch, A. M., Berlin, K. S., & Martell, C. R. (2007). The Behavioral activation for depression scale (BADS): Psychometric properties

and factor structure. *Journal of Psychopathology and Behavioral Assessment*, 29, 191-202.

- Kanter, J.W., Rusch, L. C. **Busch, A.M., &** Sedivy, S.K. (2009). Confirmatory factor analysis of the Behavioral Activation for Depression Scale (BADS) in a depressed sample. *Journal of Psychopathology and Behavioral Assessment, 31*, 36-42.
- *Kelly, J.F., Magill, M., Slaymaker, V., & Kahler, C. (2010). Psychometric Validation of the Leeds Dependence Questionnaire (LDQ) in a young adult clinical sample. Addictive Behaviours, 35 (4): 331-336.*
- Kolts, R. L. (2016). *CFT Made Simple: A Clinician's Guide to Practicing Compassion-Focused Therapy*. New Harbinger Publications.
- Kroenke K, Spitzer R L, Williams J B (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9): 606-613
- Leaviss, K. & Uttley, L. (2014). Psychotherapeutic benefits of compassion focused therapy: An early systematic review. *Psychological Medicine,* 1-19.
- Lee, R. M., & Robbins, S. B. (1995). Measuring belongingness: The social connectedness and the social assurance scales. *Journal of counseling psychology, 42(2),* 232.
- Lesinskiene, S., Senina, J. & Ranceva, N. (2007). Use of the HoNOSCA scale in the teamwork of inpatient child psychiatry unit. *Journal of Psychiatric and Mental Health Nursing*, 14, 727-733.
- Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Looney, K., & Doyle, J. (2008). An Evaluation of the Living through Distress Group: A Brief Intervention for Deliberate Self-Harm.
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour research and therapy, 33(3),* 335-343.
- Luce, K. H., & Crowther, J. H. (1999). The reliability of the eating disorder examination—Self-report questionnaire version (EDE-Q). *International Journal of Eating Disorders, 25(3),* 349-351.

- Lucre, K.M. & Corten, N. (2012). An exploration of group compassion focused therapy for personality disorders. *Psychology and Psychotherapy: Theory, research and practice, 86*(4), 387-400.

- Lykins, E.L.B., & Baer, R.A. (2009). Psychological functioning in a sample of long-term practitioners of mindfulness meditation. *Journal of Cognitive Psychotherapy, 23,* 226-241.

- Lynch, T. R. (2018). *Radically open dialectical behavior therapy: Theory and practice for treating disorders of overcontrol*. New Harbinger Publications.

- Lynch , T.R., Cheavens, J.S., Cukrowicz, K.C., Thorp, S.R., Bronner, L., & Beyer, J. (2007). Treatment of older adults with co-morbid personality disorder and depression: A dialectical behavior therapy approach. *International Journal of Geriatric Psychiatry, 22*, 131-143.

- Lynch, T.R., & Cheavens, J.S. (2008). Dialectical behavior therapy for comorbid personality disorders. *Journal of Clinical Psychology: In Session, 64(2),* 154-167.

- Lynch, T.R., Hempel, R.J. and Dunkley, C. (2015) Radically Open-Dialectical Behavior Therapy for disorders of over-control: signaling matters, *American Journal of Psychotherapy*, *69*(2), 141-162.

- Lynch, T.R., Morse, J.Q., Mendelson, T., & Robins, C.J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *The American Journal of Geriatric Psychiatry, 11*, 1–13.

- Marks, I.M. & Matthews, A.N. (1979). Brief standard self-rating for phobic patients. *Behavior Research and Therapy, 17*, 263 -267.

- Mental Health Commission (2013). *The Administration of Electro-convulsive Therapy in Approved Centres: Activity Report 2012*, Dublin. http://www.mhcirl.ie/

- Mernagh, M., Baird, K., & Guerin, S. (submitted). Mind-body attunement: subjective body-related changes associated with attending a trans-diagnostic compassion focused therapy group.

- Meyer, T.J., Miller, M.L., Metzger, R.L., & Borkovec, T.D. (1990). Development and validation of the Pennstate Worry Questionnaire. *Behaviour Research and Therapy, 28*(6), 487-495.

- Mundt, J.C., Marks, I.M., Shear, M.K., & Greist, J.H. (2002). The Work and Social Adjustment Scale: a simple measure of impairment in functioning. *British Journal of Psychiatry, 180*, 461-4.

- Neacsiu, A.D., Rizvi, S.L., Vitaliano, P.P., Lynch, T.R., & Linehan, M.M. (2010). The Dialectical Behaviour Therapy Ways of Coping Checklist: Development and psychometric properties. *Journal of Clinical Psychology, 66*, 6, 1-20.
- Neff, K. D. & Germer, C. (2017). Self-Compassion and Psychological Wellbeing. In J.Doty (Ed.) Oxford Handbook of Compassion Science, Chap. 27. Oxford University Press.
- Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity, 2,* 223-250.
- Neuberg, S.L. & Newsom, J.T. Newsom (1993). Personal need for structure: individual differences in the desire for simple structure. *Journal of Personality and Social Psychology 65*(1), 113-131.
- Nielsen, R.E., Lindstrom, E., Nielsen, J., & Levander, S. (2012). DAI-10 is as good as DAI-30 in schizophrenia. *European Neuropsychopharmacology, 22(10),* 747-750.
- Oei, T.P.S., Moylan, A., & Evans, L. (1991). The validity of Fear Questionnaire in anxiety disorders. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 29*, 429-452.
- Olantunji, B.O., Cisler, J.M., Deacon, B.J. (2010). Efficacy of cognitive behavioural therapy for anxiety disorders: a review of meta-analytic findings. *The Psychiatric Clinics of North America, 33(3),* 557-577.
- Piet, J., & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: a systematic review and meta-analysis. *Clinical Psychology Review*, *31*(6), 1032-1040.
- Raistrick, D., Bradshaw, J., Tober, G., Weiner, J., Allison, J., & Healey, C. (1994). Development of the Leeds Dependence Questionnaire (LDQ): a questionnaire to measure alcohol and opiate dependence in the context of a treatment evaluation package. *Addiction, 89* (5), 563-572.
- Simons, J.S., & Gaher, R.M. (2005). The Distress Tolerance Scale: Development and validation of a self-report measure. *Motivation and Emotion*, *29*(2), 83-102.
- Taylor, S. (1995). Assessment of obsessions and compulsions: reliability, validity, and sensitivity to treatment effects. *Clinical Psychology Reviews, 15*, 261–296.
- Tober, G., Brearley, R., Kenyon, R., Raistick, D. & Morley, S. (2000). Measuring outcomes in a health service addiction clinic. *Addiction Research, 8*(2), 169-182.

- Yates, P., Garralda, M.E. & Higginson, I. (1999). Paddington Complexity Scale and Health of the Nation Outcome Scales for Child and Adolescents. *British Journal of Psychiatry, 174*, 417-423.