St Patrick's
Mental Health Services

Outcomes Report 2019

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 ninth year that an outcomes report has been produced by SPMHS and this report is central to the organisation's promotion of excellence in mental healthcare. By measuring and publishing outcomes of the services we provide, we continually strive to understand what we do well and what we need to continue to improve. Wherever possible validated tools are utilised throughout this report and the choice of clinical outcome measures used is constantly under review to ensure we are attaining the best possible standards of service delivery.

Leading healthcare providers around the world capture outcome measures related to care and treatment and make the results 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 2019 Report is divided into seven 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 2019. SPMHS provides community care through its Dean Clinic community mental health clinics and day patient services through its Wellness and Recovery Centre (WRC). 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 2019, 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 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 including community care accessed through our Dean Clinic network, day patient care accessed through our WRC and our inpatient care accessed through three approved centres. In addition, a free-of-charge Prompt Assessment of Needs (PAON) was introduced in December 2017 through the Referral and Assessment service (R&A), and aims to improve access for service users. The PAON service is delivered through technology eg. 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 2019.

2.1. Prompt Assessment of Needs

St Patrick's Mental Health Services 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 R&A 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 audio visual technologies such as 'Skype', 'Microsoft Teams' or 'FaceTime' are used to provide the assessment. The choice of communication with the R&A is based on the preference of the service user.

2.1.1. Outcomes of the PAON assessments 2019

The table below provides the number and percentages of adult PAON assessments completed and the outcome of each PAON in 2018 and 2019. These results identify the immediate outcome of the PAON assessment. There was an increase of 14.7% (number 158) adult PAONs in 2019, in comparision to PAONs completed in 2018.

	2018 Number	%	2019 Number	%
Dean Clinic referral	942	86.3%	963	77.9%
Discharge	76	8.2%	183	14.8%
Inpatient admission referral	60	5.5%	90	7.3%
Total	**1,078**	**100%**	**1,236**	**100%**

A discharge occurs when the service user did not recieve further services from SPMHS because the service user declined an offer of service or SPMHS did not have appropriate services to offer the service user on this occascion. The increase of 107 referrals discharged from the PAON in 2019 compared to 2018 was the result of a high volume of referrals from two retiring private practice consultant psychiatrists, but a number of those service users had also referred to other services (such as private practice consultant psychiatrists) or the service user decided they no longer required specialist mental health services.

2.2 Community-based services (Dean Clinics)

SPMHS' most recent five-year 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 five adult Dean Clinics and two adolescent clinics. Free-of-charge PAON mental health assessments are offered through the R&A, aiming to improve access for service users.

Adult Dean Clinic services

2.2.1. Dean Clinic referrals volumes

The five adult Dean Clinics provide multidisciplinary 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 2019, there was a total of 1,784 adult Dean Clinic referrals received from the centralised R&A. This compares with 1,633 in 2018 and represents an increase of 8.5% (number 151). This increase could be attributed to the retirement of two Dublin-based private consultant psychiatrists who referred service users to SPMHS before their retirement.

2.2.2. Dean Clinic referral source by province

The following table illustrates the geographical spread of Dean Clinic referrals by province from 2013 to 2019. The highest referral volumes continued to be from Leinster in 2019, with 1,238 referrals.

Year	Leinster	Munster	Connaught	Ulster	Other
2013	1336	317	195	41	0
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*	1124	280	195	34	0
2019*	1238	292	215	39	0

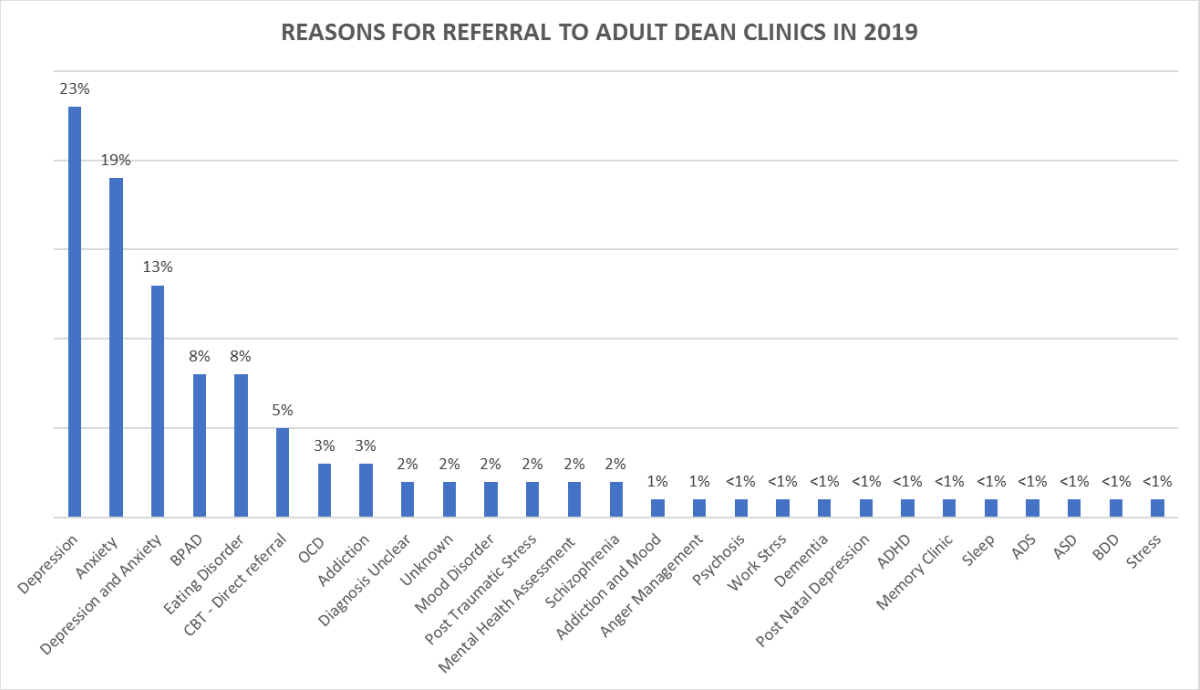
*This refers to adult services only. Adolescent services are reported separately from 2016.

2.2.3. Dean Clinic referrals by gender

The gender ratio of Dean Clinic Adult referrals for 2019 was 60% female to 40% male. This is perhaps due to females being more likely to look for support than males.

2.2.4. Dean Clinic referrals by reason for referral

The chart below documents the reasons for referral to the Dean Clinics throughout 2019 and shows depression, anxiety, mood and eating disorders as the most common reasons for referral.



2.2.5. Dean Clinic activities (2010-2019)

The table below 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 2019, 43.6% of referrals were assessed in comparison to 62.7% in 2018. This 19.7% decrease of referrals assessed was due to a decrease in consultant psychiatrist capacity and a reduction in the assessment capacity in the Associate 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	**1633****	**1012****
2019	**1784****	**770****

* 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 person's mental state and is 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 2019. 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 a 4% decrease in Dean Clinic appointments attended in 2019. This could be contributed to the introduction of the electronic health record - eSwift - enabling more reliable electronic monitoring of appointments, unexpected unplanned leave and the retirement of a consultant.

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**
2019	15,159**

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

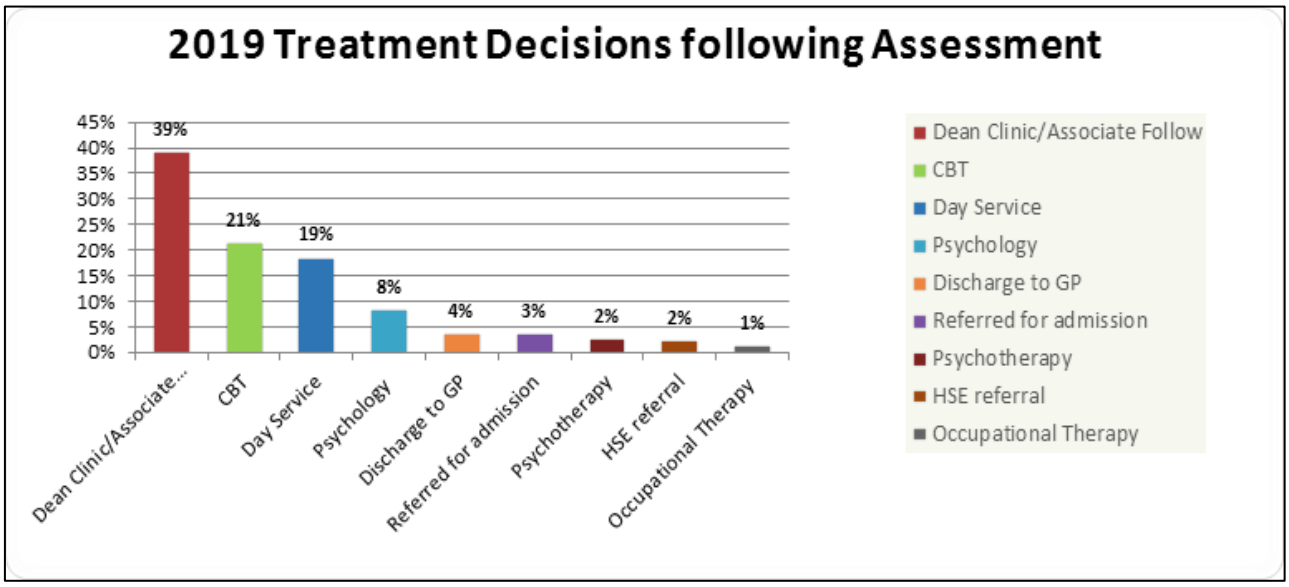
The table below summarises the number of first-time inpatient admissions to SPMHS following a Dean Clinic assessment for the period 2011 to 2019.

Year	First admission
2011	150
2012	180
2013	225
2014	202
2015	235
2016	132*
2017	182*
2018	184*
2019	174*

*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 2019.



Adolescent Dean Clinic services

2.2.7 Adolescent Dean Clinic services

The Adolescent Dean Clinics are based in Dublin and Cork. In 2019, there was a total of 651 referrals received for the adolescent service – an increase of 7% from 2018. The introduction of the centralised PAONs in 2018 streamlined referral management. Some 250 Adolescent PAONs were performed in 2019.

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.

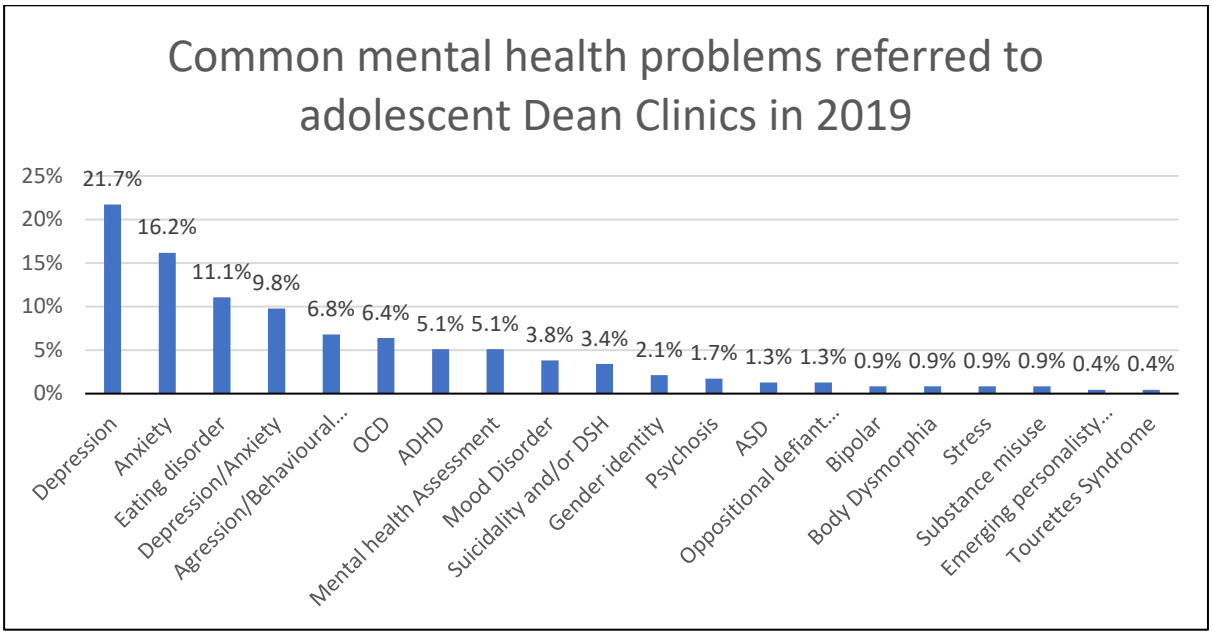
Year	Leinster	Munster	Connaught	Ulster	Other
2016	311	231	39	8	4
2017	343	232	23	16	0
2018	358	143	20	14	0
2019	425	199	17	10	0

2.2.9 Dean Clinic referrals by gender

The gender ratio of Dean Clinic adolescent referrals for 2019 was 65% female to 35% male. This is perhaps related to the fact that young females are more likely to address problems and seek help earlier than young men.

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 2019. Depression, anxiety disorders, mood disorders and deliberate self -harm were the primary reasons for referral. There was a noticeable increase in referrals for aggression and behavioural problems.



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 2019. Not all referrals result in an assessment due to a service user already being 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 engage with an alternative 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
2019	651	144

The 10.7% increase in the adolescent Dean Clinic assessments is attributed to clinical resources returning from unplanned leave and the positive impact the PAONs 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 2019 total number of adolescent Dean Clinic appointments provided by the adolescent Dean Clinics nationwide summarised in the table below demonstrates an increase of 18.6%. This noticeable increase can be attributed to improvements in clinical structures and additional clinical capacity. Appointments include assessments, consultant reviews, clinical nurse manager reviews, nurse practitioner appointments, medication reviews, cognitive behavioural therapy, occupational therapy, social work, psychology, psychotherapy and a dietitian service.

Year	Total No. of Dean Clinic Adolescent Appointments
2016	1,944
2017	1,658
2018	1,983
2019	2,352

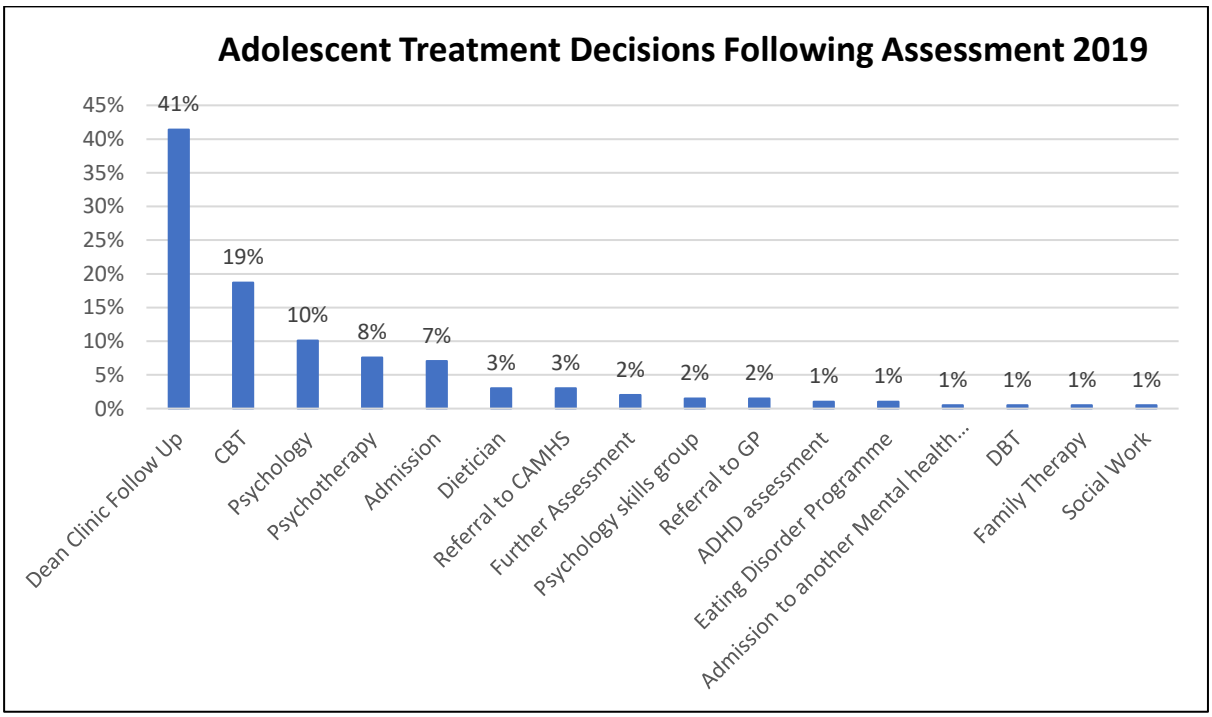
The total number of admissions to Willow Grove Adolescent Unit in 2019 was 88.

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
2019	71

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 2019.



2.3. SPMHS inpatient care

SPMHS comprises three seperate approved centres including St Patrick's University Hospital (SPUH), with 241 inpatients beds; St Edmundsbury Hospital (SEH) (St Patrick's, Lucan), with 52 inpatient beds; and Willow Grove Adolescent Unit (WGAU), with 14 inpatient beds. In 2019, there were a total of 2,954 inpatient admissions across the organisation's three approved centres compared to 3,041 for 2018.

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 three SPMHS approved centres - SPUH, SEH and WGAU for 2019.

The table below shows inpatient admission numbers and the percentage rates for Male and Female admissions. In 2019, 60.9% of admissions across all three approved centres were female, compared to 61.9% in 2018 and 60.6% in 2018.

No. of Admissions (% of Admissions) 2019				
	SEH	**SPUH**	**WGAU**	**Total**
Female	339 (67.1%)	1,389 (58.9%)	70 (78.7%)	1,798 (60.9%)
Male	166 (32.9%)	971 (39.9%)	19 (21.3%)	1,155 (39.1%)
Total	**527 (100%)**	**2,360 (100%)**	**89 (100%)**	**2,954 (100%)**

The table below shows the average age of service users admitted across the three approved centres was 48.53 years in 2019. This compares to a figure of 49.14 years in 2018. The average age of adolescents admitted to WGAU was 15.63 years in 2019 as compared with 16.17 years in 2018. The average age of adults admitted to SEH was 55.30 years in 2019 and 55.36 years in 2018. Finally, the average age of adults admitted to SPUH was 48.89 years in 2019 compared with 49.66 years in 2018.

Average Age at Admission 2019					
	SEH	**SPUH**	**Total Adult**	**WGAU**	**Total**
Female	55.47	50.35	51.26	15.58	49.38
Male	54.98	46.87	47.99	15.78	47.26

Total	55.30	48.89	49.92	15.63	48.53

2.3.2. SPMHS inpatient length of stay 2019

The following tables present the 2019 average 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 LOS was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under one week up to five years.

SPMHS Length of Stay (LOS) for Adults

2019 Adults	Number of Discharges	Percentage
Under 1 week	528	18.3%
1 -<2 weeks	258	9.0%
2-<4 weeks	489	17.0%
4-<5 weeks	321	11.1%
5-<6 weeks	310	10.8%
6-<7 weeks	249	8.6%
7-<8 weeks	179	6.2%
8-<9 weeks	146	5.1%
9-<10 weeks	118	4.1%
10-<11 weeks	74	2.6%
11 weeks -< 3 months	109	3.8%
3-<6 months	94	3.3%
6 + months	6	0.2%
Total Number of Adult Discharges 2018	2,881	100.00%

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

2019 WG	Number of Discharges	Percentage
Under 1 week	9	9.9%
1 -<2 weeks	7	7.7%
2-<4 weeks	12	13.2%
4-<5 weeks	2	2.2%
5-<6 weeks	10	11.0%
6-<7 weeks	5	5.5%
7-<8 weeks	10	11.0%
8-<9 weeks	13	14.3%
9-<10 weeks	4	4.4%
10-<11 weeks	5	5.5%
11 weeks -< 3 months	10	11.0%
3-<6 months	4	4.4%
Total Number of Adolescent Discharges 2018	91	100%

2.3.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (For all inpatients discharged in 2019)

The table below outlines the prevalence of diagnoses across SPMHS' three 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 three of SPMHS' approved centres and the total adult columns represent SPUH and SEH combined. The data presented is based on all inpatients discharged from SPMHS in 2019.

SPMHS Analysis of Inpatient Primary ICD Diagnoses
(For all inpatients discharged in 2019)

SPUH: St Patrick's University Hospital. **SEH**: St Edmundsbury Hospital. **WGAU:** Willow Grove Adolescent 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	52	2.2	52	2.2	1	0.2	1	0.2	53	1.8	53	1.8	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	403	17.0	425	17.9	34	6.7	45	8.9	437	15.2	470	16.3	0	0.0	3	3.2
F20-F29 Schizophrenia, schizotypal and delusional disorders	194	8.2	194	8.2	21	4.2	22	4.4	215	7.5	216	7.5	1	1.1	2	2.2
F30-F39 Mood [affective] disorders	1100	46.3	1045	44.0	297	58.8	281	55.6	1397	48.5	1326	46.1	43	46.2	29	31.2
F40-F48 Neurotic, stress-related and somatoform disorders	398	16.8	381	16.0	130	25.7	119	23.6	528	18.3	500	17.4	23	24.7	23	24.7
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	64	2.7	77	3.2	3	0.6	11	2.2	67	2.3	88	3.1	18	19.4	15	16.1
F60-F69 Disorders of adult personality and behaviour	143	6.0	181	7.6	16	3.2	22	4.4	159	5.5	203	7.1	4	4.3	13	14.0
F70-F79 Mental retardation	0	0.0	0.0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
F80-F89 Disorders of psychological development	1	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	1	1.1	1	1.1
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	5	0.2	6	0.3	0	0.0	0	0.0	5	0.2	6	0.2	3	3.2	7	7.5
F99-F99 Unspecified	14	0.6	13	0.5	3	0.6	4	0.8	17	0.6	17	0.6	0	0.0	0	0.0
Totals	2374	100	2374	100	505	100	505	100	2879	100	2879	100	93	100	93	100

2.4 SPMHS' day patient: Wellness and Recovery Centre

The 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 multidisciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports and include the following:

1. Acceptance Commitment Therapy (ACT)
2. Access to Recovery
3. Addictions Programmes
4. Anxiety Programme
5. Bipolar Disorder Programme
6. Compassion Focused Therapy
7. Compassion Focused Therapy for Eating Disorders (CFT-E)
8. Depression Programme
9. Driving Assessment
10. Eating Disorders Programme (EDP)
11. Formulation Group Therapy
12. Healthy Self Esteem Programme
13. Living Through Distress Programme
14. Living Through Psychosis Programme
15. Mindfulness Based Stress Reduction (MBSR)
16. Pathways to Wellness
17. Psychology Skills for Adolescents
18. Psychology Skills for Older Adults (Sage)
19. Psychosis Recovery Programme
20. Radical Openness Programme
21. Recovery Programme
22. Schema Group Therapy
23. Transitions to Recovery
24. Trauma Group Therapy
25. Young Adult Programme

The table below in section 2.4.1 provides information on the types of services accessed by service users. In 2019, the WRC received a total of 1,799 referrals compared to a total of 1,449 for 2018; a year-on-year increase of 24%. Of the day programme referrals for 2019, 263 were received from Dean Clinics. This compares to a total of 260 day programme referrals received from Dean Clinics in 2018.

The methodology for data collection was improved in 2019 resulting in a clearer overview in referral trends.

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 2018 and 2019. In addition, day programme referrals received from the Dean Clinics are presented.

SPMHS day programmes	Total day patient referrals from Dean Clinics 2018	Total day patient referrals from Dean Clinics 2019	Total day patient referrals 2018	Total day patient referrals 2019
Access to Recovery	61	42	157	229
ACT	28	39	106	161
Addictions Programmes	0	0	177	265
Anxiety Programme	44	47	195	203
Bipolar Programme	4	0	50	29
Compassion Focused Therapy	11	11	82	82
CFT Eating Disorders	6	1	22	12
Depression Programme	8	15	137	133
Driving Assessments	0	0	4	4
EDP	14	21	48	68
Formulation Group Therapy	0	1	0	18
Healthy Self Esteem	11	13	31	41
Living Through Distress	0	1	90	51
Living Through Psychosis	7	1	33	22
MBSR	26	28	53	70
Pathways to Wellness	12	15	73	157
Psychology Skills for Adolescents	1	12	13	12
Psychology Skills for Older Adults	3	1	35	20
Psychosis Recovery Programme	0	0	0	4
Radical Openness	2	0	46	28
Recovery Programme	12	11	102	157
Schema Therapy	1	0	14	1
Transitions to Recovery	8	3	36	11
Trauma Group Therapy	0	1	0	21
Young Adult Programme	1	0	5	0
Total	**260**	**263**	**1,449**	**1,799**

2.4.2. Day patient referrals by gender

Of all referrals to day services in 2019, 1,267 (70.42%) were female and 532 (29.57%) were male. This compares to 956 (69.57%) female and 493 (30.43%) male in 2018.

2.4.3 Day patient referrals from Dean Clinics

In 2019, a total of 263 day patient referrals were made from Dean Clinics, representing 14.6% of the total referrals to day programmes.
In 2018 a total of 260 day patient referrals were received from Dean Clinics, representing 17.9% of the total referrals to day programmes.

2.4.4. Day patient attendances for clinical programmes 2018-2019

In 2019, of the 1,799 referrals to a day programme, 1,582 day patients commenced day programmes; this compares to 1,449 referrals and 1,375 commencing a programme in 2018. These registrations represented a total of 17,652 (2019) and 15,638 (2018) half-day attendances respectively. Therefore in 2018 each registered day service user attended on average 11.37 half-days, while in 2019, each registered day service user attended on average 11.15 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 2018	Total day patient registrations 2019	Total day patient attendances 2018	Total day patient attendances 2019
ACT	187	178	822	1134
Access to Recovery	96	178	1563	2307

Addictions Programmes	168	144	1242	1276
Anxiety Programme	116	170	1287	1278
Bipolar Programme	65	38	238	191
Compassion Focused Therapy	44	81	778	683
CFT Eating Disorders	16	29	300	255
Depression Programme	126	131	1516	1440
Driving Assessments	4	4	4	4
Eating Disorders Programme	32	66	1566	2043
Formulation Group	0	18	0	65
Healthy Self Esteem	24	35	144	183
Living Through Distress	92	81	1348	1406
Living Through Psychosis	42	26	200	101
Mindfulness	40	62	277	254
Pathways to Wellness	68	86	1174	1465
Psychology Skills for Adolescents	12	13	168	190
Psychology Skills for Older Adults (SAGE)	35	35	303	295
Psychosis Recovery	3	4	11	16
Radical Openness	52	43	874	1014
Recovery Programme	97	118	1450	1562
Schema Therapy	20	8	228	276
Transition to Recovery	33	25	111	101
Trauma Group Therapy	0	9	0	216
Young Adult Programme	3	0	34	0
	1,375	**1,582**	**15,638**	**17,652**

SECTION 3

Clinical governance

3. Clinical governance and quality management

SPMHS aspires to provide services to the highest standard and quality. Through clinical governance structures, we ensure regulatory, quality and relevant accreditation standards are implemented, monitored and reviewed.

The following table provides a summary of key clinical governance measures, between 2014 and 2019.

3.1 Clinical governance measures summary

Governance measure	2014	2015	2016	2017	2018	2019
Clinical audits						
Number of complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**627**	**666**	**860**	**818**	**782**	**739**
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.	**2227**	**2423**	**2601**	**2594**	**2352**	**2186**
Root cause analyses and 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.	**11**	**9**	**3**	**8**	**4**	**16**
Number of Section 23s – 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**	**92**	**84**	**73**	**64**	**63**
% Section 23s which progress to involuntary admission (Section 24 - Form 13 Admissions) Following Section 23, an examination by the responsible consultant psychiatrist and a second consultant psychiatrist will be carried out. The person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	**43% (46)**	**44% (41)**	**48% (41)**	**47% (34)**	**62% (39)**	**57% (36)**
Number of Section 14s – 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.	**52**	**39**	**60**	**61**	77	**32**
% of Section 14s which progress to involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	**80% (42)**	**87% (34)**	**88% (53)**	**90% (55)**	**91% (70)**	**75% (24)**
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.	**13**	**19**	**18**	**47**	**15**	**41**
Assisted admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**37**	**18**	**15**	**20**	**51**	**40**
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 three 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.	**11**	**10**	**4**	**12**	**18**	**9**
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.	**2**	**2**	**0**	**3**	**6**	**3**
Number of tribunals held	**91**	**63**	**72**	**86**	**104**	**71**
Mental Health Commission reporting – Number of ECT programmes (signed off) in 2019	**143**	**103**	**142**	**132**	**166**	**161**
Mental Health Commission Reporting – Number of physical restraint episodes (SPUH/SHE/WGAU)	**129**	**178**	**174**	**204**	**151**	**127**

3.2. Clinical audits

This section summarises the clinical audit activity for St Patrick's Mental Health Services in 2019. 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, where necessary, taking action to bring practice in line with these standards. A complete clinical audit cycle involves remeasurement 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 2019 including those facilitated by clinical staff at local level and those carried out throughout the organisation 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 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 Mental Health Commission standards and local policies at SPUH, SEH and WGAU	Clinical Governance Committee	Routine quarterly audits completed
3.	**Key Workers Activity** To ensure that key workers are allocated to service users on admission to inpatient services and they meet service users on a weekly basis. To ensure compliance with the Mental Health Commission standards and local policies at SPUH, SEH and WGAU	Clinical Governance Committee	Routine audits completed
4.	**Quality of the Admission Psychiatric Assessment documentation** To assess the quality of the psychiatric admission assessments record and to ensure that the documentation meets the MHC requirements of the Code of Practice on Admissions, Transfers and Discharges to and from an Approved Centre, section 15.3.	Clinical Governance Committee	Re-audit completed
5.	**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, which is designated for women of childbearing potential if prescribed Sodium Valproate.	Clinical Governance Committee	Re-audits completed

No.	Audit Title	Audit Lead	Status at year end
6.	**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.	Clinical Governance Committee	Re-audits completed
7.	**Routine Electrocardiography on Admission to Inpatient Services.** To ensure that ECGs are routinely performed on admission to inpatient service users of SUH, SEH and WGAU	Clinical Governance Committee	Baseline audit completed
8.	**Pre-lithium Commencement Therapy Treatments Checks** To ensure that Lithium therapy is efficacious and monitored effectively.	Clinical Governance Committee	Re-audit completed
9.	**Assessment of the Side-Effects of Depot/Long-Acting Injection (LAI) Anti-psychotics (audit Facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from NICE Guideline CG178 'Psychosis and schizophrenia in adults: prevention and management'.	Clinical Governance Committee	Baseline audit completed
10.	**The Use of Clozapine (audit facilitated by Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards derived from NICE Guideline CG178 'Psychosis and schizophrenia in adults: prevention and management' and from the literature.	Clinical Governance Committee	Baseline audit completed
11.	**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 2019

* 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
12.	**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 episodes of falls are managed appropriately to reduce any future fall incidents and to increase service users' safety.	Falls Committee	Bimonthly audits completed
13.	**Benzodiazepine and Hypnotic Snapshot** To determine the percentage of in-patients prescribed benzodiazepines and night sedation (z-drugs) in St. Patrick's University Hospital, St. Edmundsbury Hospital and Willow Grove Unit and to facilitate consideration of the findings by multidisciplinary teams.	Drug and Therapeutic Committee	A full audit cycle completed
14.	**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.
15.	**Physical health monitoring of patients prescribed antipsychotic medication in an acute care setting** To ensure safe practice of antipsychotic prescribing in inpatients receiving care in an acute care setting.	Multidisciplinary Team	Baseline audit completed
16.	**Care pathways for inpatients with dysthymia (persistent depressive disorder)** To determine the characteristics, assessment and management of patients with dysthymia (pervasive depressive disorder) within our service, in order to form the basis for further service development.	Multidisciplinary Team	Service evaluation completed
17.	**Prescribing for Alcohol Detoxification** To evaluate current practice in screening patients adequately on admission for potential for alcohol withdrawals, as well as whether the NICE quality standards were being achieved.	Multidisciplinary Team	Re-audit completed

3.2.2. Key audit outcomes for 2019

- 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 in 2019 showed that a small number of female inpatients of child-bearing potential were prescribed this drug. The most recent audit confirmed that the conditions of the National Pregnancy Prevention Programme designated to women of childbearing potential if prescribed Sodium Valproate were met.

- The clinical audit on monitoring of service users that initiated lithium therapy confirmed that they are monitored effectively.

- The clinical audit showed a high level of adherence to local protocols on monitoring of service users undertaking alcohol detoxification regime.

- SPMHS benchmarked its practice with UK mental health services by taking part in two POMH-UK audits. The reported findings highlighted a need to strengthen the practice of ongoing physical health monitoring of service users prescribed anti-psychotic medication.

- Routine audits designed to assess the level of key working and effective care planning in the three approved centres were conducted in 2019. 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.

- 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. In 2019, the MHC inspection process confirmed once more 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 clinical audit programme for medical students was piloted in 2019.

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 2019 outcome measurement expanded to incorporate new clinical programmes and to further improve data capture for programmes already being measured. This report reflects a continuing shift towards an organisational culture that recognises the value of integrated outcome measurement in informing practice and service development. A strong desire for transparency underpins the approach taken in analysing and reporting the clinical outcomes that follow.

4.1. Important considerations for interpretation of outcomes

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

- The data reported in this chapter represent pre and post-programme measurements.
- Pre and post-measurement are 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 Wilcoxon 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 eg. 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 standardised 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 a treatment was effective enough to change whether 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 2019

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 CGI-Severity (CGIS) or Clinical Global Assessment Scale (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 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 electronic health record, eSwift, which provided details on the SPUH and SHE hospital admissions and admissions to 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	85
Admissions	First admission	40%	87%
	Re-admission	60%	13%
Average age ± standard deviation		51±18	16±1
Gender breakdown	Female	56%	75%
	Male	44%	24%
	Not specified		1%

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		**2017**	**2018**	**2019**	**2017**	**2018**	**2019**
F30-F39	Mood disorders	58%	50%	51%	39%	33%	47%
F40-F48	Neurotic, stress-related and somatoform disorders	13%	13%	17%	21%	18%	25%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	14%	17%	13%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	8%	7%	1%	1%	1%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	1%	4%	2%	30%	21%	19%
F00-F09	Organic, including symptomatic, mental disorders	1%	2%	1%	0%	0%	0%
F60-F69	Disorders of adult personality and behaviour	5%	7%	6%	4%	1%	2%
F80-F89	Disorders of psychological development	0.3%	0.3%	0%	2%	4%	1%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	0%	1%	2%	22%	5%
	Other			1%			

4.2.3. Breakdown of baseline and final assessment scale scores

Table: Total adult service

CGIS - Baseline measure of severity of illness		2017	2018	2019
		TOTAL	TOTAL	TOTAL
1	Normal, not at all ill	0%	0%	0%
2	Borderline mentally ill	1%	1%	2%
3	Mildly ill	9%	9%	8%
4	Moderately ill	40%	43%	37%
5	Markedly ill	32%	27%	31%
6	Severely ill	9%	9%	12%
7	Extremely ill	1%	1%	1%
	Not scored	8%	9%	9%

Table: Total adult service

CGIC – Final global improvement or change score		2017	2018	2019
		Total	Total	Total
1	Very much improved	15%	8%	7%
2	Much improved	45%	42%	44%
3	Minimally improved	15%	19%	23%
4	No change	5%	7%	5%
5	Minimally worse	0%	1%	0%
6	Much worse	0%	0%	0%
7	Very much worse	0%	0%	0%
	Not scored	20%	24%	21%

Table: Willow Grove Adolescent Unit

Children's Global Assessment Scale		2017		2018		2019	
		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%	1%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	26%	0%	21%	0%	49%
60-51	Variable functioning with sporadic difficulties	7%	68%	0%	62%	0%	33%
50-41	Moderate degree of interference in functioning	56%	2%	41%	13%	25%	2%
40-31	Major impairment to functioning in several areas	36%	2%	46%	3%	59%	5%
30-21	Unable to function in almost all areas	1%	1%	13%	0%	12%	2%
20-11	Needs considerable supervision	0%	0%	0%	0%	4%	1%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	0%	0%	0%	3%	1%	6%
Mean ±SD		41±6	57±6	38±6	56±6	36±6	58±10
Median		42	58	39	58	38	61
Wilcoxon Signed Ranks Test:		Z=-7.841, p<.001		Z=-7.525, p<.001		Z=-7.517, 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 seven days following admission:

Exception: Short admission

Target level of performance: 100%.

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

Exception: Short admission, unplanned discharge

Target level of performance: 100%

4.2.4.2. Results

	TOTAL ADULT SERVICE			WGAU		
	2017	2018	2019	2017	2018	2019
Baseline assessment scale score						
% of admission notes with recorded baseline scores	92%	91%	91%	100%	100%	99%
% compliance with clinical audit standard No 1	85%	87%	85%	100%	100%	99%
Final assessment scale score						
% of admission notes with recorded final scores	80%	76%	79%	100%	100%	94%
% compliance with clinical audit standard No 2	85%	86%	89%	100%	100%	95%

4.2.5. Summary of findings

- A sample was chosen out of a dataset of SPMHS discharges for 2019

- Among the adults, there was a 10% increase in the percentage of service users who were admitted for the first time in comparison to 2018. In the 2019 sample, first admissions accounted for 40% of adult service users.
- The 2019 analysis of the primary ICD-10 codes showed for the adults' population the most frequent reasons for admission were mood disorders followed by neurotic, stress-related, somatoform disorders and behavioural disorders due to psychoactive substance use.

- In 2019, 37% of SPUH and SEH service users were moderately ill. Another 31% were markedly ill; 12% were severely ill; 1% of service users were 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 and 2018 data.

- Based on a sample of 253 (total cases with discharge CGI score documented), 94% of the sample were rated with an overall improvement; 1 - very much improved (8%); 2 - much improved (56%); and 3 - minimally improved (29%). This percentage of sample rated with an overall improvement is similar to those observed between 2014 and 2017.

- 2019 analysis of the primary ICD-10 codes showed for the adolescent' population the most frequent reasons for admission were mood disorders followed by neurotic, stress-related, somatoform disorders.

- There was a substantial 16% increase in the percentage of service users who were severely ill on admission in comparison to 2018 data. In 2019 the majority (59%) of WGAU service users were scored as having a major degree of impairment in functioning on admission and another 12% were rated as unable to function.

- The overall improvement rate WGAU was 88%, and 8% lower than reported in 2018. Four adolescents disimproved following inpatient care.

- The audit shows no major changes in recording the baseline and final assessment scales scores in adult and adolescent population. The calculated compliance with the standards slightly decreased in WGAU.

4.3. Acceptance and Commitment Therapy Programme

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

The ACT programme, which was implemented in SEH in 2010, runs recurrently over an eight-week period for one half-day per week. During the eight-week programme, participants engage in a range of experiential exercises to help them develop the six core processes of ACT; mindfulness, thought diffusion, acceptance, perspective taking, values and committed action. Participants are given three CDs to accompany the experiential exercises covered in session which assists in integrating ACT processes into their daily lives. The essential aim of this programme is to help

people connect with what matters most to them and develop skills to help overcome the obstacles that get in the way of living a value-guided life. The programme aims to foster a key shift in terms of helping people to look at their lives in terms of workability; what helps them move closer towards who and where they want to be, and what brings them further away. This programme is primarily facilitated by an experienced counselling psychologist who also trains other clinicians in the ACT approach.

4.3.1. Descriptors

In 2019, data were available for a total of 81 participants. Both pre and post measures were available for 71 of those completing the programme, representing 87% of the sample.

4.3.2. ACT outcomes measures

The following programme measures were used:

- **Acceptance and 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 one - 'never true' - to seven - 'always true'. Scores range from one 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 three 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 hypothesised 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 six – '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 five-point rating scale ranging from one – 'never or very rarely true' - to five '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 practise mindfulness had a mean of 154.2 (*SD* = 17.5) while those who did not practise 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 five-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 nine-point Likert scale from 0 – 'not at all' – to eight – '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.

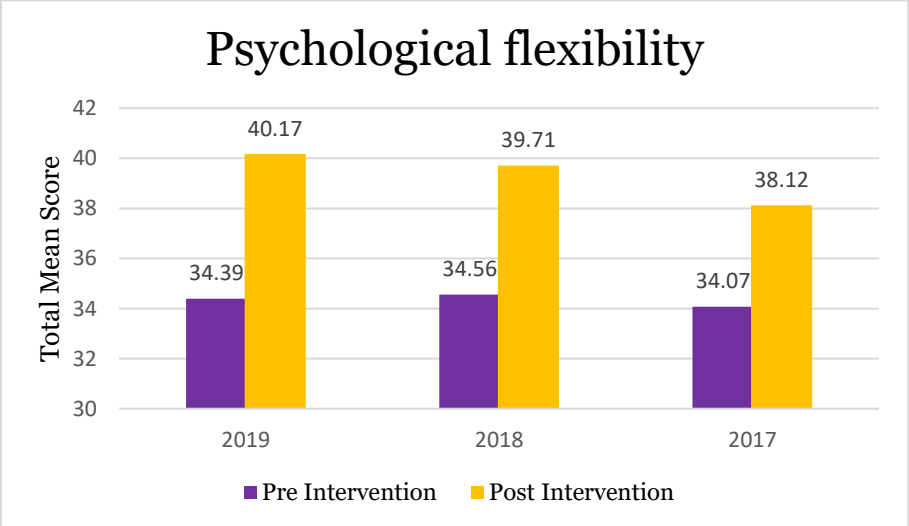
- **The Self-Compassion Scale**

The Self-Compassion Scale (SCS) is a 26- 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 five-point Likert scale, from one – almost never – to five – almost always.

4.3.3. Results

Acceptance and Action Questionnaire-II

Graph: Psychological flexibility as measured by the AAQ-II

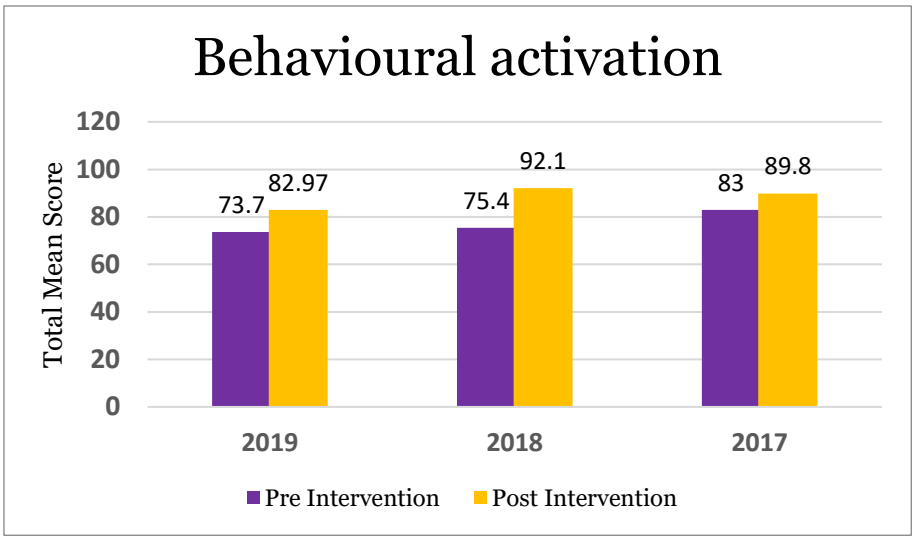


Total scores on the AAQ-II did showed a statistically significant change, t (70) = -5.66, p =.000, which indicates that flexibility remained stable between pre-and post-measures. An effect size (Cohen's *d) of* 0.61, indicates a medium effect size. There has been an increase in the overall number of pre and post measures captured this year from 41 to 71 participants. This shows a marked improvement in the completion of these measures. It is more difficult to identify significant differences between pre and post-measures in larger cohorts, however any change captured is

considered a more reliable reflection of the general population. As seen in the graph, post-intervention mean scores on the AAQ-II have increased year on year.

Behavioural Activation for Depression Scale (BADS)

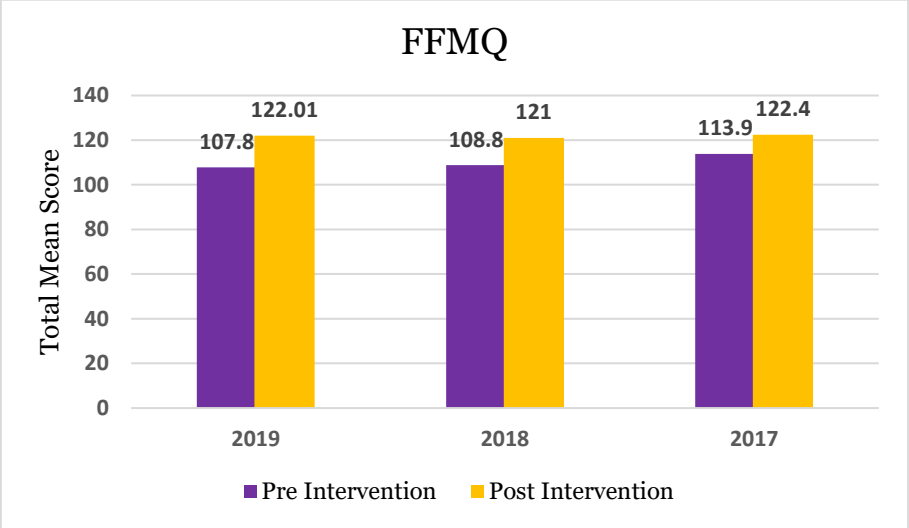
Graph: Behavioural activation as measured by the BADS



Mean BADS scores increased significantly from (M = 73.7, SD =19.9) to (M = 82.97, SD = 20.5) indicating greater behavioural activation, t (67) = -3.22, p < .05, representing a small effect size (Cohen's d = 0.45). 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 42.2% to 22% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

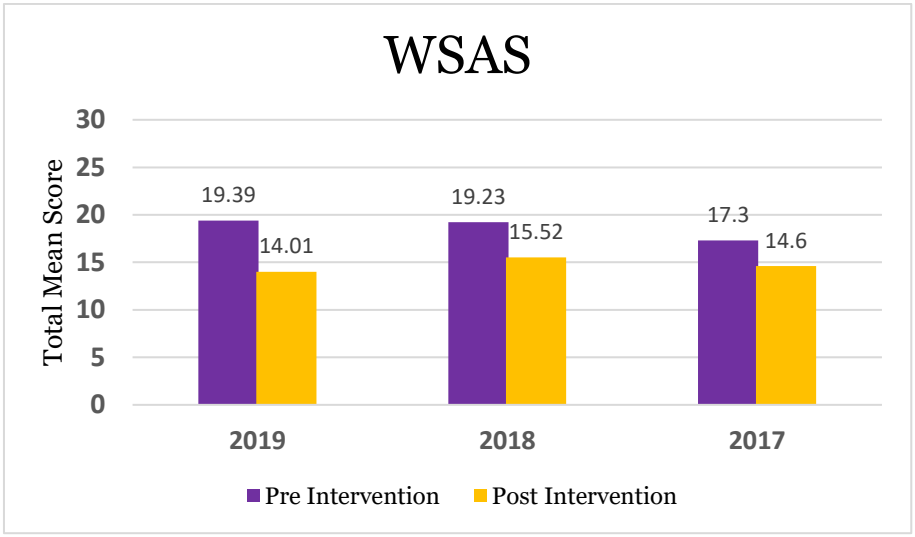
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (66) = -3.08, $p < .05$, from pre (M = 107.8, SD = 23.2) to post (M =122.01, SD = 29.7) indicating greater levels of overall mindfulness, with a medium effect size observed (Cohen's d =-0.56). 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 (62) = 4.49, p = .000, from 19.39

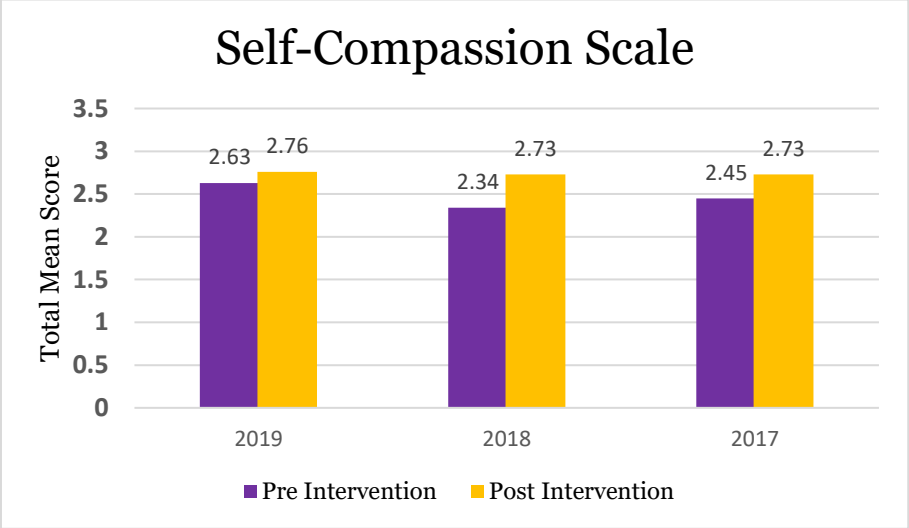
(SD = 7.9) to 14.01 (SD =7.5), indicating less functional impairment. The effect size of Cohen's *d* =0.69 indicates a medium effect.

The percentage of people falling below a sub-clinical threshold, as indicated on the WSAS, increased from 12% to 26% post group.

These findings are in line with the 2018, 2017 and 2016 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 (64) = -2.10, $p < .05$, from pre (M = 2.63, SD = 0.70) to post (M = 2.76, SD = 0.63) indicating higher overall levels of self-compassion post-intervention. A small effect size was observed (Cohen's *d* =-0.15). Self-compassion is measured in six domains: self-kindness, self-judgement, humanity, isolation, mindfulness and identification or 'over-identification'.

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 2019, 2018 and 2017. 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 support individuals with alcohol and/or chemical dependence or abuse to achieve abstinence by enabling them to develop an increased awareness of the implications and consequences of their drinking or drug-taking. The 'staged' recovery programme is delivered by psychiatrists, addiction counsellors and ward-based nursing staff, with input from other disciplines including psychology, social work and occupational therapy. The programme includes:

- Inpatient residential service for four weeks
- 12-week step-down programme
- After-care

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

- The service user is over the age of 18 years
- The service user is believed to be experiencing alcohol and/or chemical dependence or abuse.
- 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
- The service user is not intoxicated and is safely detoxified
- The service user's mental state will not impede their participation in 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 dependency 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 four-point scale from 0 – 'never' - to three – 'nearly always', with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = 95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an appropriate measure for use with inpatient psychiatric populations (Ford, 2003) and in evaluating the effectiveness of substance disorder treatments in adults with substance dependency (Tober, Brearley, Kenyon, Raistick & Morley, 2000).

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

4.4.2. Descriptors

A total of 165 participants completed the full or modified programme and returned pre and post- data. The sample size used was n = 76 as some data were incomplete and therefore excluded. Thus, it is important to note that the results may not be fully

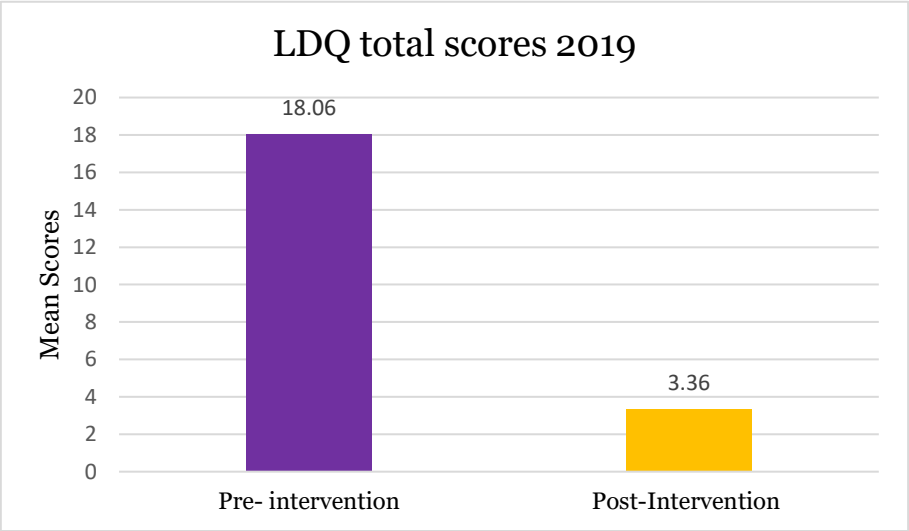
representative of responders and should be interpreted with this in mind. Of those that completed the programme, 53.9% of participants were male and 46.1% were female.

4.4.3 Results

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post programme participation. Following completion of the programme, 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= -7.50, p<.001, with a large effect size (r= 0.8). The mean score on the total LDQ scores decreased from pre-programme (18.06) to post-programme (3.36), 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 2020. Response rates have improved since post measures are being conducted as part of the discharge plan and we hope 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 2020 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 both group and individual intervention and support based on the cognitive behavioural 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 five-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. These workshops 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 consists of a CBT-based structured eight-week programme which focuses 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 focused service for individuals experiencing 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 2019. All service users attending the Anxiety Programme complete (or are rated on) the following measures; before starting the programme, after completing Level 1 of the programme and again after completing Level 2 (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 impacted him/her in the past week. The symptoms are rated on a four-point Likert scale, ranging from 0 – not at all – to three – severely - (0). The BAI scores range from 0 - 63 and scores can be interpreted in relation to four qualitative categories; minimal level anxiety (0-7), mild anxiety (8-15), moderate anxiety (16-25) and severe anxiety (26-63). The instrument has excellent internal consistency (α= .92) and high test–retest reliability (r = .75) (Beck & Steer, 1990).

- **Beck Depression Inventory**

The Beck Depression Inventory (BDI: Beck et al 1996) is a 21-item questionnaire developed to measure the intensity, severity and depth of depression symptoms in

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

- **Fear Questionnaire**

The Fear Questionnaire (FQ: Marks & Matthews, 1979) consists of 23 items that measure the extent to which potentially anxiety-provoking situations are avoided using a nine-point Likert scale ranging from 0 – would not avoid – to eight – 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. 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." 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 eg. (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 five-point Likert scale ranging from 0 – no symptoms – to four - 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), and extreme (32-40)

- **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 five-point Likert 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, five-point Likert scale, with responses ranging from 0 – almost never – to four – almost all the time. Previous research has suggested that this scale's psychometric reliability is good (α =.92; Gilbert et al., 2009). This instrument was administered at two-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, which 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 correlated significantly with other self-reported measures of agoraphobia (Mobility Inventory and Fear Questionnaire). This instrument was also administered at two time points, pre- and post- Level 1.

4.5.2. Descriptors

Data was available for 117 people who completed the programme in 2019, of which 59 (50.4%) were female and 58 were male (49.6%). Programme attendees ranged in age from 18 to 71, with a mean age of 37.19 years (*SD* = 14.68). Post data were collected after Level 1 and Level 2 of the anxiety programme.

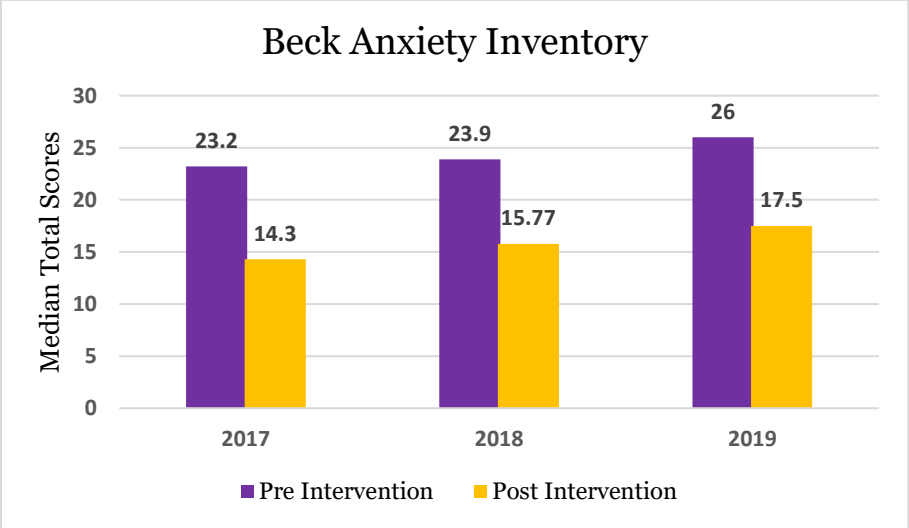
Data regarding diagnosis were returned for 117 individuals. OCD accounted for the largest subgroup (46.2%), followed by GAD (22.2%), social phobia/anxiety (12.8%), agoraphobia (with/without panic) (7.7%) and panic disorder (6%), health anxiety (3.4%), and specific phobia (1.7%). The table below shows the percentage of people with each diagnosis over the past three years.

	17	2018	2019
OCD			
)			
al phobia/anxiety			
ic disorder			
rophobia			
lth anxiety			
cific phobia			

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory median total scores pre and post-intervention for 2017, 2018 and 2019.



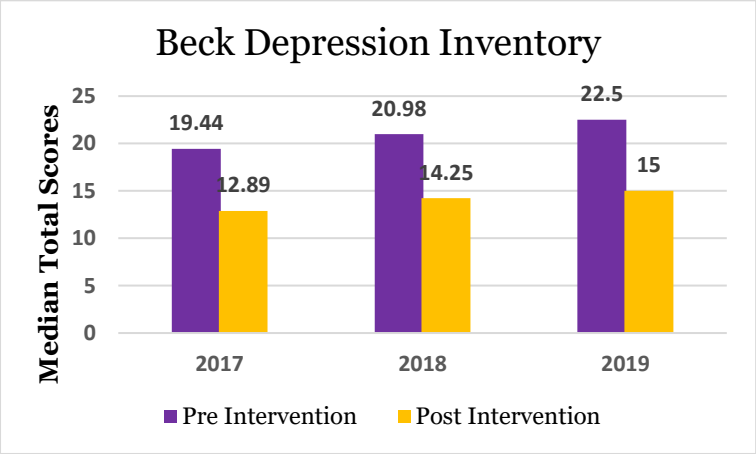
Pre and post scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme moved a presentation of the moderate severity (*M*d= 26.00, *SD* = 10.76) to bordering on the mild range of presention (*M*= 17.50, *SD* = 10.46) on the measure. Analysis using the Wilcoxon Signed Rank insicated that this change was statistically significant, z = -6.31, p < .001, and reflect a large effect size (*r* = -0.60). At the pre-measurement time point, 80.9% had anxiety scores in the severe and moderate ranges, this dropped to 55.7% by the end of Level 1. See the table below for how these scores redistributed into the other categories.

ı each category	iety (BAI)		ression (BDI)	
	E	ST	E	ST
imal	4.5	14.2	8.2	29.2
d	14.6	30.1	25.4	31.2
derate	27.3	29.3	38.2	31.1

ere als	53.6	26.4	28.2	8.5

Beck Depression Inventory (BDI)

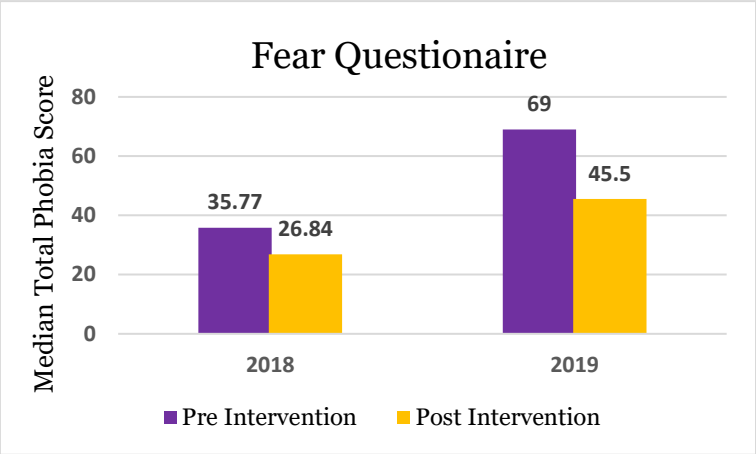
Graph: Beck Depression Inventory median scores pre and post-intervention for 2017, 2018 and 2019.



Service users median scores on the Beck Depression Inventory presented in the moderate range of severity pre-intervention (*Md*=22.50, *SD* =9.70) and moved to falling within the mild range post-intervention (*Md*= 15.00, SD = 9.10). Analysis using a Wilcoxon Signed Rank test revealed a statistically significant, z = -7.02, p < .001, which represented a large effect size (r = -0.66). While 66.4% were classified has having moderate and severe depression before the programme, 39.6% were classified as such by the end (See the table above).

The Fear Questionnaire

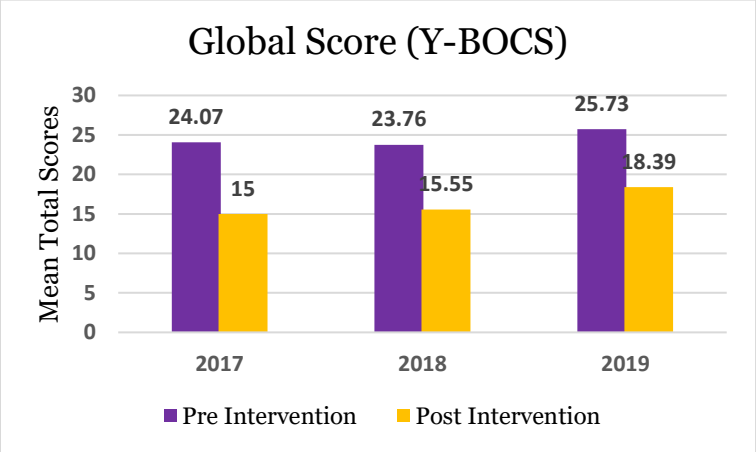
Graph: Fear Questionnaire Median Total Phobia Scores Pre and Post intervention for 2018 and 2019.



Analysis using a Wilcoxon Signed Rank test revealed a statistically significant change between pre and post-intervention at level 1 on the total phobia scores within the Fear Questionnaire, $z = 7.34$, $p < .001$. The median total phobia score decreased from 69.00 (SD = 30.15) to 45.50 (SD = 27.52), representing a large effect size (r = -0.70).

The Yale Brown Obsessive Compulsive Scale

Graph: Yale Brown Obsessive Compulsive Scale Mean Total Scores pre and post intervention for 2018 and 2019.

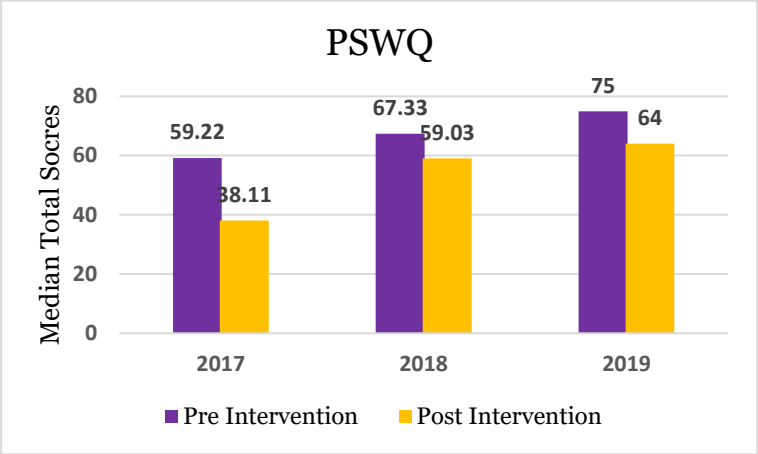


For those presenting with OCD symptoms, symptomatology was indicated to reduce significantly as measured by the Y-BOSC. Analysis using a t-test indicated that scores on this measure dropped significantly, t (48) = -9.37, p <.001, with the total

mean score changing from 25.73 (*SD* = 6.04) to 18.39 (*SD* = 6.20. Indicating an overall reduction in the severity of OCD symptoms with a large effect size (Cohen's *d* = 1.19).

Penn State Worry Questionnaire (PSWQ)

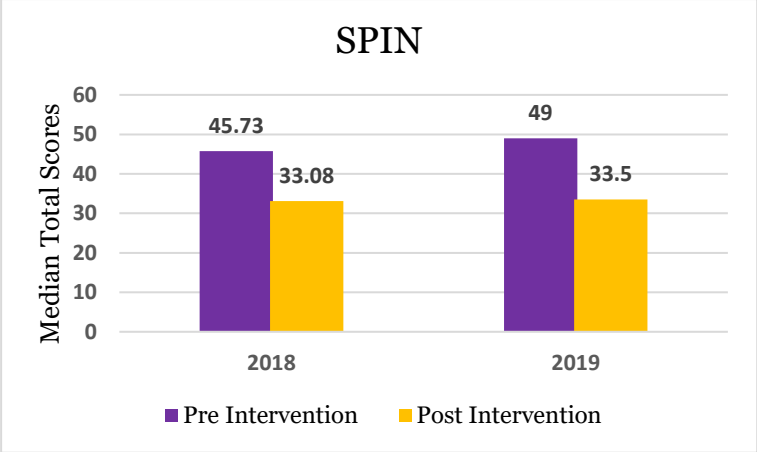
Graph: Penn State Worry Questionnaire Median Total Scores Pre and Post Intervention for 2017, 2018 and 2019.



Analysis of service user scores on the Penn State Worry Questionnaire, using a Wilcoxon Signed Rank test, indicated a statistically significantly change in scores, *z* = -3.41, p = .001, between pre-intervention (*Md*= 75.0, SD = 7.74) and post-intervention (*Md*=64.0, SD = 8.22). This change reflected a large effect size (*r*= -0.71)

Social Phobia Inventory (SPIN)

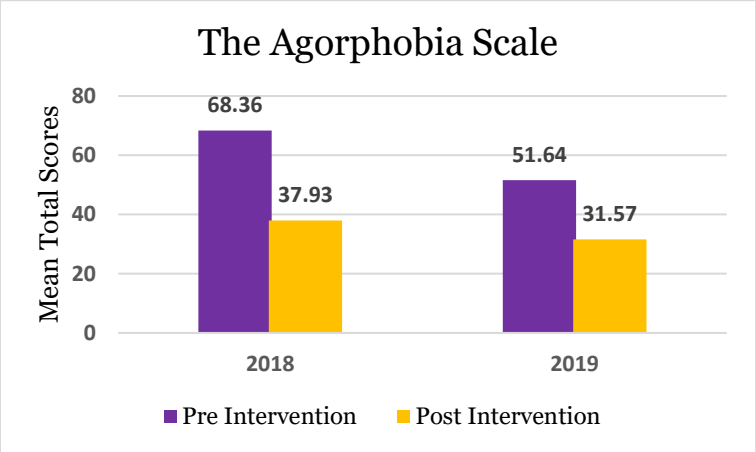
Graph: Social Phobia Inventory median total scores pre and post intervention in 2018 and 2019.



Analysis of the SPIN using a Wilcoxon Signed Rank test indicated a statistically significant reduction in service users scores, z = -3.41, p=.001, from pre-intervention (M= 49, SD= 10.27) to post-intervention (M= 33.5, SD= 13.78). This reflected a large effect size (r = 0.85).

The Agoraphobia Scale

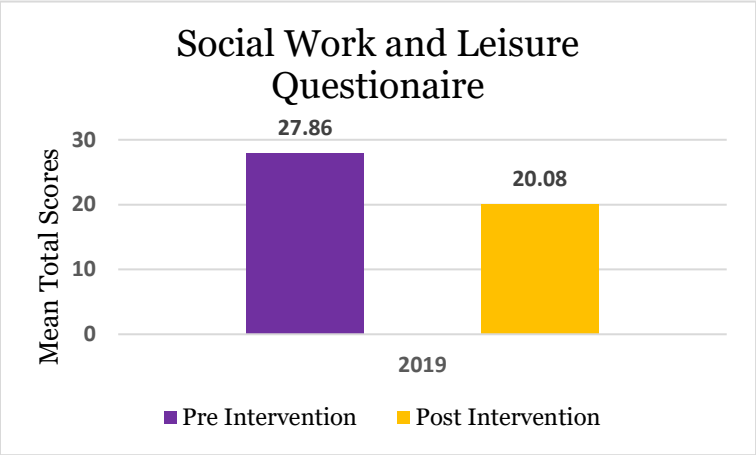
Graph: The Agoraphobia Scale Mean Total Scores Pre and Post Intervention for 2018 and 2019.



Analysis of the Agoraphobia Scale using a T-Test indicated that there was a statistically significant reduction in mean total scores observed, $t\ (14)$ = 3.76, p < .005, from pre-intervention (M= 51.64, SD = 32.06) to post-intervention (M= 31.57, SD = 27.00) at Level 1, reflecting a medium effect size (Cohen's d = 0.67).

The Social Work and Leisure Questionnaire

Graph: Social Work and Leisure Questionnaire Group Mean Score Pre and Post Intervention.

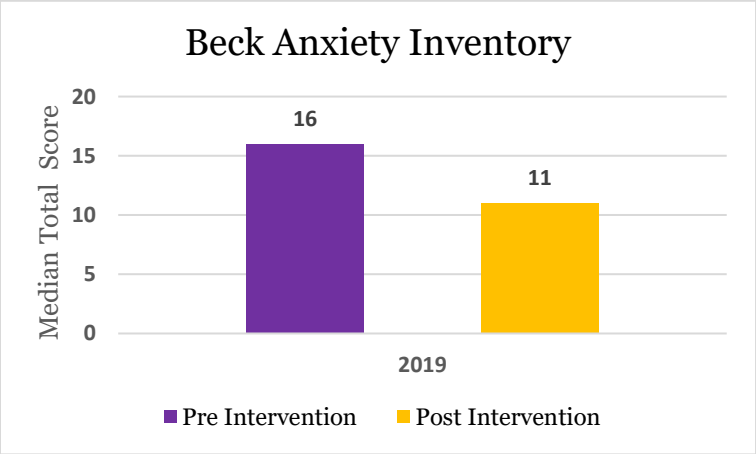


Analysis of the SWLQ using a T-Test indicated that there has been a statistically significant reduction in mean scores observed, *t (103)* = 8.06, p = .000, from pre-intervention (*M* = 27.68, *SD* = 9.10) to post-intervention (*M* = 20.08, *SD* = 10.60) at level 1, reflecting a medium effect size (Cohen's *d* = 0.77).

4.5.4. Level 2 results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory median total scores pre and post-intervention for 2019



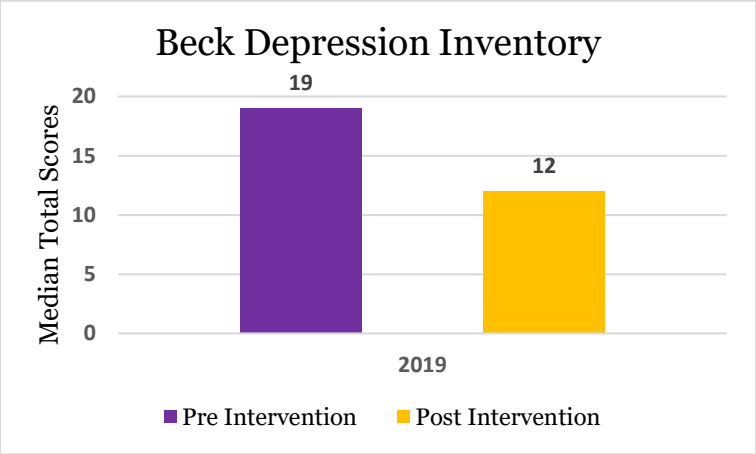
Analysis using a Wilcoxon Signed Rank test of pre (*Md* = 16.0, SD = 9.35) and post (*Md*= 11.0, SD = 9.56) intervetion scores on the Beck Anxiety Inventory suggested a statistically significant change in scores, z = -2.96, p < .005. This reflected a large

effect size (r = -.67). At the pre-measurement time point, 52.6% had anxiety scores in the severe and moderate ranges, this dropped to 36.8% by the end of Level 2 (See the table below).

ı each category	ıiety (BAI)		›ression (BDI)	
	Ł	ST	Ł	ST
ıimal	15.8%	%	15.8%	%
d	31.6%	%	31.6%	%
derate	26.3%	%	47.3%	%
ere	26.3%	%	5.3%	
ıls				

Beck Depression Inventory (BDI)

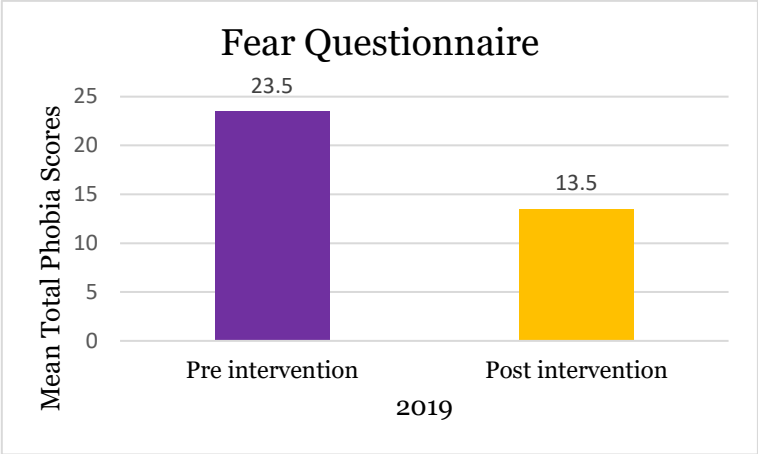
Graph: Beck Depression Inventory median total scores pre and post-intervention for 2019



Average depression scores for those who completed the level 2 programme (indicated on the graph above) were in the mild range pre-intervention (Md= 19.0, SD = 7.43) and showed a statistically significant drop to the lower mild range post-intervention, (M = 12.0, SD = 7.8), z = -3.10, p < .005, which represented a large effect size (r =0.71).

The Fear Questionnaire

Graph: The Fear Questionnaire, Total Phobia Score Pre and Post Intervetion.

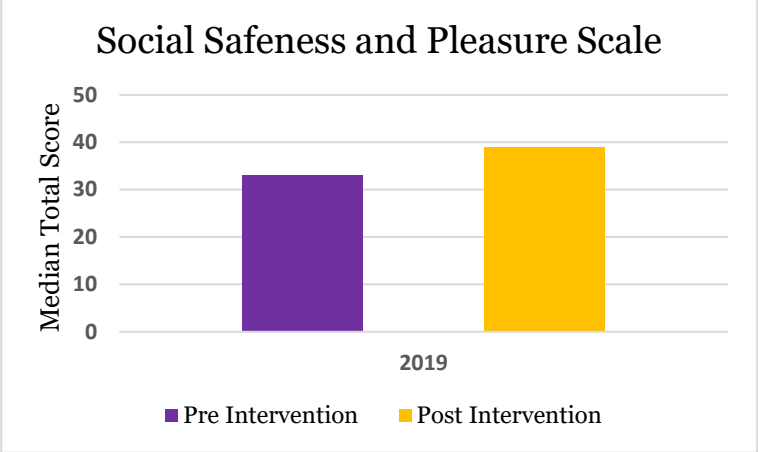


Total phobia scores on the Fear Questionnaire were found to have dropped from a median score of 23.50 (*SD* = 11.74) to 13.50 (*SD* = 10.25) following statistical analysis using the Wilcoxon Signed Rank test at level 2 of the Anxiety Disorder Programme. This reduction was statistically significant, z = -2.27, p < .05 with a large effect size (r= 0.53).

The Social Safeness and Pleasure Scale

Service users scores on the Social Safeness and Pleasure Scale showed a change from a mean of 33.0 (SD= 7.72) pre-intervention to 39.0 (SD=8.64) post-intervention. This increase was statistically significant z = -3.27, p < .001, with a large effect size (r =0.75).

Graph: The Social Safeness and Pleasure Scale Total Scores Pre and Post Intervention.



4.5.5. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2019 suggested significant reductions in anxiety and depression symptoms, OCD symptoms and reductions in pathological worrying and social anxiety; in line with previous years.

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

Instrument	Effect Size	
	2018	2019
BAI	-0.48 (r)	-0.60(r)
BDI	-0.48 (r)	-0.66(r)
Fear Questionnaire	-0.40 (r)	-0.70(r)
Y-BOCS (Global Score)	1.26 (Cohen's *d*)	1.19(Cohen's *d*)
Penn State Worry Questionnaire	-0.60 (r)	-0.71(r)
Social Phobia Inventory	1.01 (Cohen's *d*)	0.85(Cohen's *d*)
Agoraphobia Scale	1.49 (Cohen's *d*)	0.67(Cohen's *d*)
Social Work and Leisure Questionnaire	_	0.77(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 Disorders Programme in 2019 suggest 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. This would indicate that these results are robust and generalisable.

Changes in scores for most measures have been consistently positive across the data since 2011, following both Level 1 and Level 2, indicating that the Anxiety Disorders programme continues to be a reliable and effective support to those who have completed the programme.

4.6. Compassion-focused Therapy

Compassion-focused Therpay (CFT) was developed by Prof Paul Gilbert for individuals with mental health difficulties linked to high levels of shame and critical thinking (Gilbert, 2009; Leaviss & Uttley, 2014). It is an integrative, multi-modal approach that draws on evolutionary psychology, neuroscience, attachment theory, cognitive behaviour therapy and mindfulness and compassion-focused 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). Jazaeir 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 in SPMHS 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 SPMHS to investigate subjective bodily changes associated with attending a trans-diagnostic CFT group (Mernagh, Baird & Guerin, under review). Results suggest that service users who attended a CFT group developed an increase in mind-body attunement. That is, they developed their capacity to listen to, and trust, their own bodily sensations as a source of important information about their emotions, as well as to regulate their emotions through responding to associated physical sensations with increased compassion and understanding.

The Compassion-Focused Therapy group commenced in SPUH in February 2014 and in SEH in July 2014. Both 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 2019.

All service users attending the CFT Programme in both SPUH and SHE are invited to complete the following measures before starting the programme and again after completion. These measures were selected on the basis of their use in published international scientific research relating to Compassion Focused Therapy, and having established reliability and validity (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 questionnaire that measures the three related states of depression, anxiety and stress. Each item is rated on a four-point Likert scale from 0 – did not apply to me at all – to four – 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 (eg. “I fear that if I am too compassionate towards myself bad things will happen”); fear of compassion from others (eg. “I try to keep my distance from others even I know they are kind);

and fear of compassion for others (eg. “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 Likert scale from 0 – don’t agree at all – to four – 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 (ie. motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgmental) and an action sub-scale (ie. 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; one – never – to 10 – always. High scores indicate high compassion. This measure was introduced in April 2017.

- **The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)**

  The FSCRS was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004). This scale was developed to measure self-criticism and the ability to self-reassure. It is a 22-item scale that measures different ways people think and feel about themselves when things go wrong for them. The items make up three components, there are two forms of self-criticalness; inadequate self, which focuses on a sense of personal inadequacy (“I am easily disappointed with myself”), and hated self, which measures the desire to hurt or persecute the self (“I have become so angry with myself that I want to hurt or injury myself”), and one form to self-reassure, reassured self (“I am able to remind myself of positive things about myself”). The responses are given on a five-point Likert scale ranging from 0 – ‘not at all like me - to four - extremely like me. Cronbach alphas were .90 for inadequate self and .86 for hated self and reassured self respectively.

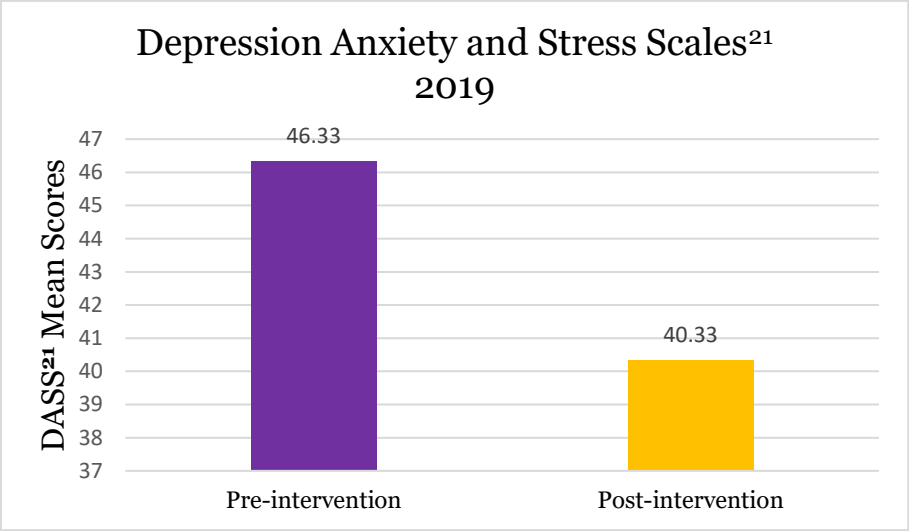
4.6.2. Descriptors

Altogether, 63 people completed the CFT programme at either SPUH or SEH in 2019. Of these participants, 75.4% were female and 24.6% were male. Programme attendees ranged in age from 20 to 75 years with an average age of 42.75 years (SD= 14.09).

4.6.3. Results

Depression Anxiety and Stress Scales (DASS)

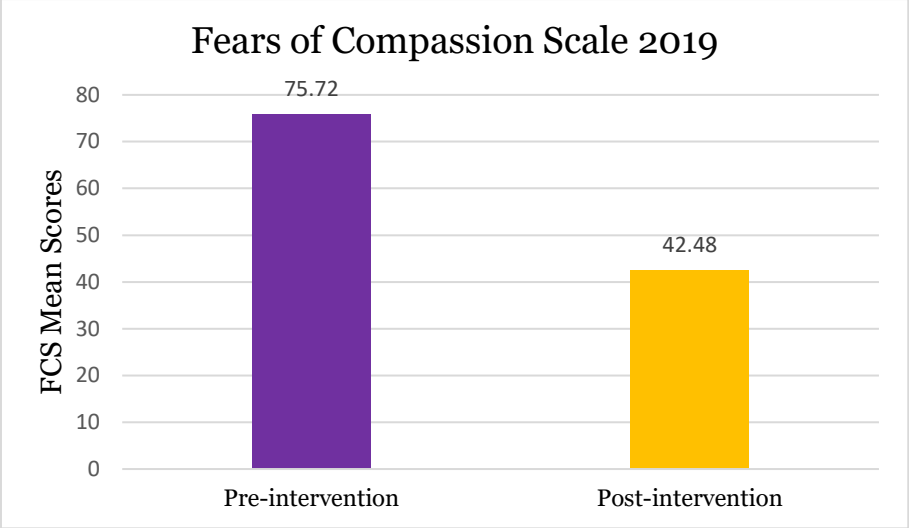
Graph: Depression Anxiety and Stress Scores



A decrease in psychological difficulty as measured by the Depression Anxiety and Stress (DASS^{21}) Inventory was observed between pre-intervention (M = 46.33, SD = 21.48) and post-intervention (M = 40.33, SD = 26.98), where t (36) = 1.27, p>.05. However, a paired samples t-test suggests this decrease was non-significant.

The Fears of Compassion Scale

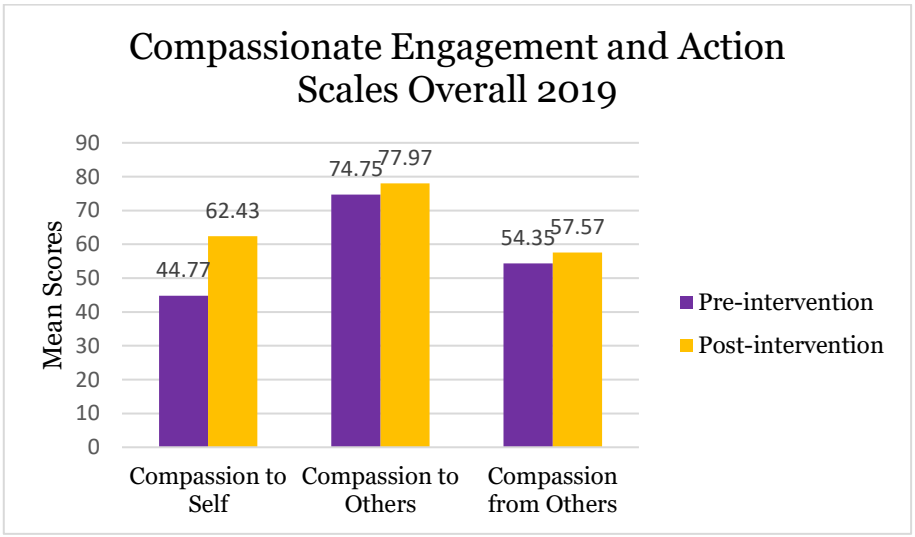
Graph: The Fears of Compassion Scale



A Wilcoxon Signed Ranks Tests demonstrated 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) for those attending the programme in 2019. At pre-intervention, participants mean scores on the FCS were 75.72 (SD = 20.30), compared to 42.48 (SD = 23.12) post-intervention, $p<.01$ with a medium effect size ($r = -.68$). These findings suggest that fears of expressing and receiving compassion decreased from pre to post-programme participation.

Compassionate Engagement and Action Scale

Graph: Compassionate Engagement and Action – overall scores

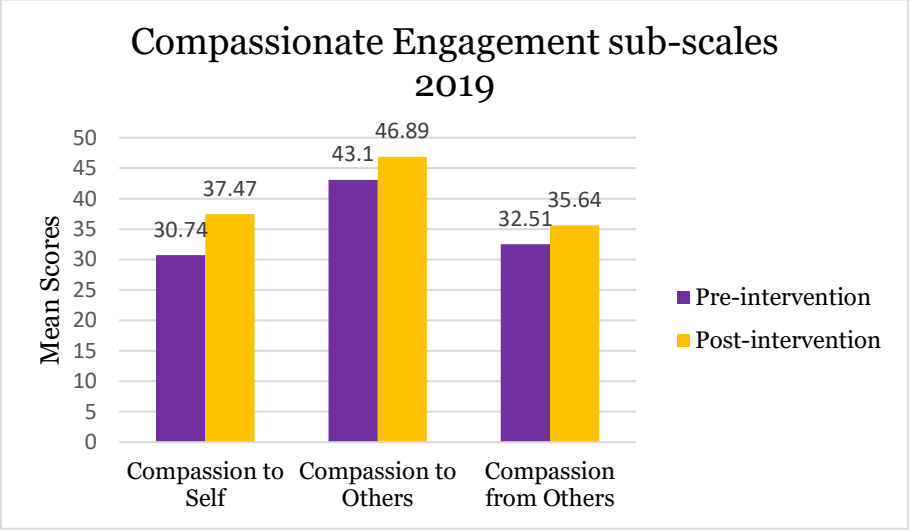


Significant increases were demonstrated by a Wilcoxon Signed Ranks Tests from pre-intervention (M = 44.77, SD = 12.15) to post-intervention (M = 62.43, SD = 14.10) on the Compassion to Self Scale overall, p< .05, with a medium effect size (r = -.65). These findings illustrate that participants' self-directed compassion increased from pre to post-intervention.

Significant increases in mean scores on the Compassion to Others Scale overall from pre-intervention (M = 74.75, SD = 12.39) to post-intervention (M = 77.97, SD = 11.65) were also observed, p< .05, with a small effect size (r = -.36).

Pre-intervention (M = 54.35, SD = 18.96) and post-intervention (M = 57.57, SD = 19.06) scores on the Compassion from Others Scale overall also increased, however these increases were non-significant with p>.05

Graph: Compassionate Engagement sub-scales

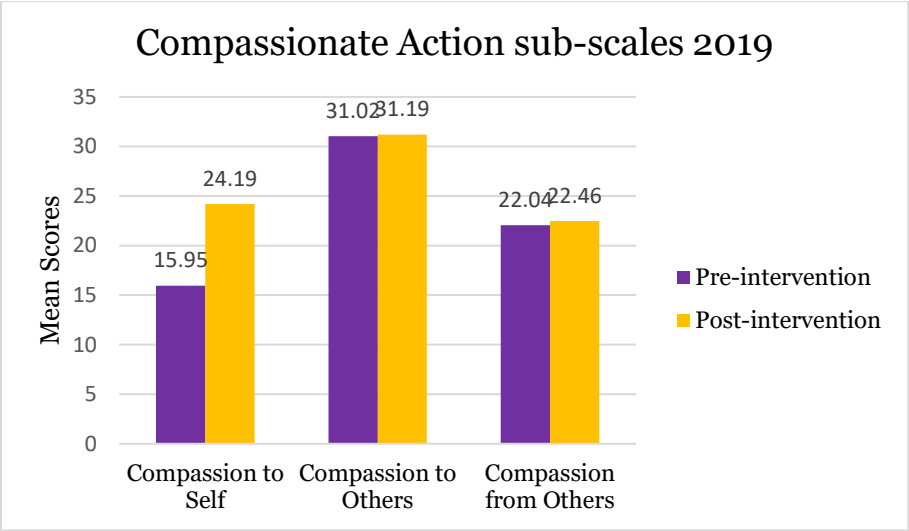


Within the Compassionate Engagement sub-scales, significant increases in mean scores were achieved on the Compassion to Self sub-scale. Participant scores increased from pre-intervention (M = 30.74, SD = 6.79) to post-intervention (M = 37.47, SD = 8.12), t (35) = -4.277, p<.01, demonstrating a large effect size (*d* = 0.89).

Scores obtained on the Compassion to Others sub-scale were statistically significant with mean scores increasing from (M = 43.10, SD = 8.43) pre-intervention to (M = 46.89, SD = 7.22) post-intervention, t (36) = -3.46, p<.01, approaching a medium effect size (*d* = 0.48).

The increase in scores obtained on the Compassion from Others sub-scale was found to be non-significant, p>.05.

Graph: Compassionate Action sub-scales



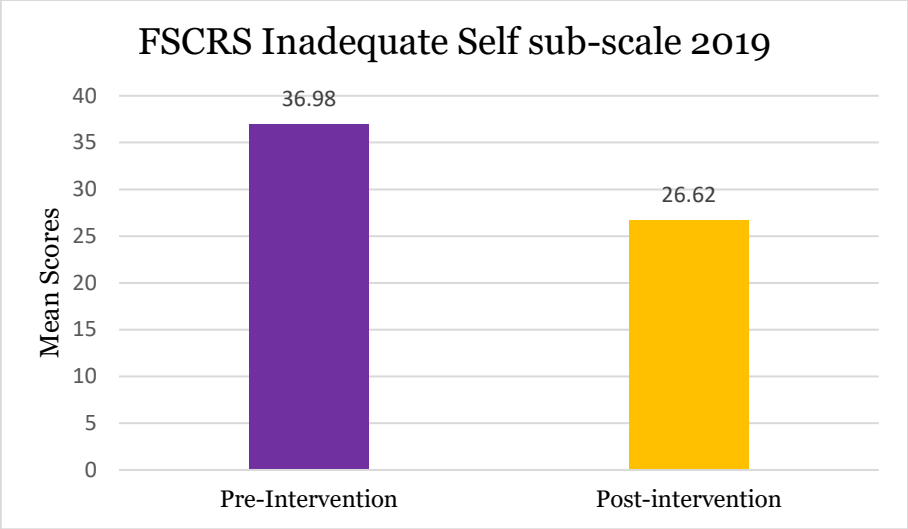
Within the Compassionate Action sub-scales, a significant increase in mean scores can be observed on the Compassion to Self subscale. Participant mean scores increased from (M = 15.95, SD = 6.10) pre-intervention to (M = 24.19, SD = 7.00) post-intervention, t (40) = -6.595, p<.01, with a medium effect size (*d* = 0.82).

A non-significant increase in mean scores was observed on the Compassion to Others and Compassion from Others subscales, where p>.05.

These findings suggest that on completion of the programme, service users' compassion for themselves and openness to receiving compassion from others increased.

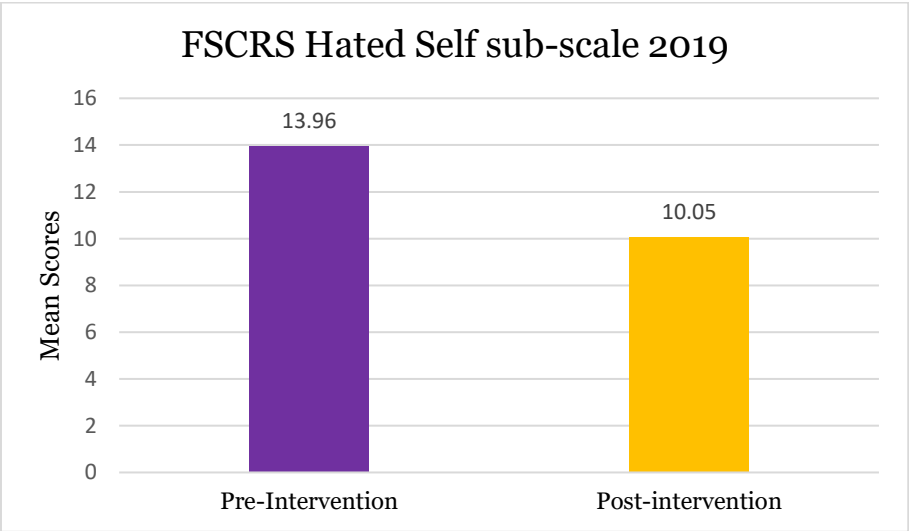
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Graph: FSCRS Inadequate Self sub-scale



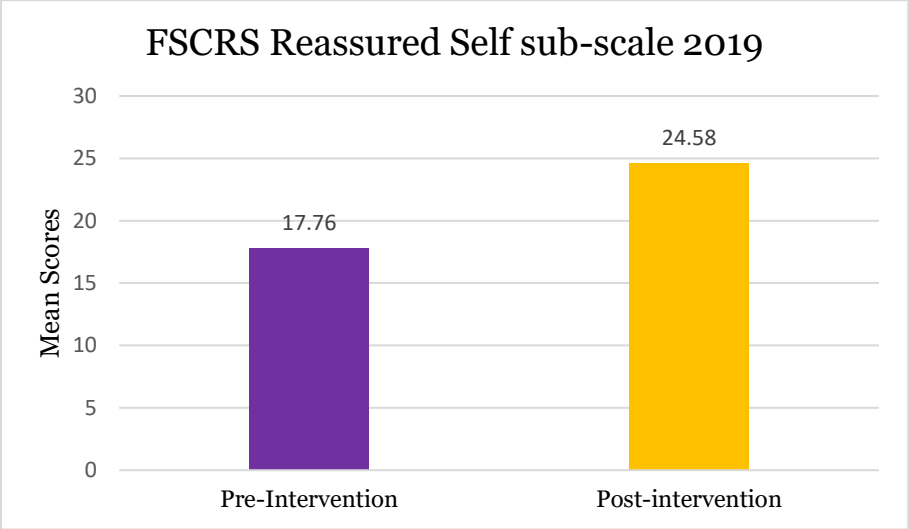
A Wilcoxon Signed Ranks test demonstrated a significant decrease in mean scores on the FSCRS 'inadequate self' sub-scale from pre (M = 36.98, SD = 5.12) to post-intervention (M = 26.62, SD =6.68), $p<.01$, demonstrating a large effect size ($r = -0.76$). This suggests that post-completion of the programme, participants experienced reduced feelings of inadequacy.

Graph: FSCRS Hated Self sub-scale



A significant reduction in mean scores on the 'hated self' sub-scale was also observed from pre- (M = 13.96, SD = 4.30) to post-intervention (M = 10.05, SD = 4.18), p<.01, demonstrating a medium effect size (r = -.59). These scores suggest that participant levels of self-directed hostility decreased upon completion of the programme.

Graph: FSCRS Reassured Self sub-scale



A significant increase in mean scores on the 'reassured self' sub-scale was achieved from pre (M = 17.76, SD = 4.59) to post-intervention (M = 24.58, SD = 5.82), p<.01, demonstrating a medium effect size (r = -.64). These results indicate that participants' ability to cope and reassure themselves increased following engagement with the CFT programme.

4.6.4. Summary

The Compassion-Focused Therapy programme started in SPMHS in 2014. Since then, 30 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. The 2019 results indicate that attendance at the CFT programme is associated with a significant reduction in fears of self-compassion, sense of personal inadequacy and desire to persecute oneself. There is evidence also of a reduction in overall levels of depression, anxiety and stress; though not statistically significant for 2019. The results also indicate that attendance at the

programme is associated with a significant increase in self-compassion, as well as compassion toward others, and an increase in capacity for self-reassurance. These are a positive set of results that provide support for the continued effectiveness of the CFT programme.

4.7 Compassion-Focused Therapy for Eating Disorders

Compassion Focused Therapy for Eating Disorders (CFT-E) aims to support participants with:

- Establishing regular and sufficient eating
- Increasing attentional control and compassion skills
- Experiencing giving and receiving compassion within a group
- Increasing access to social support and self-compassion (Allan & Goss, 2012).

Gilbert (2014) defines compassion as involving two parts: a sensitivity to, and an awareness of, suffering of self and others; and a motivation to try to prevent and alleviate suffering.

CFT is underpinned by evolutionary theory and the neuroscience of emotion, thus scientifically explaining the application of compassion to promote mental health (Mullen, Dowling, Doyle, & O'Reilly, 2019). A systematic review conducted by Leaviss & Uttley (2014) suggested CFT as a particularly helpful intervention for clients experiencing high levels of shame and self-criticism, which are more common amongst people experiencing eating disorders than any other mental health population (Ferreira, Pinto Gouveia, & Duarte, 2014).

CFT categorises emotions by their functions for:

- Alert to threat and activation of defence behaviours
- Incentivisation of seeking behaviour
- Allow for rest and digest (Gilbert, 2014).

These have been named the threat, drive and soothing systems respectively. The CFT-E model suggests that people who experience eating disorders have learned to regulate their experience of threat through their drive system, with little access to their healthy soothing system (Allan & Goss, 2012). For example, experiences of

threat such as shame and self-criticism can be managed through the drive of goal-directed food restriction or accessing soothing through food. Research indicates that food restriction stems from experiences of threat which are overly responded to by the drive system through excessive dieting which becomes reinforced through feelings of pride (Kelly & Tasca, 2016). Bingeing behaviour is regulated by the soothing system through dissociation from negative emotions and an increase in pleasurable sensation and soothing affect (Allan & Goss, 2012).

Research carried out in SPMHS (Mullen, Dowling, Doyle, & O'Reilly 2019) reported that after completing the group, people described a more compassionate way of relating to themselves; building new ways of living without an eating disorder; and positive experiences with the programme, particularly from connections made with other group members.

The CFT-E group commenced in SPMHS in 2015 and is facilitated by the psychology department comprising two psychologists and one assistant psychologist. For cycles one to six, the intervention was delivered across 25 sessions. The amount of sessions increased to 30 in cycle seven, which will be reported on in the 2020 Outcomes Report. CFT-E is delivered across four levels: psycho-education, compassionate skills teaching, therapy and after-care.

4.7.1. Compassion-Focused Therapy for Eating Disorders outcome measures

The following section presents a summary of the routine clinical outcome measures used by the CFT-E programme from cycle one to six.

All service users attending the CFT-E programme are invited to complete the following measures at assessment for the programme, at post-skills (mid-way) and again upon completion.

Clinical Outcome Routine Evaluation – Outcome Measures (CORE-OM)

The Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) is a 34-item self-report questionnaire developed to monitor clinically significant change in out-patients. The client is asked to respond to 34 questions about how they have been feeling over the last week using a five-point Likert scale ranging from – not at

all – to most or all of the time. The 34 items of the measure cover four dimensions: subjective wellbeing, problems/symptoms, life functioning and risk/harm.

The responses are designed to be averaged by the practitioner to produce a mean score to indicate the level of current psychological global distress (from healthy to severe). The CORE Outcome Measure (CORE-OM) was conceived as a non-proprietary measure of psychological distress. Crucially, it was informed by feedback from practitioners as to what they considered to be important to include (Barkham et al., 2010). Since its development, the CORE-OM has been validated with samples from the general population, NHS primary and secondary care and in older adults. Furthermore, analyses of over 2,000 responses show good reliability and convergent validity against longer and less general measures; small gender effects, large clinical/non-clinical differences and good sensitivity to change (Evans et al., 2009).

Eating Disorder Examination Questionnaire (EDE-Q)

The Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn, Cooper, & O'Connor, 2008) is a well-established self-report instrument that investigates eating disorder behaviours and attitudes. It is a 36-item self-report questionnaire that measures change in eating disorder symptoms over the course of treatment. It is considered the 'gold standard' measure of eating disorder psychopathology and is designed to assess past month cognitive sub-scales related to eating disorders; restraint, eating concern, shape concern and weight concern, as well as behavioural symptoms related to these concerns (eg. frequency of binge-eating, vomiting, use of laxatives or diuretics and over-exercise).

Participants are asked how often they have engaged in a range of eating disorder behaviours over the past 28 days, e.g. "have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?" or "over the past 28 days, how many days have you eaten in secret?". Answers range from 'no days', 'six to 12 days', '23 to 27 days and 'every day'.

Participants are also asked about how their weight/shape impacts their thoughts about themselves, eg. "has your weight influenced how you think about yourself as a person?" or "how dissatisfied have you been with your shape?" Answers range from 'not at all', 'slightly', 'moderately' and markedly'.

The EDE-Q reports good internal consistency. Cronbach's α ranged from .75 (Restraint at Time 1) to .93 (Shape Concern at Time 2) for women and from .73 (Eating Concern at Time 2) to .89 (Shape Concern at Time 2) for men. With the exception of some of the eating disorder behaviours, test re-test reliability has been reported to be fairly strong for both men and women (Rose et al., 2013).

Fears of Compassion (FCS)

The Fears of Compassion Scale (FCS; Gilbert, McEwan, Matos & Rivis, 2011) consists of three sub-scales measuring: fear of compassion for self (eg. "I fear that if I am too compassionate towards myself bad things will happen"); fear of compassion from others (eg. "I try to keep my distance from others even I know they are kind); and fear of compassion for others (eg. "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 Likert scale from 0 – don't agree at all – to four – completely agree. Higher scores are indicative of greater fears of self-compassion.

The Functions of Self-Criticising/Attacking Scale (FSCS)

The Functions of Self-Criticising/Attacking Scale (FSCS) was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004) to measure the functions of self-criticism; why people think they self-criticise and self-attack. Factor analysis suggests two very different functions for being self-critical; one is to try and improve the self and stop the self from making mistakes (self-correction) and the other involves expressing anger and wanting to harm the self (self-persecution). It is a 21-item scale measuring both these factors. The responses are given on a five-point Likert scale ranging from 0 - not at all like me – to four - extremely like me. Cronbach alphas were .92 for correcting and persecuting respectively.

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

The FSCRS was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004). This scale was developed to measure self-criticism and the ability to self-reassure. It is a 22-item scale that measures different ways people think and feel about themselves when things go wrong for them. The items make up three components; there are two forms of self-criticalness; inadequate self, which focuses on a sense of personal inadequacy ("I am easily disappointed with myself"), and hated self, which measures

the desire to hurt or persecute the self ("I have become so angry with myself that I want to hurt or injury myself"), and one form to self-reassure, reassured self ("I am able to remind myself of positive things about myself"). The responses are given on a five-point Likert scale ranging from 0 – 'not at all like me - to four - extremely like me. Cronbach alphas were .90 for inadequate self and .86 for hated self and reassured self respectively.

4.7.2. Descriptors

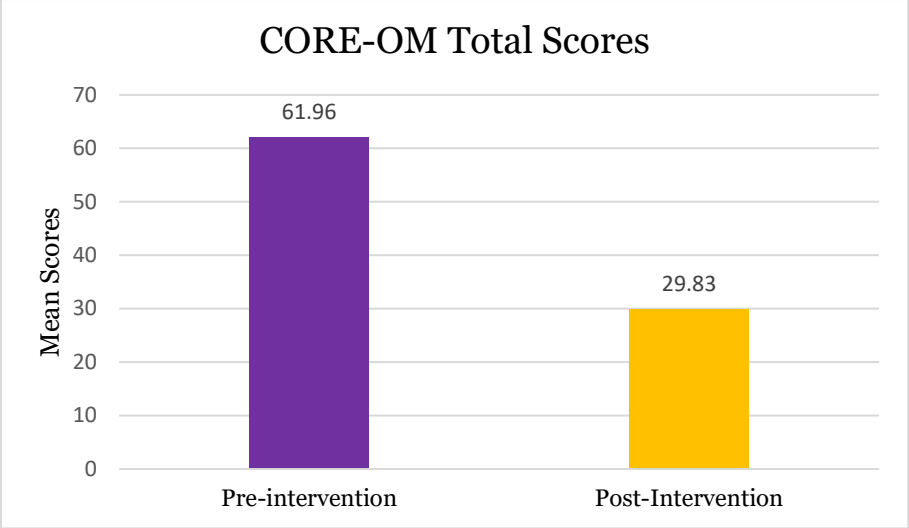
From Cycle 1 to Cycle 6, pre and post-intervention data were available for 36 participants who completed the CFT-E programme. Of these participants, 35 were female and one was male. Programme attendees ranged in age from 19 to 58 years, with an average age of 33.92 years (SD= 14.14). A further 11 people completed the group but did not return post-intervention measures. Over the past six CFT-E Cycles, 16 people dropped out from the programme. This attrition rate has been shown to be consistent in the treatment of eating disorders (Fassino, Tomba and Abbate-Daga, 2009).

4.7.3. Results

Clinical Outcome Routine Evaluation – Outcome Measures (CORE-OM)

A Wilcoxon Signed Ranks Test revealed that participants experienced a decrease in psychological distress, moving from a median score of 61.96 (*SD* = 20.62) on the CORE-OM pre-intervention to 29.83 (*SD* = 19.77) post-completion of the programme, $z = -3.062$, $p < .01$. Interpretation of these scores illustrates a transition from 'moderate-severe' psychological distress to 'mild' psychological distress on the measure. This change represented a medium effect size ($r = -.51$).

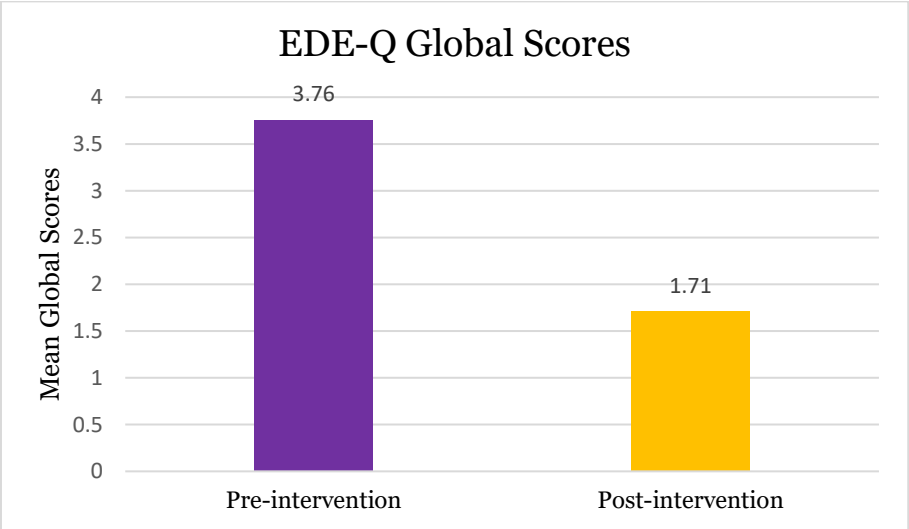
Graph: CORE-OM Total Mean Scores



Eating Disorder Examination Questionnaire (EDE-Q)

Participants reported a reduction of eating disorder symptomatology as measured by scores on the EDE-Q. The global score on the EDE-Q reflected decreased symptomatology between pre-intervention (M = 3.76, SD = 0.937) and post-intervention (M = 1.71, SD = 0.964). A Wilcoxon Signed Rank test demonstrated this was a statistically significant change, z= -2.97, p<.01, with a large effect size (*r* = 0.9).

Graph: EDE-Q Global Scores



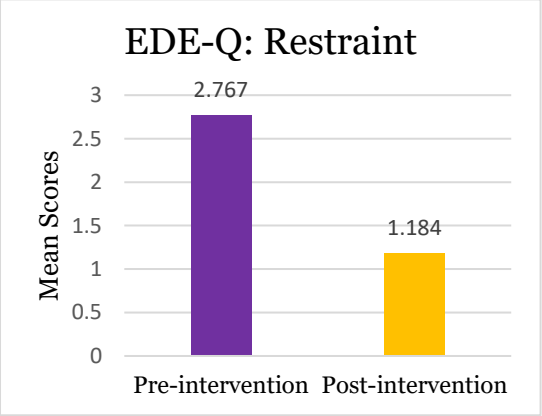
There are four sub-scales measured within the EDE-Q – restraint, eating concern, shape concern and weight concern. A series of Wilcoxon Signed Ranks Tests were carried out and the pre and post-intervention scores are depicted in the table below.

Statistically significant reductions in eating disorder symptoms and behaviours are observed across each of the four sub-scales from pre-intervention to post-intervention, reflecting a large effect size.

Table: EDE-Q Subscale Scores

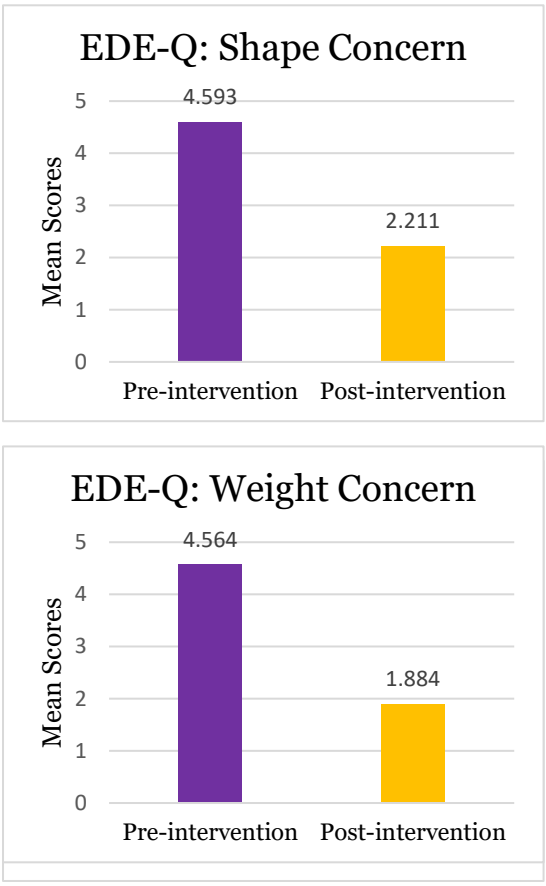
E-Q	m	t m			R
traint	7	4	74	p<.05	
ng cern	3.143	3	.0	5	
pe cern	3	1	30	1	
ght cern	4.564	4	71	1	

Graphs: EDE-Q Subscales

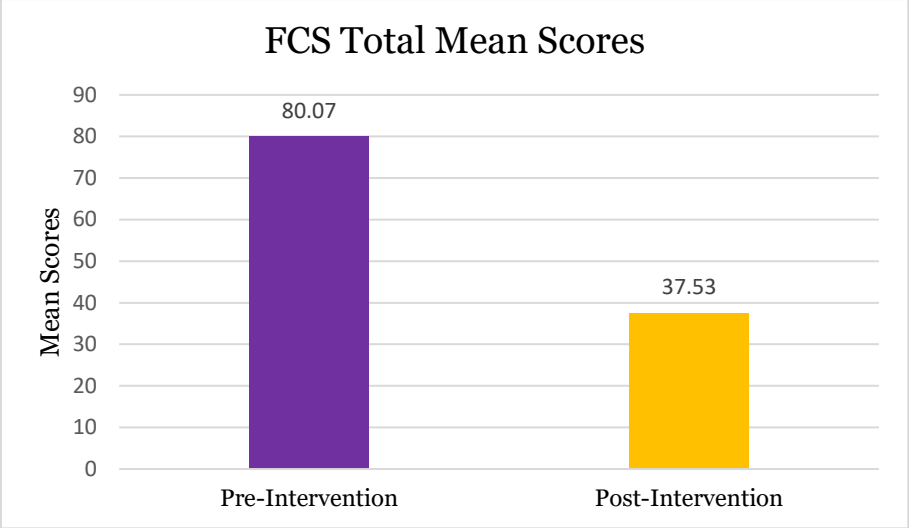


Fears of Compassion Scale (FCS)

Participants reported a statistically significant decrease in their fear of compassion. Total mean scores on the scale transitioned from (M = 80.07, SD = 31.22) pre-intervention to (M = 37.53, SD = 22.18) post-intervention, $p<.01$, $z = -2.971$, reflecting a medium effect size ($r = -.49$). See Graph (a).

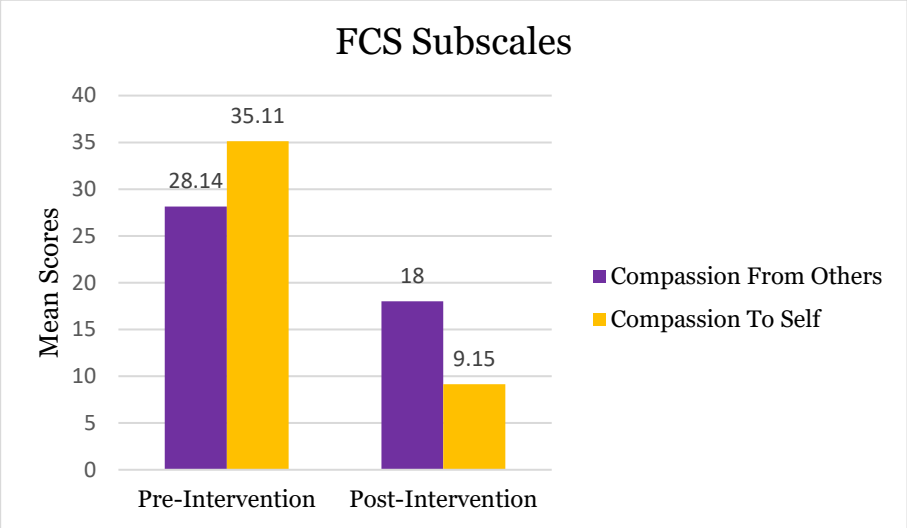


(a) Graph: Fears of Compassion Total Mean Scores



The scale is divided into two sub-scales, measuring participants' fear of recieving compassion from others and fear of giving compassion to self. Participants fear of recieiving compassion from others decreased from (M = 28.14, SD = 11.56) pre-intervention to (M = 18, SD = 10.95) post-intervention. This was statistically significant with p<.01, z=-2.778, illustrating a medium effect size (r = -.48). Participants fear of giving compassion to themselves also reduced from pre to post-intervention. Scores on the FCS for fear of compassion to self transitioned from (M = 35.11, SD = 19.9) to (M = 9.15, SD = 6.28), p<.01, z = -2.972, demonstrating a medium effect size (r = -.49). See graph (b).

(b) Graph: Fears of Compassion Subscales – (i) Compassion from Others (ii) Compassion to Self



The Functions of Self-Criticising/Attacking Scale (FSCS)

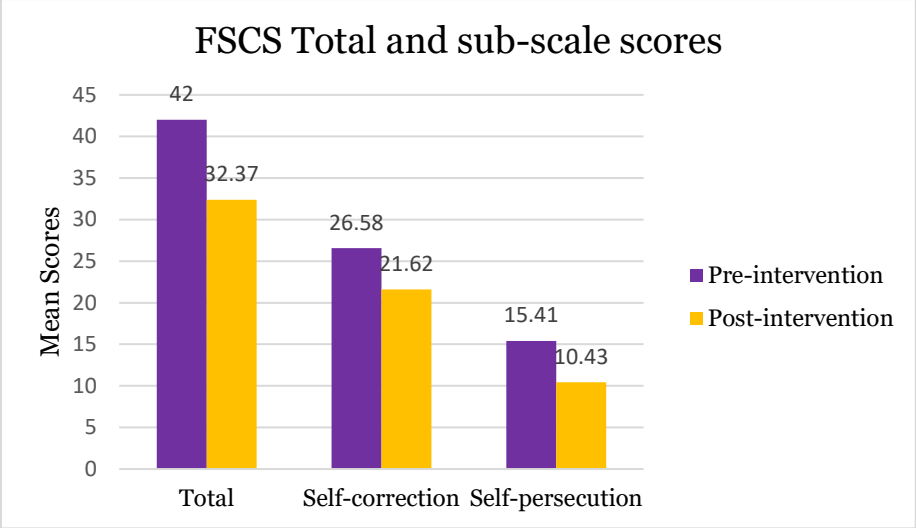
A reduction in self-criticising and self-attacking was observed from pre to post-intervention as measured by the FSCS. Participants total mean scores on the FSCS decreased from (M = 42, SD = 18.85) pre-intervention to (M = 32.37, SD = 22.63) post-intervention, $p<.05$, $z=-2.261$, reflecting a medium effect size ($r = -.4$).

The FSCS is divided into two sub-scales, measuring the function of self-criticising/attacking in terms of self-correction and self-persecution. On the self-correction subscale, participant's self-criticising/attacking scores reduced from (M = 26.58, SD = 12.24) to (M = 21.62, SD = 15.91). However, this reduction was found to be non-significant with $p>.5$.

A statistically significant reduction was revealed on the self-persecution sub-scale, with participants' self-criticising/attacking scores transitioning from (M = 15.41, SD = 8.44) pre-intervention to (M = 10.43, SD = 9.04) post-intervention, $p<.05$, $z = -2.2$, $r =-.39$.

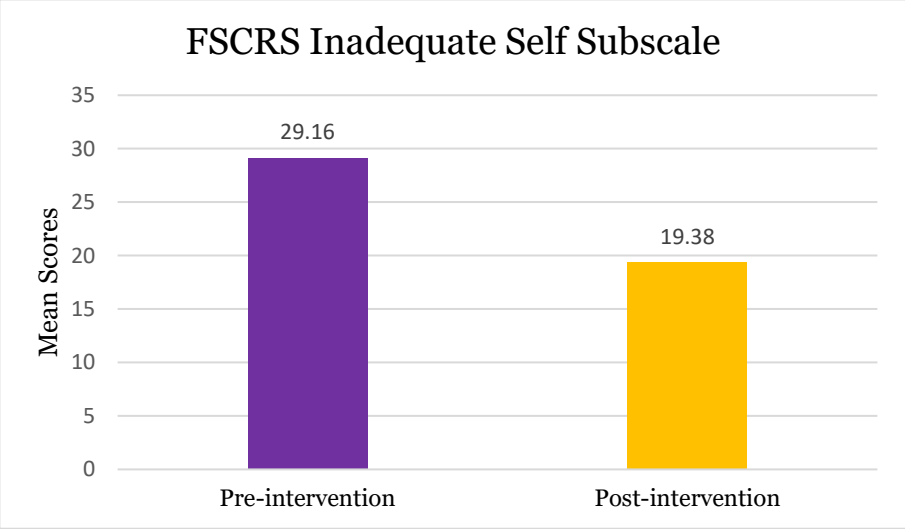
See visual representation in graph below.

Graph: FSCS Total and sub-scale scores



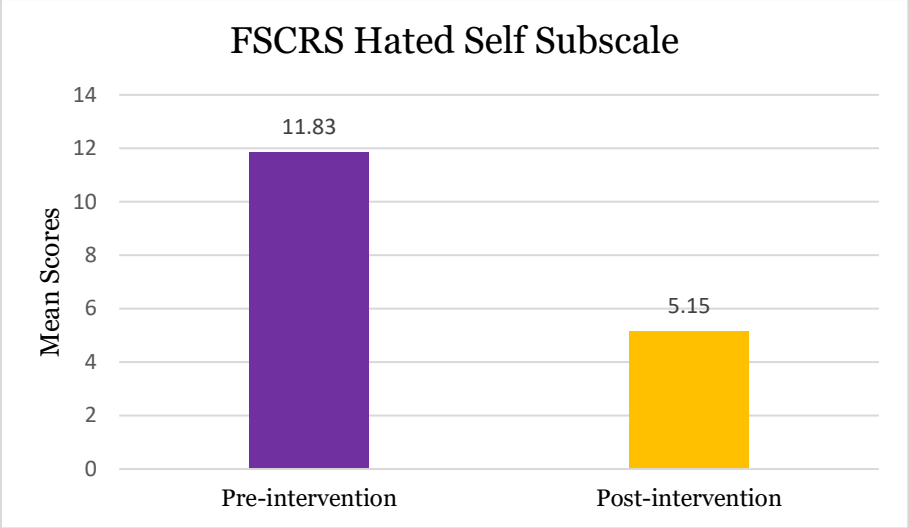
The Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCRS)

Graph: FSCRS Inadequate Self sub-scale scores



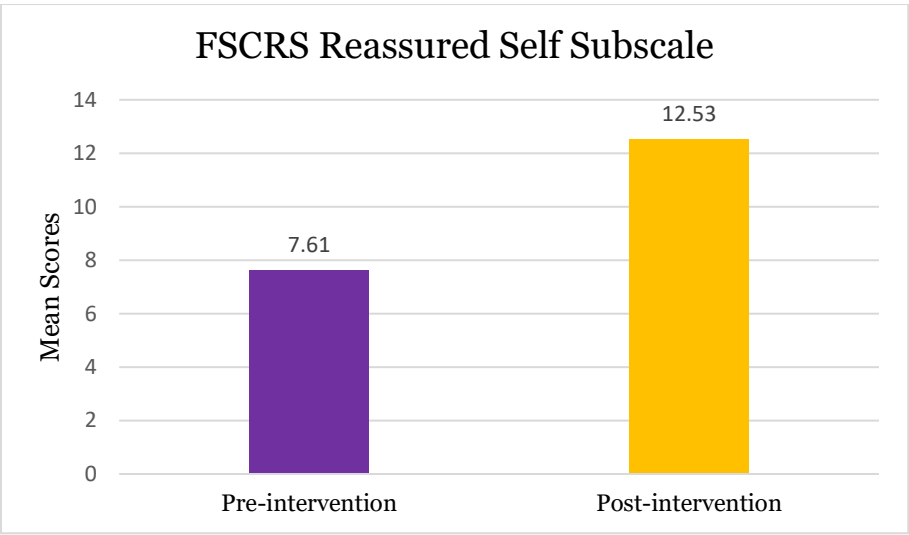
A Wilcoxon Signed Ranks test demonstrated a significant decrease in mean scores on the FSCRS 'inadequate self' sub-scale from pre (M = 29.16, SD = 6.5) to post-intervention (M = 19.38, SD =9.04), $p<.01$, demonstrating a medium effect size (r = -0.55). This suggests that post-completion of the programme participants experienced reduced feelings of inadequacy.

Graph: FSCRS Hated Self sub-scale scores



A significant reduction in mean scores on the 'hated self' sub-scale was also observed from pre (M = 11.83, SD = 5.0) to post-intervention (M = 5.15, SD = 3.6), p<.01, demonstrating a medium effect size (r = -.50). These scores suggest that participant levels of self-directed hostility decreased upon completion of the programme.

Graph: FSCRS Reassured Self sub-scale scores



A significant increase in mean scores on the 'reassured self' sub-scale was achieved from pre\ (M = 7.61, SD = 4.96) to post-intervention (M = 12.53, SD = 7.46), p<.01, demonstrating a medium effect size (r = -.45). These results indicate that participants ability to cope and reassure themselves increased following engagement with the CFT-E programme.

4.7.4 Summary

Since CFT-E began in SPMHS in 2015, seven cycles have been facilitated. The eight commenced in early 2020.

The programme receives referrals from within the hospital and from external referrers. Cycles one to six were delivered across 25 sessions. From cycle seven, the number of weekly sessions increased to 30.

Qualitative research from group members has been largely positive, with group members reporting a reduction in their eating disorder symptoms and an increase in their ability to give and receive compassion, which is statistically supported in the findings presented (Mullen, Dowling, Doyle, & O'Reilly, 2019).

Quantitative research further substantiates the efficacy of the CFT-E programme, with participants demonstrating less psychological distress pre and post-intervention, a reduction in eating disorder cognitions and behaviours, a reduction in experience of shame and self-criticism and a greater capacity to give and receive compassion.

4.8. Depression Recovery Programme

The Depression Recovery Service is a comprehensive multidisciplinary assessment, treatment and after-care 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 two-week psycho-educational programme open to service users currently in hospital or attending from home on a daily 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 step-down group for those who have completed Level B - building recovery. This programme runs for four half days over a six-month period.

Level A (activating recovery) is a group-based psycho-educational programme facilitated two days per week for two weeks. The group includes 12 to 14 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 programme).

Workshop B is an introduction to the level B programme which has been added for service users who have completed level A.

Level B (building recovery – a psychotherapy group) is a 10-week programme. The programme aims to introduce the concepts of CBT and mindfulness accompanied by compassionate role modelling and compassionate self- talk. Workshops have been designed as a means of exploring the thought-mood connection and the development of the vicious cycle of depression. It assists with the development of a deeper understanding of the impact of depression on daily life as well as building an awareness of factors that may have increased your vulnerability to depression.

4.8.1. Depression Recovery Programme outcome measures

- **Quick Inventory of Depression Symptomatology (QIDS)**

The Quick Inventory of Depression Symptomatology (Rush AJ, Gullion CM, Basco MR, Jarrett RB, Trivedi MH, 2003) is a 16-item measure used to assess the severity of depression symptoms. The items cover the nine diagnostic domains of depression as identified in the DSMS-IV: sad mood, concentration, self-criticism, suicidal ideation, interest, energy/fatigue, sleep disturbance and decrease or increase in appetite. It utilises a four-point rating scale, with a score of 0 = none, one = mild, two = moderate, three = severe and, four = very severe. Total scores range from 0-27. The QIDS has been found to have high internal consistency with a Cronbach's alpha of 0.83. The QIDS is based on the 30-item IDS questionnaire, for which it has good concurrent validity (Ware et al. 1996). The IDS is shown to have comparative

sensitivity and specificity to the IDS the HRSD (Rush et al. 1996, 2000, 2003, in press), BDI (Rush et al. 1996), MADRS and SCL-90 (Corruble et al. 1999).

This QIUDS has been used this year in place of the BDI, which has comparable construct validity.

4.8.2. Descriptors

Paired data were available for 190 participants who completed the programme in 2019; 96 females (50.3%) and 95 males (49.7%).

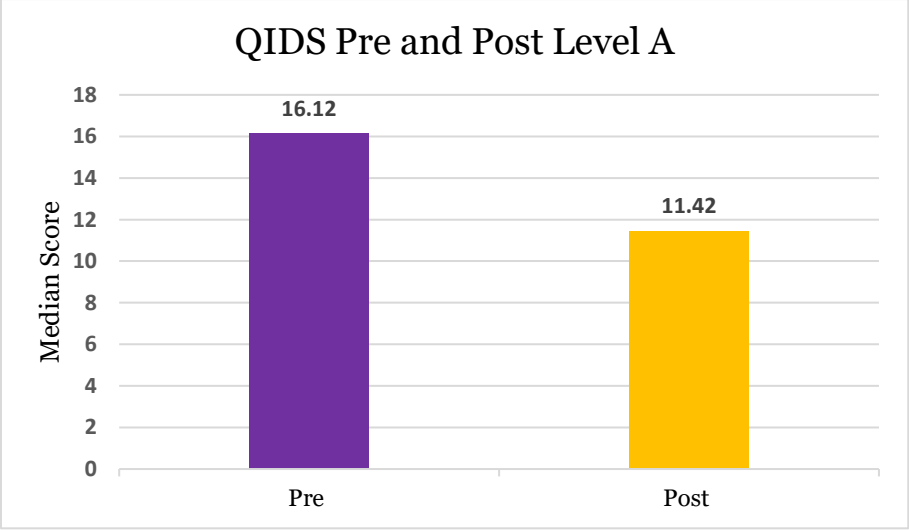
4.8.3. Results

Pre Level A and post Level A

Quick Inventory of Depression Symptomatology (QIDS)

Comparison of service user scores on the QIDS from pre and post-level A indicated a reduction of depression severity from pre-intervention (*Md* = 16) to post-intervention (*Md* = 11) (see graph below). This reduction in median scores is statistically significant. A Wilcoxon Signed Rank test revealed z= -9.081, p = .000, with a large effect size (Cohen's *r* = 0.65).

Graph: Quick Inventory of Depression Symptomatology total 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 personal 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.

Quick Inventory of Depression Symptomatology

Pre and post-intervention scores on the QIDS demonstrate that the average score for people who completed Level B of the Depression Programme remained stable, in the mild range, pre Level B (*Md* = 9) to post Level B (*Md* = 8). This reduction in symptom severity as measured by the QIDS was not statistically significant.

4.8.4. Summary

This is the fifth year the Depression has been included in the SPMHS Outcomes Report. This is the first year that the QIDS has been used to capture the profile of group attendees and investigate the programme's effectiveness at reducing symptoms of depression.

These results provide evidence to suggest that, on average, people who complete the programme experience a significant reduction in symptoms associated with depression at Level A and that these changes remain stable at Level B of the programme. In future years the programme will consider including more demographic information on patients who complete the programme (eg. 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.

4.9. 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-psycho-social support structure and the therapeutic environment necessary to foster their recovery. This includes a combination of group and one-to-one 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 programme is a staged recovery programme and is delivered by psychiatrists, addiction counsellors, ward-based nursing staff, with input from other disciplines including psychology, social work and occupational therapy. It includes:

- Initial detoxification and assessment by MDT
- Inpatient residential service for approximately four weeks (longer if required)
- 12-week step-down programme (not always required, pending treatment pathway)
- After-care 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 eg. 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 focusing on mental health-related topics such as depression, anxiety and recovery.
- **Role play groups:** This group aims to allow clients to actively practise 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 and work balance etc.
- **Reflection group:** This group provides a safe place to support clients through the process of change and 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.

4.9.1. 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 four-point scale from 0 – never – to three – 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).

4.9.2. Descriptors

Participants attended and completed the full or modified programme in 2019. The sample size used was n=101 as some data was incomplete and therefore excluded. Of the 101 participants, 55.6% were male and 44.4% female. The age ranged from 19 to 77, with a mean age of 45.

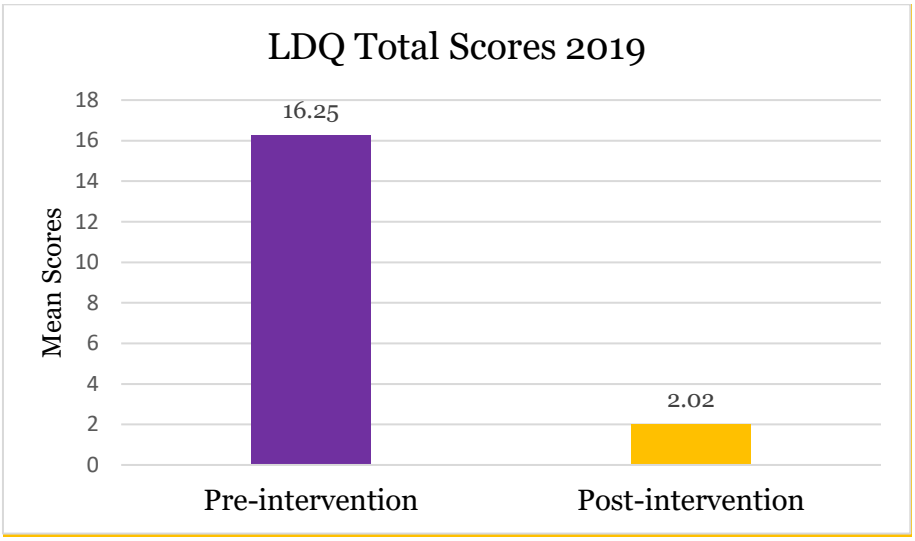
4.9.3. Results

Leeds Dependency Questionnaire

A Wilcoxon Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency following participation in the programme, $z=-8.55$, $p<.001$, with a large effect size ($r=-.83$).

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



4.9.4. 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 2020.

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 we hope 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 2020 with the aim of collecting data from these service users.

4.10. Eating Disorders Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the needs of people with anorexia nervosa, bulimia nervosa, binge eating disorder and Other Specified Feeding and Eating Disorders (OSFED). 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 CBT treatment model which is applied throughout inpatient, day patient and outpatient treatment stages, as needed by the patient. The programme is structured into three stages. Initially service users are assessed at the Dean Clinic. The typical care pathway then involves inpatient care, day care and follow-up outpatient care. Treatment can also be provided in a standalone capacity as an inpatient, day care patient or an outpatient

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.
- Care planning, goal-setting and personal development
- 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 support and education 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, social work, dietitian and psychology MDT members including:

- Occupational therapy groups
- Goal-setting and care planning
- Meal planning, preparation and Cooking groups
- Meal spervision and dietetics
- Body image and self-esteem
- relaxation/self-reflection groups
- Recovery-focused intervention (WRAP)
- Social and relationship 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 dietitian reviews, along with CBT-E, MANTRA and SSCM in order to support service users in their recovery.

4.10.1. EDP outcome measures

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

- **Eating Disorder Examination – Questionnaire**

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

  27 items contribute to global score and four sub-scales including restraint, eating concern, weight concern and shape concern. Items from each sub-scale are summed and averaged with the global score generated by summing and averaging the sub-scale scores (resulting scores range from 0 to six for each sub-scale 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 (eg. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

- **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 three components of self-esteem: performance self-esteem, social self-esteem and appearance self-esteem. All items are answered using a five-point scale (one = not at all, two = a little bit, three = somewhat, four = very much, five = extremely).

Higher scores indicate higher levels of self-esteem.

4.10.2. Descriptors

Data was available for a total of 28 service users attending the EDP as an inpatient in 2019 and 23 attending as a day patient.

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

1. Inpatient admission
2. Inpatient discharge
3. Day patient admission
4. Day patient discharge

Due to these multiple timepoints, data was grouped and analysed according to inpatient and day patient categories.

4.10.3. 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 pre-treatment (*Md* = 4.3) and post-treatment (Md = 3.5). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.48, p = .000, with a large effect size (Cohen's *r* = 0.64).

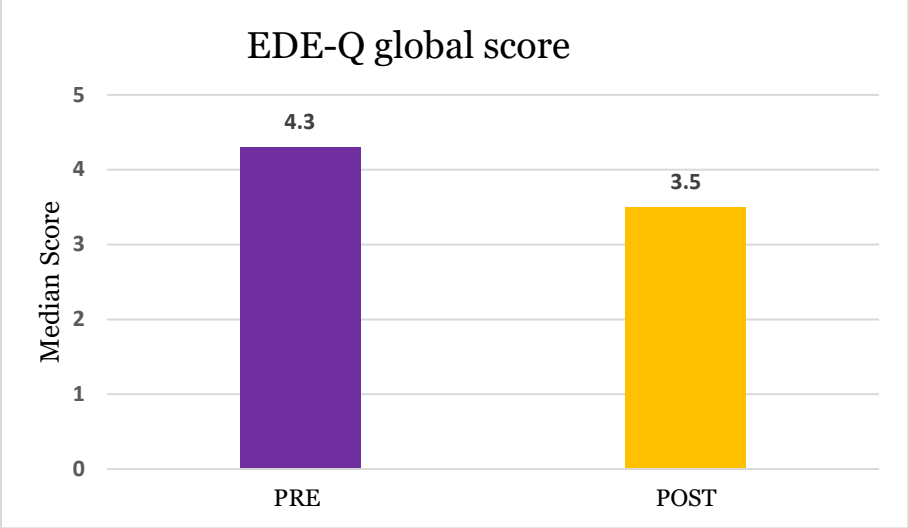
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restraint sub-scale decreased from pre-treatment (*Md*= 3.0) to post-treatment (*Md* = 1.3). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -4.16, p = .000, with a large effect size (Cohen's *r* = 0.77).

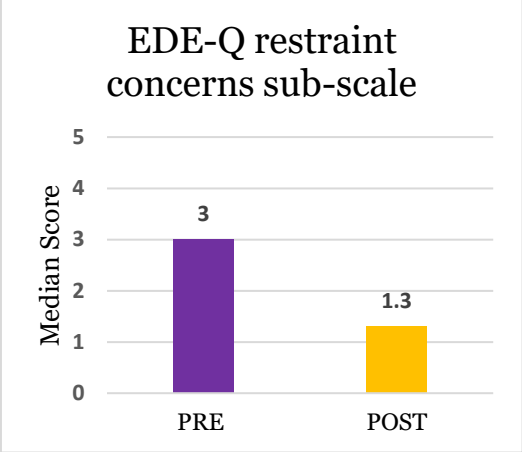
Symptomatology on the eating concern sub-scale decreased from (*Md* = 3.1) to (*Md* = 2.0). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -4.01, p = .000, with a large effect size (Cohen's *r* = 0.75). The shape concern sub-scale decreased from pre-treatment (*Md* = 4.2) to post-treatment (*Md* = 2.0).

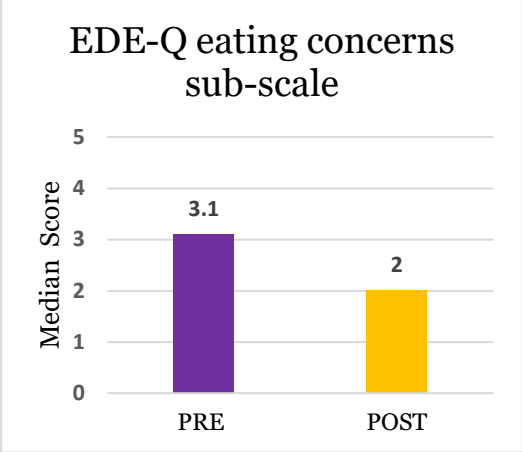
A Wilcoxin Signed Rank test analysis of shape concerns indicated there was a statistically significant change, z= -2.11, p < .05, between pre-treatment (*Md*= 4.2) and post-treatment (*Md* = 4.1). A medium effect size (Cohen's *r* = 0.39) was recorded.

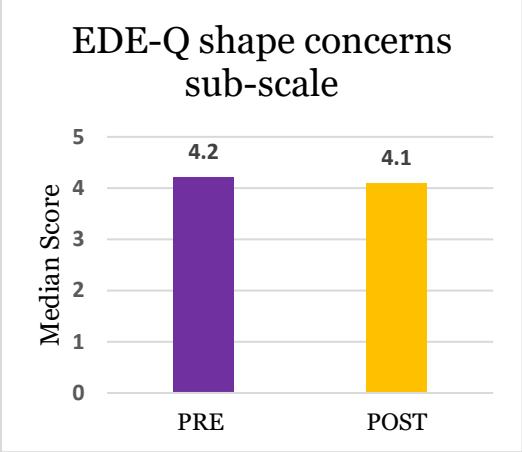
Finally, symptomatology on the weight concern sub-scale reduced between pre-treatment (*Md* = 4.30) and post-treatment (*Md* = 3.80). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -3.20, p = .001, with a large effect size (Cohen's *r* = 0.60).

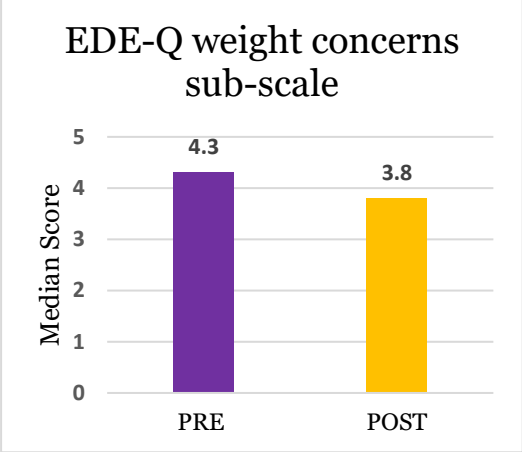
Graph: EDE-Q Global and sub-scale scores pre and post-intervention











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 three sub-scales: performance self-esteem, appearance self-esteem and social self-esteem. At time two (inpatient

discharge) mean score across all scales had increased suggesting improvements across all domains. Data was collected from 28 attendees.

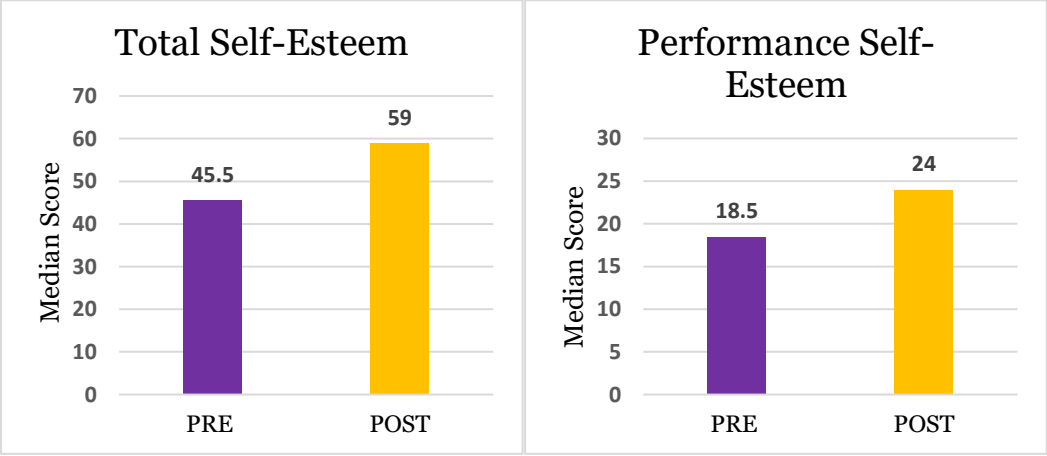
The total score on the SESS showed an increase between pre-treatment (*Md*=45.5) and post-treatment (*Md*=59). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.77, p = .000, with a large effect size (Cohen's *r* = 0.71).

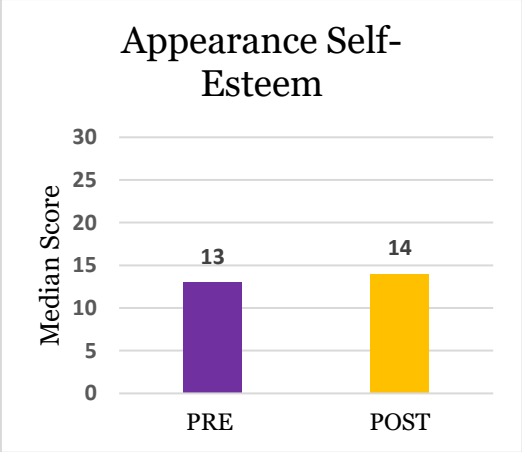
Results indicate increased average medians across all the domains. Performance self-esteem increased from pre-treatment (*Md*=18.5) to post-treatment (*Md*=24). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.27, p = .001, with a large effect size (Cohen's *r* = 0.61).

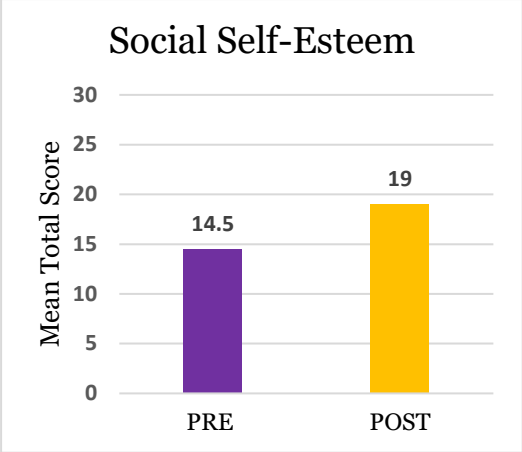
Social self-esteem increased from pre-treatment (*Md*=14.5) to post-treatment (*Md*=19). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.48, p = .000, with a large effect size (Cohen's *r* = 0.65).

Appearance self-esteem increased from pre-treatment (*Md*=13) to post-treatment (*Md*=14). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -2.72, p < .05, with a large effect size (Cohen's *r* = 0.51).

Graph: State Self-Esteem Scale median total scores pre and post-intervention







Day patient 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 pre-treatment (*Md* = 3.5) and post-treatment (Md = 2.4) A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.25, p = 0.001, with a large effect size (Cohen's *r* = 0.67).

Some sub-scales of the EDE-Q showed statistically significant change decreases in symptomatology by time point, eating concerns, shape concerns and weight concerns.

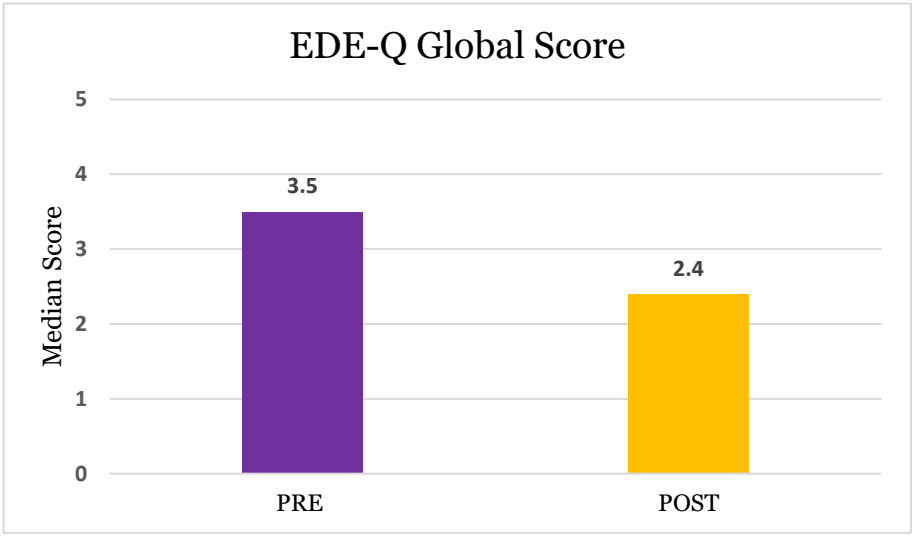
Symptomatology on the eating concerns sub-scale decreased from (*Md*= 2.0) to (Md = 0.8). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -3.34, p = 0.001, with a large effect size (Cohen's *r* = 0.69).

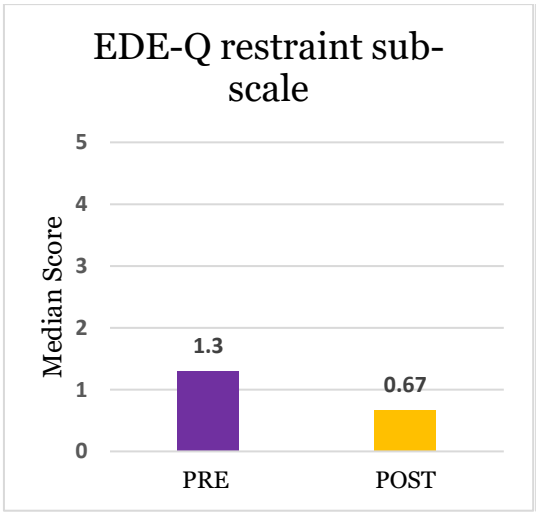
While symptomatology on the shape concerns sub-scale decreased from (Md = 4.1) to (Md = 2.6). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -2.84, p < .05, with a large effect size (Cohen's *r* = 0.59).

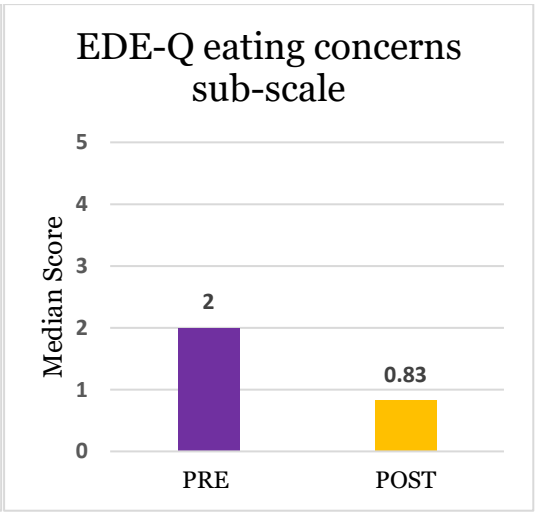
Finally, symptomatology on the weight concern sub-scale reduced from (Md = 3.80) to (Md = 2.10). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -2.58, p < .05, with a large effect size (Cohen's *r* = 0.53).

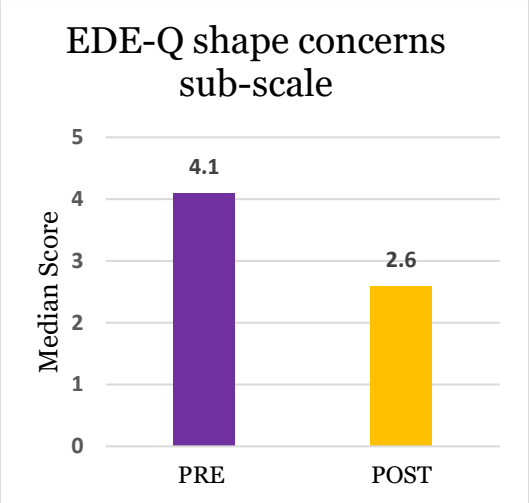
The failure to observe statistical differences in some of the sub-scales may be due to many factors and it is not possible to determine these in this report.

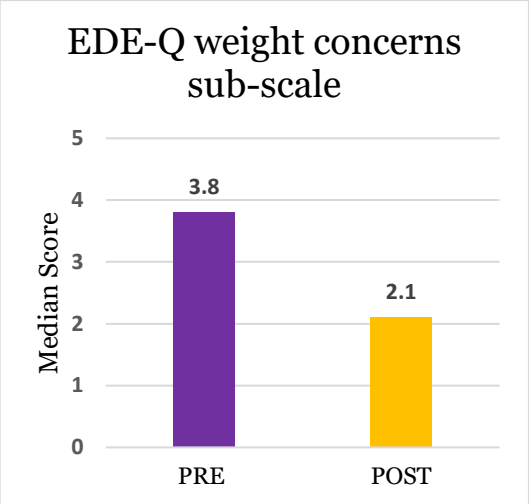
Graph: Eating Disorder Examination Questionnaire global and sub-scale median total scores pre and post-intervention











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 the three sub-scales (performance self-esteem, appearance self-esteem and social self-esteem.) At time two (day patient discharge) mean scores across all scales had increased, suggesting improvements across all domains.

The total score on the SESS showed an increase between day patient admission (*Md*=59) and day patient discharge (M=61). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z = -2.78, p = .005, with a large effect size (Cohen's *r* = 0.57).

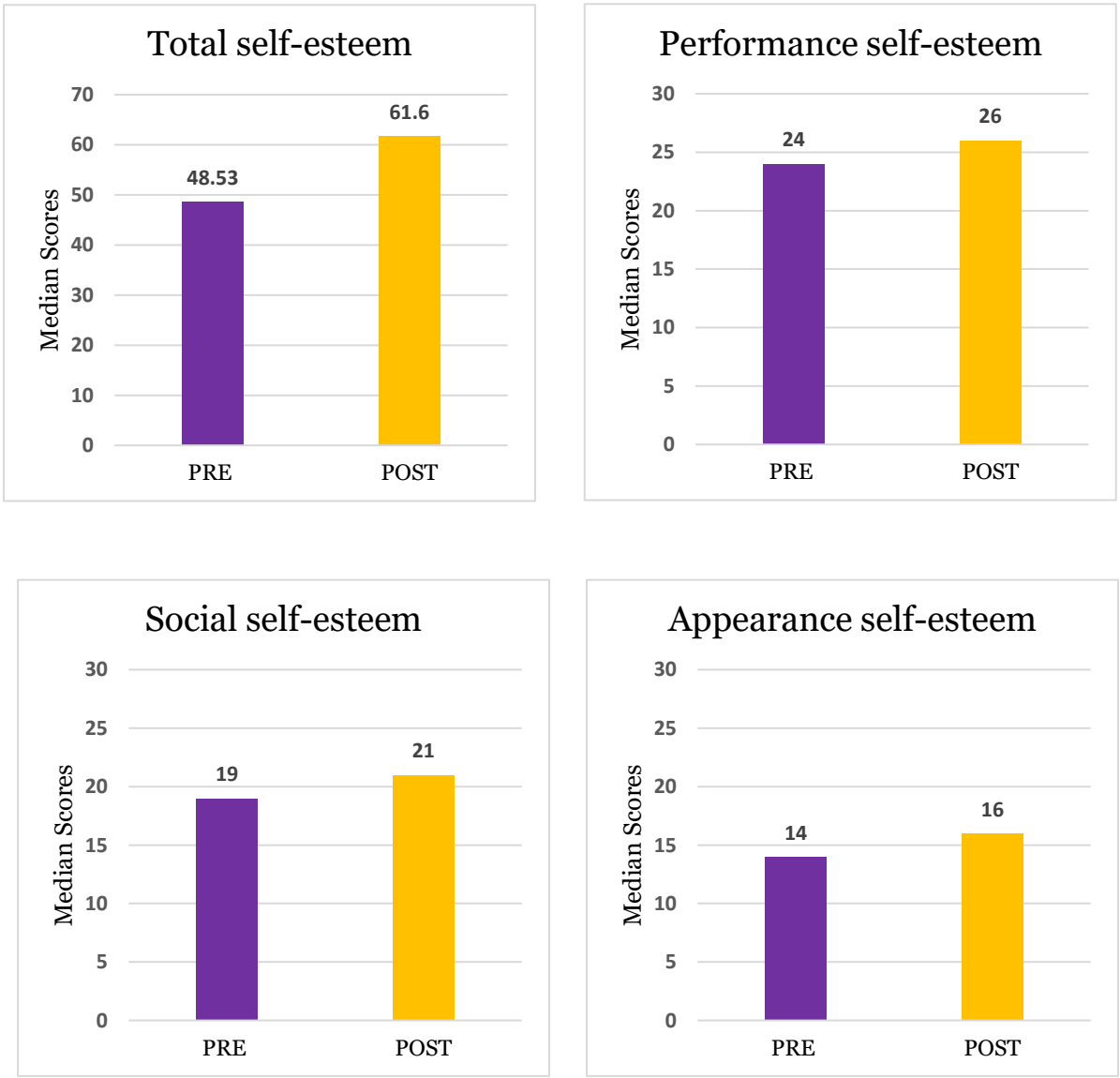
Results indicate increased average medians across all of the domains. Performance self-esteem increased from pre-intervention (*Md*=24) to post-intervention

(*Md*=26). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= 2.20, p < .05, with a medium effect size (Cohen's *r* = 0.45).

Social self-esteem increased from pre-intervention (*Md*=19) to post-intervention (*Md*=21). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= 2.68, p < .05, with a medium effect size (Cohen's *r* = 0.55).

Appearance self-esteem increased from pre-intervention (*Md*=14) to post-intervention (*Md*=16). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.06, p = .002, with a large effect size (Cohen's *r* = 0.63).

Graph: State Self Esteem Questionnaire median total scores pre and post-intervention



4.10.4. 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 day patients on the Eating Disorder Programme experienced a significant reduction in eating disorder symptomology as measured by the EDE-Q, as well as significant improvements in self-esteem across a range of domains as measured by the SSES. This is indicative of the aims of the programme and reflects promising service user outcomes on completion of the Eating Disorders Programme.

4.11. 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 who experience behaviour dyscontrol in the context of emotional dysregulation. Linehan (1993a) proposed that emotional dysregulation underlies much maladaptive coping behaviour. Research suggests that behaviours such as deliberate self-harm (DSH) function as emotion regulation strategies (Chapman et al., 2006), that our clients are attempting to solve problems in their lives in this way.

Linehan's bio-social theory posits that difficulties with emotional under-control are disorders of self-regulation arising from a skills deficit. Emotional regulation difficulties result from biological irregularities combined with certain dysfunctional environments, as well as from the interaction between them over time (Linehan, 1993a). DBT-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 that aid individuals to regulate their emotions are at the core of LTD. LTD focuses on both change and acceptance skills in order to help participants develop new solutions to the problems in their lives. 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.

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).

4.11.1. Living Through Distress Programme outcome measures

- **Difficulties in Emotion Regulation Scale**

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

- **Distress Tolerance Scale**

The Distress Tolerance Scale (DTS; Simons & Gaher, 2005) is a 15-item measure of levels of distress and readiness to tolerate distress. Respondents are asked to rate each statement on a five-point Likert scale from one – strongly agree – to five – 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).

4.11.2. Descriptors

Pre and post-data were available for 90 participants who completed Level 1 ('getting in control') of the programme in 2019. Of those who had pre and post-data, 77.8% were female and 22.2% were male. LTD attendees ranged in age from 18 to 66 years, with an average age of 30.34 (*SD* = 11.79). Their highest level of educational attainment ranged from Junior Certificate (7.9%) to Leaving Certificate (34.8%) to non-degree third-level qualification (20.2%), to third-level degree (16.9%) to postgraduate qualification (19.1%). 1.1% chose 'other'.

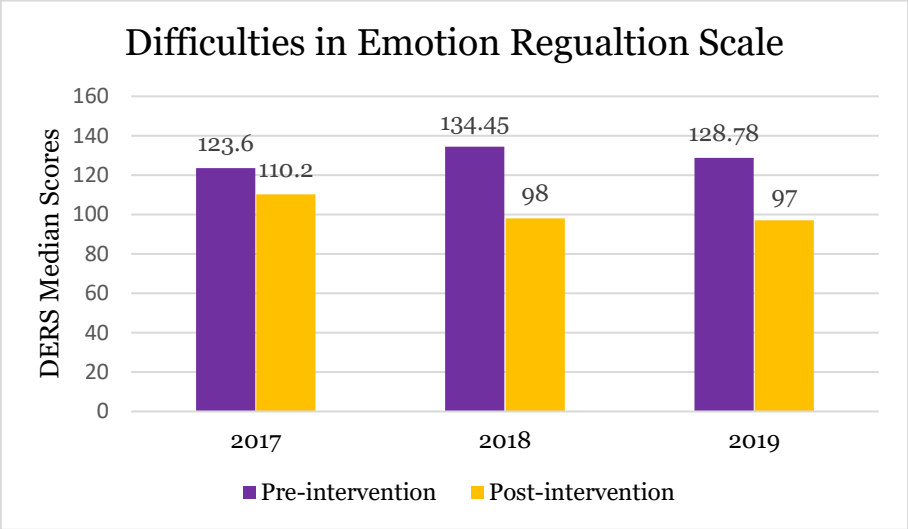
Those who attended the groups' current employment status was also recorded. 2.2% worked in the home, 13.5% were in part-time employment, 27% were in full-time employment, 22.5% were unemployed, 4.5% were retired, 22.5% were students and 7.8% chose other.

4.11.3. 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 a median score of 128.78 (*SD* = 22.54) on the DERS pre to 97.06 (*SD* = 23.20) post-completion of the programme, $z = -5.793$, $p < .001$. This change represented a medium effect size ($r = -.67$). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores

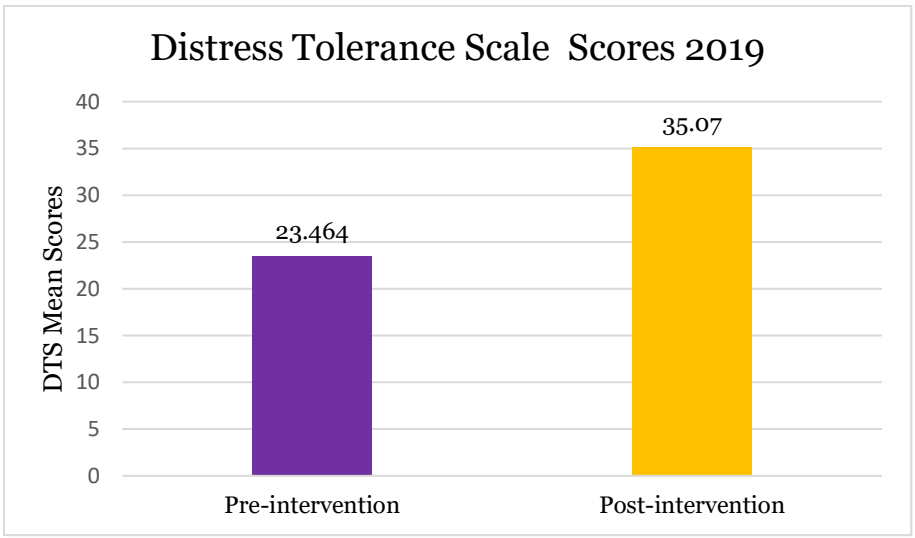


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 23.46 (*SD* = 8.11) before the programme on the DTS to 35.07 (*SD* = 10.63) after completing the programme, z = -6.074, p < .001, representing a large effect size (r = -.66)

Graph: Distress Tolerance Scale Total Scores

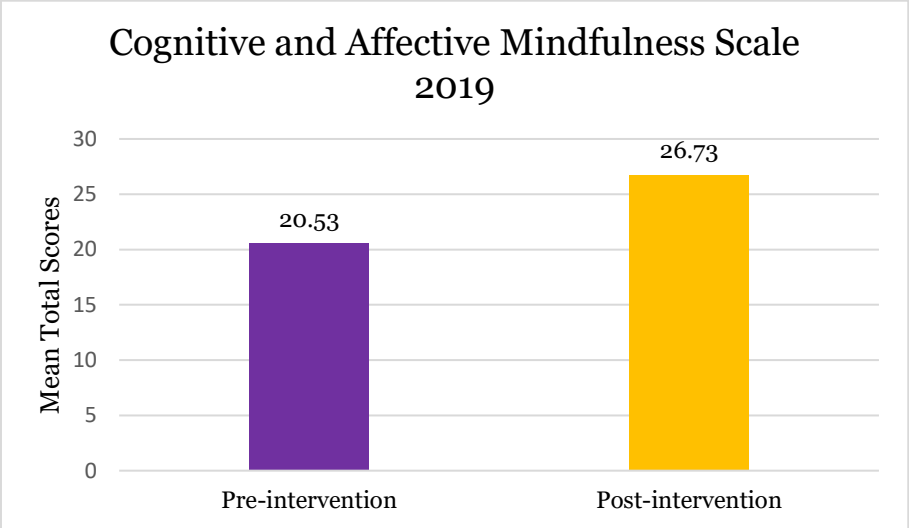


Note: Higher scores indicate increased ability to tolerate distress

Cognitive and Affective Mindfulness Scale

Participants also had greater mindful qualities post-intervention moving from a mean score of 20.53 (*SD* = 3.74) before the programme on the CAMS-R to 26.73 (*SD* = 2.98) after completing the programme. This was a statistically significant change; $z = -5.454$, $p < .001$, and represents a large effect size (r = -.85).

Graph: Cognitive and Affective Mindfulness Scale Total Scores



4.11.4. Summary

For those participants with pre and post-data, significant improvements were observed in increased mindfulness, improved distress tolerance and increases in emotion regulation. Effect size calculations demonstrated both medium and large effect sizes.

In 2020, the Living Through Distress Programme will undergo a number of changes to provide a more comprehensive outpatient treatment package, which will include up to eight individual sessions, as well as 24 group sessions. Outcome measures for the programme will be reviewed accordingly to adequately assess programme outcomes considering these changes.

4.12. Living through Psychosis Programme

Living Through Psychosis (LTP) is a group-based psychology programme for adults who have experienced psychosis. It aims to help individuals to learn how to cope with emotional and psychological difficulties associated with living with psychosis.

In 2019, the programme focused on offering its Level 1 intervention; an eight-week group informed predominantly by CFT for psychosis (CFT; Gilbert, 2014; Heriot-Maitland et al., 2019) and some elements of DBT (DBT; Linehan, 1993). The programme involves an individual pre-group screening session focused on establishing suitability of the group, as well as a mid-way individual check-in session focused on supporting engagement and application of skills. The programme's Level 2, offering a 14-week intervention-based primarily on the CFT model, is currently on hold.

The Level 1 group focuses on helping group members to develop a psychological understanding of psychosis, to develop skills to help regulate emotion/affect and to increase a sense of social safeness. Group work facilitates increased awareness of the common humanity of mental health difficulties, thereby promoting self-compassion and reducing shame and stigma often associated with experiences of psychosis.

4.12.1 Living Through Psychosis Programme Outcome Measures

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

  The Southampton Mindfulness Questionnaire (SMQ; (Chadwick, Hember, Mead, Lilley, & 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 seven-point Likert scale, from 0 – strongly disagree – to six – 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.

- **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 five-point scale from one – almost never – to five – 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.

- **Depression Anxiety Stress Scale (DASS)**

  The Depression Anxiety Stress Scale (DASS; Lovibond, P.F. & Lovibond, S.H., 1995) is a self-report measure designed to assess emotional difficulties associated with depression, anxiety and stress using a dimensional model. It is made up of three scales which assess emotional states of depression, anxiety and stress. The short form of this measure consists of 21 items and is measured on a four-point Likert scale from 0 – did not apply to me at all – to four – applied to me very much or most of the time. Each scale is made up of seven items divided into sub-scales. Scores falling into the severe categories differ between scales, with scores of 12 and above on the depression scale, 15 and above on the anxiety scale and scores of 26 and above on the stress scale all being suggestive as severe presentations.

  Research has found it to have adequate reliability and internal consistency, with a Cronbach α:0.761 (Le, M. Tran, T.D, Holton, S. Et al, 2017).

- **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, five-point Likert scale, with responses ranging from 0 – almost never – to four – almost all of the time. Higher scores indicated an increased sense of safety and belonging. Previous research has suggested that this scale had good psychometric reliability with Cronbach's α =.92 (Gilbert et al., 2009).

- **Qualitative feedback**

  A bespoke qualitative feedback form was used in 2019 to capture anonymous group members' experiences of the programme. Group members were asked to consent for their feedback to be included anonymously in public communication about the programme. This feedback form included the following questions:

  - Is there anything that you found particularly helpful about attending the LTP programme? If yes, what was this?
  - Is there anything that you found particularly unhelpful about attending the LTP programme? If yes, what was this?
  - Is there anything that you think we could do to improve the LTP programme?
  - Is there anything else that you would like to say about your experience of the LTP programme?

4.12.2. Descriptors

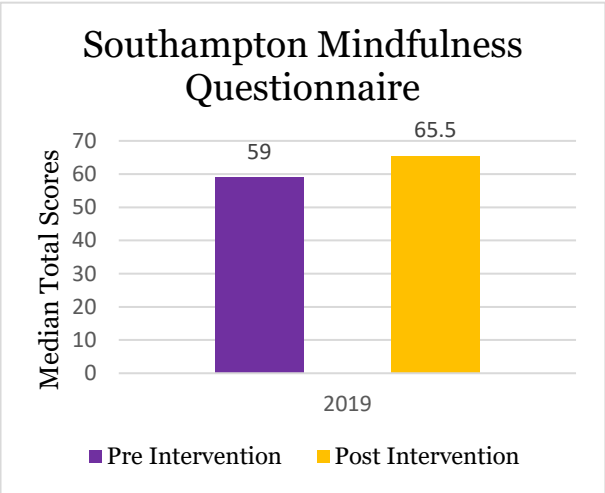
Data were available for 17 people who completed the programme in 2019, nine of whom were female and eight were male. Programme attendees ranged in age from 21 to 70 years, with a mean age of 39.24 (SD = 13.8).

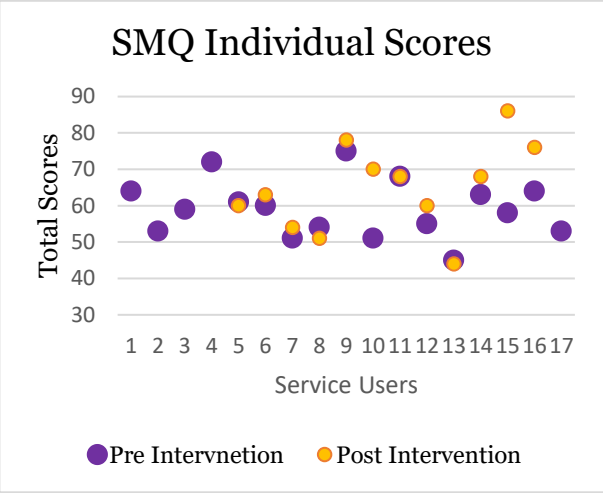
4.12.3. Results

Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ indicated that in terms of the degree to which individuals mindfully responded to distressing thoughts and images, there was a statistically significant increase from the median score of 59 (*SD* = 7.96) to 65.5 (*SD* = 12) on the SMQ from pre to post-intervention, z=-2.28, p<.05, with a medium effect size (*Cohn's r*=-0.55).

Graph: The Southampton Mindfulness Questionnaire (SMQ) median total scores pre and post-intervention

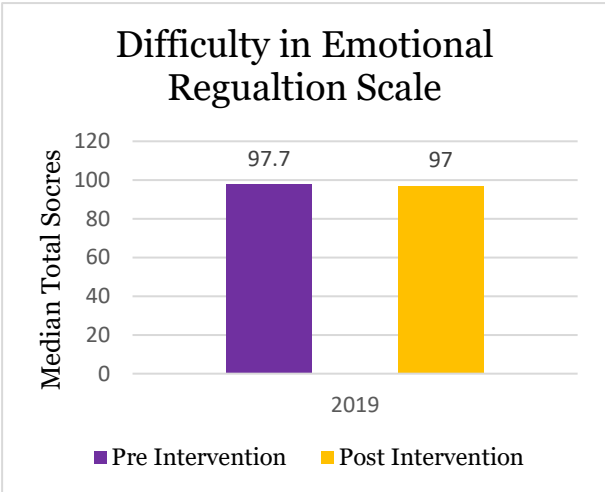


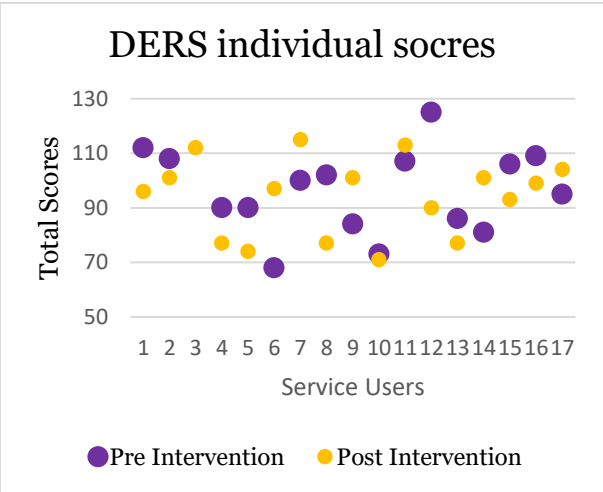


Difficulties in Emotion Regulation Scale (DERS)

Participants experienced a decrease in difficulties regulating emotions as measured by the DERS, moving from a median score of 97.5 (*SD* = 15.35) pre-intervention to 97 (*SD* = 14.19) post-intervention. However, this change was not found to be statistically significant z=-0.647, p>0.5.

Graph: Difficulties in Emotion Regulation Scale Total Scores Pre and Post Intervention.





**Note: Higher scores indicate greater difficulties with emotion regulation*

Depression Anxiety Stress Scale (DASS)

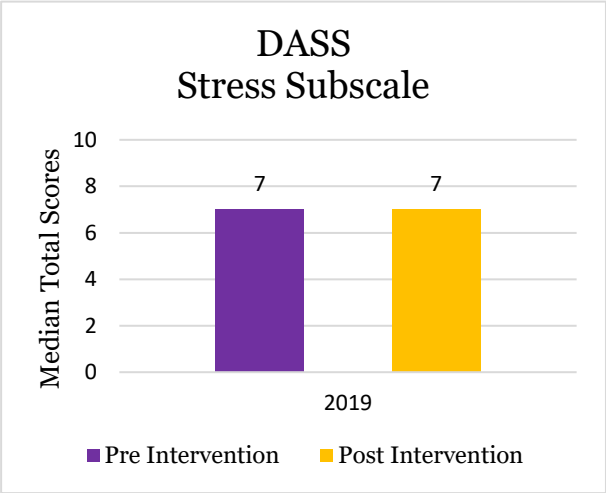
Analysis of the three sub-scales, which make up the DASS - stress, anxiety and depression - using a Wilcoxon Signed Ranking found no statistical significant change in symptomatology between pre and post-intervention.

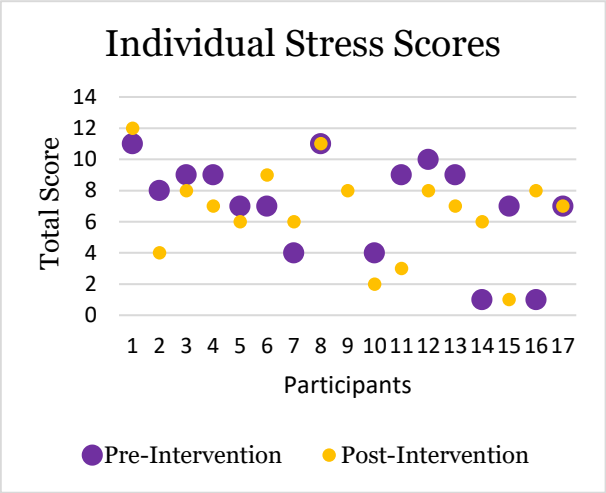
On the measure of stress, pre (*Md*=7, *SD*= 3.49) and post-intervention (*Md* =7, *SD* = 2.91) showed no change. This was confirmed in the statistical analysis z=-0.28, p>0.5.

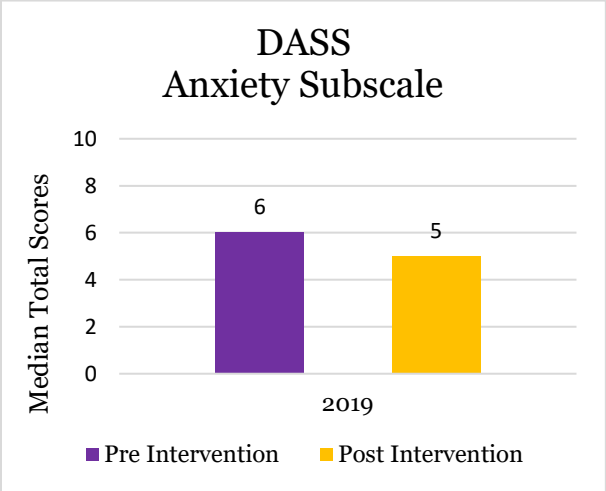
On the measure of anxiety, pre (*Md*=6, *SD*= 3.90) and post-intervention (*Md* =5, *SD*=3.43) showed a decrease in scores however this was not statistically significant z=-1.38, p>0.5.

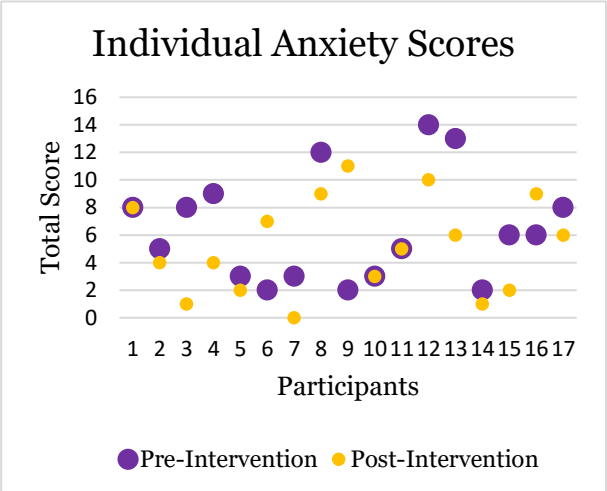
Finally, on the measure of depression, pre (*Md* = 7, *SD*=4.89) and post-intervention (*Md* =9, *SD*=5.28) showed some increase in scores. Once again, this change was not statistically significant (z=-0.33, p>0.5).

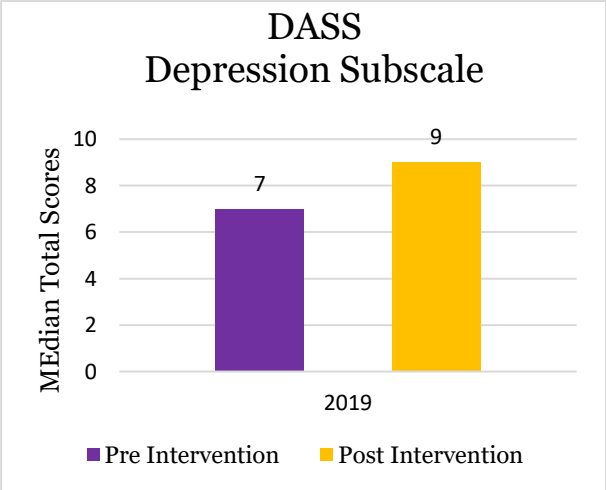
Graph: Depression Anxiety Stress Scale (DASS) group and individual pre and post-stress scores

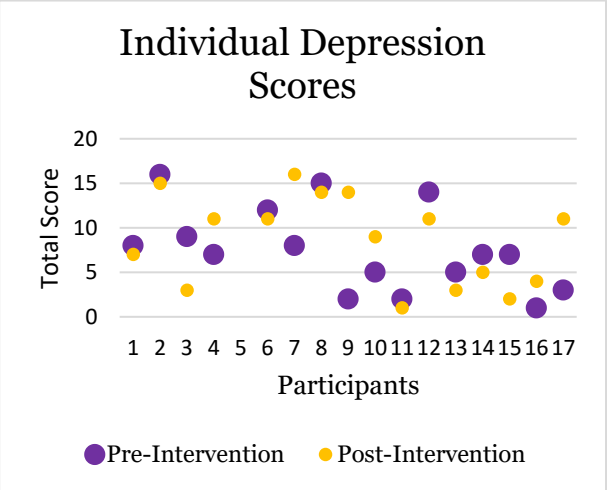










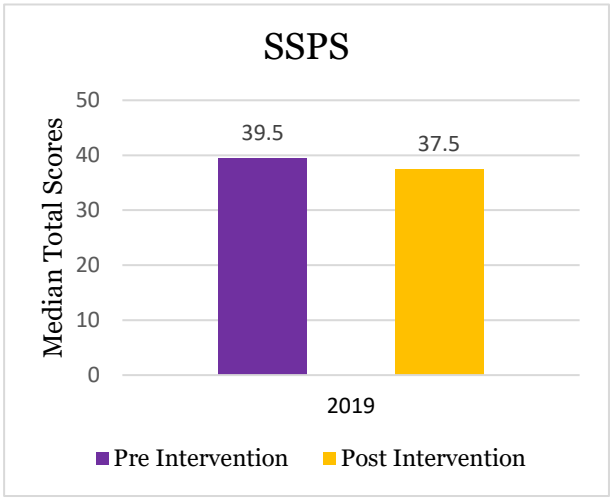


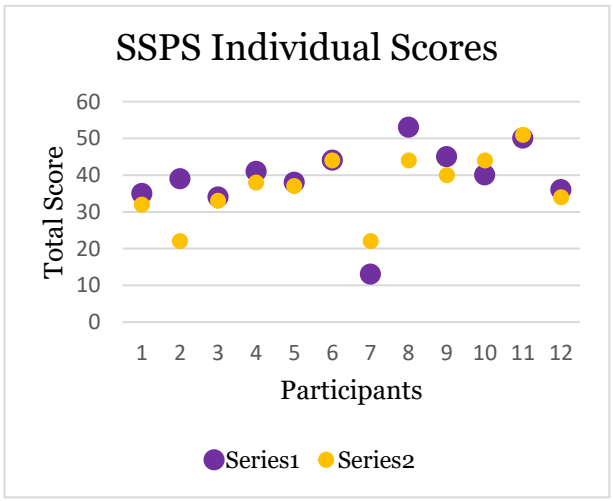
Social Safeness and Pleasure Scale (SSPS)

Analysis of the SSPS using a Wilcoxon Signed Ranking found no statistical significant change in symptomatology between pre (*Md*=39.5, *SD*= 10.0) and post-intervention (*Md*=37.5, *SD*= 8.80) (total possible score = 55). The overall reduction in median scores was not statistically significant.

Group facilitators observed improvements in group cohesion and connections between group members over the course of the programme. This was evidenced through increased sharing of personal concerns and fears, and warm, compassionate responding towards each other. The concept of feeling safe in relation to others is a key concept in the area of CFT and psychosis (Heriot-Maitland et al. 2019).

Graph: Social Safeness and Pleasure Scale (SSPS) group and individual pre and post-intervention scores





**Note: Higher scores indicates a greater sense of safety and belonging.*

Qualitative feedback

The following is a summary of the qualitative feedback captured from LTP group members in 2019.

Is there anything that you found particularly helpful about attending the LTP programme? If yes, what was this?

Group members reported a variety of aspects of the programme useful. Several group members identified skills taught in the programme as helpful, for example:

- “The various skills, in particular, rhythm breathing, wise mind and radical acceptance.”
- “SOS and labelling emotions were the most beneficial skills I found.”
- “The mindfulness exercises and labelling emotions were the most helpful to me.”

Others shared that they felt the connection with others was helpful, for example:

- “Connecting with other people who have experienced psychosis.”
- “Knowing and hearing that others had similar experiences.”

For some group members, the compassion element was particularly helpful, for example:

- “Personally, experiencing feeling compassion can help cope better with difficult emotions”
- “Learning about compassion and acceptance.”
- One shared “I found staff very caring and encouraging”.

Is there anything that you found particularly unhelpful about attending the LTP programme? If yes, what was this?

The majority of group members reported that they did not feel there was an unhelpful aspect of the programme. Feedback varied by individual. One group member found the session length challenging. Another shared that they would like more time for the group. One group member shared how “some of the skills can trigger past experiences and how this can be difficult to voice in a group setting.”

Is there anything that you think we could do to improve the LTP programme?

Some group members provided varied feedback including:

- “More group activities”
- “Speak more about how do you get over and move on from psychosis and integrate it into your life”
- “More group sharing about their problems maybe.”

Other group members fed back that they did not feel the programme needed to change.

Is there anything else that you would like to say about your experience of the LTP programme?

Group members who completed the feedback forms all reported finding the group a positive experience. Several reflected on it being an enjoyable and helpful experience, for example:

- "Very enjoying and fulfilling and looked forward to attending."
- "I found the course very helpful overall."
- "I really enjoyed the programme."

Another group member shared that "It was helpful hearing other stories and not feeling alone with it", while another shared the comment "Supportive and patient facilitators."

Others reflected on how they felt they were taking new skills and learnings from the group, for example:

- "The three circles provided me with a new way of looking at things. I find mindfulness really helpful and the idea of labelling emotions helps me to look at the way I react to emotions."
- "I have learned how to be more compassionate and accepting of myself and learn how to deal with situations differently. The course has given me tools I will use for life."
- "I took lots away with me."

4.12.4. Summary

The LTP Programme continues to offer an opportunity for service users to develop skills to cope with emotional and psychological challenges relating to recovering from psychosis. The qualitative outcomes indicate that service users generally found the programme to be enjoyable and helpful and that they benefited from being able to connect with others with similar difficulties, as well as from learning skills to help cope in their recovery from psychosis.

The quantitative results indicate that group members appear to be developing their capacity for mindful awareness, in particular. LTP programme facilitators will draw on these results to help with the continued development and delivery of an intervention that meets the psychological needs of service users recovering from psychosis.

4.13. Mindfulness Programme

The Mindfulness Programme provides eight weekly group training sessions in mindful awareness in SEH. The course is offered in the evening in order to accommodate service users. The group is facilitated by staff trained with Level 1 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 practising this non-judgemental awareness has been found to reduce psychological distress and prevent relapse of some mental ill-health experiences (see Piet & Hougaard, 2011).

4.13.1. 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 five-point rating scale ranging from one – 'never or very rarely true' to five - 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).

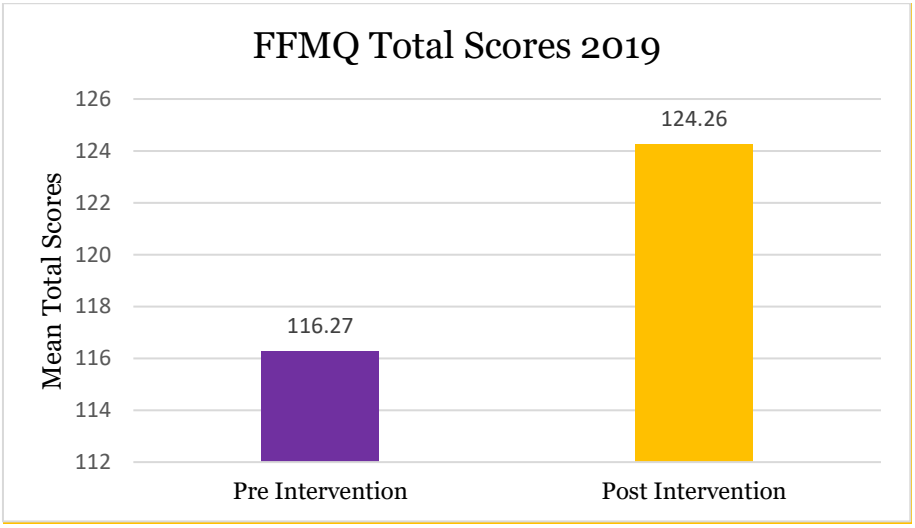
4.13.2. Descriptors

Data was collected on 40 participants; 12 males (29.3%) and 28 females (68.3%). Pre and post-data were available for 19 participants. Participants' age ranged from 30 to 72 years old (mean = 50 years).

4.13.3. Results

Five Fact Mindfulness Scale (FFMQ)

Graph: Five Facet Mindfulness Scale mean total scores pre and post-intervention



Analysis revealed a significant increase in total scores on the FFMQ from pre-intervention (M=116.27; SD=13.24) to post-intervention (M=124.26; SD=14.20). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (18) = -4.49, p<.000, with a medium effect size (Cohen's *d* = -0.58). These results suggest that, on average, service users who completed the outcome measures showed an increase in their tendency to be mindful in daily life.

Statistically significant increases were reported on all sub-scales except for the 'observe' and 'awareness' domain. A medium effect size for the 'describe' (Cohen's *d* = -0.43), and the 'non-judgement of inner experience' domains (Cohen's *d* = -0.59).

Table: FFMQ mean scores by sub-scales, t values and effect size

FFMQ	Pre-Mean (SD)	Post Mean (SD)	*t*	*df*	*P value*	*Cohen's d*
Observe	26.2 (4.7)	28.4 (4.2)	-1.8	18	.074	-0.43
Describe	26.0 (5.6)	27.8 (4.5)	-2.4	18	.026*	-0.31
Awareness	18.7 (4.8)	20.4 (4.4)	-1.5	18	.146	-0.36
Non-Judgement	21.7 (8.6)	26.7 (8.2)	-5.0	18	.000*	-0.56
Non-Reactivity	23.5 (5.2)	20.6 (4.2)	3.2	18	.004*	0.61

4.13.4. Summary

In line with the 2018 report, results for 2019 indicates 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 sub-scales.

4.14 Psychology Skills Group for Adolescents

The Psychology Skills Group for Adolescents is a psychological group therapy that aims to provide young people who are experiencing a range of mental health difficulties with new helpful ways of coping. The group is centred on young people learning a mixture of skills from DBT for adolescents and group radical openness. The group invites parents or caregivers to attend and participate alongside their young person to help support them in learning and practising new coping skills. The group runs on a rolling basis for one afternoon per week for 20 weeks. The structure of the group features four modules, varying in length between two and six sessions:

- Orientation/mindfulness
- Walk the middle path
- Emotions

- Relationships.

Due to the small numbers attending the group (the group has a maximum of six young people attending at any one time), data from 2015 to 2019 were analysed together in order to provide more statistically meaningful feedback in relation to the effectiveness of the group.

4.14.1 Psychology Skills for Adolescents Measures

- **Child Behaviour Checklist (CBCL)**

  The CBCL is a measure that is completed by parents or caregivers to provide an indication of behavioural and emotional difficulties experienced by young people aged six to 18 years. It consists of 113 questions and is scored on a three-point Likert scale (0 = absent, one = occurs sometimes, two = occurs often). The measure consists of seven 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 and Roemer, 2004) assesses emotion dysregulation and 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 five-point Likert scale from one – almost never – to five – 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.

- **DBT Ways of Coping Checklist**

  Both parents and young people completed this measure at pre and post-intervention. The DBT Ways of Coping Checklist measures use of DBT skills. It is

comprised of two sub-scales; one which assesses coping using DBT skills (DSS) and one which assesses coping using dysfunctional strategies (DCS). The measure consists of 59 items scored on a four-point Likert scale, from 0 – never used -to three – regularly used. Higher scores 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.

4.14.2. Descriptors

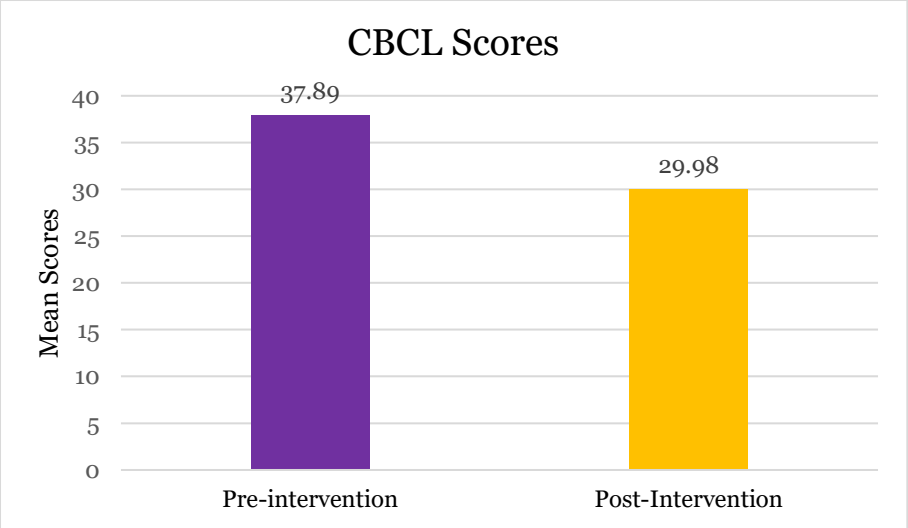
From 2015 – 2019, 123 service users have taken part in the Psychology Skills Group for Adolescents; 42 young people and 81 parents. The average age of young people attending was 16 years.

4.14.3 Results

Child Behaviour Checklist (CBCL)

This measure is completed by caregivers only. N = 45 for parents who returned measures at pre and post- intervention. Total problem scores on the CBCL as completed by the young person's caregivers decreased from M = 37.89 at pre-intervention to M = 29.98 at post-intervention. A paired sample t-test indicated that this was a statistically significant change, whereby t (45) = 2.57, p < .05, reflecting a large effect size (d= 0.84).

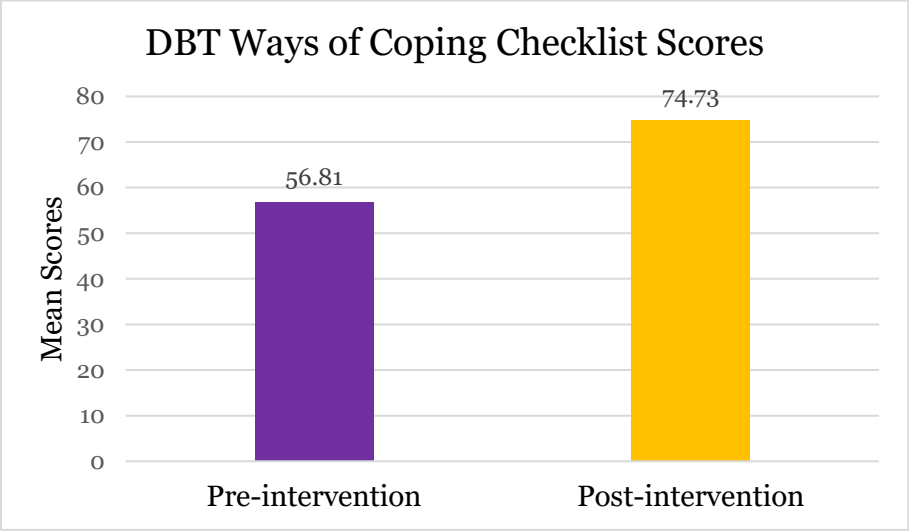
Graph: CBCL Scores



DBT Ways of Coping Checklist

For parents and young people who returned pre and post-DBT Ways of Coping Checklist measures, N = 49. Scores obtained demonstrate that DBT skill use increased from pre-intervention to post-intervention. At pre-intervention, parents and young people had a mean score of 56.81. Post-intervention, parents and young people achieved a mean score of 74.73. Paired sample t-tests indicated that this was a statistically significant change, whereby t (49) = -3.53, p < .001, reflecting a small effect size (d = .42).

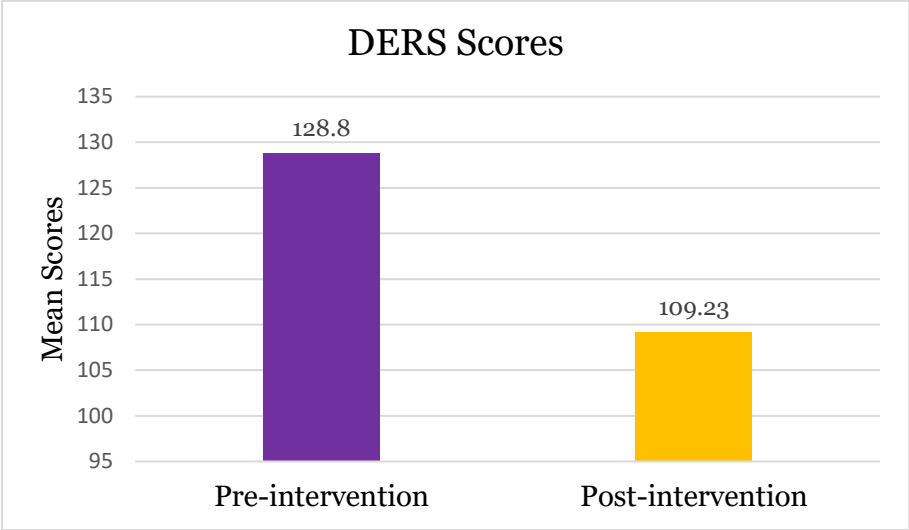
Graph: DBT Ways of Coping Checklist Scores



Difficulties in Emotion Regulation Scale (DERS)

This measure is completed by young people only. Pre and post-intervention data were available for N=21. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=128.8, SD = 21.87) to post-intervention (M=109.23, SD = 23.42). Paired sample t-tests indicated that this was a statistically significant change, whereby t (21) = 3.58, p < .05, reflecting a large effect size (d = 0.79).

Graph: DERS Scores



**note: lower scores indicate decreased difficulty in regulating emotions*

4.14.4. Summary

The Psychology Skills Group for Adolescents aims to teach young people new skills for regulating emotions, fostering healthy relationships and managing distressing situations. It also seeks to enable parents and caregivers to support their young people in the use of more adaptive coping strategies.

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 unpleasant emotions. Young people who completed the group also evidenced an increase in the use of DBT skills when coping with difficulty. 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.

4.15. (Group) Radical Openness Programme

The Group Radical Openness (GRO) Programme is a therapeutic group delivered by the Psychology Department. The programme is based on an adaptation of Radically Open Dialectical Behaviour Therapy (RO-DBT) for 'emotional overcontrol', developed by Tom Lynch (Lynch, 2018; Lynch, Morse, Mendelson, & Robins, 2003; Lynch et al., 2007; Lynch and Cheavens, 2008). The programme is aimed at individuals who have developed an over-controlled style of coping. This style

includes inhibiting emotional experience and expression, maintaining aloof and distant relationships and having rigid cognitions and behaviours.

The GRO programme aims to enhance participants' ability to experience and express emotion, to develop more fulfilling relationships and to be more flexible and open to what life can offer. The group is underpinned by a model that suggests that behavioural over-control, psychological rigidity and emotional constriction can underlie difficulties such as recurrent depression, obsessive-compulsive characteristics and restrictive eating difficulties. GRO is offered over a five-month period, twice a week for 11 weeks and then once a week for four weeks.

4.15.1. Group Radical Openness Programme outcome measures

GRO introduced four new measures in 2019 to better capture the over-control traits targeted by this programme. The Brief Symptom Inventory (BSI) continues to be used, however, the Social Connectedness Scale and the Distress Tolerance Scale have been discontinued. The new measures include: the Five-Factor Obsessive Compulsive Inventory – Short Form (FFOCI-SF), the Revised Adult Attachment Scale (RAAS), the Emotion Regulation Questionnaire (ERQ), and the Personal Need for Structure (PNS) scale.

- **Brief symptom Inventory (BSI)**

The BSI (BSI; Derogatis, 1983) is a 53-item scale that measures symptoms of psychological distress within the previous week. Psychometric evaluations have shown that the BSI is a reliable and valid measure (Derogatis & Melisartos, 1983: Derogatis & Fitzpatrick, 2004). 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 four - extremely. The Global Severity Index score, which is used in this report, is the best indicator of current distress levels.

- **Five Factor Obsessive Compulsive Inventory (Short Form) (FFOCI-SF)**

The FFOCI-SF (Samuel, B., et al 2014) is a 48-item self-report questionnaire that is designed to assess obsessive compulsive personality disorder (OCDP) based on the

conceptual framework of the five-factor model of personality. The questionnaire is made up of 12 sub-scales: excessive worry, detached coldness, risk-aversion, constricted, inflexibility, dogmatism, perfectionism, fastidiousness, punctiliousness, workaholism, doggedness, and ruminative deliberation. Each item is rated on a five-point Likert scale from one - strongly disagree - to five - strongly agree. Higher scores indicate greater identification with OCPD traits.

Research has found that the FFOCI-SF has good psychometric properties with strong internal and external validity, and strong reliability with a Cronbach's alpha ranging from .77 to .87 (Samuel, D., Riddell, A., Lyman, D., 2012). Additionally, a strong similarity coefficient has been found between the long and short form of the measure. (Griffin, S., Suzuki, T., Lyman, D., et al 2018).

- **Revised Adult Attachment Scale (RAAS)**

The RAAS (Collins, 1996) is an 18-item measure of relationship attachment. It contains three sub-scales: closeness, dependence and anxiety. Respondents are asked to rate each statement on a five-point scale from one - not characteristic of me at all - to five - very characteristic of me. Higher scores on the closeness and dependence sub-scales indicate greater comfort with closeness and intimacy in everyday life. Lower scores on the anxiety sub-scale indicate less fear of rejection. The RAAS is highly correlated with the long form Adult Attachment Scale (AAS) and has been found to have good internal and external validity (Graham & Marta, 2015).

- **Emotion Regulation Questionnaire (ERQ)**

The ERQ (Gross & John, 2003) is a 10-item self-report measure of two emotion regulation strategies: cognitive reappraisal and expressive suppression. Cognitive reappraisal describes the process of confronting automatic thoughts and assumptions and reframing them in a more helpful way. Expressive suppression describes the ability to control or suppress the urge to respond to emotional experiences. Respondents are asked to rate each statement on a seven-point scale from one – strongly disagree – to seven – strongly agree. The ERQ has been found to have high internal validity, convergent and discriminant validity (Preece, Becerra, Robincon et al. 2019).

- **Personal Need for Structure Scale (PNS)**

The PNS (Neuberg & Newsom, 1993) is an 11-item self-report questionnaire consisting of two sub-scales: desire for structure and response to lack of structure. Respondents are asked to rate each statement on a six-point scale from one - strongly disagree – to six – strongly agree. The measure has shown good reliability in previous research, with a Cronbach's alpha of 0.62 for 'desire for structure' and 0.73 for 'response to lack of structure' (Hamtiaux & Houssemand, 2012).

4.15.2. Descriptors

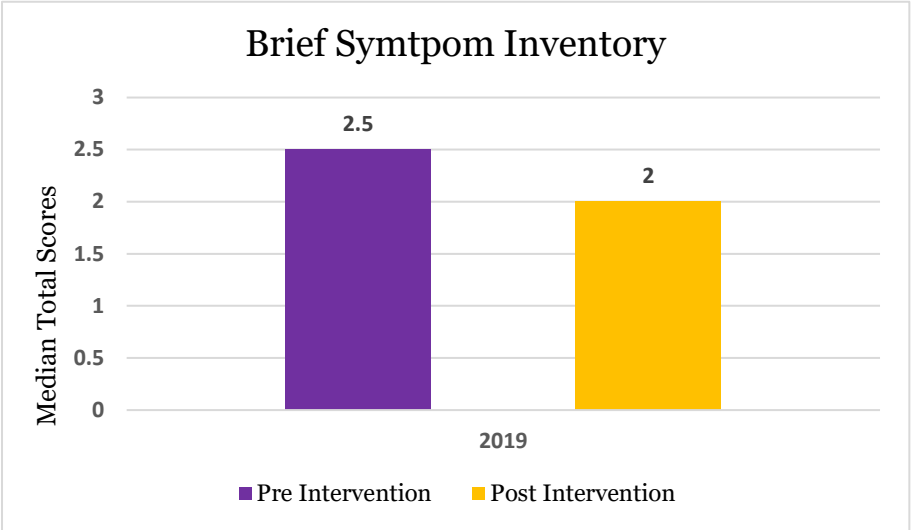
A total of 39 people completed the GRO programme in 2019. Pre and post outcome data were available for 27 people, representing a 75% return rate. 51.3% of the participants were female and 48.7% were male. Participant's ages ranged from 18 years to 63 years (M=43.72, SD=12.71).

4.15.3. 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 BSI, whereby t (34) = 4.30, p=.000, reflecting a large effect size (*Cohen's d*= 0.71).

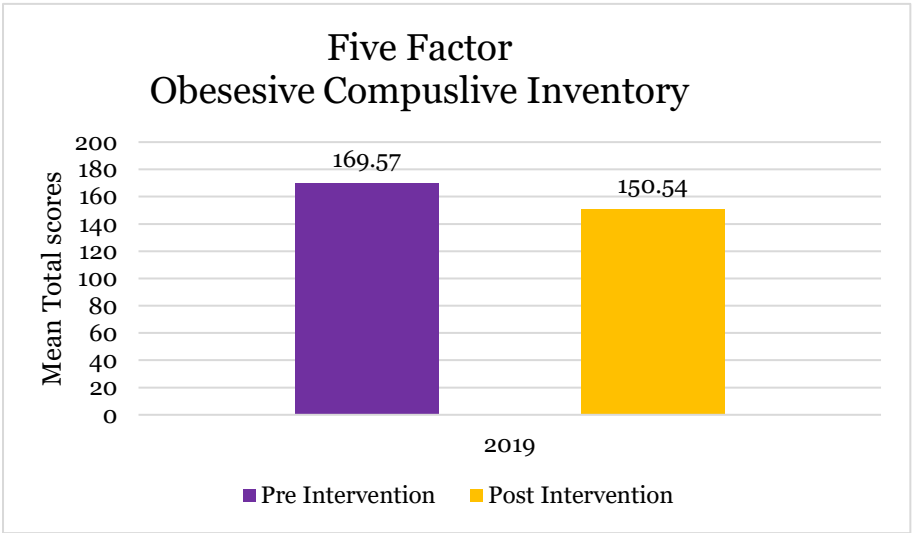
Graph: Brief Symptom Inventory, Global Severity Index pre and post-intervention median total score



Five Factor Obsessive Compulsive Inventory (Short Form)

A significant change was also observed on the FFOCI-SF, whereby t (34) = 7.33, p= .000, reflecting a large effect size (Cohen's *d* = 0.79). This suggests that after completing the programme participants were experiencing a reduction in traits associated with OCPD.

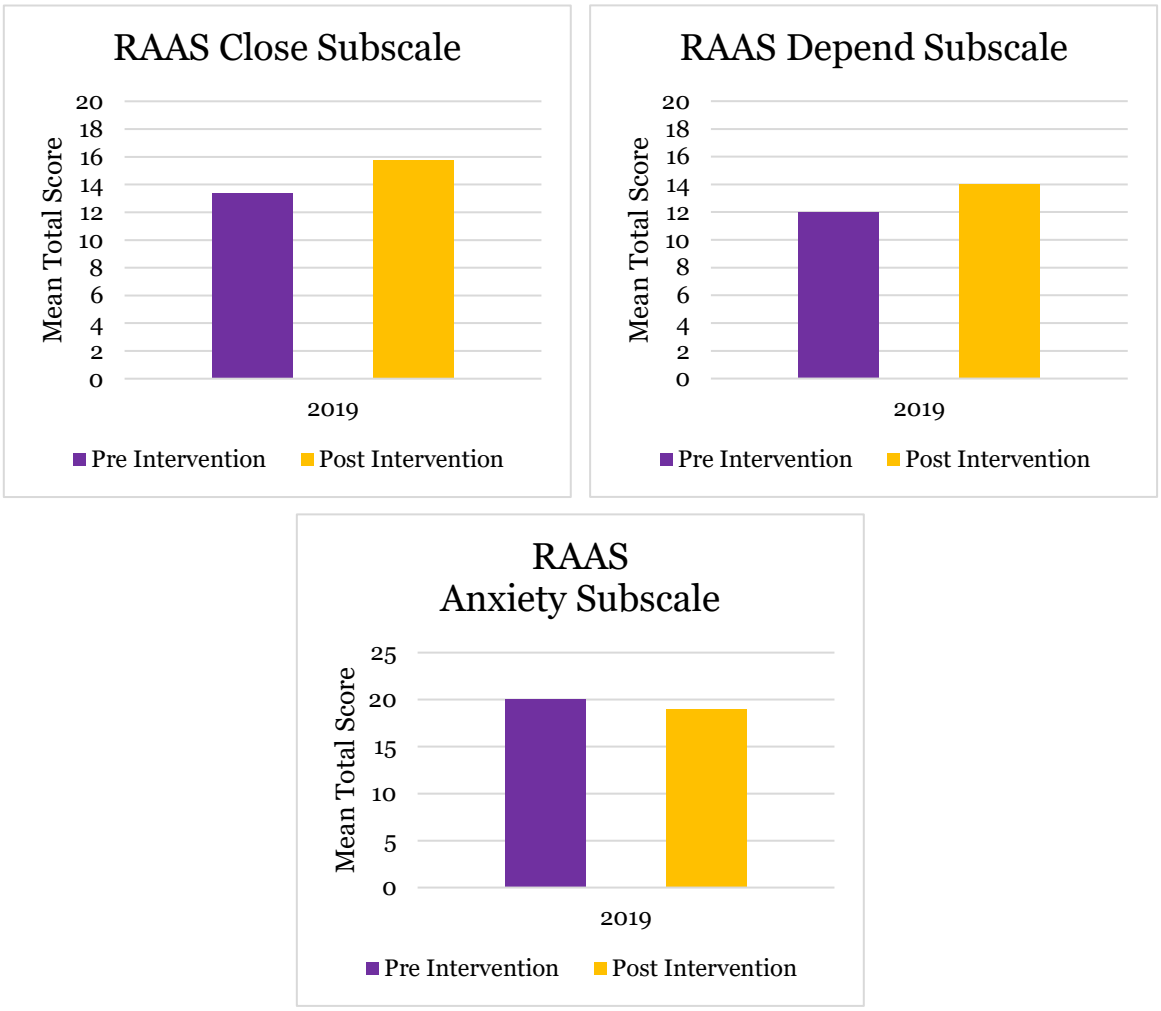
Graph: Five Factor Obsessive Compulsive Inventory – Short Form Mean total scores pre and post-intervention



Revised Adult Attachment Scale (RAAS)

A significant change was observed on two of the three RAAS sub-scales: closeness and dependence. In the closeness sub-scale, t (34) = -3.85, p = .000, reflecting a small effect size (Cohen's d = 0.48). This suggests that after completing the programme participants felt more connected in their relationships. However, the small effect size suggests that this result must be interpreted with caution. In the dependence sub-scale, t (34) = -4.63, p = .000, reflecting a medium effect size (Cohen's d = 0.59). This suggests that after completing the programme participants felt more comfortable depending on others. There was no statistically significant difference on the anxiety sub-scale pre and post-intervention. This indicates that participants' anxiety levels (with regards to close relationships) did not change after completing the programme.

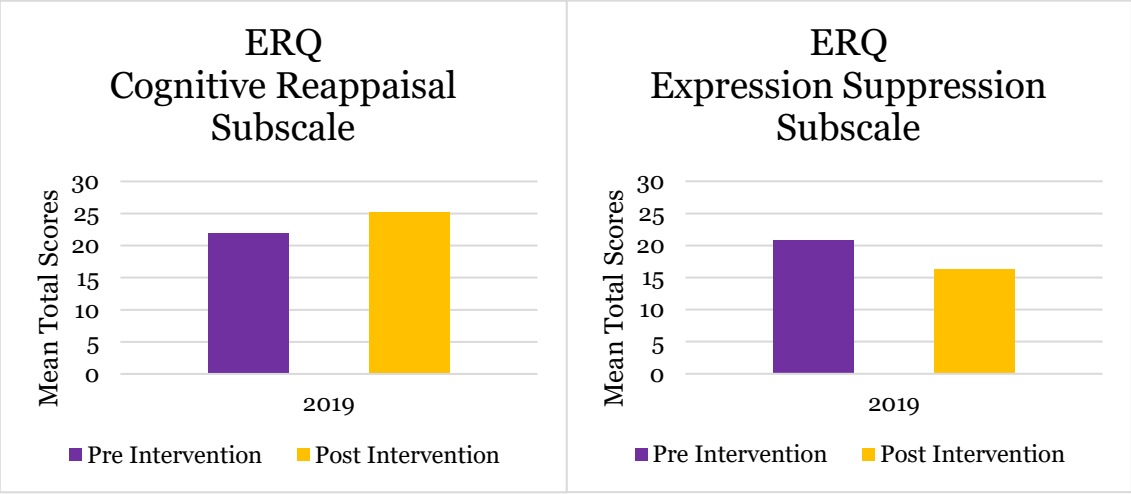
Graph: Revised Adult Attachment Scale (RAAS) mean total score pre and post-intervention



Emotion Regulation Questionnaire (ERQ)

Significant change was observed in the two emotion regulation strategy subscales; cognitive reappraisal and expressive supression. On the measure of cognitive reappraisal t (34) = -2.15, p < .05, reflecting a small effect size (Cohen's d=0.43). This suggests that participants felt better able to reappraise unhelpful cognitions regarding emotions following completion of the programme. However, the small effect size suggests that this result must be interpreted with caution. Expressive suppression also showed a statistically significant change post treatment, t (34) = 5.04, p = .000, with a large effect size (Cohen's d=0.91) indicated. This suggests that participants reported less suppression of their emotions following completion of the programme.

Graph: Emotion Regulation Questionnaire (ERQ) Subscales Mean Total Scores Pre and Post Intervention.

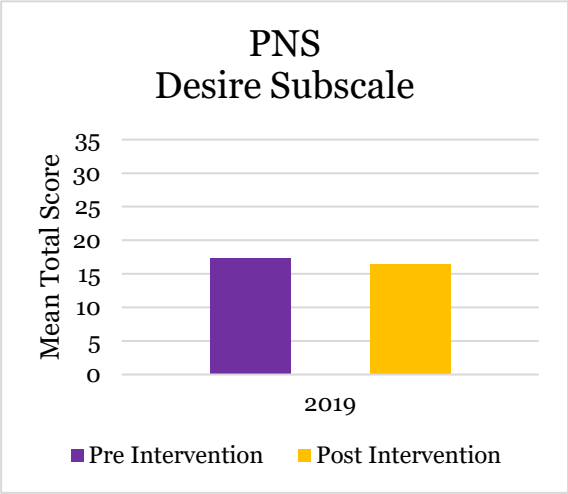


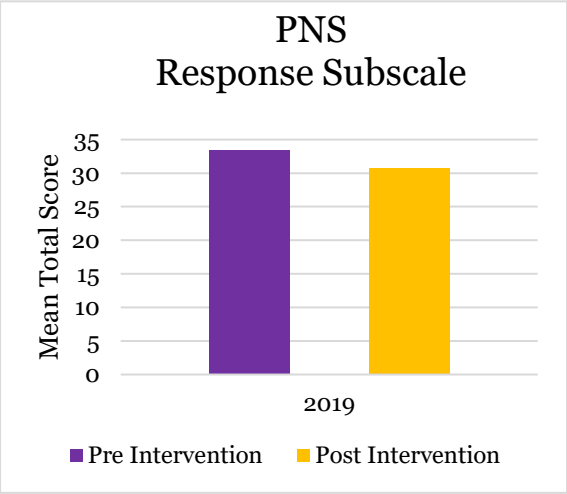
Personal Need for Structure (PNS)

Significant change was observed on one of the two subscales of the PNS, Response to Lack of Structure, where t (34) = 3.46, p = .001, reflecting a small effect size (Cohen's d=0.47). This suggests that participants reported increased flexibility after completing the programme. However, the small effect size suggests that this result must be interpreted with caution. No statistically significant change was observed

on the sub-scale desire for structure, suggesting that participants maintained a similar desire for structure in their environment after attending the programme.

Graph: Personal Need for Structure Subscales mean total scores pre and post-intervention





4.15.4. Summary

The Group Radical Openness (GRO) programme helps individuals develop a better understanding and awareness of their emotional and behavioural over-control. The programme targets and encourages new ways of coping that are less costly and less harmful. This is a vital programme for service users who are often underserved in mental healthcare.

In 2019, service users who completed the GRO programme showed reductions in overall psychological distress in addition to reductions in traits associated with OCPD. Service users reported greater connections in their relationships, specifically being more comfortable with closeness and depending on others. Service users also showed a positive change in their ability to reframe unhelpful cognitions and a decrease in suppressing the expression of their emotions. Finally, service users reported an increase in flexibility when responding to changes in their environment.

Analysis of outcome measures of the GRO Programme indicates that this intervention has had a positive impact on service users' lives across the domains targeted by this intervention.

4.16. 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 CBT skills to help participants to cope with distressing symptoms. 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 an MDT which includes a consultant psychiatrist, clinical nurse specialist, clinical psychologist, occupational therapist and a pharmacist.

4.16.1. 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 five-point Likert scale from one – strongly disagree – to five – strongly agree. 24 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

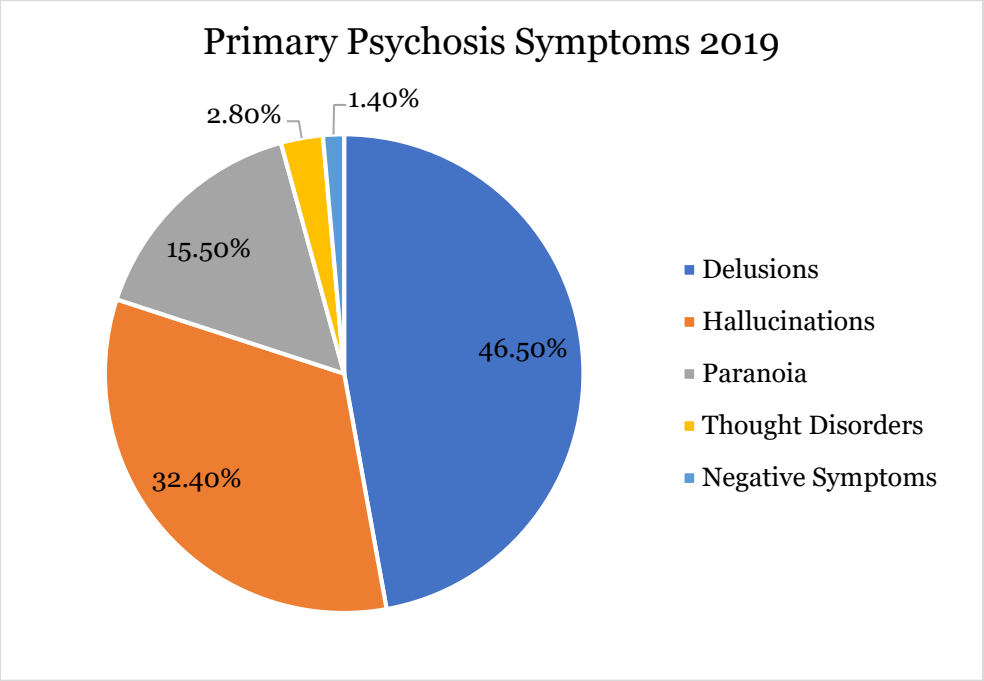
medications. DAI-30 and DAI-10 were homogenous (r=0.82 and 0.72, respectively) with good test–retest reliability (0.79). The correlation between the DAI versions was high (0.94).

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.

4.16.2. Descriptors

In 2019, out of 71 participants completed pre and post-RAS and DAI scores were available for 23 participants. The average age of psychosis programme participants was 39.01 years (ranging from 18-75 years) with a slightly lower number of females (n=10) than males (n=13). 62% were single, 16.9% married, and 2.8% were separated or divorced while 5.6% were cohabiting with a partner. 12.7% did not provide this information. 40.8% were in employment, 18.3% were unemployed, 8.5% were students, 14.1% were receiving disability allowance, and a further 15.5% were either in part-time employment or retired. 40.8% had attained a third-level degree, 31% had completed the Leaving Certificate, with 12.7% having a non-degree third-level qualification. 11.3% had completed the Junior Certificate and 31% had completed their Leaving Certificate. The majority lived with family (64.8%) followed by living alone (23.5%). 8.4% were living with friends or cohabiting. The majority of service users reported their ethnicity as white Irish (94.4%). 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 2018 and 2019. In 2018 the primary reported symptoms were delusions (65.2%), followed by hallucinations (26.1%) and paranoia (8.7%). In 2019 the primary reported symptoms were delusions (46.5%), followed by hallucinations (32.4%), paranoia (15.5%), thought disorders (2.8%), and negative symptoms (1.4%). See graph below for reported primary psychosis symptoms in 2019. The average attendance at sessions per client in 2019 was 9.99 (SD = 5.59). Participants are permitted to attend multiple cycles of the programme.

Graph: Primary Psychosis Symptoms 2019



4.16.3. Results

Recovery Assessment Scale

A Wilcoxon Signed Rank test identified a statistically significant difference in mean total scores for the RAS from pre-intervention (M=3.63; SD=.50) to post-intervention (M=3.99; SD=.53), z=-3.57, p=<.05 with a large effect size (*r*=-0.74). This indicates that overall, service users experienced an increase in coping ability and quality life following completion of the programme.

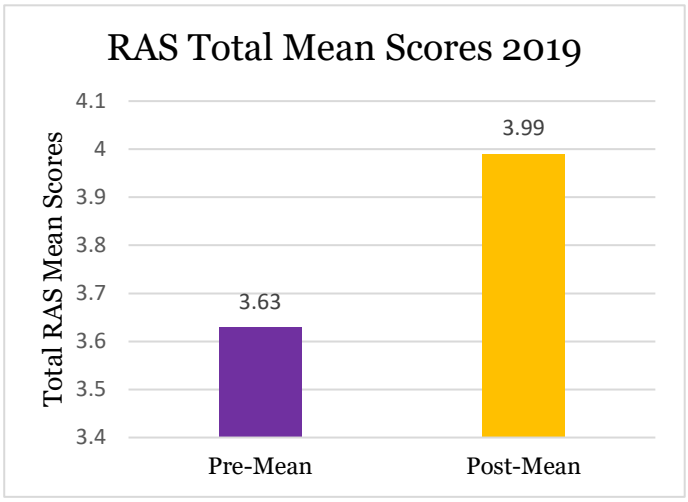
Looking at the RAS sub-scale scores, significantly higher mean scores were identified post intervention for users on the 'confidence and hope' sub-scale, z=-3.51, p<.01, the 'goal and success orientation' sub-scale, z=-3.27, p<.01, the 'ability to rely on others', z=-1.99, p<.05 and 'willingness to ask for help', z=-2.31, p<.05. The difference between pre and post-intervention means on the 'no domination by symptoms' was not statistically significant. The table below outlines test statistics and figures for differences in pre and post- intervention means and graphs on the following page for visual representations.

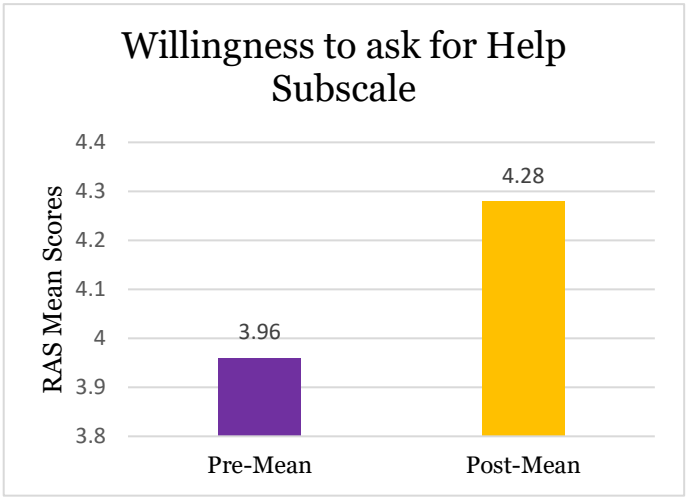
Table: Results from Wilcoxon Signed Rank tests for the RAS pre and post scores

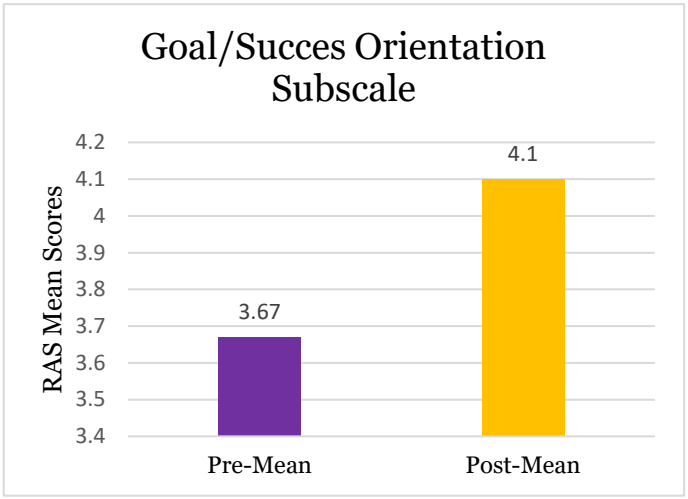
RAS = Recovery Assessment Scale.

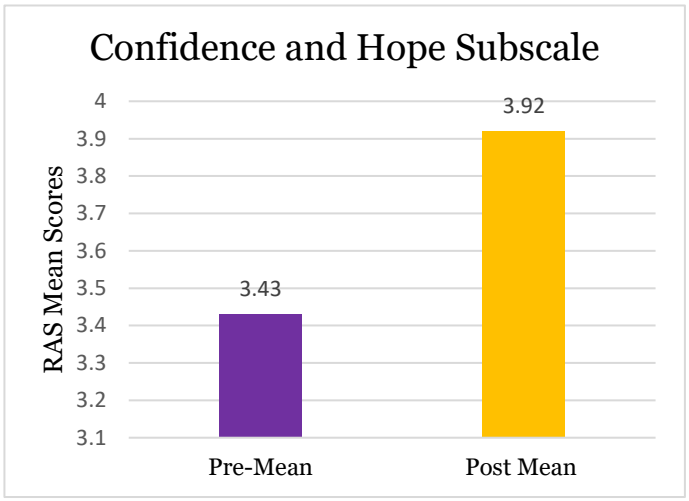
RAS	Pre-Mean	Post Mean	*z*	*p*	*r*
Mean Total	3.63	3.99	-3.57	<.05	-0.74
Confidence and Hope	3.43	3.92	-3.51	<.01	-0.73
Willingness to ask for Help	3.96	4.28	-2.31	<.05	-0.48
Goal/ Success Orientation	3.67	4.1	-3.27	<.01	-0.68
Ability to Rely on Others	3.98	4.28	-1.99	<.05	-0.41
No Domination by Symptoms	3.11	3.5	-1.55	>.1	-0.32

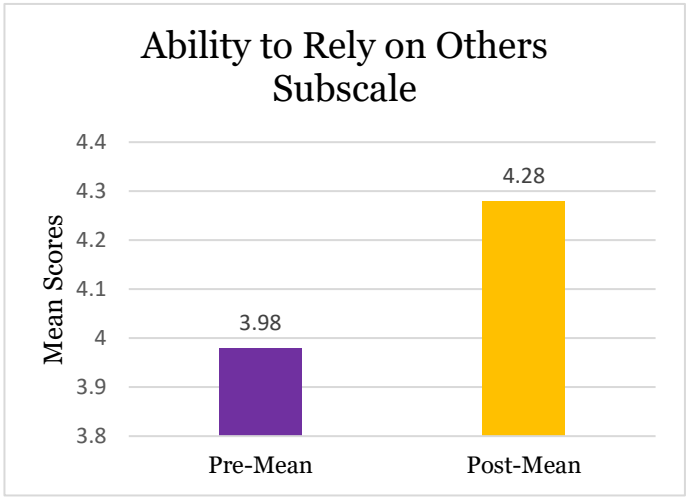
Graphs: Recovery Assessment Scale sub-scales







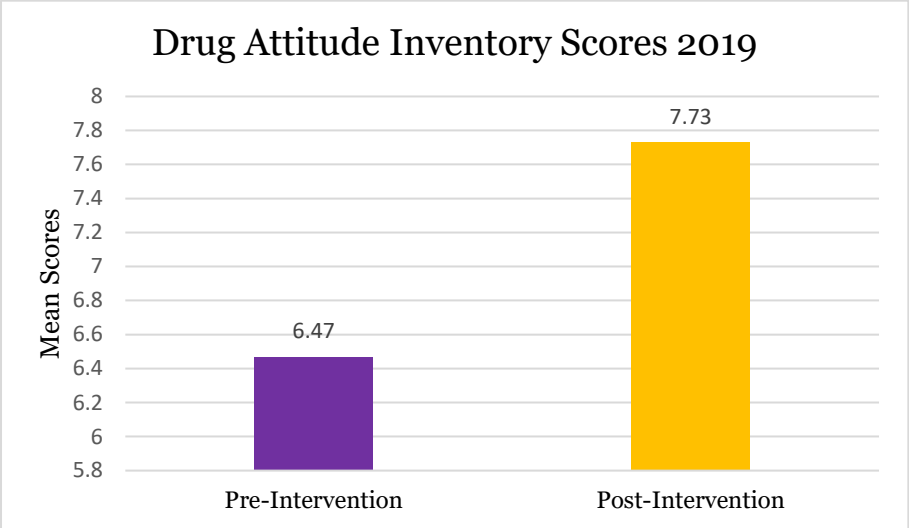




Drug Attitude Inventory

A Wilcoxon Signed Rank test identified an increase in mean scores on the DAI-10 from pre-intervention (M=6.47 SD=2.55) to post-intervention (M=7.73; SD=2.39), demonstrating a medium effect size; z=-2.75, p<.05, (r=-0.57). The mean scores indicate that some service users who completed the measures reported more positive views towards medication after completing the programme.

Graph: Drug Attitude Inventory mean scores



4.16.4. 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 71 service users who attended the programme in 2019, therefore the results outlined above may not be indicative of all views of those attending the

programme. Programme staff will continue to be proactive in encouraging completion of measures accurately in order to increase response rates in 2020.

4.17. 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 difficulties 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 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 healthcare, 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 after-care meetings is 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.

4.17.1. 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.

4.17.2. Descriptors

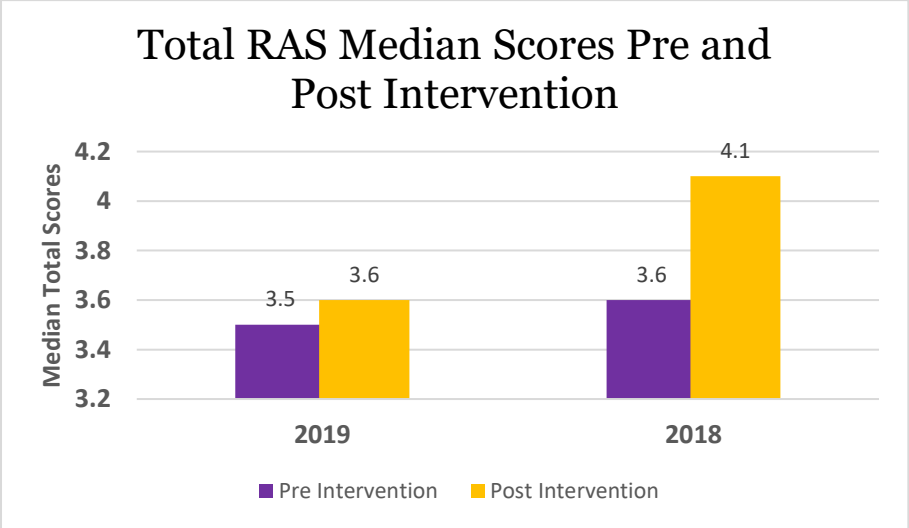
Pre and post data were available for 34 participants who attended in 2019. The average age of participants was 50 years, with 57.6% of participants female.

4.17.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre-measurement (*Md* = 3.5, *SD*=0.52) to post-measurement (*Md* = 3.6, *SD*= 0.51) indicating greater overall recovery. A Wilcoxon Signed Rank Test revealed this increase was statistically significant, z = -4.31, p < 0.00, with a medium effect size, *Cohen's r* = 0.6.

Graph: Recovery Assessment Scale, median total scores pre and post-intervention 2018 and 2019



The figures below show pre and post scores on each of the five sub-scales: 'willingness to ask for help', 'personal confidence and hope', 'ability to rely on others', 'not dominated by symptoms' and 'goal and success orientation'. A series of Wilcoxon Signed Rank tests were run in order to compare pre and post scores, median scores, standard deviations, z values, *p* values and effect sizes for each of the sub-scales. A significant change was seen across almost all sub-scales as can be seen in the tables below.

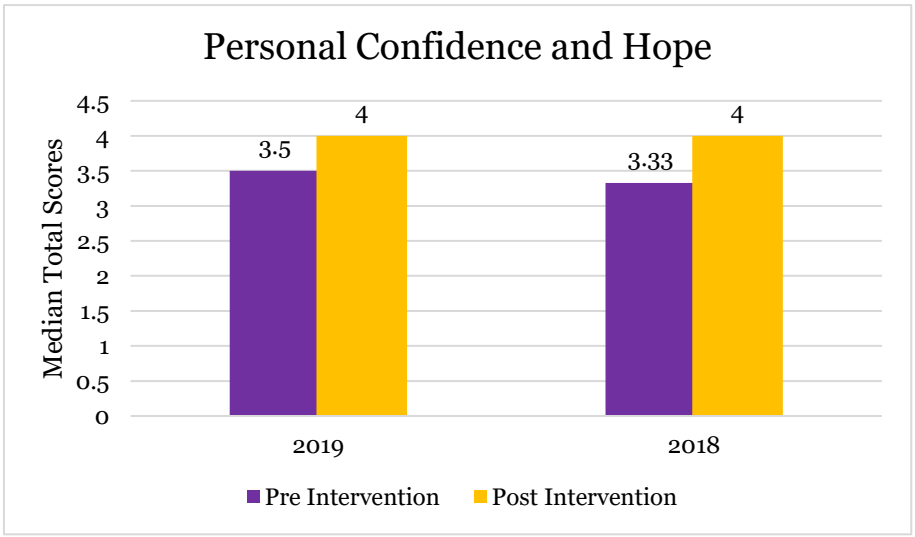
Scores on four of the five sub-scales improved significantly from pre to post-measurement (see the graphs below).

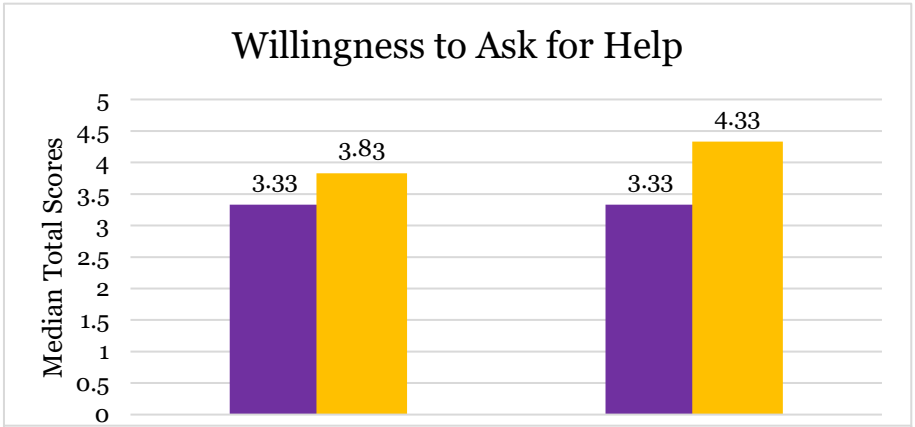
Table 2: Median scores on RAS (Wilcoxon Signed Rank tests)

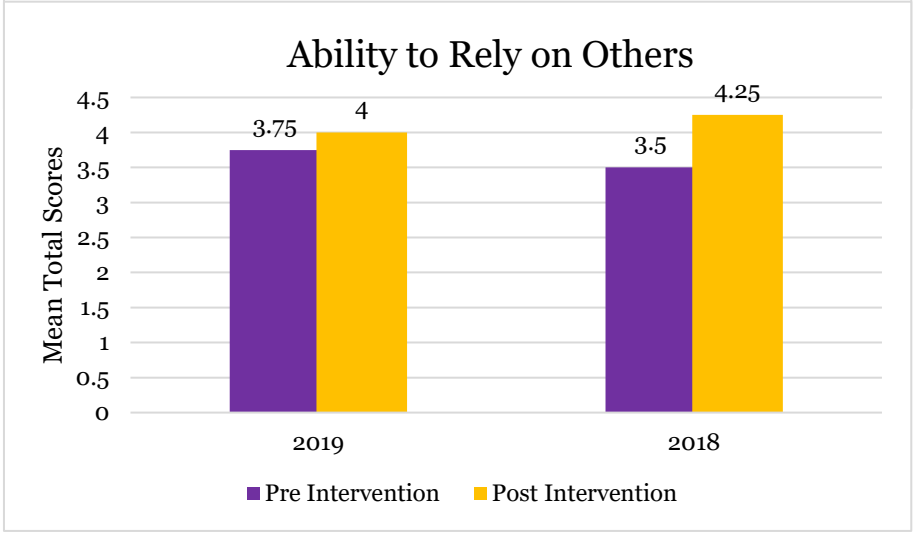
	lian	lian	alue		Cohen's r
ingness to Ask For p		3.83	7	*	0.69
sonal Confidence			)	)*	0.78
ity to Rely on Others			:		0.32
Dominated ymptoms	3.66		3	)*	0.63

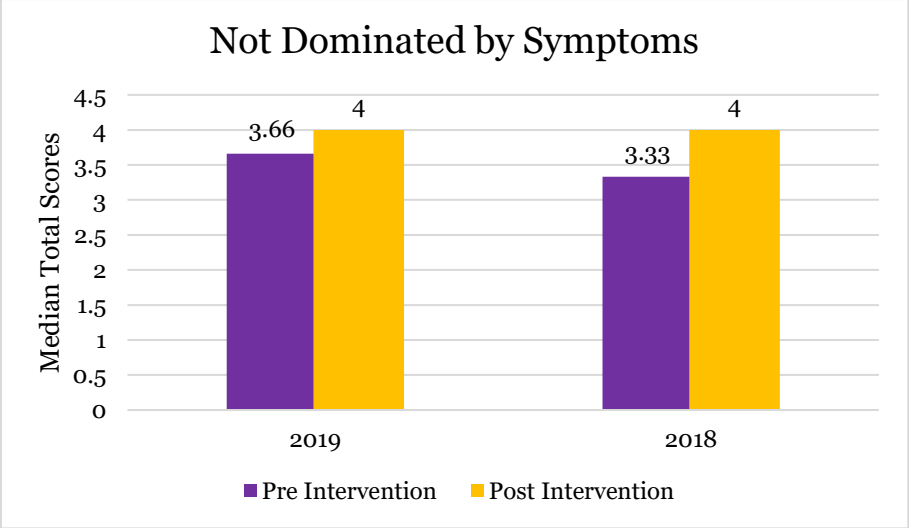
l and Success entation	3.60	3	)*	0.73

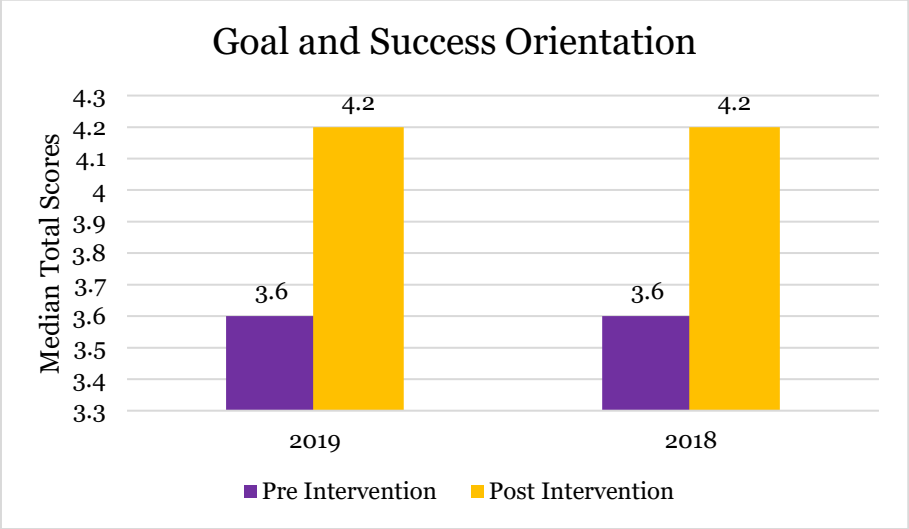
Graphs: Recovery Assessment Scale sub-scale median total scores pre and post-intervention







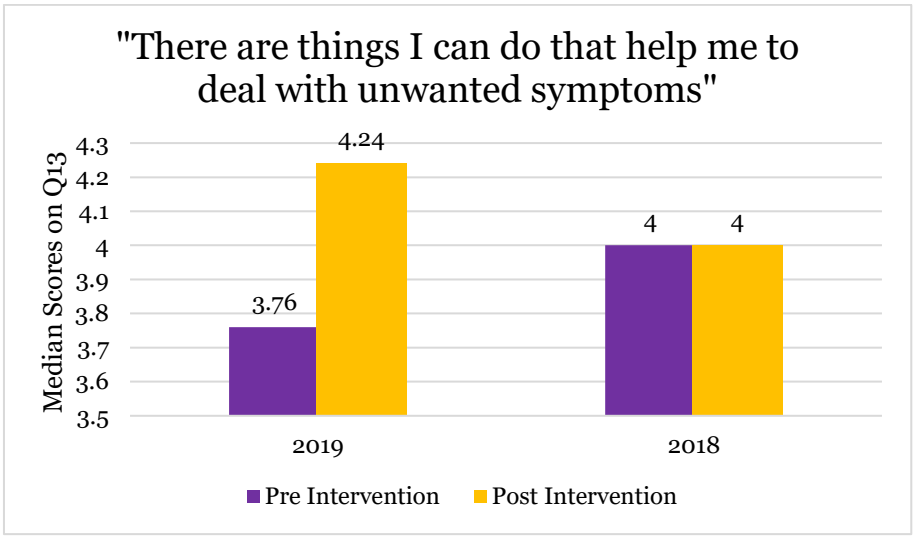


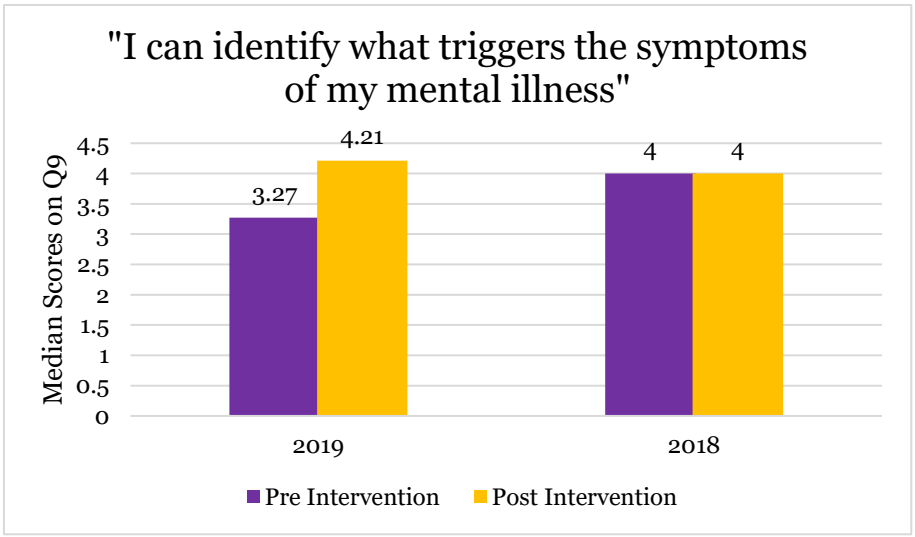


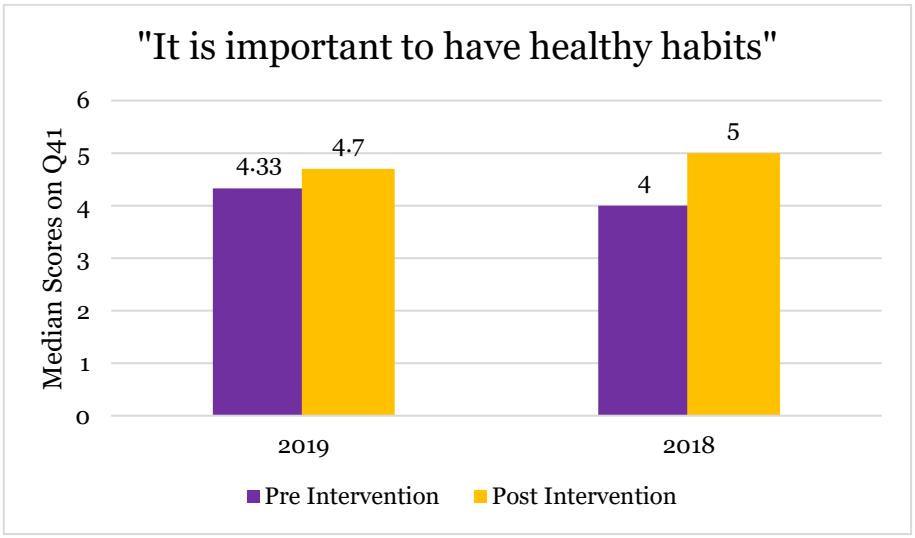
From clinician reflection, it was recommended in the 2012 report to examine certain individual items not included in the sub-scale scores that reflect elements of the programme. These included item nine – 'I can identify what triggers the symptoms of my mental illness'; item 13 – 'There are things I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

A series of Wilcoxon Signed Rank tests were run, on items nine, 13 and 41 to identify any significant changes in scores. Pre to post-measurement for item nine (z = -4.20, p = 0.000) and item 13 (z = -2.90, $p < 0.05$) both showed statistically significant change in scores. Item 41 also indicated significant improvements, z = -2.81, p = 0.005. Item nine showed a large effect size, *Cohen's r* = 0.73, while items 13 and 41 evidenced medium effect sizes, *Cohen's r* = 0.49 and *Cohen's r* = 0.48 respectively.

Graph: Recovery Assessment Scale items nine, 13, 41 median total scores pre and post-intervention 2018 and 2019







4.17.4. 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 five sub-scales. A significant change was observed on the total RAS scale. Improvements made demonstrated medium effect sizes. 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.

To increase the number of responses for 2020, it is hoped to operate the programme to full capacity (15) and to be more vigilant with the completion of the RAS forms. The RAS forms will be redesigned so that they are more user-friendly and a written record will be kept of the number of service users that started and completed the programme.

4.18 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 based on emotional regulation and emotional over-control (Linehan, 1993; Lynch et al, 2016), and how these can contribute to recurrent mental health difficulties. The format of the group is skills-based, with eight psychological skills taught twice over 16 sessions, addressing difficulties with emotional regulation, interpersonal aloofness, emotional loneliness and cognitive and behavioural rigidity.

4.18.1 Sage outcome measures

In October 2019, the Sage outcome measures were reviewed and updated to capture more relevant and clinically meaningful changes occurring for service users over the course of the programme. The Emotional Control Questionnaire-Emotional Inhibition (ECQ-EI) (Roger & Najarian, 1989) measure was introduced to evaluate the construct of emotional inhibition more closely, as this is one of the variables targeted within the group. As well as this, an overlap between the Personal Need for Structure (PNS) Scale (Neuberg & Newsom, 1993) and the Acceptance and Action Questionnaire (AAQ) (Bond et al, 2011) was identified, with both scales measuring the same variable of interest; that of inflexibility/rigidity. As the PNS was found to be a more suitable measure for older adults, it has been retained and the AAQ is no longer being used. Finally, the Social Connectedness Scale-Revised (SCS-R) (Lee & Robins, 1995) will no longer be included due to inconsistencies with regard to the version of the scale being used by the programme and the scoring guidelines available in the literature. The Revised Adult Attachment Scale (R-AAS) (Collins, 1996) was introduced as an alternative measure of social connectedness.

- **Depression Anxiety and Stress Scale (DASS)**

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 seven items, divided into sub-scales 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 three – 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 populations 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.

- **Personal Need for Structure Questionnaire (PNS)**

  The Personal Need for Structure Questionnaire aims to measure how people respond to new or uncertain situations. A person's ability to reduce their ambivalence around any new situation is associated with a greater ability to cope with stressful situations. Individual differences in the desire for structure may influence how people understand, experience and interact with their worlds. Research suggests that people differ in their desire for structure and that this difference can have social, cognitive and behavioural implications. A high need for structure is related to the need for rapid, simple and exact responses and for diverting away from uncertain or ambiguous information (Kruglanski et al. 2000). Neuberg and Newsom (1993) identified two conceptual different factors of the *need* for structure versus the desire for structure (F1—to have a structured environment) and response to the lack of structure (F2—an individual's response to the lack of structure in a specific situation).

  The F1 factor—desire for the structure is referred to as the extent to which the individuals want to establish a structure in their daily lives. People with a high desire for structure prefer the clear and structured way of life and a certain place for everything. The F2 factor—response to the lack of structure is referred to as the extent to which the individuals respond to unstructured, unpredictable situations. People who expressively dislike uncertain situations or changes in their plans at the last moment achieve a high score in the response to the lack of structure (Thompson, et al. 2001). Lower scores on the PNS indicate a greater ability to manage novel situations. A study conducted by Thompson, Naccarato and Parker revealed that the Personal Need for Structure (PNS) scale possesses sufficient reliability and convergent and discriminant validity.

- **Acceptance and Action Questionnaire (AAQ-II)**

The Acceptance and Action Questionnaire (AAQ-II) is a commonly used instrument designed to assess individual differences in experiential avoidance and psychological flexibility, as conceptualised within Acceptance and Commitment Therapy (Hayes et al., 2004). Experiential avoidance can be defined as an attempt to avoid or neglect unpleasant thoughts, unpleasant feelings, bitter memories, uncomfortable physical sensations and consequently lead to an action that is against one's values and causing long-term harm (Hayes, Strosahl, Wilson, 1999). The items on the AAQ-II are rated on a sevn-point Likert-type scale from one – never true – to seven – always true. (never true) to 7 (always true). High scores on the AAQ-II are reflective of greater experiential avoidance and immobility, while low scores reflect greater acceptance and action.

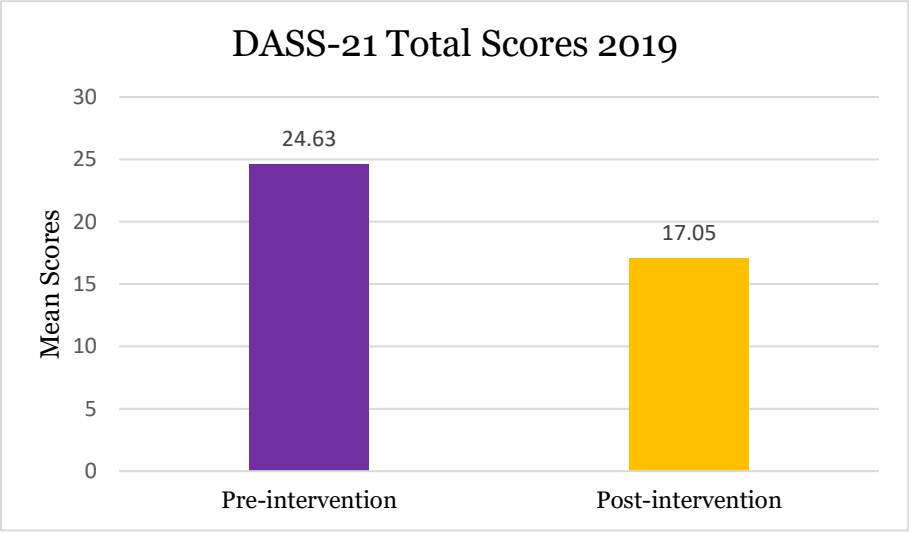
4.18.2 Descriptors

Pre and post-data were available for 19 people who completed the programme in 2019. Of these participants, 10 were female (52.6%) and nine were male (47.4%). Programme attendees ranged in age from 64 to 84 with a mean age of 72.89 (SD = 5.46). Participants attended an average of 14.89 sessions.

4.18.3 Results

Depression Anxiety and Stress Scale (DASS)

Graph: Depression, Anxiety and Stress Scale (Total)



A decrease in psychological difficulty as measured by the Depression Anxiety and Stress (DASS[21]) Inventory was observed in service users who completed the SAGE programme in 2019. A Wilcoxon Signed Ranks Test revealed a significant decrease in mean scores on the DASS from pre-intervention (M = 24.63, SD = 13.06) to post-intervention (M = 17.05, SD = 9.87), p<.05, demonstrating a medium effect size (r = -.53).

There are three sub-scales within the DASS and the figures below show pre and post-scores on each of these sub-scales 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 sub-scales are illustrated in the following table.

Table: DASS Subscale Scores 2019

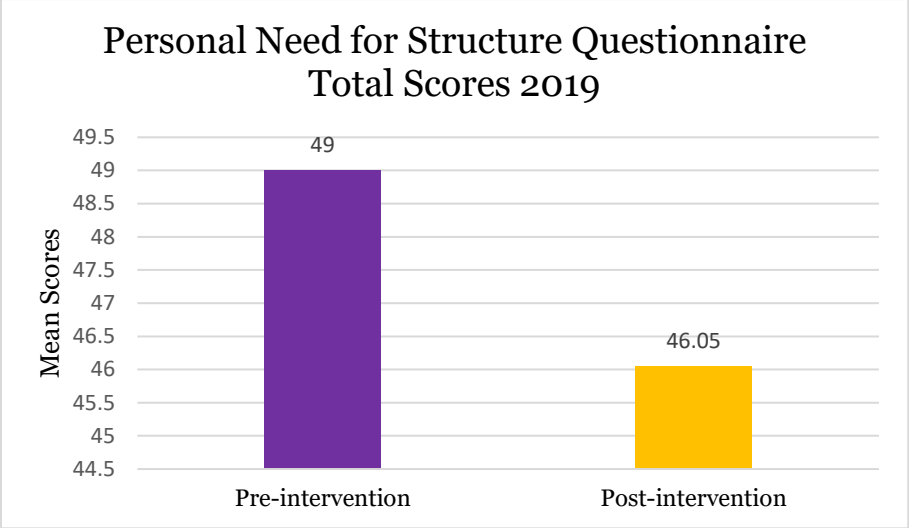
SS	*m*	t *m*			*r*
ression	9	4	32	>.05	6
iety	12.10		40	;	3
ess	6	5	56	;	8

A significant decrease in mean scores can be observed on the 'depression' and 'stress' sub-scales of the DASS.

Although there was a reduction in mean scores on the 'anxiety' sub-scale, this was not found to be statistically significant with p>.05.

Personal Need for Structure Questionnaire

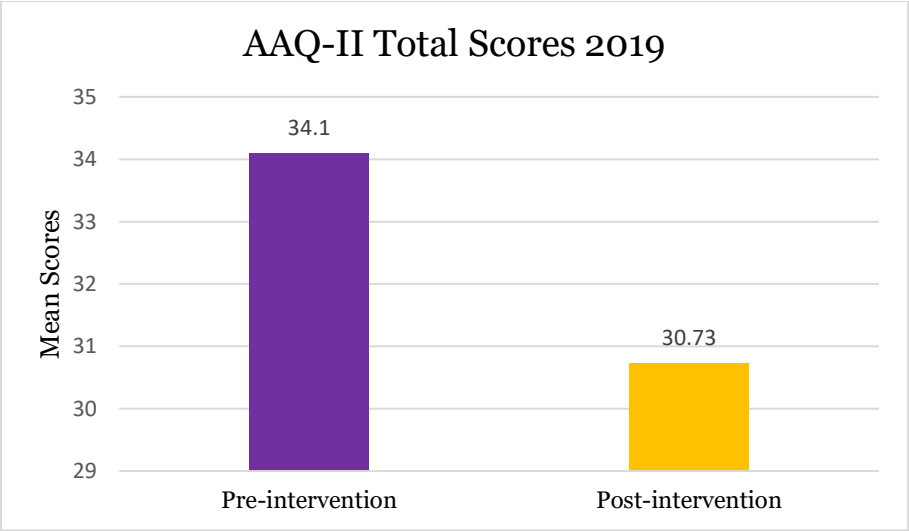
Graph: Personal Need for Structure Questionnaire Total Score



A Wilcoxon Signed Ranks Test revealed a significant reduction in scores on the PNS from pre-intervention (M = 49, SD = 8.22) to post-intervention (M = 46.05, SD = 7.10), $p<.05$, demonstrating a medium effect size (r = -0.5). This indicates that participants developed greater coping skills and an increased ability to manage novel situations after completing the SAGE programme.

Acceptance and Action Questionnaire (AAQ-II)

Graph: Acceptance and Action Questionnaire (AAQ-II) Total Score



**note: lower scores indicate greater acceptance and action.*

At pre-intervention, participants scored a mean of 34.1 (SD = 8.73) on the AAQ-II. Post-intervention, mean scores reduced to 30.73 (SD = 10.68). However, this was not found to be statistically significant with $p>.05$.

4.18.4 Summary

Significant reductions were evident in a self-reported measure of depression and stress, 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.

Clinical Psychology Trainee Research: A qualitative research project was undertaken in 2019 on the service users' experiences of change in the Sage programme. The research was completed in 2020 and the findings will be shared at a later date.

4.19 Group Schema Therapy Programme

The Group Schema Therapy (GST) Programme is a therapeutic group delivered by the Psychology Department. Group Schema Therapy (GST) is a closed long-term group designed to treat individuals with a diagnosis of borderline personality disorder (BPD). The group provides an evidenced-based treatment to service users (Farrell, Shaw & Webber, 2009).

GST helps service users to change their entrenched, self-defeating life patterns or schemas using cognitive, behavioural and emotion-focused techniques. We also introduce some sensorimotor elements and build on somatic resources to aid with this. The treatment focuses on the relationship with the therapists, daily life and trigger patterns inside and outside of therapy, and the traumatic childhood experiences that are common in this disorder. Group Schema Therapy is a long-term (70 sessions over 22 months) closed group running one morning each week.

4.19.1 Group Schema Therapy Programme outcome measures

- **Borderline Personality Disorder Severity Index (BPDSI)**

The BPDSI-IV is a semi-structured interview that assesses frequency and severity across the nine symptom domains of BPD within the last three months (Arntz & Giesen-Bloo, 1999). In terms of psychometric value, the BPDSI-IV has shown strong interrater reliability, internal consistency, discriminant, construct and concurrent

validity (Giesen-Bloo. Wachters, Schouten & Arntz. 2010). Interviewers explore each symptom domain and ask clients to indicate the frequency they experience each set of symptoms. All frequency questions are scored on a 10-point scale (0 = never; 10 = daily), with the mean scores of each domain summed to produce a total index score. Index scores over 15 indicate a clinical level of BPD symptoms.

- **Borderline Symptom List (BSL 23)**

The BSL (Bohus et al., 2009) is a 23-item version of a 95-item self-report scale assessing clients subjective experience of Borderline symptoms. Items are scored using a five–point Likert scale (0 = not at all, four = very strong), which generates a global score of all 23 items.

- **Schema Mode Inventory (SMI)**

The Schema Mode Inventory (SMI; Young et al., 2007) is a 124-item self-report measure to assess presence of schema modes, which includes five child modes, five dysfunctional coping modes, two dysfunctional parent modes and the adaptive healthy adult mode. Respondents are asked to rate each statement from one to six (one = never or almost never to six = all of the time). Positive outcomes include a reduction in scores for all modes with the exception of the happy child and healthy adult modes, which are intended to increase over the course of treatment.

- **The Young Schema Questionnaire (YSQ)**

The YSQ (Young, 2003) assesses clients' early maladaptive schemas, which are proposed to underlie a variety of mental health difficulties associated with personality disorders. 18 schemas are examined in total across 232 items. Each item is rated from one to six (one = completely untrue of me, six = describes me perfectly). Only items scored four or higher are included for total scores for each schema.

- **Symptom Checklist (SCL-90)**

The Symptom Checklist-90-Revised (Derogatis, 1994) evaluates a range of psychological problems and symptoms of psychopathology under nine different domains: somatisation, obsessive compulsive disorder, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Each item is rated from 0 to four (0 = not at all, four = severe). The main index of distress is the global severity index (GSI), which is the average of all responses.

- **WHO Quality of Life (WHOQOL)**

The WHOQOL-BREF (WHOQOL Group, 1993) is a 26-item instrument consisting of four domains relating to quality of life: physical health, psychological health, social relationships and environmental health. Scores range from one to five within each domain, relating to frequency and relatability of different items.

4.19.2 Descriptors

Data were collected for eight participants in 2018, of whom seven of the participants were female and one was male, with an age range of 27 to 59 years.

4.19.3 Results

Borderline Personality Disorder Severity Index

A significant reduction in service users' overall symptom severity was observed after completing the programme. This was shown by a reduction in mean scores on the Borderline Personality Disorder Severity Index (BPDSI), whereby t (5) = 3.93, p<.011, reflecting a large effect size (d= 1.13). Of the sub-scales for the BPDSI, only the sub-scale 'identify' showed any statistically significant change, whereby t (5) =2.57), p<.050, reflecting a large effect size (d= 0.97). All other sub-scales, with the exception of 'interpersonal relationships', showed reductions from pre to post-intervention.

Graph: BPD Severity Index mean total scores pre and post-intervention

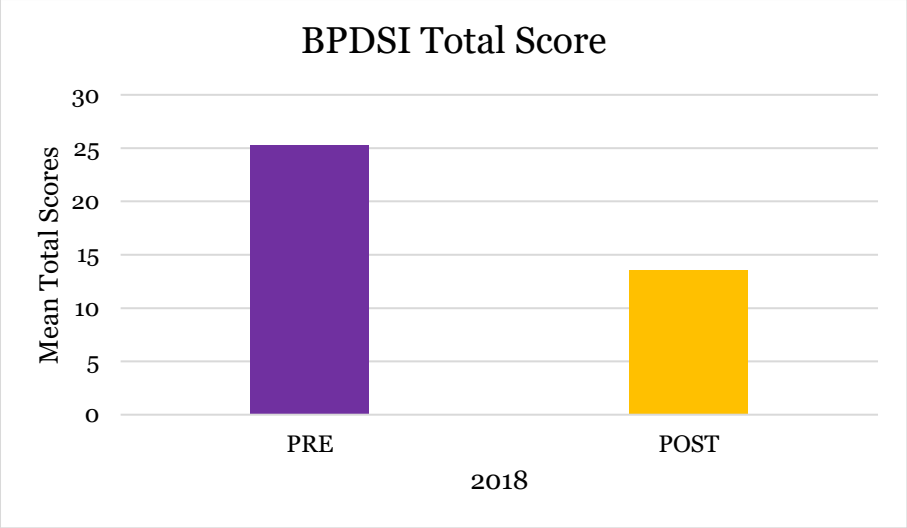


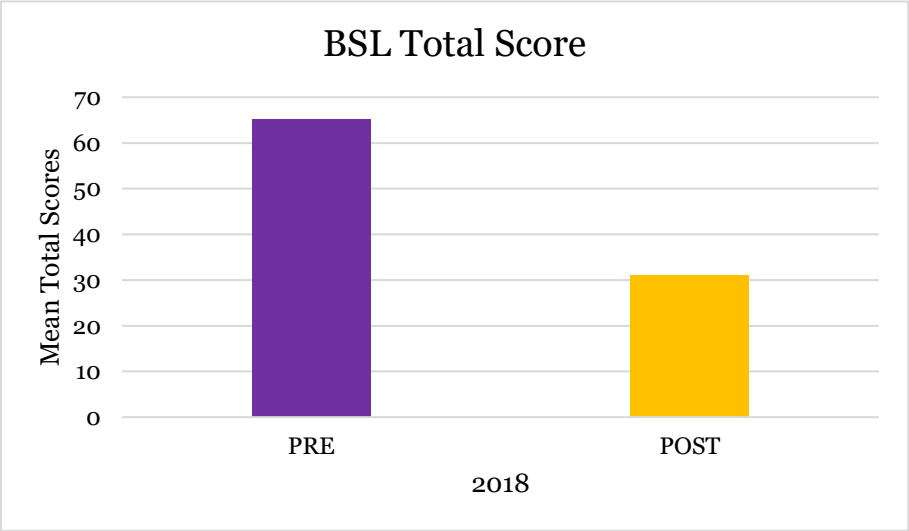
Table 1: BPDSI mean scores by sub-scale, t-value, and effect size

BPDSI	Pre-Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
Abandonment	2.88 (2.42)	1.14 (1.15)	2.50	5	0.55	
Interpersonal Relationships	0.97 (0.55)	1.27 (0.97)	-.91	5	0.41	
Identity	3.64 (2.11)	1.66 (1.93)	2.57	5	0.50	0.97
Impulsivity	1.10 (0.86)	0.74 (0.57)	0.92	5	0.39	
Parasuicidal Behaviour	1.44 (1.71)	0.56 (0.81)	2.25	5	0.74	
Affective Instability	5.23 (3.65)	3.83 (2.06)	1.39	5	0.22	
Emptiness	3.75 (3.43)	1.13 (1.87)	2.05	5	0.09	
Outbursts of Anger	3.61 (2.60)	1.28 (1.67)	1.56	5	0.18	
Dissociation and Paranoid Ideation	2.60 (1.70)	1.96 (2.21)	0.88	5	0.42	

Borderline Symptom List

A statistically significant reduction in mean scores on the Borderline Symptom List (BSL) was observed, t (4) = 3.14, p < .035, from pre (M = 65.20, SD = 24.20) to post-intervention (M = 31.00, SD = 26.31), reflecting a large effect size (Cohen's *d* = 1.35).

Graph: Borderline Symptom List mean total score pre and post-intervention



Schema Mode Inventory

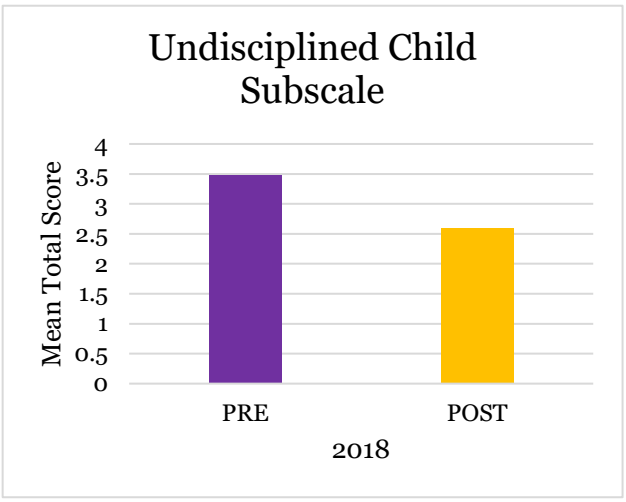
Paired samples t-tests showed a reduction in mean scores across all negatively associated schema modes from pre to post-intervention, as well as increases in mean scores across all positively associated schema modes from pre to post-intervention in the Schema Mode Inventory (SMI) (see table below).

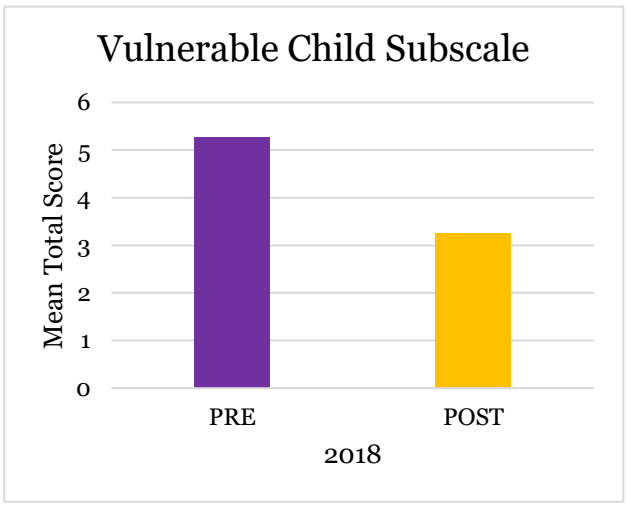
Statistically significant reductions were observed between pre and post scores for vulnerable child (p= 0.41), undisciplined child (p=0.42), and punitive parent (p= 0.35) schemas, while a statistically significant increase was found for the healthy adult schema (p= .007).

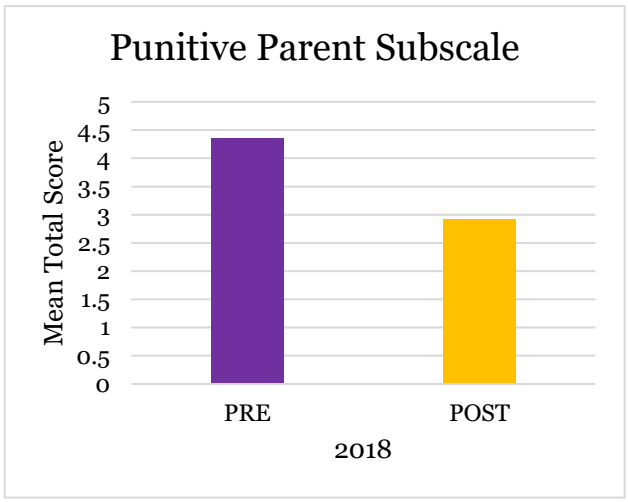
Table 2: SMI mean scores by sub-scale, t-value and effect size

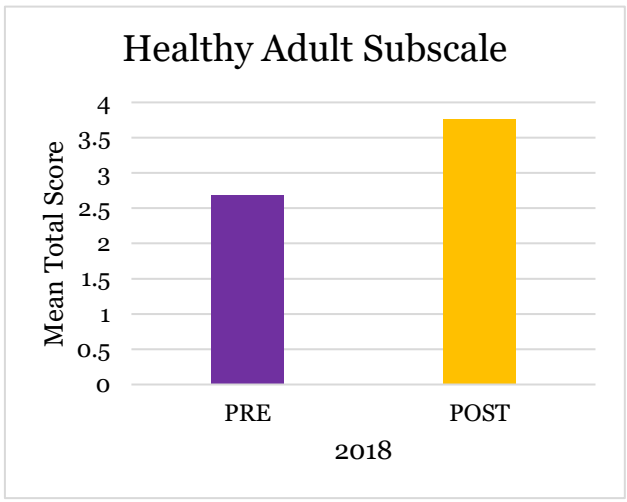
SMI	Pre-Mean	Post Mean	*t*			*df*	*p*	Cohen's *d*
Vulnerable Child	5.26 (0.53)	3.56 (1.63)	2.97			4	**.041**	1.40
Angry Child	3.88 (1.13)	3.08 (0.81)	1.07			4	.346	
Enraged Child	2.60 (1.00)	1.70 (0.23)	1.86			4	.138	
Impulsive Child	3.60 (1.26)	2.34 (0.90)	1.47			4	.216	
Undisciplined Child	3.48 (0.64)	2.60 (0.46)	2.96			4	**.042**	1.58
Contented / Happy Child	2.12 (0.62)		3.26 (1.30)		-2.30	4	.075	
Compliant Surrenderer	4.32 (0.82)		2.60 (1.28)		2.48	4	.068	
Detached Protector	3.80 (0.91)		2.70 (1.43)		1.38	4	.241	
Detached Self-Soother	3.78 (0.48)		3.08 (1.19)		.99	4	.375	
Self-Aggrandizer	2.80 (1.51)		2.26 (0.55)	.99	4	.375		
Bully & Attack	2.34 (1.16)		1.64 (0.56)	1.42	4	.228		
Punitive Parent	4.36 (0.95)		2.92 (1.58)	3.12	4	**.035**	1.10	
Demanding Parent	4.0 (0.51)		3.74 (0.91)	.63	4	.561		
Healthy Adult	2.68 (0.59)		3.76 (0.98)	-5.18	4	**.007**	1.34	

Graph: Schema Mode Inventory mean total scores pre and post-intervention









Young Schema Questionnaire

A reduction in mean scores was observed on all 18 schemas from pre to post-intervention. Statistically significant reductions were observed for abandonment, mistrust abuse, dependence, entitlement, insufficient self-control, approval seeking and punitiveness schema. Pre and post scores are illustrated in the table below for all schema, with effect sizes provided for statistically significant reductions.

Table 3: YSQ Mean scores by sub-scale, t-value and effect size

YSQ	Pre-Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*

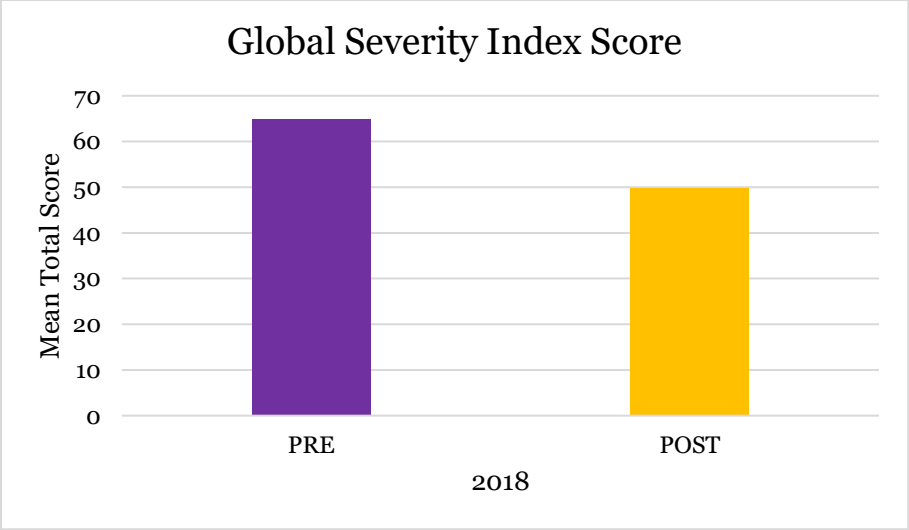
Abandonment	4.20 (0.97)	3.22 (1.49)	3.13	4	**.035**	0.78
Mistrust Abuse	4.05 (0.66)	2.94 (1.05)	3.26	4	**.031**	1.26
Social Isolation	6.48 (2.68)	3.92 (1.65)	2.16	4	.097	
Defectiveness	4.97 (0.66)	3.95 (1.75)	1.65	4	.174	
Failure	4.86 (1.08)	3.89 (1.84)	1.34	4	.250	
Dependence	4.03 (0.99)	2.41 (0.54)	3.75	4	**.020**	2.03
Vulnerability	4.56 (1.31)	3.15 (1.43)	1.80	4	.146	
Enmeshment	3.74 (2.11)	2.76 (2.3)	3.71	4	.066	
Subjugation	3.85 (1.51)	2.83 (1.79)	1.28	4	.291	
Self-Sacrifice	3.37 (1.33)	3.34 (1.57)	0.13	4	.907	
Emotional Inhibition	3.71 (1.21)	2.08 (0.82)	2.01	4	.138	
Unrelenting Standards	4.22 (0.74)	3.88 (1.54)	0.61	4	.572	
Entitlement	3.16 (1.61)	2.36 (1.47)	2.84	4	**.047**	0.52
Insufficient Self-Control	4.17 (1.02)	2.56 (0.75)	3.48	4	**.025**	1.80
Approval Seeking	3.75 (0.89)	2.21 (1.02)	3.26	4	**.031**	1.61

Negativity	4.68 (0.62)	4.20 (1.86)	0.53	4	.627	
Punitiveness	4.71 (0.61)	3.03 (1.28)	2.41	4	**.074**	1.68
Emotional Deprivation	5.15 (0.61)	3.90 (2.18)	1.73	4	.158	

Symptom Checklist

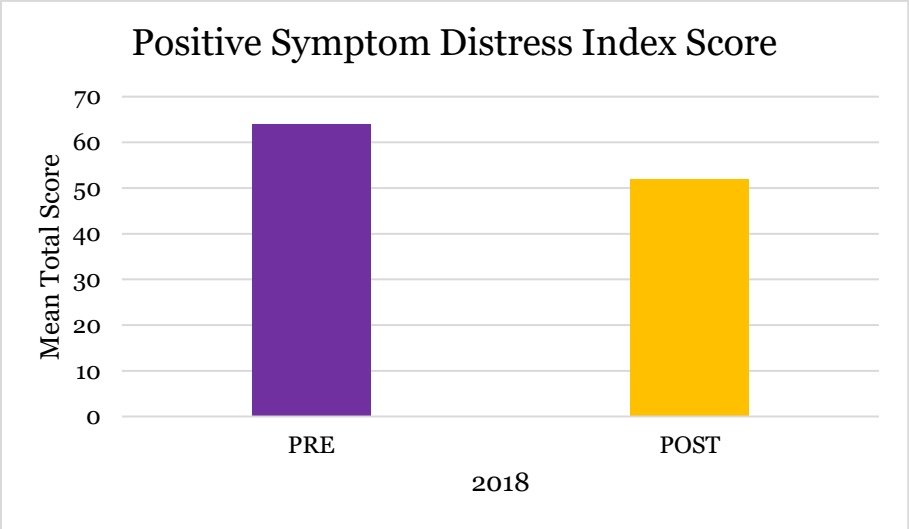
A reduction in mean scores was observed on all symptom indices of the Symptom Checklist (SCL – 90) from pre to post-intervention. Statistically significant reductions were observed for the Global Severity Index, Positive Symptom Distress Index, Interpersonal Sensitivity, Depression, Hostility, Phobic Anxiety and Psychoticism sub-scales.

Symptomatology on the Global Severity Index subscale decreased from (M = 65.00, SD = 9.14) to (M = 49.80, SD = 13.10). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 3.17, p < .034, reflecting a large effect size (*d* = 1.34).

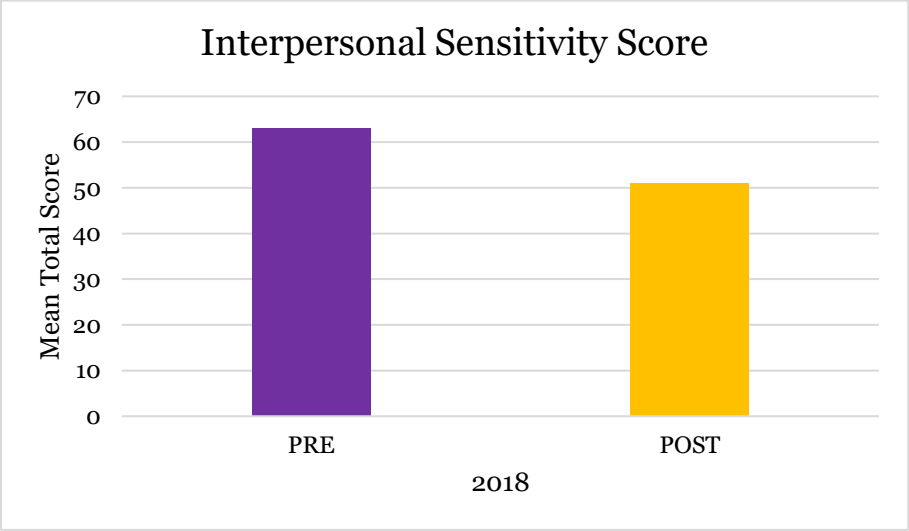


Symptomatology on the Positive Symptom Distress Index sub-scale decreased from (M = 64.00, SD = 6.40) to (M = 52.00, SD = 8.15). Paired sample t-tests indicated

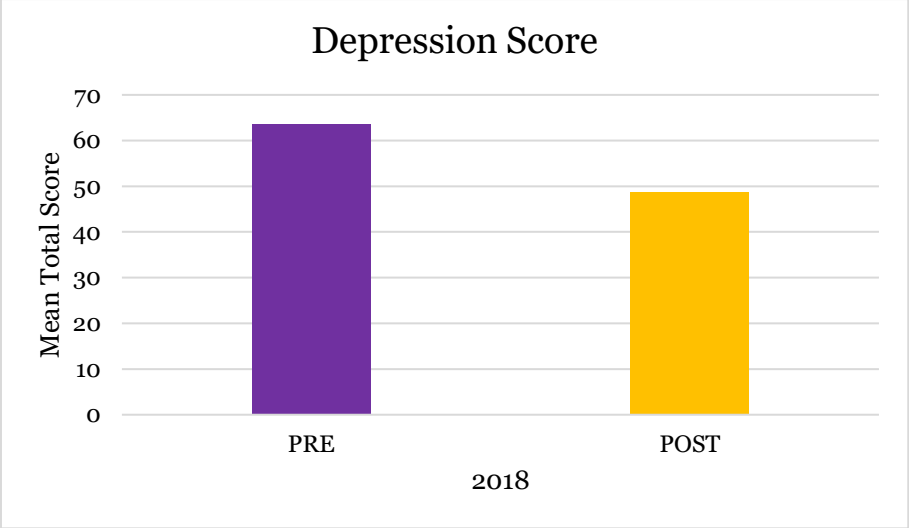
that this was a statistically significant change, whereby t (4) = 3.29, p < .030, reflecting a large effect size (*d* = 1.63).



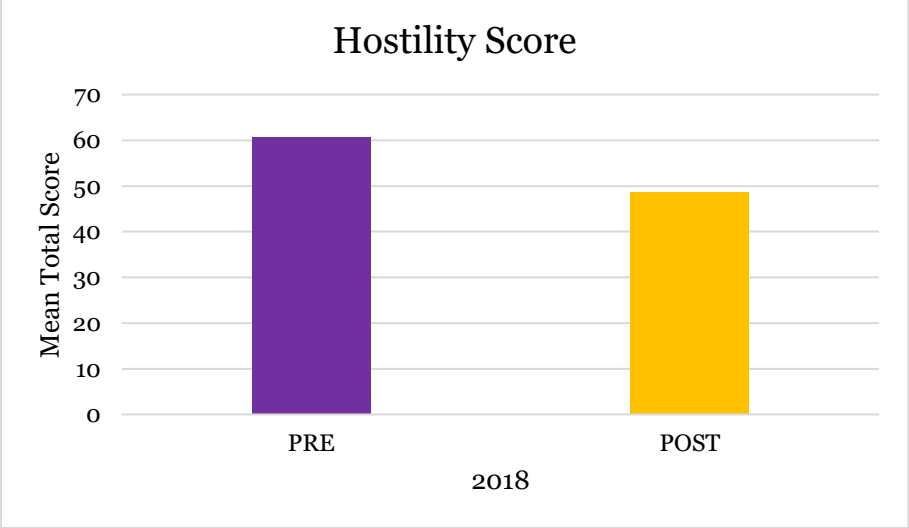
Symptomatology on the Interpersonal Sensitivity sub-scale decreased from (M = 63.00, SD = 11.04) to (M = 51.00, SD = 13.55). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 4.86, p < .008, reflecting a large effect size (*d* = 0.97).



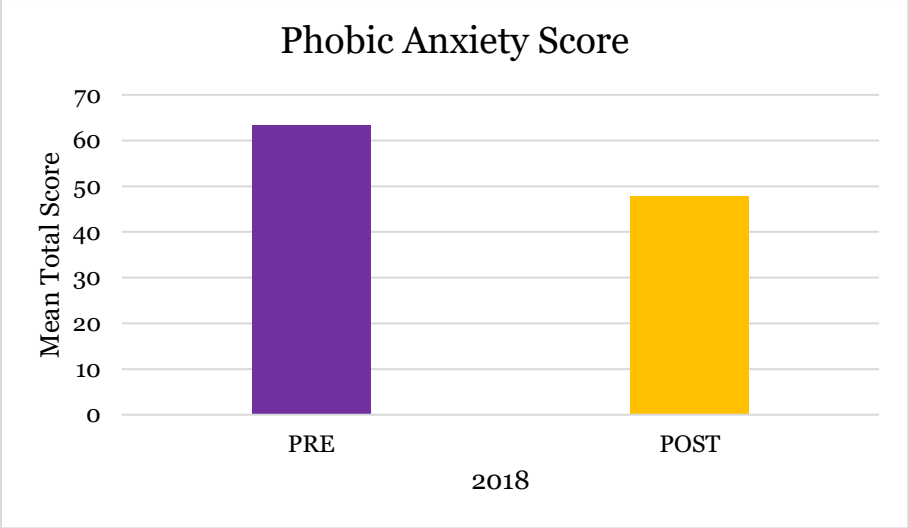
Symptomatology on the depression sub-scale decreased from (M = 63.60, SD = 9.40) to (M = 48.80, SD = 9.76). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 4.30, p < .013, reflecting a large effect size (*d* = 1.54).



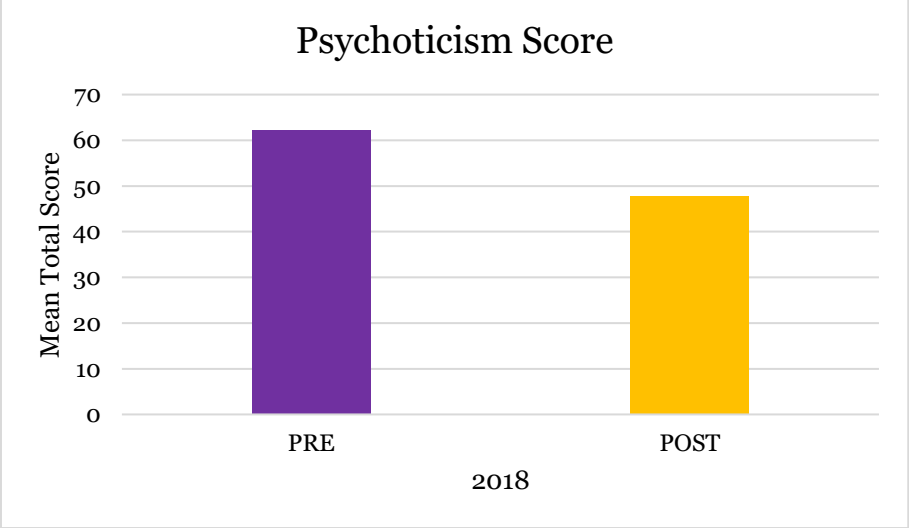
Symptomatology on the hostility sub-scale decreased from (M = 60.60, SD = 7.64) to (M = 48.60, SD = 5.60). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 3.24, p < .032, reflecting a large effect size (*d* = 1.79).



Symptomatology on the phobic anxiety sub-scale decreased from (M = 63.40, SD = 10.21) to (M = 47.80, SD = 9.65). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 7.08, p < .002, reflecting a large effect size (*d* = 1.57).



Symptomatology on the psychoticism sub-scale decreased from (M = 62.20, SD = 5.63) to (M = 47.80, SD = 12.87). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 3.08, p < .037, reflecting a large effect size (*d* = 1.45).



WHO Quality of Life

Increases in participant's quality of life was observed across all four domains of the WHO Quality of Life (WHOQOL): Physical Health, Psychological Health, Social Relationships, and Environment. A statistically significant increase was found for Psychological Health from pre (M = 21.2, SD = 16.5) to post intervention (M = 47.6, SD = 27.7), whereby t (4) =-3.37, p= .028, reflecting a large effect size (*d*= 1.16).

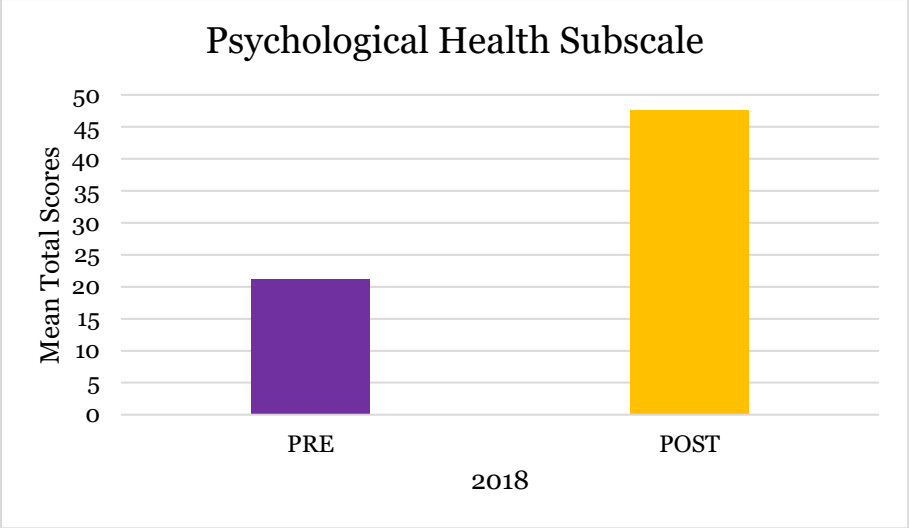


Table 4: WHOQOL Mean scores by sub-scale, t-value and effect size

WHOQOL	Pre-Mean (SD)	Post Mean (SD)	*t*	*df*	*p*	Cohen's *d*
Physical Health	30.2 (22.6)	51.6 (19.7)	-1.87	4	0.14	
Psychological Health	21.2 (16.5)	47.6 (27.7)	-3.37	4	0.028	
Social Relationships	26.4 (10.3)	41.2 (25.4)	-1.46	4	0.22	1.16
Environment	54.0 (19.3)	66.2 (30.9)	-1.84	4	0.14	

4.19.4 Summary

The Group Schema Therapy programme helps individuals change their entrenched, self-defeating life patterns or schemas, using cognitive, behavioural and emotion-focused techniques. In 2018 service users who completed Group Schema Therapy showed reductions in areas of each of the six outcome measures used. Significant reductions were evident in symptom frequency and severity, as indicated by patient scores on the BPDSI and BSI. Significant reductions were seen in a variety of schemas, as indicated by scores on both SMI and YSQ. Improvements to patient's psychological health were observed in the WHOQOL. Improvements made across outcome measures demonstrated large effect sizes.

4.20 Trauma Group Programme

The Trauma Group Programme is a new therapeutic group delivered by the Psychology Department. The programme is for individuals with a history of complex trauma. The group has three stages adapted from Judith Herman's Model of Trauma Recovery. It incorporates both group and individual work, memory reprocessing, compassion-focused therapy and attachment theory. Stage one includes safety, stabilisation and connection. Stage two aims to work on remembering and reprocessing memories. Individual work runs alongside the group in Stage two. Stage three focuses on looking forward and reclaiming the participants' life from trauma. The group is offered over a seven-month period which includes twice a week for six weeks, then once a week for twelve weeks (during this time participants also engage in individual memory processing therapy work) and then twice a week for five weeks.

4.20.1 Trauma Group Programme Outcome Measures

- **Post-Traumatic Stress Disorder Checklist DSM 5**

  The PTSD Checklist is a 20-item self-report checklist of post-traumatic stress disorder (PTSD) symptoms based closely on the DSM-5 criteria (PCL-5; Lang & Stein, 2005). Service users rate each item from 0 – not at all – to four – extremely - to indicate the degree to which they have been impacted by that symptom over the past month. The PCL has demonstrated strong psychometric properties. Estimates of internal consistency (Cronbach's alpha) range between 0.94 (Blanchard et al, 1996) to 0.97 (Weathers et al. 1993). Test-retest reliability has been reported as .96 at two to three days and 0.88 at one week (Blanchard et al.,1996; Ruggiero et al.,2003). Higher scores indicate higher experiencing of PTSD symptoms.

- **The Post Traumatic Cognitions Inventory (PTCI)**

  The PTCI (Foa, Ehlers, Clark, Tolin & Orsillo, 1999) is a 36-item self-report scale that was designed to measure trauma-related thoughts and beliefs. Each item is rated on a seven-point Likert scale from 0 – totally disagree – to seven - totally agree. The measure consists of three scales measuring negative cognitions about self, negative cognitions about the world and self-blame. A total score is also

calculated through the measures. Higher scores indicate high post-traumatic cognitions.

- **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 (ie. motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgmental) and an action sub-scale (ie. 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 (one =never to 10 = always). High scores indicate high compassion.

4.20.2 Descriptors

Data was collected on seven participants; four males (57.1%) and three females (42.8%). Pre and post-data were available for seven participants. Participants age ranged from 42 to 60 years old (mean = 51 years).

Pre-treatment completion of the Adverse Childhood Experience (ACEs) indicated that all participants scored above three, with 22% scoring four and five respectively; 33% scoring seven; and 11% scoring an eight and 10. The higher the ACE score the more at risk the client is to chronic health problems, mental health difficulties, social difficulties and substance misuse in adulthood.

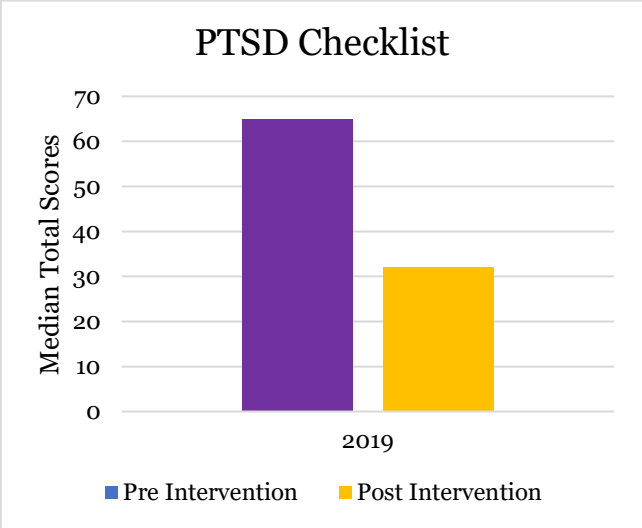
Of the two attendees not captured in this analysis, one of the attendees decided to leave the group mid-way through the programme. The second attendee completed the programme and completed qualitative measure captured for research, however they failed to return the quantitative measures used for this report. Within the qualitative measures returned by this service user, he stated that: “It was positive. I found the discussions helpful and benefited from the contributions from the group facilitators and members. I have suggested this group to two friends who are struggling. So, in

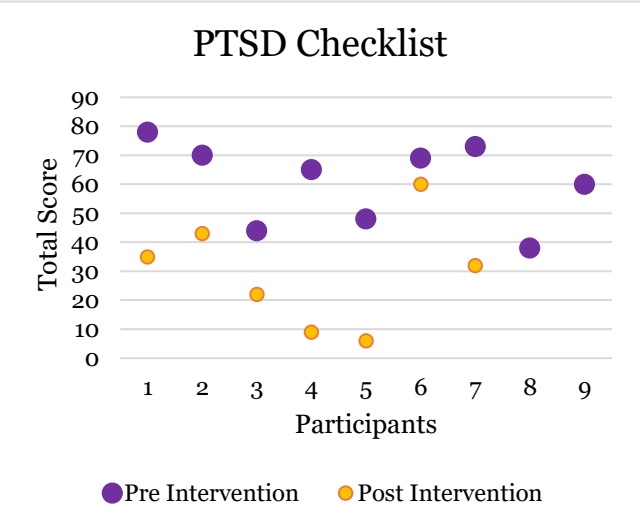
that sense I am happy to recommend the programme." This would indicate that this service user found the group a helpful support.

4.20.3 Results

- **Post-Traumatic Stress Disorder Checklist DSM 5 (PCL)**
  The analysis revealed a significant decrease in total scores on the PTSD Checklist from pre-intervention (*Md*=65; *SD*=14.05) to post-intervention (*Md*=32; *SD*=19.05). A Wilcoxon Signed Ranks tested revealed a statistically significant decrease in total scores following participation in the programme, *z* (7) = -2.366, p<.05, with a large effect size (*Cohen's r* = -0.89). These results suggest that, on average, service users who completed the outcome measure showed a decrease in PTSD symptoms.

Graph: Post-Traumatic Stress Disorder (PTSD) Checklist DSM 5 Group median scores and individual scores pre and post-intervention





- **The Post Traumatic Cognitions Inventory (PTCI)**
  Analysis using a Wilcoxon Signed Ranks revealed a decrease in total scores on the Post Traumatic Cognitions Inventory from pre-intervention (*Md*=172; *SD*=19.78) to post-intervention (*Md*=153; *SD*=42.74). A Wilcoxon Signed Ranks did not find a significant change in total scores following participation in the programme.

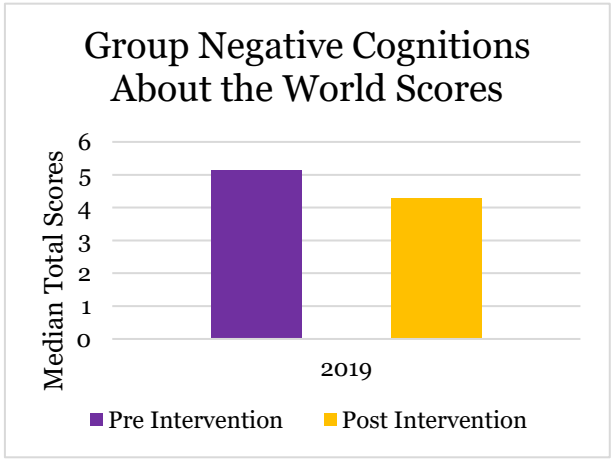
However, on closer analysis two of the three sub-scales were found to show statistically significant change post-intervention.

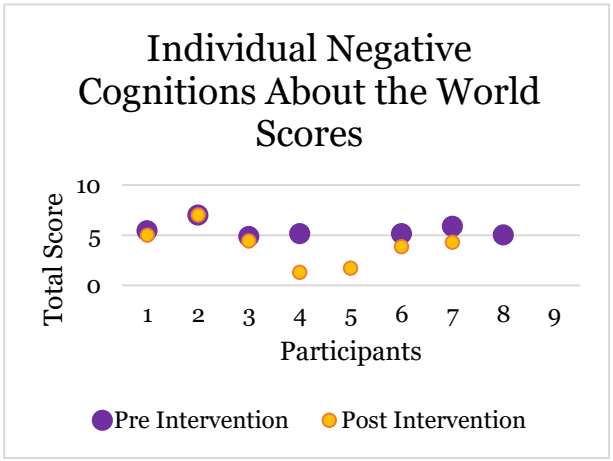
The analysis revealed a significant decrease in total scores Negative Cognitions About the Worldfrom pre-intervention (*Md*=5.14; *SD*=0.74) to post-intervention (*Md*=4.28; *SD*=1.95). A Wilcoxon Signed Ranks tested revealed a statistically significant decrease in total scores following participation in the programme, *z* (6) = -2.03, p<.05, with a large effect size (*Cohen's r*=-0.82). These results suggest that, on average, service users who completed the outcome measure showed a reduction in negative cognitions about the world.

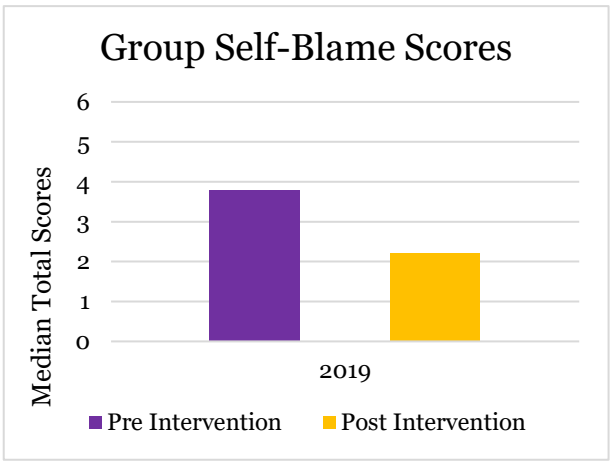
The analysis revealed a significant decrease in total scores Self-blame from pre-intervention (*Md*=3.8; *SD*=1.82) to post-intervention (*Md*=2.2; *SD*=0.90). A Wilcoxon Signed Ranks tested revealed a statistically significant decrease in total scores following participation in the programme, *z* (7) = -2.20, p<.05, with a large effect size (*Cohen's r* = -0.83). These results suggest that, on average, service users who completed the outcome measure showed a reduction in thoughts of self-blame after attending this treatment.

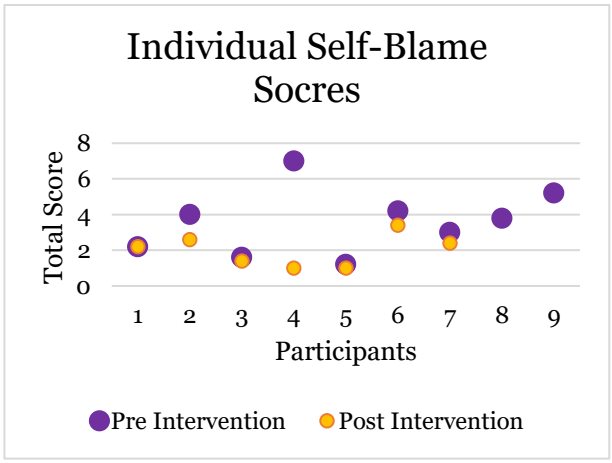
The analysis revealed a non-significant decrease in total Negative Cognitions about Self from pre-intervention (*Md*=4.57; *SD*=0.65) to post-intervention (*Md*=3.23; *SD*=1.90). A Wilcoxon Signed Ranks tested revealed a statistically significant decrease in total scores following participation in the programme, *z* (7) = -1.35, p=.176. These results suggest that, on average, this treatment did not result in a significant change in service users' negative cognitions about self. It is plausible to suggest that this specific feature may take more time to respond to the effect of treatment, however, the positive change found in this analysis is promising.

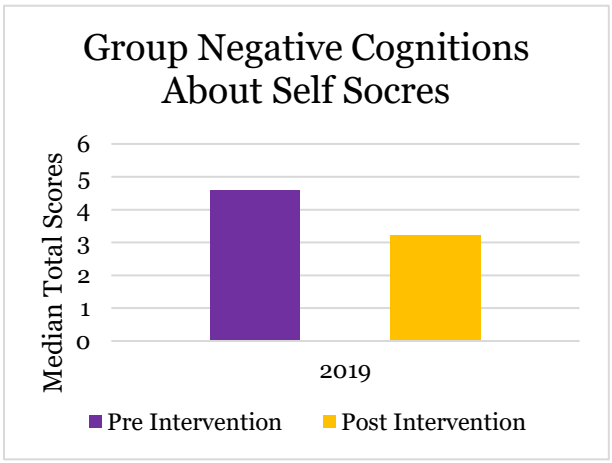
Graph: The Post Traumatic Cognitions Inventory sub-scales median scores and individual scores pre and post-intervention

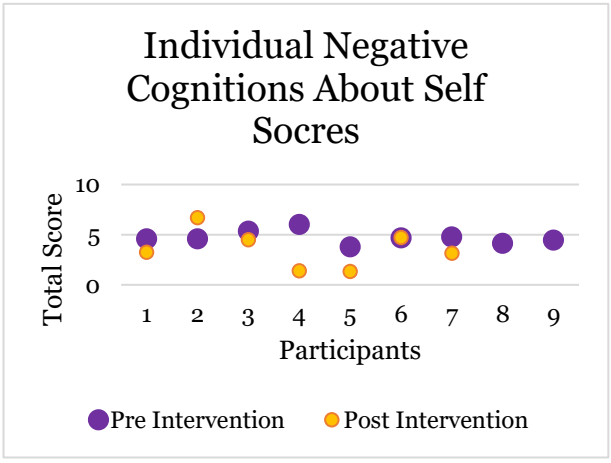












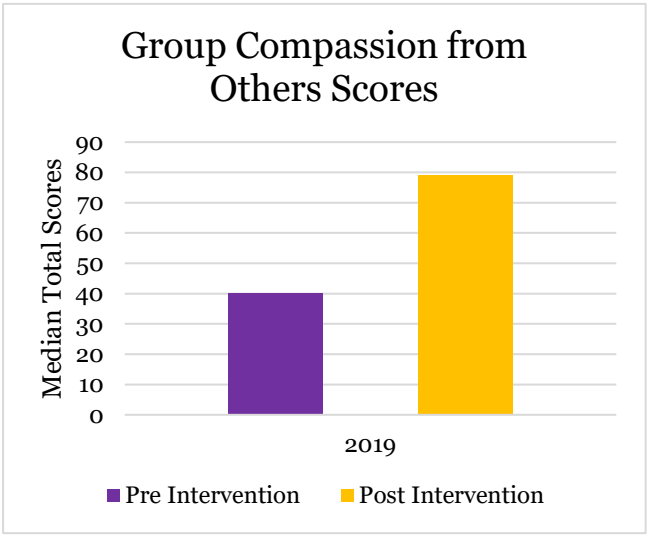
Compassionate Engagement and Action Scales

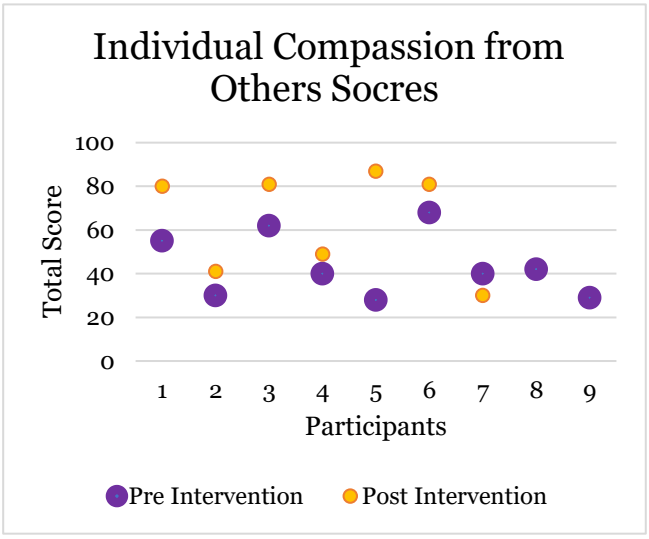
Analysis using a Wilcoxon Signed Ranking test revealed a significant increase in two of the three subscales; compassion from others and self-compassion sub-scale intervention. The analysis revealed a significant increase in total scores for the compassion from others scale from pre-intervention *(Md*=40; *SD*=14.72) to post-intervention (*Md*=80; *SD*=23.35). A Wilcoxon Signed Ranks tested revealed a statistically significant increase in total scores following participation in the programme, *z* (7) = -2.02, p<.05, with a large effect size (*Cohen's r* = -0.83). These results suggest that, on average, service users who completed the outcome measure showed an increase in their ability to receive compassion from others after attending this treatment.

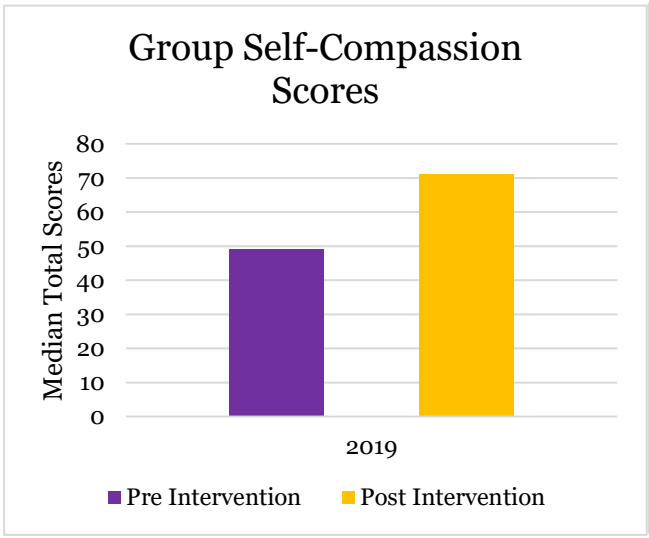
Analysis of the self-compassion sub-scale revealed a significant increase in total scores from pre-intervention (*Md*=49; *SD*=9.46) to post-intervention (*Md*=71; *SD*=8.55). A Wilcoxon Signed Ranks tested revealed a statistically significant increase in total scores following participation in the programme, *z* (7) = -2.37, p < 0.05, with a large effect size (Cohen's *r* = -0.89). These results suggest that, on average, service users who completed the outcome measure showed an increase in self-compassion after attending this treatment.

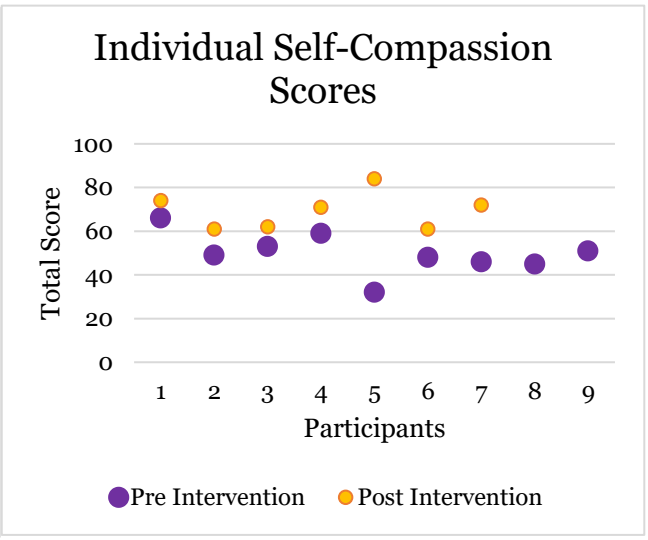
Analysis of the compassion to others sub-scale revealed no significant increase in total scores of compassion to others scale from pre-intervention (*Md*=79; *SD*=9.12) to post-intervention (*Md*=79; *SD*=6.75). A Wilcoxon Signed Ranks tested revealed no significant increase in total scores following participation in the programme, *z* (7) = -1.15, p =0.248. These results suggest that, on average, service began the group with a high level of compassion toward others which remained stable following the group.

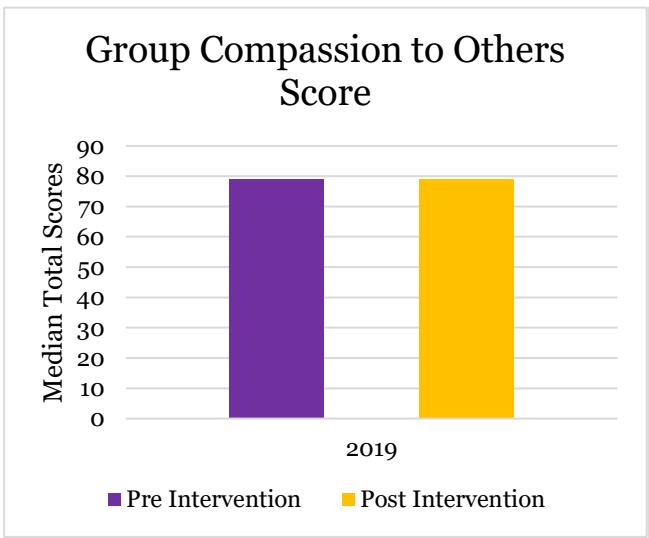
Graph: Compassionate Engagement and Action sub-scales median scores and individual scores pre and post-intervention

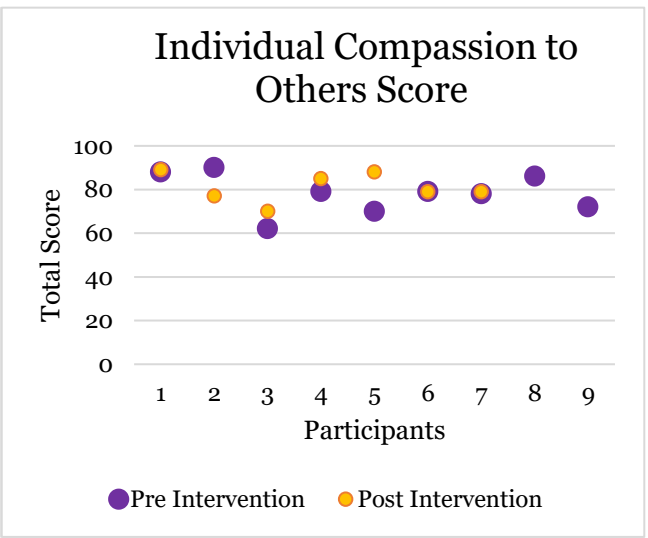












4.20.4 Summary

The Trauma Programme is a new programme in the hospital delivered by the Psychology Department. It aims to reduce suffering by reducing participants' symptoms of distress and increasing their capacity for compassion in their relationships with themselves and others. In 2019 service users who completed the Trauma Programme reported statistically significant reductions in trauma symptom frequency and severity. The participants also reported statically significant positive changes in their capacity to engage more compassionately with themselves and in their ability to receive compassion from others. These results suggest that the Trauma Programme is effective in delivering its aims, however further research with more participants is recommended.

4.21. Willow Grove Adolescent Unit

Willow Grove is the inpatient adolescent service of SPMHS. 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.

4.21.1 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 (three to 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 MDT 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, non-organic somatic symptoms, emotional symptoms, peer relationships, self-care, family relationships and school attendance. All scales are scored on a 0 to four-point Likert scale from 'no problems' to 'severe problems'. Higher scores are indicative of greater severity of difficulty.

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 HoNOSCAs were completed at admission and discharge by the young person (self-rated), MDT (clinicians) and parent.

4.21.2 Descriptors

There were data available for 79 patients who were admitted in 2019; 62 (78.5%) females and 16 (20.3%) males. The age ranged from 13 to 19 years, with a mean of 16.42 (SD=1.52).

4.21.3 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	24.56 SD = 10.4	18.27 SD = 9.76	4.09	65	.000	.62
Clinician Rated	50.40 SD = 21.42	35.74 SD = 20.33	4.70	69	.000	.70
Parent Rated	23.12 SD = 8.5	13.75 SD = 7.57	6.59	64	.000	1.1

Pre and post scores on the measure were not available for all participants, thus the data is not representative of all the patients who attended Willow Grove in 2019. Analysis was therefore run on the completion rates.

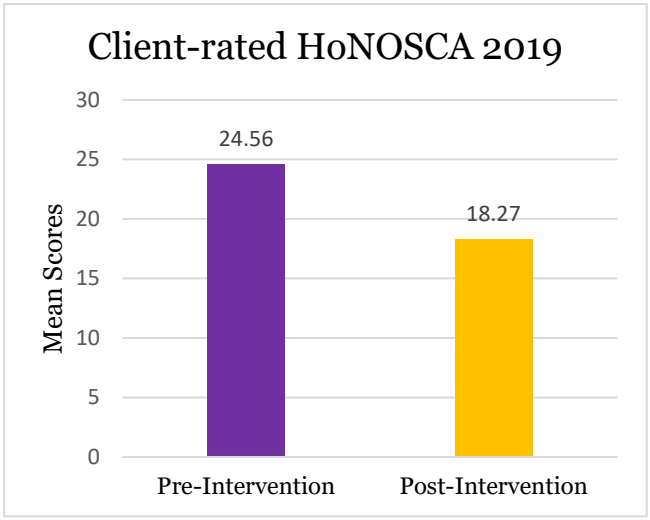
As illustrated in the table above, a significant decrease in total scores for the self-rated HoNOSCA was apparent at the post-intervention time point ($t(65) = 4.09$, $p<.001$), reflecting a medium effect size (Cohen's d =.62).

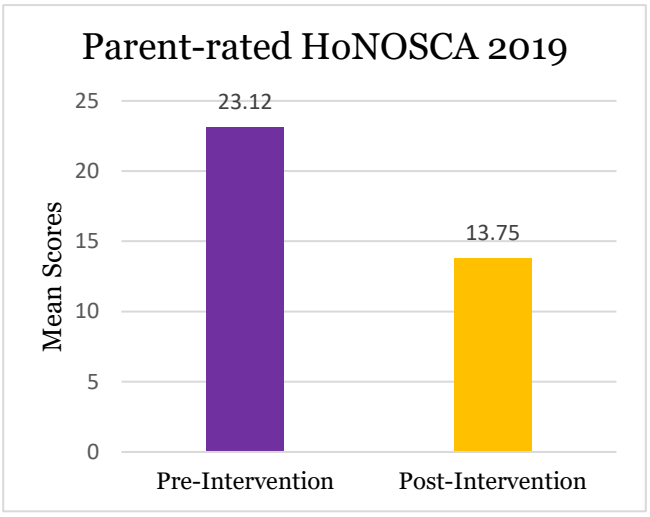
A significant decrease in total scores was also identified post-intervention on the clinician-rated HoNOSCA, (t (69) = 4.7, p<.001), demonstrating a medium effect size (Cohen's *d* =.70).

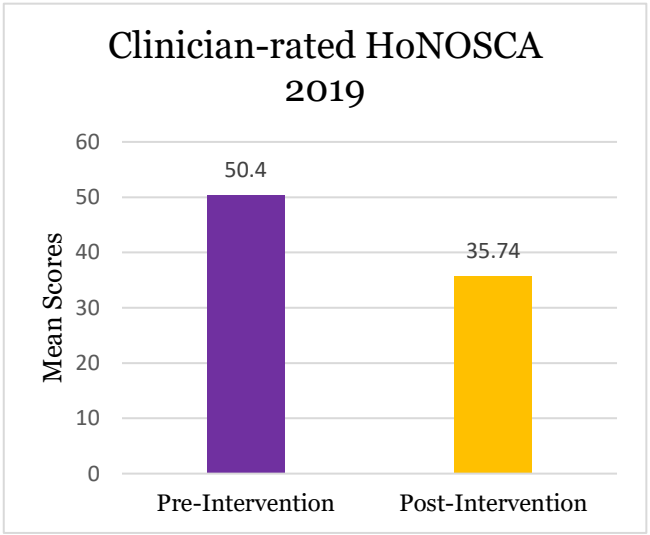
On the parent-rated HoNOSCA, a significant decrease in total scores was also observed at post-intervention, (t (64) = 6.59, p<.001), where a large effect size can be observed (Cohen's *d* = 1.1).

Note: a reduction in HoNOSCA scores indicates a decrease in mental health difficulty.

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







4.21.4 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, and parent-rated HoNOSCA, reflecting both medium and 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 2019 (79) were higher than 2018 (61). It is anticipated that response rates will continue to improve in 2020 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 2020.

SECTION 5

Measures of service user satisfaction

5.1 Service user satisfaction questionnaires

5.1.1 Introduction

SPMHS is committed to listening to, and acting upon, the views of those who use and engage with its service. To enhance communication between service users and providers, a service user satisfaction survey was developed and is distributed to service users who attend inpatient care, Dean Clinics and day programme services. This report outlines the views of a portion of inpatient, Dean Clinic and day programme service users from January to December 2019. 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 (eg. service users' perception of stigma after receiving mental healthcare). The Dean Clinic and day programme surveys were subsequently adapted from the inpatient survey and tailored to collect data regarding the respective services.

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

5.1.3 Data collection

The three surveys for the Dean Clinics, inpatient and day programmes were continually distributed from January to December 2019 to gather information about

service users' journey through SPMHS, 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 to increase accessibility. The employment of the service users satisfaction survey is part of a larger quality improvement process undertaken by SPMHS. 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 SPMHS or to complete the survey online. All service users were given an opportunity to complete the questionnaire except for those attending a first appointment or assessment and those whom Dean Clinic administration staff felt may have been too unwell to complete the questionnaire. There has been a notable increase in the number of service users completing survey's this year from 24 in 2018 to 139 in 2019. This is due to the successful implementation of an awareness by all clinics participating, informing service users that there is an avenue for feedback.

Inpatient adult services

All service users discharged between January and December 2019 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 SPMHS invited all service users finishing a programme to complete a copy of the questionnaire and return it in person, by post to SPMHS, or to complete the survey online.

5.1.4.1. Dean Clinic (Community Services)

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

Dean Clinic	n	%
SPUH	30	21.6

Sandyford	40	28.8
Galway	14	10.1
Cork	35	25.2
Lucan Adolescent	3	2.2
SEH	10	7.2
No Answer	7	4.9
Total	139	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	13	9.4
<2 weeks	10	7.2
<1 month	44	31.7
<2 months	25	18.0
>2 months	21	15.1
>4 months	16	11.5
No Answer	10	7.1
Total	139	100

Were you seen at your appointment time?

42.4 % of respondents reported being seen on time, 35.3 % of respondents reported that they were seen by clinicians within 15 minutes of arriving at the Dean Clinic and 15.1% of respondents reported a half-hour wait for their appointment on arrival to the clinic. Cumulatively, 92.8% of respondents were seen within half an hour of their appointment time. 1.4% of respondents reported a delay in over one hour to being seen by a clinician.

Respondents who endorsed each waiting time frame

Waiting Time	n	%
Seen on time	59	42.4
Seen within 15 minutes	49	35.3
Seen within a half hour	21	15.1
Seen within an hour	3	2.2

Seen within over 2 hours	2	1.4
No Answer	5	3.6
Total	139	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?	120	86.3	10	2	4	2.9	5	3.6
Did a member of the clinic staff explain clearly what would be happening?	96	69.1	23	.5	10	7.2	10	7.2
Were you told about the services available to you to assist you in looking after your mental health?	77	55.4	29	.9	16	11.5	17	12.2

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

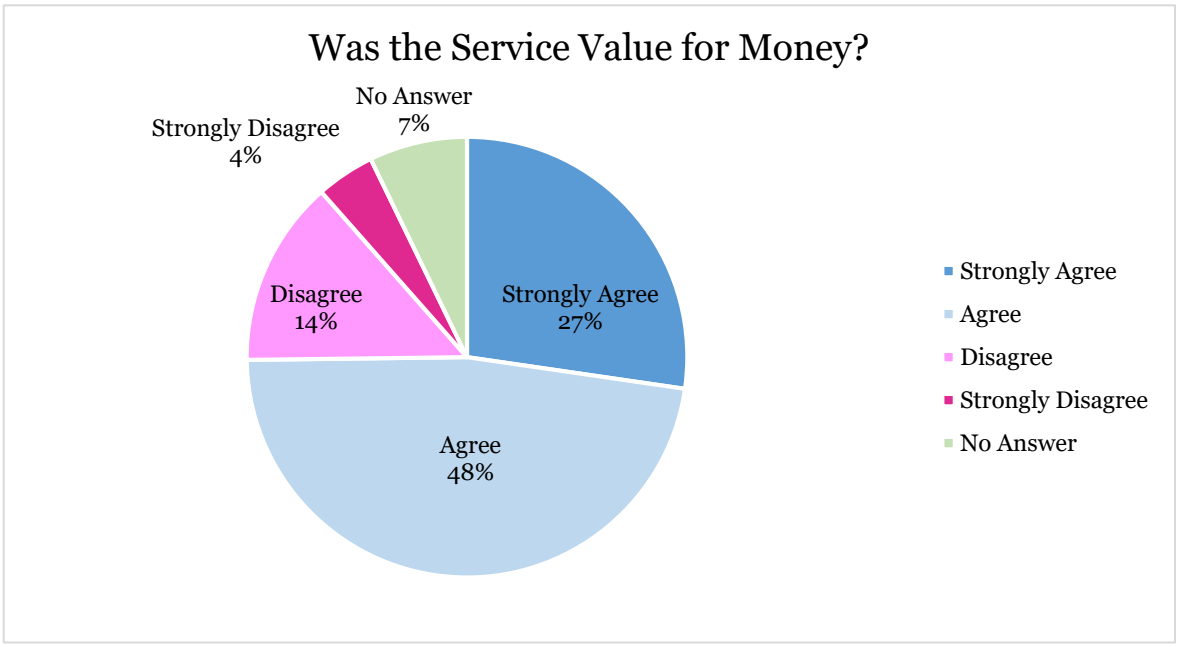
Respondents were asked about the quality of their care at the Dean Clinic following assessment. Service users were offered a number of statements describing their care which they were asked to endorse.

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	122	87.8	6	4.3	3	2.2	0	0	8	5.7
Treated with dignity & respect	125	89.9	3	2.2	5	3.6	1	0.7	5	3.6
Confidentiality was protected	123	88.5	4	2.9	5	3.6	0	0	7	5.0
Privacy was respected	120	86.3	7	5.0	5	3.6	0	0	7	5.1
Staff were courteous	125	89.9	5	3.6	2	1.4	1	0.7	6	4.4

Felt included in decisions about my treatment	103	74.1	13	9.4	8	5.8	0	0	15	10.7
Trusted my doctor/therapist/nurse	114	82	9	6.5	6	4.3	0	0	10	7.2
Appointments were flexible	89	64	15	10.8	22	15.8	0	0	13	9.4

Graph: Service Users response to question 'In your opinion was the service you received value for money?'



How would you rate the Dean Clinic facilities?

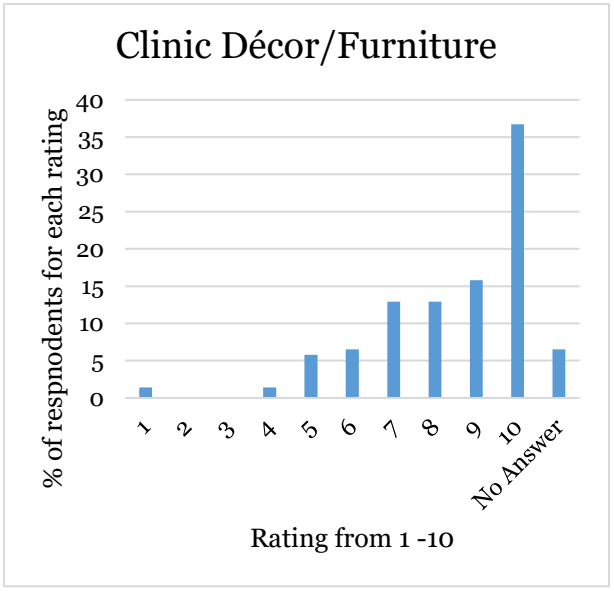
Respondents were asked to rate Dean Clinic facilities on a scale of one (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held positive opinions of the Dean Clinic facilities, with all means ranging close to a rating of 7.5. Furthermore, the standard deviation was below four across all four areas showing small variation between responses.

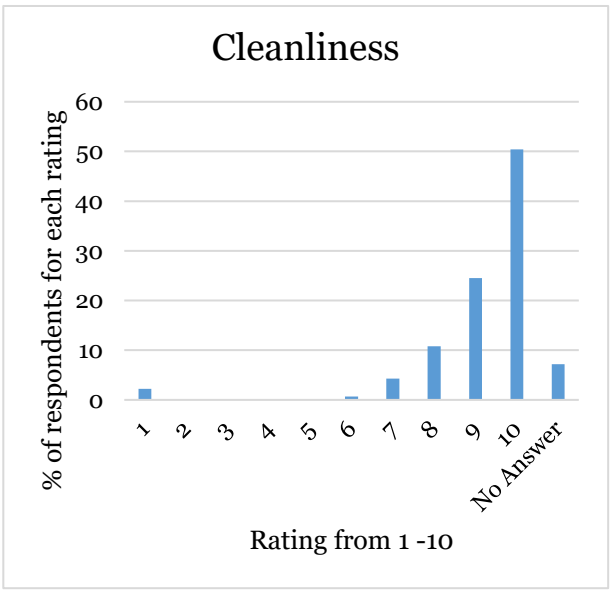
Table: Mean and standard deviation of respondents' scores of Dean Clinic facilities

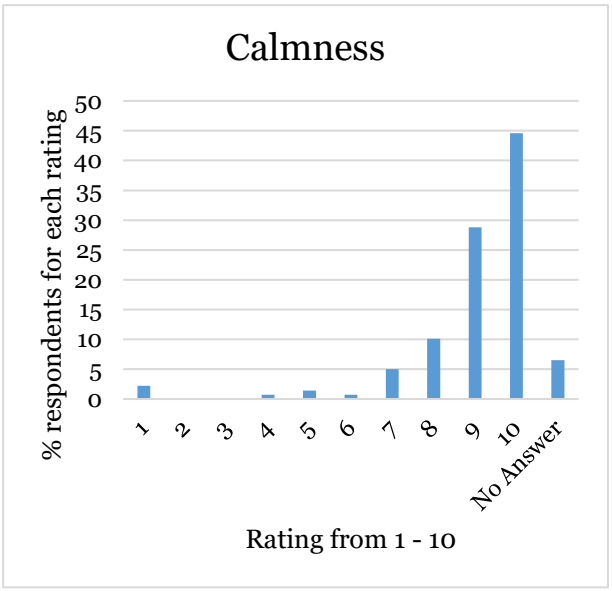
Rate the following in relation to the Clinic...	N	Mean (μ)	Standard Deviation (∂)

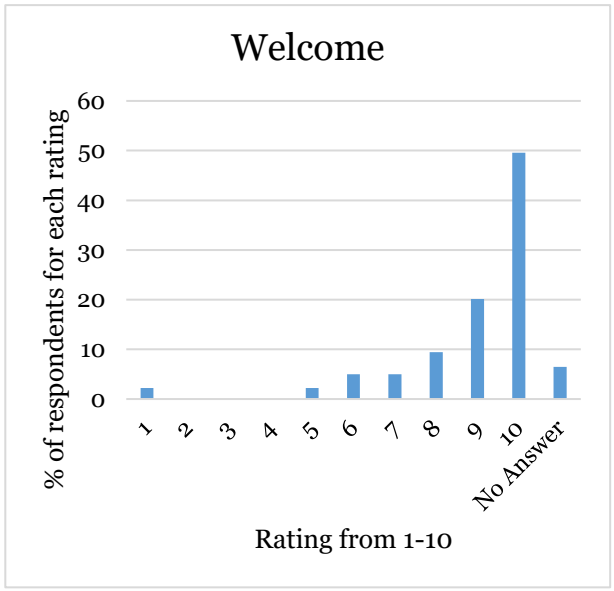
Décor/Furniture	130	8.32	1.90
Cleanliness of Clinic	129	9.12	1.55
Calmness of environment	130	8.95	1.67
Welcome environment	130	8.88	1.78

Graph: Respondents' rating scores of facilities in Dean Clinic









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 one to 10, showing a mean score of 8.73 (N=129; SD=1.83).

Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 8.50 (N=129; SD=2.09).

Table: Respondents' ratings of a) care and treatment b) the overall Dean Clinic

How would you rate...?	Your Care & Treatment		The Dean Clinic Overall	
	n	%	n	%
1	3	2.2	5	3.6
2	0	0	0	0
3	1	0.7	2	1.4
4	0	0	1	0.7
5	3	2.2	1	0.7
6	6	4.3	4	2.9
7	7	5.0	13	9.4
8	21	15.1	19	13.7
9	28	20.1	30	21.6
10	60	43.2	54	38.8
No Answer	10	7.2	10	7.2
1-5	7	5.1	9	6.4
6-10	122	87.7	120	86.4
Total	139	100	139	100

Table: Mean and standard deviation of ratings of: a) care and treatment b) The Overall Dean Clinic

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	129	8.73	1.83
Overall, the Dean Clinic	129	8.50	2.09

Further service user views

Dean Clinic respondents were invited to answer three open-ended qualitative questions 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?

- “Genuinely feel both my doctor and therapist saved me, and I do not believe I would be as healthy today had I gone somewhere else for help.”
- “They were quick to act when I needed hospital care.”
- “Felt like I was listened to in relation to possible treatment options which was refreshing.”

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

- “The reception was extremely friendly and helpful.”
- “All staff were very nice welcoming which was particularly important when I was quite anxious and distressed.”
- “From the initial appointment, onward everyone has been very professional, welcoming and kind. The administrator as a point of contact has always been excellent and extremely understanding and excellent at reassuring you upon arrival. The same applies to the other members of reception. The consultant was also continuous to be very compassionate, extremely perceptive and we are extremely grateful for the help and support we have received along the way. Most recently the help and support from the CNM II also.”

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

- “It would be convenient if there was a clinic in the midlands.”
- “Not sure Sandyford and offices are the most appropriate setting particularly for adolescents’ mental health patients.”
- “Very grateful to you all, maybe advertise services more as only for my counsellor I wouldn't have heard about here and I know others who would've come if they know.”
- “I would like to design the rooms better more colour walls not the cream colour all over.”

5.1.4.2 Adult inpatient services

Demographics

Service users discharged between January and December 2019 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. Some 2,879

discharges were processed in 2019, with a total of 219 (7.6%) surveys being returned to SPMHS adult inpatient services.

Table: Number of adult inpatient surveys returned and discharges in 2019

Month	Surveys Returned	Discharges
January	18	230
February	35	201
March	25	230
April	8	227
May	20	295
June	16	228
July	8	220
August	17	266
September	14	213
October	21	254
November	2	232
December	35	283
Total	219	2879

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 'one to two weeks (30.6%), and 'three to four weeks' (21.5%), (see table below).

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

Waiting Time	n	%
<1 day	16	7.3
1-3 days	39	17.8
4-7 days	38	17.4
1-2 weeks	67	30.6
3-4 weeks	47	21.5

Don't know	6	2.7
No answer	6	2.7
Total	219	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 one hour, with 76.8% 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	168	76.8
1-2 hrs	33	15.1
2-3 hrs	11	5.0
3-4 hrs	1	0.5
>4 hrs	2	1.0
Don't know	2	0.9
No answer	2.9	1.8
Total	219	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 one to two hours (35.2%) and two to three hours (20.8%) (see table below).

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

Waiting Time	n	%
<1 hr	63	28.8
1-2 hrs	77	35.2
2-3 hrs	44	20.8

3-4 hrs	14	6.4
>4 hrs	8	3.7
Don't know	4	1.8
No answer	9	4.1
Total	219	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?	179	81.7	21	9.6	16	7.3	3	1.4
When you came to the Hospital did a member of the assessment team explain clearly what would be happening?	176	80.4	26	11.9	14	6.4	3	1.4
When you arrived on the ward, or soon afterwards, did a member of staff tell you about the daily routine on the ward?	169	77.2	36	16.4	13	5.9	1	0.5
Were you given written information about the Hospital and the services provided?	164	74.9	37	16.9	15	6.8	3	1.4

"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	185	84.5	8	3.7	8	3.7	4	1.8	14	6.3
I was involved in the development of my care plan	115	52.5	36	16.4	40	18.3	9	4.1	19	8.7
I was offered a copy of my care plan	143	65.3	14	6.4	45	20.5	7	3.2	10	4.6
I was involved in the review of my care plan	121	55.3	28	12.8	43	19.6	12	5.5	15	6.8

There was a focus on recovery in the care and treatment offered	157	71.7	23	10.5	23	10.5	6	2.7	10	4.6
My care plan is key to my recovery	129	58.9	49	22.4	24	11	5	2.3	12	5.4

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 ongoing work at MDT 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 ongoing on an organisational level through a regular morning lecture and information booklets provided to all service users on inpatient admission. This ongoing focus has produced positive results, for example, as can be seen above 84.5% reported that they understood what a care plan is, and 71.7% 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	169	77.2	12	5.5	36	16.4	0	0	2	0.9
Registrar	154	70.3	27	12.3	25	11.4	2	0.9	11	5.1
Key Worker	134	61.2	19	8.7	44	20.1	7	3.2	15	6.8
Nursing Staff	184	84	6	2.7	14	6.4	2	0.9	13	6
Psychologist	63	28.8	34	15.5	64	29.2	13	5.9	45	20.6
Occupational Therapist	104	47.5	28	12.8	43	19.6	14	6.4	30	13.7
Social Worker	80	36.5	30	13.7	39	17.8	23	10.5	47	21.5
Pharmacist	56	25.6	36	16.4	46	21	29	13.2	52	23.8
Other	53	24.2	24	11	33	15.1	24	11	85	38.7

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

Waiting Time	n	%
<1 week	29	13.3
1-2 weeks	29	13.2
2-3 weeks	16	7.3
>3 weeks	38	17.4
Not on programme	24	11.0
No Answer	83	37.8
Total	219	100.0

Tell us about your care…

Table: Respondents' experiences of the team during their inpatient 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	143	65.3	52	23.7	9	4.1	5	2.3	10	4.6
Treated with dignity and respect	142	64.8	46	21.0	14	6.4	3	1.4	14	6.4
Protected my confidentiality	156	71.2	45	20.5	5	2.3	2	0.9	11	5.1
Respected my privacy	150	68.5	44	20.1	7	3.2	3	1.4	15	6.8
Were courteous	151	68.9	54	24.7	5	2.3	2	0.9	7	3.2
Felt included when my team discussed medical issues at my beside / in my room	136	62.1	56	25.6	11	5.0	2	0.9	14	6.4
Respected me as an individual	148	67.6	46	21.0	11	5.0	3	1.4	11	5.0

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	84.9	19	8.7	3	1.4	11	5
Do you think you were given enough notice of your discharge from hospital?	193	88.1	17	7.8	2	1.0	7	3.1
Do you have a discharge plan?	148	67.6	45	20.5	17	6.8	9	5.1
Do you know what to do in the event of a further mental health crisis?	168	76.7	28	12.8	7	3.2	16	7.3

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?	199	90.9	12	5.5	1	0.5	7	3.1
Did you attend any of the activities in the evenings and at weekends?	162	74.0	50	22.8	1	0.5	6	2.7
Was there a range of activities that you could get involved in?	180	82.2	30	13.7	5	2.3	4	1.8
At the weekend were there enough activities available for you?	85	38.8	100	45.7	18	8.2	16	7.3

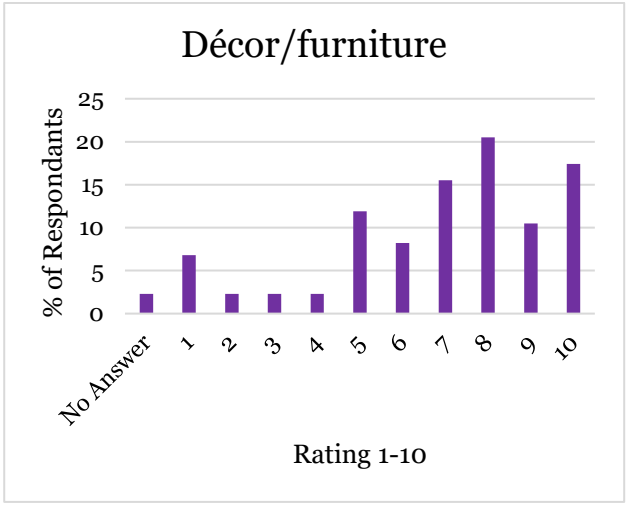
Most respondents felt that there was a range of activities they could get involved in (82.2%). However, 38.8% indicated that there were not enough activities available in the hospital at weekends.

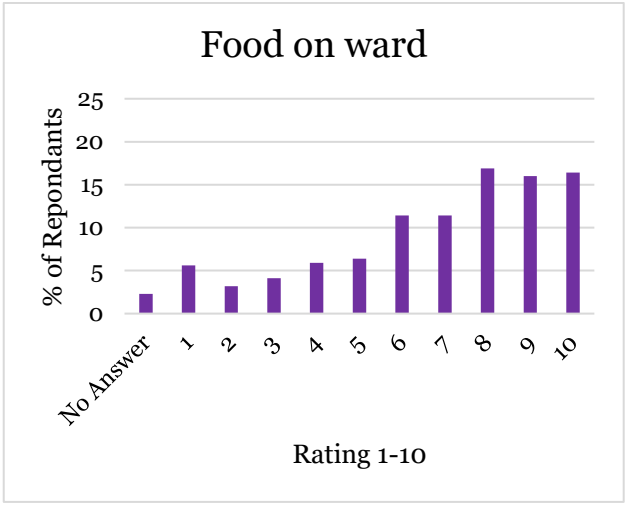
Tell us about your experience of hospital facilities...

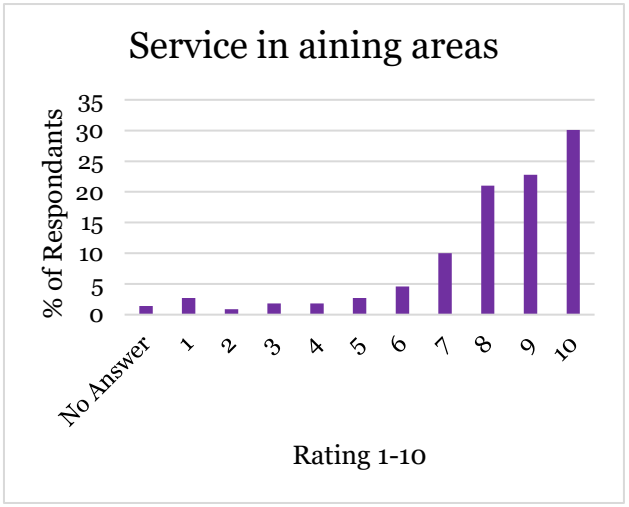
A series of questions asked respondents to rate hospital facilities on a scale of one (poor) to 10 (excellent). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the hospital facilities, with all means above or approaching seven. In particular, the service in cCleanliness of ward areas (8.43) and cleanliness of communal areas (8.39) received high scores as well. The standard deviation across most areas was close to two, indicating that there was significant variation in responses.

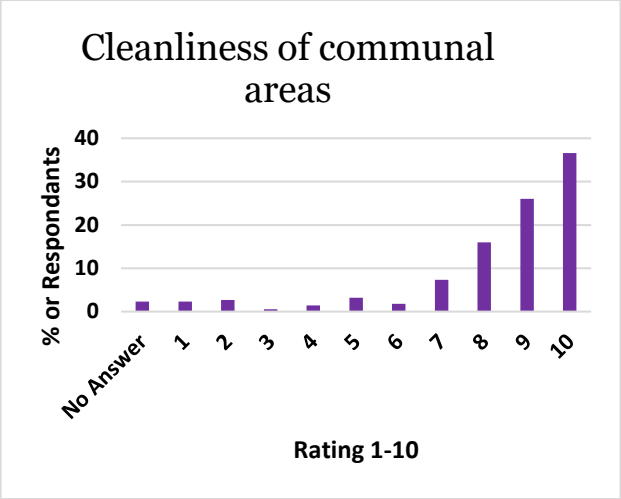
Table: Respondents' scores of hospital facilities

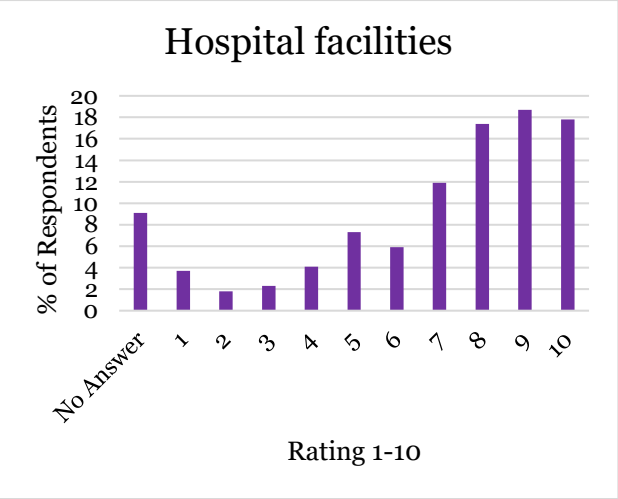
Rate the following in relation to the Hospital…	N	Mean (μ)	Standard Deviation (∂)
Décor/furniture	214	6.93	2.5
Food on ward	214	6.88	2.6
Service in ward dining areas	216	8.15	2.1
Cleanliness of ward areas	214	8.43	2.2
Cleanliness of communal areas	203	8.39	2.0
Hospital facilities	199	7.39	2.4
Garden spaces	211	8.21	1.9

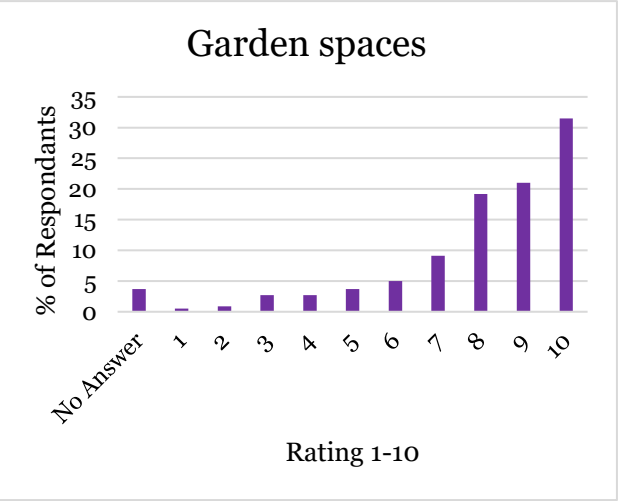

Décor/furniture
% of Respondants
25
20
15
10
5
0
No Answer
1
2
3
4
5
6
7
8
9
10
Rating 1-10


Food on ward
% of Repondants
25
20
15
10
5
0
No Answer
1
2
3
4
5
6
7
8
9
10
Rating 1-10


Service in aining areas
% of Respondants
35
30
25
20
15
10
5
0
No Answer
1
2
3
4
5
6
7
8
9
10
Rating 1-10


Cleanliness of communal areas
% or Respondants
40
30
20
10
0
No Answer
1
2
3
4
5
6
7
8
9
10
Rating 1-10


Hospital facilities
% of Respondents
20
18
16
14
12
10
8
6
4
2
0
No Answer
1
2
3
4
5
6
7
8
9
10
Rating 1-10


Garden spaces
% of Respondants
35
30
25
20
15
10
5
0
No Answer
1
2
3
4
5
6
7
8
9
10
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 SPMHS. The majority of respondents felt they had more positive views towards mental health difficulties in general (80.4%) and towards their own mental health difficulties (78.1%) and felt that they would share with others that they received support from SPMHS (66.7%).

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?	176	80.4	16	7.3	14	6.4	13	5.9
Are your views regarding your own mental illness more positive than they were?	171	78.1	24	11.0	12	5.5	12	5.4
Will you tell people that you have stayed in St Patrick's?	146	66.7	34	15.5	30	13.7	9	4.1

Overall views of SPMHS

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 one to 10, with a mean of 8.25 (N=217; SD=2.03). 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 8.27 (N=215; SD=2.11).

Table: Respondents' ratings of care and treatment and overall experience of hospital

How would you rate...?	...your care and treatment		...the hospital overall	
	n	%	n	%
1	3	1.4	5	2.7
2	2	0.9	4	1.8
3	6	2.7	4	1.8
4	3	1.4	1	0.5
5	7	3.2	7	3.2
6	15	6.8	11	5.0
7	17	7.8	16	7.3
8	43	19.6	40	18.3
9	44	20.1	54	24.7
10	77	35.2	73	33.3
No Answer	2	0.9	4	1.4
1-5	21	9.6	21	10
6-10	196	89.5	194	88.6
Total	219	100.0	219	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	217	8.25	2.03
The Hospital	215	8.27	2.11

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:

- I just like to say all the staff from the cleaners to the nurses and doctors were amazing
- I can actually say I loved my stay in St Pat's because I didn't need to pretend anymore, and people understood me for once
- The activities (particularly relaxation) have improved greatly. The compassion and care shown by those involved was extraordinary. They were patient and understanding
- My stay in Ed's was nothing but positive and has changed my view on mental health services
- My stay at St Pat's was excellent. I came in crying out for help and was mentally in a bad way. The care, especially from the nursing staff, was second to none. I was treated with the utmost respect, support, and only for St Pats, I feel I would be broken

Comments to learn from include:

- Boredom is a major problem, nothing to do in the evenings except for bingo twice a week, no creative activities like in St Pat's. Also, not all people can eat dinner in the middle of the day; sandwiches or roles would be a nice option
- I felt uninformed about the day-to-day routine on the ward. I felt that there wasn't anyone to talk to on the ward. My key worker was not appointed until my last week. There was no therapeutic intervention. I found the Depression Programme very basic and not useful
- Overall with relation to nursing care, I felt there was a lack of compassion and interaction. Nurses did not, by and large, introduce themselves and had little interest in interaction. Nurses were focused on check-ins re mood etc. in order to complete their report
- There is no air conditioning for the warm hot summer, have the air con on.

- I did not like the MDT meeting once a week, when you are sick it is very daunting to have to sit in front of three nurses, one registrar, a consultant, and two medical students. It would be better to have an one-to-one meeting sometimes with the consultant psychiatrist.

Q: Was there anything particularly good about your care?

- Amazing nurse staff who gave me wonderful support treating me with respect and dignity
- My psychiatrist and my psychologist were both caring and helpful during my recovery
- The mindful yoga and pottery were very good
- You were so well taken care of and given the necessary space and regular check-in's. The staff were super. I would highly recommend Pat's.
- Yes, I felt from the start my illness was attacked from all areas and directions from a variety of different people before the correct people for my care were chosen. Also, the follow-up sessions that were recommended were chosen carefully and are very good
- All of the support staff were excellent. The cleaning staff on my ward provided me with huge support. The food was very good. The morning lectures were very worthwhile
- Yes, my doctor, all the team, nursing staff, catering, cleaning staff, in my opinion, are beyond reproach. Angels without wings I think you all are. Thank you
- The care has been wonderful. I have suffered depression since I was a teenager. St Patrick's has achieved in the three months more than I achieved with outside help in a year
- Kindness and understanding of all staff members particularly nurses were amazing
- Medical care of the team, art and pottery, HCA activities, household catering and repair staff all good
- Felt I was listened to
- Even if I was irritable I was met with patience and the nursing staff were very kind people
- The Ward staff (Kilroot) were extremely caring and always available if required

- The courses were great from occupational therapy health, CBT and self-care programmes were all great. I've learnt a lot on how to cope with my condition
- The catering staff were always very friendly and dealt with individual needs.
- My consultant was insightful and "got me" very quickly having an assigned nurse each day was a particular comfort.

Q: What could we improve?

- More involvement with my key worker
- Rooms. People need modern spacious ensuite rooms. The hospital needs to be rebuilt. Current wards are not fit for purpose
- Talking and explaining more about medications and care to patients
- Some staff would benefit from training in dealing with those who are dealing with trauma. I understand it may often come from experiences, but I feel there may be ways to help those less experienced
- Introduce a quiet time at night. The TV can be on very late
- Tea and coffee early morning and during the night
- Communication between patient and consultant. Please get an ATM
- The entire discharge process did not reflect the care I was given during my stay. I think an exiting lecture would be very useful and would ease the transition.

5.1.4.3 Day services

SPMHS offers mental health programmes through the day service's Wellness and Recovery Centre. A range of programmes are offered which aim to support people experiencing recovery from mental ill-health and promote positive mental health. The total number of surveys returned in 2019 was 99. Some respondents attended multiple programmes at different times throughout the year, thus N = 183.

Day services service user satisfaction survey response rate

Month	Surveys distributed	Surveys returned
January	30	21

February	80	10
March	145	0
April	63	18
May	99	4
June	67	9
July	147	2
August	134	1
September	135	7
October	47	7
November	189	5
December	182	15
Total	1318	99

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
Recovery	15	15%
Mindfulness	13	13.5%
Other	25	26%
Depression	6	6.3%
St Edmundsbury	29	28.2%
Bipolar	1	1%
Eating Disorder	0	0
No answer	3	3%
Anxiety	4	4%
Radical Openness	0	0
Living Through Distress	1	1%
Alcohol Step Down	1	1%
Young adult	0	0

Pathways to Wellness	1	1%

The other programmes included in the table above, include: compassion-focused therapy, acceptance and commitment therapy, cognitive behaviour therapy, healthy self-esteem and WRAP.

The breakdown of respondents by county is illustrated in the table below.

Province	N	%
Leinster	88	88.9%
Connaught	2	2%
Munster	3	3%
Ulster	0	0
Don't want to say	6	6.1%
Total	99	100%

The majority of respondents had previous experiences attending SPMHS before attending a day programme. Respondents previous experiences with SPMHS are illustrated in the table below.

Service	N	%
Dean Clinic	37	37.4%
Inpatient stay	34	34.3%
Inpatient day programme	4	4%
Other day programme	8	8%
Not applicable	12	12.1%
Associate Dean consultation	1	1%
No answer	3	3%

Service user responses

Respondents' perceptions of the time they waited for communication from a member of the programme staff following their referral are outlined in the table below.

'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	7	7.1%
1-3 days	24	24.2%
4-7 days	29	29.3%
1-2 weeks	12	12.1%
2-4 weeks	15	15.2%
More than 4 weeks	8	8.1%
No answer provided	4	4%
Total	99	100%

Service users were asked about their experience of beginning the programme. The majority reported 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?	88	88.9%	3	3%	7	7.1%	1	1%
When you came to hospital did a member of day services explain clearly what would be happening?	89	89.9%	3	3%	6	6.1%	1	1%
When you commenced the programme did a member of staff explain the timetable?	89	89.9%	6	6.1%	3	3%	1	1%
Were you given a written copy of the timetable and other relevant information?	85	85.9%	9	9.1 %	5	5%	0	0

Respondents also generally reported an informed ending to the programme, with 98% agreeing that they knew when the programme was to end. 88.9% of respondents felt that the programme met their expectations and 86.9% felt that they know what to do in the event of a further mental health crisis. 79.8% of respondents reported that they had received information regarding the organisation's support and information service. This service can be an important one to be aware of for those who are transitioning from a more intensive to a less intensive period of care.

Tell us about your experience of finishing the programme

	Yes		No		Don't know		No answer	
	n	%	n	%	n	%	n	%
Did you know in advance when the programme was due to end?	97	98%	2	2%	0	0	0	0
Did the programme meet all your expectations?	88	88.9%	7	7.1%	2	2%	2	2%

As you prepare to complete the programme do you know what to do in the event of a further mental health crisis?	86	86.9%	7	7.1%	0	0	3	3.6%
Have you been given the details of the hospital support and information service?	79	79.8%	12	12.1%	5	5.1%	3	3%

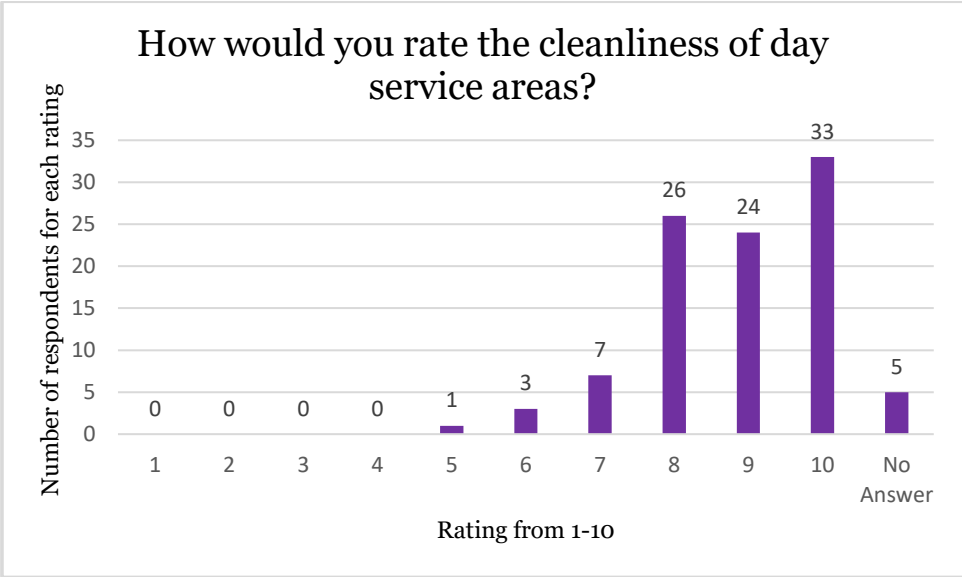
The service user satisfaction questionnaire also asks for service users' experiences of stigma after having attended SPMHS.

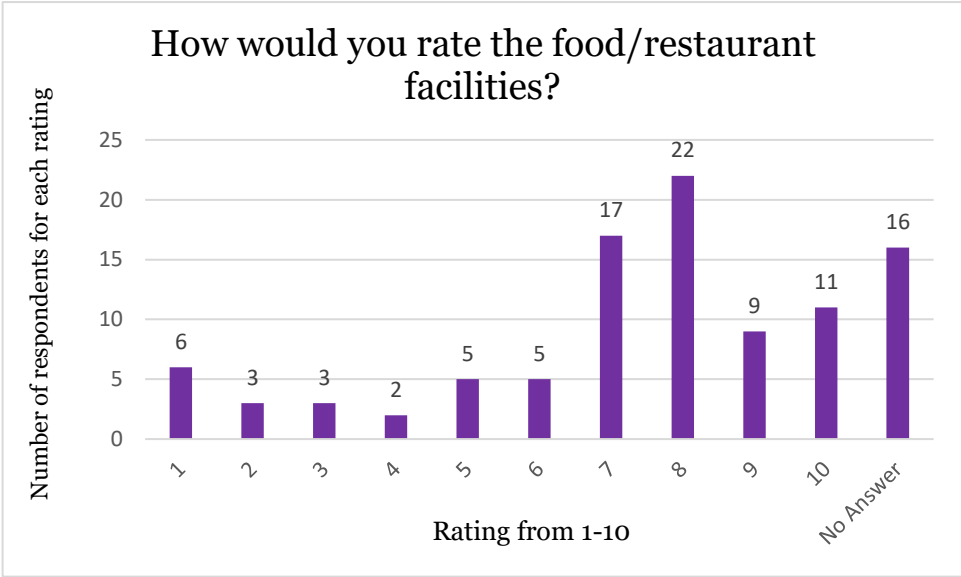
Tell us about your experience of stigma following your attendance at SPMHS

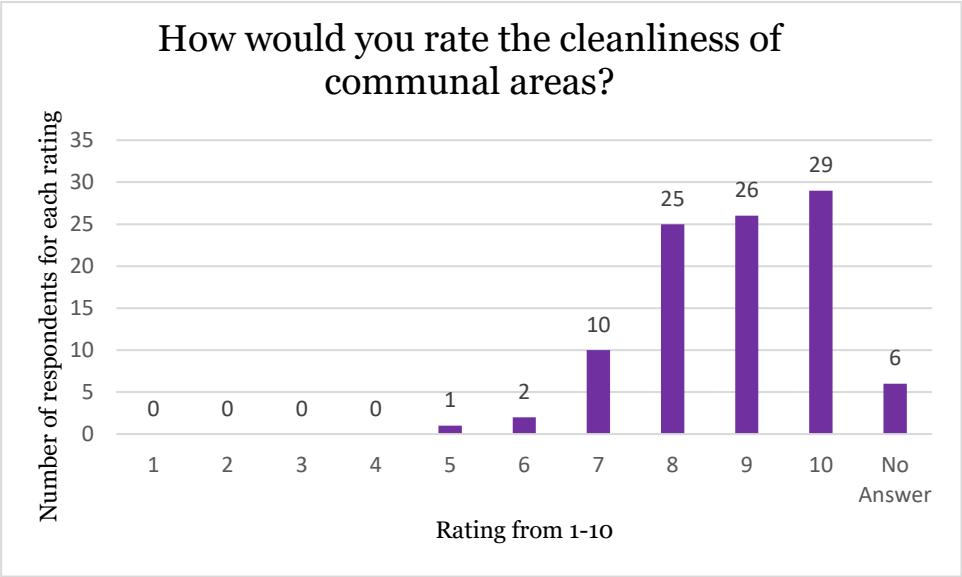
As you are prepared to leave the programme...	**Yes**		**No**		**Don't know**		**No answer**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Do you feel that your views regarding mental ill-health in general are more positive than they were?	89	89.9%	4	4%	5	5.1%	1	1%
Do you feel that your views regarding your own mental health difficulty are more positive than they were?	91	92%	4	4%	4	4%	0	0
Will you tell people that you have attended St Patrick's	65	65.7%	13	13.1%	21	21.2%	0	0

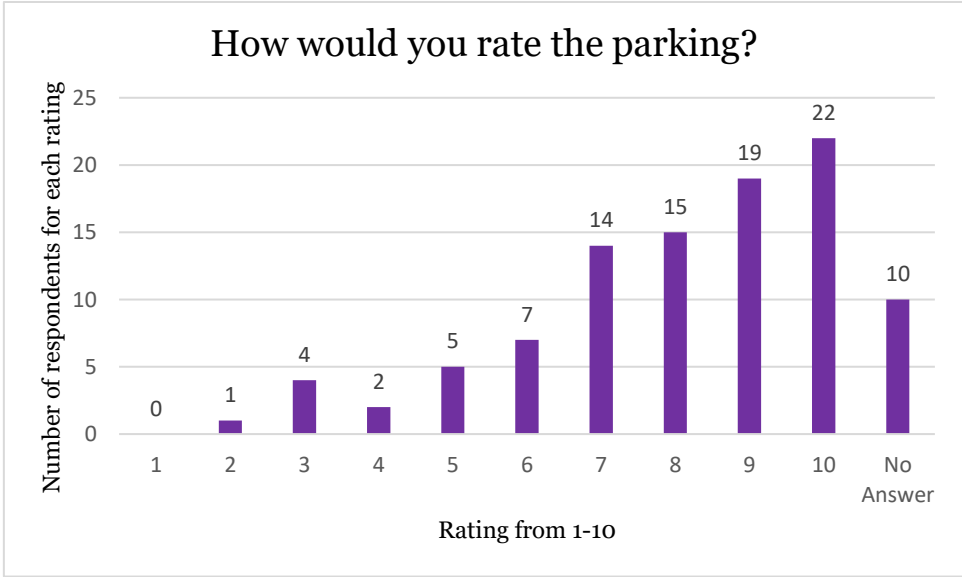
How would you rate the day services facilities?

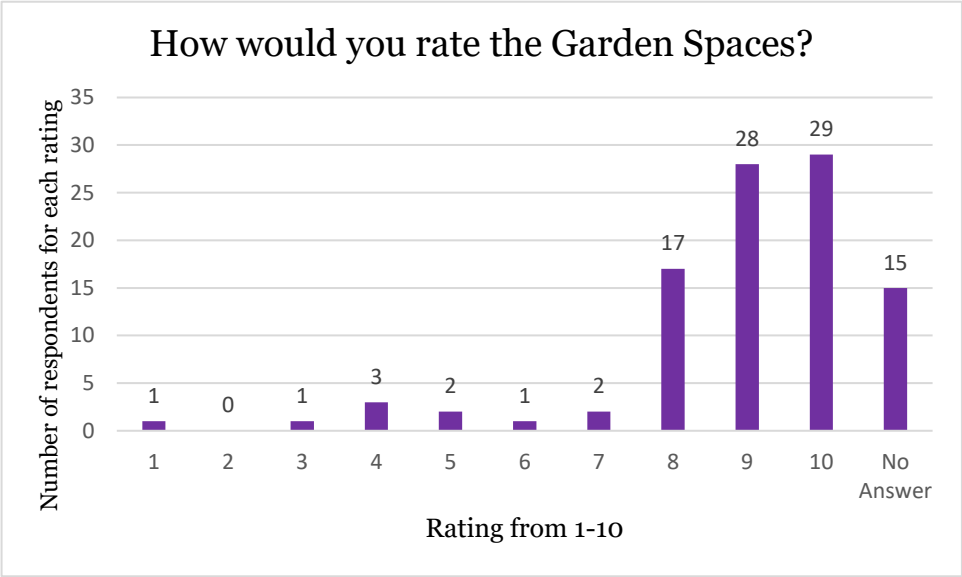
Respondents were asked to comment on their experiences of the facilities in the hospital, rating them on a scale of one to 10. For each of the facilities, the most endorsed scores were eight, nine and 10 (please see the following graphical depictions).

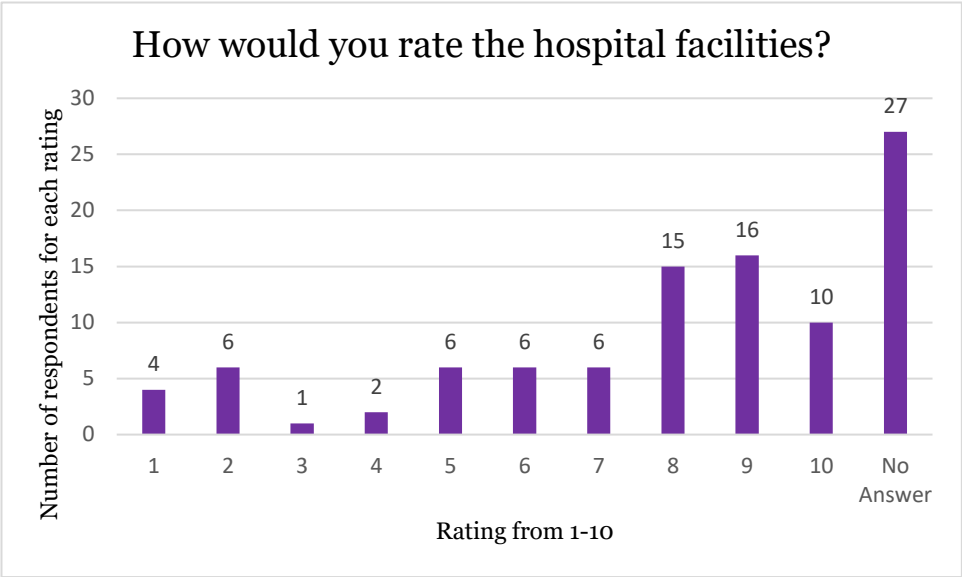

How would you rate the cleanliness of day service areas?
Number of respondents for each rating
0 0 0 0 1 3 7 26 24 33 5
1 2 3 4 5 6 7 8 9 10 No Answer
Rating from 1-10


How would you rate the food/restaurant facilities?
Number of respondents for each rating
6 3 3 2 5 5 17 22 9 11 16
1 2 3 4 5 6 7 8 9 10 No Answer
Rating from 1-10


How would you rate the cleanliness of communal areas?
Number of respondents for each rating
0 0 0 0 1 2 10 25 26 29 6
1 2 3 4 5 6 7 8 9 10 No Answer
Rating from 1-10


How would you rate the parking?
Number of respondents for each rating
0 1 4 2 5 7 14 15 19 22 10
1 2 3 4 5 6 7 8 9 10 No Answer
Rating from 1-10


How would you rate the Garden Spaces?
Number of respondents for each rating
35
30
25
20
15
10
5
0
1
0
1
3
2
1
2
17
28
29
15
1
2
3
4
5
6
7
8
9
10
No Answer
Rating from 1-10


How would you rate the hospital facilities?
Number of respondents for each rating
30
25
20
15
10
5
0
4
6
1
2
6
6
6
15
16
10
27
1
2
3
4
5
6
7
8
9
10
No Answer
Rating from 1-10

Respondents were also asked to rate their care and treatment, and SPMHS day services overall, on a scale of one to 10.

How would you rate...?	...your care and treatment		...the hospital overall	
	n	%	n	%
1	0	0	0	0
2	0	0	0	0
3	0	0	0	0
4	1	1	2	2
5	3	3	2	2
6	4	4	3	3
7	2	2	5	5
8	19	19	23	23
9	27	27	23	23
10	42	43	41	41
No Answer	1	1	0	0
1-5	4	4	4	4
6-10	94	95	95	95
Total	99	100	99	100

Further service users views

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

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

Positive comments include:

- "I feel thankful for the help and understanding that all staff have shown."
- "I found all my visits to day care to be excellent. Very professional, appropriate, and helpful."

- “I felt it gave me a great perspective of my mental health. I have the tools now to cope with my health anxiety. It has been a long road but well worth it.”
- “I feel I am not alone.”
- “All staff members were genuinely considerate, polite, respectful, and very caring.”
- “My experience has been great. I will recommend anyone in my situation to ask their consultant for a referral to SPMHS. I felt treated with care compassion by all the staff. Great professionalism as I said, highly recommended it!”

Comments to learn from include:

- “Need more warning about pained exercises in group. Disconnect between what was happening in St Pat‘s and St Edmundsbury, consultant had not read that ACT had started.”
- “Facilitators could challenge participants who go off topic.”
- “The through traffic in St Ed‘s is difficult, perhaps a one-way reception. There aren’t enough day services or enough in the evening. Most people are trying to keep jobs and evening courses would help.”
- “There needs to be more structure. No clear module descriptor/agenda/timetable for the 12 weeks was provided. Time was managed very poorly. The weeks were very repetitive in terms of content. There didn’t seem to be any real coherence to the programme.”
- “For people working in the city 5.30pm is an early starting time.”

Q: Was there anything particularly good about your care in day services?

- “The people I met were so understanding and professional.”
- “The group were engaging and supportive. The facilities were great, always clean and inviting.”
- “The people were extremely knowledgeable and kind.”
- “Structured but relaxed. Friendly and supportive.”

- “Great handouts. Great skills and tools. Rolled out and practised great workshops and skills in class and activities to use at home and practice reviewed weekly so we have to show we practised them.”
- “They helped me focus on the positives which I found very helpful.”
- “I felt at ease, less inadequate more 'normal’. I did the work and some days takes a lot of my energy but so worthy. I hope with the aftercare programme I will keep improving. Although I repeated this programme I noticed that 10 weeks were not enough.”

Q: What could we improve about your experience of day services?

- “Air conditioning and more toilets please.”
- “Perhaps a clearer explanation at the start of how all the various items tie together.”
- “Access to canteen for lunch.”
- “More evening programmes. Aftercare programmes for example, for mindfulness.”
- “More weekend and evening programs so as not to interfere with work.”
- “Ensure ‘non-speakers’ continue to speak up. Focus even more on thoughts and how mindfulness can help.”
- “To have some courses available at the weekend. I would love to do an ACT course but can't miss days from work each week.”
- “Shop would be more useful than a vending machine.”
- “I would like brighter colors in the day service rooms - Its very dull (the walls).”

5.2. Willow Grove Adolescent Unit service user satisfaction survey 2019

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

The MDT are committed to ongoing 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 2019.

5.2.1. Methodology

Willow Grove is part of the Quality Network of Inpatient Child and Adolescent Mental Health Services (QNIC), 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 QNIC.

5.2.1.1. Respondents

Parents and young people were asked to complete this measure on the day of discharge. 67 young people and 95 parents/carers completed the questionnaire. Response rates for service users were 74%. 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 up 10.5% and 25% respectively in 2019 compared with 2018, where responses were provided from 56 young people and 55 parents/carers.

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 of the unit, the therapeutic services offered, the ability of the service to support young people and parents to 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 one - very unhappy - to five - very happy. The young person's questionnaire also included a five-point Likert scale ranging from one - very poor to five - '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 (ie. 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. Consequentially, 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 reported that they were pleased or very pleased with the service. The majority of median responses for young people were a five - 'very happy' (46.3%), followed by four - 'happy' (34.3%) and three - 'mixed' (14.9%). 4.5% of young people reported that they were unhappy with the service. For the parents/carers, the most common response across questions was five - 'very happy' (62.4%), followed by four - 'happy' (32.3%) and three 'mixed' (5.3%).

The least positive answer given by service users was in relation meals provided, whereas parents/caregivers rated this more favourably. Service users rated five - 'very happy' on the confidentiality of the service and four - 'happy' on items including experience of accessing the service, overall atmosphere of the unit and safety of the unit. Parents/caregivers rated five - '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 five - 'very happy' for experience of care and treatment.

Table: Median responses to Willow Grove service user satisfaction questionnaire

Please tell us how satisfied you were with aspects of our service	Median rating

	Young person	Parent/ Carer
Experience of accessing the service	4	4
Information received prior to admission	3	5
Information provided by St Patrick's 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	4	5
The cleanliness/ appearance of the unit	4	4
The meals provided	3	4
Visiting arrangements	4	5
Safety arrangements on the unit	4	5
Experience of care and treatment	5	5
Access to group therapy	4	5
Access to individual therapy	4	4
Access to leisure activities and outings	4	4
Access to a range of professionals	4	5
Access to key workers/allocated nurse	4	5
Access to educational support	4	4
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	5
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	4	5
Your preparation for discharge	4	N/A
Weekend/midweek therapeutic leave arrangements	4	4
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	4	4
Provision of family support	4	4
Opportunity to attend parents support group	N/A	4
Opportunity to attend Positive Parenting Course	N/A	4
Was your child's stay helpful in addressing mental health difficulty?	N/A	4
Providing you with Skills to manage your mental health	4	N/A

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 adolescents and nurses making sure you are safe."
- "Really well trained and caring staff, group bonding and activities, routine is well laid out, regular meetings with keyworkers and one-on-ones, entertainment, openness and honesty between carers and patient, confidentiality."
- "The group members for understanding and the nursing staff."
- "Having people to talk to that can relate to you in a way."

- "My individual therapy and dietician was very helpful. Group outings were very fun and the cooking/baking and pottery group."
- "The structure and atmosphere of the group."

Parents/caregivers:

- "Team is very professional and supportive. This was the best care we have seen over the 2+ years. Thank you to everyone on the programme for all the help and support."
- "Professional care, family atmosphere. People are so kind and helpful, phone calls were never rushed."
- "The colour and all the art around that encouraged the young adults. The nurses were all very friendly and helpful. The bond the adolescents had."
- "All staff were very accommodating to the individual needs of our son which enabled him to engage in the programme. The respect and care shown was excellent and a great comfort at a difficult time."

Q: What did you dislike about the unit?

Young people

- "We didn't get out much, which wasn't nice because we were all just inside a lot."
- "Sometimes not feeling like I could vocalise problems or have a say, urgency and pressure around school return, sometimes appointments would be forgotten about or cancelled last minute after being organised with key workers/family therapy/school."
- "Physical contact - overcontrolling and partially unnecessary."
- "I didn't have key working every night. Some of the meals weren't that nice. We need to leave the unit more. Some of the groups only take five to 10 minutes when they are given an hour."
- "One person out at smoking area at a time. Staying the full half hour for meals"

Parents/ caregivers

- “Did not dislike anything but think it would have helped to bring our son into family therapy sessions earlier than third one.”
- “Obviously, no parent wants their child in an inpatient unit but the emphasis on regular education system annoyed us a little. Please be more open to other ways of educating children. Some do not thrive in mainstream despite their ability. Bear in mind for future clients there are other paths to education - ie. PLC etc.”
- “Would have really benefitted from follow-up care from this team.”
- “Just the timing, when our daughter was admitted a lot of services weren’t available to her. Understandable though as it was Christmas.”

Is there anything you would change about the unit?

Young people

- “Access to advocacy group.”
- “Allowed to listen to music on YouTube in free time.”
- “If the young people could go out more and to always keep 2 different groups for cooking a baking, a lot of people dislike so many people in a stuffy room.”
- “It’s really fantastic as is, but would be ideal if we could have more regular or pre-planned one-on-ones, or at least more group therapy because it would be really helpful to have extra support.”
- “Showing scars policy.”
- “Get something to make it smell nice as there is a strong smell of cleaning agents.”
- “An outside area where kids can go any time (supervised).”
- “More groups like WRAP that gives you coping mechanisms, soothing exercises, grounding exercises etc.”

Parents/caregivers

- “A slightly longer discharge process/return to school starting earlier in the programme.”

- “Learning how to deal with challenging situations in school including role play. Could have included school work as part of weekly routine, so habit is not needed to be rebuilt.”
- “Just in our son's case a return to school earlier in the process as this is his major issue.”
- “An update after MDT meetings - even if it's just to say all is well. Also, more regular information on BMI and weight. This seemed to depend on the keyworker and maybe it should be policy?”
- “Maybe a family meeting room for the evenings (visits) but the canteen in the main hospital works well.”
- “Should work more around social media. General follow up of one hour per week is a failure to patients.”
- “Could care staff wear name badges.”

SECTION 6

Conclusions

6.1. Conclusions

1. The SPMHS ninth 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 2019, consistent with the requirements of the Mental Health Commission's 2019 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. Outcome measures were added for three programmes in 2019. 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. There was a review in 2019 of the content and structure of the survey, as well as the processes around how and when completion by service users is requested. Following this review a new service user experience survey was introduced on 1 January 2020, with more concise and carefully selected questions, focused on the key aspects of services and the service user experience.

The COVID-19 pandemic has created huge challenges for the service users and staff of SPMHS in 2020. However, SPMHS is committed to continuing to deliver the highest standards of services and outcome measurement is continuing despite the challenges resulting from this pandemic.

SECTION 7
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7.1 References

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