St Patrick's
Mental Health Services

Outcomes Report 2020

Annual review of St Patrick's Mental Health Services' outcomes

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SECTION ONE

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 10th 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. The organisation delivered a full and comprehensive outcomes report in 2020, despite the challenges posed by the Covid-19 pandemic, demonstrating the commitment of all SPMHS staff to continuously measure and improve our services.

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).

In response to the national public health restrictions resulting from the Covid-19 pandemic, from March 2020, some of SPMHS services transitioned to remote participation via audio-visual technology. Remote delivery of care was offered across the hospital, day services and the community Dean Clinics, based on an assessment of needs of the service user. These technology-mediated interventions did not replace inpatient admission for those requiring care delivered on-site.

SPMHS introduced a homecare service, offering all the elements of our inpatient services, but provided remotely in the service users' own home. This involves the

highest levels of one-to-one mental health support, delivered remotely through daily or more frequent contact over videocall and other technological channels.

The 2020 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 2020. 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 Patrick's, Lucan (SPL) 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 2020, 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 TWO

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 2020.

2.1 Prompt Assessment of Needs

SPMHS made improvements to the way referrals are assessed in order to improve speed of access. This was in response to feedback from service users and referrers about the waiting times to access initial outpatient assessment in the Dean Clinics. Any referrals received for Dean Clinic assessment are transferred into the new Referral and Assessment 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 are used to provide the assessment. The choice of communication with the Referral and Assessment Service is based on the preference of the service user.

2.1.1. Outcomes of the PAON assessments

The table below provides the number and percentages of adult PAON assessments completed and the outcome of each PAON in 2019 and 2020. These results identify the immediate outcome of the PAON assessment. There was a decrease of 19% (number 241) adult PAONs in 2020, in comparision to PAONs completed in 2019. This decrease was due to low numbers of of PAON referrals received

throughout the second and third quarters of 2020, when GPs were seeing lower numbers of patients in person due to public health restrictions. The number of referrals increased in the fourth quarter.

	2019 Number	%	2020 Number	%
Dean Clinic referral	963	77.9%	798	80.2%
Discharge	183	14.8%	59	5.93%
Admission referral	90	7.3%	138	13.87%
Total	**1,236**	**100%**	**995**	**100%**

A discharge occurs when the service user did not receive 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.

2.2. Community-based services (Dean Clinics)

The SPMHS strategy, *Changing Minds. Changing Lives (2018-2022)*, reinforces the Organisation's commitment to the development of community-based mental health clinics. Since 2009, a nationwide network of multidisciplinary 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 Prompt Assessment of Needs (PAON) mental health assessments are offered through the Referral and Assessment Service aimed to improve access for service users.

Adult Dean Clinic services

2.2.1. Dean Clinic referrals volume

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 inpatient 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 2020, there was a total of 1,656 adult Dean Clinic referrals received from the centralised Referral and Assessment Service. This comparing with 1,784 referrals in 2019 represents a decrease of 7%. This decrease was due to a reduction of non-inpatient adult referrals from March to May 2020 during the initial period of the Covid-19 pandemic.

2.2.2. Dean Clinic referral source by province

The following table illustrates the geographical spread of Dean Clinic Referrals by Province from 2018 to 2020. The highest referral volumes continued to be from Leinster in 2020, with 1,212 referrals.

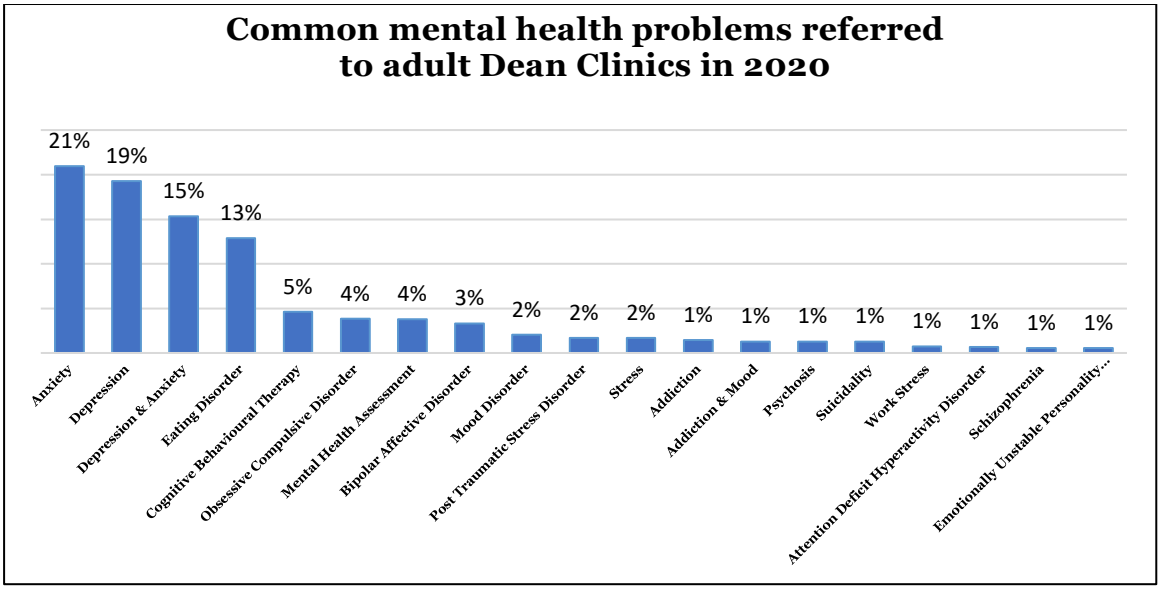
Year	Leinster	Munster	Connaught	Ulster	Other
2018	1124	280	195	34	0
2019	1238	292	215	39	0
2020	1212	241	177	26	0

2.2.3. Dean Clinic referrals by gender

The gender ratio of Dean Clinic Adult referrals for 2020 was 60% female to 40% male. This is perhaps due to females being more likely look for support than males.

2.2.4. Dean Clinic referrals by reason for referral

The chart below documents the common mental health problems referred to the Dean Clinics throughout 2020 and shows depression and/or anxiety and eating disorders as the most common reasons for referral.



2.2.5. Dean Clinic activities

The table below summarises the number of referrals and mental health assessments provided across the Dean Clinics since 2018. Not all referrals resulted in an assessment and 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 2020, 27.6% of referrals were assessed in comparison to 43% in 2019. This 15% decrease could be attributed to an unexpected decrease of assessment capacity due to the unplanned reduction of clinical resources. Additionally, the Covid-19 pandemic initially precluded technological-mediated assessments for service users in vulnerable cohorts eg. young adults.

Year	No. of Referrals	No. of Assessments
2018	1633	1012
2019	1784	770
2020	1656	457

A mental health assessment involves a comprehensive evaluation of the referred person's mental state carried out by a consultant psychiatrist and members of the multidisciplinary team. An individual care plan is agreed with the referred person following assessment that may include 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 2018 to 2020. Appointments include consultant reviews, clinical nurse manager II reviews, clinical nurse specialist reviews, cognitive behavioural therapy, occupational therapy, social work and psychology. There was an 3.8% increase in Dean Clinic appointments attended in 2020.

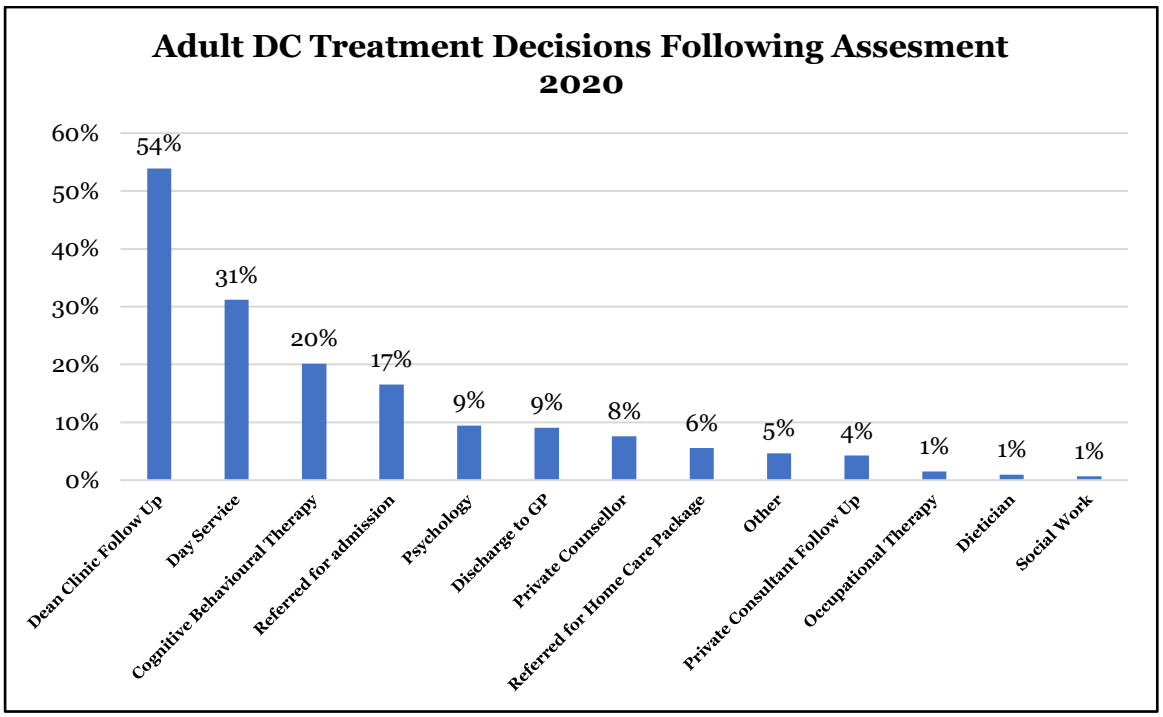
Year	Total No of Adult Dean Clinic Appointments
2018	15,801
2019	15,159
2020	15,730

The table below summarises the number of first-time inpatient admissions to SPMHS from an initial Dean Clinic referral or following a Dean Clinic assessment for the period 2018 to 2020. There was an increase of 12% in first-time admissions from the Dean Clinics.

Year	First Admission
2018	184
2019	174
2020	195

2.2.6 Dean Clinics: Outcome of assessments

The charts below summarises and compares the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics 2020.



2.2.7 Adolescent Dean Clinic services

The Adolescent Dean Clinics are based in Dublin and Cork. In 2020, there were a total of 710 referrals received for the Adolescent Service; an increase of 10% from 2019. Some 224 adolescent PAONs were performed in 2020. This represents a reduction of 10.4% in comparison with 251 PAONs in 2019. This reduction could be attributed to a reduction in adolescent referrals between March to May 2020 in the initial period of Covid-19 pandemic. Some 305 of the Adolescent Service referrals were referred to the Adolescent Dean Clinics in 2020, which was on par with the number of referrals 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 2018. The highest referral volume is from Leinster.

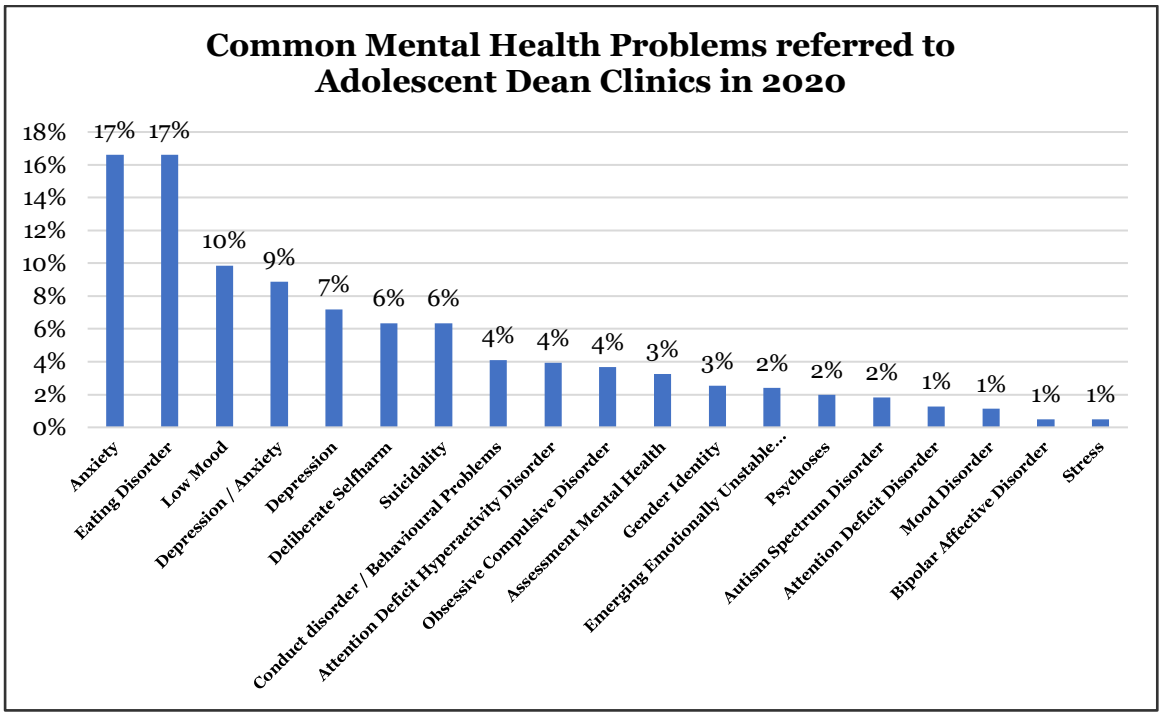
Year	Leinster	Munster	Connaught	Ulster	Other
2018	358	143	20	14	0
2019	425	199	17	10	0
2020	509	162	25	14	0

2.2.9 Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic adolescent referrals for 2020 was 70% female to 30% 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 2020. Depression, anxiety disorders, mood disorders and deliberate self-harm were the primary reasons for referral.



2.2.11 Dean Clinic activities

All referrals to the adolescent Service are centrally received and reviewed by the clinical team. The table below summarises the total number of referrals received by

the adolescent service and details the number of referrals sent to the adolescent Dean Clinics and the mental health assessments provided across the adolescent Dean Clinics in 2020. Not all referrals result in an assessment due to service user already under the care of another service; non-attendance of assessment appointments; decline of the assessment offered and/or may be referred for an admission assessment. In addition, service users may have been referred to several services and opted to take a local service. Parental consent is required prior to adolescent assessments taking place.

Year	Total No. of Referrals to Adolescent Service	No. of Referrals to Dean clinics	No. of Assessments in the Dean clinics
2018	606	327	130
2019	651	306	144
2020	710	305	113

The 6% decrease in the Adolescent Dean Clinic assessments is attributed to the Covid-19 pandemic initially precluding technological-mediated assessments for service users in vulnerable cohorts eg. adolescents.

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 adolescent's recovery.

The 2020 total number of adolescent Dean Clinic appointments provided by the Adolescent Dean Clinics nationwide – summarised in the table below - demonstrates a decrease of 8.3%. This decrease could be attributed to the unexpected and unplanned reduction of clinical resources. Appointments include consultant reviews, clinical nurse manager reviews, nurse practitioner

appointments, cognitive behavioural therapy, occupational therapy, social work, psychology and dietetic services.

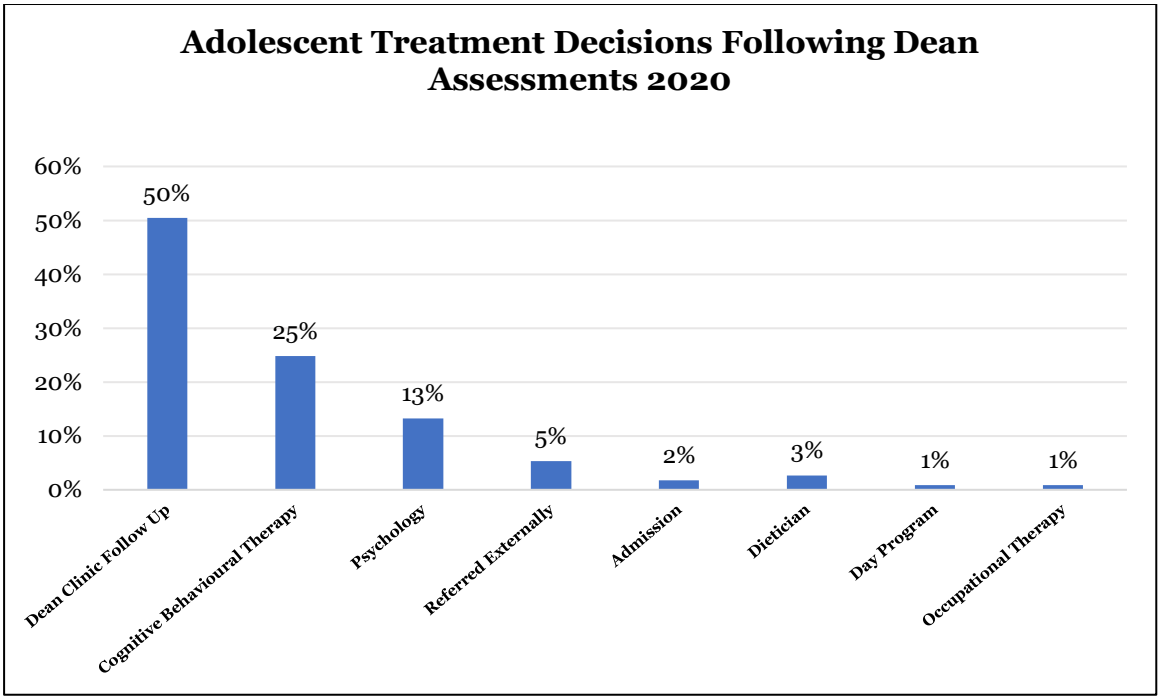
Year	Total No. of Dean Clinic Adolescent Appointments
2018	1,983
2019	2,352
2020	2,156

The total number of admissions to Willow Grove Adolescent Unit in 2020 was 88. This presents an increase of 24% in comparison to 2019. The table below summarises the number of first-time inpatient admissions to Willow Grove following an Adolescent Dean Clinic assessment from 2018.

Year	First Admission
2018	76
2019	71
2020	88

2.2.12 Dean Clinics: Outcome of assessments

The chart below summarises the treatment decisions recorded from individual care plans following initial assessment in Adolescent Dean Clinics in 2020.



2.3. SPMHS' inpatient care and Homecare

In response to the national public health restrictions resulting from the Covid-19 pandemic, from March 2020 SPMHS introduced a Homecare service, offering all the elements of our inpatient services, but provided remotely in the service users' own home. This involves the highest levels of one-to-one mental health support, delivered remotely through daily or more frequent contact over videocall and other technological channels. Some service users only accessed either inpatient admission or Homecare, but a significant percentage of service users transitioned between both these care options. Therefore, the admission rates, length of stay and ICD code information presented in this section includes service users admitted for inpatient stay; Homecare; and those that accessed both care options within a single admission.

SPMHS comprises three separate approved centres including St Patrick's University Hospital (SPUH), with 241 inpatients beds; St Patrick', Lucan (SPL), with 52 inpatient beds; and Willow Grove Adolescent Unit (WGAU), with 14 inpatient beds. On 7 December, 2020, adolescent capacity was increased to facilitate two additional young people on Homecare admission. Therefore, since 7

December, 2020, the Willow Grove unit can provide care for 16 young people for Homecare or Inpatient care, with a maximum inpatient bed capacity of 14 beds.

In 2020, there were a total of 3,182 inpatient admissions across the organisation's three approved centres compared to 2,954 for 2019.

2.3.1. SPMHS inpatient admission rates

The following analyses summarises inpatient admission information including gender ratios; age and length of stay (LOS) distributions across the three SPMHS approved centres; SPUH, SPL and WGAU for 2020.

The table below shows inpatient admission numbers and the percentage rates for male and female admissions. In 2020, 64.2% of admissions across all three approved Centres were female, compared to 60.9% in 2019 and 61.9% in 2018.

No. of Admissions (% of Admissions) 2020				
	SEH	**SPUH**	**WGAU**	**Total**
Female	410 (64.0%)	1,547 (63.6%)	85 (79.4%)	2,042 (64.2%)
Male	231 (36.0%)	887 (36.4%)	22 (20.6%)	1,140 (35.8%)
Total	**641 (100%)**	**2,434 (100%)**	**107 (100%)**	**3,182 (100%)**

The table below shows the numbers and percentages of admission care/treatment days delivered in 2020, providing a breakdown of the inpatient care days versus the Homecare days.

No. (%) of Inpatient Admission Days & Homecare Admissions Days 2020			
	Total Adult	**WGAU**	**Total**
Homecare Admission Days	17,775 (18%)	1,143 (22.5%)	18,918 (18.2%)
Inpatient Admission Days	81,221 (82%)	3,936 (77.5%)	85,157 (81.8%)

Total Admission Days	98,996	5,079	104,075

The table below shows the average age of service users admitted across the three approved centres was 47.33 years in 2020. This compares to a figure of 48.53 years in 2019. The average age of adolescents admitted to WGAU was 15.38 years in 2020, as compared with 15.63 years in 2019. The average age of adults admitted to SPL was 51.72 years in 2020 and 55.30 years in 2019. Finally, the average age of adults admitted to SPUH was 48.45 years in 2020 compared with 48.89 years in 2019.

Average Age at Admission 2020

	SEH	SPUH	Total Adult	WGAU	Total
Female	51.15	49.17	49.46	15.27	47.36
Male	52.59	47.32	48.11	15.78	47.28
Total	51.72	48.45	48.93	15.38	47.33

2.3.2. SPMHS inpatient length of stay 2020

The following tables present the 2020 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 for adults

2020 Adults	Number of Discharges	Percentage
Under 1 week	551	18.1%
1 -<2 weeks	331	10.9%
2-<4 weeks	630	20.7%

4-<5 weeks	304	10.0%
5-<6 weeks	319	10.5%
6-<7 weeks	232	7.6%
7-<8 weeks	167	5.5%
8-<9 weeks	137	4.5%
9-<10 weeks	106	3.5%
10-<11 weeks	77	2.5%
11 weeks -< 3 months	87	2.9%
3-<6 months	92	3.0%
6 + months	10	0.3%
Total Number of Adult Discharges 2020	3,043	100.00%

SPMHS length of stay for adolescents (WGAU)

2020 WG	Number of Discharges	Percentage
Under 1 week	1	1.0%
1 -<2 weeks	5	4.9%
2-<4 weeks	11	10.7%
4-<5 weeks	9	8.7%
5-<6 weeks	13	12.6%
6-<7 weeks	13	12.6%
7-<8 weeks	9	8.7%
8-<9 weeks	11	10.7%
9-<10 weeks	8	7.8%
10-<11 weeks	6	5.8%
11 weeks -< 3 months	11	10.7%
3-<6 months	6	5.8%
Total Number of Adolescent Discharges 2020	103	100%

2.3.3. SPMHS analysis of inpatient primary ICD diagnoses (for all inpatients discharged in 2020)

The table below outlines the prevalence of diagnoses across SPMHS' three approved centres during 2020 using the International Classification of Diseases Tenth 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 SPL combined. The data presented is based on all inpatients discharged from SPMHS in 2020.

SPMHS Analysis of Inpatient Primary ICD Diagnoses
(For all inpatients discharged in 2020)

SPUH: St Patrick's University Hospital. **SPL**: St Patrick's, Lucan. **WGAU:** Willow Grove Adolescent Mental Health Unit.

ICD Codes: Admission & Discharge For All Service Users Discharged in 2020	SPUH Admissions Number %		SPUH Discharges Number %		SPL Admissions Number %		SPL Discharges Number %		Total Adult Admissions Number %		Total Adults Discharges Number %		Willow Grove Admissions Number %		Willow Grove Discharges Number %	
F00-F09 Organic, including symptomatic, mental disorders	40	1.7	48	2.0	15	2.4	13	2.1	55	1.8	61	2.0	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	370	15.3	392	16.3	24	3.8	28	4.4	394	12.9	420	13.8	0	0.0	0	0.0
F20-F29 Schizophrenia,	173	7.2	185	7.7	26	4.1	26	4.1	199	6.5	211	6.9	0	0.0	0	0.0

schizotypal and delusional disorders																
F30-F39 Mood [affective] disorders	1060	44.0	1001	41.5	311	49.2	302	47.8	1371	45.1	1303	42.8	38	36.9	26	25.2
F40-F48 Neurotic, stress-related and somatoform disorders	451	18.7	400	16.6	171	27.1	171	27.1	622	20.4	571	18.8	25	24.3	24	23.3
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	79	3.3	82	3.4	9	1.4	9	1.4	88	2.9	91	3.0	28	27.2	25	24.3
F60-F69 Disorders of adult personality and behaviour	211	8.8	280	11.6	69	10.9	74	11.7	280	9.2	354	11.6	1	1.0	7	6.8
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	6	0.2	7	0.3	1	0.2	1	0.2	7	0.2	8	0.3		0.0	0	0.0
F90-F98 Behavioural and emotional disorders	3	0.1	1	0.0	0	0.0	1	0.2	3	0.1	2	0.1	11	10.7	21	20.4

with onset usually occurring in childhood and adolescence																
F99-F99 Unspecified	18	0.7	15	0.6	6	0.9	7	1.1	24	0.8	22	0.7	0	0.0	0	0.0
Totals	2411	100	2411	100	632	100	632	100	3043	100	3043	100	103	100	103	100

2.5. Day Services: Wellness & 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.

Since March 2020 all day programmes are delivered entirely via technology-mediated interventions. Clinical programmes are delivered by specialist multidisciplinary teams and focus primarily on disorder-specific interventions, psychoeducation and supports and include the following:

- Acceptance Commitment Therapy (ACT)
- Access to Recovery
- Addictions Programmes
- Anxiety Programme
- Bipolar Disorder Programme
- Compassion Focused Therapy
- Compassion Focused Therapy for Eating Disorders (CFTe)
- Coping with CovidDepression Programme
- Driving Assessment
- Eating Disorders Programme (EDP)
- Formulation Group Therapy
- Healthy Self Esteem Programme
- Living Through Distress Programme
- Living Through Psychosis Programme
- Mindfulness Based Stress Reduction (MBSR)
- Pathways to Wellness
- Psychology Skills for Adolescents
- Psychology Skills for Older Adults (Sage)
- Psychosis Recovery Programme
- Radical Openness Programme
- Recovery Programme

- Schema Group Therapy
- Transitions to Recovery
- Trauma Group Therapy

The table below in section 2.4.1 provides information on the types of services accessed by service users. In 2020, the WRC received a total of 1,618 referrals compared to a total of 1,799 for 2019, a year-on-year decrease of 10%. The decrease in referrals is in the context of the global Covid-19 pandemic. Of the day programme referrals for 2020, 260 were received from Dean Clinics. This compares to a total of 263 day programme referrals received from Dean Clinics in 2019.

2.5.1. Day patient referrals by clinical programmes

The following table compares the total number of day programme referrals to each clinical programme for 2019 and 2020. Referrals came from a number of sources, including GPs, SPMHS multidisciplinary teams, Dean Clinics and external mental health services. Of note, 260 of the referrals received in 2020 were from the Dean Clinics.

SPMHS Day Programmes	Total Day Patient Referrals 2019	Total Day Patient Referrals 2020
Access to Recovery	229	166
ACT	161	245
Addictions Programmes	265	289
Anxiety Programme	203	115
Bipolar Programme	29	68
Compassion Focused Therapy	82	29
CFT Eating Disorders	12	18
Coping with Covid (new)	0	32
Depression Programme	133	167

Driving Assessments	4	0
EDP	68	79
Formulation Group Therapy	18	58
Healthy Self Esteem	41	11
Living Through Distress	51	53
Living Through Psychosis	22	17
MBSR	70	69
Pathways to Wellness	157	31
Psychology Skills for Adolescents	12	0
Psychology Skills for Older Adults	20	15
Psychosis Recovery Programme	4	0
Radical Openness	28	14
Recovery Programme	157	109
Schema Therapy	1	7
Transitions to Recovery	11	9
Trauma Group Therapy	21	17
Total	**1,799**	**1,618**

2.5.2. Day patient referrals by gender

Of all referrals to day services in 2020, 1,014 (62.66%) were female; 601 (37.14%) were male; and three (0.29%) were other.

2.5.3. Day patient attendances for clinical programmes 2019-2020

In 2019, of the 1,799 referrals to a day programme, 1,582 day patients commenced day programmes. This compares to 1,618 referrals and 1,533 commencing a programme, in 2020. These registrations represented a total of 17,652 (2019) and 15,930 (2020) half-day attendances respectively. Therefore, in 2020, each registered day service user attended on average 10.39 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. In 2020, some service users disengaged from programmes due to poor technical ability or internet connectivity. Some service users have also deferred programme commencement until such time programmes can be delivered on-site.

Day patient attendances at clinical programmes

SPMHS Day Programmes	Total Day Patient Registrations 2019	Total Day Patient Registrations 2020	Total Day Patient Attendances 2019	Total Day Patient Attendances 2020
ACT	178	220	1134	1675
Access to Recovery	178	149	2307	1710
Addictions Programmes	144	253	1276	1485
Anxiety Programme	170	105	1278	1229
Bipolar Programme	38	58	191	322
Compassion Focused Therapy	81	53	683	616
CFT Eating Disorders	29	32	255	302
Coping with Covid (commenced 2020)	N/A	13	N/A	40
Depression Programme	131	147	1440	1148
Driving Assessments	4	0	4	0
Eating Disorders Programme	66	59	2043	1387
Formulation Groups	18	36	65	226
Healthy Self Esteem	35	0	183	17
Living Through Distress	81	59	1406	973
Living Through Psychosis	26	13	101	112

Mindfulness	62	50	254	252
Pathways to Wellness	86	85	1465	986
Psychology Skills for Adolescents	13	11	190	190
SAGE	35	10	295	128
Psychosis recovery	4	0	16	0
Radical Openness	43	37	1014	851
Recovery Programme	118	83	1562	1428
Schema Therapy	8	16	276	93
Transition to Recovery	25	10	101	68
Trauma Group Therapy	9	18	216	364
Transdiagnostic Adolescent CBT (commenced 2020)	N/A	16	N/A	71
	1,582	**1,533**	**17,652**	**15,930**

SECTION THREE

Clinical governance

3. Clinical governance and quality management

SPMHS' primary mission is to provide the highest standard of mental health service provision. Exceptional clinical governance is required to maintain and deliver this level of excellence. The Mental Health Commission inspects mental health services against a series of codes of practice; rules; and the Judgement Support Framework, a document developed to assist approved centres comply with the Mental Health Act 2001, and to promote continuous quality improvement. Since the establishment of the Mental Health Commission, SPMHS has maintained an exemplary record of consistently achieving the highest quality standards.

Other accreditation and peer review activities include:

- SPMHS' electroconvulsive therapy (ECT) clinic is accredited by Electroconvulsive Therapy Accreditation Service (ECTAS). ECTAS works ECT service providers to assure and improve the quality of the administration of ECT. ECTAS is a voluntary network which uses a system of peer review, using standards agreed by the network. In this way ECTAS seeks, over time, to support members to raise standards.
- WGAU participates in the Quality Network for Inpatient CAMHS (QNIC) annual external review process. QNIC was developed from the National Inpatient Child and Adolescent Psychiatry Study (NICAPS) in 2001. Approximately 99% of units in the UK are members, with international members in Australia, Estonia, Ireland, Norway and Turkey. QNIC demonstrates and improves the quality of child and adolescent psychiatric inpatient care through a system of reviews against standards. The process is supportive and enables information sharing between units that can otherwise be isolated. Each year, the standards are applied through a process of self-review and peer review.

3.1 Clinical governance measures summary

Governance Measure	2018	2019	2020
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**782**	**739**	**638**
Number of Incidents An event or ciscumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	**2352**	**2186**	**2349**
Root Cause Analyses & Focused Reviews commenced A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	**4**	**16**	**8**
Number of Section 23's – Involuntary detention of a voluntary service user A person who is admitted voluntarily may be subsequently involuntarily detained by staff of the Approved Centre (SPUH) - where the person indicates an intention to discharge from the Approved Centre but following examination is deemed to be suffering from a mental disorder. Section 23(1) allows the Centre to detain a voluntary person for a period not exceeding 24 hours for assessment.	**64**	**63**	**80**
% Section 23's which progress to Involuntary admission (Section 24 - Form 13 Admissions) Following Section 23 an examination by the Responsible Consultant Psychiatrist and a second Consultant Psychiatrist the person may be ultimately detained for ongoing treatment and care (Section 24) for up to 21 days.	**62% (39)**	**57% (36)**	**48% (39)**
Number of Section 14's – Involuntary Admissions An involuntary admission that occurs as a result of an application from a spouse or relative, a member of An Garda Síochána, an Authorised Officer or a member of the public and a	77	**32**	**35**

recommendation from a GP (the person is admitted as involuntary). A person subject to such an admission may decide to remain voluntarily.			
% of Section 14's which progress to Involuntary admission (Section 15 - Form 6 Admission) Where a service user, under Section 14 admission, does not wish to remain voluntarily and is deemed to be suffering from a mental disorder following assesment, that service user can be detained involuntarily for ongoing treatment and care (Section 15) for up to 21 days.	**91% (70)**	**75% (24)**	**88% (31)**
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.	**15**	**41**	**48**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**51**	**40**	**37**
Number of Section 60 – Medication Reviews Where medication has been administered to an involuntary patient for the purpose of treating their mental disorder for a continuous period of 3 months, the administration of that medicine cannot continue unless specific consent is obtained for the continued administration of medication or, in the absence of such consent, a review of this medication must be undertaken by a psychiatrist, other than the responsible consultant psychiatrist.	**18**	**9**	**22**
Number of Section 19 – Appeal to Circuit Court A service user has the right to appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him / her on the grounds that he / she is not suffering from a mental illness.	**6**	**3**	**2**

Number of Tribunals held	**104**	**71**	**93**
Mental Health Commission Reporting – Number of ECT Programme's (Signed off) in 2020	**166**	**161**	**108**
Mental Health Commission Reporting – Number of Physical Restraint Episodes (SPUH + SEH + WGAU)	**151**	**127**	**162**

3.2. Clinical audits

This section summarises the clinical audit activity for SPMHS in 2020. 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 2020, including those facilitated by clinical staff at local level and those carried out throughout the organisation led by various committees. SPMHS also participates in audits conducted by The Prescribing Observatory for Mental Health (POMH-UK). This is a subscription-based project that helps specialist mental health services across the UK and Ireland improve their prescribing practice. To achieve this, POMH-UK develop audit-based Quality Improvement Programmes (QIPs) that focus on specific topics within mental health prescribing. SPMHS participates in relevant POMH-UK audits on an ongoing basis.

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	Annual audit completed
2.	**Individual Care Plan and 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 MHC requirements of the Code of	Clinical Governance Committee	Re-audit completed

	Practice on Admissions, Transfers and Discharges to and from an Approved Centre, section 15.3.		
5.	**Prescribing Valproate for Bipolar Disorder** To ensure that Valproate prescribing practice in SPMHS is in line with local policy and conditions of the national pregnancy prevention programme, which is designated for women of childbearing potential if prescribed Sodium Valproate.	Clinical Governance Committee	Re-audit completed

No.	Audit Title	Audit Lead	Status at year end
6.	**ECT Processes** To ensure consistency and appropriateness of ECT documentation in accordance with the MHC Code of practice and the ECTAS guidelines as stated in SPMHS policies.	Clinical Governance Committee	Re-audit completed
7.	**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
8.	**Follow up of abnormal laboratory test results** To ensure that critical and notifiable laboratory test results are correctly communicated, documented and reviewed.	Clinical Governance Committee	Re-audit completed
9.	**Turnaround times of the MedLab Pathology laboratory test results** To ensure that laboratory test results are reported to the clinical teams of St. Patrick's Mental Health Services in a timely manner.	Clinical Governance Committee	Re-audit completed

10.	**Improving the quality of valproate prescribing in adult mental health services (audit facilitated by the Prescribing Observatory for Mental Health-UK*)** To assess adherence to best practice standards and benchmark the results with the UK Trusts.	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 Mental Health Commission guidelines, code of practice and rules.	Departmental Audits	Baseline audits and re-audits completed in 2020
12.	**Service review on Dean Clinic clinical data quality** To review the current practice on the quality of clinical records of Dean Clinics' appointments.	Clinical Governance Committee	Service review completed

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

No.	Audit Title	Audit Lead	Status at year end
13.	**Adherence to the organisations protocol on falls risk prevention interventions**	Falls Committee	Bimonthly audits completed

	To ensure that service users identified as a medium or high falls risk, or with episodes of falls, are managed appropriately to reduce any future fall incidents and to increase service user safety.		
14.	**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	Re-audit completed
15.	**Service review: Low dose antipsychotics prescribed as sedatives at night time** To determine the percentage of in-patients prescribed low dose antipsychotics at night time and provide feedback of findings to multidisciplinary teams.	Clinical Governance Committee	Service review completed
16.	**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.
17.	**Clinical characteristics and immediate outcome of patients who participate in the Depression Program in St Patrick's University Hospital (service review)** To describe the demographic and clinical profile of those attending the Depression Program.	Multidisciplinary Team	Service review completed

	To assess the impact of the Depression Program on depressive symptoms and to describe the relationship between personality features. To generate information to inform local decision-making.		

3.2.2. Key audit outcomes for 2020

- Clinical audit activity in SPMHS continued despite a range of challenges presented by the Covid-19 pandemic
- Routine audits designed to assess the level of key working and effective care planning in the three approved centres were continued in 2020. The audit findings confirmed that good practice was maintained during the pandemic
- A Clinical Audit Programme for audits and monitoring of compliance with regulations for approved centres continued during 2020 and all clinical and non-clinical departments were actively involved. The MHC inspection process confirmed that SPMHS were fully compliant with all regulations, rules and the codes of practice
- Two clinical audits on laboratory results confirmed that these are reported to clinical staff and followed up in a timely manner
- Clinical audit showed a high level of adherence to local protocols on performing pregnancy testing on admission
- The local clinical audit on sodium valproate showed that a small number of female inpatients of child-bearing potential were prescribed this drug. Nevertheless, there is a need to monitor and further enhance practice to meet the conditions of the National Pregnancy Prevention Programme designated to women of childbearing potential prescribed sodium valproate
- In addition to the local audit on prescribing valproate for bipolar disorder, SPMHS benchmarked its practice with UK mental health services by taking part in the POMH-UK audit on valproate prescribing practice in adult mental health services. The final reported is awaited.

SECTION FOUR

Clinical outcomes

4. Clinical outcomes

Clinical outcome measurement has been in place in SPMHS 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 2020

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: CGIS that is used to establish the severity of psychopathology at point of assessment; 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 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 SPL hospital admissions and admissions to WGAU.

A random sample was chosen from admissions to SPUH and SPL. The chosen sample size was minimum of 328 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		328	86
Admissions	First admission	41%	84%
	Re-admission	59%	16%
Average age ± standard deviation		51±19	15±1
Gender breakdown	Female	63%	78%
	Male	37%	22%

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		**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
F30-F39	Mood disorders	50%	51%	50%	33%	47%	38%
F40-F48	Neurotic, stress-related and somatoform disorders	13%	17%	19%	18%	25%	22%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	17%	13%	10%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	8%	7%	7%	1%	1%	0%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	4%	2%	3%	21%	19%	27%
F00-F09	Organic, including symptomatic, mental disorders	2%	1%	1%	0%	0%	0%
F60-F69	Disorders of adult personality and behaviour	7%	6%	9%	1%	2%	1%
F80-F89	Disorders of psychological development	0.3%	0%	1%	4%	1%	0%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	0%	1%	0%	22%	5%	12%

Other	1%	

4.2.3. Breakdown of baseline and final assessment scale scores

Table: Total adult service

CGIS - Baseline measure of severity of illness		2018 TOTAL	2019 TOTAL	2020 TOTAL
1	Normal, not at all ill	0%	0%	0%
2	Borderline mentally ill	1%	2%	1%
3	Mildly ill	9%	8%	12%
4	Moderately ill	43%	37%	39%
5	Markedly ill	27%	31%	28%
6	Severely ill	9%	12%	12%
7	Extremely ill	1%	1%	1%
	Not scored	9%	9%	7%

Table: Total adult service

CGIC – Final global improvement or change score		2018 Total	2019 Total	2020 Total
1	Very much improved	8%	7%	9%
2	Much improved	42%	44%	40%
3	Minimally improved	19%	23%	29%
4	No change	7%	5%	10%
5	Minimally worse	1%	0%	1%
6	Much worse	0%	0%	0%
7	Very much worse	0%	0%	0%
	Not scored	24%	21%	10%

Table: Willow Grove Adolescent Unit

Children's Global Assessment Scale		2018		2019		2020	
		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%	1%	0%	1%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	21%	0%	49%	1%	41%
60-51	Variable functioning with sporadic difficulties	0%	62%	0%	33%	1%	41%
50-41	Moderate degree of interference in functioning	41%	13%	25%	2%	17%	9%
40-31	Major impairment to functioning in several areas	46%	3%	59%	5%	67%	8%
30-21	Unable to function in almost all areas	13%	0%	12%	2%	9%	0%
20-11	Needs considerable supervision	0%	0%	4%	1%	2%	0%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	0%	3%	1%	6%	1%	0%
Mean ±SD		38±6	56±6	36±6	58±10	36±7	57±9
Median		39	58	38	61	35	59
Wilcoxon Signed Ranks Test:		Z=-7.525, p<.001		Z=-7.517, p<.001		Z=-5.973, p<.001	

4.2.4. Audit on completion rates of baseline and final CGI scores

4.2.4.1. Clinical audit standards

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		
	2018	2019	2020	2018	2019	2020
Baseline assessment scale score						
% of admission notes with recorded baseline scores	91%	91%	93%	100%	99%	99%
% compliance with clinical audit standard No 1	87%	85%	81%	100%	99%	97%
Final assessment scale score						
% of admission notes with recorded final scores	76%	79%	90%	100%	94%	100%
% compliance with clinical audit standard No 2	86%	89%	80%	100%	95%	97%

4.2.5. Summary of findings

- A sample was chosen out of a dataset of SPMHS' discharges for 2020
- A female to male ratio was 1.7:1 for adults and WGAU 3.5:1 for adolescents.
- In the 2020 sample, first admissions accounted for 41% of adult service users and 84% of adolescent service users.
- 2020 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 2020, 39% of SPUH and SPL service users were moderately ill. Another 28% were markedly ill. 12% were severely ill. 1% of service users was extremely ill on admission.
- Based on a sample of 294 (total cases with discharge CGI score documented), 87% of the sample were rated with an overall improvement (1 - very much improved (10%), 2 - much improved (44%) and 3 - minimally improved (33%)). This percentage of sample rated with an overall improvement is 6% lower than those observed in the previously reported years.
- 2020 analysis of the primary ICD-10 codes showed for the adolescent' population the most frequent reasons for admission were mood disorders followed by behavioral syndromes associated with physiological disturbances and physical factors.
- There was a further increase in the percentage of service users were severely ill on admission in comparison to 2018 and 2019 data. In 2020 the majority (67%) of Willow Grove Adolescent Unit service users were scored as having a major degree of impairment in functioning on admission and another 9% was unable to function.
- Overall improvement rate for Willow Grove Adolescent Unit was 92% and 4% higher than reported in 2019.
- The audit shows improvements in recording the baseline and final assessment scales scores in adult and adolescent population. The calculated compliance with the standards slightly decreased.

4.3. Acceptance and Commitment Therapy (ACT) 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 SPMHS in 2010, runs recurrently over a ten-week period for one half-day per week. During the 10-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 2020, data were available for a total of 137 participants. Both pre and post measures were available for 70 of those completing the programme, representing 51% 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 seven-item measure of experiential avoidance or the tendency to avoid unwanted internal experiences – the opposite of which is psychological flexibility. The AAQ-II was developed to establish an internally consistent measure of ACT's model of mental health and behavioural effectiveness. 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 reduced psychological flexibility/increased 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 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 that 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**

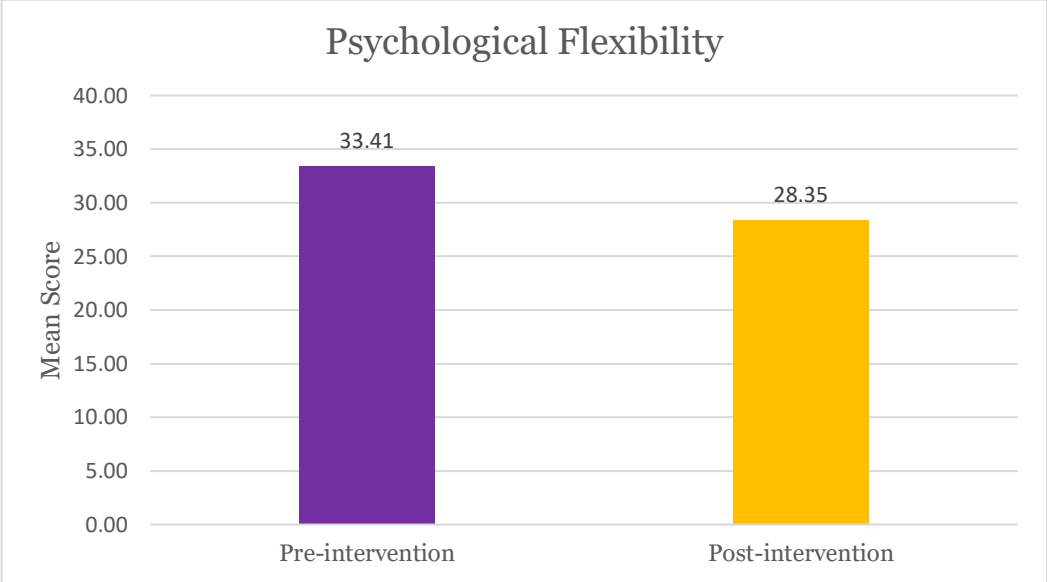
The Self-Compassion Scale (SCS) is a 26- item self-report scale, which was designed to assess an individual's levels of self-compassion (Neff, 2003). Self-compassion is measured through six domains: self-kindness; self-judgement; humanity; isolation; mindfulness; and identification or over-identification 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

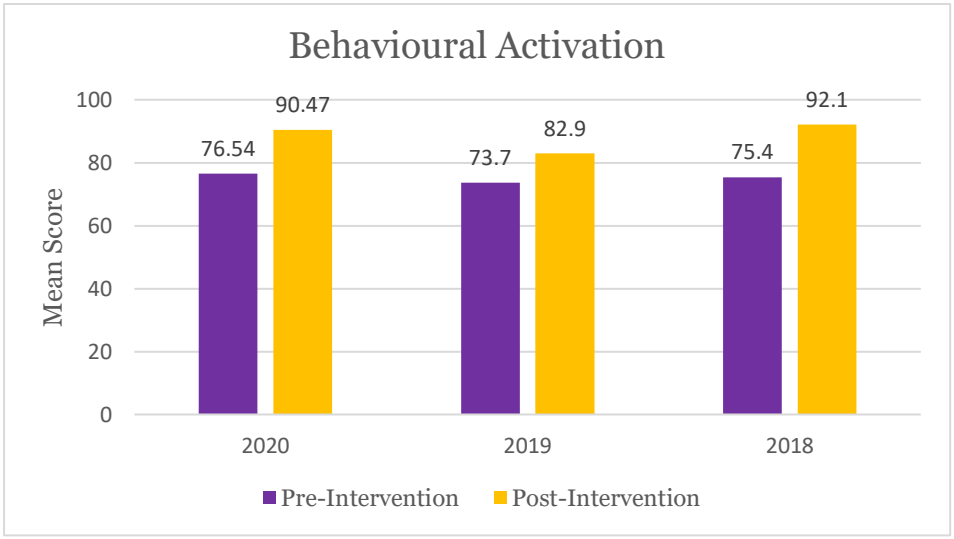
Graph: Psychological flexibility as measured by the AAQ-II



Mean scores on the AAQ-II decreased significantly from (M = 33.41, SD =8.27) to (M = 28.35, SD = 8.64) indicating greater psychological flexibility post-intervention, t (69) = 5.527, p <.000. An effect size (Cohen's d = 0.60) indicates a medium effect size. Pre and post data was captured from 70 participants in 2020 overall, signifying a continued improvement in the completion of these measures.

Behavioural Activation for Depression Scale (BADS)

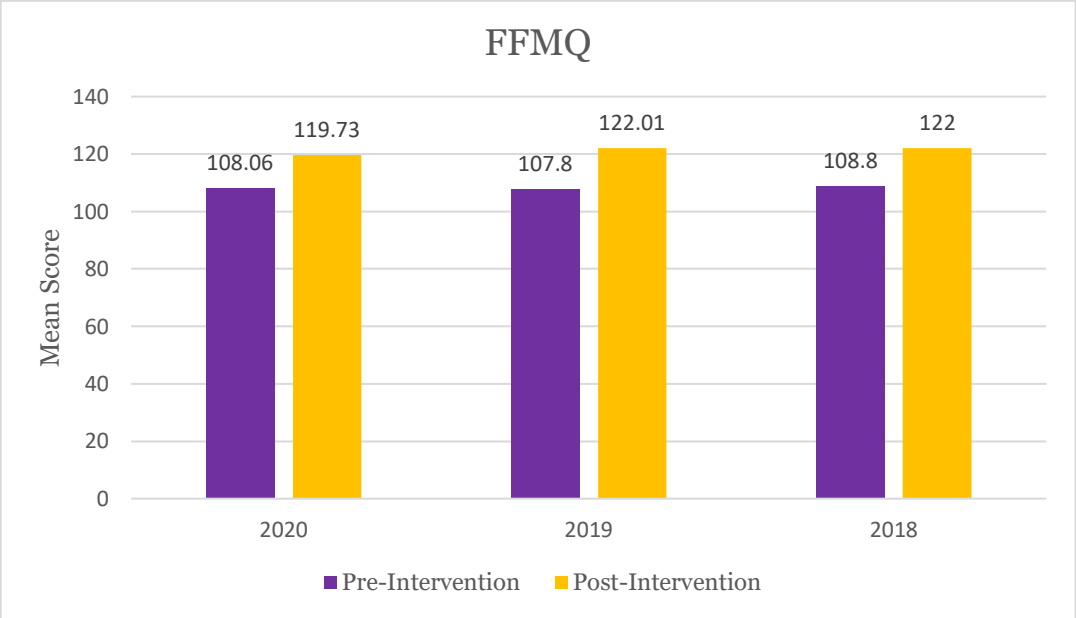
Graph: Behavioural activation as measured by the BADS



Mean BADS scores increased significantly from (*M* = 76.54, *SD* =30.67) to (*M* = 90.47, *SD* = 31.21) indicating greater behavioural activation, t (69) = -4.549, *p* < .000, 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 43.5% to 23.9% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

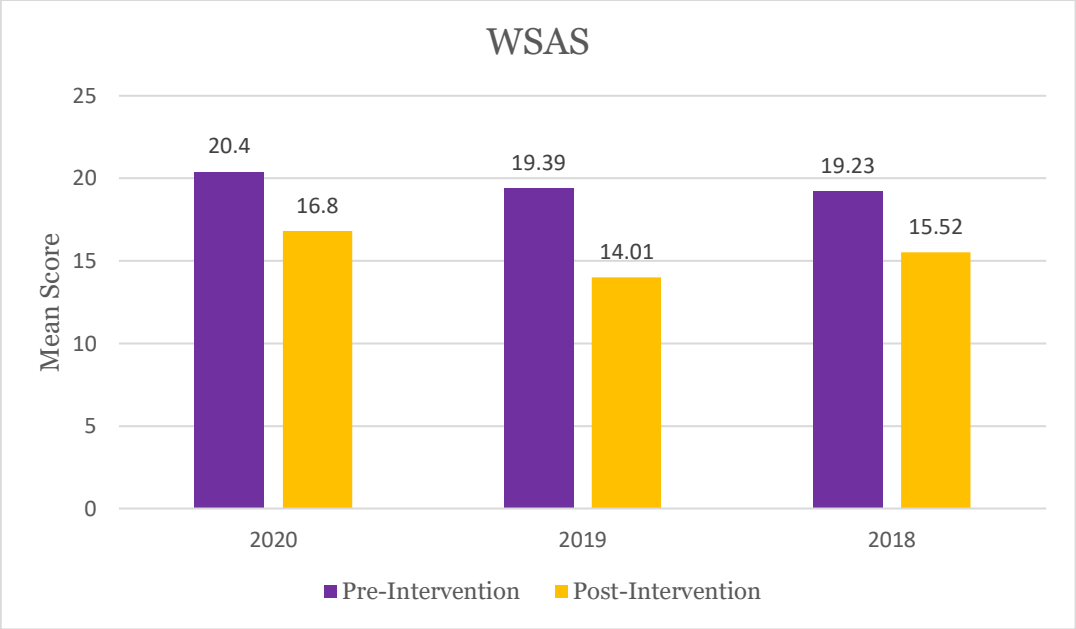
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, t (69) = -5.492, *p* < .000, from pre (*M* = 108.06, *SD* = 21.5) to post (*M* =119.73, *SD* = 23.9) indicating greater levels of overall mindfulness, with a medium effect size observed (Cohen's *d* = 0.51). 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



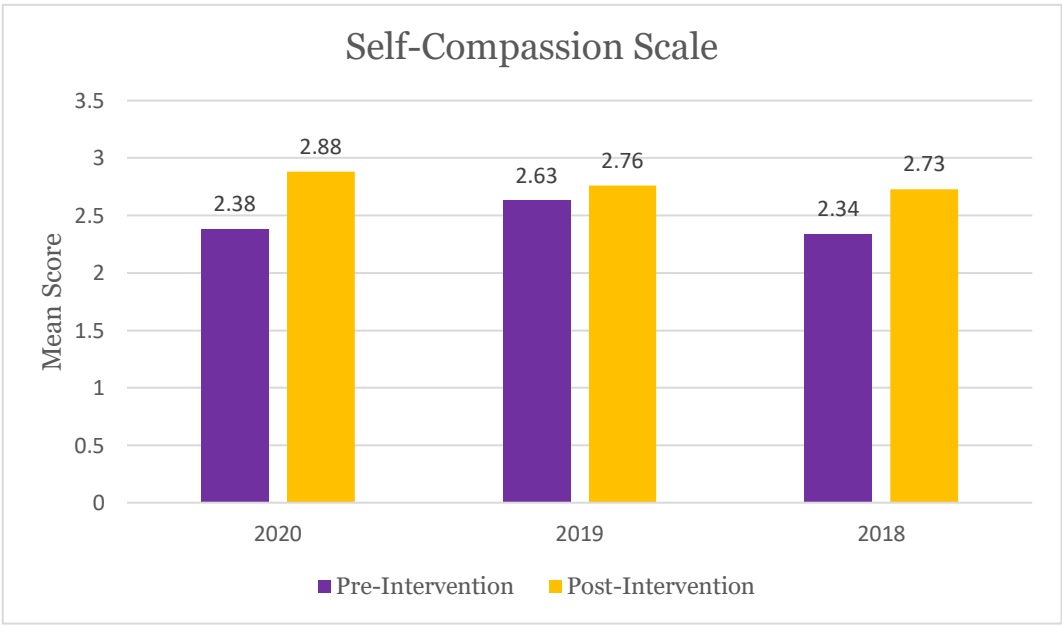
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (69) = 4.236, $p < .000$, from 20.40 (SD = 9.10) to 16.80 (SD =9.04), indicating less functional impairment. The effect size of Cohen's d =0.39 indicates a medium effect.

The percentage of people falling below a sub-clinical threshold, as indicated on the WSAS, increased from 12% to 22.5% post group.

These findings are in line with the 2019 and 2018 outcomes reports, which 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 (69) = -6.631, $p < .000$, from pre (M = 2.38, SD = 0.63) to post (M = 2.88, SD = 0.77) indicating higher overall levels of self-compassion post-intervention. A large effect size was observed (Cohen's d =0.71). 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 2020, 2019 and 2018. A recording and analysis of the five distinct sub-scales 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

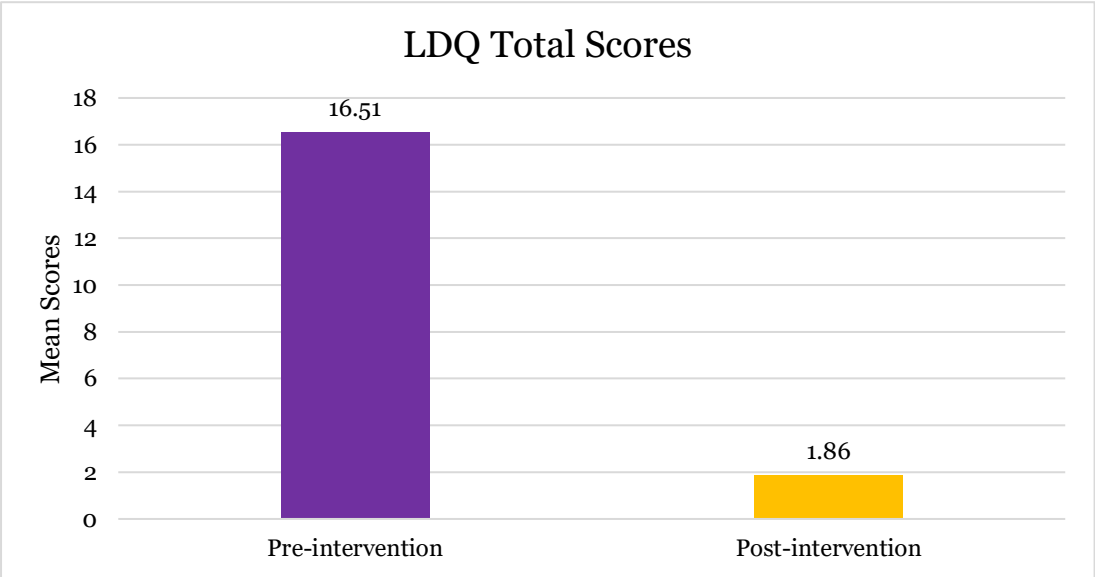
84 participants completed the full programme and 27 participants completed the modified programme and returned pre- and post- data. 59.45% of participants were male and 40.55% were female.

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, $z = -7.916$, $p < 0.05$, with a large effect size ($r = -0.61$). The mean score on the total LDQ scores decreased from pre-intervention ($M = 16.51$, $SD = 7.05$) to post-intervention ($M = 1.86$, $SD = 2.40$), 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).

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 psychoeducation 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 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 that 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 2020. 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 123 people who completed the programme in 2020, of which 66 (53.7%) were female and 57 were male (46.3%). Programme attendees ranged in age from 19 to 71, with a mean age of 36.65 years (*SD* = 14.02). Post data were collected after Level 1 and Level 2 of the anxiety programme.

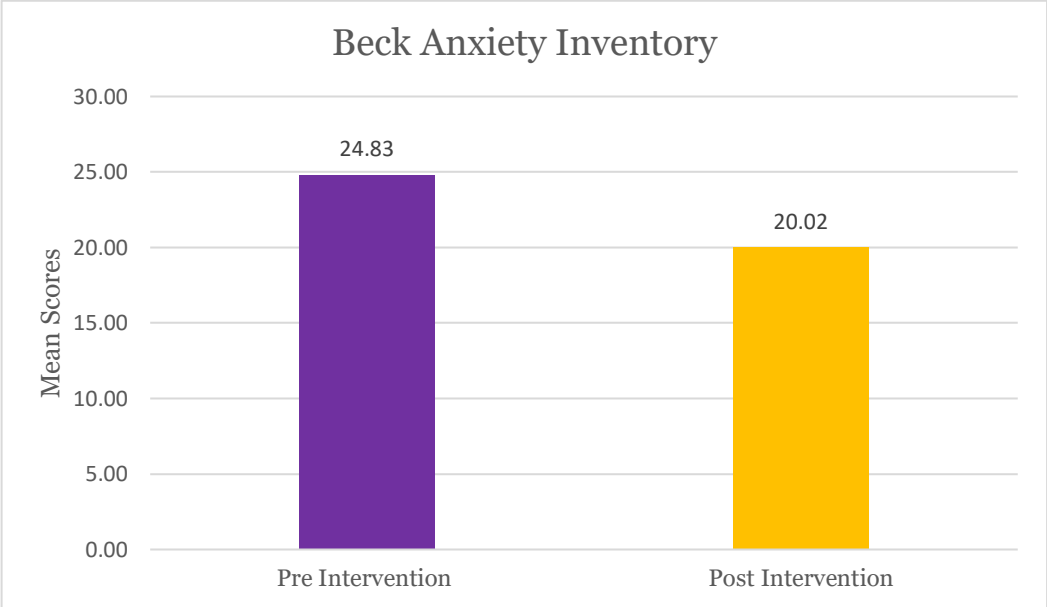
Data regarding diagnosis were returned for 117 individuals. OCD accounted for the largest sub-group (46.3%), followed by GAD (24.4%); social phobia/anxiety (8.9%); agoraphobia (with/without panic) (4.9%); panic disorder (7.3%); health anxiety (5.7%); and specific phobia (0.8%). The table below shows the percentage of people with each diagnosis over the past three years.

	2018		**2019**		**202**	
	N	**%**	**N**	**%**	**N**	**%**
OCD	52	42.6	54	46.2	57	46.3
GAD	22	18.0	26	22.2	30	24.4
Social	25	20.5	2	1.7	11	8.9
Panic Disorder	6	4.9	7	6.0	9	7.3
Agorophobia	8	6.6	9	7.7	6	4.9
Health Anxiety	7	5.7	4	3.4	7	5.7
Specific Phobia	1	.8	2	1.7	1	0.8

4.5.3. Level 1 Results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory mean total scores pre and post-Intervention for 2020.



Scores on the Beck Anxiety Inventory (shown in the graph above) suggest that those who completed the programme (N = 41) experienced an improvement in scores from pre-test to post-test (M = 24.83, SD = 10.51; M = 20.02, SD = 12.93).

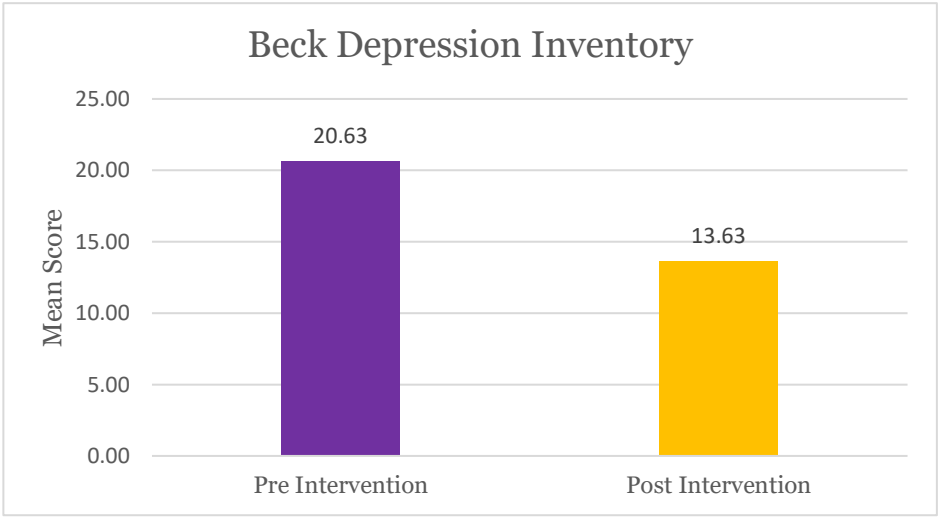
Analysis using the Wilcoxon Signed Rank indicated that this change was statistically significant (z = -3.56, p < .001) and reflected a small effect size (r = 0.19). At the pre-measurement time point, 80% of service users' anxiety scores fell within either the severe or moderate range. Post-intervention, 59% of service users' anxiety scores fell within either the severe or moderate range. See the table below for a further breakdown of anxiety scores by category.

ı each category	**iety (BAI)**		**›ression (BDI)**	
	Ɛ	**ST**	**Ɛ**	**ST**
imal	0%	17%	12%	29%
d	20%	24%	29%	41%
lerate	34%	27%	49%	24%

ere	46%	32%	10%	5%

Beck Depression Inventory (BDI)

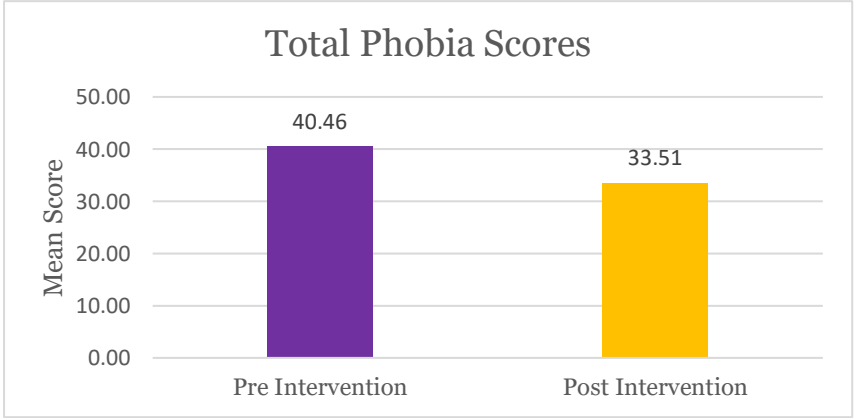
Graph: Beck Depression Inventory mean scores pre and post-intervention for 2020.



Service users mean scores on the Beck Depression Inventory suggest that those who completed the programme (N = 41) experienced an improvement in scores from pre-test to post-test (*M* = 20.63, *SD* = 8.78; *M* = 13.63, *SD* = 8.75). Analysis using the Wilcoxon Signed Rank indicated that this change was statistically significant (z = -4.32, p < .001) and reflected a medium effect size (*r* = 0.37). At the pre-measurement time point, 59% of service users' depression scores fell within either the severe or moderate range. Post-intervention, 29% of service users' depression scores fell within either the severe or moderate range.

The Fear Questionnaire

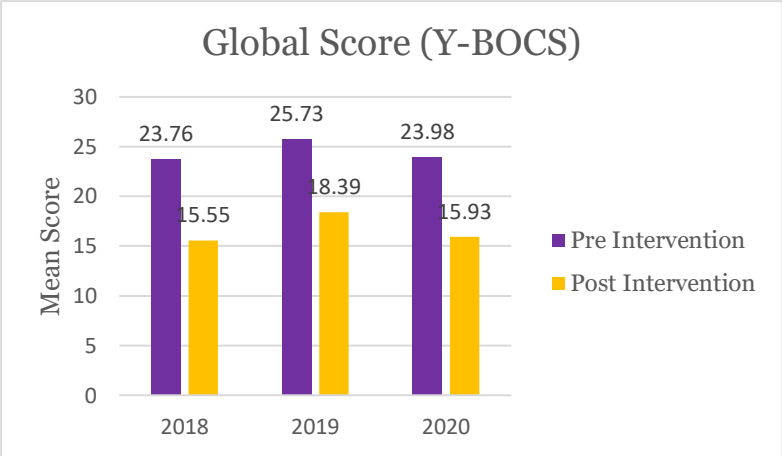
Graph: Fear Questionnaire Mean Total Phobia Scores Pre and Post-intervention for 2020.



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, $z = -5.51$, $p < .001$. The mean Total Phobia score decreased from 40.46 (SD = 20.82) to 33.51 (SD = 18.11), representing a small effect size (r = 0.18).

The Yale Brown Obsessive Compulsive Scale

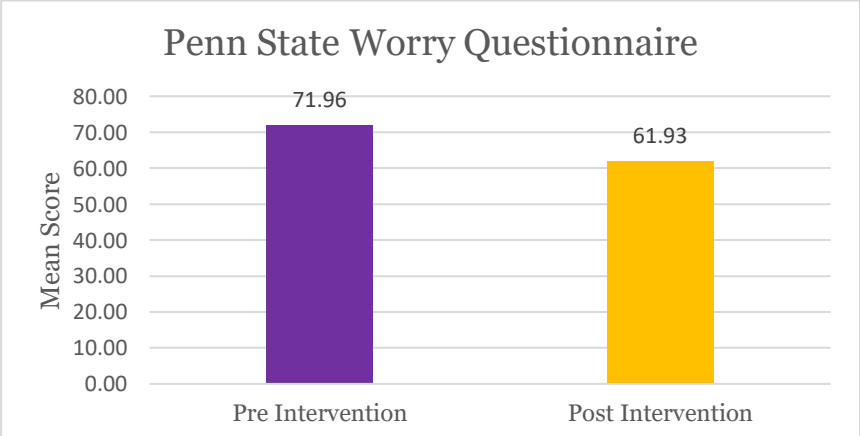
Graph: Yale Brown Obsessive Compulsive Scale Mean Total Scores pre and post intervention for 2018, 2019 and 2020.



OCD symptomatology, as measured by the Y-BOCS, reduced from pre-intervention to post-intervention. Analysis using a t-test indicated that scores on this measure dropped significantly, t (45) = 8.55, p <.001, with the total mean score changing from 23.98 (SD = 7.84) to 15.93 (SD = 7.25). This indicates an overall significant reduction in the severity of OCD symptoms post intervention with a medium effect size (Cohen's d = 1.06).

Penn State Worry Questionnaire (PSWQ)

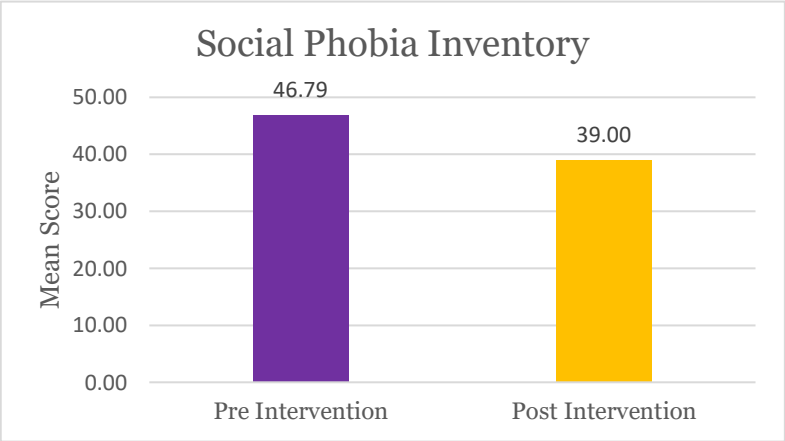
Graph: Penn State Worry Questionnaire Mean Scores Pre and Post Intervention for 2020.



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* = -4.46, p < .001, between pre-intervention (*M*= 71.96, SD = 8.06) and post-intervention (*M*=61.93, SD = 9.91). This change reflected a medium effect size (*r*= 0.48)

Social Phobia Inventory (SPIN)

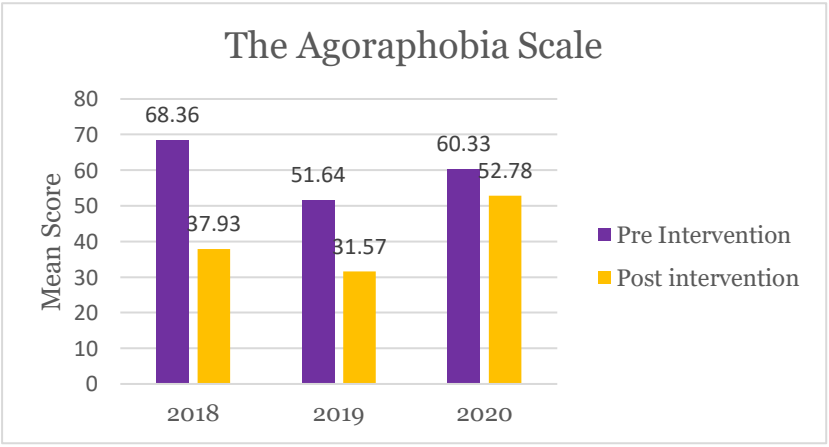
Graph: Social Phobia Inventory mean scores pre and post intervention in 2020.



Analysis of the SPIN using a Wilcoxon Signed Rank test indicated a statistically significant reduction in service users scores, *z* = -3.207, p < .001, from pre-intervention (*M*= 46.79, SD = 11.08) to post-intervention (*M*= 39.0, *SD* = 12.05). This reflected a medium effect size (r = 0.31).

The Agoraphobia Scale

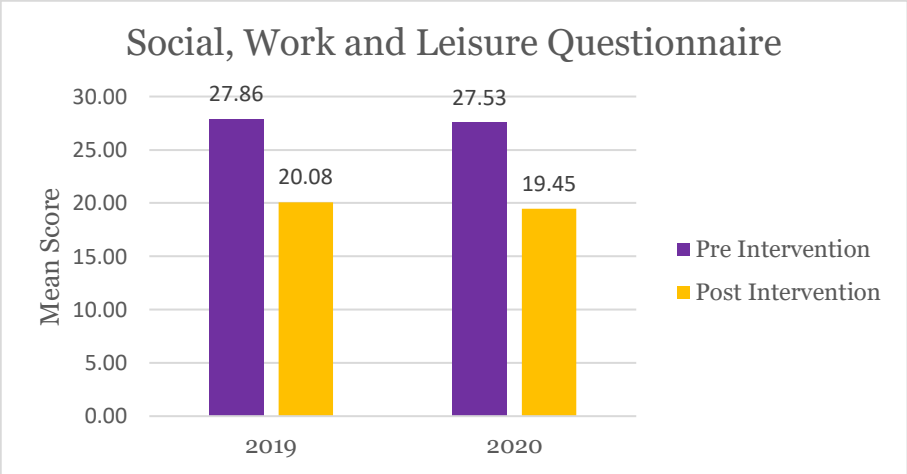
Graph: The Agoraphobia Scale mean Scores pre and post-intervention for 2018, 2019 and 2020.



Scores on the Agoraphobia Scale reduced from pre-intervention (M= 60.33, SD = 26.94) to post-intervention (M= 52.77, SD = 19.35). However, analysis of the Agoraphobia Scale using a t-test indicated that this result did not represent a statistically significant reduction in mean total scores ($t\ (8)$ = 1.54, p > .05).

The Social Work and Leisure Questionnaire

Graph: Social Work and Leisure Questionnaire Group mean score pre and post-intervention for 2019 and 2020.

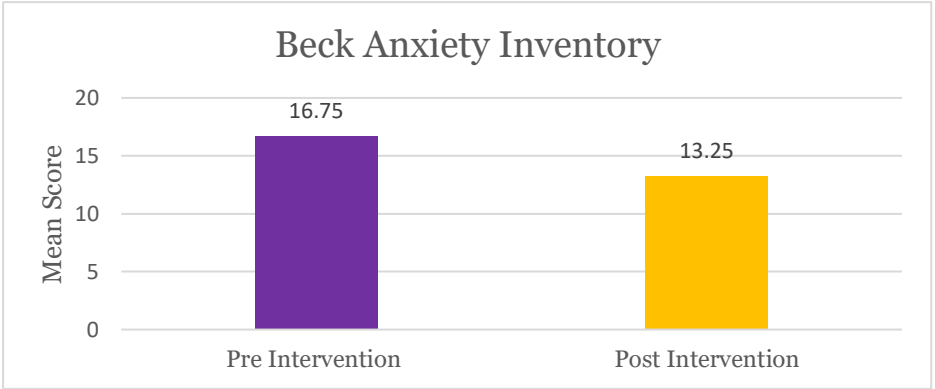


Analysis of the SWLQ using a t-test indicated that there was a statistically significant reduction in mean scores observed, $t\ (106)$ = 9.82, p < .001, from pre-intervention (M = 27.53, SD = 8.83) to post-intervention (M = 19.45, SD = 10.62) at level 1. This result reflected a large effect size (Cohen's d = 0.83).

4.5.4. Level 2 results

Beck Anxiety Inventory (BAI)

Graph: Beck Anxiety Inventory Mean Scores pre and post-intervention for 2020

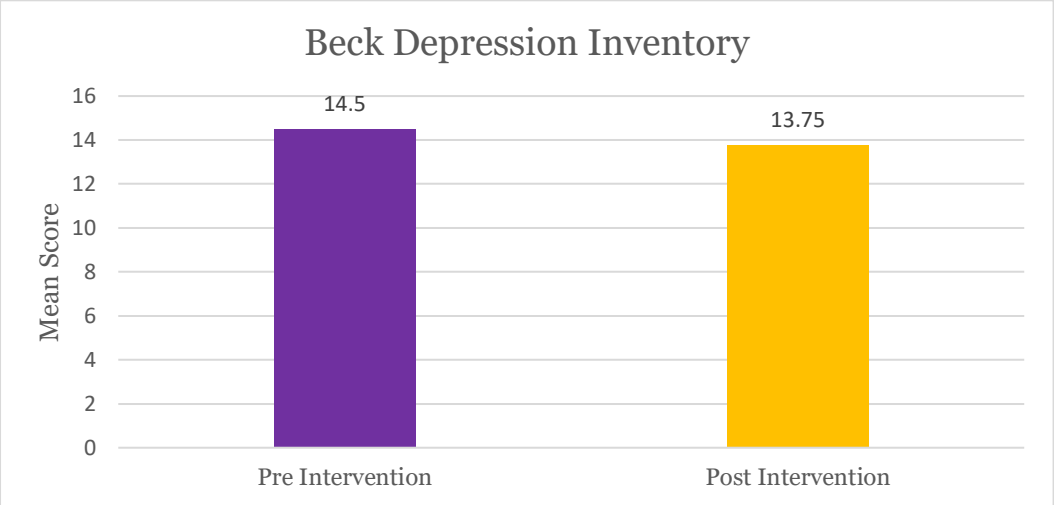


Analysis using a Wilcoxon Signed Rank test of pre (*M* = 16.75, SD = 10.89) and post (*M* = 13.25, SD = 7.96) intervetion scores on the Beck Anxiety Inventory suggested a statistically significant change in scores, z = -.981, p = .326. At the pre-measurement time point, 50% had anxiety scores in the severe and moderate ranges; this dropped to 25% by the end of Level 2 (See the table below).

ı each category	**ıiety (BAI)**		**ıression (BDI)**	
	Ɛ	**ƽT**		**ƽT**
ıimal	0.0%	%	12.5%	%
d	50.0%	%	75.0%	%
derate	25.0%	%	12.5%	%
ere	25.0%	%	0.0%	%
ıls				

Beck Depression Inventory (BDI)

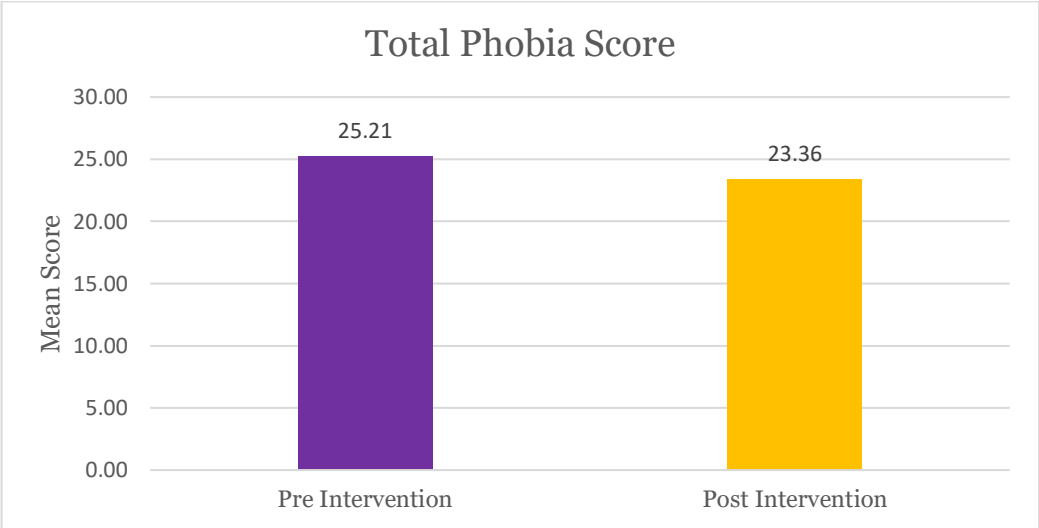
Graph: Beck Depression Inventory mean scores Pre and Post Intervention for 2020



Average depression scores for those who completed the Level 2 programme (indicated on the graph above) were in the mild range pre-intervention (*M*= 14.50, *SD* = 4.98) and showed a statistically significant drop to the lower mild range post-intervention, (*M* = 13.75, SD = 6.54), *z* = -6.37, *p* = .524.

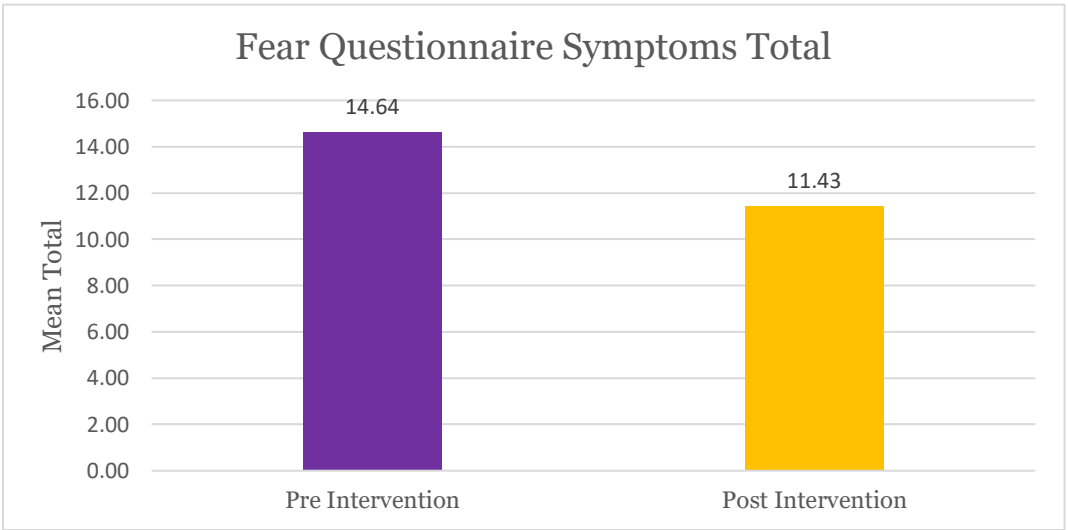
The Fear Questionnaire

Graph: The Fear Questionnaire, Mean Phobia Score Pre and Post Intervention



Total phobia scores on the Fear Questionnaire were found to have dropped from a mean score of 25.21 (*SD* = 16.21) to 23.36 (*SD* = 11.85) following statistical analysis using the Wilcoxon Signed Rank test at level 2 of the Anxiety Disorder Programme. This reduction was not statistically significant, z = -.315, p = .753.

Graph: The Fear Questionnaire, Mean Symptom Pre and Post Intervention

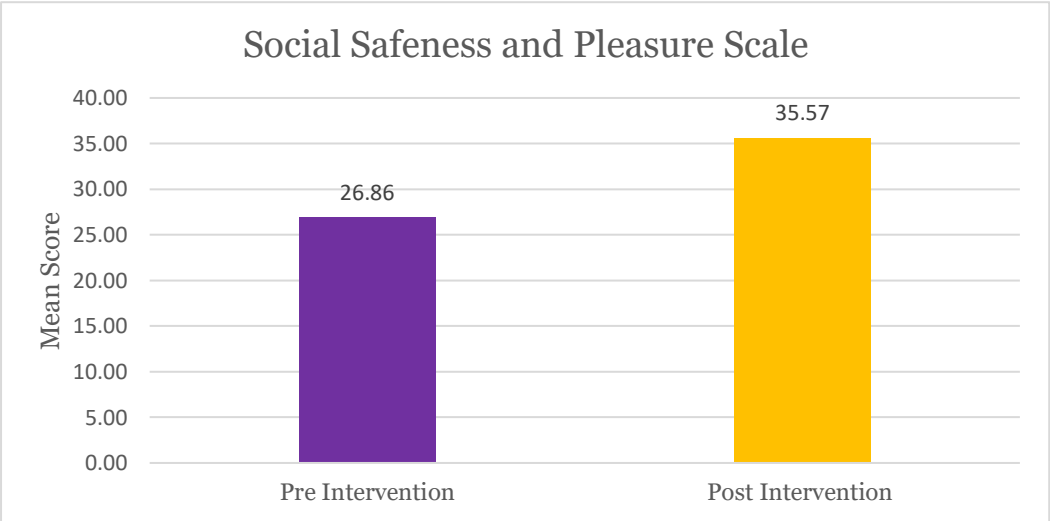


Total symptom scores on the Fear Questionnaire were found to have dropped from a mean score of 14.64 (*SD* = 5.7) to 11.43 (*SD* = 7.5) following statistical analysis using the Wilcoxon Signed Rank test at level 2 of the Anxiety Disorder Programme. This reduction is approaching statistical significant, z = -1.923, p = 0.54.

The Social Safeness and Pleasure Scale

Service users' scores on the Social Safeness and Pleasure Scale showed a change from a mean of 26.86 (SD= 10.29) pre-intervention to 35.57 (SD=8.03) post-intervention. This increase was statistically significant z = -3.239, p < .001, with a large effect size (r =0.94).

Graph: The Social Safeness and Pleasure Scale Mean 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 2020 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	2020

BAI	-0.48 (r)	-0.60(r)	0.19(r)
BDI	-0.48 (r)	-0.66(r)	0.37(r)
Fear Questionnaire	-0.40 (r)	-0.70(r)	0.18(r)
Y-BOCS (Global Score)	1.26 (Cohen's *d*)	1.19(Cohen's *d*)	1.06(Cohen's *d)*
Penn State Worry Questionnaire	-0.60 (r)	-0.71(r)	0.48(r)
Social Phobia Inventory	1.01 (Cohen's *d*)	0.85(Cohen's *d*)	0.31(r)
Agoraphobia Scale	1.49 (Cohen's *d*)	0.67(Cohen's *d*)	-
Social Work and Leisure Questionnaire	–	0.77(Cohen's *d*)	0.83(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 2020 suggest further decreases in anxiety and depression symptoms.

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 therapy (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 SPL 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 2020.

All service users attending the CFT Programme in both SPUH and SPL 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.

Data is described below for four cycles for this programme which finished in 2020. Groups transitioned from face-to-face to remote running in March 2020, via MS Teams, due to national public health restrictions. Due to the difficulties adjusting to an online format and postal issues, data collection proved challenging and so unfortunately, data could not be collected from all those who participated in the programme.

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

  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 (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.

- **Compassionate Engagement and Action Scales (CEAS)**

  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.

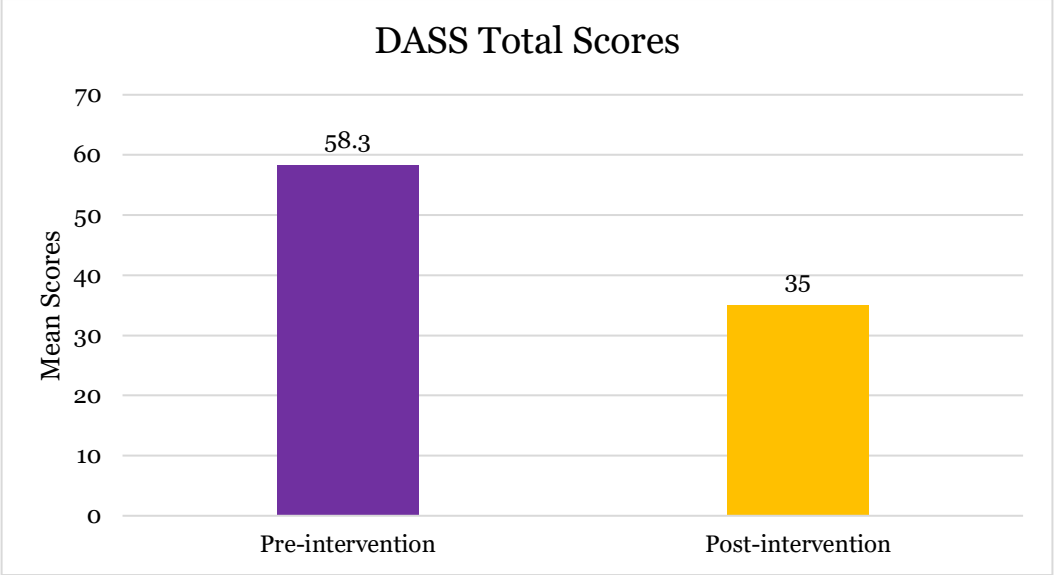
4.6.2. Descriptors

38 individuals completed the CFT programme at either SPUH or SPL in 2020. Of these participants, complete pre- and post- data was available for 23 people. 56.5% of these were female and 43.5% were male. Programme attendees ranged in age from 21 to 66 years with a mean age of 44 years.

4.6.3. Results

Depression Anxiety and Stress Scales (DASS)

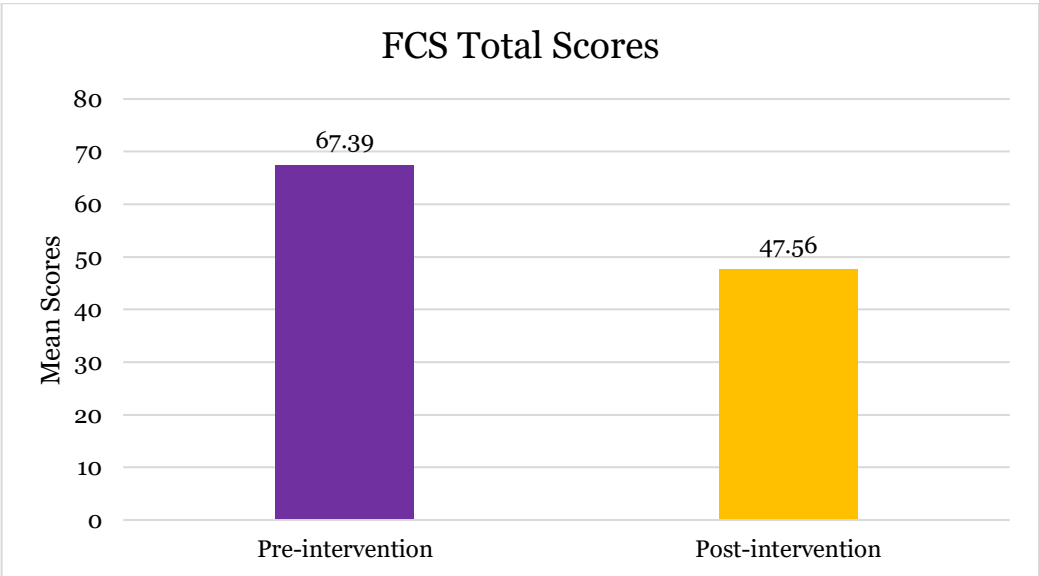
Graph: Depression Anxiety and Stress Scores



Analysis of the total DASS scores from the CFT programme indicated that there was a significant decrease in reported psychological difficulties, $z = -3.286$, $p < 0.05$, with a medium effect size ($r = -0.48$). Participants mean scores decreased from 58.3 (SD = 40) at pre-intervention to 35 (SD = 27) after completing the programme. Individual sub-scale scores were not available for all 23 participants, and are therefore not reported.

The Fears of Compassion Scale (FCS)

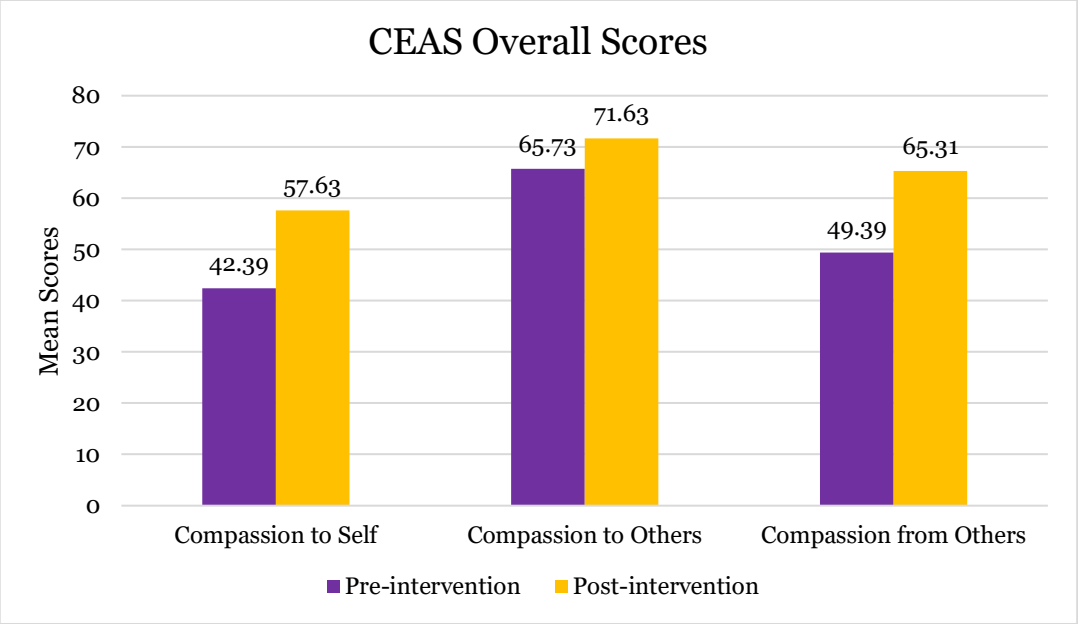
Graph: The Fears of Compassion Scale



A Wilcoxon Signed Ranks Tests demonstrated a statistically significant reduction in total scores on the FCS (expressing kindness and compassion towards self, expressing compassion for others, and responding to compassion from others). At pre-intervention, participants mean scores on the FCS were 67.39 (SD = 25.5), compared to 47.56 (SD = 26.9) post-intervention, $z = -3.225$, $p < 0.05$ with a medium effect size ($r = -0.48$). These findings suggest that fears of expressing and receiving compassion decreased from pre- to post- programme participation.

Compassionate Engagement and Action Scale (CEAS)

Graph: Compassionate Engagement and Action Total Scores



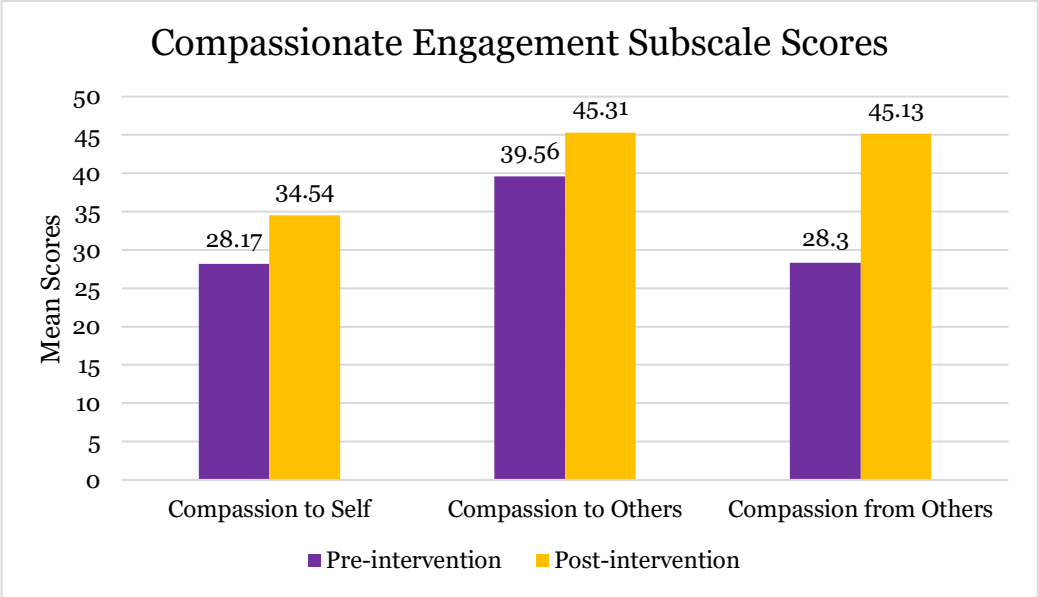
The CEAS is divided into three scales 'Compassion to Self', 'Compassion to Others' and 'Compassion from Others'. Overall scores and scores on the engagement and action subscales are reported below.

Significant increases were reported on the overall Compassion to Self-Scale from pre-intervention ($M = 42.39$, $SD = 17.58$) to post-intervention ($M = 57.63$, $SD = 13.36$), $z = -3.136$, $p < .05$, with a medium effect size ($r = -0.46$). These findings illustrate that participants' self-directed compassion increased from pre- to post-intervention.

Mean scores on the Compassion to Others Scale also increased overall from pre-intervention (M = 65.73, SD = 23.59) to post-intervention (M = 71.63, SD = 15.29), however this was non-significant.

Mean scores on the Compassion from Others Scale showed a significant increase from pre-intervention (M = 49.39, SD = 22) to post-intervention (M = 65.31, SD = 14.08), z = -2.549, p < 0.05 with a medium effect size (r = -0.38).

Graph: Compassionate Engagement sub-scales

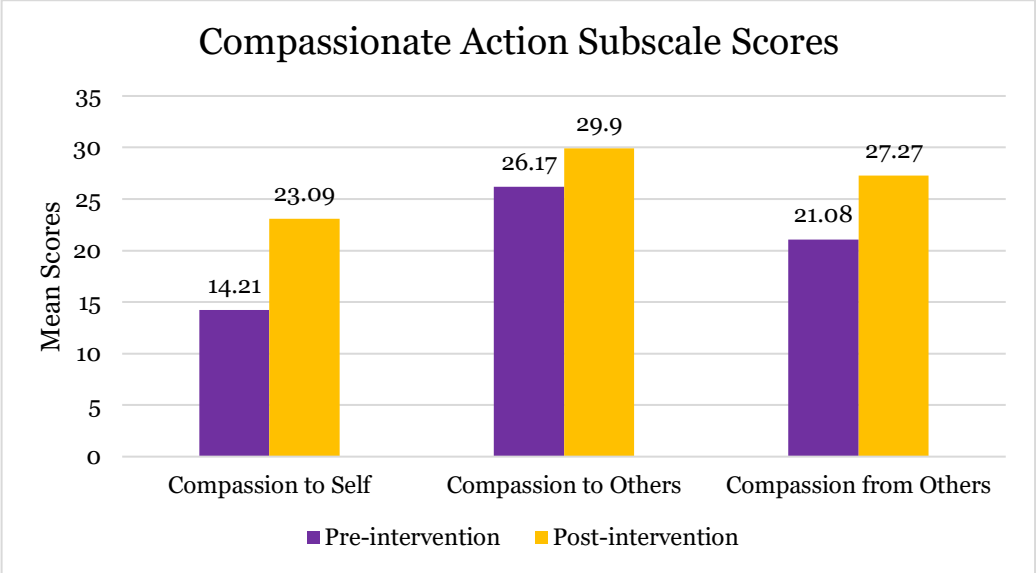


Within the Compassionate Engagement sub-scales, statistically significant increases in mean scores were achieved on the Compassion to Self sub-scale. Participant scores increased from pre-intervention (M = 28.17, SD = 11.17) to post-intervention (M = 34.54, SD = 6.92), z = -2.506, p < 0.05, demonstrating a medium effect size (*r* = -0.37).

Mean scores obtained on the Compassion to Others sub-scale also increased from (M = 39.56, SD = 14.25) pre-intervention to (M = 46.89, SD = 7.22). This difference was not statistically significant.

Mean scores obtained on the Compassion from Others sub-scale significantly increased from 28.30 (SD = 13.34) at pre-intervention to 45.13 (SD = 30.11) post-intervention, z = -2.924, p < 0.05, demonstrating a medium effect size (r = -0.43).

Graph: Compassionate Action sub-scales



Within the Compassionate Action sub-scales, a statistically significant increase in mean scores can be observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 14.21, SD = 7.94) to post-intervention (M = 23.09, SD = 7.48), z = -3.339, $p < 0.05$, with a medium effect size (r = -0.49).

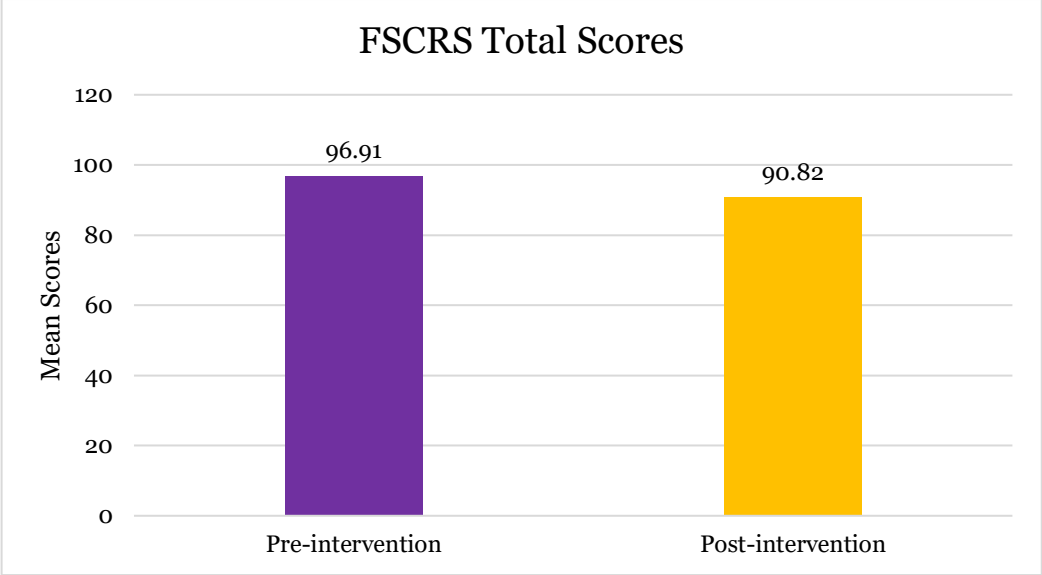
A non-significant increase in mean scores was observed on the Compassion to Others subscale, where $p > 0.05$.

Mean scores also significantly increased from 21.08 (SD = 9.48) at pre-intervention to 27.27 (SD = 5.72) at post-intervention on the Compassion from Others subscale, z = -2.357, $p < 0.05$, with a medium effect size (r = -0.35).

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 Total Scores



Mean scores on the FSCRS showed a non-statistically significant decrease between pre-intervention (M = 96.91, SD = 23) and post-intervention (M = 90.82, SD = 33.49), $p > 0.05$. Decreases in scores indicate reduced feelings of inadequacy. The small sample size used in this analysis may have impacted on results. Scores for the FSCRS subscales were not included in this analysis.

4.6.4. Summary

The Compassion-Focused Therapy Programme started in SPMHS in 2014. Since then, 30 cycles of the group have been facilitated in SPUH, with an additional cycle each year running in SPL. The programme has received considerable interest within the hospital. Anecdotal feedback from clients who attended these groups has been overwhelmingly positive, with clients reporting noticeable improvements in their lives.

CFT continues to be an effective, well-received group-based psychological intervention to SPMHS service users. The demand for this programme has meant that the waiting list for it has grown. To address this, we intend to run additional cycles of CFT in the coming year, as well as working to further develop the format of its delivery to ensure we are best meeting the client's needs.

4.7 Coping with Covid-19 for Older Adults (CoCoa): a Teletherapy Psychology Programme.

CoCoa is a new group programme which was devised and launched in 2020 as a response to the mental health needs of older adults in the context of the Covid-19 pandemic. The programme aims to support older adults in coping with the challenges of Covid-19, while nurturing a broader sense of curiosity and openness to psychological approaches to mental health and wellbeing. The programme encourages the development of an increased sense of agency over mental health management and connection with others, in line with research supporting the use of group programmes with older adult service users and emergent research highlighting approaches to supporting mental health during a pandemic. The group is held online and runs for four weekly sessions, with a closed group format. It follows an integrative approach, drawing upon a number of models, including compassion-focused therapy, dialectical behaviour therapy, radically open dialectal behaviour therapy and trauma-informed approaches. Four cycles of the programme were run in 2020 and continues to be offered into 2021 as the need has continued.

4.7.1 Coping with Covid-19 for Older Adults (COCOA) programme Outcome Measures

- **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).

4.7.2. Descriptors

Pre and post-data were available for 18 people who completed the programme in 2020. Of these participants, 14 were female (77.8%) and four were male (22.2%). Programme attendees ranged in age from 64 to 84 with a mean age of 72.89 (SD = 5.46).

4.7.3. Results

Depression Anxiety Stress Scale (DASS)

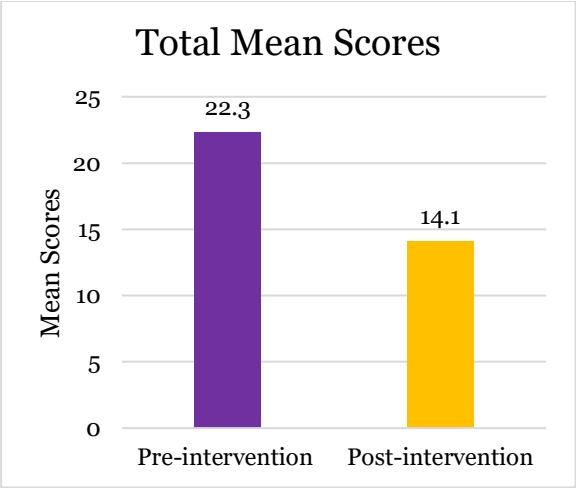
Analysis of the three sub-scales, which make up the DASS - stress, anxiety and depression – using a paired samples t-test showed a significant difference in psychological difficulties between pre (M= 22.3, SD = 14.6) and post-intervention (M = 14.1, SD = 9.6); t (17) = 2.785, $p<0.05$, demonstrating a medium effect size (r = 0.67).

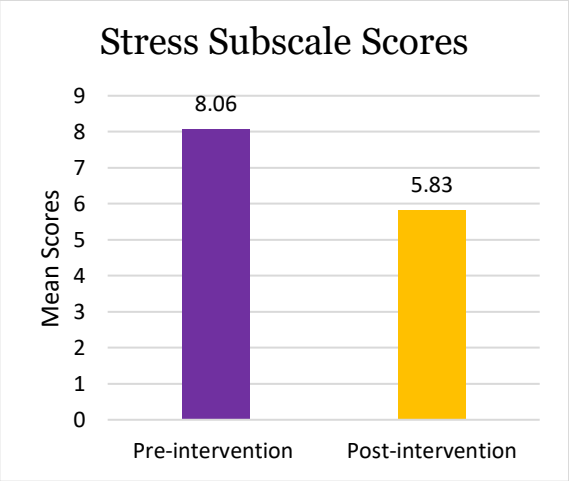
On the measure of stress, pre (M = 8.06, SD = 5.1) and post-intervention (M = 5.83, SD = 4.4) showed a reduction in mean stress scores, however this was not found to be statistically significant with $p>0.05$.

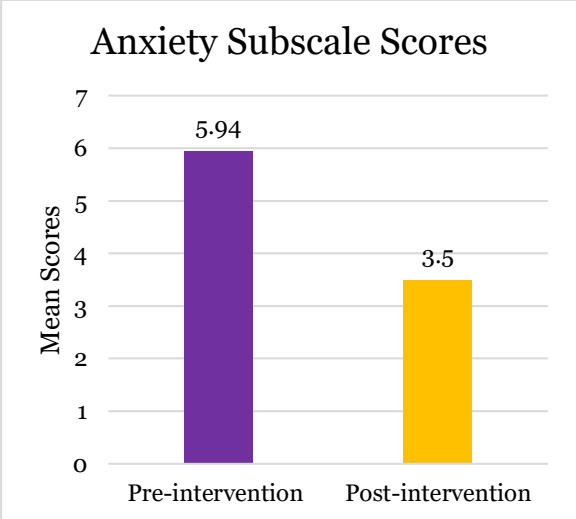
On the measure of anxiety, pre (M = 5.94, SD = 4.8) and post-intervention (M = 3.5, SD = 2.2) showed a significant decrease in anxiety scores, t (17) = 2.61, $p<0.05$, with a medium effect size (r = 0.61).

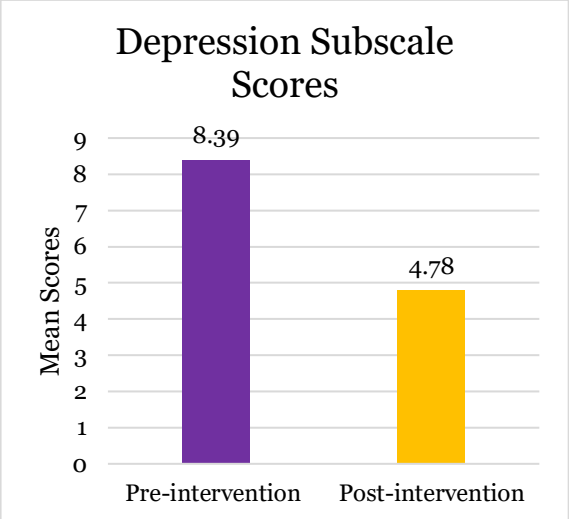
Finally, on the measure of depression, pre (M= 8.39, SD= 6.8) and post-intervention (M = 4.78, SD = 4.7) showed a statistically significant decrease in depression scores, t (17) = 2.728, $p<0.05$, with a medium effect size (r = 0.64).

Graph: DASS score and subscale scores pre-and post-intervention









4.7.4 Summary

The COCOA programme began in 2020 in response to Covid-19. Four cycles have been facilitated, with further cycles due to take place in 2021. Each cycle contains four sessions.

The programme receives referrals within the hospital to support the mental health needs of older adults in the context of the pandemic.

The quantitative research indicates that participants experienced significantly less psychological distress after completing the programme and reported experiences

of anxiety, depression and stress all decreased. This suggests that this novel programme has been an effective support for older adults in coping with the challenges of Covid-19.

4.8. Depression Recovery Programme

The Depression Recovery Programme 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 psychoeducational 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 psychoeducational 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).

- **The Standardised Assessment of Personality – Abbreviated Scale (SAPAS)**

The SAPAS is a brief interview-based screening instrument consisting of eight dichotomously rated items taken from the opening section of an informant-based interview, the Standardised Assessment of Personality, and has been found to have high sensitivity and specificity as a screener for personality disorders.

4.8.2. Descriptors

Paired data were available for 165 participants who completed the programme in 2020; 94 females (57%) and 71 males (43%). The age profile of participants ranged from 19 to 84 years, with a median age of 52 years.

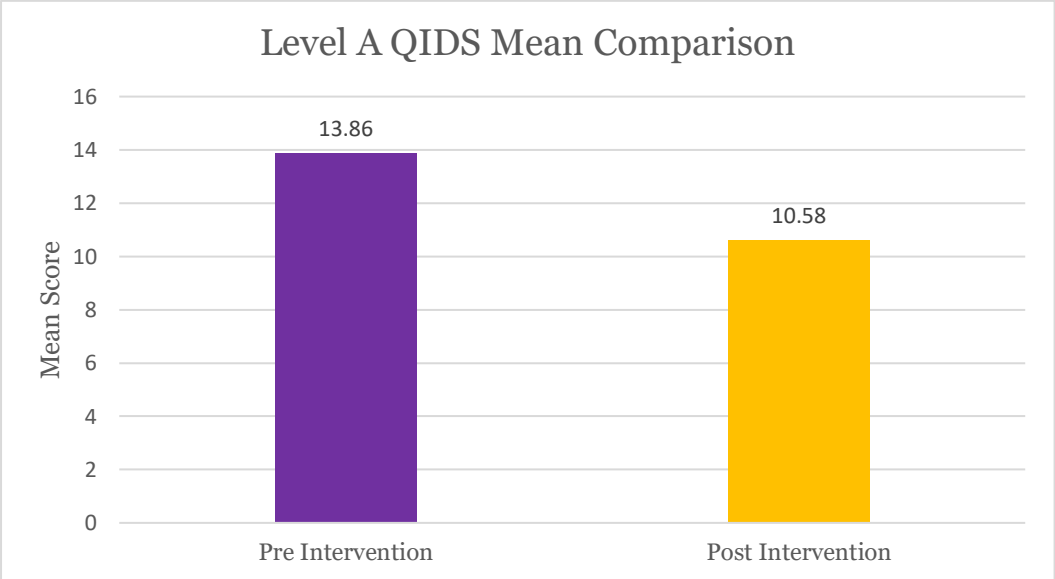
4.8.3. Results

Pre Level A and post Level A

Quick Inventory of Depression Symptomatology (QIDS)

Comparison of participant scores on the QIDS indicated a reduction of depression severity from pre-intervention (M = 13.86) to post-intervention (M = 10.58) for those attending the Level A programme (see graph below). This reduction in mean scores is statistically significant. A Wilcoxon Signed Rank test revealed Z= -6.567, p < .000, with a medium effect size (Cohen's d = 0.59).

Graph: Quick Inventory of Depression Symptomatology Mean Scores



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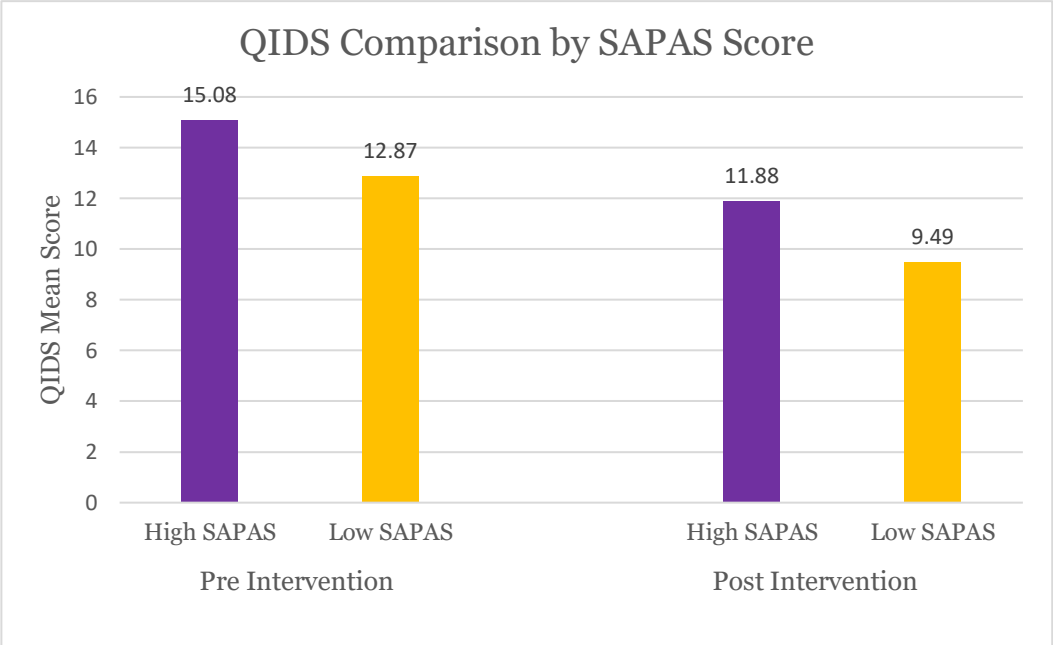
The Standardised Assessment of Personality – Abbreviated Scale (SAPAS)

A median split was conducted to categorise SAPAS scores into two categories: High SAPAS Score (indicating potential personality disorder) and Low SAPAS Score (see graph below). Further analysis was then conducted on these two groups to determine whether SAPAS score category was related to outcome post-intervention. Two Wilcoxon Signed Rank tests revealed similar results to that of the overall cohort. A statistically significant reduction in mean scores was observed from pre to post-intervention in both the High SAPAS Score group (Z = -4.273, p <.000) and the Low SAPAS Score group (Z = -4.506, p < .000). This indicates that the intervention was successful in reducing depression symptomatology irrespective of one's score on the SAPAS.

Graph: QIDS mean scores Categorized by SAPAS Score



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

Comparison of service user's scores on the QIDS indicated a reduction of depression severity scores from pre-intervention (M = 19.0, SD = 4.94) to post-intervention (M = 7.0, SD = 2.97). This reduction in mean scores is statistically significant. A Wilcoxon Signed Rank test revealed Z= -2.207, p = .027, with a large effect size (Cohen's d = 2.94). A Cohen's d of this size indicates that the difference between the two groups is approaching three standard deviations in size. This result should be interpreted with caution due to the small sample size providing pre and post-data for the Level B intervention (N=6).

4.8.4. Summary

This is the sixth year depression has been included in the SPMHS Outcomes Report. This is the second 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 strong evidence to suggest that overall people who complete both the Level A and Level B programmes experience a significant reduction in symptoms associated with depression.

Level A has now ceased and has been replaced by Pillars of Wellness, an educational programme open to all inpatients and those on the Homecare service. Also, level C has been extended to 12 months on a trial basis.

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-psychosocial 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 and 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)
- Aftercare for 12 months.

The programme includes the following elements:

- **Individual multidisciplinary assessment:** This facilitates the development of an individual treatment care plan for each client.
- **Psychoeducation 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 psychoeducational 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

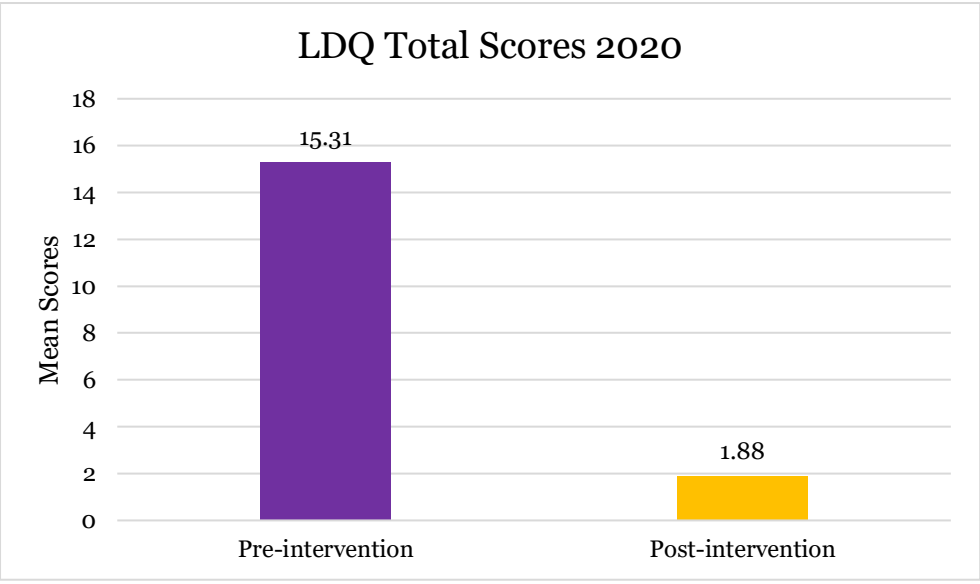
109 individuals with complete data were included in this analysis. These participants attended and completed the full or modified programme in 2020. Of these, 48.62% were male and 51.38% female. The age ranged from 18 to 70, with a mean age of 45.

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 = -8.772, p<.001, with a large effect size (r = -0.60). The mean score on the total LDQ decreased from pre-programme to post-programme, as depicted in the graph below.

Graph: Leeds Dependency Questionnaire Scores



4.9.4. Summary

Following completion of the Dual Diagnosis Programme, significant and large reductions in psychological markers of alcohol/substance 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.

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.

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 because 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. Eating Disorders Programme 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, Cooper & O'Connor, 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 (e.g. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

- **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 sub-divided 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 25 service users attending the EDP as an inpatient in 2020.

Inpatient data was collected at two points; inpatient admission and discharge.

In previous years, data was also available for service users attending the EDP as a day patients. However, the Covid-19 pandemic impacted on the collection of data for day patients and therefore we did not have enough data to complete analysis for the day patient service.

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 (M = 4.2, SD = 1.33) and post-treatment (M = 2.7, SD = 1.14). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.68, p < .001, with a moderate effect size (r = 0.51).

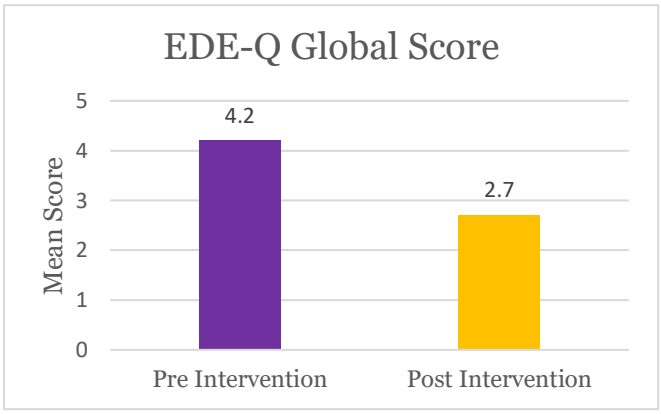
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restraint sub-scale decreased from pre-treatment (M = 3.66, SD = 1.96) to post-treatment (M = 1.5, SD = 1.45). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -3.63, p < .001, with a moderate effect size (r = 0.52).

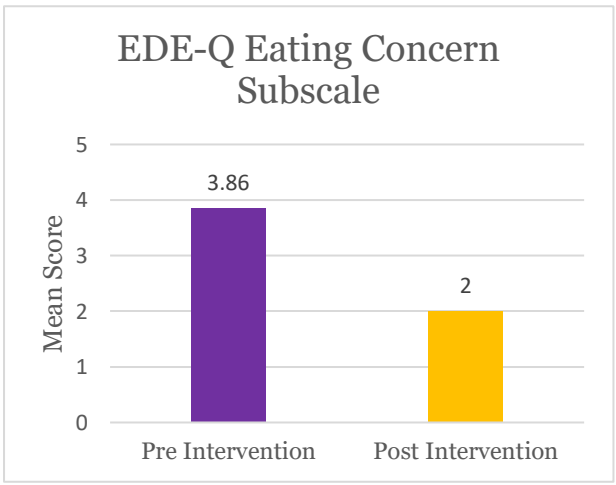
Symptomatology on the eating concern sub-scale decreased from (M = 3.86, SD = 1.14) to (M = 2.0, SD = 1.03). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -3.59, p < .001, with a moderate effect size (r = 0.63).

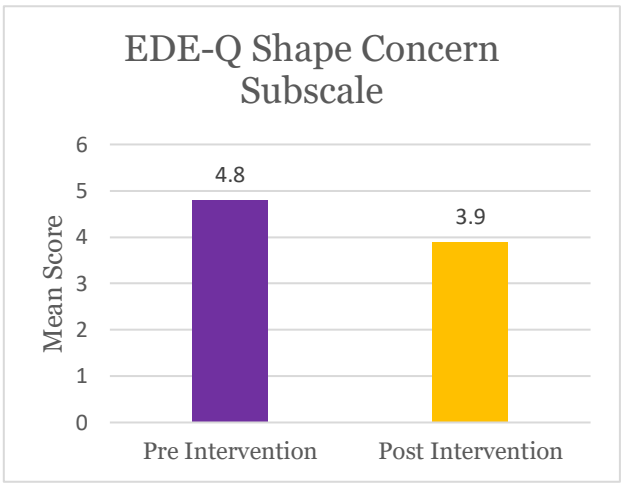
The shape concern sub-scale decreased from pre-treatment (M = 4.8, SD = 1.49) to post-treatment (M = 3.9, SD = 1.52). A Wilcoxin Signed Rank test analysis of shape concerns indicated there was a statistically significant change, z= -2.87, p < .01. A small effect size (r = 0.27) was recorded.

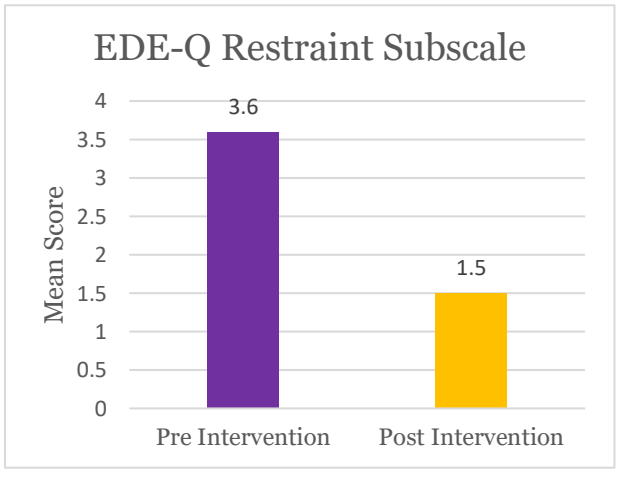
Finally, symptomatology on the weight concern sub-scale reduced between pre-treatment (M = 4.50, SD = 1.55) and post-treatment (M = 3.37, SD = 1.57). A Wilcoxin Signed Rank test indicated this was a statistically significant change, z= -3.25, p = .001, with a small effect size (r = 0.34).

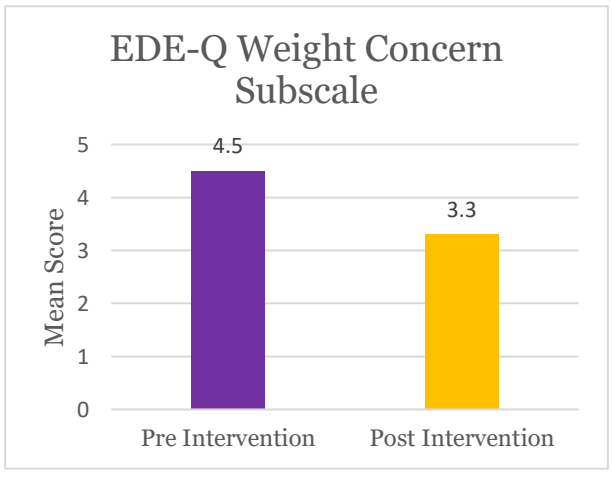
Graph: EDE-Q Global and sub-scale scores pre and post-intervention











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 25 attendees.

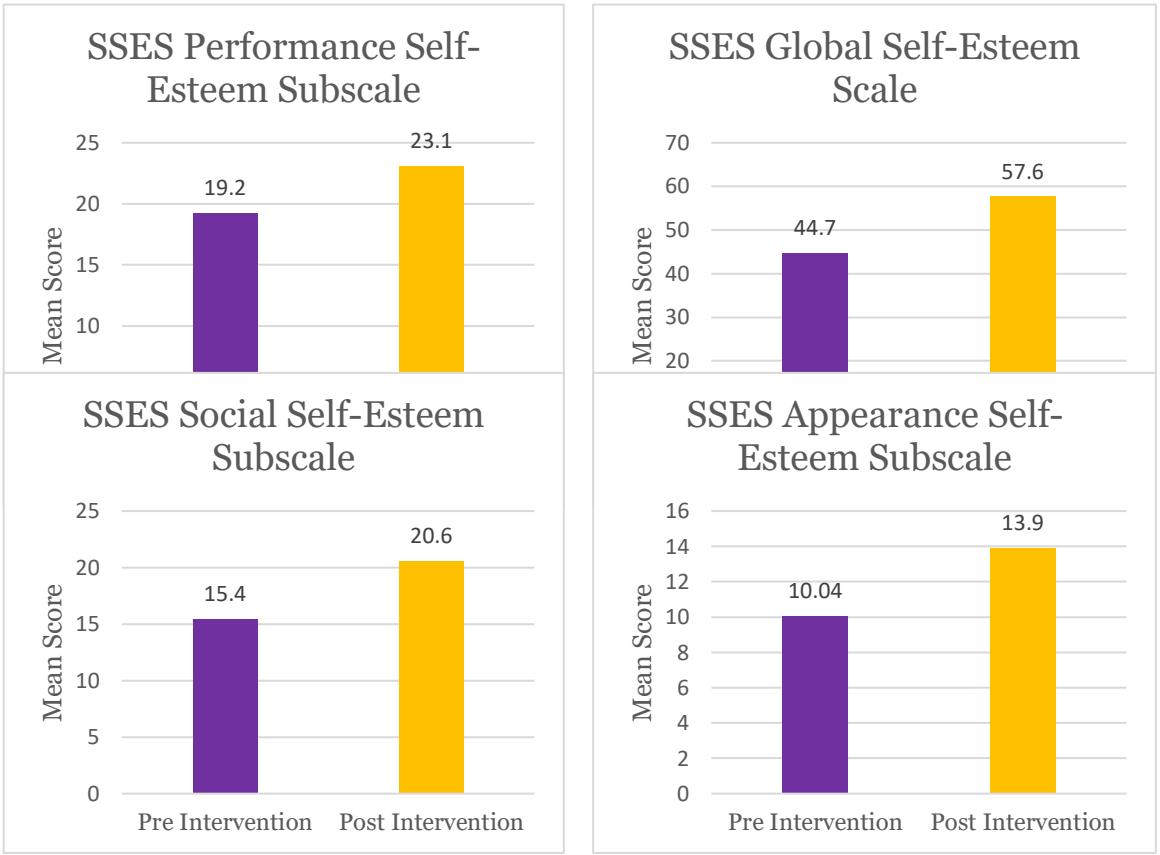
The total score on the SESS showed an increase between pre-treatment (M=44.7, SD = 13.18) and post-treatment (M= 57.6, SD = 14.1). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.48, p < .001, with a moderate effect size (r = -0.42).

Results indicate increased average mean across all the domains. Performance self-esteem increased from pre-treatment (M = 19.2, SD = 5.8) to post-treatment (M = 23.1, SD = 4.8). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -2.92, p = .003, with a moderate effect size (r = -0.34).

Social self-esteem increased from pre-treatment (M = 15.4, SD = 5.3) to post-treatment (M = 20.6, SD = 6.4). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.25, p = .001, with a moderate effect size (r = -0.40).

Appearance self-esteem increased from pre-treatment (M =10.04, SD = 3.69) to post-treatment (M =13.9, SD = 4.2). A Wilcoxon Signed Rank test indicated this was a statistically significant change, z= -3.62, p < .001, with a moderate effect size (r = -0.44).

Graph: State Self-Esteem Scale 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 as inpatients 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.

In response to the national public health restrictions resulting from the Covid-19 pandemic, EDP Day services transitioned to remote participation via audio-visual technology. However, this introduced challenges collecting outcome measures remotely during Covid-19. The service is working to improve the numbers of completed outcome measures in 2021 for both inpatient and day patient services.

4.11. Living Through Distress Programme

Living Through Distress (LTD) is a dialectical behaviour therapy (DBT) programme. The programme aims to teach emotional regulation, distress tolerance, mindfulness and interpersonal effectiveness skills for individuals who experience out of control behaviour in the context of emotional dysregulation.

DBT is a multimodal staged psychotherapeutic approach. LTD is a stage 1 DBT programme "focussing on moving from out of control behaviour to behaviour control, even (or especially) in the presence of high-intensity emotions" (Rizvi & Sayrs, 2020). Client behaviours determine the stage of treatment and this determination is done via assessment (not just based on report of diagnostic status). Stage 1 DBT targets life-threatening behaviours, severe therapy interfering behaviours and severe quality of life interfering behaviours. It provides a number of modes of intervention, group skills training, individual DBT sessions, phone coaching and DBT consultation team. Living Through Distress runs as a twice weekly group for 12 weeks and offers eight concurrent one-to-one sessions and phone coaching.

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 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.

Data is described below for cycle 64 - 67 for this programme which finished in 2020. Groups transitioned from face-to-face to telehealth in March 2020 via MS Teams due to national public health restrictions. Due to the difficulties adjusting to an online format data collection proved challenging and so unfortunately, data could not be collected from all those who participated in the programme.

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).

- **Ways of Coping Checklist**

The Ways of Coping Checklist (WCCL) is a measure of coping based on Lazarus and Folkman's (1984) stress and coping theory. The WCCL contains 66 items that describe thoughts and acts that people use to deal with the internal and/or external demands of specific stressful encounters. Participants respond on a four-point Likert scale (0 = does not apply and/or not used; 3 = used a great deal), the extent to which the item was used in the specific stressful encounter.

4.11.2. Descriptors

Pre and post-data were available for 17 participants who completed Level 1 ('getting in control') of the programme in 2020. Of these, 88.2% were female and 11.8% were male. LTD attendees ranged in age from 18 to 56 years, with an average age of 28.7 (*SD* = 12.14). Their highest level of educational attainment ranged from Junior Certificate (5.9%) to Leaving Certificate (41.2%) to non-degree third-level qualification (23.5%), to third-level degree (29.4%).

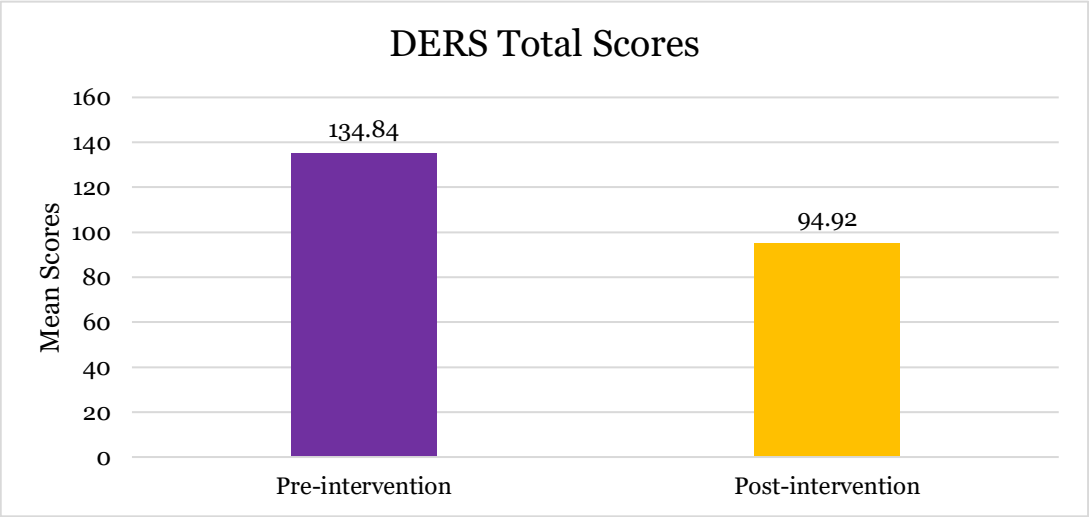
Attendees' current employment status was also recorded. 11.8% were in part-time employment, 11.8% were in full-time employment, 52.9% were unemployed, 17.6% were students and 5.9% chose other.

4.11.3. Results

Difficulties in Emotion Regulation Scale (DERS)

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 mean score of 134.84 (*SD* = 26.14) on the DERS at pre-intervention to 94.92 (*SD* = 28.46) post-completion of the programme, $z = -2.599$, $p < .05$. This change represented a medium effect size ($r = -0.45$). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores 2020

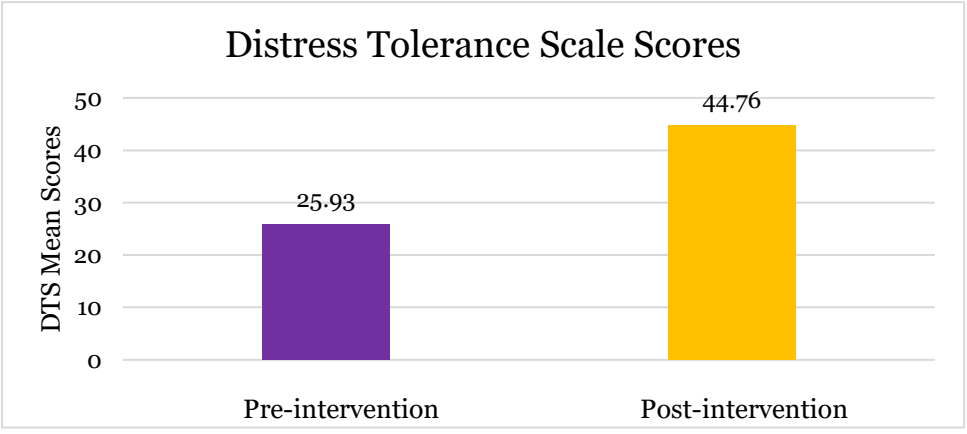


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale (DTS)

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 25.93 (*SD* = 7.68) before the programme on the DTS to 44.76 (*SD* = 12.86) after completing the programme, $z = -3.409$, $p = .001$. representing a medium effect size (r = -.58).

Graph: Distress Tolerance Scale Total Scores 2020

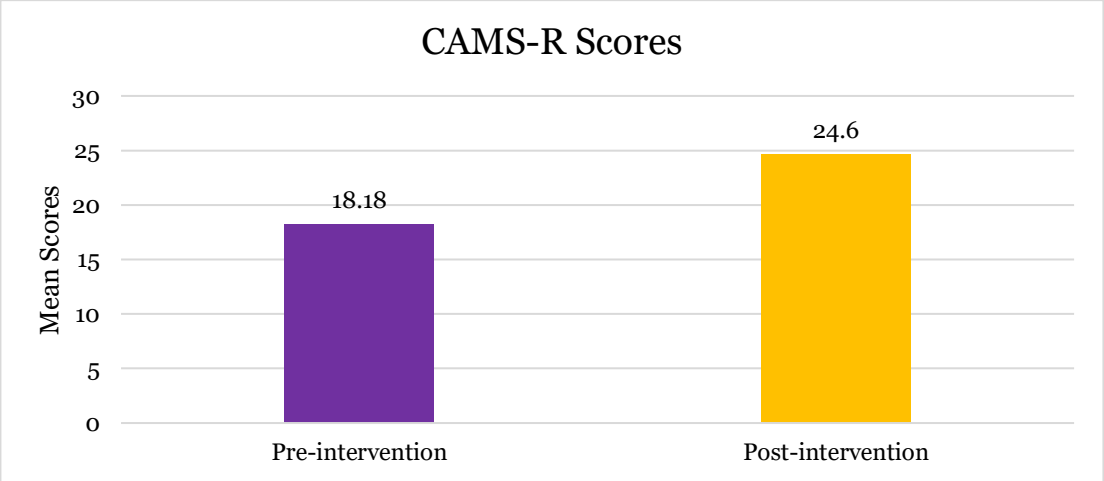


Note: Higher scores indicate increased ability to tolerate distress

Cognitive and Affective Mindfulness Scale Revised (CAMS-R)

Participants also had greater mindful qualities after completing the programme. Mean scores of 18.18 (*SD* = 3.98) at pre-intervention increased to 24.6 (*SD* = 5.02) at post-intervention. This was a statistically significant change; $z = -3.39$, $p = 0.001$, and represents a medium effect size (r = -0.58).

Graph: Cognitive and Affective Mindfulness Scale Total Scores 2020



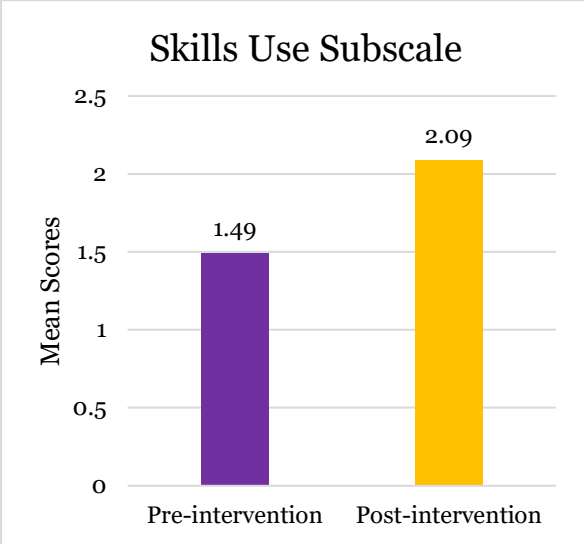
Ways of Coping Checklist (WCCL)

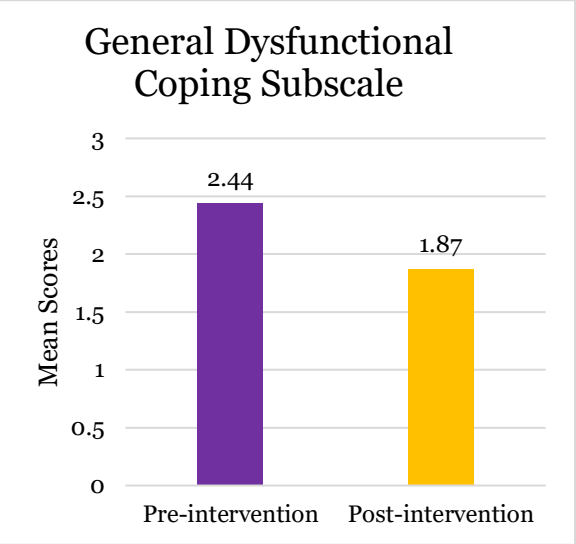
Results for the WCCL sub-scales indicated that participants reported a significant increase in the use of their DBT Skills. Mean scores on the Skills Use Sub-scale increased from 1.49 (*SD* = 0.57) at pre-intervention to 2.09 (*SD* = 0.53) at post-intervention, $z = -3.108$, $p < 0.05$, with a medium effect size (r = -0.57).

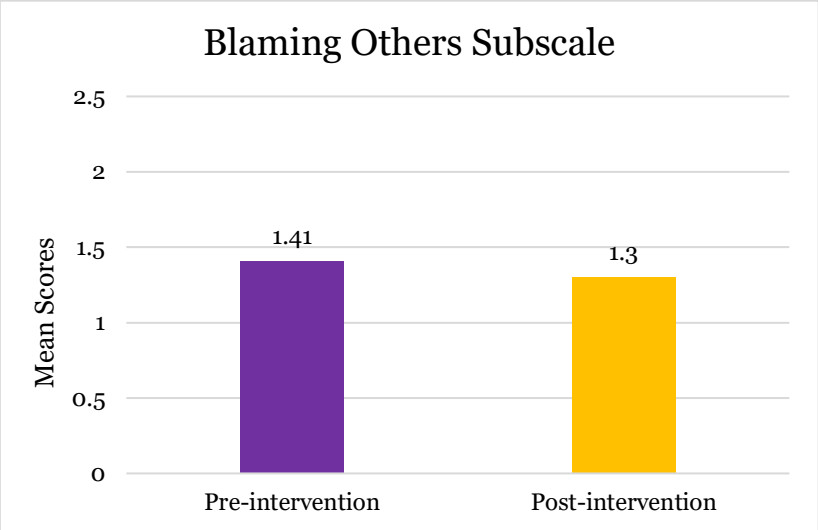
Mean scores on the General Dysfunctional Coping Sub-scale significantly decreased from 2.44 (SD = 0.33) at pre-intervention to 1.87 (SD = 0.54) at post-intervention, $z = -2.89$, $p < 0.05$. This represented a medium effect size (r = -0.5). This indicates that participants' abilities to cope improved upon completing the intervention.

Participants mean scores on the Blaming Others Subscale also showed a reduction from 1.41 (SD = 0.83) to 1.30 (SD= 0.5) post-intervention, however this result was non-significant.

Graph: Ways of Coping Checklist Subscale Scores 2020







4.11.4. Summary

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

LTD will reintroduce a Skills Only DBT programme in 2021. This will consist of 24 group sessions only. This programme will be primarily for service users who have pervasive difficulties regulating emotions, resulting in patterns of impulsive behaviours (excluding self-harm or suicidal behaviour in the last 12 months). Data collected from this programme will be included in the 2021 outcomes report.

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 2020, 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 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, promoting self-compassion and reducing shame and stigma often associated with experiences of psychosis.

Data is described below for two cycles for this programme which finished in 2020. Groups transitioned from face-to-face to remote running in March 2020 via MS Teams due to national public health restrictions.

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 qualitative feedback form was used in 2020 to capture group member 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 helpful about attending the LTP programme? If yes, what was this?
  - Is there anything that you found 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

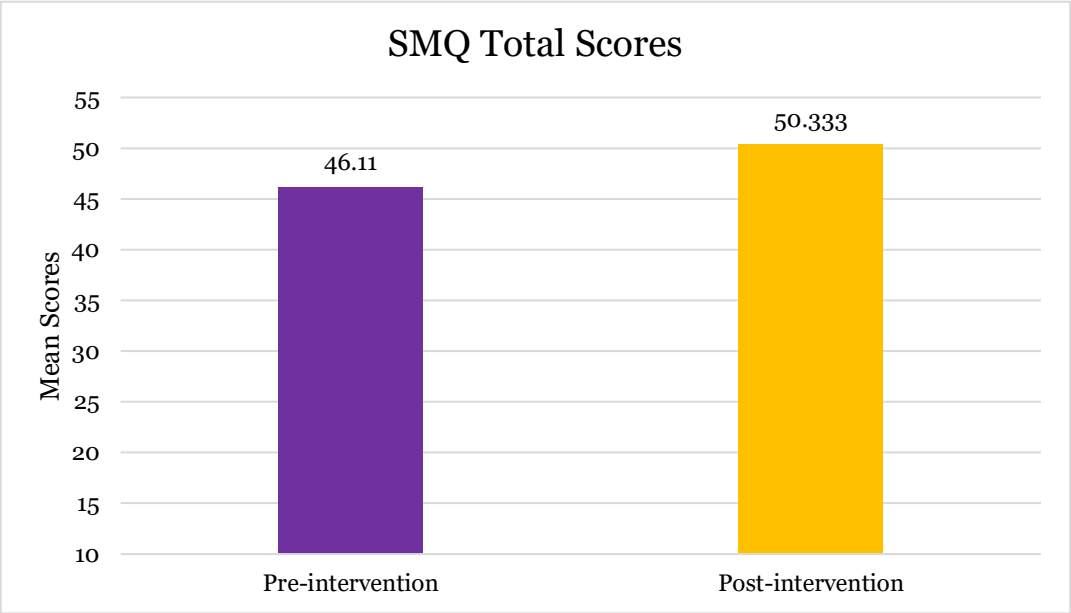
14 individuals completed the LTP programme in 2020. Programme attendees ranged in age from 19 to 65 years, with a mean age of 34.4 (SD = 13.1). Due to difficulties in collecting post-data during Covid-19, pre- and post-data was only available for nine individuals. Of the nine with complete data, five were female (56%) and three were male (44%).

4.12.3. Results

Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ indicated that individuals' tendency to mindfully respond to distressing thoughts and images significantly increased. The mean score of 46.1 (*SD* = 4.67) at pre-intervention increased to 50.3 (*SD* = 3.9) on the SMQ after completing the intervention, z = -2.03, p<.05, with a medium effect size (*r* = -0.47). Higher scores on this measure indicate greater mindful awareness.

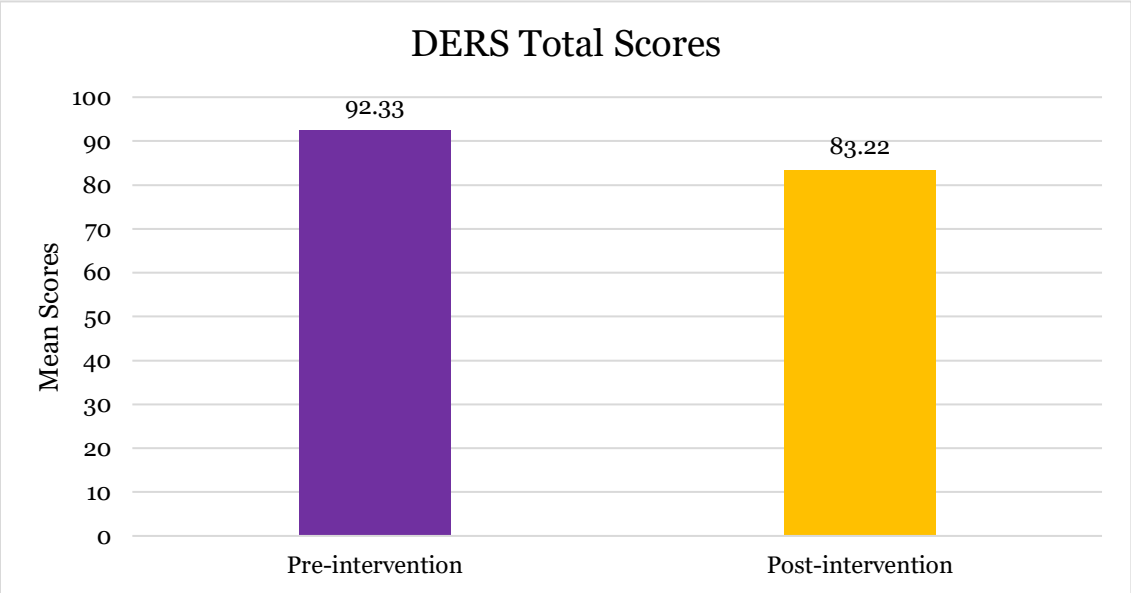
Graph: Southampton Mindfulness Questionnaire (SMQ) Total Scores



Difficulties in Emotion Regulation Scale (DERS)

Group members experienced a decrease in difficulties regulating emotions as measured by the DERS, moving from a mean score of 92.33 (*SD* = 28.73) at pre-intervention to 83.22 (*SD* = 20.06) post-intervention. However, this change was not found to be statistically significant z = -1.127, p > 0.5. Higher scores on the DERS indicate greater difficulties with emotion regulation.

Graph: Difficulties in Emotion Regulation Scale (DERS) Total Scores

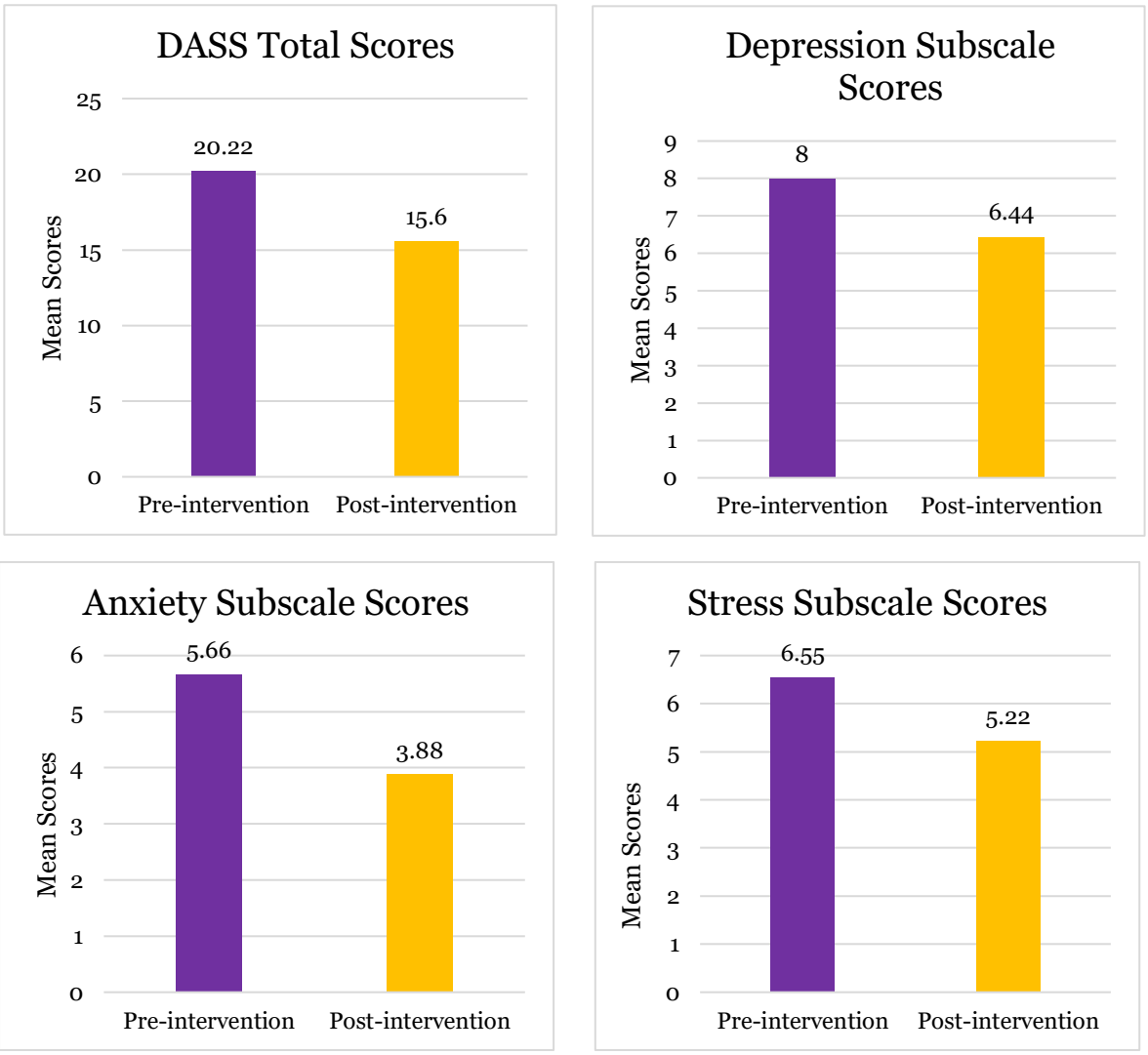


Depression Anxiety Stress Scale (DASS)

Analysis of the three sub-scales, which make up the DASS - stress, anxiety and depression – showed a decrease in total mean scores in psychological difficulties between pre (*M* = 20.2, *SD* = 14.73) and post-intervention (*M* = 15.55, *SD* = 13.37). A Wilcoxon ranks test showed that this difference was not statistically significant.

Group members' reported mean scores on the stress, depression and anxiety subscales all showed decreases between pre- and post-intervention, however these changes were non-significant.

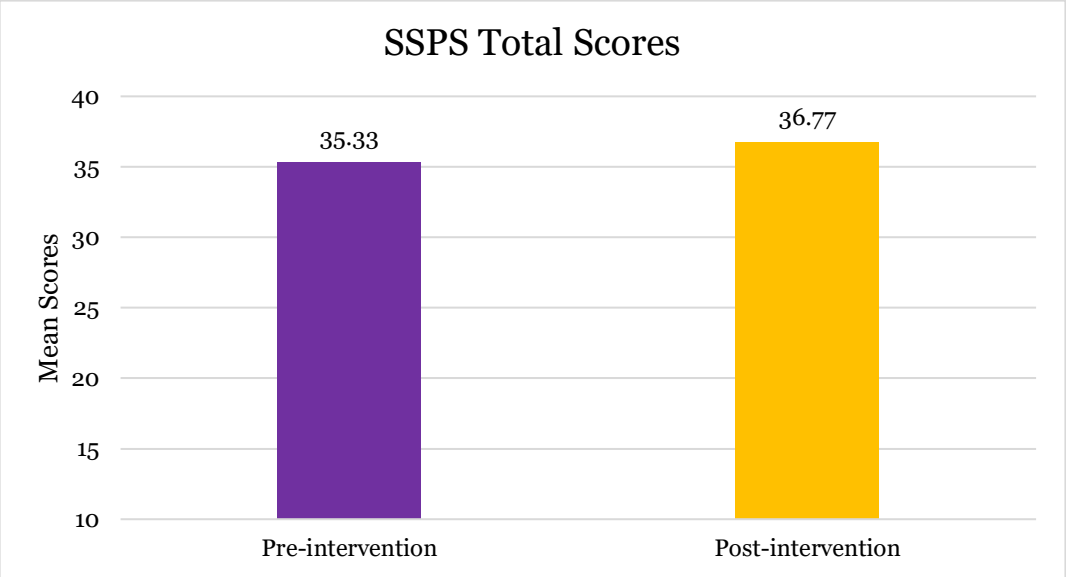
Graph: Depression Anxiety Stress Scale (DASS) and Subscale Scores



Social Safeness and Pleasure Scale (SSPS)

Higher scores in the SPSS indicates a greater sense of safety and belonging. Analysis of this measure found no statistical significant changes in mean scores between pre (*M* = 35.33, *SD*= 10.7) and post-intervention (*M* = 36.7, *SD*= 7.47) (total possible mean score = 55). The small sample size may have impacted on this measures sensitivity to statistically meaningful change.

Graph: Social Safeness and Pleasure Scale (SSPS) scores



Qualitative Feedback

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

Group members attending during 2020 reported to find various aspects of LTP helpful. Several reported that they found skills and practices taught on the group to be helpful, including practices focused on grounding and noticing emotional states, and on developing a capacity for mindful awareness. One group member reported that they found it "helpful how skills are introduced gradually with added complexity each week."

Others highlighted aspects of the CFT model as helpful, including learning about self-compassion. The CFT 3 circles emotion regulation model was reported to be "helpful" and aided group members to "move from threat to soothe" more readily.

Despite Covid-19 restrictions, a key feature reported by group members was a collective sense of feeling "connected with others who understand the struggle associated with psychosis". As one group member commented "knowing that there's others in the same situation as me makes my illness feel more common, less isolation". Group members also named finding the facilitators as warm, congruent, insightful and encouraging, and that the format of the group was helpful.

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

Some group members indicated that the move to remote working online was difficult, for example, one commented that "Face-to-Face sessions would've been nice, virtual worked ok however." Another commented that they felt the group was "too short".

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

One group member reported that they found the programme to be 'excellent', and another commented that "each topic as interesting and fully comprehensive." Others named the following areas as points for improvement. It was suggested by one group member that it would be helpful to "discuss psychosis more and understand when it's happening". Similarly, it was noted by another that it would be beneficial if facilitators were to "give more of a background to psychosis" including the percentage of people affected and the symptoms they experience. Another suggestion was for handouts sent out from group sessions to include references for further reading. Some group members named that they would also like to see the programme lengthened, with "more focus on emotions" and "more practices".

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

One group member commented on how they perceived group sessions to be “very well-planned”, and that they “could tell a lot of work went into it”. Another shared that they found the experience of doing the LTP group to be “very positive”. Other comments included that the “facilitators were patient and attentive”, and that it was possible to “share without pressure.”

One group member commented that they were “looking forward to using skills” following the group. Another shared that they “learned so much”, that the programme was “very beneficial” and that they “learned from others and felt accepted and cared for’. One group member shared the following,

> ‘It’s challenging to engage in group work and try to integrate the practice of new skills at those times but I always felt encouraged and supported, and that the group was meeting me at the place I found myself rather than demanding too much. It was lovely to feel accepted and understood, in as much as anyone can be understood by someone else.’
>
> LTP Group Member

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 results of this analysis indicate that group members appear to be developing their capacity for mindful awareness in particular. It is important to consider the impact of the small sample size when measuring significant change. Qualitative feedback suggests that the LTP programme continues to provide individuals with a space to explore psychosis in a non-judgmental manner while building skills and insights to help navigate moments of threat and move towards their own soothe systems. The qualitative feedback also provides helpful steer in terms of improving and developing the programme for future service users. At the outset of 2021, LTP programme facilitators are focused on continuing to develop and deliver a high-quality 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 SPL. 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).

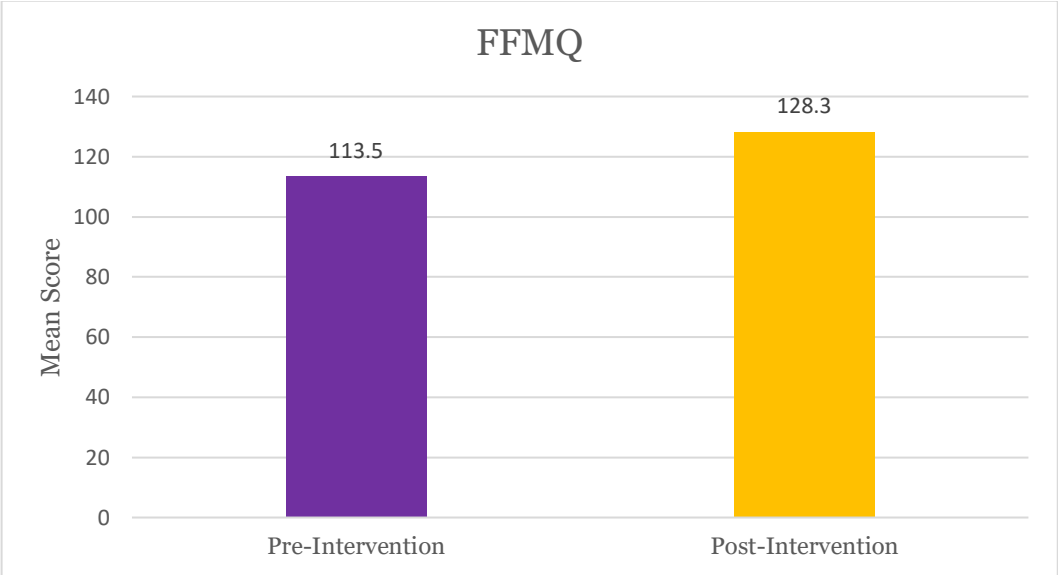
4.13.2. Descriptors

Data was collected on 41 participants; 18 males (43.9%) and 23 females (56%). Pre and post-data were available for 20 participants. Participants' age ranged from 22 to 67 years old (mean = 48 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=113.50; SD=16.63) to post-intervention (M=128.30; SD=14.50). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (19) = -4.682, p<.000, with a large effect size (Cohen's *d* = 1.23). 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 'describe' domain. A medium effect size for the 'awareness' (Cohen's *d* = 0.49), and the 'non-judgement of inner experience' domains (Cohen's *d* = 0.45) was found as well as a large effect size for the 'observe' (Cohen's *d* =0.73) and 'non-reactivity' domains (Cohen's *d* =1.06).

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	25.1 (4.1)	28.3 (4.5)	-4.488	19	.000	0.73

Describe	26.9 (7.1)	28.1 (6.5)	-1.091	19	.289	0.16
Awareness	21.4 (6.7)	24.6 (6.4)	-3.277	19	.004	0.49
Non-Judgement	23.1 (6.4)	25.8 (5.8)	-2.961	19	.008	0.45
Non-Reactivity	17.1 (5.0)	21.6 (3.3)	-4.754	19	.000	1.06

4.13.4. Summary

In line with the 2019 report, results for 2020 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 to large effect size apparent for changes on the measure overall. Medium to large effect sizes were reported for most significant sub-scales.

4.14.1 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 practicing 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: Orientation/mindfulness, Walk the Middle Path, Emotions and Relationships. Modules vary in length between two and six sessions.

Due to the small numbers attending the group (the group has a maximum of six young people attending at any one time), data from 2016 to 2020 were analysed together in order to provide more statistically meaningful feedback in relation to the effectiveness of the group.

Groups transitioned from face-to-face to remote running in March 2020 via MS Teams. Due to the difficulties adjusting to an online format data collection proved challenging and so unfortunately, data could not be collected from all those who participated in the programme.

4.14.1 Psychology Skills for Adolescents Outcome Measures

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

The Borderline Symptom List 23 is completed by young people. It was developed in 2009 to provide a way to quantify the symptoms experienced by people diagnosed with borderline personality disorder in a quick and efficient manner (Bohus et al., 2009). It was created from the original BSL-95 which was developed in 2007, based on a sample of 379 borderline patients (Bohus et al., 2007). It is a self-report questionnaire using a four-point Likert scale rating (0 = 'not at all' to four = 'very strong'). It asks the clients to evaluate their symptoms for the past week in a series of 23 questions. Research findings by Bohus et al. (2009) have found good psychometric properties for the BSL-23, which are comparable to those found longer BSL-95. There is also a high correlation between the BSL-23 scores from all samples they tested (range: 0.95–0.96) Internal consistency was also high with Cronbach's α ranging between 0.93–0.96.

- **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 (α = .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 2016 – 2020, 126 service users took part in the Psychology Skills Group for adolescents; 43 young people and 83 parents. Young people ranged in age from 14 – 18, with the average age of young people attending being 16.45 years. 88.4% of young people included in this analysis were female, 9.3% were male and 2.3% were transgender.

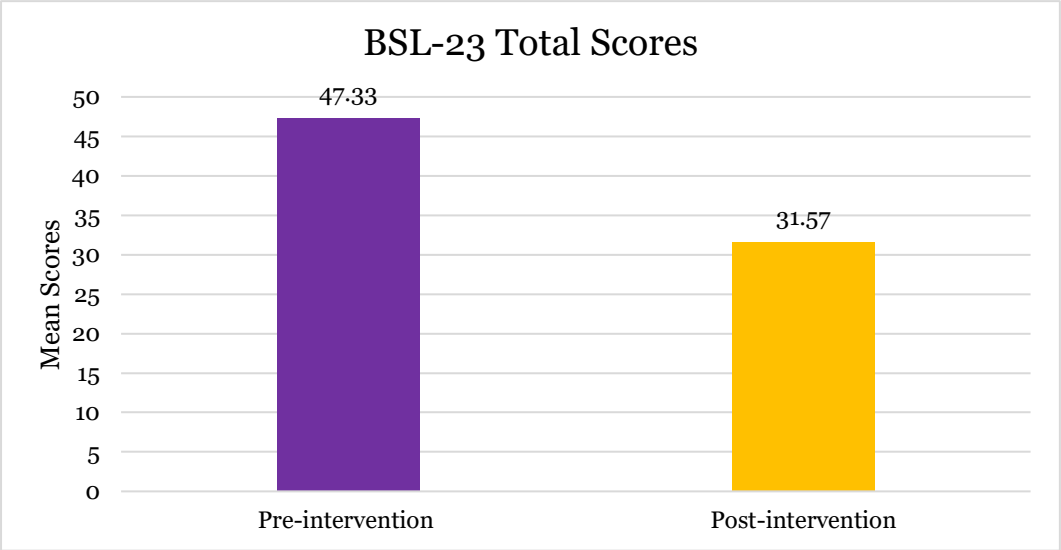
4.14.3 Results

Borderline Symptom List 23 (BSL-23)

This measure is completed by young people only. N = 21 for the number of adolescents which completed and returned pre- and post BSL-23 data.

A paired samples t-test showed there was a statistically significant decrease in borderline symptom scores for adolescents from pre (M = 47.33, SD = 22.35) to post intervention (M = 31.57, SD = 15.55), t(20) = 3.54, p < 0.05.

Graph: Borderline Symptoms List 23 Total Scores

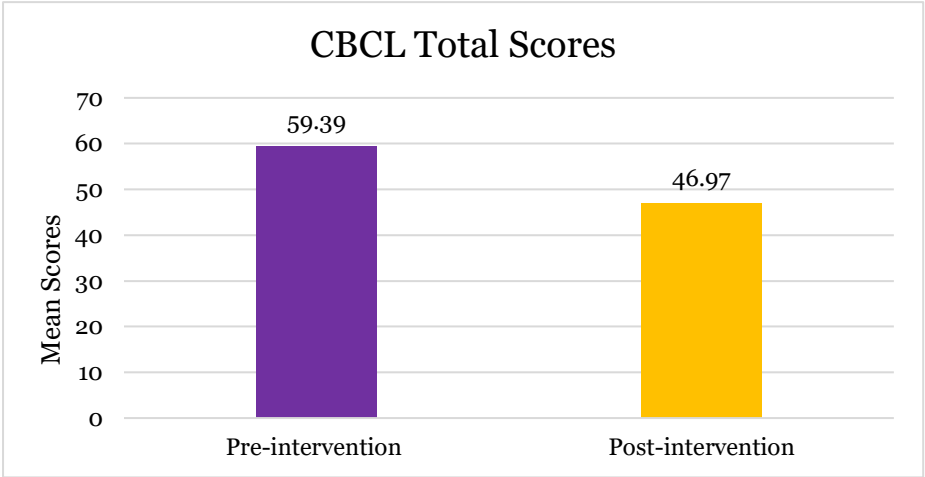


Child Behaviour Checklist (CBCL)

This measure is completed by parents only. N = 38 for the number of parents which completed and returned pre- and post- CBCL data.

There was a statistically significant decrease in total problems reported by parents from pre (M = 59.39, SD = 27.13) to post-intervention (M = 46.97, SD = 22.56), t(37) = 2.75, p < .05.

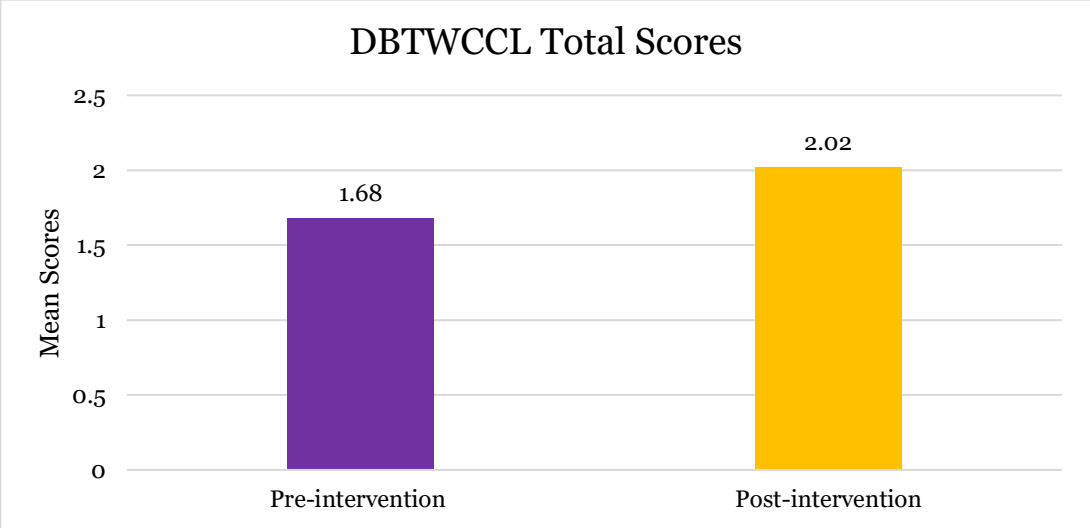
Graph: Child Behaviour Checklist Total Scores



DBT Ways of Coping Checklist (DBTWCCL)

For parents and young people who returned pre- and post- DBTWCCL measures, N = 19. Scores obtained demonstrate that DBT skill-use increased from pre-intervention to post-intervention. There was a statistically significant increase in the mean adaptive skill use scores for adolescents from pre (M = 1.68, SD = 0.11) to post intervention (M = 2.02, SD = 0.06), t(18) = 3.46, p < 0.05. There was no statistically significant decrease in DBT general dysfunctional coping or blaming others subscales for adolescents.

Graph: DBT Ways of Coping Checklist Total Scores

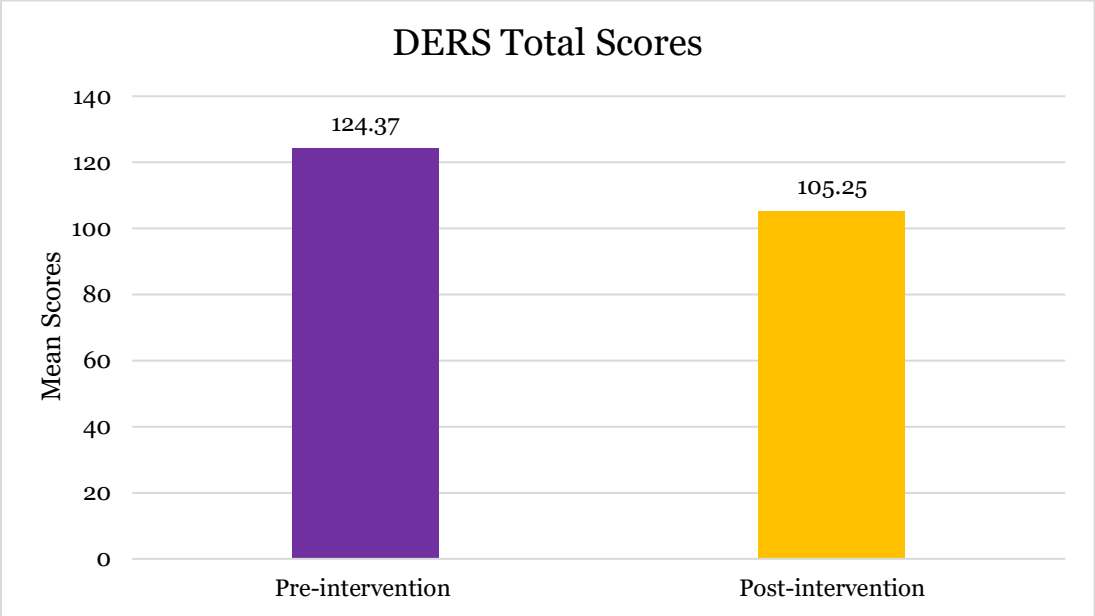


Difficulties in Emotion Regulation Scale (DERS)

This measure is completed by young people only. A paired samples t-test was conducted to determine whether adolescents demonstrated any significant changes in terms of their difficulties in emotion regulation from pre- to post-intervention. N = 16 for the number of adolescents which completed and returned pre- and post- difficulties in emotion regulation data.

There was a statistically significant decrease in difficulties in emotion regulation scores for adolescents from pre (M = 124.37, SD = 20.80) to post-intervention (M = 105.25, SD = 22.79), t(15) = 2.77, p < .05. Lower scores on the DERS indicate decreased difficulty in regulating emotions.

Graph: Difficulties in Emotion Regulation Scale Total Scores



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 rt their young people in the use of more adaptive coping strategies.

The findings presented provide a meaningful insight into the effectiveness of the programme. However, due to the small sample size, results should still be interpreted with caution. The results indicate that by attending the group, young people evidenced an increase in the use of DBT skills when coping with difficulty. They also reported experiencing less borderline symptoms after completing the programme.

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 and one new measure in 2020 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), the Personal Need for Structure (PNS) scale and the OC Trait Rating Scale (OC-TRS).

- **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 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 OCD personality 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).

- **The OC Trait Rating Scale (OC-TRS)**

The OC Trait Rating Scale (OC-TRS) (Seretis, Hemple, & Lynch, 2015) is a 24-item tool, using a six-point Likert scale response ranging from "disagree completely" to "completely agree." The OC-TRS was designed to measure eight domains of the OC trait: low openness to experience, low affiliation needs, negative emotionality, low positive emotionality, emotion expression inhibition, high moral certitude, compulsive striving and high detail-focused processing. A higher score indicates a higher degree of alignment with the OC trait.

4.15.2. Descriptors

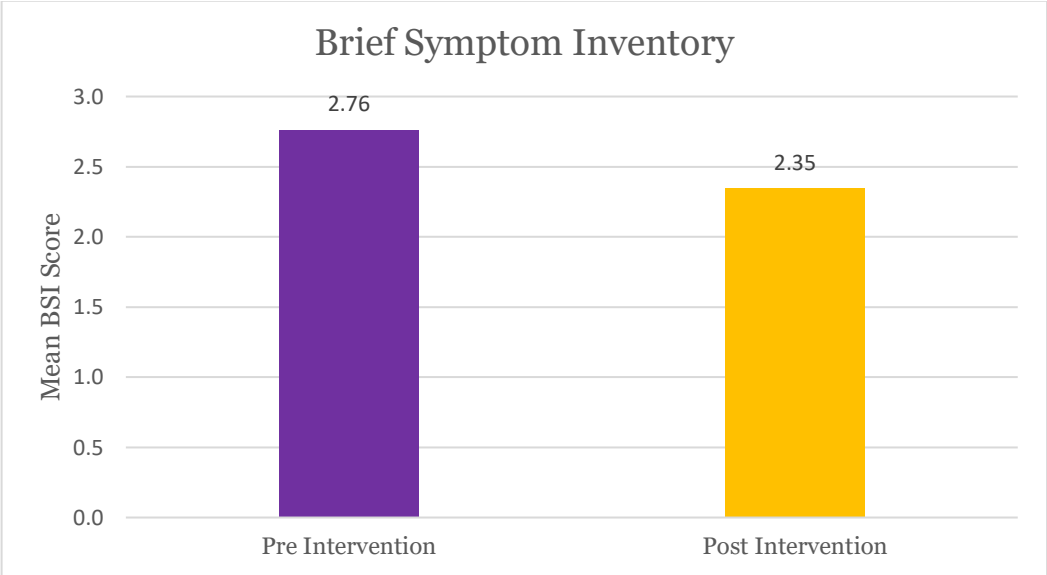
A total of 35 people completed the GRO programme in 2020. Pre and post-outcome data were available for 27 people, representing a 77% return rate. 54.3% of the participants were female and 45.7% were male. Participant's ages ranged from 19 years to 66 years (M=38.46, SD=14.67).

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 (26) = 4.49, p<.000, reflecting a moderate effect size (*Cohen's d*= 0.62).

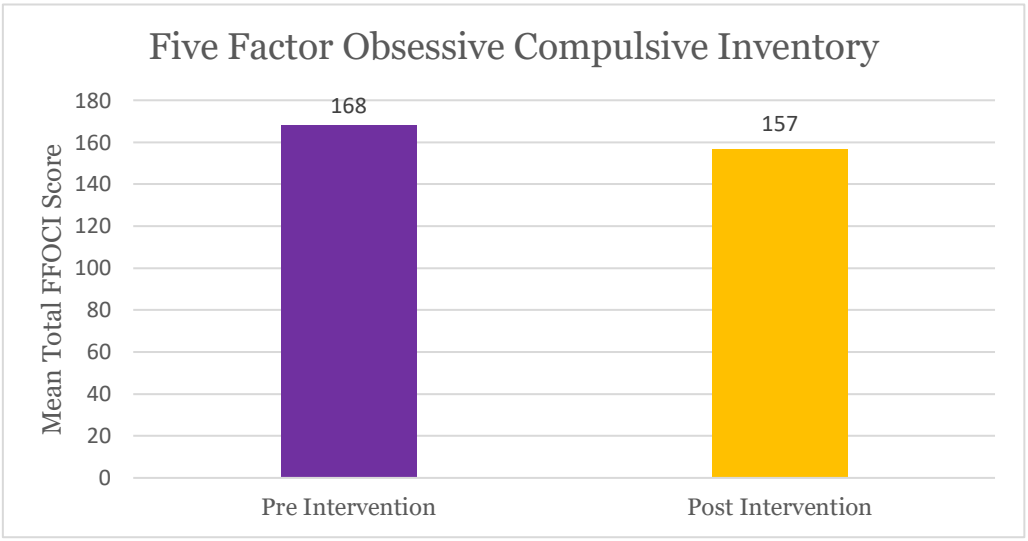
Graph: Brief Symptom Inventory, Global Severity Index (GSI) pre and post-intervention means comparison



Five Factor Obsessive Compulsive Inventory (Short Form)

A significant change was also observed on the FFOCI-SF, whereby t (26) = 3.23, p= .003, reflecting a moderate effect size (Cohen's *d* = 0.50). This suggests that after completing the programme participants were experiencing a reduction in traits associated with OCPD.

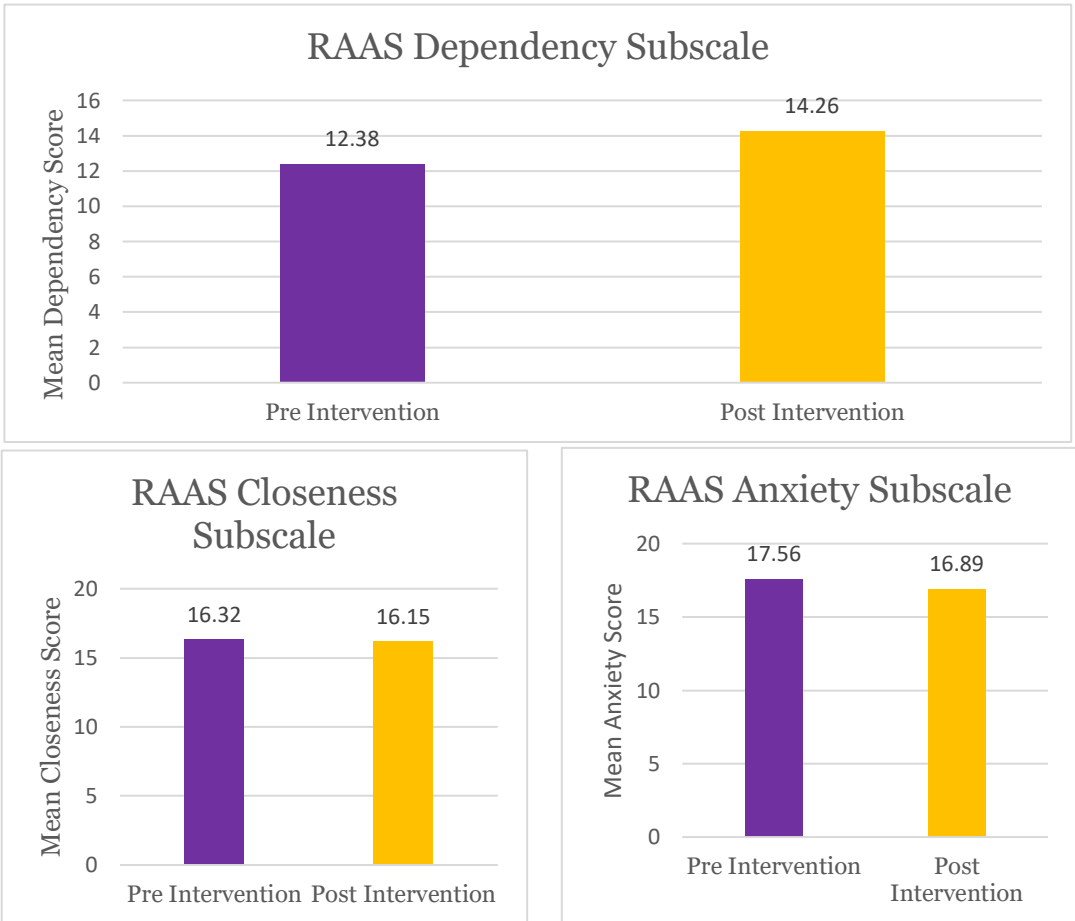
Graph: Five Factor Obsessive Compulsive Inventory – Short Form Mean total scores pre and post-intervention



Revised Adult Attachment Scale (RAAS)

A significant change was observed on one of the three RAAS sub-scales; dependence. In the dependence sub-scale, t (26) = -2.16, p = .040, reflecting a small effect size (Cohen's d = 0.39). This suggests that after completing the programme participants felt more comfortable depending on others. However, the small effect size suggests that this result must be interpreted with caution. There was no statistically significant difference on the anxiety and closeness sub-scale pre and post-intervention. This indicates that participants' anxiety levels (with regards to close relationships) and feelings of comfort with closeness and intimacy in everyday life did not change after completing the programme.

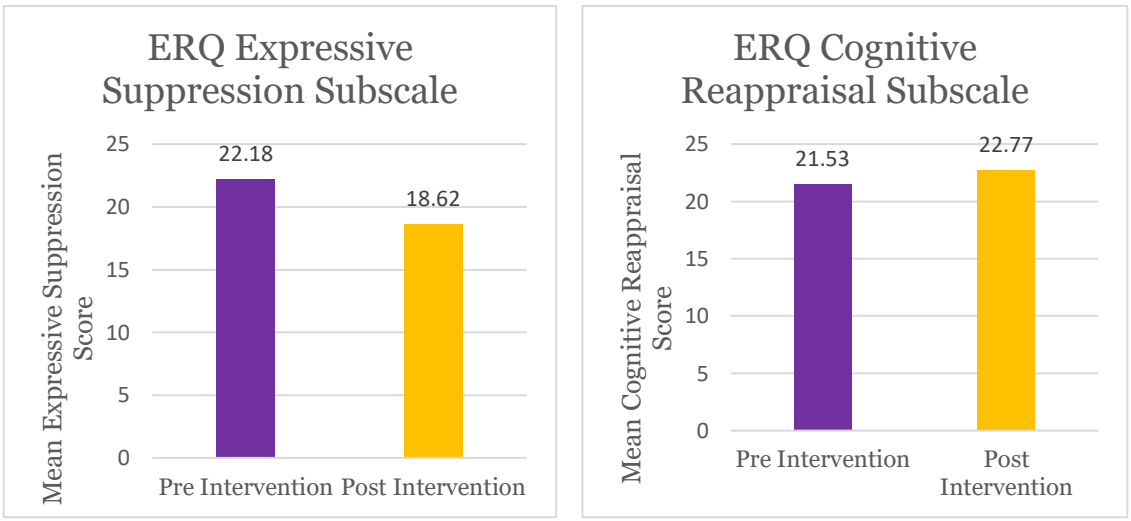
Graph: Revised Adult Attachment Scale (RAAS) Subscales Mean Total Score Pre and Post-Intervention



Emotion Regulation Questionnaire (ERQ)

Significant change was observed in the emotion regulation strategy sub-scale of expressive suppression [t (26) = 3.52, p = .002] with a large effect size (Cohen's d=0.74) indicated. This suggests that participants reported less suppression of their emotions following completion of the programme. There was no statistically significant difference on the sub-scale of cognitive reappraisal. This suggests that participants did not demonstrate statistically significant improvements in their ability to reappraise unhelpful cognitions regarding emotions following completion of the programme.

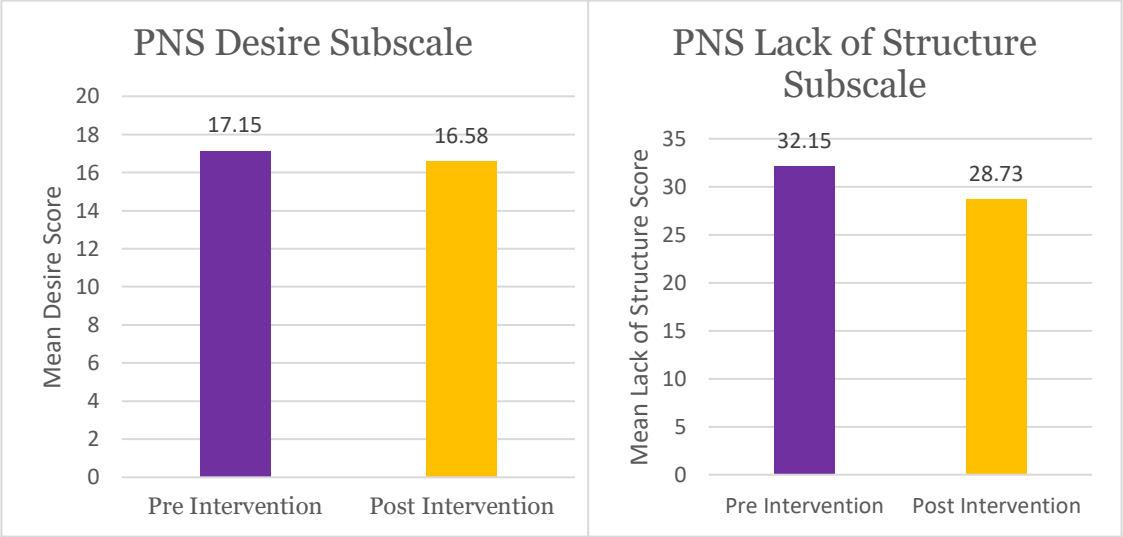
Graph: Emotion Regulation Questionnaire (ERQ) Subscales Mean Total Scores Pre and Post Intervention.



Personal Need for Structure (PNS)

Significant change was observed on one of the two sub-scales of the PNS; response to lack of structure, where t (25) = 3.63, p = .001, reflecting a moderate effect size (Cohen's d=0.68). This suggests that participants reported increased flexibility after completing the programme. 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.

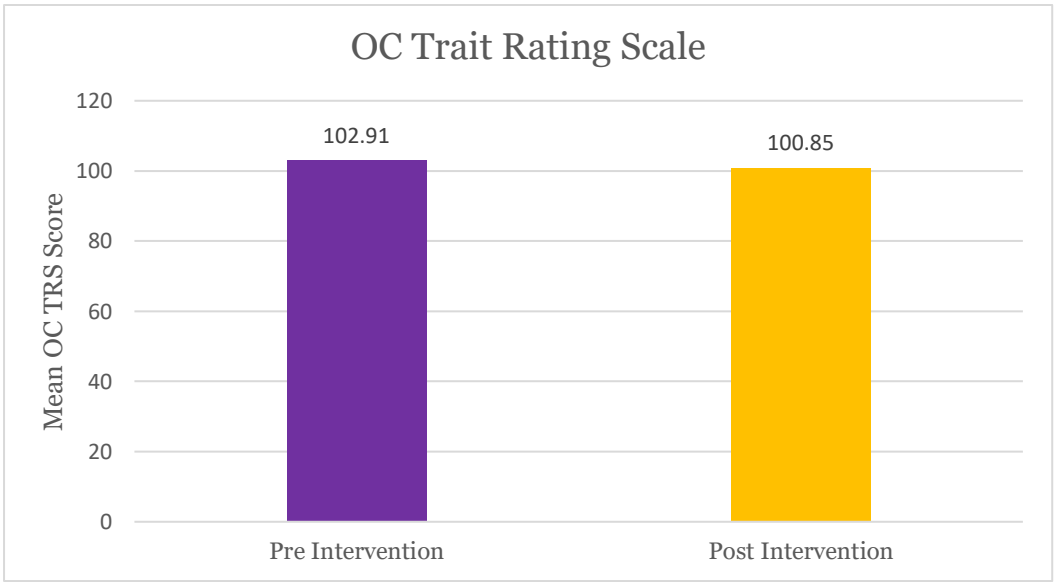
Graph: Personal Need for Structure Subscales mean total scores pre and post-intervention



OC Trait Rating Scale (OC-TRS)

No significant change was also observed on the OC Trait Rating Scale, t(25) = .547, p= .589. Though a small reduction was observed it did not reach a level of statistical significance.

Graph: OC Train Rating Scale (OC-TRS) mean 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 2020, 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 depending on others. Service users also showed 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.

It is also important to note that in response to Covid-19 restrictions, service delivery was adapted and changed to online delivery. In order to ensure the highest possible quality of service delivery, the number of places offered per group was lowered. However, the online delivery had an impact on outcome measure returns. The GRO programme is hoping to facilitate the completion of outcome measures online in 2021 in order to maximise outcome responses. It is predicted that numbers and outcomes will continue to improve in 2021.

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 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, occupational therapist, pharmacist, art therapist and input from a social work student at specified periods.

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.

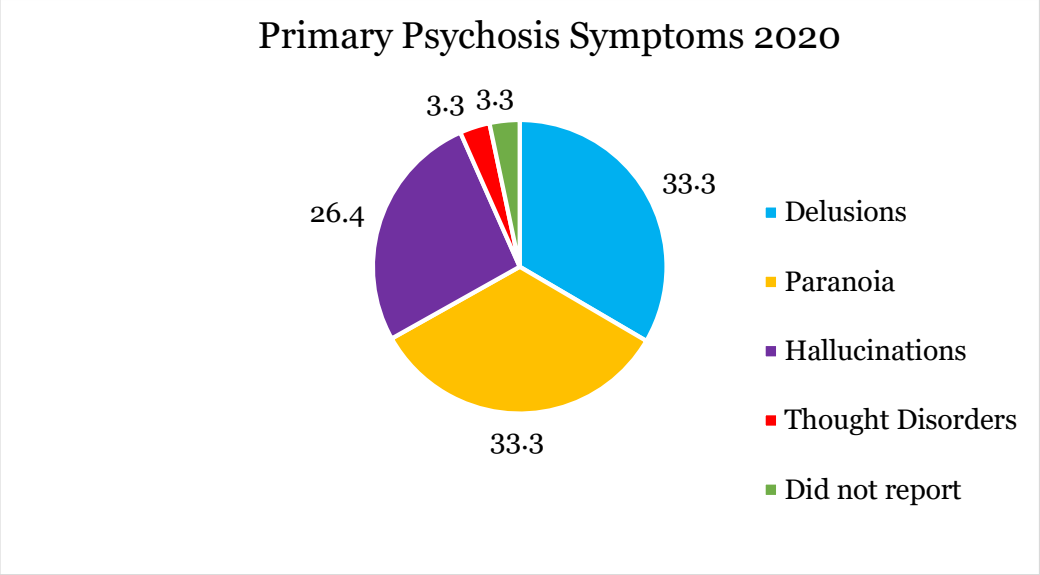
4.16.2. Descriptors

In 2020, complete pre and post-RAS and DAI scores were available for 30 participants. The average age of Psychosis Programme participants was 37.6 years (ranging from 18 - 76 years). 50% were female (n = 10) and 43.3% were male (n= 13). 76.6% were single, 16.7% married, and 3.3% were cohabiting with a partner. 3.3% did not provide this information. 23.3% were in employment, 20% were unemployed, 20% were students, 16.3% were receiving disability allowance and a further 16.6% were either in part-time employment or retired.

Regards highest level of education attained, 46.7% had completed the Leaving Certificate, 36.7% had attained a third-level degree, 6.7% had completed the Junior Certificate and with 3.3% had a non-degree third level qualification. 3.3% had finished education at primary school level and a final 3.3% did not provide this information. The majority lived with family (76.7%), followed by living alone (16.7%). 3.3% were living with friends or cohabiting. The majority of service users reported their ethnicity as white Irish (96.7%). Comparing 2019 to 2020, service users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

In 2019 and 2020, service users reported that delusions were the primary psychosis experience. However, there has been an increase in the reported primary experience of paranoia and a decrease in hallucinations. 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%). In 2020, the primary reported symptoms were delusions (33.3%) and paranoia (33.3%), followed by hallucinations (26.7%), and then thought disorders (3.4%). No participants rated negative symptoms as their primary psychosis experience. See graph below for reported primary psychosis symptoms in 2020. The average attendance at sessions per client in 2020 was 9.63 (SD = 4.13). Participants are permitted to attend multiple cycles of the programme.

Graph: Primary Psychosis Symptoms 2020



4.16.3. Results

Recovery Assessment Scale (RAS)

A Wilcoxon Signed Rank test identified a statistically significant difference in mean total scores for the RAS from pre- intervention (M = 3.68; SD = 0.38) to post-intervention (M = 4.06; SD = 0.39), z = -4.169, p < 0.05 with a large effect size (*r* = -0.76). This indicates that overall, service users experienced an increase in coping ability and quality of life following completion of the programme.

Significantly higher mean scores were identified post-intervention for services users on all RAS sub-scales. This indicates that participants had increased confidence and hope, had greater abilities to ask for help and rely on others, could be goal directed and 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.

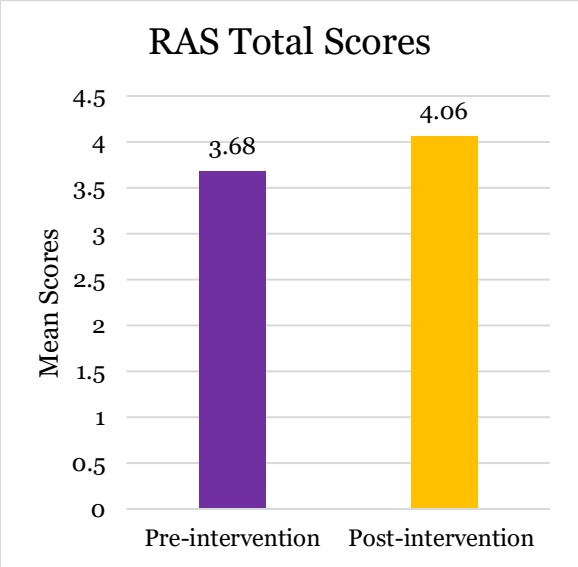
RAS	Pre Mean	Post Mean	*z*	*p*	*r*
Mean Total	3.68	4.06	-4.169	< 0.05	-0.76
Confidence and Hope	3.60	4.00	-3.742	< 0.05	-0.68

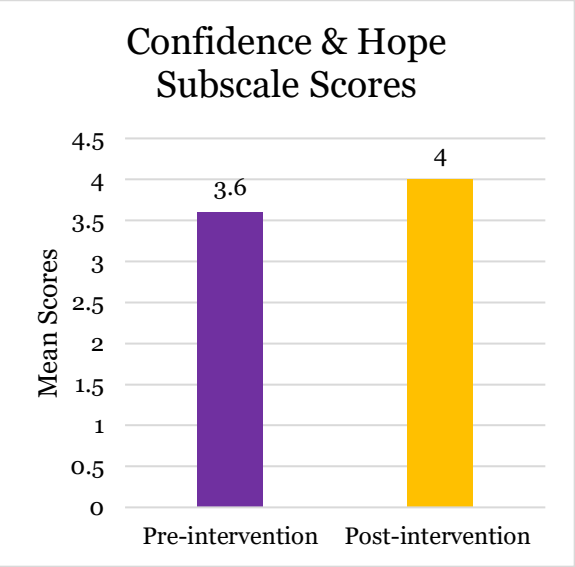
Willingness to ask for Help	3.94	4.14	-3.509	< 0.05	-0.64
Goal/ Success Orientation	3.685	4.27	-3.553	< 0.05	-0.64
Ability to Rely on Others	3.98	4.28	-2.357	< 0.05	-0.43
Not Dominated by Symptoms	3.02	3.42	-2.927	< 0.05	-0.53

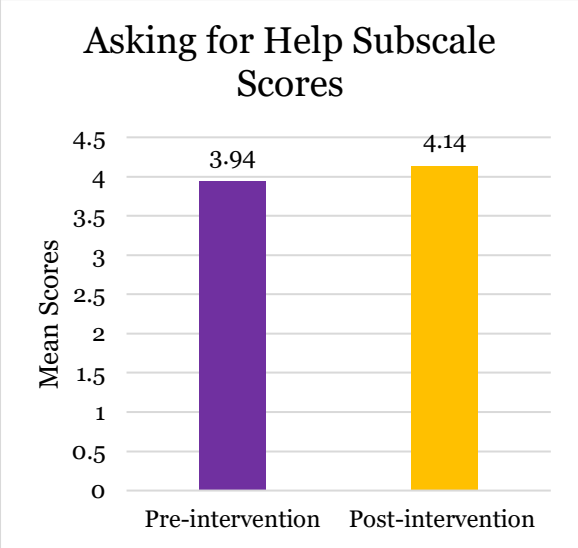
Table: *Results from Wilcoxon Signed Rank tests for the RAS pre- and post-scores*

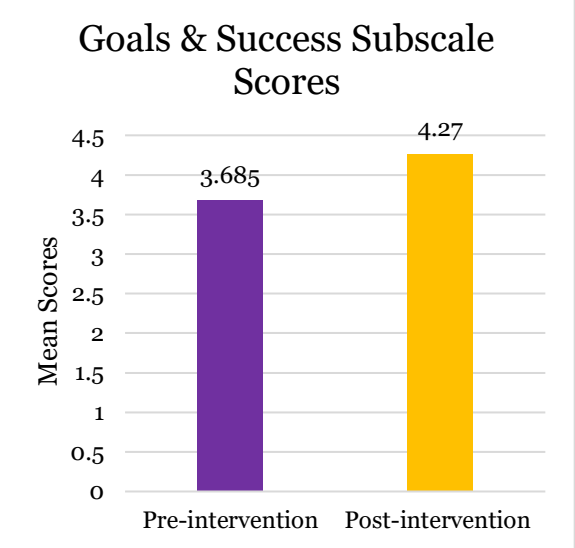
RAS = Recovery Assessment Scale.

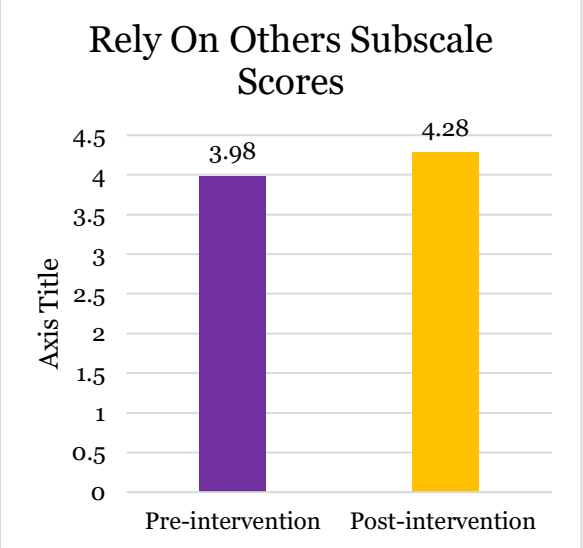
Graphs: Recovery Assessment Scale Total and Subscale Scores

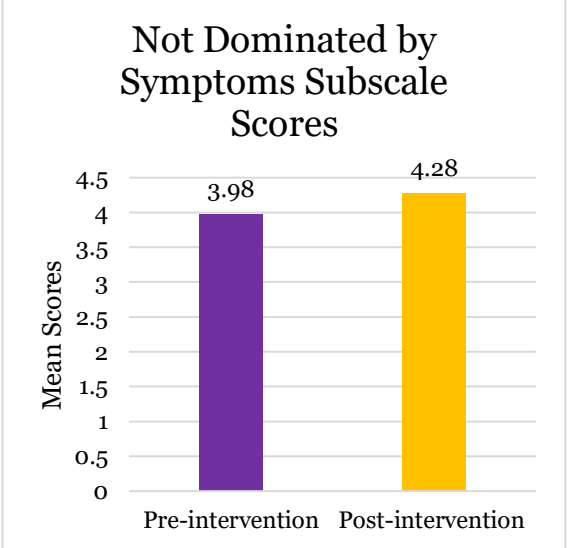








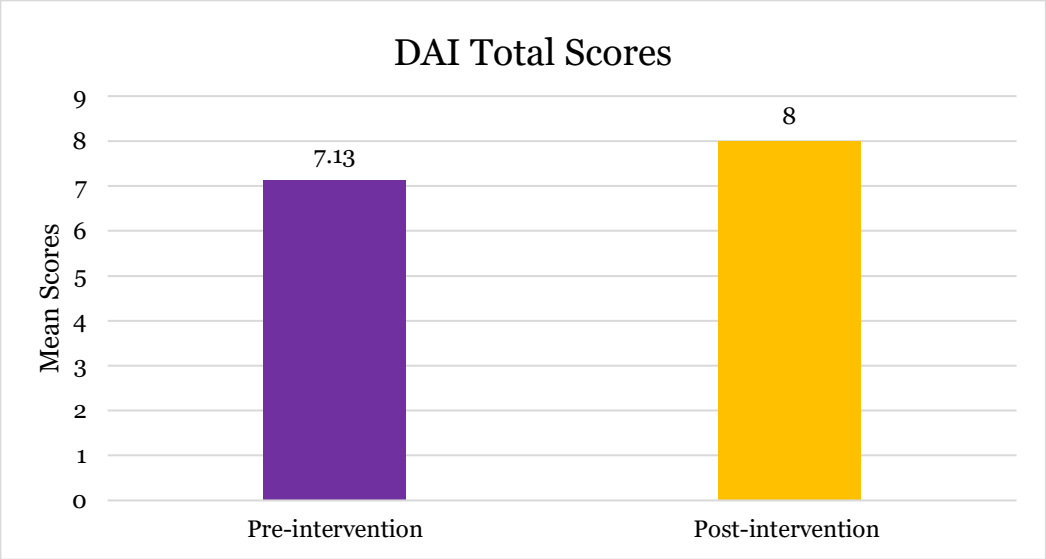




Drug Attitude Inventory (DAI)

A Wilcoxon Signed Rank test identified an increase in mean scores on the DAI-10 from pre-intervention (M = 7.13, SD= 2.62) to post-intervention (M = 8; SD = 2.22); z = -2.468, p < 0.05, demonstrating a medium effect size (r = -0.45). 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.

It is important to note that questionnaires were distributed to 56 service users who attended the programme in 2020, therefore the results outlined above may not be indicative of all views of those attending the Psychosis Programme. Programme staff explained that clients' inability to complete the measures accurately was often due to the acute nature of their illness. Covid-19 may also have impacted on the number of

returned outcome measures, but despite this, the response rate by those who attended the Psychosis Programme increased by 30% 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 and 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 aftercare 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

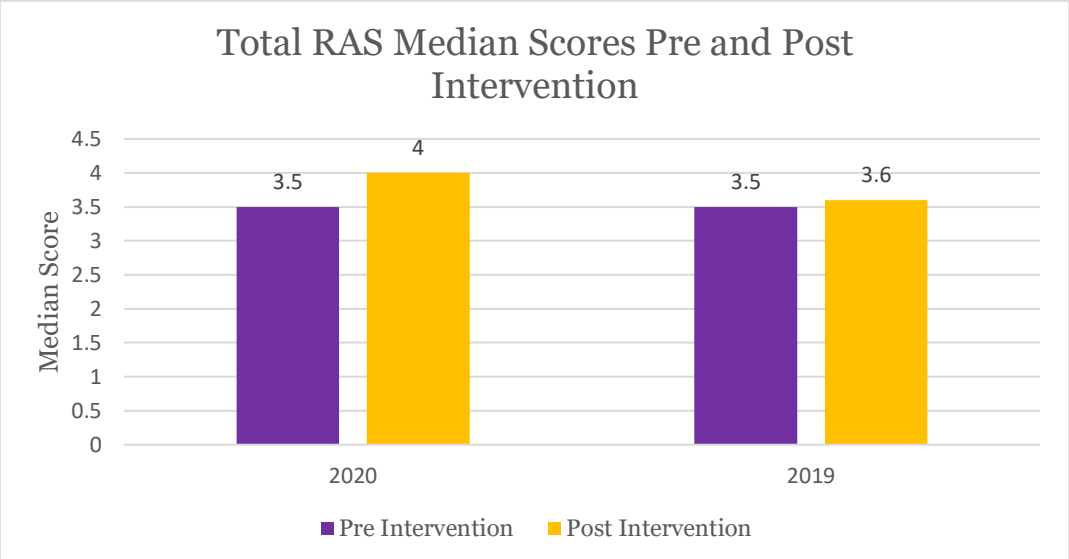
Pre and post data were available for 27 participants who attended in 2020. The average age of participants was 54 years, with 55.5% of participant's being female.

4.17.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre-measurement (*Md* = 3.5, *SD*=0.50) to post-measurement (*Md* = 4.0, *SD*= 0.52), indicating greater overall recovery. A Wilcoxon Signed Rank Test revealed this increase was statistically significant, $z = -4.026$, $p < 0.00$, with a large effect size, *Cohen's r* = 0.91.

Graph: Recovery Assessment Scale, median scores pre and post-intervention 2019 and 2020

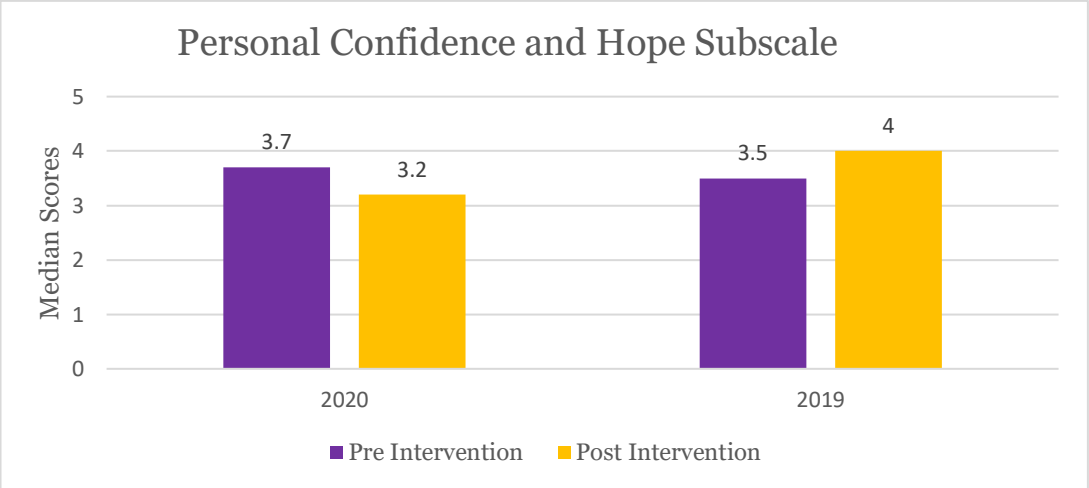


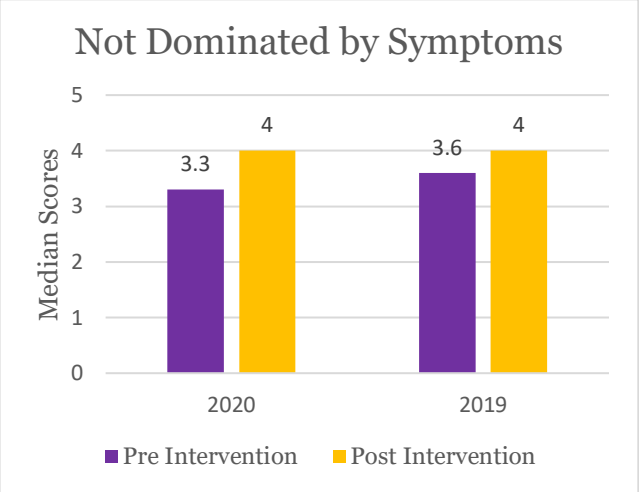
The figures below show pre and post scores on each of the five sub-scales; willingness to ask for help, personal confidence and hope, ability to rely on others, not dominated by symptoms and goal and success orientation. A series of Wilcoxon Signed Rank tests were run in order to compare pre and post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

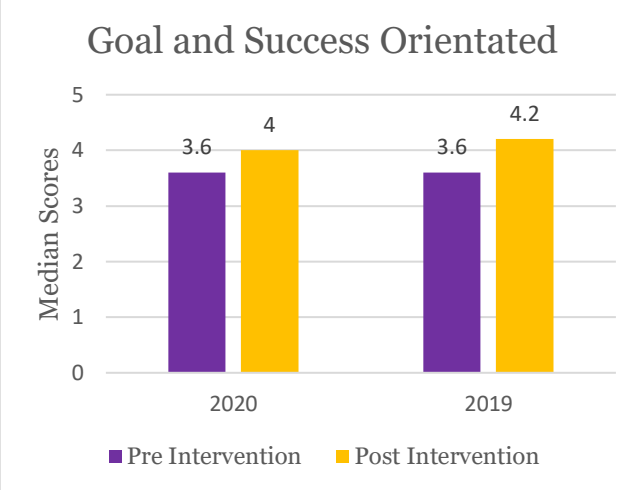
Table 2: Median scores on RAS (Wilcoxon Signed Rank tests)

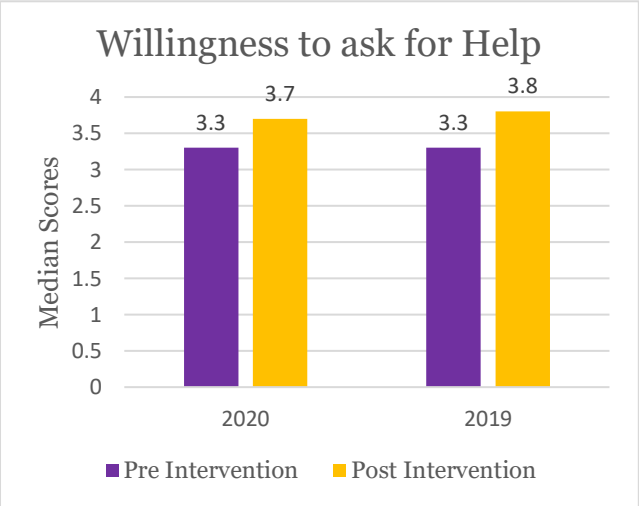
s		t	lue		Cohen's r
	m	m			
lingness to Ask For p		3.80	5	)*	0.68
sonal Confidence			2	)*	0.99
bility to Rely on Others			9	*	
Dominated Symptoms	3.22		7	)*	)
l and Success entation	3.35		3	)*	

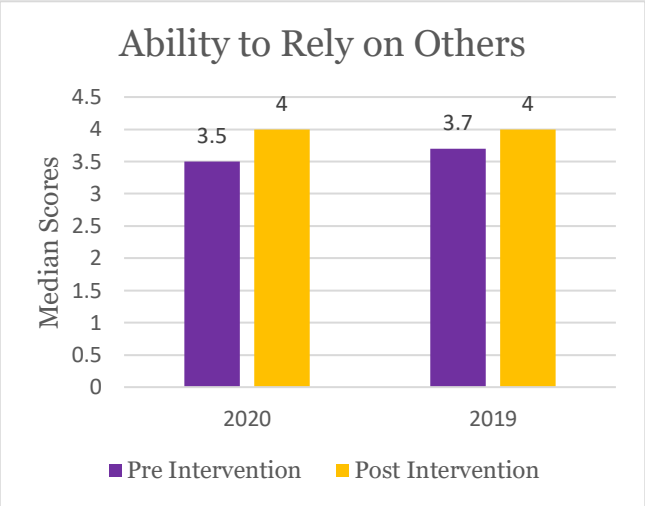
Graphs: Recovery Assessment Scale sub-scale median total scores pre and post intervention







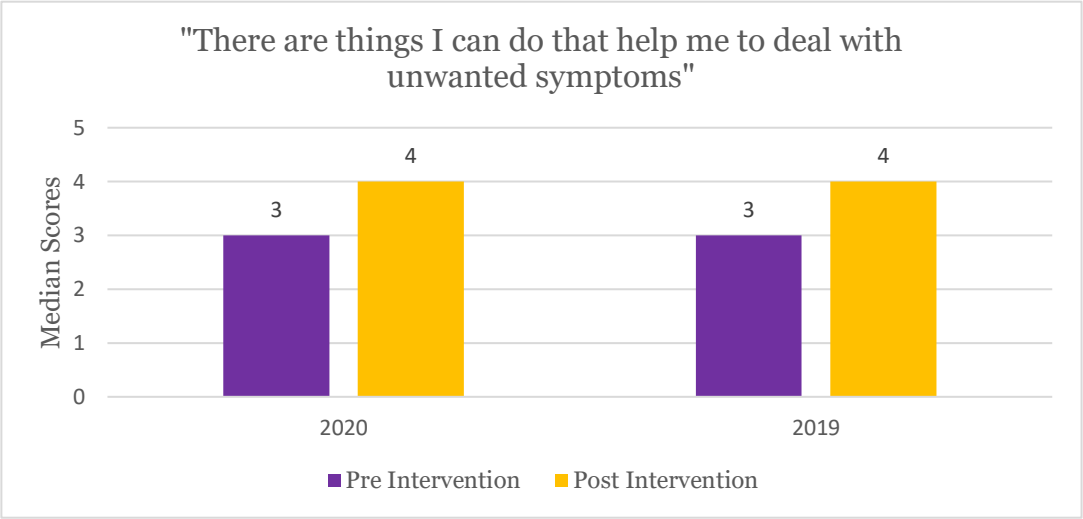


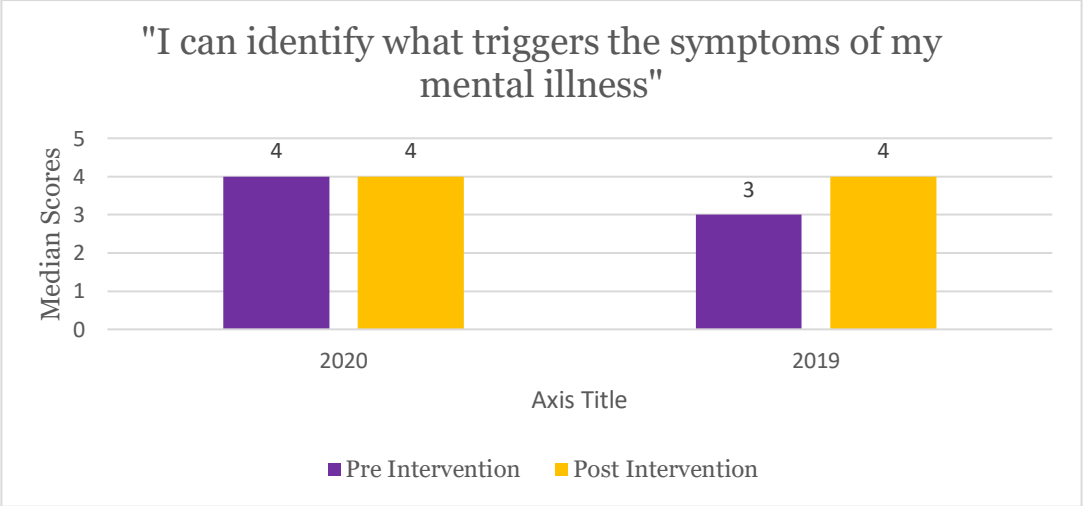


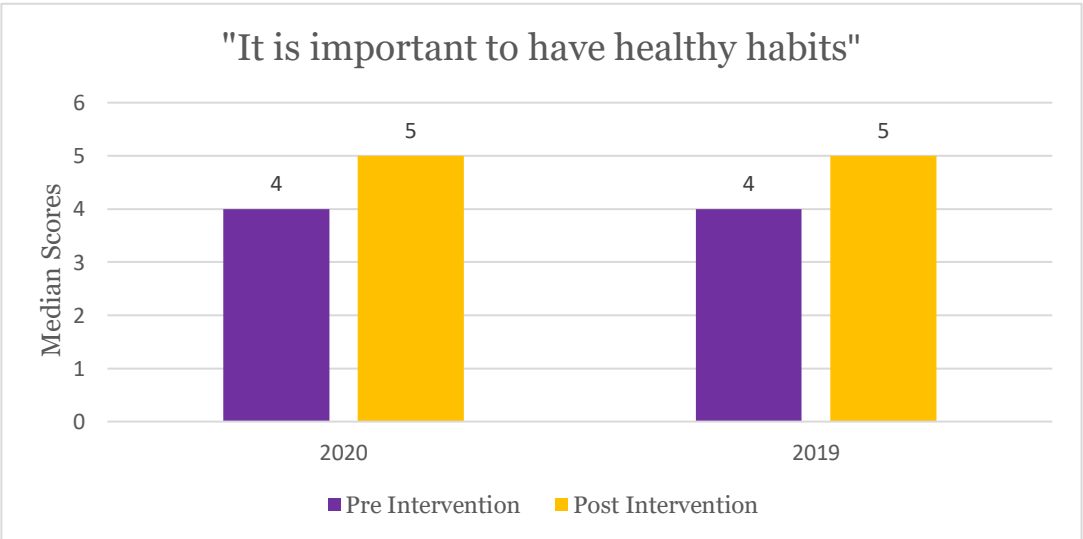
From clinician reflection, it was recommended in the 2012 report to examine certain individual items not included in the sub-scale scores that reflect elements of the programme. These included item nine – 'I can identify what triggers the symptoms of my mental illness'; item 13 – 'There are things I 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 9 (z = -2.368, p = 0.018) and item 13 (z = -2.667, p < 0.008) both showed statistically significant change in scores. Item 41 did not indicate significant improvements, z = .0.333, p = 0.739. Item 9 and 13 both showed a medium effect size, *Cohen's d* = 0.65, *Cohen's d* = 0.68.

Graph: Recovery Assessment Scale items nine, 13, 41 median total scores pre and post-intervention 2019 and 2020







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 to large 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.

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, 2018; Booth et al, 2018), and how these can contribute to recurrent mental health difficulties. The programme is comprised of 16 group sessions and two individual sessions, addressing difficulties with emotional regulation, interpersonal aloofness, emotional loneliness and cognitive and behavioural rigidity.

Data is described below for cycle 12 of this programme, which was completed in February 2020. Due to national public health restrictions, the programme transitioned to participation through audio-visual technologies. Data collection proved challenging for this remote cycle and so unfortunately, no valid data was collected for cycle 13.

Cycle 14, again run remotely via MS Teams, started on 18 November, 2020 and pre-group data was successfully collected on this occasion. We look forward to completing this cycle in March 2021 and completing analysis of the data.

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.

- **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 reframing emotions 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).

4.18.2 Descriptors

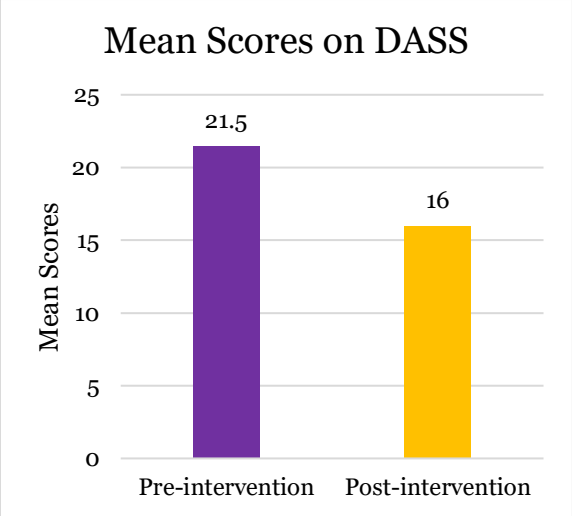
Data was available for 10 people who completed the programme in 2020, however due to the impact of Covid-19 on collecting data, there was only complete data for six people. Programme attendees ranged in age from 64 to 84 with a mean age of 72.89 (SD = 5.46).

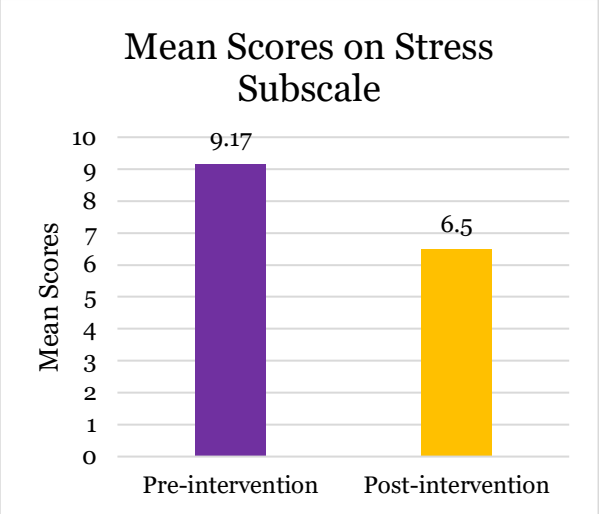
4.18.3 Results

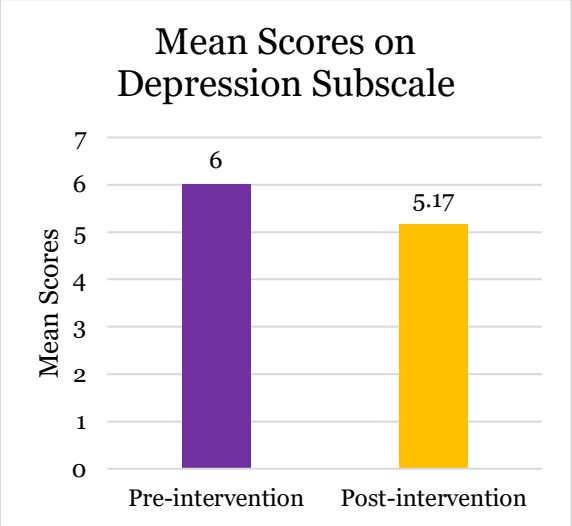
Depression Anxiety and Stress Scale (DASS)

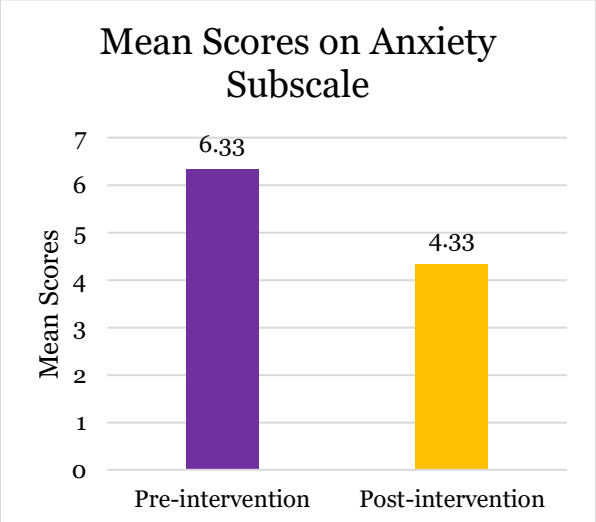
Analysis of the three sub-scales, which make up the DASS - stress, anxiety and depression – using a paired samples t-test showed a significant difference in psychological difficulties between pre (*M*= 21.5, SD = 9.24) and post-intervention (*M* = 16, *SD* = 5.62); t (5) = 2.569, p<0.05, demonstrating a medium effect size (r = -0.7). Participants reported experiences of stress also significantly decreased after completing the programme; t (5) = 2.609, p < 0.05. Scores on the anxiety and depression subscales both decreased, however neither of these differences were statistically significant.

Graphs: Mean Scores on DASS and subscales


Mean Scores on DASS
25
20
15
10
5
0
Mean Scores
21.5
16
Pre-intervention
Post-intervention


Mean Scores on Stress Subscale
10
9
8
7
6
5
4
3
2
1
0
Mean Scores
9.17
6.5
Pre-intervention
Post-intervention

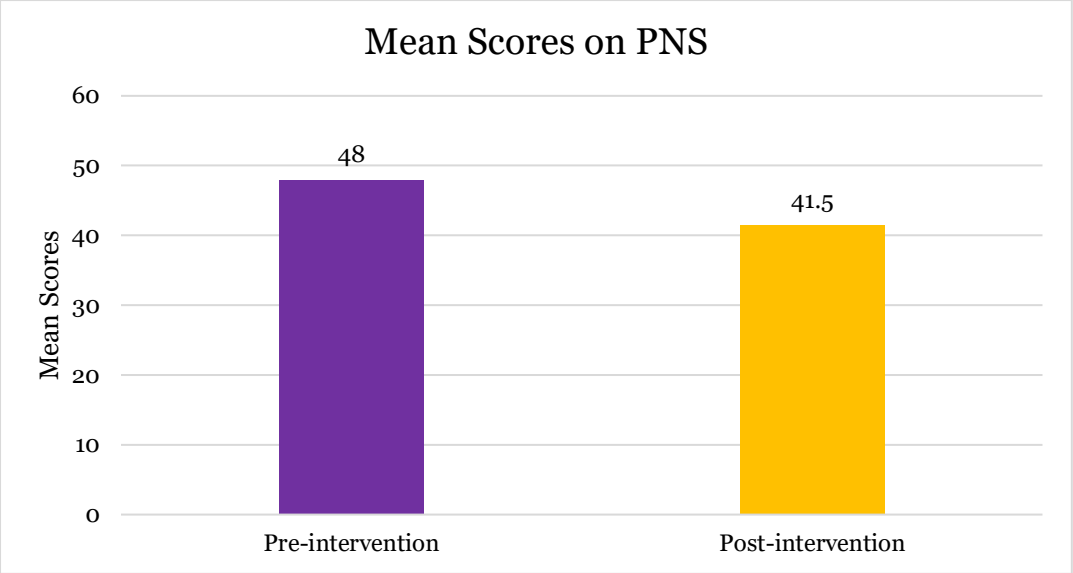

Mean Scores on Depression Subscale
7
6
5
4
3
2
1
0
Mean Scores
6
5.17
Pre-intervention
Post-intervention


Mean Scores on Anxiety Subscale
7
6
5
4
3
2
1
0
Mean Scores
6.33
4.33
Pre-intervention
Post-intervention

Personal Need for Structure (PNS)

There was no significant difference in means total scores on the PNS. Mean scores decreased from 48 (SD = 11.15) at pre-intervention to 41.5 (SD = 9.354) at post-intervention. Reduction in mean scores indicate increased flexibility.

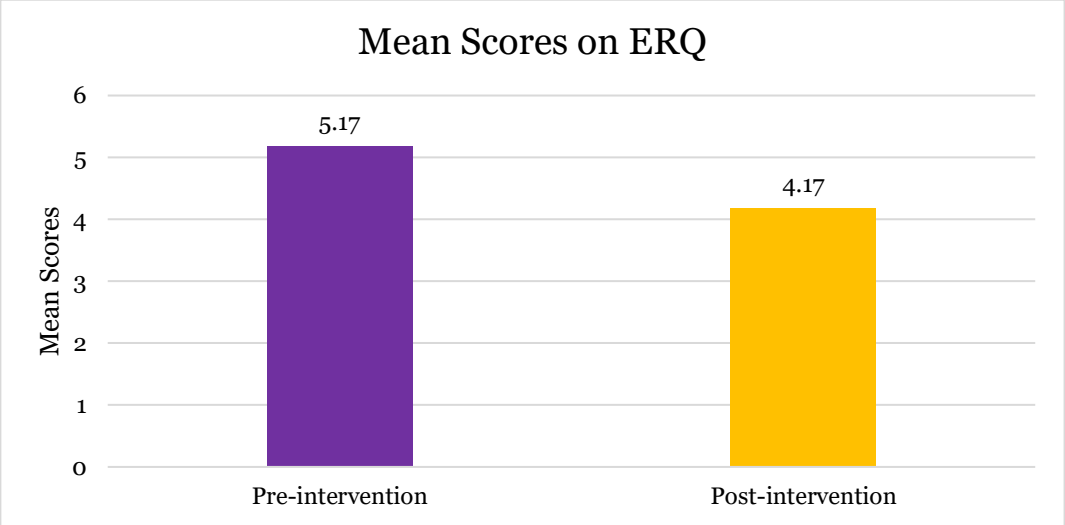
Graph: Personal Need for Structure (PNS) mean score



Emotion Regulation Questionnaire (ERQ)

The total mean score on the ERQ decreased from 5.17 (SD = 3.76) at pre-intervention to 4.17 (SD = 2.137) at post-intervention, however this difference was non-significant. Decreases in ERQ scores indicate that participants are reporting less suppression of their emotions and have an improved ability to reappraise unhelpful cognitions regarding emotion.

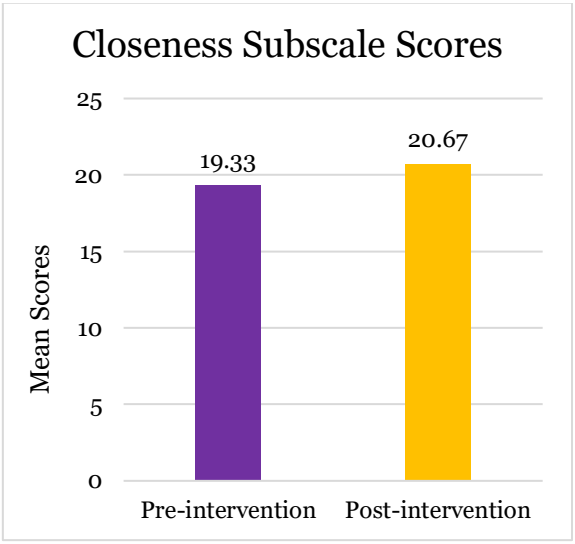
Graph: Emotion Regulation Questionnaire (ERQ) mean scores

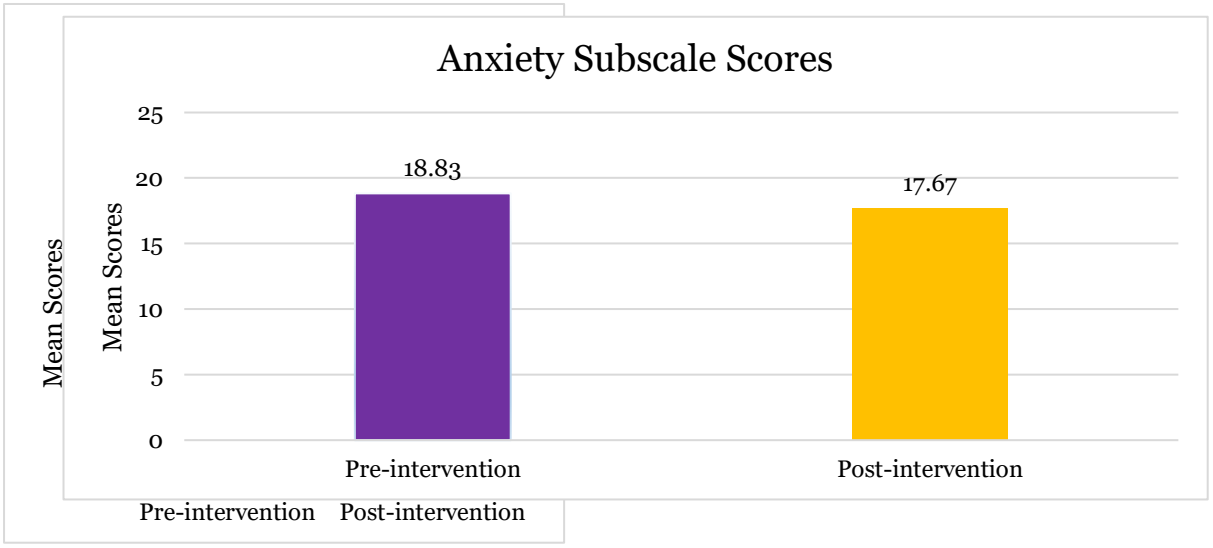


Revised Adult Attachment Scale (RASS)

There were no statistically significant differences in means scores on any of the three RAAS subscales, however mean scores saw positive changes indicating that participants may have benefited from the programme despite statistical significance not being achieved. Mean scores on the closeness and dependent subscales did increase at post-intervention from 19.33 (SD = 7.789) and 19.17 (SD = 7.57) at pre-intervention to 20.67 (SD = 5.78) and 19.83 (SD = 6.79) at post-intervention respectively. This suggests that after completing the programme, participants felt more comfortable depending on others and had increased feelings of comfort with closeness and intimacy in everyday life. Mean scores on the anxiety subscale decreased indicating that participants' anxiety levels (with regards to close relationships) reduced after completing the programme.

Graph: Revised Adult Attachment Scale (RASS) mean total scores and sub scale scores pre and post intervention





4.18.4 Summary

SAGE completed two cycles in 2020, but data was only available from one cycle. The programme showed positive gains in participant scores, particularly in participants' reported experiences of psychological difficulties on the DASS. However, the smaller sample size may have impacted the power to detect meaningful differences on other measures and it is important to hold this in mind when interpreting the results.

4.19 Group Schema Therapy Programme

The Group Schema Therapy (GST) Programme is a therapeutic group delivered by the Psychology Department. Group Schema Therapy is a closed long-term group designed to treat individuals with a diagnosis of borderline personality disorder (BPD). Group Schema Therapy provides an evidenced-based treatment to service users which reduces BPD symptom severity and improves psychosocial functioning (Farrell, Shaw & Webber, 2009; Fassbinder et al. 2016). GST has been shown to increase life satisfaction and reduce early maladaptive schemas (Altın & Alsancak-Akbulut, 2018).

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 processing of traumatic childhood experiences that are common in this disorder. Group Schema Therapy is a long-term (70 sessions over 20 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

A total of seven people completed the Schema programme in 2020, one participant disengaged at the step-down period. Pre and post outcome data on all measures were available for five participants, representing a 62.5% response rate. 87.5% of the participants were female and 12.5% were male. Participants' ages ranged from 27 years to 58 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) from pre-intervention (M = 32.4, SD = 6.1) to post-intervention (M = 17.3, SD = 8.4). A paired samples t-test revealed this to be a statistically significant difference, t (5) = 3.55, p= .016, reflecting a large effect size (*d*= 2.06). A Cohen's d of this size indicates that the difference between the two groups is over two standard deviations in size. This result should be interpreted with caution due to the small sample size of the therapy group (N=6).

Of the nine sub-scales for the BPDSI, two of the sub-scales showed statistically significant change from pre-intervention to post-intervention; abandonment [t (5) =4.125, p= .009, Cohen's *d* = 2.4] and Identity [t (5) =3.802, p= .013, Cohen's *d* = 2.0]. The abandonment items in the scale refer to frantic efforts to prevent someone who the individual has a relationship, is bonded with or is dependent on from abandoning him/her. Identity refers to a stable sense of self. Identity disturbance characteristics include extreme shifts in the self-image ("who am I?"). These shifts manifest themselves in sudden changes of job, career goals, sexual orientation, personal values, friends and the fundamental feeling one has about oneself (e.g. good or bad). All other sub-scales showed reductions from pre to post-intervention. These results did not reach the level of statistical significance.

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

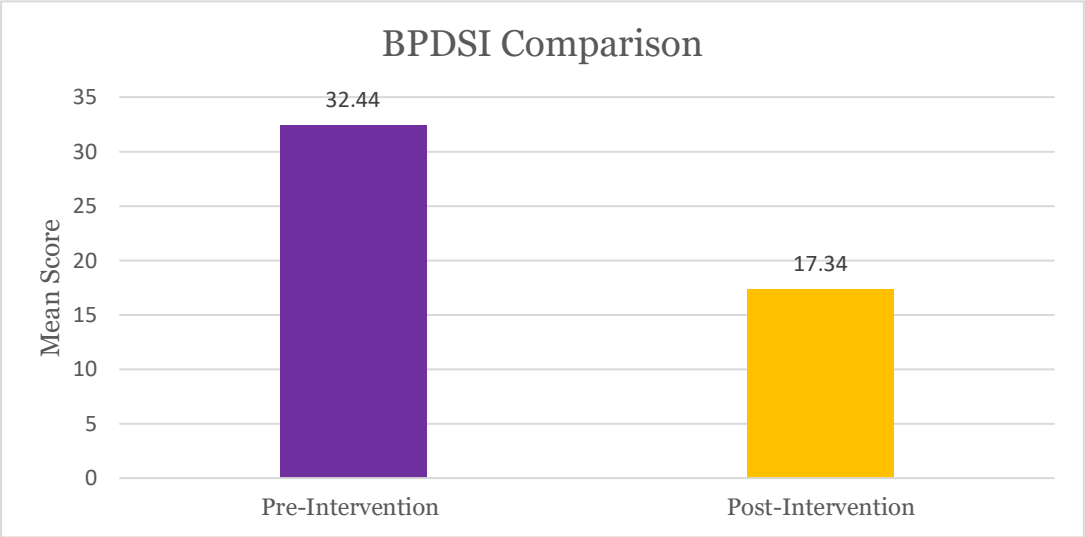


Table 1: BPDSI mean scores by sub-scale, t-value, and effect size

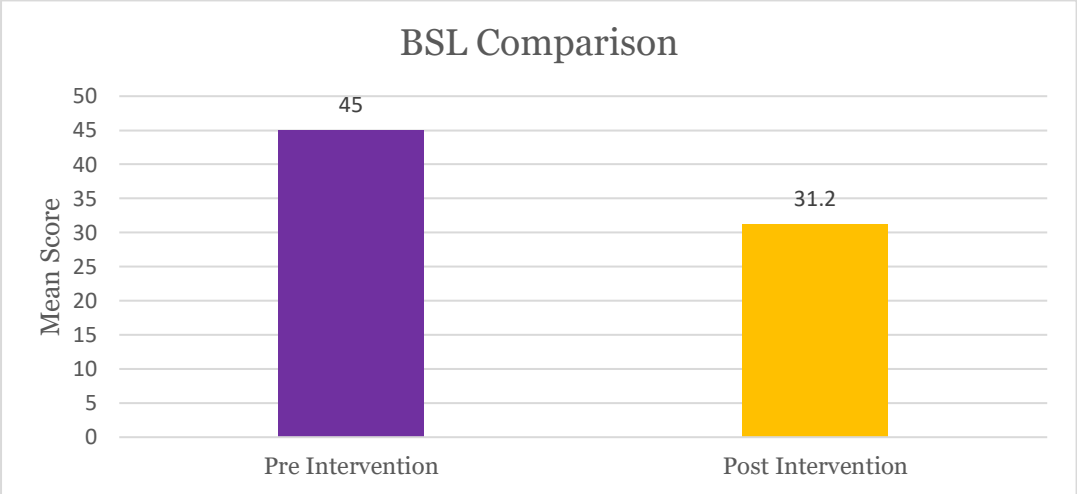
BPDSI	Pre-Mean	Post Mean	*t*	*df*	*p*	Cohen's *d*
Abandonment	3.36 (1.43)	0.69 (0.66)	4.125	5	.009	2.4
Interpersonal Relationships	3.98 (2.56)	1.60 (0.79)	2.012	5	0.100	
Identity	3.28 (1.48)	0.89 (0.80)	3.802	5	0.013	2.0
Impulsivity	0.98 (0.29)	0.47 (0.81)	1.331	5	0.241	
Para suicidal Behaviour	1.20 (0.68)	0.70 (0.91)	1.949	5	.109	
Affective Instability	7.03 (1.11)	5.17 (2.80)	1.970	5	0.106	
Emptiness	7.60 (1.37)	4.58 (2.42)	2.327	5	0.067	
Outbursts of Anger	1.33 (0.74)	0.78 (0.67)	1.488	5	0.197	

Dissociation and Paranoid Ideation	3.67 (2.31)	2.48 (2.22)	1.216	5	0.278

Borderline Symptom List (BSL)

A non-statistically significant reduction in mean scores on the Borderline Symptom List (BSL) was observed from pre-intervention (M = 45.0, SD = 16.81) to post-intervention (M = 31.2, SD = 15.40); t (4) = 1.496, p = 0.209.

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



Schema Mode Inventory (SMI)

Paired samples t-tests showed a reduction in mean scores across all maladaptive 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).

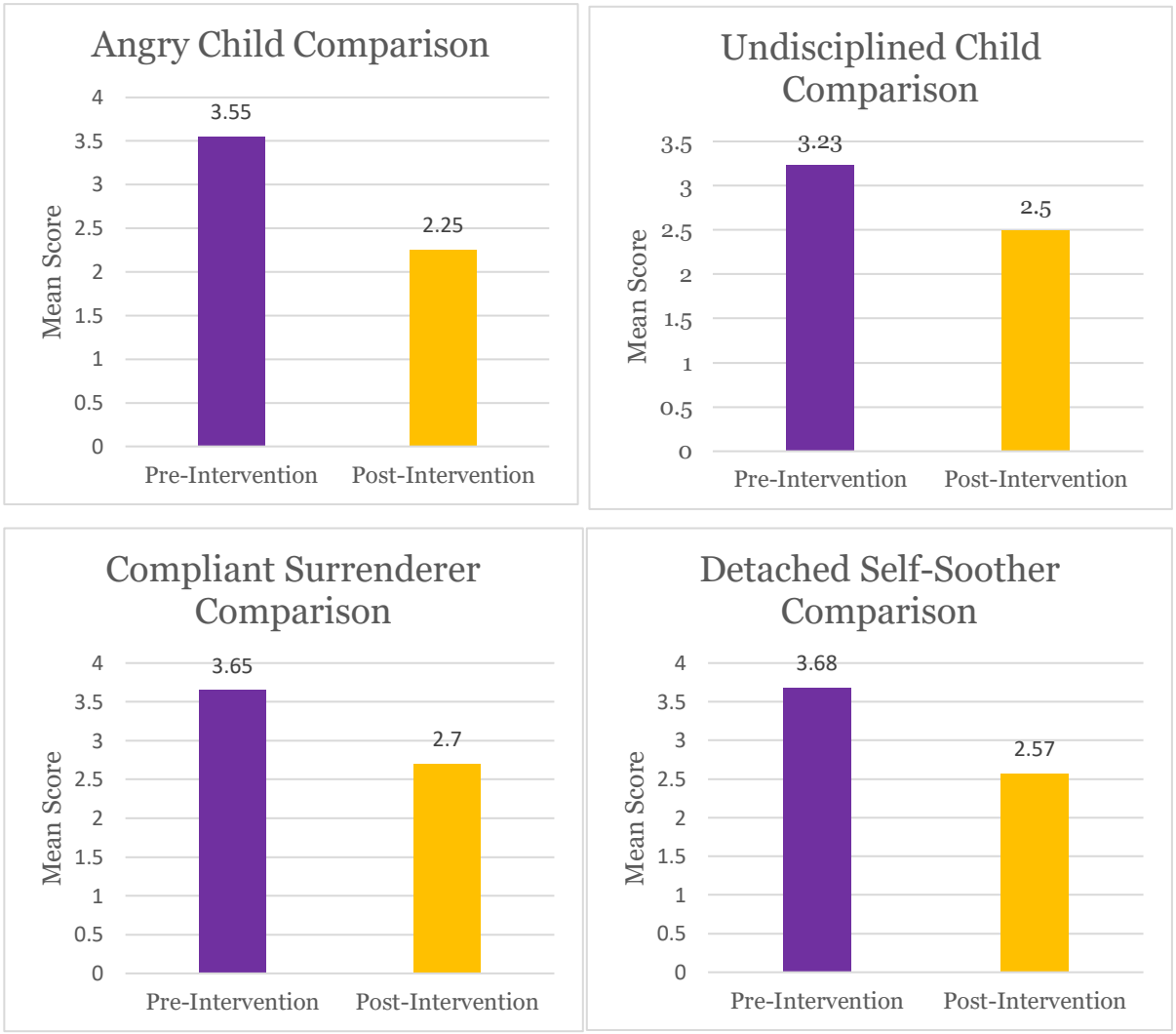
Table 2: SMI mean scores by sub-scale, t-value and effect size

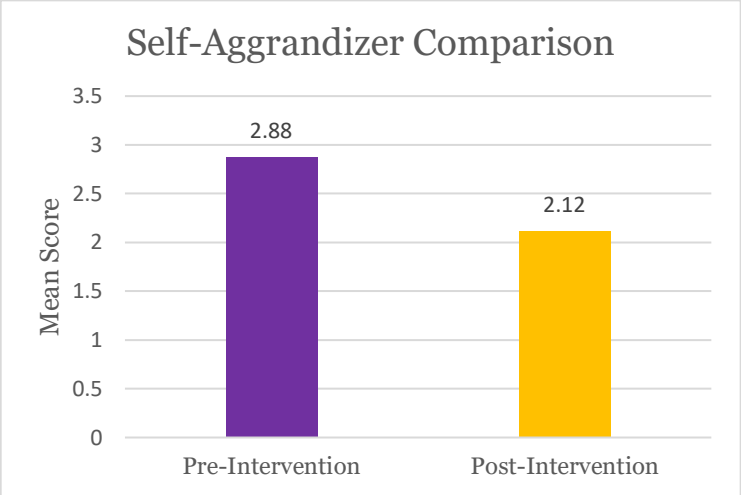
SMI	Related BPD Symptoms	Pre-Mean (SD)	Post Mean	*t*	*df*	*p*	Cohen's *d*
Vulnerable Child	Abandonment fears - real or imagined	4.32 (1.10)	3.02 (1.01)	2.282	5	.071	
Angry Child	Intense inappropriate anger Stormy relationships	3.55 (0.82)	2.25 (0.38)	2.931	5	**.033**	2.0
Enraged Child	Intense inappropriate anger Stormy relationships	1.92 (0.88)	1.38 (0.26)	1.231	5	.273	
Impulsive Child	Difficulty controlling anger Self-injury Impulsivity that is potentially damaging	3.13 (1.13)	2.18 (0.44)	2.493	5	.055	
Undisciplined Child	Difficulty controlling anger Impulsivity that is potentially damaging	3.23 (4.83)	2.50 (0.46)	4.231	5	**.008**	1.65
Contented / Happy Child	Engage in pursuits that give vitality Ability to be spontaneous and	2.62 (0.80)	3.73 (1.15)	-2.463	5	.057	
Compliant Surrenderer	Emptiness Unstable identity Dissociation	3.65 (0.66)	2.70 (0.70)	3.181	5	**.024**	1.4

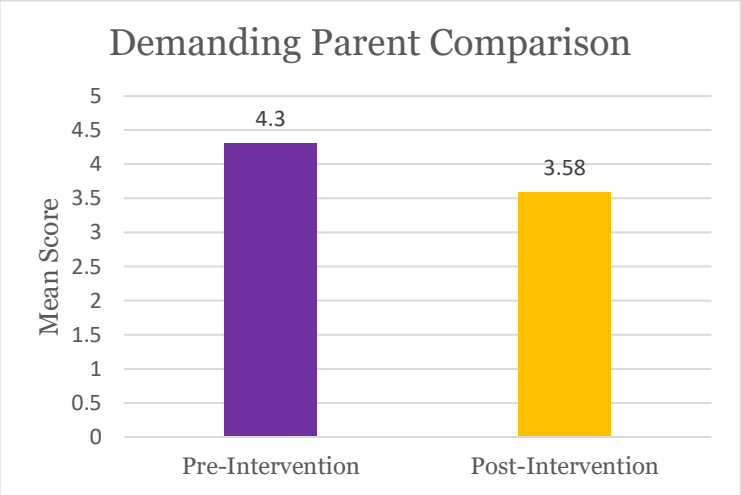
Detached Protector	Emptiness Unstable identity Dissociation	3.82 (0.60)	2.60 (1.06)	2.455	5	.058	
Detached Self-Soother	Emptiness Dissociation	3.68 (0.86)	2.57 (0.53)	3.333	5	**.021**	1.57
Self-Aggrandizer	Emptiness Unstable identity Dissociation	2.88 (0.40)	2.12 (0.30)	3.692	5	**.014**	2.15
Bully & Attack	Unstable relationships Uncontrolled anger	2.18 (0.89)	1.62 (0.38)	2.156	5	.084	
Punitive Parent	Suicidal gestures or attempts	3.98 (1.08)	2.81 (1.04)	2.470	5	.057	
Demanding Parent	Unstable sense of self Suicidal gestures or attempts	4.30 (0.85)	3.58 (0.81)	4.313	5	**.008**	0.86
Healthy Adult	Is able to meet emotional needs in a healthy way Takes on adult responsibilities Feels loved, connected and	3.47 (0.51)	3.97 (0.81)	-2.421	5	.060	

Statistically significant reductions were observed between pre and post scores for Angry Child [t(5) = 2.931, p = .033, Cohen's *d* = 2.0], Undisciplined child [t(5) = 4.231, p= .008, Cohen's *d* = 1.65], Compliant Surrenderer [t(5) = 3.181, p= .024, Cohen's *d* = 1.4]. Detached Self-Soother [t(5) = 3.33, p= .021, Cohen's *d* = 1.57], Self-Aggrandizer [t(5) = 3.692, p= .014, Cohen's *d* = 2.15], and Demanding Parent [t(5) = 4.313, p= .008, Cohen's *d* = 0.86] Modes. Similarly, three further subscales were found to be approaching statistical significance; Contented Child (p= .057) and Healthy Adult (p= .060) and Impulsive Child (p= .055).

Graph: SMI Mean Scores Pre and Post-Intervention







Young Schema Questionnaire

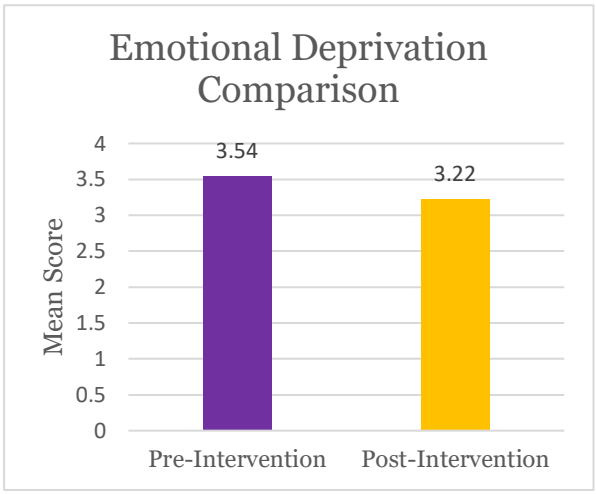
A reduction in mean scores was observed on all 18 schemas from pre to post-intervention. Statistically significant reductions were observed for Emotional Deprivation [t(4) = 2.803, p= .049, Cohen's *d* = 0.18), Enmeshment [t(4) = 4.391, p= .012, Cohen's *d* = 1.35), and Insufficient Self-Control schema [t(4) = 3.005, p= .040, Cohen's *d* = 0.40]. Pre and post scores are illustrated in the table below for all schema, with effect sizes provided for statistically significant reductions.

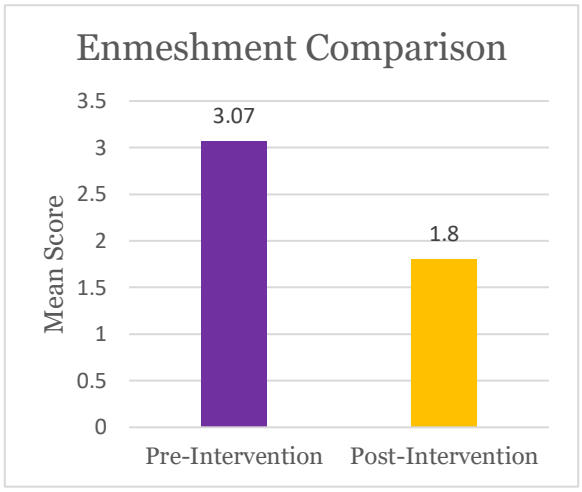
Table 3: YSQ Mean scores by sub-scale, t-value and effect size

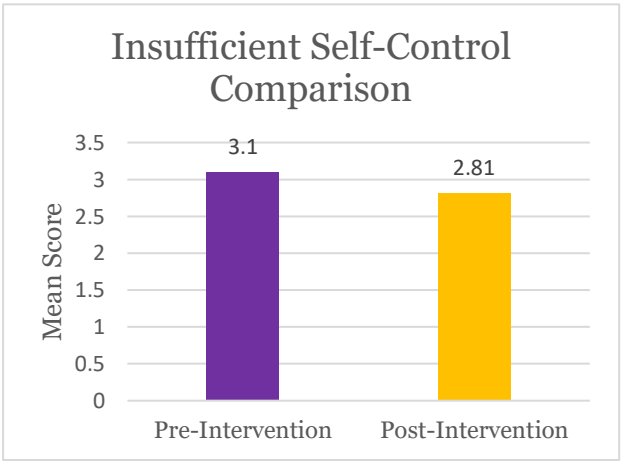
YSQ	Pre-Mean	Post Mean	*t*	*df*	*p*	Cohen's *d*
Emotional Deprivation	3.54 (1.84)	3.22 (1.62)	2.803	4	.049	0.18
Abandonment	3.51 (1.64)	2.93 (1.38)	2.179	4	.095	
Mistrust Abuse	4.05 (2.23)	3.01 (0.42)	1.079	4	.341	
Social Isolation	4.04 (1.53)	3.7 (1.34)	.569	4	.600	
Defectiveness	3.95 (1.45)	3.29 (1.27)	2.343	4	.079	

Failure	3.75 (1.51)	3.80 (1.22)	-.227	4	.832	
Dependence	2.54 (0.49)	2.17 (0.38)	1.696	4	.165	
Vulnerability	3.11 (0.72)	2.10 (0.52)	2.367	4	.077	
Enmeshment	3.07 (1.16)	1.80 (0.65)	4.391	4	.012	1.35
Subjugation	3.96 (1.25)	2.85 (1.10)	1.496	4	.209	
Self-Sacrifice	4.50 (1.15)	3.72 (1.21)	2.308	4	.082	
Emotional Inhibition	3.49 (0.80)	2.55 (0.80)	1.805	4	.145	
Unrelenting Standards	3.16 (1.03)	2.96 (0.76)	.492	4	.649	
Entitlement	2.80 (1.08)	2.45 (0.91)	1.957	4	.122	
Insufficient Self-Control	3.10 (0.80)	2.81 (0.64)	3.005	4	.040	0.40
Approval Seeking	3.66 (1.45)	2.96 (1.10)	1.750	4	.155	
Negativity	3.41 (0.75)	2.95 (1.02)	1.131	4	.321	
Punitiveness	3.74 (0.84)	3.42 (0.97)	.904	4	.417	

Graph: Young Schema Questionnaire Sub-scale Mean Scores Pre and Post-Intervention







Symptom Checklist

A reduction in mean scores was observed on all symptom indices of the Symptom Checklist (SCL – 90) from pre to post-intervention. These results did not all reach the level of statistical significance. Symptomatology on the Depression sub-scale decreased from (M = 74.8, SD = 5.26) to (M = 64.0, SD = 5.79). Paired sample t-tests indicated that this was a statistically significant change, whereby t (4) = 2.813, p < .048, reflecting a large effect size (d = 1.95).

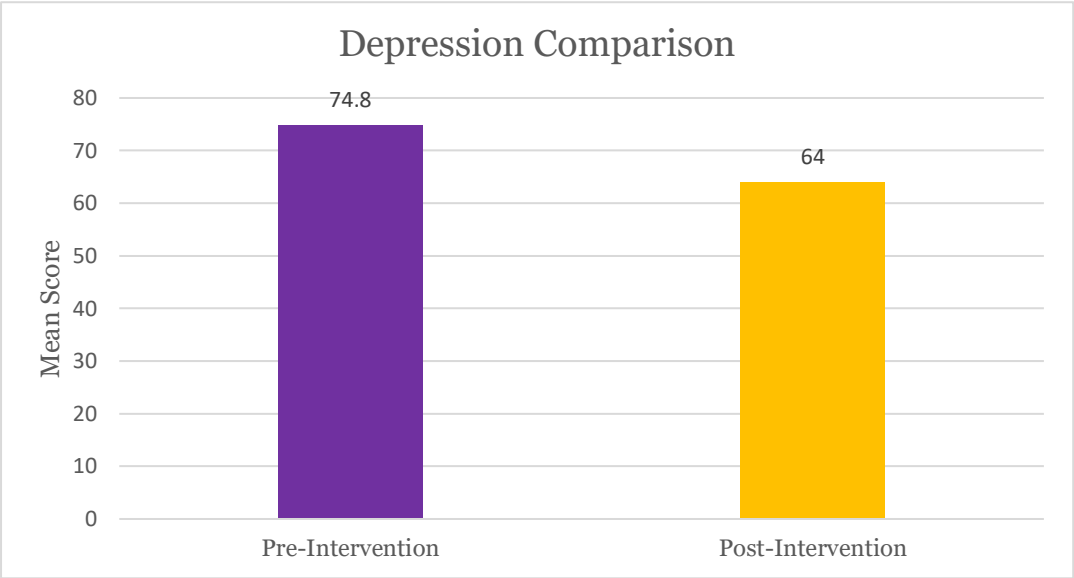


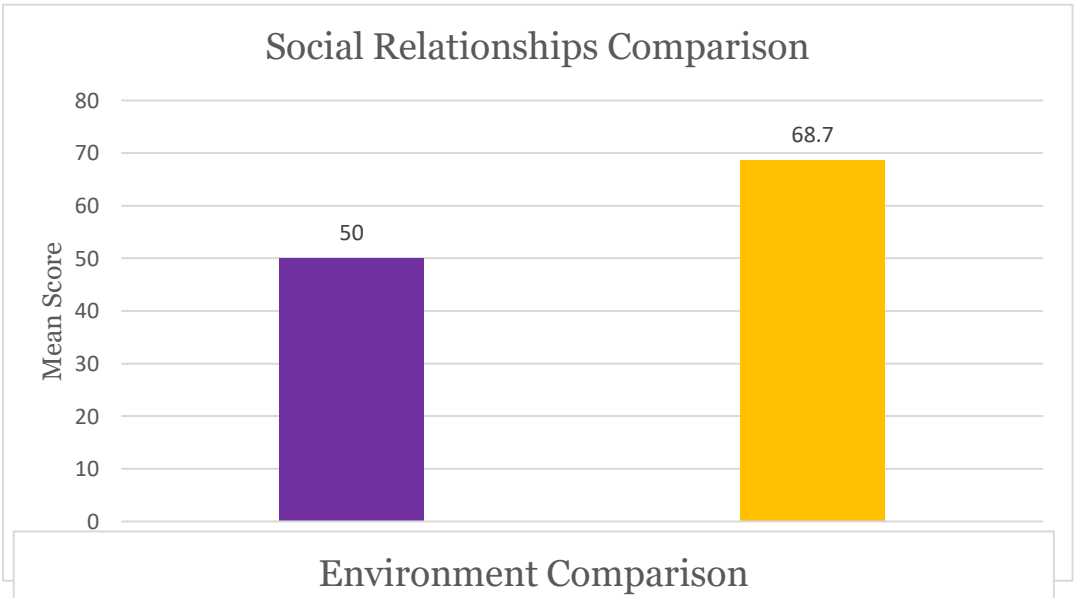
Table 4: SCL Mean scores by sub-scale, t-value and effect size

SCL	Pre-Mean	Post Mean	*t*	*df*	*p*	Cohen's *d*
Somatization	69.2 (7.16)	66.2 (5.81)	.666	4	.542	
Obsessive Compulsive	74.0 (3.54)	67.8 (6.80)	2.122	4	.101	
Interpersonal Sensitivity	71.2 (5.80)	63.2 (8.81)	2.319	4	.081	
Depression	74.8 (5.26)	64.0 (5.79)	2.813	4	.048	
Anxiety	71.6 (6.29)	64.0 (7.52)	1.420	4	.229	
Hostility	63.6 (6.54)	58.8 (7.53)	1.202	4	.296	
Phobic Anxiety	65.8 (7.40)	60.2 (9.30)	1.081	4	.341	
Paranoid Ideation	61.4 (8.64)	57.4 (7.77)	1.252	4	.279	

Psychoticism	70.8 (8.70)	65.0 (7.70)	2.171	4	.096
Global Severity Index	73.4 (5.90)	66.2 (4.43)	1.994	4	.117
Positive Symptom Distress Index	68.6 (3.85)	65.0 (4.73)	1.832	4	.141
Positive Symptom Total	71.6 (5.94)	65.4 (5.37)	1.698	4	.165

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 social relationships from pre-intervention (M = 50.0, SD = 32.5) to post-intervention (M = 68.7, SD = 36.5), [t(3) =-7.055, p= .006, Cohen's *d*= 0.54]. Similarly, a statistically significant increase was found for the environment sub-scale from pre-intervention (M = 61.4, SD = 14.81) to post-intervention (M = 76.4, SD = 15.32); [t(4) =-9.129, p= .001, Cohen's *d*= 0.97].



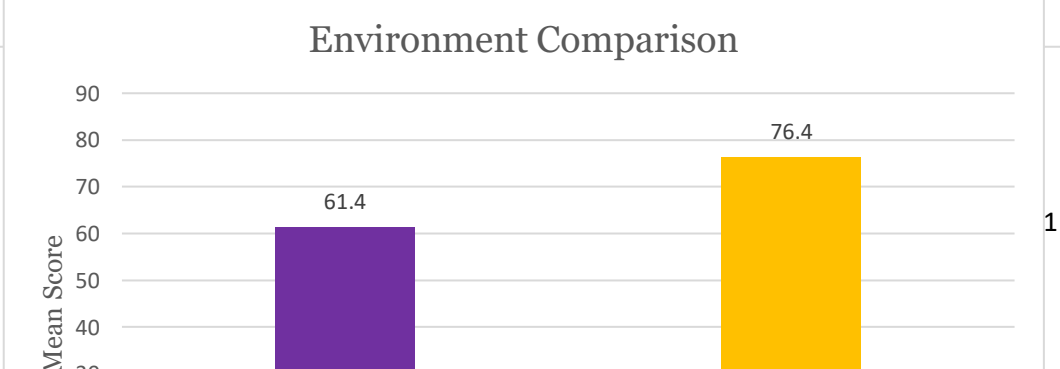


Table 5: WHOQOL Mean scores by sub-scale, t-value and effect size

WHOQOL	Pre-Mean	Post Mean	*t*	*df*	*p*	Cohen's *d*
Physical Health	51.6 (16.62)	61.2 (10.06)	-1.315	4	.259	
Psychological Health	32.6 (16.62)	46.4 (10.88)	-2.427	4	.072	
Social Relationships	50.0 (32.52)	68.75 (36.47)	-7.055	3	.006	0.54
Environment	61.40 (14.81)	76.4 (15.32)	-9.129	4	.001	1.0

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 2020, 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 social relationships and environment 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 12 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 (PTSD) Checklist DSM 5**

The PTSD Checklist is a 20-item self-report checklist of 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 checklist 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. A cut-off raw score of 38 indicates a provisional diagnosis of PTSD. This cut-off has high sensitivity (.78) and specificity (.98) (Cohen et al., 2015). When used to track symptoms over time, a minimum 10-point change represents clinically significant change.

- **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 one – totally disagree – to seven - totally agree. The measure consists of three sub-scales measuring negative cognitions about self, negative cognitions about the world and self-blame. Higher scores indicate higher post-traumatic cognitions. This scale has been normed using three categories of individuals; a non-traumatised population, a traumatised population without PTSD and a traumatised population with PTSD. The median score for the non-traumatised group was 45.5, for the traumatised group without PTSD was 49 and for the traumatised group with PTSD, the median score was 133.

- **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 sub-scale (motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being accepting and non-judgmental) and an action sub-scale (directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10-point Likert scale (1 =never to 10 = always). Higher scores indicate higher compassion levels.

4.20.2 Descriptors

A total of nine people began the Trauma Programme in 2020. One person withdrew from group at the beginning of Stage 2 due to COVID-19. Pre and post outcome data were available for six of the eight participants who completed the programme. Four of the participants were female and two were male. Participant's ages ranged from 25 years to 56 years (M=43, SD=10.4).

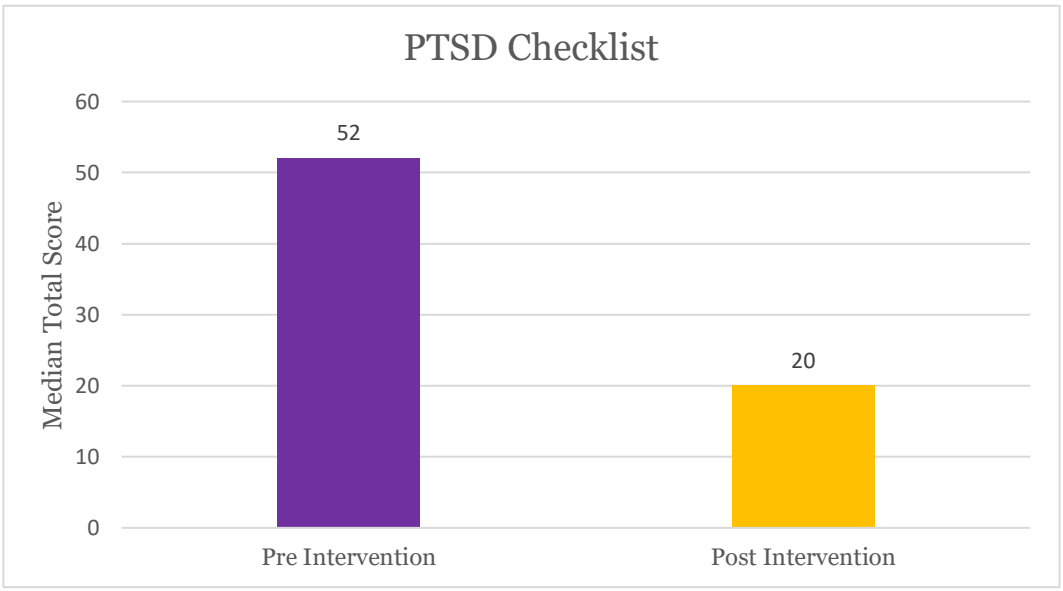
Pre-treatment completion of the Adverse Childhood Experience (ACEs) indicated that six of eight returned ACEs measures scored above four, with three participants scoring four; one participant scoring five; two participants scoring six; and one participant scoring seven. The higher the ACE score the more at risk the client is to chronic health problems, mental health difficulties, social difficulties and substance misuse in adulthood.

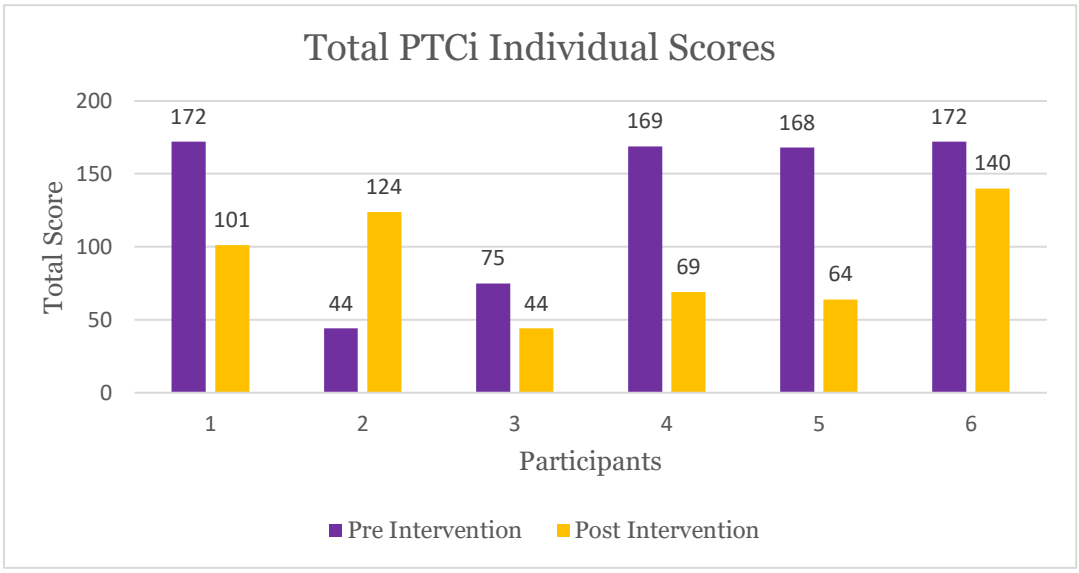
4.20.3 Results

Due to the small sample size, statistical analysis of the outcome measures was not possible. Acceptable power was not achieved to reliably conduct statistical operations on the data. G*Power analysis indicated that in order to achieve sufficient statistical power, a sample size of 57 participants would have been required to detect a medium effect size (Cohen's d=0.5). Therefore, for each measure, individual results for the six participants who returned both pre and post measures are given to reflect the outcome of the intervention.

- **Post-Traumatic Stress Disorder Checklist DSM 5 (PTSD)**

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



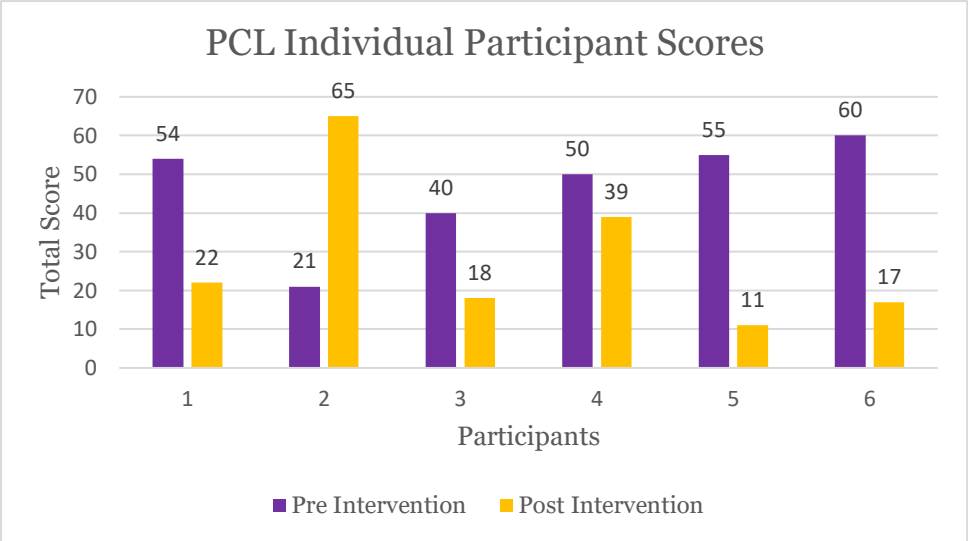


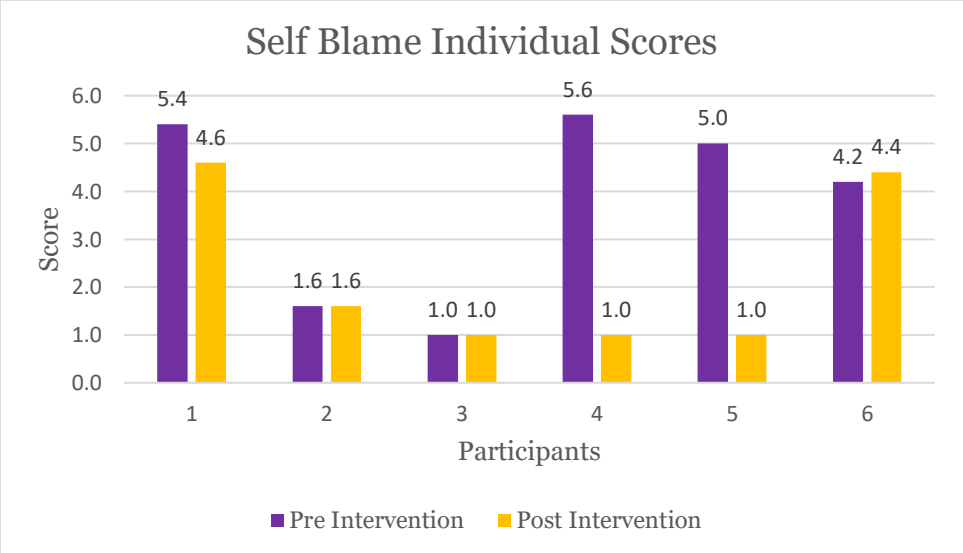
As can be seen from the above graph, five out of six participants (83%) demonstrated a clinically significant reduction in PCL scores from pre-intervention to post-intervention (10 points or greater). In addition, four participants (67%) have moved from meeting criteria for a provisional diagnosis of

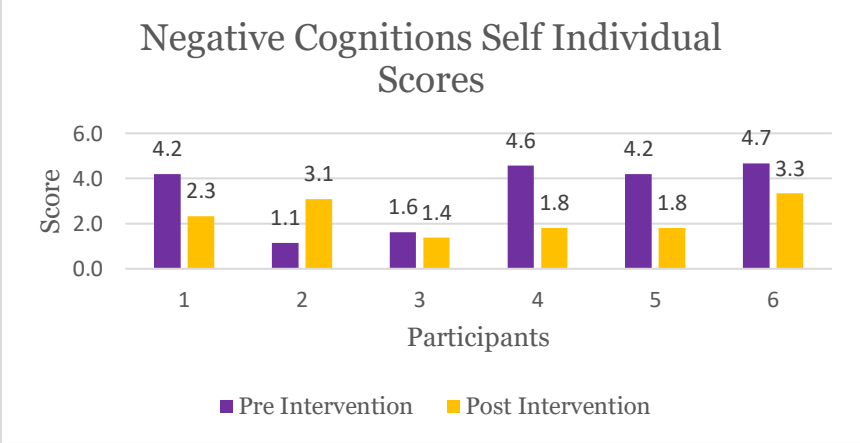
PTSD pre-intervention (cut off score of 38 or higher) to no longer meeting criteria post-intervention.

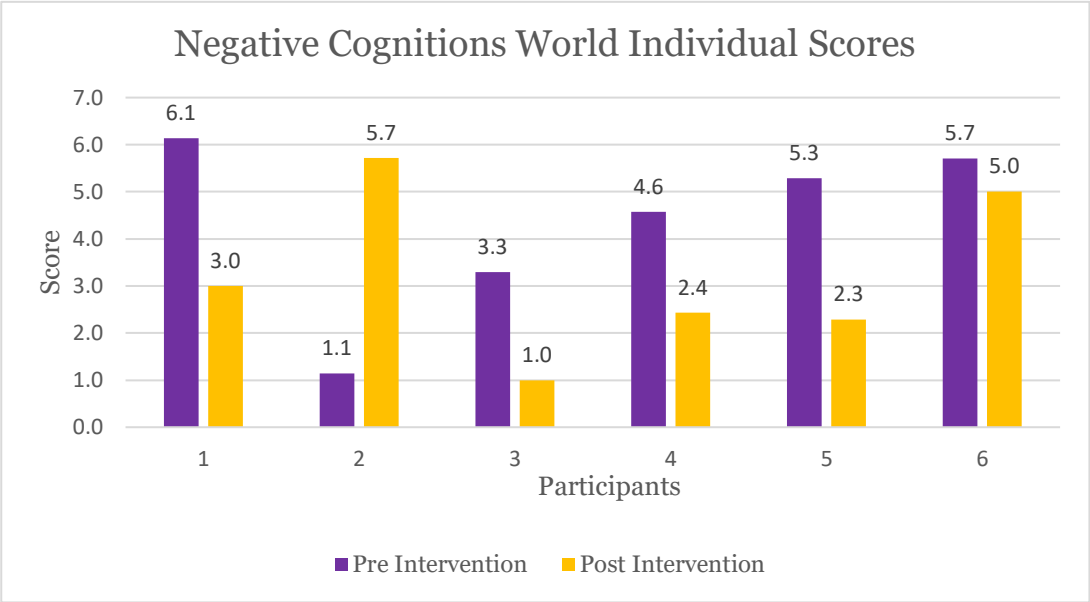
The Post Traumatic Cognitions Inventory (PTCI)

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





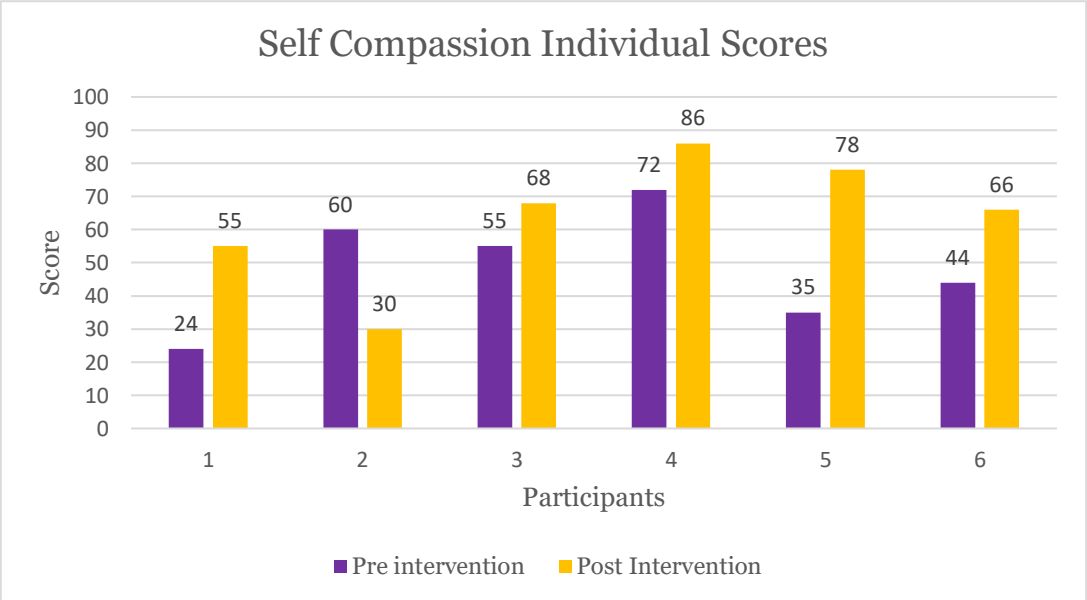


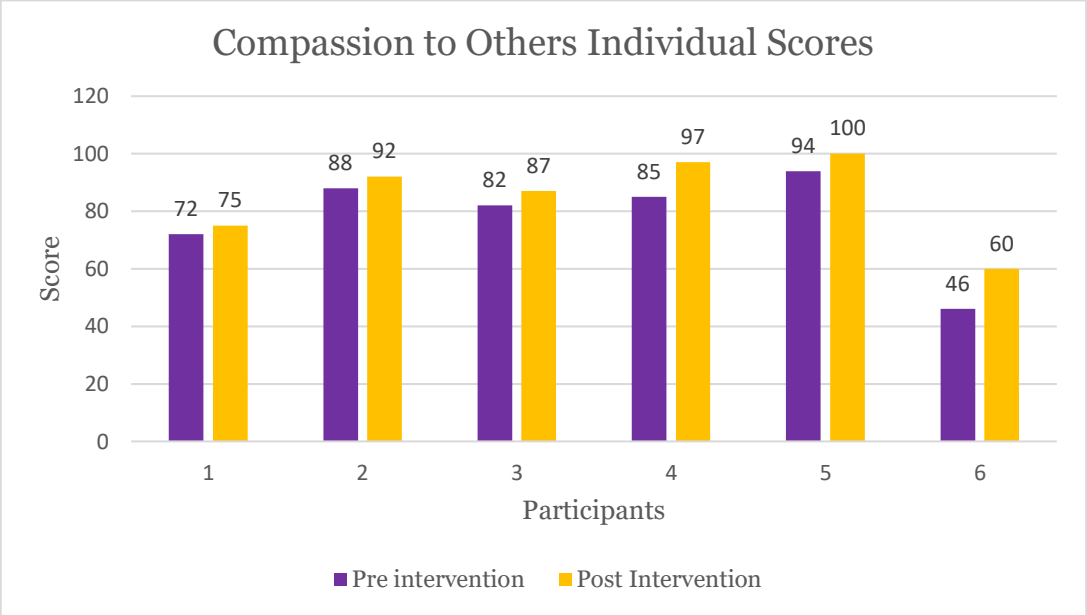


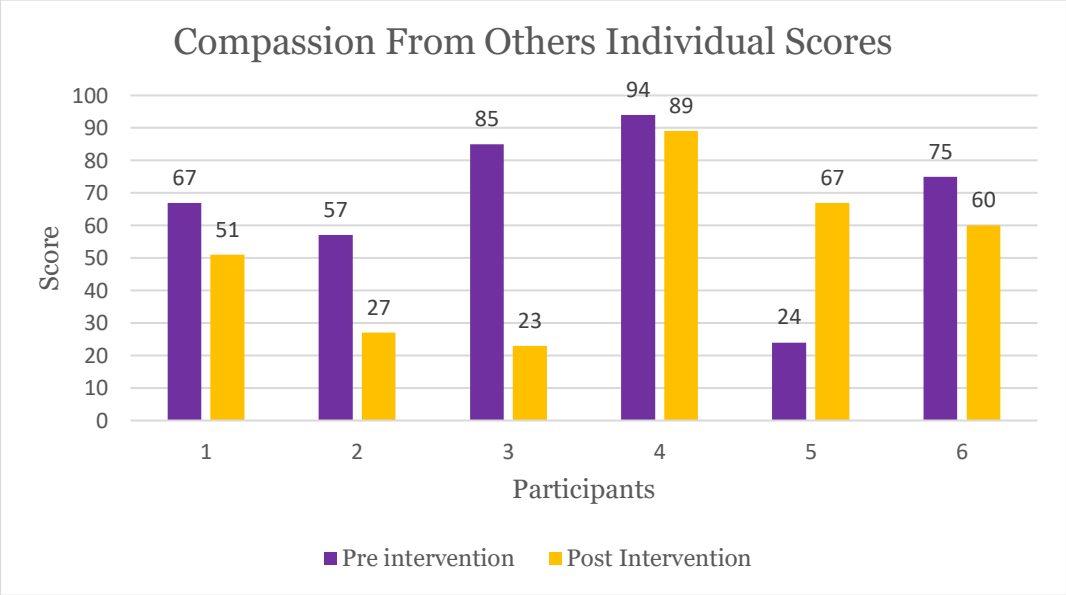
As can be seen on the Total PTCi Individual Scores graph, four participants (67%) scored 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. These participants demonstrated a significant reduction in scores, no longer meeting this criteria post-intervention. Three out of six participants (50%) also demonstrated reductions across all three subscales; self-blame, negative cognitions about the self, negative cognitions about the world.

Compassionate Engagement and Action (CEA) Scales

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







As can be seen from the above graphs, five out of six participants (83%) demonstrated an improvement on the self-compassion sub-scale, with all six participants (100%) indicating increased compassion to others. However, individual scores on the compassion from others sub-scale indicated that one out of six (16.7%) participants reported increased compassion from others.

4.20.4 Summary

The Trauma Programme is a relatively new programme in the hospital delivered by the Psychology Department. It aims to reduce suffering by reducing participants'

symptoms of PTSD and increasing their capacity for compassion in their relationships with themselves and others. Unfortunately, due to the small sample size, statistical analysis of the outcome measures was not possible. However, the analysis of individual scores overall demonstrated promising positive results. These results suggest that the Trauma Programme is effective in delivering its aims, however further research establishing clients' experiences of the programme has begun.

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 87 patients who were admitted to Willow Grove Adolescent Unit in 2020; 69 (79.3%) females and 18 (20.6%) males. The age ranged from 13 to 18 years, with a mean of 16.19 (SD=1.31).

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	21.40 SD = 9.57	15.62 SD = 8.91	5.110	58	.000	.62
Clinician Rated	15.24 SD = 6.60	8.37 SD = 3.64	12.181	86	.000	1.28
Parent Rated	18.75 SD = 9.44	11.9 SD = 6.79	4.757	35	.000	0.83

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 2020. Analysis was therefore run on pre and post data received.

As illustrated in the table above, a significant decrease in total scores for the service user's self-rated HoNOSCA was apparent at the post-intervention time point (t (58) = 5.110, p<.000), reflecting a medium effect size (Cohen's *d* =.62).

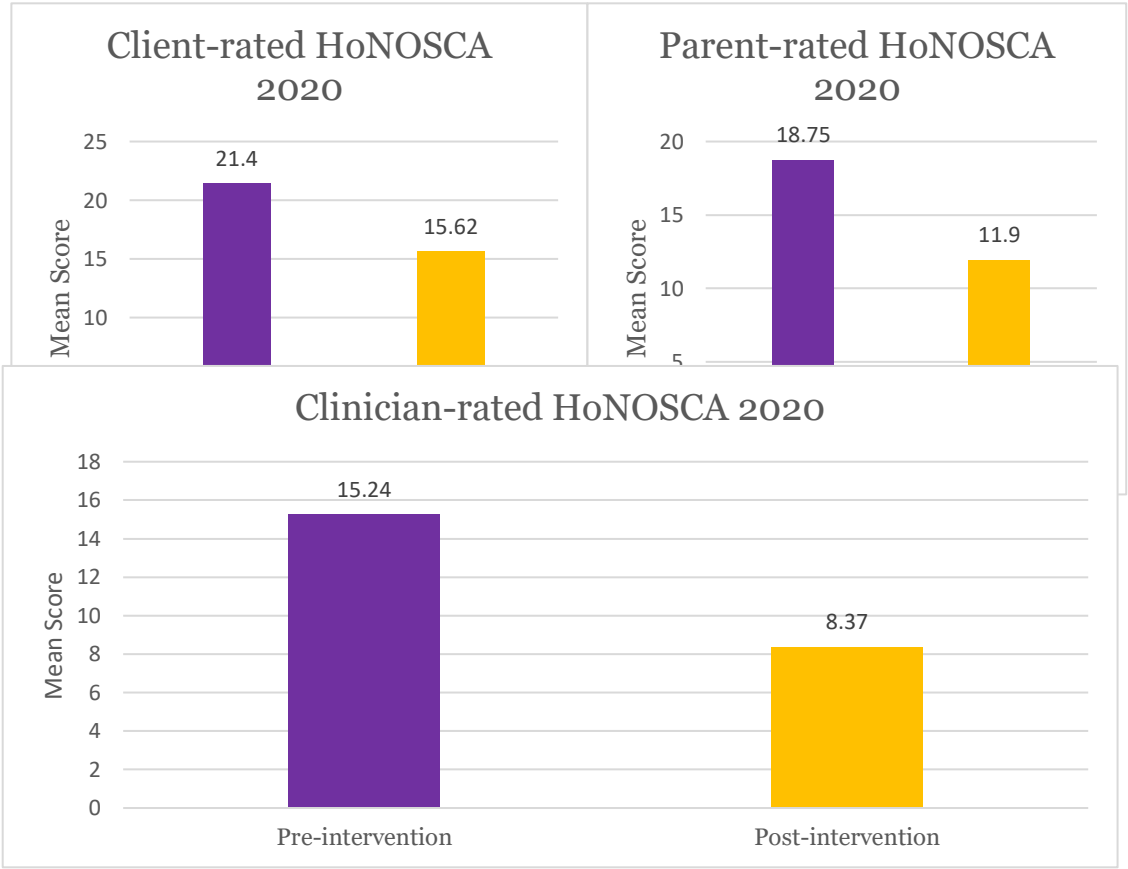
A significant decrease in total scores was also identified post-intervention on the clinician-rated HoNOSCA, (t (86) = 12.181, p<.000), demonstrating a large effect size (Cohen's *d* =1.28).

On the parent-rated HoNOSCA, a significant decrease in total scores was also observed at post-intervention, (t (35) = 4.757, p<.000), where a large effect size can be observed (Cohen's *d* = 0.83).

For the parent-rated measure, separate forms were given to both 'mom' and 'dad' to complete at each time point, where appropriate. In the instances where both 'mom' and 'dad' returned data at a single time point, the average score was calculated to provide a unitary parent score.

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

WGAU 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 2020 (87) were higher than 2019 (79). It is anticipated that response rates will continue to improve in 2021 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 FIVE

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 proportion of inpatient, Dean Clinic and day programme service users from January to December 2020. 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.

In response to the national public health restrictions resulting from the COVID-19 pandemic, some of SPMHS services transitioned to remote participation via audio-visual technologies. Remote delivery of care was offered across the hospital, day services and the community Dean Clinics, based on a service user's assessment of needs. This technology-mediated clinical care interventions did not replace inpatient admission for those requiring care delivered on-site. SPMHS introduced a Homecare service, offering all the elements of our inpatient services, but provided remotely in the service users' own home. This involves the highest levels of one-to-one mental health support, delivered remotely through daily or more frequent contact over videocall and other technological channels.

To appropriately measure service users' experiences of remote technology-mediated services, SPMHS also sought the views of service users across the organisation who engaged with services remotely via technology, in the form of a bespoke service user experience survey. Therefore, within this service user experience section of the report you will find the results for both modes of care

delivery (in-person delivered care and technology-mediated care) for inpatient and Homecare services, day services and the community Dean Clinics.

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. Additional surveys were introduced from March 2020 for those engaged in remote technology-mediated services. These surveys were designed differently to the on-site service survey as they were intended to inform the service users' experience of services and the technology used to mediate the 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 designed for service user's attending on-site in the Dean Clinics, inpatient and day programmes were continually distributed from January to December 2020 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 surveys for the Dean Clinics, inpatient and day programmes have also been available online to increase accessibility.

Following the introduction of remote access to services in March 2020 in response to the public health restrictions, the Remote Access Service User Experience

Surveys was developed and sent to service users throughout 2020 for day programmes, Dean Clinics and for service users who had accessed the new Homecare service. This meant that from March there were two different versions of the Service User Satisfaction Surveys for the three service areas. As several service users had attended both on-site and remote services through stages of their care, they were advised to complete the version or versions of the survey they felt was most applicable to their experience. The employment of the service user 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 decrease in the number of service users completing surveys this year; from 139 in 2019 to 75 in 2020, however, this is still a notable increase from 24 in 2018. This decrease in survey completion is likely due to the impact of COVID-19. In response to COVID 19, all service users who attended the Dean Clinic remotely were also given an opportunity to complete the questionnaire. This resulted in 200 complete questionnaires returned; this is likely due to the successful implementation of all clinics participating in informing service users that there is an avenue for feedback.

Inpatient adult services

All service users discharged between January and December 2020 from inpatient and Homecare 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 or by post to SPMHS, or to complete the survey online.

5.1.4.1. Dean Clinic (outpatient services)

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

Dean Clinic	n	%
SPUH	38	50.7
Sandyford	10	13.4
Galway	5	6.7
Cork	13	17.3
Lucan Adolescent	8	10.7
Capel Street	1	1.3
No Answer	0	0
Total	75	100

Service user responses

How did you hear about the Dean Clinic service?

Dean Clinic	n	%
General Practitioner	53	70.7
Family/Friends	12	16.0
Website	3	4.0
Newspaper Article	0	0
Radio	0	0
Don't Know	5	6.7
No Answer	2	2.7
Total	75	100

Tell us about your experience of the location of the Dean Clinic?

Respondents experience of location of the Dean Clinic

Experience of location of the Dean Clinic?	Strongly Agree		Agree		Neither Agree/Disagree		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	N	%
It is convenient for me to access	32	42.7	23	30.7	2	2.7	8	10.7	9	12
I choose to use public transport to access the Dean Clinic and the location is suitable for this	15	20	12	16	14	18.7	15	20	16	21.3
I choose to drive to the Dean Clinic and there is sufficient parking available nearby	23	30.7	20	26.7	6	8	4	5.3	16	21.3

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

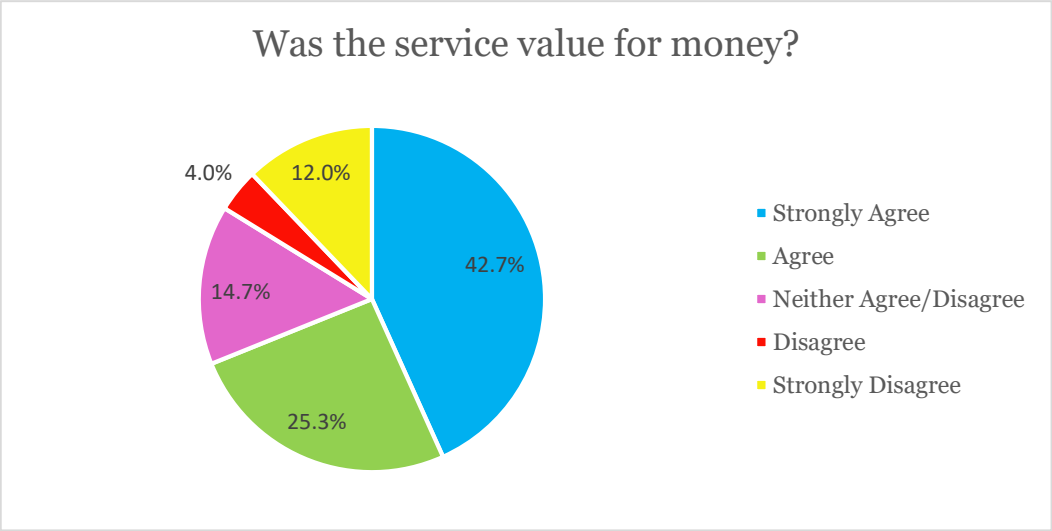
Respondents were asked about the quality of their care at the Dean Clinic following assessment. Service users were offered a number of statements describing their care which they were asked to endorse.

Respondents experience of care and treatment at the Clinic following assessment

Experience of Care & Treatment following your assessment?	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	n	%

Treated with dignity & respect	51	68	15	20	1	1.3	3	4	5	6.7
Confidentiality was protected	53	70.7	16	21.3	1	1.3	0	0	5	6.7
Privacy was respected	51	68	17	22.7	1	1.3	1	1.3	5	6.7
Staff were courteous	47	62.7	18	24	4	5.3	1	1.3	5	6.7
Felt included in decisions about my treatment	41	54.7	21	28	5	6.7	1	1.3	6	8.0
Trusted my doctor/therapist/nurse	48	64	14	18.7	2	2.7	3	4	7	9.3
My appointment was value for money	32	42.7	19	25.3	11	14.7	3	4	9	12
I will recommend the Dean Clinic to family and friends	43	57.3	17	22.7	4	5.3	4	5.3	7	9.3

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



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 7.78 (N=75; SD=2.85). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 7.76 (N=75; SD=2.94).

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	7	9.3	8	10.6
2	0	0.0	0	0.0
3	3	4.0	3	4.0
4	1	1.3	0	0.0
5	3	4.0	0	0.0
6	1	1.3	2	2.6
7	4	5.3	8	10.6
8	13	17.3	8	10.6
9	15	20.0	16	21.3
10	26	34.6	25	33.3
No Answer	2	2.6	5	6.7
1-5	14	18.6	11	14.6
6-10	59	78.5	59	78.4
Total	75	100	75	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	75	7.78	2.85
Overall, the Dean Clinic	75	7.76	2.94

Further service user views

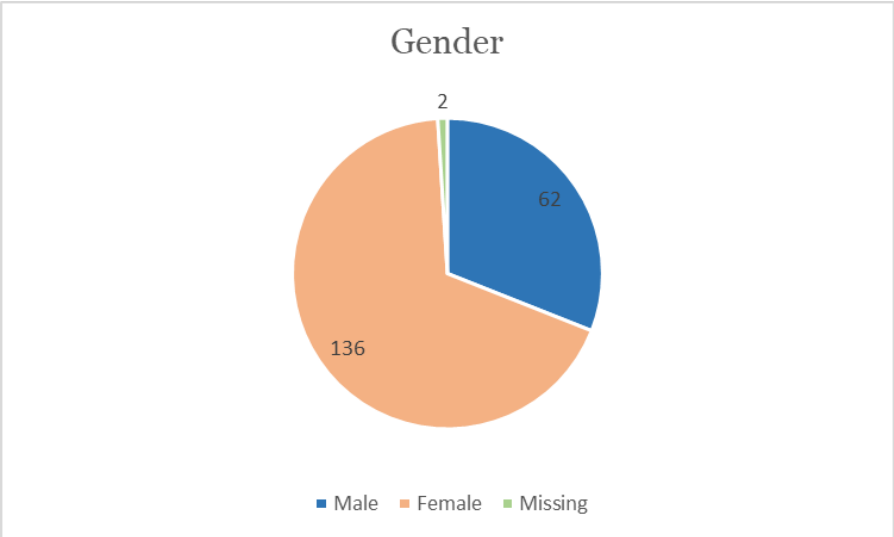
Dean Clinic respondents were invited to answer open-ended qualitative questions to identify any points of interest not contained within the closed statements and to give further voice their experiences. Not all respondents answered these questions. Please find below a sample of answers:

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

- "It was very rewarding and received good advice on medication and treatment plan."
- "Excellent, professional staff could not have asked for more."
- "I felt very supported and listened to."
- "I would like to say that I was treated with compassion, non-judgement and with care."
- "Cork experience very good, efficient, pleasant and at all times courteous."
- "It was very rewarding and received good advice on medication and treatment plan"

Dean Clinic remote technology-mediated service survey

Graph: Service user gender breakdown



Tell us about your experience of using technology to access the Dean Clinic remotely?

Respondents experience of using technology to access the Dean Clinic remotely

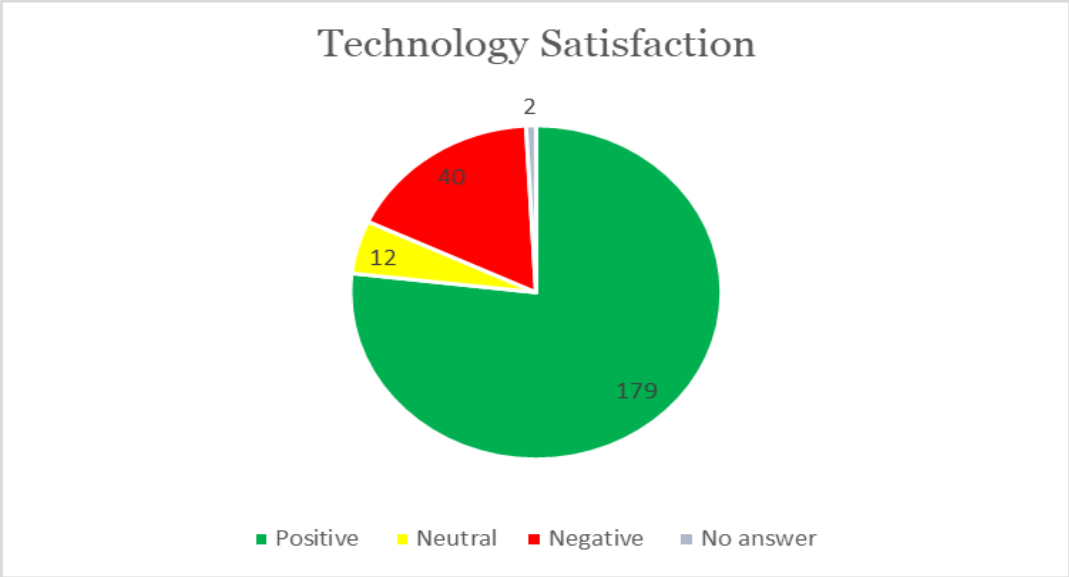
Experience of using technology to access the Dean Clinic	**Strongly Agree**		**Agree**		**Neither Agree/Disagree**		**Disagree**		**Strongly Disagree**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
a) It was clearly explained to me how to access my appointment using either video or telephone calls	115	57.8	68	34.2	10	5	5	2.5	1	0.5
b) I found it was easy to access my appointment using video and/or telephone calls	110	55.3	68	34.2	8	4	8	4	5	2.5
c) I found the quality of sound on video and/or phone calls was generally good	99	49.5	87	43.5	8	4	4	2	2	1
d) I found the quality of video was generally good when using video calls	23	30.7	20	26.7	6	8	4	5.3	16	21.3

e) The internet connection on video calls was generally good	61	37.7	57	35.2	35	21.6	3	1.9	6	3.7
f) I found using technology to access my appointment to be convenient	57	34.6	64	38.8	33	20	8	4.9	3	1.8
g) I felt using video and/or telephone calls did not stop me from being able to express myself when talking to Dean Clinic staff	86	45	70	36.7	20	10.5	11	5.8	4	2
h) I felt using video and/or telephone calls did not stop me from feeling understood by Dean Clinic staff	78	36.4	66	33.3	23	11.6	22	11.1	9	4.6
i) I felt using video and/or telephone calls did not stop me from understanding what was being said to me by Dean Clinic staff	77	39	79	40.1	20	10.2	14	7.1	7	3.6
j) I felt using video and/or telephone calls did not stop me from	88	44.7	92	46.7	11	5.6	3	1.5	3	1.5

understanding changes made to my medication										
k) I felt using technology did not negatively impact on my experience of attending my Dean Clinic appointment	75	38.5	76	39.0	41	21	2	1	1	0.5
l) I would consider the option of attending appointments by video or phone when visitor restrictions have been lifted and on-site services have fully resumed	72	36.6	70	35.5	22	11.2	22	11.2	11	5.6
m) I am comfortable using technology, and regularly use video calls to stay in touch with friends and family	6	30.2	55	27.6	26	13	36	18	22	11

Q. In your opinion, what aspects of using technology to access your appointment worked well?

Graph: Service user gender breakdown



Q. In your opinion, what aspects of using technology to access your appointment worked well?

- “Seamless process.”
- “Saved having to commute and cut down on contact with other people during COVID-19.”
- “The quality of the video made conversation easy and free flowing and relaxed. I did not have the anxiety of traveling an hour to get to appointment. More relaxed at home.”
- “I feel more comfortable having appointment in my home. Less travel time. Less use of fuels so better for the environment.”
- “My appointments continued despite pandemic which gave me some level of comfort and understanding.”

Q. In your opinion, what aspects of using technology to access your appointment did not work well?

- “Face-to-face consultations are best to read body language and access non-verbal reactions.”

- "Connection wasn't always good on both ends."
- "I was a little paranoid that someone in my house would overhear what I was saying so I held back certain info for fear of exposing my private life to family."

Tell us about your experience of care and treatment using remote access to attend your appointments?

Respondents were asked about the quality of their care at the Dean Clinic using remote access to attend appointments. Service users were offered several 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?	**Strongly Agree**		**Agree**		**Neither Agree or Disagree**		**Disagree**		**Strongly Disagree**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**n**	**%**
Treated with dignity & respect	144	72.4	46	23.1	5	2.5	2	1	2	1
Confidentiality was protected	133	67.2	49	24.8	10	5	1	0.5	0	0
Privacy was respected	137	69.2	50	25.3	10	5	0	0.5	0	0
Staff were courteous	148	75.1	42	21.3	6	3	1	0.5	0	0
Felt included in decisions about my treatment	125	62.8	53	26.6	12	6	7	3.5	2	1
Trusted my doctor/therapist/nurse	138	69.4	39	19.6	13	6.5	3	1.5	6	3
My appointment was value for money	68	34.2	62	31.2	33	16.6	18	9	18	9

I will recommend the Dean Clinic to family and friends	112	56.3	53	26.6	30	15	2	1	2	1
I was informed of my treatment plan and follow-up arrangements were clear	108	54.3	65	32.7	14	7	5	2.5	7	3.5

How would you rate your care and treatment while remotely attending the Dean Clinic?

Service users who completed and returned the service user satisfaction survey between January and December demonstrated a high level of satisfaction with the care they received. Service users rated their care and treatment accessing the Dean Clinic remotely on a scale of one to 10, showing a median score of nine (N=200; SD=2.37). Respondents also indicated a high level of satisfaction with the overall remote Dean Clinic service, with a median also of nine (N=200; 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	7	3.5	5	2.5
2	4	2.0	1	0.5
3	7	3.5	4	2.0
4	1	0.5	2	1.0
5	6	3.0	7	3.5
6	10	5.0	7	3.5
7	18	9.0	17	8.5
8	40	20.0	32	16.0
9	35	17.5	37	18.5
10	70	35.0	86	43.0
No Answer	2	1.0	2	1.0

1-5	25	12.5	19	9.5
6-10	173	86.5	179	89.5
Total	200	100	200	100

5.1.4.2 Adult inpatient services

Demographics

Service users discharged between January and December 2020 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, 3043 discharges were processed in 2020, with a total of 166 surveys being returned to SPMHS adult inpatient services.

Table: Number of adult inpatient surveys returned and discharges in 2020

Month	Surveys Returned	Discharges
January	39	196
February	9	193
March	12	245
April	4	241
May	6	248
June	3	249
July	18	254
August	16	277
September	14	280
October	16	292
November	2	270
December	26	298
Missing	1	
Total	166	3043

Service User Responses

Q. Tell us about your experience of admission?

Table: Respondents' opinions regarding their experience of admission to hospital

Experience of Admission to hospital:	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%	n	%
a) A member of staff explained what was happening	62	31.3	72	43.4	9	5.4	11	6.6	11	6.6
b) A member of staff explained the ward routine such as meal times and visiting arrangements	66	39.8	58	34.9	14	8.4	12	7.2	10	6
c) A member of staff explained about activities available	47	28.3	51	30.7	22	13.3	25	15.1	16	9.6

Table: Tell us about your experience of how the hospital staff looked after you while you were an in-patient in St Patrick's Hospital

	Excellent		Good		N/A		Poor		No answer	
	n	%	n	%	n	%	n	%	n	%
Consultant Psychiatrist	105	63.3	33	19.9	2	1.2	25	15.1	1	0.6
Registrar	89	53.6	43	25.9	5	3.0	23	13.9	6	3.6
Key Worker	64	38.6	44	26.5	18	10.8	31	18.7	9	5.4
Nursing Staff	98	59	55	33.1	1	0.6	12	7.2	0	0
Psychologist	60	36.1	27	16.3	57	34.3	12	7.2	10	6.0

Occupational Therapist	49	29.5	38	22.9	57	34.3	12	7.2	10	6.0
Social Worker	42	25.3	28	16.9	68	41	13	7.8	15	9
Pharmacist	43	25.9	31	18.7	66	39.8	14	8.4	12	7.2
Healthcare Staff	57	34.3	33	19.9	53	31.9	10	6	13	7.8
Household Staff	92	55.4	41	24.7	21	12.7	6	3.6	6	3.6
Other	41	24.7	31	18.7	68	41	8	4.8	18	10.8

Tell us about your care…

A series of questions asked respondents to rate hospital facilities on a scale of one (strongly agree) to five (strongly disagree). Further examination of the mean and standard deviation suggests that respondents held highly positive opinions of the hospital facilities. In particular, the quality of the food available was of high standard, with 60.3% rating it strongly agree and agree. Similarly, daily activities provided were helpful and interesting, receiving high scores, with 66.3% of responses indicating strongly agree and agree.

Table: Tell us about your experience of the following while you were an inpatient in St Patrick's Hospital

Experience of the following while you were an in-patient:	**Strongly Agree**		**Agree**		**Neither Agree/Disagree**		**Disagree**		**Strongly Disagree**		**No answer**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
The quality of the food available was of a high standard	37	22.3	63	38	24	14.5	25	15.1	14	8.4	3	1.8
There was always a good selection of food available	36	21.7	59	35.5	22	13.3	32	19.3	14	8.4	3	1.8
The daily activities provided were interesting and helpful	45	27.1	65	39.2	26	15.7	14	8.4	13	7.8	3	1.8

The weekend activities were interesting and helpful	28	16.9	48	28.9	35	21.1	27	16.3	13	7.8	3	1.8
The cleanliness in the hospital was of a high standard	28	16.9	48	28.9	35	21.1	27	16.3	24	14.5	4	2.4

Q. Tell us about your experience of discharge…

Table: Respondents' experience of discharge from hospital…

Experience of Discharge from Hospital:	**Strongly Agree**		**Agree**		**Neither Agree/Disagree**		**Disagree**		**Strongly Disagree**		**No answer**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a) I was given notice of my discharge	65	39.2	50	30.1	18	10.8	9	5.4	12	7.2	12	7.2
b) I felt ready to go home	54	32.5	57	34.3	16	9.6	13	7.8	13	7.8	13	7.8
c) I was provided with details of the St Patrick's Mental Health Services Support and Information Service	42	25.3	57	34.3	21	12.7	18	10.8	15	9.0	13	7.8
d) I was provided with details about the St Patrick's Day Services available	33	19.9	58	34.9	26	15.7	14	8.4	20	12.0	15	9.0
e) I was provided with details of my follow-up appointments	44	26.5	55	33.1	27	16.3	13	7.8	14	8.4	13	7.8

f) I know what to do in the event of a further mental health crisis	53	31.9	58	34.9	13	7.8	15	9	12	7.2	15	9

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 and towards their own mental health difficulties (72.8%) and felt that they would share with others that they received support from SPMHS (60.2%).

Table: Experiences of Stigma

Tell us about your views and perceptions regarding mental illness following your stay…	**Strongly Agree**		**Agree**		**Neither Agree/Disagree**		**Disagree**		**Strongly Disagree**		**No answer**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
a) My views and perceptions regarding my own mental health difficulties and mental health in general are more positive	59	35.5	62	37.3	17	10.2	6	3.6	11	6.6	11	6.5
b) I will tell people that I was admitted to St Patrick's Hospital	46	27.7	54	32.5	26	15.7	21	12.7	12	7.2	7	4.2

c) I would recommend St Patrick's Hospital to others	82	49.4	45	27.1	18	10.8	3	1.8	12	7.2	6	3.6

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 7.28 (N=166; SD=2.56). Respondents also demonstrated a high level of satisfaction with the hospital overall, rating the hospital on a scale of one to 10, with a mean of 7.29 (N=166; SD=2.64).

Table 1: Respondents' ratings of care and treatment and overall experience of Hospital; 1st Jan- 31st December 2020

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	%	n	%
1	10	6.02	14	8.43
2	3	1.81	1	0.60
3	4	2.41	1	0.60
4	1	0.60	4	2.41
5	11	6.63	10	6.02
6	9	5.42	5	3.01
7	22	13.25	19	11.45
8	33	19.90	36	21.70
9	21	12.61	26	15.70
10	46	27.71	44	26.50
No Answer	6	3.62	6	3.62
Total	**166**	100.00	166	100.00
0-5	**29**	**17.47**	**30**	**18.06**
6+	131	78.89	130	78.36

Total	**166**	**100**	**166**	**100**

Table 2: 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	166	7.28	2.56
The Hospital	166	7.29	2.64

Table 3: Respondents' ratings of care and treatment and overall experience of Hospital (Physical Forms only)

How would you rate…?	**…your care & treatment**		**…the Hospital overall**	
	n	**%**	**n**	**%**
1	7	7.22	10	10.31
2	**1**	1.03	0	0.00
3	2	2.06	1	1.03
4	1	1.03	2	2.06
5	5	5.15	3	3.09
6	4	4.12	2	2.06
7	9	9.28	10	10.31
8	19	19.59	21	21.65
9	11	11.34	13	13.40
10	34	35.05	31	31.96
No Answer	4	4.12	4	4.12
Total	**97**	100.00	**97**	100.00
0-5	**16**	**16.49**	**16**	**16.49**
6+	77	79.38	77	79.38

Total	**97**	**100**	**97**	**100**

Table 4: Respondents' ratings of care and treatment and overall experience of Hospital (Physical Forms only)

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	97	7.76	2.67
The Hospital	97	7.67	2.79

Table 5: Respondents' ratings of care and treatment and overall experience of Hospital (Online Forms only)

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	**%**	**n**	**%**
1	3	4.35	4	5.80
2	2	2.90	1	1.45
3	2	2.90	0	0.00
4	0	0.00	2	2.90
5	6	8.70	7	10.14
6	5	7.25	3	4.35
7	13	18.84	9	13.04
8	14	20.29	15	21.74
9	10	14.49	13	18.84
10	12	17.39	13	18.84
No Answer	2	2.90	2	2.90
Total	**69**	100.0	**69**	100.0
0-5	**13**	**18.84**	**14**	**20.29**
6+	54	78.26	53	76.81
Total	**69**	**100**	**69**	**100**

Table 6: Respondents' ratings of care and treatment and overall experience of Hospital (Online Forms only)

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in Hospital	69	7.25	2.39
The Hospital	69	7.42	2.43

Figure 1: Q9 Care and treatment ratings comparison (online vs. physical forms)

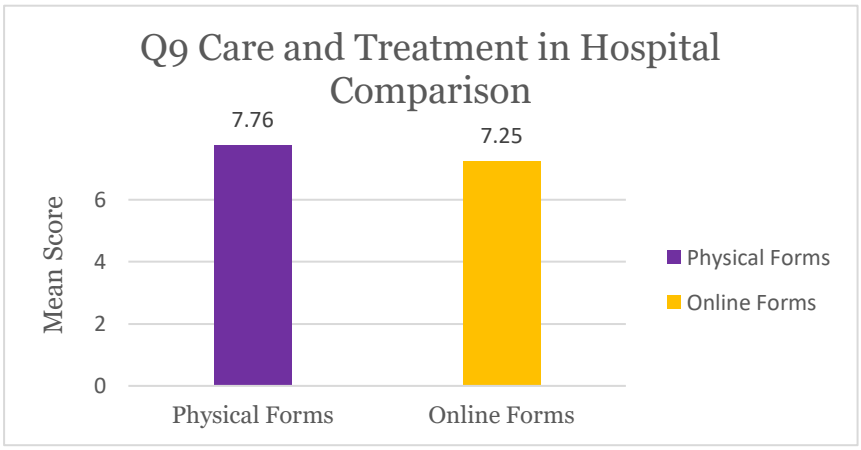
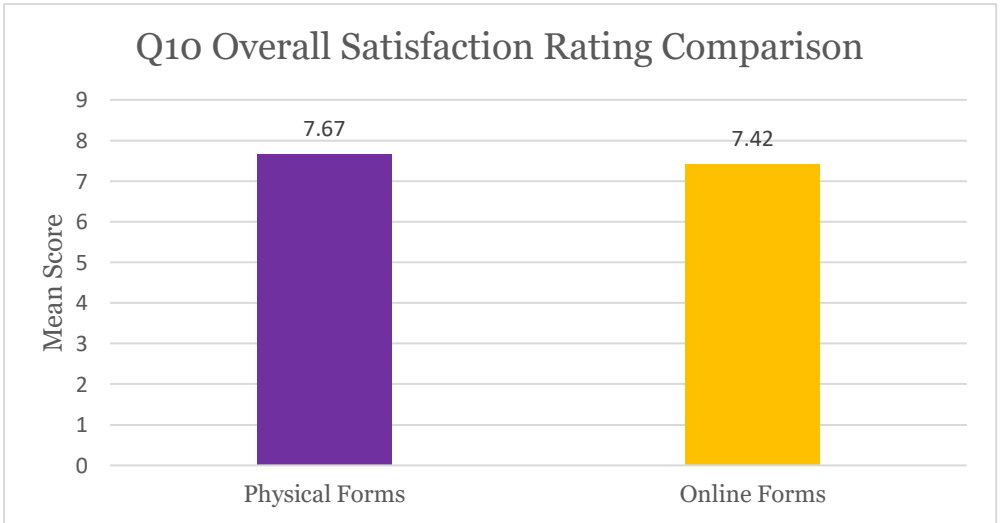
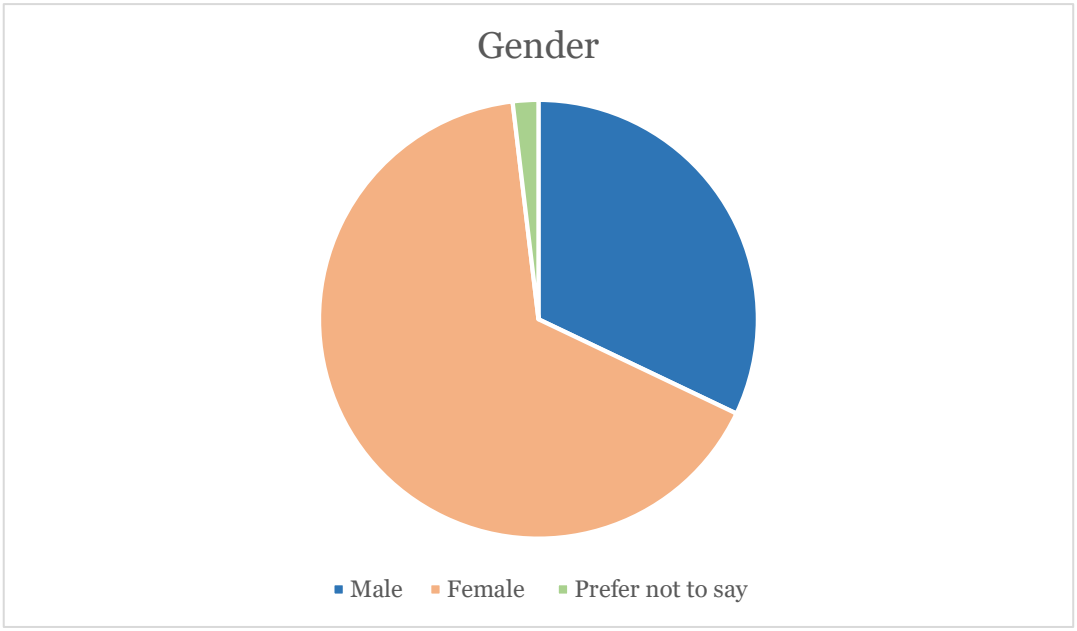


Figure 2: Q10 Overall hospital experience satisfaction ratings comparison (online vs. physical forms)



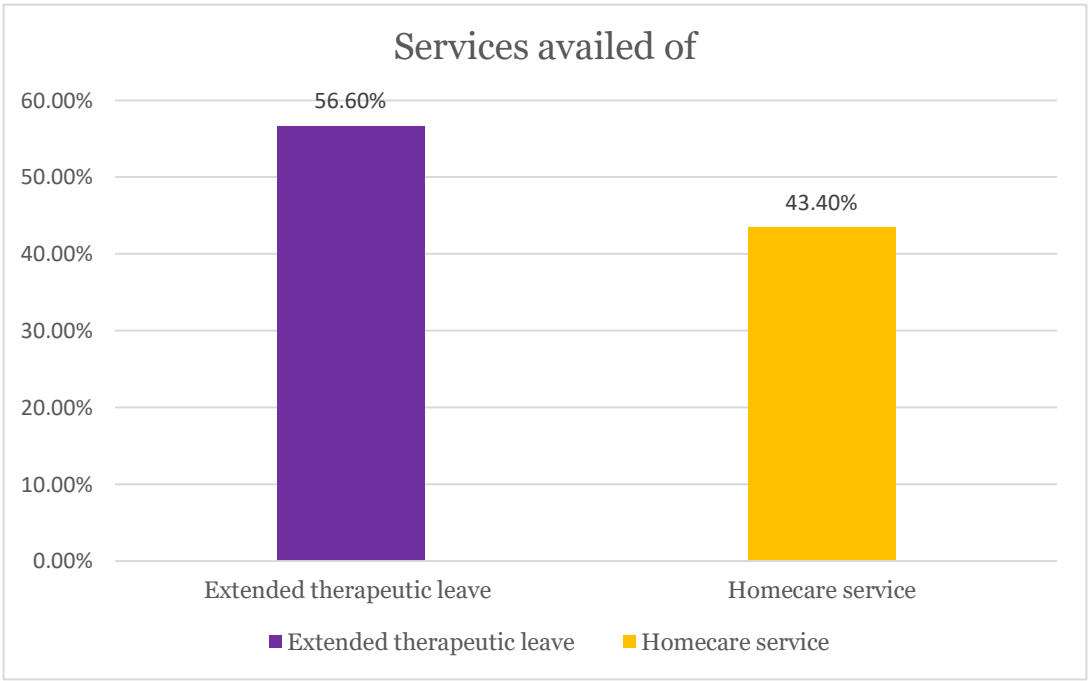
5.1 Homecare Service User Experience Survey

Graph: Service User gender breakdown



Q. Which of the following services did you avail of?

A total of 53 responses were received (N = 53).



Q. Tell us about your experience of using phone and video calls to access our services?

Respondents were asked about their experience using phone and video calls to access services. Service users were offered several statements describing their care which they were asked to endorse.

Respondents experience of care and treatment using technology to access services

	Strongly ;ree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree	Not Applicable	Total
a) It was clearly explained to me how I would access the services provided as part of the homecare service	41.51% 22	37.74% 20	5.66% 3	5.66% 3	7.55% 4	1.89% 1	53
b) I found it was easy to access my care and treatment by video communications or phone	33.96% 18	39.62% 21	7.55% 4	11.32% 6	5.66% 3	1.89% 1	53
c) The quality of sound on phone calls or video calls was generally good	33.96% 18	45.28% 24	11.32% 6	7.55% 4	1.89% 1	0.00% 0	53

d) The quality of video was generally good	17.31% 9	46.15% 24	11.54% 6	7.69% 4	3.85% 2	13.46% 7	52
e) The internet connection was generally good	25.00% 13	42.31% 22	11.54% 6	3.85% 2	5.77% 3	11.54% 6	52
f) I found using technology to access services to be convenient	34.62% 18	32.69% 17	5.77% 3	11.54% 6	9.62% 5	5.77% 3	52
g) I felt using technology did not negatively impact on my care and treatment	22.64% 12	35.85% 19	18.87% 10	9.43% 5	11.32% 6	1.89% 1	53
h) I would consider the option of attending appointments by video or phone when visitor restrictions have been lifted and on-site services have fully resumed	18.87% 10	30.19% 16	7.55% 4	16.98% 9	20.75% 11	5.66% 3	53
i) I am comfortable using technology, and	26.42% 14	33.96% 18	22.64% 12	11.32% 6	3.77% 2	1.89% 1	53

regularly use video calls to stay in touch with friends and family

Q. In your opinion, what aspect of using phone or video calls to access our service worked well?

- "Safety of home."
- "Video calls were a good substitute for physical meetings during the crisis. The phone calls were helpful from the perspective of knowing help was at hand and for a basic check-in each day."
- "I found it easy to access and very convenient."
- "I felt more comfortable at home compared to the inpatient experience. I got daily contact from ward staff inquiring how I was. This inquiry rarely happened on ward ie. three times per week if lucky! Felt I got more support out than in. Hated ward experience so was glad to have had to leave. Then got the therapeutic interventions at home which did not happen on ward. Even though it wasn't in person I found my sessions still private and intimate. It was still a one-on-one interaction which worked well."
- "The best service via video link was the ward rounds, I found it less intimidating in my own space rather than sitting before what feels like a panel interview in an inpatient setting."

Q. Tell us about your experience of how the hospital staff looked after you while receiving our homecare service?

	Poor	Good –	Excellent	Not applicable	Total
a) Nursing staff	13.21% 7 11.54%	18.87% 10 30.77%	60.38% 32 50.00%	7.55% 4 7.69%	53

b) Consultant Psychiatrist	6	16	26	4	52
	7.69%	28.85%	51.92%	11.54%	
c) Registrar	4	15	27	6	52
	13.73%	39.22%	23.53%	23.53%	
d) Key Worker	7	20	12	12	51
	1.89%	15.09%	43.40%	39.62%	
e) Psychologist	1	8	23	21	53
	3.85%	17.31%	23.08%	55.77%	
f) Occupational Therapist	2	9	12	29	52
	5.88%	5.88%	13.73%	74.51%	
g) Social Worker	3	3	7	38	51
	3.92%	11.76%	21.57%	62.75%	
h) Pharmacist	2	6	11	32	51
	0.00%	5.77%	13.46%	80.77%	
i) Healthcare Assistants	0	3	7	42	52
	5.77%	7.69%	28.85%	57.69%	
k) Other (e.g. Counsellor, therapist etc.)	3	4	15	30	52

Q. In your opinion what aspect of your care and treatment provided by our homecare service worked well?

- "My meetings with doctors (by phone) and OT and CBT therapist were very good."
- "The standard of services and support provided exceeded my expectations."
- "Being in constant contact with my counsellors has been a great help and has brought me to a MUCH better place."
- "Regular meetings with team and key worker continued uninterrupted; could be at home while having the assurance that my hospital bed is available should I need it."
- "The nurses who call was reassuring and positive."

Q. In your opinion, what aspects of your care and treatment provided by our Homecare service did not work well?

- “I found not physically being in hospital was difficult at times of stress.”
- “Did not have opportunity to give feedback after the Monday consultation.”
- “Consultant check ins and key worker. I only found out I had a key worker towards the end of my care. The structure of my care wasn't fully explained to me.”
- “Personally, I don't think anything can replace the direct one-to-one contact with such professional staff. There simply isn't anything more you can have, but in the current climate of COVID-19 I do think the remote access will work for some of us very well.”
- “Just found it hard to engage at times just not the same as being there in person.”

Q. Overall, can you tell us about how using technology impacted on the following:

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree	Total
a) I felt using video and/or telephone calls did not stop me from being able to express myself when talking to my team	28.85% 15	36.54% 19	13.46% 7	17.31% 9	3.85% 2	52
b) I felt using video and/or telephone calls did not stop me from feeling understood by my team	28.85% 15	38.46% 20	13.46% 7	9.62% 5	9.62% 5	52

c) I felt using video and/or telephone calls did not stop me from understanding what was being said to me by my team	30.77% 16	50.00% 26	9.62% 5	7.69% 4	1.92% 1	52
d) I felt using video and/or telephone calls did not stop me from understanding if changes were made to my medication	38.78% 19	36.73% 18	16.33% 8	6.12% 3	2.04% 1	49
e) I had access to my medication	34.00% 17	38.00% 19	16.00% 8	6.00% 3	6.00% 3	50
f) I received regular calls from my consultant	25.00% 13	38.46% 20	9.62% 5	21.15% 11	5.77% 3	52
g) I received regular calls from nursing staff	47.06% 24	35.29% 18	3.92% 2	9.80% 5	3.92% 2	51
h) I received regular calls from my key worker	20.00% 10	20.00% 10	28.00% 14	14.00% 7	18.00% 9	50
i) I felt any issues I had were understood by my team	28.85% 15	40.38% 21	17.31% 9	3.85% 2	9.62% 5	52
j) I felt any issues I had were addressed by my team	26.92% 14	44.23% 23	13.46% 7	5.77% 3	9.62% 5	52

Q. Please tell us about your experience of completing your homecare treatment

	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree	Total
a) I was given notice of my discharge	34.62% 18	34.62% 18	19.23% 10	7.69% 4	3.85% 2	52
b) I felt ready to go home	23.53% 12	49.02% 25	11.76% 6	9.80% 5	5.88% 3	51
c) I was provided with details of the St Patrick's Mental Health Services Support and Information Service	25.00% 13	38.46% 20	15.38% 8	15.38% 8	5.77% 3	52
d) I was provided with details about the St Patrick's day services available	13.46% 7	36.54% 19	17.31% 9	17.31% 9	15.38% 8	52
e) I was provided with details of my follow-up appointments	23.08% 12	42.31% 22	11.54% 6	13.46% 7	9.62% 5	52
f) I know what to do in the event of a further mental health crisis	32.69% 17	36.54% 19	13.46% 7	7.69% 4	9.62% 5	52

Is there any additional feedback you would like to share with us about how you felt when your Homecare treatment was completed?

- "No it was and is excellent."
- "I now feel that I am back to where I was two years ago and I am feeling so much better."
- "I was nervous but felt I could manage. The team in St Ed's were excellent. I felt genuinely cared for."
- "More phone calls and options for areas that don't have 5g internet. It's very easy to not tell the truth on a phone call."
- "Surprisingly more ready to embark on my journey to better mental health as I had had a supportive easing in. I think without it discharge would have been a lot more intimidating."

Q. Overall, on a scale of 1-10, how would you rate your care and treatment while receiving homecare services provided by St Patrick's Mental Health Services where 1 star = poor and 10 stars = excellent.

1 =poor	2	3	4	5	6	7	8	9	10=Excellent	Total	Weighted Average
11.5%	1.9%	5.7%	7.6%	13.4%	1.9%	3.8%	15.3%	5.7%	32.6%		
6	1	3	4	7	1	2	8	3	17	52	6.71

Q. Overall, on a scale of 1-10, how would you rate St Patrick's Mental Health Services based on your experience of our homecare service where 1 star = poor and 10 stars = excellent.

1 =poor	2	3	4	5	6	7	8	9	10=Excellent	Total	Weighted Average
11.7%	3.9%	7.8%	5.8%	11.7%	0%	9.8%	11.7%	5.88%	31.3%		
6	2	4	3	6	0	5	6	3	16	51	6.55

5.1.4.3 Wellness and Recovery 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 2020 was 56.

Day service programmes attended by survey respondents

Programme	Number of respondents attending	Percentage of respondents attending
WRAP	19	33.9%
Mindfulness	3	7.1%
Depression	1	1.8%
CFT	1	1.8%
Healthy Self-Esteem	4	7.1%
Dual Diagnosis	2	3.6%
Alcohol & Chemical Dependency	2	3.6%
ACT	13	23.2%
Roles in Transition	7	12.5%
Access to Recovery	1	1.8%
No answer	3	5.4%

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

Province	N	%
Leinster	48	85.6%
Connaught	3	5.4%
Munster	3	5.4%
Ulster	1	1.8%
Don't want to say	1	1.8%
Total	56	100%

Service user responses

Tell us about your experience of starting a programme

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.

	Agree		Disagree		Neither Agree/ Disagree		No answer	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
A member of day services explain clearly what would be happening	49	87.5%	3	5.3%	4	7%	0	0

A member of staff explained the timetable	49	87.5%	2	3.5%	4	7%	0	0

Tell us about your experience of the team that worked with you on your day programme

Respondents were asked about their experiences of working with their day programme team. 76.8% (n = 43) strongly agreed that they trusted the members of their day programme team. 83.9% (n = 47) strongly agreed that they were always treated with dignity and respected as an individual. 83.9% (n = 47) also strongly agreed that their team were courteous and respectful. 80.4% (n = 45) strongly agreed that members of the team were knowledgeable and easy to understand.

	Agree		**Disagree**		**Neither Agree/Disagree**		**No answer**	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
I trusted the members of my programme team	54	96.4%	1	1.7%	1	1.7%	0	0
I was always treated with dignity and respect	54	96.4%	1	1.7%	1	1.7%	0	0
Members of my programme team were courteous and respected me as an individual	53	94.6%	1	1.7%	2	3.5%	0	0

Members of my team were knowledgeable and easy to understand	54	96.4%	1	1.7%	1	1.7%	0	0

Tell us about your experience of finishing the programme

Respondents also generally reported an informed ending to the programme, with 92.8% (n = 52) agreeing that they knew when the programme was to end. 82.7% (n = 43) of respondents felt that the programme met their expectations and 90.6% (n = 48) felt that they know what to do in the event of a further mental health crisis. 88.9% (n = 48) 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.

As I am preparing to complete the programme…	**Agree**		**Disagree**		**Neither Agree/ Disagree**		**No answer**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I knew in advance when the programme was due to finish	52	92.8%	3	5.3%	1	1.7%	0	0
The programme met all of my expectations	43	76.7%	3	5.3%	6	10.7%	0	0
I know how to get help in in the event of a further mental health crisis	48	85.7%	1	1.7%	5	8.9%	0	0
I have been given details of the St Patrick's Mental Health Services support and information service	48	85.7%	1	1.7%	4	7.1%	0	0

The Service User Satisfaction Survey also asks for service users' experiences of stigma after attending SPMHS.

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

As you prepare to leave the programme...	Agree		Disagree		Neither agree/disagree		No answer	
	n	%	n	%	n	%	n	%
I feel my views and perceptions regarding mental health difficulties and mental health in general are more positive than they were	50	89.2%	2	3.5%	4	7.1%	0	0
I will tell people that I have attended a St Patrick's Wellness & Recovery day programme	35	62.5%	10	17.8%	10	17.8%	0	0
I would recommend St Patrick's Wellness & Recovery day programmes	52	92.8%	0	0	3	5.3%	0	0

Respondents were also asked to rate their care and treatment while attending St Patrick's Wellness and Recovery Centre on a scale of one to 10, where one is poor and 10 is excellent. 96.4% of respondents (n = 54) rated their care and treatment a score of 6 or above. Respondents were also asked to rate the Wellness and Recovery Centre overall. 98.2% of respondents (n = 55) rated the Wellness and Recovery Centre a score of 6 or above. See the table below for further information.

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	0	0	0	0
5	2	3.6	1	1.8
6	0	0	2	3.6
7	3	5.4	2	3.6
8	8	14.3	9	16.1
9	13	23.2	11	19.6
10	30	53.6	31	55.4
No Answer	0	0	0	0
1-5	2	3.6	1	1.8
6-10	54	96.4	55	98.2
Total	56	100	56	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:

Positive comments include:

- "Really enjoyed attending WRAP. I looked forward to attending every week. I would highly recommend it. The programme really helped me in my transition back to work and life after discharge from hospital. "
- 'The WRAP programme has been invaluable and will be of huge benefit to me going forward. The OT section was excellent'."

- "I cannot recommend this course highly enough. The staff are all outstanding. I really wish more people were aware of the services and safe environment that St Pat's offers.'
- "Very well run course with excellent facilitators who were caring, courteous and very knowledgable.'
- "Learned so much more about me, not afraid to ask for help from supports. Felt connected to other service users. Program providers are excellent, very professional and extremely understanding, and available to speak with you in private.'

Comments to learn from include:

- "I found this programme [WRAP] excellent, not sure about having 30 minute break at 11:30am when we only start at 10:30am - could it be 15 minutes then 15 minutes at 2:45/3pm. Coffee to keep alert for afternoon session!"
- "I travelled from Limerick to Lucan for programme and this was stressful - had to leave home at 6:15am and not back until 4:45pm."
- "Getting materials in advance for some classes would be helpful'.
- "I wish St Patrick's had been a bit more proactive about offering remote support once the pandemic started."
- "The Stepdown programme has a lot of focus on alcohol so is sometimes not relevant for someone with another addiction. I understand that's all evidence based, I also don't believe that it's one size fits all because people are individuals."

Remote day services

The total number of online surveys completed in 2020 was 172. These surveys were completed by 109 females (63.3%) and 63 males (36.7%).

Day service programmes attended by survey respondents

Programme	N	Percentage of respondents attending
Access to Recovery	13	7.5%
Depression	15	8.7%
Acceptance and commitment therapy	45	26.1%
Bipolar	9	5.2%
Eating Disorder	8	4.6%
Anxiety	10	5.9%
Group Radical Openness	10	5.9%
Living Through Distress	6	3.5%
Alcohol Step Down	8	4.6%
Compassion Focused Therapy	9	5.2%
WRAP	10	5.9%
Other	18	10.5%
No answer	11	6.4%

The other programmes included in the table above include CFT-E, CBT, Sage, COCOA, Alcohol Dependency, Dual Diagnosis, Trauma, Mindfulness, LTP, Formulation and Pathways to Wellness.

The breakdown of respondents by county is illustrated in the table below. 2020

Province	N	%
Leinster	139	80.8%

Connaught	6	3.5%
Munster	20	11.6%
Ulster	3	1.74%
Don't want to say	2	1.7%
No answer	2	1.7%
Total	172	100%

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.

How did you remotely access your Wellness and Recovery programme?

Technology	N	%
Phone call only	3	1.8%
Video call only	123	71.5%
Phone and video call	46	26.7%
Total	172	100%

Service users were asked about their experience of using technology to access their Wellness and Recovery programme. The majority reported that it was clearly explained to them how to access their programme using either video or telephone calls and this was easy to do. See table below for further details of respondents' experiences of technology programme.

Technology	Strongly Agree	Agree	Neither Agree or disagree	Disagree	Strongly Disagree	No response
a) It was clearly explained to me how to access my programme using either video or telephone calls	106 (62%)	55 (32%)	7 (4%)	1 (0.5%)	2 (1%)	1 (0.5%)
b) I found it was easy to access my programme using video and/or telephone calls	99 (58%)	56 (32%)	8 (4.5%)	5 (3%)	3 (2%)	1 (0.5%)
c) I found the quality of sound on video and/or phone calls was generally good	61 (36%)	79 (46%)	18 (10.5%)	11 (6%)	2 (1%)	1 (0.5%)
d) I found the quality of video was	65 (38%)	82 (47.5%)	12 (7%)	9 (5%)	3 (2%)	1 (0.5%)

generally good when using video calls						
e) The internet connection on video calls was generally good	58 (34%)	86 (50%)	15 (8.5%)	8 (4.5%)	3 (2%)	2 (1%)
f) I found using technology to access my programme to be convenient	69 (40%)	69 (40%)	14 (8%)	12 (7%)	5 (3%)	3 (2%)
g) I felt using video and/or telephone calls did not stop me from being able to express myself when talking to programme staff	59 (34.5%)	58 (34%)	23 (13%)	19 (11%)	10 (5.5%)	3 (2%)
h) I felt using video and/or telephone calls did not stop me from feeling understood by	68 (40%)	66 (38.5%)	21 (12%)	11 (6%)	5 (3%)	1 (0.5%)

programme staff						
i) I felt using video and/or telephone calls did not stop me from understanding what was being said to me by programme staff	73 (42.5%)	79 (46%)	12 (7%)	6 (3.5%)	1 (0.5%)	1 (0.5%)
j) I felt using technology did not negatively impact on my experience of attending my programme	46 (27%)	65 (38%)	27 (16%)	22 (12.5%)	11 (6%)	1 (0.5%)
k) I would consider the option of attending programmes by video or phone when visitor restrictions have been lifted and on-	41 (24%)	56 (33%)	23 (13%)	30 (17.5%)	21 (12%)	1 (0.5%)

site services have fully resumed						
l) I am comfortable using technology, and regularly use video calls to stay in touch with friends and family	64 (37%)	54 (32%)	18 (10.5%)	28 (16%)	7 (4%)	1 (0.5%)

Tell us about your experience of your Wellness and Recovery programme

Respondents were also asked about their experiences of attending their Wellness and Recovery programme. 58% (n = 99) strongly agreed that a member of the Wellness and Recovery Centre or the programme explained clearly what would be happening in the programme, 60% (n = 102) strongly agreed that a staff member explained the timetable when starting the programme. Over 94% of respondents reported that they trusted the members of their programme team (n = 161), they were always treated with dignity and respect (n = 160), and members of their programme team were courteous and respected them as an individual (n = 162). 92% of respondents agreed that members of their programme team were knowledgeable and easy to understand. 86% of respondents knew when the programme was due to finish. 78% of respondents felt that the programme met their expectations and 89% felt that they know what to do in the event of a further mental health crisis. 82.5% 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 stigma following your completion of your programme at St Patrick's Wellness and Recovery Centre

The service user satisfaction questionnaire also asks for service users' experiences of stigma after having attended SPMHS. 35.2% (n = 60) of respondents strongly agreed and 47% (n = respondents agreed that their views and perceptions of their own mental health difficulties and mental health in general are more positive than they were previously. Over 60% respondents reported that they strongly agreed (n = 49, 28.4%) or agreed (n = 57, 33.06%) that they will tell people that they attended a St Patrick's Wellness and Recovery day programme. Over half of all respondents (n = 96, 55.6%) strongly agreed that they would recommend St Patrick's Wellness and Recovery day programmes to others.

As you are prepared to leave the programme...	Agree		Disagree		Neither agree/disagree		No answer	
	n	%	n	%	n	%	n	%
I feel my views and perceptions regarding mental health difficulties and mental health in general are more positive than they were	140	81.3%	3	1.7%	26	15.1%	2	1.1%
I will tell people that I have attended a St Patrick's Wellness & Recovery day programme	96	55.8%	30	17.4%	33	19.1%	3	1.7%
I would recommend St Patrick's Wellness	152	88.3%	9	5.2%	9	5.2%	2	1.1%

& Recovery day programmes

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

How would you rate...?	...your care and treatment		...remote programmes overall	
	n	%	n	%
1	7	4.06	7	4.06
2	3	1.74	2	1.2
3	1	0.6	5	2.9
4	2	1.2	3	1.74
5	3	1.74	8	4.7
6	8	4.7	7	4.06
7	19	11.02	32	18.6
8	26	15.1	27	15.7
9	34	19.8	27	15.7
10	66	38.3	49	28.44
No Answer	3	2	5	3
1-5	16	9	25	15
6-10	153	89	142	82
Total	172	100	172	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:

In your opinion what aspects of completing your Wellness and Recovery programme remotely worked well?

- "Obviously throughout COVID-19 being able to get help and support remotely was incredible. It is convenient to be able to access the recovery services from home and not be in a scary, unfamiliar environment which can be stressful."
- "It did not affect the quality of the programme delivery, and enabled us to access the content from a safe space at home."
- "Programme was expertly delivered and in a humorous way. I was able to interact and give opinions."
- "Not having to commute meant I was not tired going to work."
- "Staff were very knowledgeable and shared the information very well."
- "Being able to continue to have the support of the programme and get the help I needed, in particular when I had a difficult health diagnoses."
- "The course was very well delivered, with scheduled modules and the course facilitators were very good at delivering the course."
- "Comfort of your own home and also that everyone had to turn their camera on."
- "Technology worked well. The benefit of participating in mindfulness exercises was still exercised as attending hospital."
- "Keeping some form of contact was essential to keep my recovery in check, when we were unable to physically attend the programme."
- "It felt quite intense. You could fully see the face of the person speaking which meant concentrating on the dialogue was easier. There was still a sense of community with the other participants even though we weren't together in the same room."
- "I think that it was an effective way to facilitate continued sessions during the COVID19 pandemic restrictions. I can see how remote access to sessions might facilitate access to programmes that might be difficult for people to attend because they cannot get to the hospital for different reasons, e.g. geographical distance, disability or physical illness or caring responsibilities."

- “Having the programme and supports available at this time. As a ' cocooner' having the weekly input and homework to complete was helpful to me.”

In your opinion, what aspects of completing your Wellness and Recovery programme remotely did not work well?

- “I missed the social aspect of in-person programme, both on the programme and during breaks.“
- “Too many in group to really get benefit. Would be better paying one-to-one every two weeks for same money.“
- “Sometimes Microsoft Teams was unreliable - shaky screens and participants being dropped from calls.“
- “There was a complete disconnect between members of the group. It was more like watching an online lecture.“
- “Sometimes not being able to hear other people speak clearly or not see them.“
- “Its harder to open up to people that you have never met, even meeting up in person once would be beneficial post covid.“
- “I would feel more comfortable being in the hospital context from a privacy point of view. I also don't like having one space for work, home, and attending programmes context.“
- “We couldn't hug goodbye. The programme was lifechanging and we couldn‘t celebrate that properly.“
- “Structure was not explained. Admin was not organised. Handouts were not always provided in advance and wasn't always clear what material was being covered.“
- “I don’t think you can build the same rapport or emotional connection in remote sessions compared to face-to-face contact. I also think that participants would be less committed and engaged with programmes if they were all completed remotely.“
- “Felt extremely tired and drained.“
- “I was anxious about my parents overhearing me and eves dropping.“
- “Not being able to see all participants negatively impacted my experience.“

Is there any additional feedback you would like to share with us about your most recent experience of attending St Patrick's Wellness and Recovery programme remotely?

Positive comments include:

- “I can't emphasise enough the value I have received from this programme and would like to thank everyone involved.“
- “Having attended a programme on-site in the past, I can confidently say that remote learning and participation is far more beneficial and enjoyable!“
- “I am glad I attended I have learnt a lot and I feel that I am more compassionate to myself.“
- “Thank you very much for facilitating programmes remotely, and for acting so swiftly to ensure that this could happen. Participating in the Wellness and Recovery programme remotely was the next best thing to attending the hospital and I am grateful for that opportunity.“
- “The facilitators were so well prepared and each session was very well structured that everything ran smoothly and you learnt new things about yourself. You felt safe and supported by the facilitators.“

Comments to learn from include:

- “‘Please continue some remote courses for those not living in Dublin or near there. Evening course would also be ideal, 4hrs over 12 weeks is a big ask of an employer to facilitate’.”
- ‘”Too impersonal. Can't broach a large number of issues owing to being in a home environment’.”
- ‘”Examine other software providers offer than MS Teams’.”
- “‘If users turn off their cameras I do not think they should be allowed to participate in the group. If we all met in a group in the hospital it would not be acceptable to purposely obscure your face/conceal your identity from others’.”
- ‘”Have constancy in facilitators when starting a programme, send out the handouts in advance of the course, ask service users to mute if not speaking to avoid noise, all users where possible please join on time’.”

5.2. Willow Grove Adolescent Unit service user satisfaction survey 2020

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 2020.

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. 68 young people and 43 parents/carers completed the questionnaire. Response rates for service users were 74.7% (total number of adolescent admissions = 91). 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 increased by 1.5% and decreased by 54.7% for parents/carers in 2020 compared with 2019, where responses were provided from 67 young people and 95 parents/carers. The decrease in returned surveys by parents/carers can be attributed to Covid-19 regulations, whereby restrictions were in place regards the number of people allowed to access the unit.

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 four - 'happy' (76%), followed by five - 'very happy' (15%) and three - 'mixed' (6%). 3% of young people reported that they were unhappy with the service. For the parents/carers, the most common response across questions was four - 'very happy' (76%), followed by five - 'very happy' (15%) and three 'mixed' (6%).

The least positive answer given by service users was in relation to access to leisure activities and outings, whereas parents/caregivers rated this more favourably. Service users rated five - 'very happy' on the cleanliness of the unit, access to individual therapy, educational support and keyworkers/allocated nurse. They rated 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 confidentiality of the service and opportunity to attend the discharge planning meeting.

The public health restrictions implemented in response to COVID-19 may have impacted on service users' experiences of the unit. This was seen in some individual's ratings of visiting arrangements and access to leisure activities, whereby these questions were left blank or rated poorly. Other service users noted that they had not accessed the unit physically and were receiving treatment online.

Table: Median responses to Willow Grove service user satisfaction questionnaire

Please tell us how satisfied you were with aspects of our service	**Median rating**	
	4	5
Experience of accessing the service	4	5
Information received prior to admission	4	4
Information provided by St Patrick's website	4	5
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	5	5
The meals provided	4	5
Visiting arrangements	3.5	5
Safety arrangements on the unit	4	5
Experience of care and treatment	4	5
Access to group therapy	4	5
Access to individual therapy	5	5
Access to leisure activities and outings	3	4
Access to a range of professionals	4	5
Access to key workers/allocated nurse	5	5
Access to educational support	5	5
Access to an independent advocacy group	4	5
Your level of contact with the treatment team	4	4
Information received on treatment plan	4	4
Your involvement (young person)/ collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4	4
How you felt you were listened to/ respected	4	5
Confidentiality of service	5	5
Opportunity to attend discharge planning meeting	5	5

Your preparation for discharge	4	N/A
Weekend/midweek therapeutic leave arrangements	4	4
Information given to you to prepare for discharge	4	4
Having a service identified for follow up care	4	5
Provision of family support	4	4
Opportunity to attend parents support group	N/A	3.5
Opportunity to attend Positive Parenting Course	5	5
Was your child's stay helpful in addressing mental health difficulty?	5	5
Providing you with Skills to manage your mental health	4	5

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:

- "Liked everything - the support, staff, therapist, other young people. I think this place is inspiring and I'm glad I got the opportunity to be cared for here.'
- "Group therapy, one-to-one therapy, key worker."
- "There was such love being on the ward. Patients and workers."
- "Other young people and access to multitude of facilities."
- "Support from other young people and structure of the day."

- “Most people I talked to were very friendly. Connected extremely well with psychologist.”

Parents/caregivers:

- “Staff couldn't have been more helpful in sharing information and answering any of our queries.”
- “It was a secure unit and I felt my child was safe and was receiving appropriate care.”
- “Variety of staff available to help. Always felt I was aware of what was going on a daily basis.”
- “No uniforms, and staff being on first name terms. It felt like a safe environment and my child was treated like a person. Staff were always available to talk to.”
- “Child was happy. Liked that different approaches were used to help her.”
- “Unit was away from the main hospital. Has a nice layout and they have their own bedroom.”

Q: What did you dislike about the unit?

Young people

- “Sometimes it was too bright in hallways when trying to sleep. Trainees/new staff don't give much space and hover for too long.”
- “Wasn't enough outside time. Short nursing staff. No activities on weekend, left to own devices where thoughts lurk in.”
- “Inconsistent rules between nurses. Not going outside.”
- “Only received my diagnosis a day and a half before discharge so nothing much has been done about it.”
- “Care plans aren't individualised and never change. Not being listened to.”
- “Rooms are closed for too long.”
- “Lack of facilities when you have a BMI of less than 16.5.”

Parents/ caregivers

- “Inability to visit our child and not being able to have in-person meetings (due to COVID-19 restrictions).”
- “Need for greater outdoor activities on-site.”
- “Think my child learned negative behaviours and is using their diagnosis as an excuse.”
- “Felt some nurses were too direct.”
- “More weekly communication on progress/MDT.”
- “Not sure how some days were being spent.”

Is there anything you would change about the unit?

Young people

- “More outdoor time, it can get very cabin fevery sometimes.”
- “For things brought up in advocacy to actually change.”
- “Process in which people receive treatment and amount of therapy could be more individualised.”
- “The amount of gym time, balance between distraction and recovery, less rules based - more recovery, equality, bring pizza nights back.”
- “Lack of programmes provided for other eating disorders eg. orthorexia, binge eating disorder, body dysmorphia. Lack of activities for those on weight restoration programmes (no distraction leads to ruminating on diet). Emphasis on weight restoration to earn back privileges rather than on efforts to recover.”
- “More activities on the weekend.”
- “Some issues addressed much too late (family therapy & ASD traits).”

Parents/caregivers

- “Communication structure between different areas could be improved eg. different information being given from different staff regards weekend leave.”
- “More parent groups, more info on coping with discharge and child coming home. Help with sibling dynamics.”

- “Children to be reminded to brush their teeth. Better eye kept on eating (eg. desserts). Felt they were left away with being disrespectful towards staff as never would have been like this before.”
- “Extended leave during COVID-19 for parents and children to see each other.”
- “Admission process involving so many people was daunting. We wondered if it might be helpful to have an adolescent that had been through the program to measure.”
- “Treatment didn’t seem individualised. It seemed like one fits all treatment plan.”

SECTION SIX

Conclusions

6.1. Conclusions

1. The SPMHS 10th 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. Clinical staff continued to drive ways to expand or improve the way outcomes are measured and utilised to maintain and improve services, despite the challenges posed by the COVID-19 pandemic.

4. The scope of audit across the organisation was further strengthened in 2020, consistent with the requirements of the Mental Health Commission's Judgement Support Framework (2019). 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 one programme in 2020. 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. The service user satisfaction survey expanded this year to include surveys for people accessing our services remotely via technology, in response to the COVID-19 public health measures.

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. Following a review in 2019 of the content and structure of the survey, 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. However, it is difficult to assess the impact of these changes, as the COVID-19 pandemic created huge challenges for the service users and staff of SPMHS in the completion and delivery of surveys. As a result completion rates remained lower than we would have targeted at the start of 2020.

SECTION SEVEN

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7.1 References

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