St Patrick's
Mental Health Services

Outcomes Report 2021

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 eleventh 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 2021, despite the challenges posed by a second year of 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 is also 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 and throughout 2021 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 a service user's assessment of needs. These technology-mediated interventions have not replaced inpatient admission or other onsite care delivery where needed. SPMHS continued to deliver the Homecare service in 2021, offering all the elements of inpatient services, but provided remotely in the service users' own home. This involves the highest levels of one-to-one mental health support,

through daily or more frequent contact over videocall and other technological channels.

The 2021 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 programme and inpatient services were accessed in 2021. SPMHS provides community mental health care through its Dean Clinics and day programme 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 2021, 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 through our Dean Clinic network, day programme care through our WRC and our inpatient care 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 e.g. telephone/audio visual technology, 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 2021.

2.1. Prompt Assessment of Needs (PAON)

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

Service users can access this assessment from their own home, without the need to travel to a clinic. A range of communication technologies including telephone and audio-visual technologies are used to provide the assessment. The choice of communication with the R&A is based on the preference of the service user.

2.1.1. Outcomes of the PAON Assessments

The table below provides the number and percentages of adult PAON assessments completed and the outcome of each PAON in 2020 and 2021. These results identify the immediate outcome of the PAON assessment. There was an increase of 35%

(343) in adult PAONs in 2021, in comparision to PAON's completed in 2020. In 2020 there had been a low number 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 the COVID-19 public health restrictions. The number of referrals increased in the fourth quarter of 2020 and remained strong thoughout 2021.

	2020 Number	%	2021 Number	%
Dean Clinic referral	798	80.2%	1038	78%
Discharge*	59	5.93%	56	4%
Admission referral	138	13.87%	244	18%
Total	**995**	**100%**	**1338**	**100%**

*A discharge occurred 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 at that time.

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 programme 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 2021, there was a total of 1,618 Adult Dean Clinic referrals

received from the centralised Referral and Assessment Service (R&A), comparable with 1,656 referrals in 2020.

2.2.2. Dean Clinic Referral Source by Province

The following table illustrates the geographical spread of Dean Clinic Referrals by Province from 2019 to 2021. The highest referral volumes continued to be from Leinster in 2021 with 1,160 referrals.

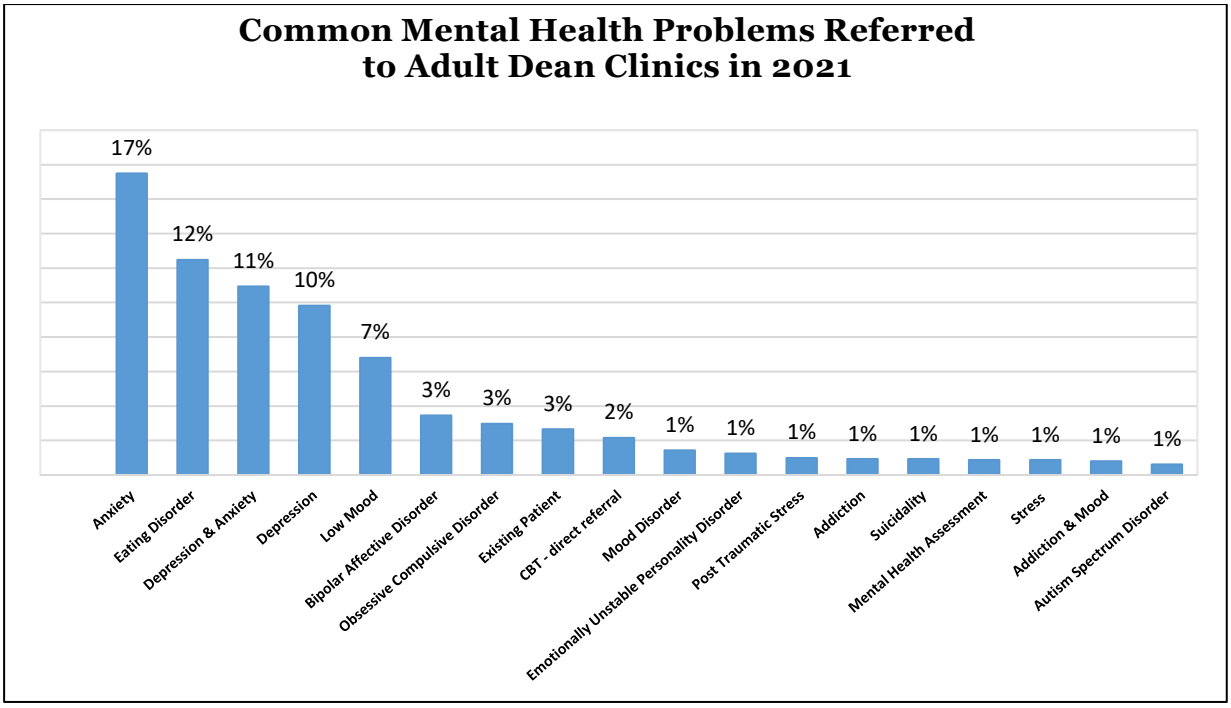
Year	Leinster	Munster	Connaught	Ulster	Other
2019	1,238	292	215	39	0
2020	1,212	241	177	26	0
2021	1,160	230	182	45	1

2.2.3. Dean Clinic Referrals by Gender

The gender ratio of Dean Clinic Adult referrals for 2021 was 65% female to 35% 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 2021 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 2019. Not all referrals resulted in an assessment, there are several reasons for this. In some cases, a decision is made not to progress with an assessment as the service user is already under the care of another service.

Others do not attend their appointments and other service users have a more immediate need and are assessed for possible urgent admission to inpatient care. In 2021 19.2% of referrals were assessed in comparison to 27.6% in 2020. This 8.4% decrease could be attributed to an unexpected decrease of assessment capacity due to the unplanned reduction of clinical resources, due to the COVID-19 public health restrictions.

Year	No. of Referrals	No. of Assessments
2019	1,784	**770**
2020	1,656	**457**
2021	1,618	**310**

A mental health assessment involves a comprehensive evaluation of the referred persons mental state carried out by a Consultant Psychiatrist and members of the multidisciplinary team. An individual care plan is agreed with the referred person following assessment which may involve follow-on community-based therapy, a referral to a day service 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 2019 to 2021. Appointments include consultant reviews, Clinical Nurse Manager II reviews, Clinical Nurse Specialist reviews, cognitive behavioural therapy, occupational therapy, social work and psychology. There was a 10.6% decrease in Dean Clinic appointments attended in 2021, compared with 2020. This was due to unplanned reduction of clinical resources due to the COVID-19 pandemic.

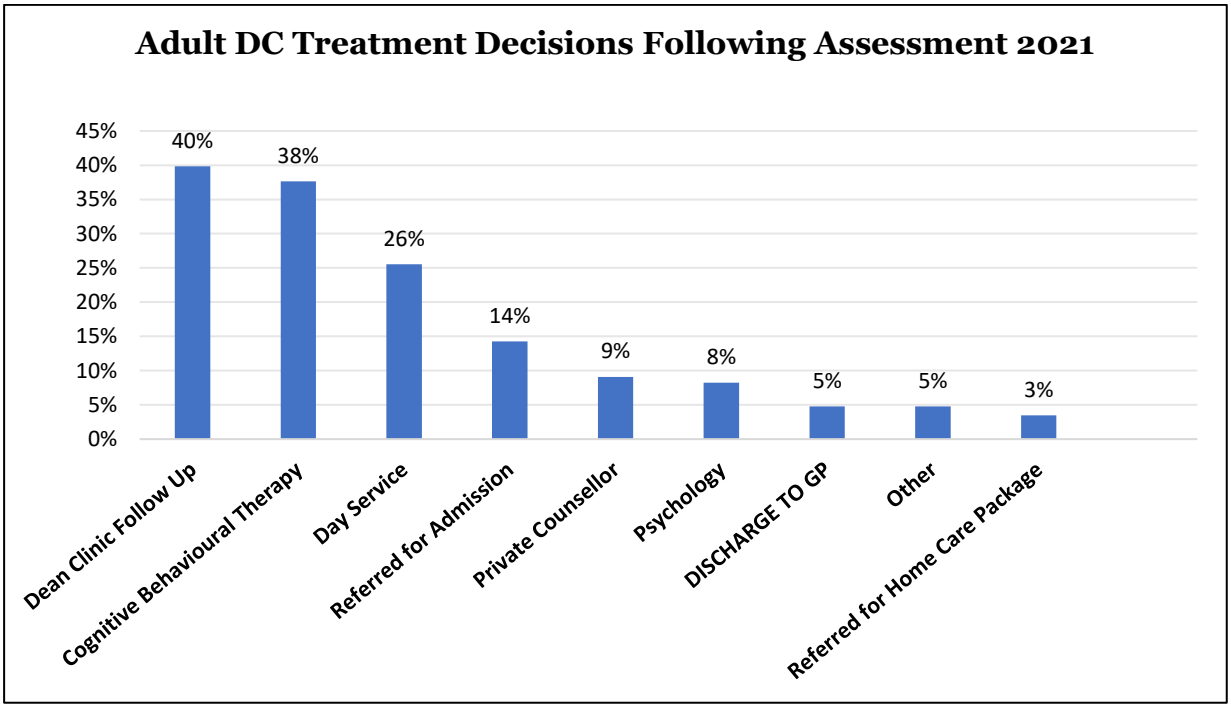
Year	Total No of Adult Dean Clinic Appointments
2019	15,159
2020	15,730
2021	14,057

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 2019 to 2021. There was a decrease of 22% in first time admissions from the Dean Clinics, compared with 2020, due to a decrease in assessment capacity.

Year	First Admission
2019	174
2020	195
2021	152

2.2.6. Dean Clinic: Outcome of Assessments

The chart below summarises and compares the treatment decisions recorded in individual care plans following initial assessment in Dean Clinics 2021.



Adolescent Dean Clinic

2.2.7.

The Adolescent Dean Clinics are based in Dublin and Cork. In 2021, there were a total of 1,105 referrals received for the Adolescent Service – an increase of 55.6% from 2020. 263 Adolescent Prompt Assessment of Needs (PAON's) were conducted in 2021. This represents an increase of 17.4% in comparison with 2020's 224 PAON's.

404 of the Adolescent Service referrals were referred to the Adolescent Dean Clinics in 2021 representing an increase of 32.5% in comparison to the number of referrals in 2020.

2.2.8. Dean Clinics Referral Source by Province

The following table illustrates the geographical spread of Adolescent Dean Clinic referrals by province from 2019. The highest referral volume is from Leinster.

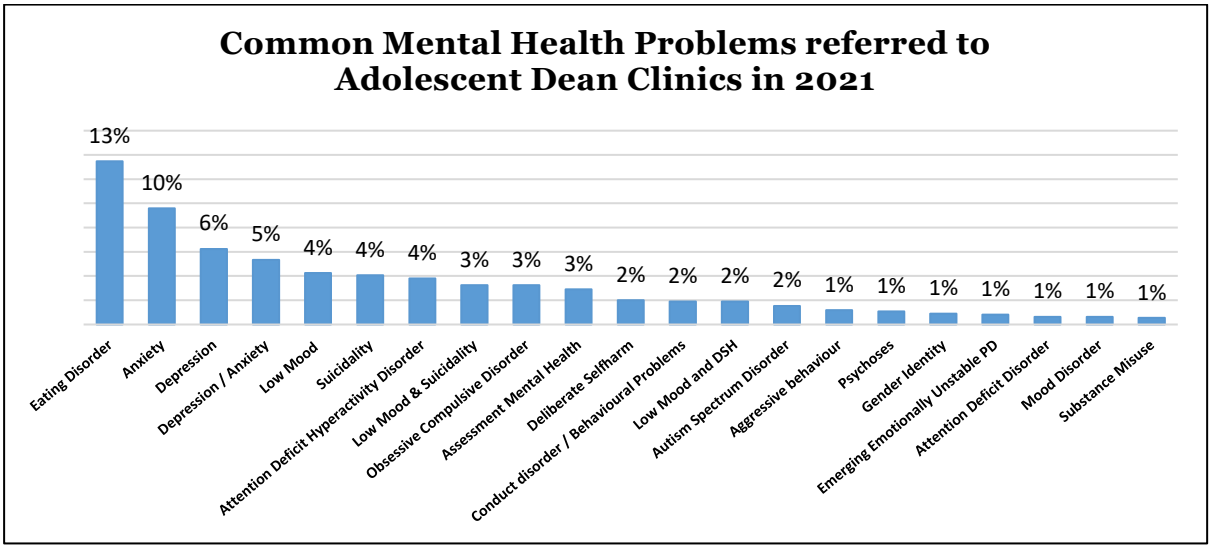
Year	Leinster	Munster	Connaught	Ulster	Other
2019	425	199	17	10	0
2020	509	162	25	14	0
2021	746	294	45	20	0

2.2.9. Dean Clinic Referrals by Gender

The Gender ratio of Dean Clinic Adolescent referrals for 2021 was 70% female to 30% male.

2.2.10. Common Mental Health Problems referred to Adolescent Dean Clinics

The chart below documents a sample of the common mental health problems referred to the Adolescent Dean Clinics throughout 2021. Depression and/or anxiety disorders and eating disorders 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 detail the number of referrals sent to the Adolescent Dean Clinics and mental health assessments provided across the Adolescent Dean Clinics in 2021. Not all referrals result in an assessment due to some service users' already being under the care of another service; non-attendance of assessment appointments; decline of the assessment offered and/or may be referred for an admission assessment. In addition, service users may have been referred to several services and opted to attend 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 Adolescent Dean Clinics	No. of Assessments in the Dean Clinics
2019	651	306	144
2020	710	305	113
2021	1,105	440	123

There was a 9% increase in the Adolescent Dean Clinic assessments in 2021. The mental health assessment involves a comprehensive evaluation of the young person's 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 service programme, admission to inpatient care and treatment or referral back to the GP with recommendations for treatment. The assessment process is collaborative and focused on assisting the young person to make a full recovery through the most appropriate treatment and care. The adolescent team provide family psycho-education to assist families in supporting the adolescents' recovery.

The 2021 total number of Adolescent Dean Clinic appointments provided by the Adolescent Dean Clinics nationwide is summarised in the table below, showing a marginal decrease of 3.1%. This decrease could be attributed to the unexpected and unplanned reduction of clinical resources due to the COVID-19 pandemic.

Appointments include Consultant reviews, Clinical Nurse Manager reviews, Nurse Practitioner appointments, cognitive behavioural therapy, occupational therapy, social work, psychology, and dietetic services.

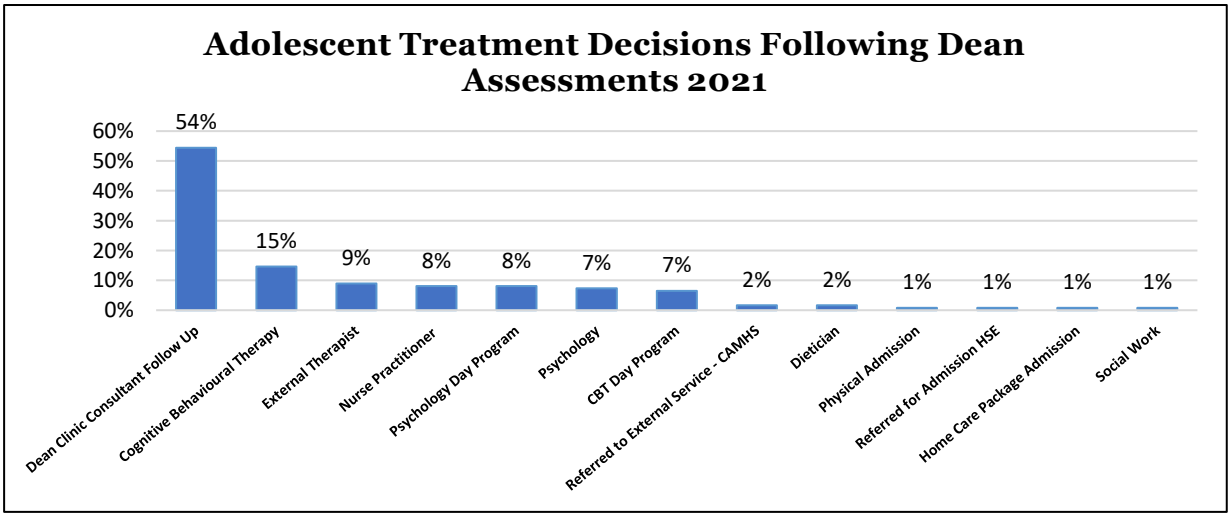
Year	Total No. of Dean Clinic Adolescent Appointments
2019	2,352
2020	2,156
2021	2,089

The total number of admissions to Willow Grove Adolescent Unit in 2021 was 111; with the total number of first-time admissions on par with 2020 at 88. The table below summarises the number of first-time inpatient admissions to Willow Grove Adolescent Unit from 2019.

Year	First Admission
2019	71
2020	88
2021	88

2.2.12. Dean Clinic: Outcome of Assessments

The chart below summarises the treatment decisions recorded from individual care plans following initial assessment in Adolescent Dean Clinics in 2021.



2.3. SPMHS's Inpatient Care and Homecare Service

During 2021, SPMHS continued its Homecare service first introduced in March 2020 in response to the national public health restrictions resulting from the COVID-19 pandemic. This service offering all the elements of our inpatient services, involves the highest levels of one-to-one mental health support, but is delivered remotely through daily or more frequent contact over videocall and other technological channels. Some service users only accessed either inpatient or Homecare services, but a significant percentage of service users transitioned between both. 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 moved between both care options.

SPMHS comprises of 3 separate approved centres including St Patrick's University Hospital (SPUH) with 241 inpatients beds, St Patrick's Lucan (SPL) with 52 inpatient beds and Willow Grove Adolescent Unit (WGAU) with 14 inpatient beds plus an additional 2 virtual beds (i.e. the Willow Grove unit can provide Homecare or inpatient care for 16 young people, but has a maximum physical inpatient bed capacity of 14).

In 2021, there were a total of 3,813 inpatient admissions across the organisation's 3 approved centres compared to 3,182 for 2020, indicating an increase in admissions to Homecare.

2.3.1. SPMHS Inpatient Admission Rates

The following analyses summarises inpatient admission information including gender ratios, age and length of stay distributions (LOS) across the 3 SPMHS approved centres; SPUH, SPL and WGAU for 2021.

The table below shows inpatient admission numbers and the percentage rates for male and female admissions. In 2021, 61.1% of admissions across all 3 approved centres were female, compared to 64.2% in 2020 and 60.9% in 2019.

No. of Admissions (% of Admissions) 2021				
	SPL	**SPUH**	**WGAU**	**Total**
Female	501 (62.7%)	1,703 (59.5%)	125 (82.2%)	2,329 (61.1%)
Male	298 (37.3%)	1,159 (40.5%)	27 (17.8%)	1,484 (38.9%)
Total	**799 (100%)**	**2,862 (100%)**	**152 (100%)**	**3,813 (100%)**

The table below shows the numbers and percentages of admission care/treatment days delivered in 2021, providing a synopsis of the inpatient care days and the Homecare days.

No. (%) of Inpatient Admission Days & Homecare Admissions Days 2021			
	Total Adult	**WGAU**	**Total**
Homecare Admission Days	26,752 (26.5%)	2,435 (44.3%)	29,187 (27.4%)
Inpatient Admission Days	74,160 (73.5%)	3,058 (55.7%)	77,218 (72.6%)
Total Admission Days	**100,912**	**5,493**	**106,405**

The table below shows the average age of service users admitted across the 3 approved centres was 46.39 and was 47.33 years in 2020. The average age of adolescents admitted to WGAU was 15.56 years in 2021 and was 15.38 years in 2020. The average age of adults admitted to SEH was 48.57 years in 2021 and was 51.72 years in 2020. Finally, the average age of adults admitted to SPUH was 48.06 years in 2021 and was 48.45 years in 2020.

Average Age at Admission 2021					
	SPL	**SPUH**	**Total Adult**	**WGAU**	**Total**
Female	48.41	48.19	48.22	15.48	45.82
Male	48.91	47.89	47.99	15.94	47.23
Total	48.57	48.06	48.13	15.56	46.39

2.3.2. SPMHS Inpatient Length of Stay 2021

The following tables present the 2021 average length of stay (LOS) for adult inpatients (18 years of age and over) and adolescent inpatients (under 18 years of age) across all approved centres. The analysis and presentation of inpatient length

of stay was informed by the methodology used by the Health Research Board which records the number and percentage of discharges within temporal categories from under 1 week up to 5 years.

SPMHS Length of Stay (LOS) for Adults

2021 Adults	Number of Discharges	Percentage
Under 1 week	838	23.1%
1 -<2 weeks	522	14.4%
2-<4 weeks	763	21.0%
4-<5 weeks	329	9.1%
5-<6 weeks	322	8.9%
6-<7 weeks	229	6.3%
7-<8 weeks	167	4.6%
8-<9 weeks	122	3.4%
9-<10 weeks	83	2.3%
10-<11 weeks	63	1.7%
11 weeks -< 3 months	94	2.6%
3-<6 months	100	2.8%
6 + months	3	0.1%
Total Number of Adult Discharges 2021	3,635	100.00%

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

2021 WG	Number of Discharges	Percentage
Under 1 week	10	6.6%
1 -<2 weeks	15	9.9%
2-<4 weeks	39	25.8%
4-<5 weeks	14	9.3%
5-<6 weeks	13	8.6%
6-<7 weeks	13	8.6%
7-<8 weeks	17	11.3%
8-<9 weeks	8	5.3%
9-<10 weeks	7	4.6%
10-<11 weeks	4	2.6%
11 weeks -< 3 months	8	5.3%
3-<6 months	3	2.0%
Total Number of Adolescent Discharges 2021	151	100%

2.3.3. SPMHS Analysis of Inpatient Primary ICD Diagnoses (for all inpatients discharged in 2021)

The table below outlines the prevalence of diagnoses across SPMHS three approved centres during 2021 using the International Classification of Diseases 10th Revision (ICD 10, WHO 2010). The Primary ICD Code Diagnoses recorded on admission and at the point of discharge are presented for all three of SPMHS approved centres and the total adult columns represent St Patrick's University Hospital (SPUH) and St Patrick's Lucan combined. The data presented is based on all inpatients discharged from SPMHS in 2021.

SPMHS Analysis of Inpatient Primary ICD Diagnoses

(For all inpatients discharged in 2021)

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

The categories listed in this table are those defined in the International Classification of Diseases 10th Revision (ICD 10, WHO 2010).

ICD Codes: Admission & Discharge **For All Service Users Discharged in 2021**	SPUH Admissions		SPUH Discharges		SPL Admissions		SPL Discharges		Total Adult Admissions		Total Adults Discharges		Willow Grove Admissions		Willow Grove Discharges	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
F00-F09 Organic, including symptomatic, mental disorders	38	1.3	37	1.3	8	1.0	6	0.7	46	1.3	43	1.2	0	0.0	0	0.0
F10-F19 Mental and behavioural disorders due to psychoactive substance use	386	13.5	419	14.6	40	5.0	39	4.9	426	11.6	458	12.5	0	0.0	1	0.7
F20-F29 Schizophrenia, schizotypal and delusional disorders	174	6.1	178	6.2	31	3.9	31	3.9	205	5.6	209	5.7	0	0.0	0	0.0
F30-F39 Mood [affective] disorders	1305	45.6	1207	42.1	363	45.3	349	43.6	1668	45.5	1556	42.5	51	33.6	35	23.0
F40-F48 Neurotic, stress-related and somatoform disorders	585	20.4	576	20.1	265	33.1	259	32.3	850	23.2	835	22.8	39	25.7	43	28.3
F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors	87	3.0	90	3.1	12	1.5	15	1.9	99	2.7	105	2.9	31	20.4	29	19.1
F60-F69 Disorders of adult personality and behaviour	271	9.5	340	11.9	77	9.6	96	12.0	348	9.5	436	11.9	5	3.3	11	7.2
F70-F79 Mental retardation	0	0.0	1	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0	0	0.0
F80-F89 Disorders of psychological development	5	0.2	9	0.3	1	0.1	2	0.2	6	0.2	11	0.3	1	0.7	2	1.3
F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	4	0.1	4	0.1	0	0.0	2	0.2	4	0.1	6	0.2	22	14.5	30	19.7
F99-F99 Unspecified	9	0.3	3	0.1	4	0.5	2	0.2	13	0.4	5	0.1	3	2.0	1	0.7
Totals	2864	100	2864	100	801	100	801	100	3665	100	3665	100	152	100	152	100

2.5. SPMHS Day Progamme – Wellness & Recovery Centre

As well as providing a number of recovery-oriented programmes, the Wellness & Recovery service 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 almost all* day programmes are delivered entirely via TMI. Clinical programmes are delivered by specialist multidisciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports, and include the following:

1. Access to Recovery
2. Acceptance Commitment Therapy (ACT)
3. Addictions Programmes
4. Anxiety Programme
5. Bipolar Programme
6. Building Strength and Resilience (BSR)
7. Building Healthy Self Esteem (BHSE)
8. CBT for Adolescents
9. Compassion Focused Therapy
10. CFT Eating Disorders
11. Coping with Covid
12. Depression Programme
13. Eating Disorders Programme
14. Family Therapy for Anorexia
15. Formulation Groups
16. Living Through Distress (DBT)
17. Living Through Psychosis
18. Mindfulness
19. Pathways to Wellness*
20. Psychology Skills for Adolescents
21. SAGE
22. Radical Openness
23. Recovery Programme
24. Schema Therapy
25. Transition to Recovery
26. Trauma Group Therapy

*Pathways to Wellness returned to in-person programme delivery in September 2021

2.5.1. Day Programme Referrals by Clinical Programme

The following table compares the total number of day programme referrals to each clinical programme for 2020 and 2021. Referrals come from a number of sources, including SPMHS multidisciplinary teams, Dean Clinics, GPs, and external mental health services. In 2021, the WRC received a total of 2,787 referrals compared to a total of 1,618 for 2020, a year on year increase of 72%. The increase is reflective of

increased demand on all SPMHS services throughout 2021 and more confidence in the remote delivery of day programmes.

Of the day programme referrals for 2021; 604 (22%) were received from Dean Clinics. This compares to a total of 260 (16%) day programme referrals received from Dean Clinics in 2020.

SPMHS Day Programmes	Total Day Programme Referrals 2020	Total Day Programme Referrals 2021
Access to Recovery	166	299
Acceptance Commitment Therapy	245	271
Addictions Programmes	289	222
Anxiety Programme	115	340
Bipolar Programme	68	112
Building Strength and Resilience (New)	0	40
Building Healthy Self Esteem	11	91
CBT for Adolescents (New)	0	29
Compassion Focused Therapy	29	151
CFT Eating Disorders	18	33
Coping with Covid	32	57
Depression Programme	167	146
Eating Disorders Programme	79	96
Family Therapy for Anorexia (New)	0	6
Formulation Group Therapy	58	101
Living Through Distress (DBT)	53	266
Living Through Psychosis	17	36
Mindfulness (MBSR)	69	69
Pathways to Wellness	31	57
Psychology Skills for Adolescents	0	18
SAGE	15	31
Radical Openness	14	85
Recovery Programme	109	195
Schema Therapy	7	9
Transitions to Recovery	9	1
Trauma Group Therapy	17	26
Total	**1,618**	**2,787**

2.5.2. Day Programme Referrals by Gender

Of all referrals to day services in 2021, 1,878 (67.38%) were female, 906 (32.5%) were male and 3 (0.12%) were unspecified. This is reflective of previous years.

2.5.3. Day Programme Attendances for Clinical Programmes 2019-2020

In 2020, of the 1,618 referrals to a day programme, 1,533 day service users commenced day programmes. This compares to 2,787 referrals and 1,780 commencing a programme, in 2021. These registrations represented a total of 15,930 (2020) and 18,260 (2021) half day attendances respectively. Therefore, in 2021 each registered day service user attended on average 10.25 half days and in 2020 each registered day service user attended on average 10.39 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. Occasionally, a service user may be referred to multiple programmes and it is not recommended that a service user attend more than one programme at a time. Service users occasionally withdraw from programmes after commencement due to; relapse of acute mental health difficulties, inpatient admission, personal circumstances or not feeling the programme meets their needs or expectations.

SPMHS Day Programmes	Total Day Service Registrations 2020	Total Day Service Registrations 2021	Total Day Service Attendances 2020	Total Day Service Attendances 2021
Access to Recovery	149	152	1,710	1,451
ACT	220	221	1,675	1,894
Addictions Programmes	298	166	1,485	1,779
Anxiety Programme	105	176	1,229	1,298
Bipolar Programme	58	77	322	421
Building Strength & Resilience	New 2021	25	0	44
BHSE	0	65	17	165
CBT for Adolescents	16	23	71	166
Compassion Focused Therapy	53	72	616	1,060
CFT Eating Disorders	32	22	302	304
Coping with COVID	13	34	40	73
Depression Programme	147	84	1,148	1,200
Driving Assessments	0	0	0	0
Eating Disorders Programme	59	71	1,387	922
Family Therapy for Anorexia	New 2021	5		60
Formulation Group Therapy	36	60	226	392
LTD (DBT)	59	163	973	1,757
Living Through Psychosis	13	17	112	141
Mindfulness (MBSR)	50	52	252	318
Pathways to Wellness	85	23	986	975
Psychology Skills for Adolescents	11	7	190	273
SAGE	10	19	128	178
Radical Openness	37	38	851	1,036
Recovery Programme	83	195	1,428	1,772
Schema Therapy	16	0	93	246
Transition to Recovery	10	0	68	0
Trauma Group Therapy	18	13	364	300
	1,533	**1,780**	**15,930**	**18,260**

SECTION THREE

CLINICAL GOVERNANCE

3. Clinical Governance and Quality Management

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

3.1. Clinical Governance Measures Summary

Governance Measure	2019	2020	2021
Clinical Audits			
Number of Complaints Total including all complaints, comments and suggestions received and processed throughout the entire year.	**739**	**638**	**434**
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.	**2,186**	**2,349**	**2,029**
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.	**16**	**8**	**5**
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.	**63**	**80**	**72**
% 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.	**57% (36)**	**48% (39)**	**51% (37)**
Number of Section 14's – Involuntary Admissions An involuntary admission that occurs as a result of an application from a spouse or relative, a member of An Garda Síochána, an Authorised Officer or a member of the public and a recommendation from a GP (the person is admitted as involuntary). A person subject to such an admission may decide to remain voluntarily.	**32**	**35**	**28**
% 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.	**75% (24)**	**88% (31)**	**85% (24)**
Number of Section 20/21 - Transfers Where an involuntary patient is transferred to an approved centre under *Section 20 or 21* of the Mental Health Act 2001, the clinical director of the centre from which he or she has been transferred shall, as soon as possible, give notice in writing of the transfer to the MHC on Statutory Form 10.	**41**	**48**	**39**
Assisted Admissions The number of instances where assisted admissions services were required to assist in the transportation of a service user	**40**	**37**	**30**
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.	**9**	**22**	**11**
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.	**3**	**2**	**0**
Number of Tribunals held	**71**	**93**	**64**
Number of ECT Programme's completed within the year	**156**	**161**	**158**
Number of Physical Restraint Episodes (SPUH + SEH + WGAU)	**127**	**162**	**42**

3.2. Clinical audits

This section summarises the clinical audit activity for St Patrick's Mental Health Services in 2021. 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 projects by type undertaken in 2021, including those facilitated by clinical staff at local level, and those carried out throughout the organisation led by various committees.

No.	Audit title	Audit lead	Status at year end
1.	**The Clinical Global Impression (CGI) and Children's Global Assessment Scale (CGAS) level of change pre and post-inpatient treatment** To measure the CGI/CGAS outcomes for service users pre and post-admission.	Clinical Governance Committee	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 Practice on Admissions, Transfers and Discharges to and from an Approved Centre, section 15.3.	Clinical Governance Committee	Re-audit completed
5.	**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

No.	Audit Title	Audit Lead	Status at year end
6.	**Medication safety for women of childbearing potential through the use of consented pregnancy screening on admission** 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-audit completed
7.	**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
8.	**Use of clozapine (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
9.	**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 2021
10.	**Adherence to the organisations protocol on falls risk prevention interventions** 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.	Falls Committee	Bimonthly audits completed
11.	**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

* 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
12.	**Monitoring of service users prescribed lithium therapy** To ensure that the lithium therapy is efficacious and monitored effectively, To increase the safety of service users prescribed lithium, To ensure that a service user is effectively educated about the lithium therapy including the side effects and benefits.	Clinical Governance Committee	Re-audit completed
13.	**Patient expectation forms** To assess the impact of the changes made to the patient expectation form, To evaluate the completion rates for the old version and the new version of the patient expectation form, To evaluate the completion rates for the specific sections of the form to assess whether simplifying the language used in the form stimulates service users to share their needs and their expectation of the inpatient treatment and care with their multidisciplinary team.	Clinical Governance Committee	Service review completed

3.2.2. Key audit outcomes for 2021

- Routine audits designed to assess the level of key working and effective care planning in the three approved centres were continued in 2021. The audit findings confirmed that good practice was maintained for that period.

- A Clinical Audit Programme for audits and monitoring of compliance with all regulations, rules and the codes of practice for approved centres continued during 2021 and all clinical and non-clinical departments were actively involved.

- The findings from the audit on use of clozapine confirmed that in most key metrics SPMHS is exceeding the comparable benchmark data provided by the POMH-UK re-audit.

- 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 clinical audit data confirmed that service users' physical health is monitored effectively. Sodium Valproate is a widely-used mood stabilising medication and one of several medications that are associated with serious teratogenic effects. Analysis of audit data showed that a small number of female inpatients of child-bearing potential were prescribed this drug. At the same time, the reported findings highlighted a need to strengthen SPMHS practice to ensure the safety of women of child-bearing potential being prescribed Sodium Valproate. This area of practice is being continuously improved and monitored by the Clinical Governance Committees.

- The re-audit on monitoring of service users prescribed lithium therapy showed a further improvement in the levels of performance of pre-treatment physical health checks and provision of information to service users.

SECTION FOUR

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

- **Statistically non-significant findings** suggest that the change from pre and post is not big enough to be anything other than chance but does not necessarily mean that there is no effect. Non-significant findings may result from small sample size, the sensitivity of the measure being used, or the time point of the measurement. As such, non-significant findings are not unimportant; rather they provide useful information and an invitation to investigate further.
- **Practical significance** indicates *how much* change there is. One indicator of practical significance is effect size. **Effect size** is a 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 service user 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 2021

4.2.1. Objective

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

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

4.2.1.1. Background

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

The CGIS asks a clinician the question: "Considering your total clinical experience with this particular population, how mentally ill is the service user 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 service user.

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

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

4.2.1.2. Data collection strategy

This report used data extracted from the electronic health record, eSwift, which provided details on the SPUH and SEH hospital admissions and admissions to WGAU.

A random sample was chosen from admissions to SPUH and SEH. The chosen sample size was 354 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		354	103
Admissions	First admission	45%	89%
	Re-admission	55%	11%
Average age ± standard deviation		48±19	16±1
Gender	Female	60%	83%
	Male	40%	17%

4.2.2.1. ICD-10 admission diagnosis

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

		TOTAL ADULT SERVICE			WGAU		
ICD-10 Admission diagnosis category		**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
F30-F39	Mood disorders	51%	50%	47%	47%	38%	32%
F40-F48	Neurotic, stress-related and somatoform disorders	17%	19%	21%	25%	22%	31%
F10-F19	Mental and behavioural disorders due to psychoactive substance use	13%	10%	10%	0%	0%	0%
F20-F29	Schizophrenia, schizotypal and delusional disorders	7%	7%	9%	1%	0%	0%
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors	2%	3%	3%	19%	27%	18%
F00-F09	Organic, including symptomatic, mental disorders	1%	1%	0%	0%	0%	0%
F60-F69	Disorders of adult personality and behaviour	6%	9%	8%	2%	1%	5%
F80-F89	Disorders of psychological development	0%	1%	0%	1%	0%	1%
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	1%	0%	0%	5%	12%	13%
	Other	1%					

4.2.3. Baseline and final assessment scale scores

Table: Total adult service

CGIS - Baseline measure of severity of illness		2019 TOTAL	2020 TOTAL	2021 TOTAL
1	Normal, not at all ill	0%	0%	1%
2	Borderline mentally ill	2%	1%	2%
3	Mildly ill	8%	12%	12%
4	Moderately ill	37%	39%	40%
5	Markedly ill	31%	28%	27%
6	Severely ill	12%	12%	11%
7	Extremely ill	1%	1%	0%
	Not scored	9%	7%	8%

Table: Total adult service

CGIC – Final global improvement or change score		2019 Total	2020 Total	2021 Total
1	Very much improved	7%	9%	8%
2	Much improved	44%	40%	41%
3	Minimally improved	23%	29%	29%
4	No change	5%	10%	12%
5	Minimally worse	0%	1%	1%
6	Much worse	0%	0%	0%
7	Very much worse	0%	0%	0%
	Not scored	21%	10%	9%

Table: Willow Grove Adolescent Unit

Children's Global Assessment Scale		2019		2020		2021	
		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%	1%	0%	1%	0%	0%
70-61	Some difficulty in a single area, but generally functioning pretty well	0%	49%	1%	41%	1%	19%
60-51	Variable functioning with sporadic difficulties	0%	33%	1%	41%	3%	37%
50-41	Moderate degree of interference in functioning	25%	2%	17%	9%	17%	28%
40-31	Major impairment to functioning in several areas	59%	5%	67%	8%	67%	15%
30-21	Unable to function in almost all areas	12%	2%	9%	0%	9%	0%
20-11	Needs considerable supervision	4%	1%	2%	0%	3%	1%
10-1	Needs constant supervision	0%	0%	0%	0%	0%	0%
	Not scored	1%	6%	1%	0%	1%	0%
Mean ±SD		36±6	58±10	36±7	57±9	37±7	51±10
Median		38	61	35	59	37	52
Wilcoxon Signed Ranks Test:		Z=-7.517, p<.001		Z=-5.973, p<.001		Z=-8.558, 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		
	2019	2020	2021	2019	2020	2021
Baseline assessment scale score						
% of admission notes with recorded baseline scores	91%	93%	92%	99%	99%	99%
% compliance with clinical audit standard No 1	85%	81%	81%	99%	97%	99%
Final assessment scale score						
% of admission notes with recorded final scores	79%	90%	91%	94%	100%	100%
% compliance with clinical audit standard No 2	89%	80%	85%	95%	97%	96%

4.2.5. Summary of findings

- A sample was chosen out of a dataset of SPMHS discharges for 2021.
- A female to male ratio was 1.5:1 for adults and WGAU 4.7:1 for adolescents.
- In the 2021 sample, 1st admissions accounted for 45% of adult service users and 89% of adolescent service users.
- 2021 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 2021, 40% of SPUH and SEH service users were moderately ill. Another 27% were markedly ill. 11% were severely ill.
- Based on a sample of 323 (total cases with discharge CGI score documented) 85% of the sample were rated with an overall improvement (1 - very much improved (9%), 2 -

much improved (45%), and 3 - minimally improved (32%)). This percentage of sample rated with an overall improvement is 2% lower than those observed in the 2020 data set.

- 2021 analysis of the primary ICD-10 codes showed for the adolescent' population the most frequent reasons for admission were mood disorders followed by neurotic, stress related, somatoform disorders.

- There was a further increase in the percentage of service users severely ill on admission in comparison to the previous years. In 2021 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. 3% required considerable supervision.

- Overall improvement rate for Willow Grove Adolescent Unit was 93%.

- The audit shows stability in the levels recording the baseline and final assessment scales scores in adult and adolescent population.

4.3. Alcohol and Chemical Dependency Programme

The Alcohol and Chemical Dependence Programme (ACDP) 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 psychoeducation, 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.

4.3.1. Descriptors

In 2021, 100 participants completed the full programme and returned pre and post data. 51% of participants were male and 49% were female.

4.3.2. 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.

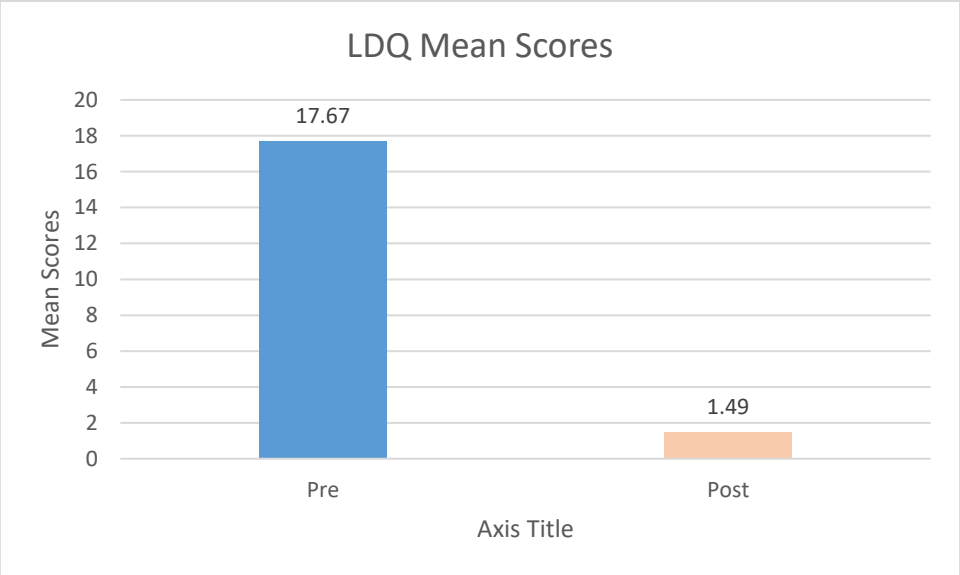
Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = 95) and has been shown to be a valid, psychometrically sound measure of substance dependence for alcohol and opiates (Raistrick et al., 1994). The LDQ has also been suggested as an 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.

4.3.3. Results

Leeds Dependency Questionnaire (LDQ)

Significant reductions in psychological markers of substance and/or alcohol dependency were obtained from pre to post-programme participation. Following completion of the programme, a Wilcoxon Signed Rank Test revealed a statistically significant reduction in psychological markers of substance and/or alcohol dependency based on their LDQ scores following participation in the programme, z = -8.31, $p < 0.05$, with a large effect size (r = -0.83). The mean score on the total LDQ scores decreased from pre-intervention (M = 17.67, SD = 7.67) to post-intervention (M = 1.49, SD = 3.68), as depicted in the graph below.

Graph: Total scores on Leeds Dependency Questionnaire



4.3.4. 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).

4.4. 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 service user 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 relevant 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.

4.4.1. Descriptors

109 individuals with complete data were included in this analysis. These participants attended and completed the full or modified programme in 2021. Of these, 57.1% were male and 40.2% female. The age ranged from 19 to 74, with a mean age of 44.5 (*SD* = 13.66).

4.4.2. 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).

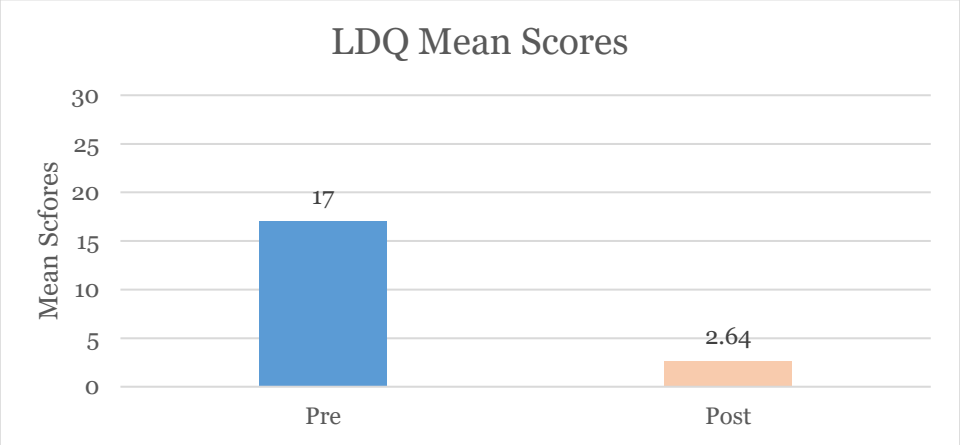
Items are scored on a four-point scale from 0 – never, to three – nearly always, with higher total scores (maximum score of 30) indicating greater dependence. Analysis of the measure has shown it to have high internal consistency (alpha = .94), good test-retest reliability (r = .95) and has been shown 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).

4.4.3. 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, $z = -8.97$, $p < .001$, with a large effect size ($r = -0.86$). 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



4.4.4. 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.

4.5. Acceptance and Commitment Therapy Programme

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

The ACT programme, which was implemented in St Patrick's Mental Health Services in 2010, runs recurrently over a ten-week period for one half-day per week. During the ten-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 has a negative effect. This programme is primarily facilitated by an experienced counselling psychologist who also trains other clinicians in the ACT approach.

4.5.1. Descriptors

In 2021, data was available for a total of 84 participants. Both pre and post measures were available for 40 of those completing the programme, representing 47% of the sample.

4.5.2. 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 7-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 in order 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 service user self-report measure, which assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. Participants are asked to rate impairment in each domain on a nine-point Likert scale from 0 – 'not at all', to eight – 'very severely'. Total scores for the measure can range from 0 to 40, with higher scores indicating greater impairment in functioning. In a study including participants with obsessive compulsive disorder or depression the scale developers report that "A WSAS score above 20 appears to suggest moderately severe or worse psychopathology. Scores between 10 and 20 are associated with significant functional impairment but less severe clinical symptomatology. Scores below 10 appear to be associated with sub-clinical populations (p. 463, Mundt, Marks, Shear & Greist, 2002). The WSAS is used for all service users 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 service user differences in disorder severity and treatment-related change.

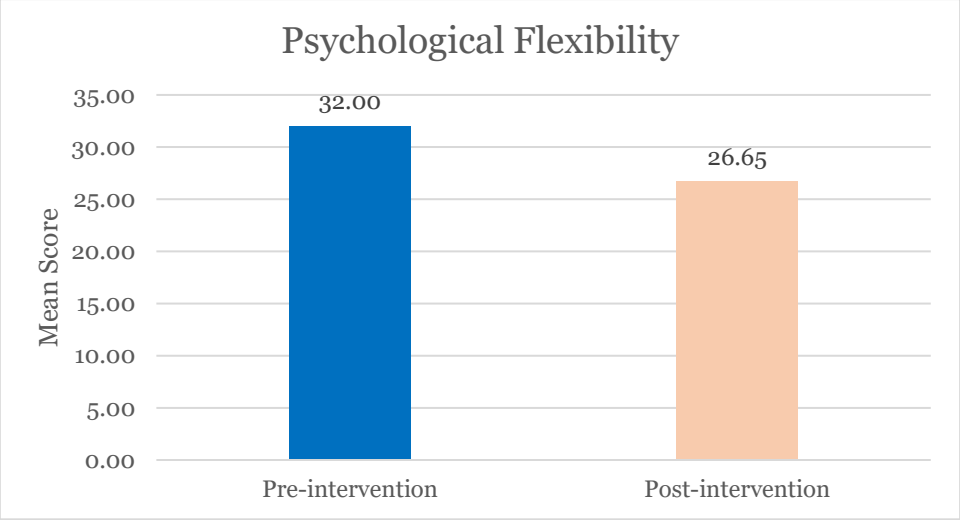
- **The Self-Compassion Scale**

The Self-Compassion Scale (SCS) is a 26- item self-report scale, which is 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.

4.5.3. Results

Acceptance and Action Questionnaire-II

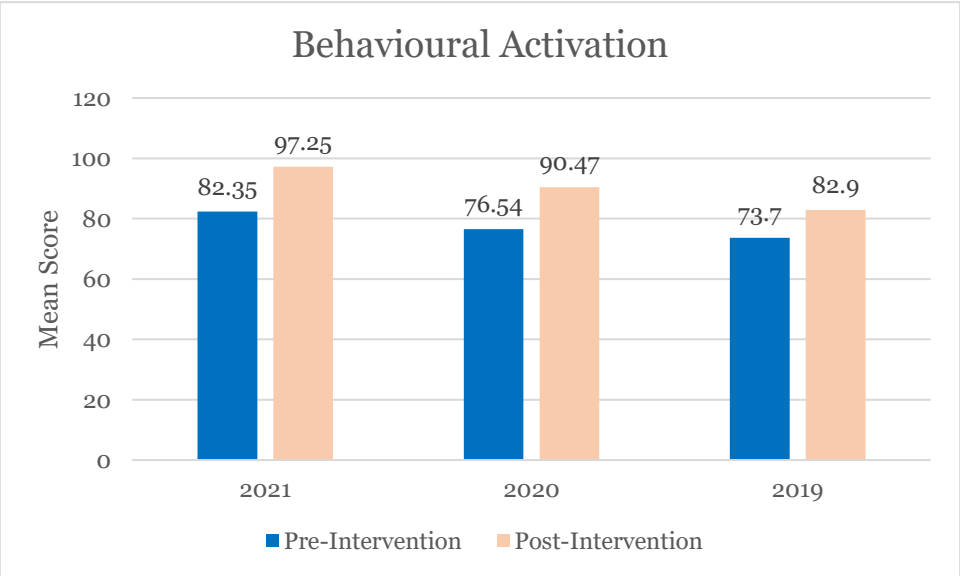
Graph: Psychological flexibility as measured by the AAQ-II



Mean scores on the AAQ-II decreased significantly from (M = 32.00, SD =9.81) to (M = 26.65, SD = 9.76) indicating greater psychological flexibility post-intervention, t (39) = 5.827, p <.001. An effect size (Cohen's d = 0.54), indicates a medium effect size. Pre and post data were captured for the AAQ-II from 40 participants in 2021 overall signifying a decrease in the completion of these measures.

Behavioural Activation for Depression Scale (BADS)

Graph: Behavioural activation as measured by the BADS

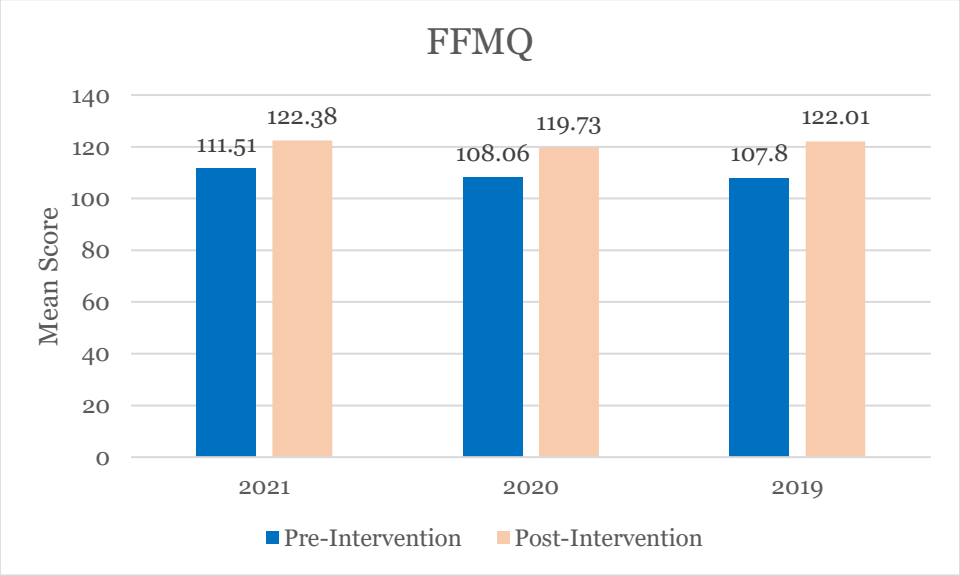


Mean BADS scores increased significantly from (M = 82.35, SD =31.08) to (M = 97.25, SD = 27.08) indicating greater behavioural activation, $t(39) = -4.696$, $p < .001$,

representing a medium effect size (Cohen's d = 0.51). 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 35.89% to 12.82% at the post measurement time point.

Five Facet Mindfulness Questionnaire (FFMQ)

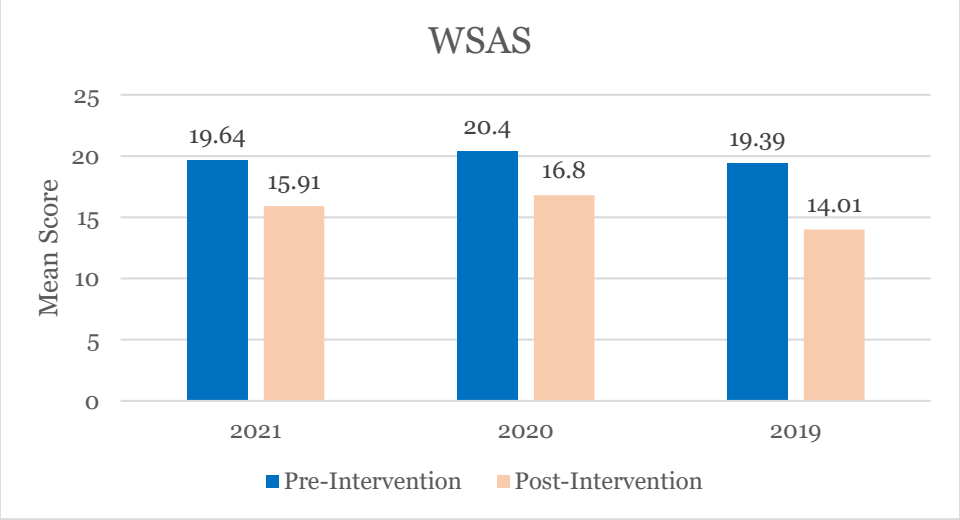
Graph: Total FFMQ Scores



Total FFMQ scores increased significantly, $t(39) = -3.473$, $p < .001$, from pre (M = 111.51, SD = 24.95) to post (M =122.38, SD = 21.22) indicating greater levels of overall mindfulness, with a small effect size observed (Cohen's d = 0.46). 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



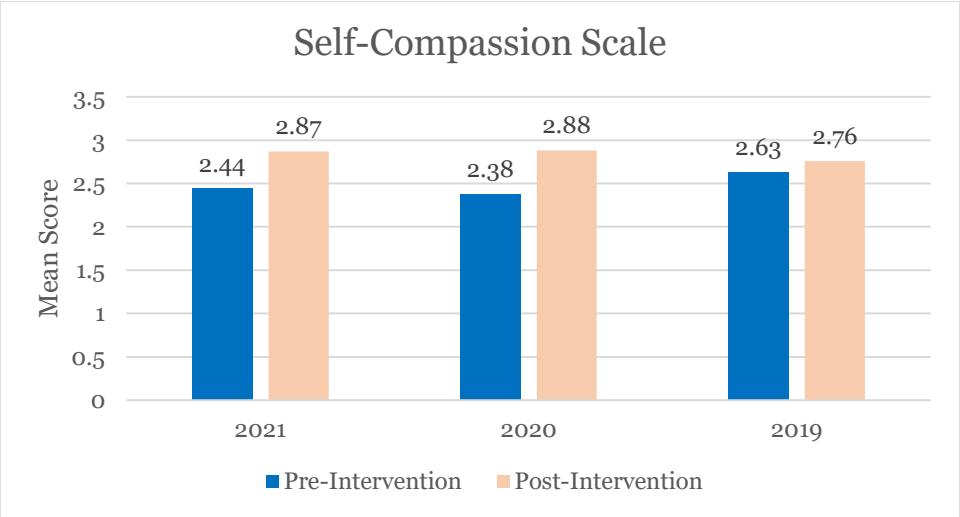
The total WSAS scale score was used to assess functioning pre and post ACT programme. Mean scores dropped significantly, t (36) = 3.191, p < .003, from M=19.64 (SD = 7.82) to M= 15.91 (SD =9.056), indicating less functional impairment. The effect size of Cohen's d =0.44 indicates a small effect.

The percentage of people falling below a sub-clinical threshold, as indicated on the WSAS, increased from 13.5% to 29.7% post group.

These findings are in line with the 2020 and 2019 outcomes reports that indicated significantly greater behavioural activation, greater levels of mindfulness and less functional impairment.

Self-Compassion Scale

Graph: Total scores on Self-Compassion Scale



Total SCS scores increased significantly, t (38) = -4.777, p < .001, from pre (M = 2.44, SD = 0.72) to post (M = 2.87, SD = 0.68) indicating higher overall levels of self-compassion post-intervention. A medium effect size was observed (Cohen's d =0.61). Self-compassion is measured in six domains: self-kindness, self-judgement, humanity, isolation, mindfulness and identification or 'over-identification'.

4.5.4. 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 2021, 2020 and 2019. A recording and analysis of the five distinct subscales of the FFMQ has provided clinically useful data about how participants are learning and utilising different aspects of mindfulness.

4.6. Anxiety Disorders Programme

The Anxiety Disorders Programme provides a clinical intervention programme for service users with primary anxiety disorders. The Anxiety Programme provides both group and individual intervention and support based on the cognitive behavioural

therapy (CBT) model. CBT has been found to be efficacious for adult anxiety disorders (Butler, Chapman, Forman & Beck, 2006; Hofmann & Smits, 2008; Olantunji, Cisler & Deacon, 2010). All programme facilitators have received training in both CBT and mindfulness.

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

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

A separate obsessive-compulsive disorder (OCD) strand of the Anxiety Programme provides a tailored and focused service for individuals experiencing OCD. This incorporates tasks such as challenging the meanings of obsessions and more tailored goal work.

4.6.1. Descriptors

Data was available for 160 people who completed the programme in 2021, of which 91 (56.9%) were female and 69 were male (43.1%). Programme attendees ranged in age from 18 to 80, with a mean age of 36.58 years (*SD* = 15.71). Post data were collected after Level 1 and Level 2 of the anxiety programme. 142 service users availed of level 1 and 18 attended the level 2 anxiety programme

Data regarding diagnosis were returned for 132 individuals. OCD accounted for the largest subgroup (46.3%), followed by GAD (24.4%), social phobia/anxiety (8.9%), agoraphobia (with/without panic) (4.9%) and 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.

	2019		2020		2021	
	n	**%**	**n**	**%**	**n**	**%**
OCD	54	46.2	57	46.3	61	38.1
GAD	26	22.2	30	24.4	33	20.6
Social Phobia/Anxiety	2	1.7	11	8.9	19	11.9
Panic Disorder	7	6.0	9	7.3	5	3.1
Agorophobia	9	7.7	6	4.9	9	5.6
Health Anxiety	4	3.4	7	5.7	2	1.3
Specific Phobia	2	1.7	1	0.8	3	1.9

4.6.2. Anxiety Programme outcome measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2021. 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).

- **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 e.g. (five items assess obsessions and five items assess compulsions) which enables the clinician to discern between the severity of obsessions and compulsions as well as have a global score of severity and response by adding the two separate scores.

Obsessions and compulsions are each assessed on a 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**

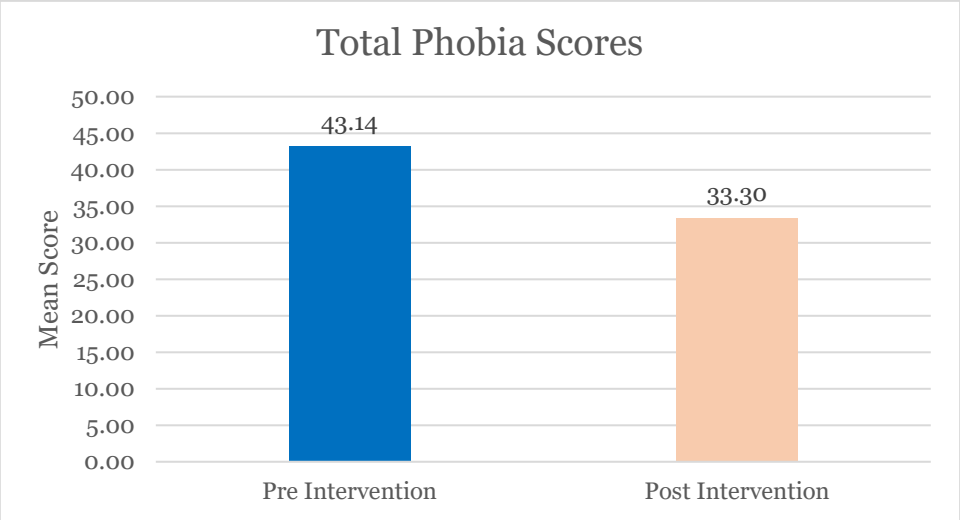
The Agoraphobia scale (Bandelow, 1995) consists of 20 items depicting various typical agoraphobic situations, which are rated for anxiety/discomfort (0-4) and avoidance (0-2). The Agoraphobia Scale has high internal consistency. Regarding concurrent validity it correlated significantly with other self-reported measures of agoraphobia (Mobility Inventory and Fear Questionnaire). This instrument was also administered at two time points, pre and post-Level 1.

4.6.3. Results

Level 1 Results

The Fear Questionnaire

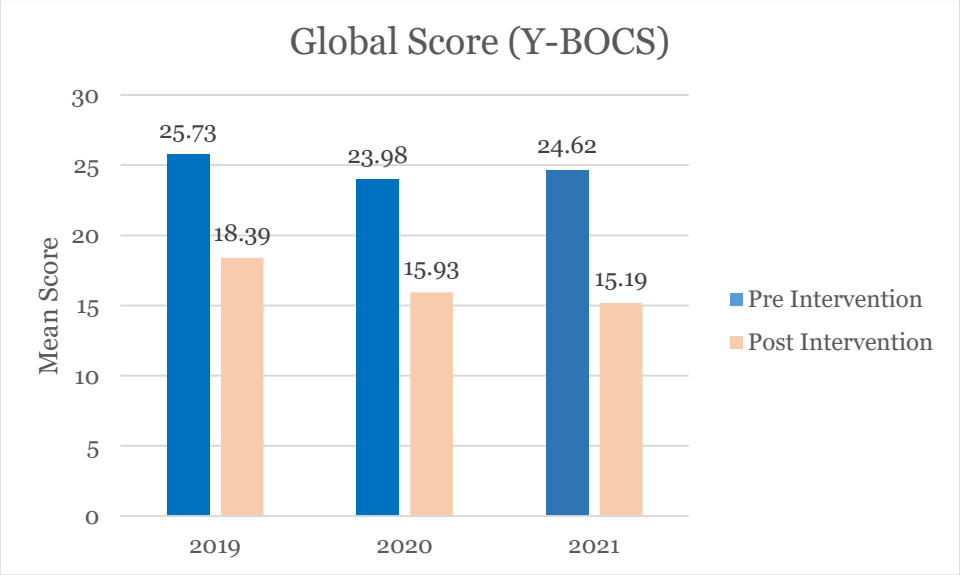
Graph: Fear Questionnaire Mean Total Phobia Scores Pre and Post intervention for 2021



Analysis using a paired sample t-test revealed a statistically significant change between pre and post-intervention at level 1 on the Total Phobia scores within the Fear Questionnaire, $t(102) = 8.028$, $p < .001$. The mean Total Phobia score decreased from 43.14 (SD = 19.28) to 33.30 (SD = 16.99), representing a medium effect size (Cohen's d= .54).

The Yale Brown Obsessive Compulsive Scale

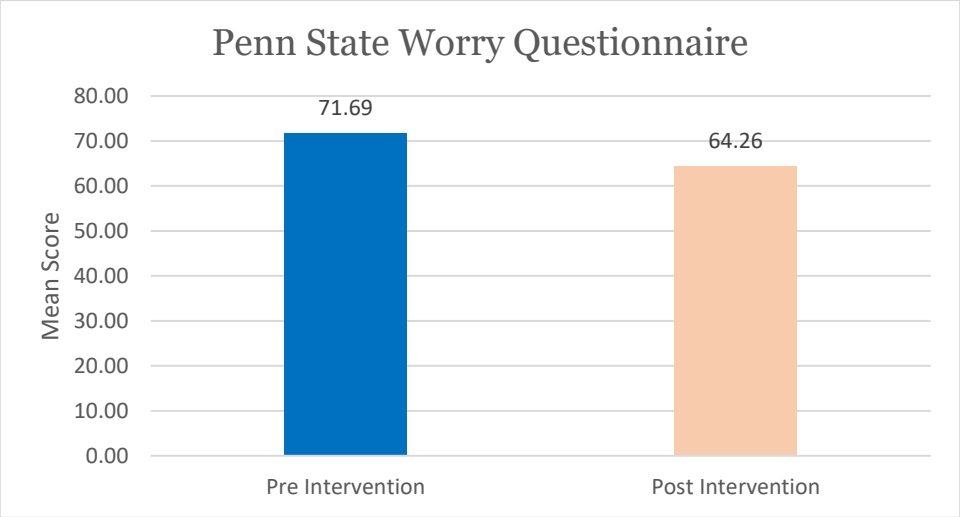
Graph: Yale Brown Obsessive Compulsive Scale Mean Total Scores pre and post intervention for 2019, 2020 and 2021



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 (50) = 11.07, p <.001, with the total mean score changing from 24.62 (SD = 6.23) to 15.19 (SD = 6.93). This indicates an overall significant reduction in the severity of OCD symptoms post intervention with a large effect size (Cohen's d = 1.43.

Penn State Worry Questionnaire (PSWQ)

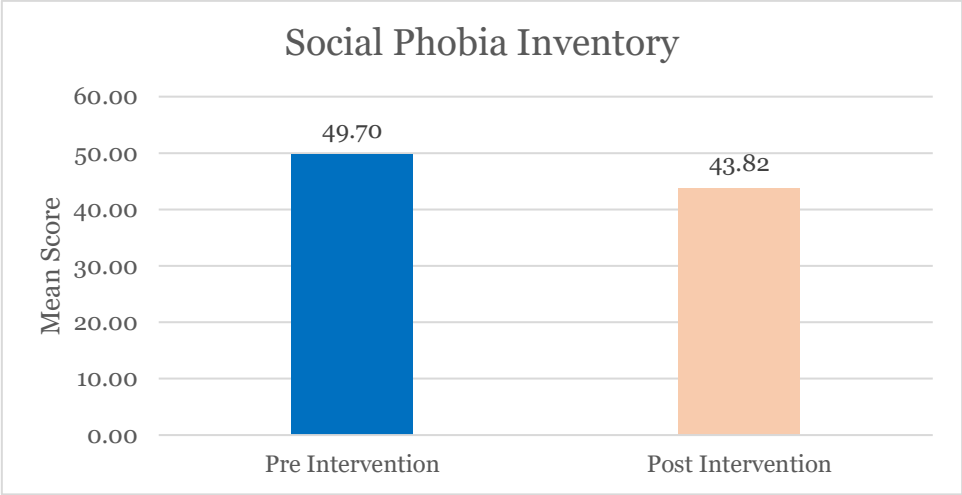
Graph: Penn State Worry Questionnaire Mean Scores Pre and Post Intervention for 2021



Analysis of service user scores on the Penn State Worry Questionnaire, using a paired sample t-test, indicated a statistically significantly change in scores, t(22) = 7.647, p < .001, between pre-intervention (M= 72.69, SD= 4.76) and post-intervention (M=64.26, SD = 9.84). This change reflected a large effect size (Cohen's d= 0.96)

Social Phobia Inventory (SPIN)

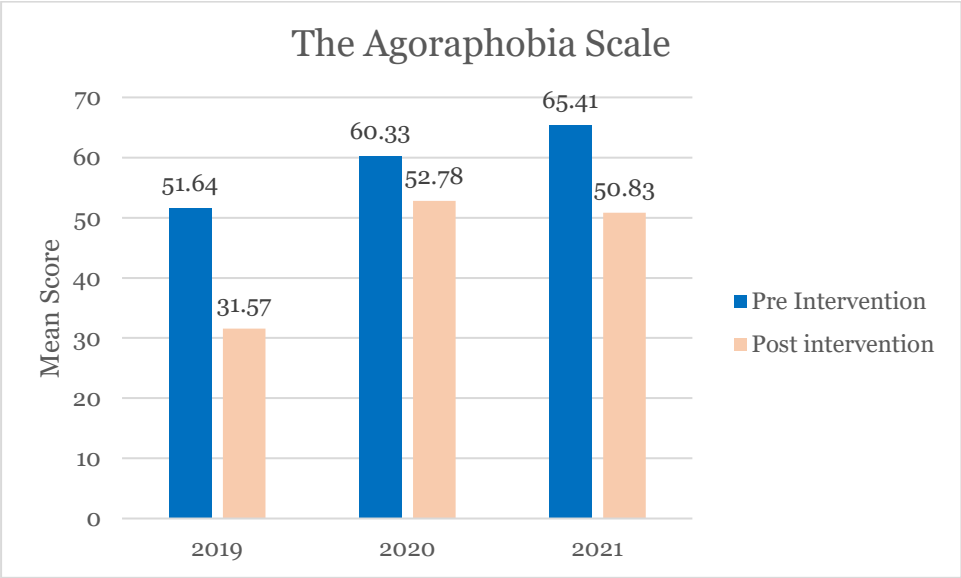
Graph: Social Phobia Inventory mean scores pre and post intervention in 2021



Analysis of the SPIN using a paired sample t-test indicated a statistically significant reduction in service users scores, $t(16) = 9.61$, $p < .001$, from pre-intervention (M= 49.70, SD = 8.29) to post-intervention (M= 43.82, SD = 10.15). This reflected a small effect size (Cohen's d= 0.43).

The Agoraphobia Scale

Graph: The Agoraphobia Scale mean Scores Pre and Post Intervention for 2019, 2020 and 2021

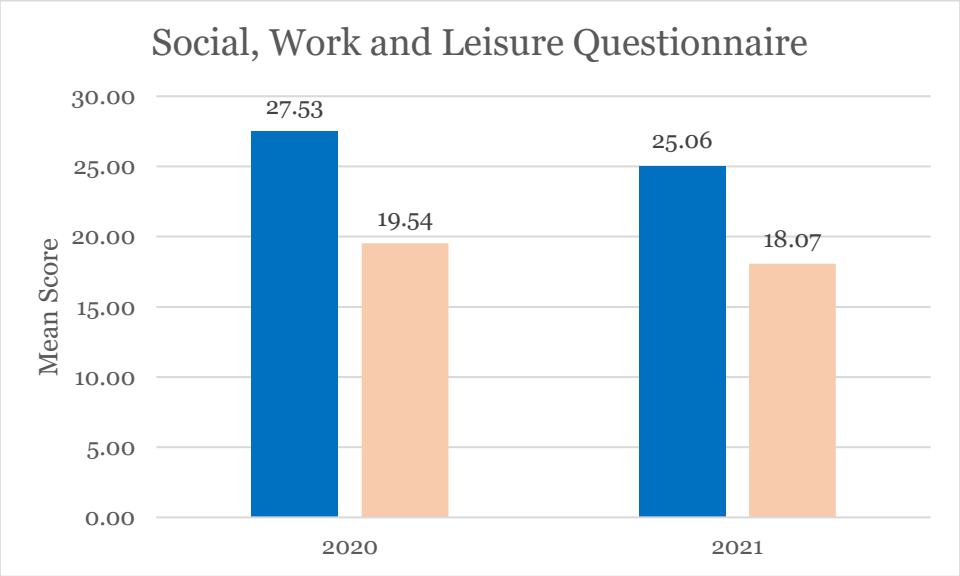


Scores on the Agoraphobia Scale reduced from pre-intervention (M= 65.41, SD = 34.23) to post-intervention (M= 50.83, SD = 26.35). However, analysis of the

Agoraphobia Scale using a t-test indicated that this result did represent a statistically significant reduction in mean total scores (t (11) = 4.039, p < .05). A small effect size was observed (Cohen's d= 0.47).

The Social Work and Leisure Questionnaire

Graph: Social Work and Leisure Questionnaire Group Mean Score Pre and Post Intervention for 2020 and 2021

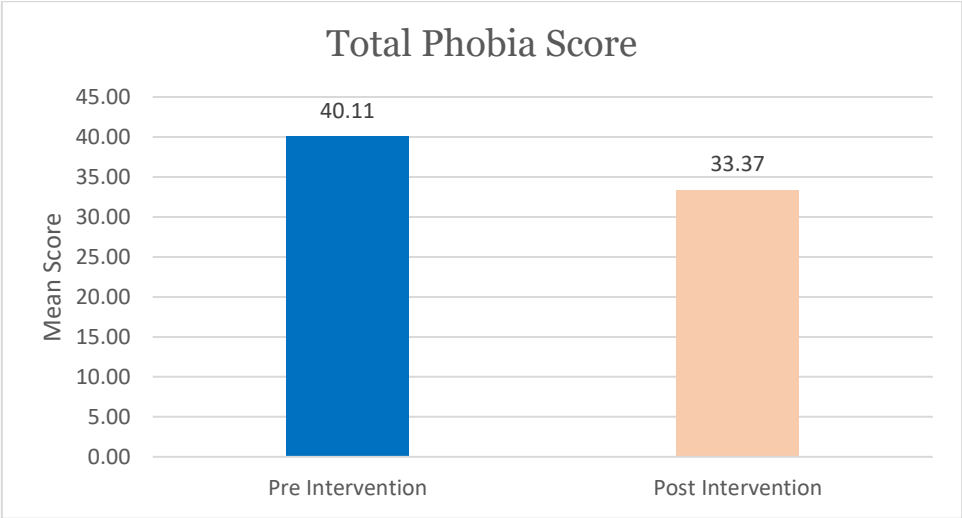


Analysis of the SWLQ using a t-test indicated that there was a statistically significant reduction in mean scores observed, t (106) = 8.041, p < .001, from pre-intervention (M = 25.06, SD = 10.09) to post-intervention (M = 18.07, SD = 10.36) at level 1. This result reflected a medium effect size (Cohen's d = 0.67).

Level 2 results

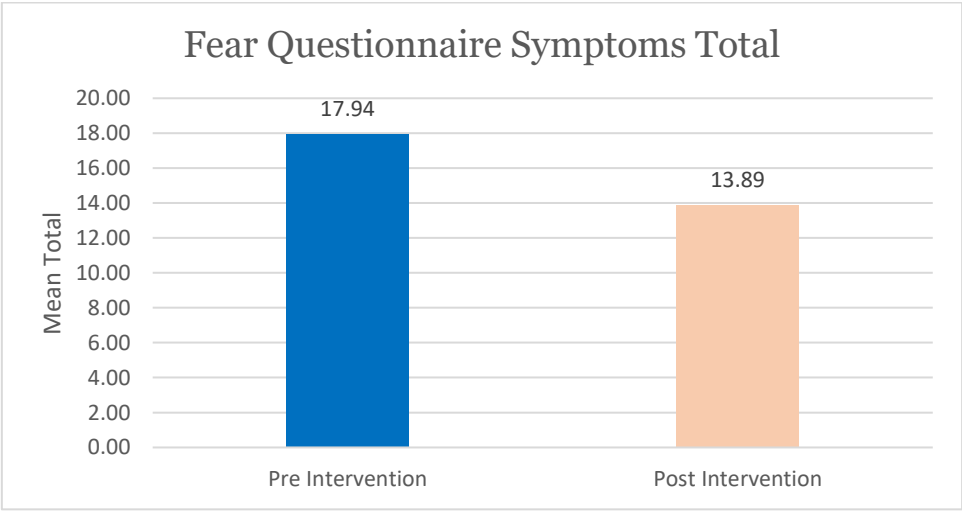
The Fear Questionnaire

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 40.11 (*SD* = 18.32) to 33.37 (*SD* = 15.64) following statistical analysis using a pairwise t-test at level 2 of the Anxiety Disorder Programme. This reduction was statistically significant, $t(17) = 3.383$, $p < .05$. A small effect size was observed (Cohen's $d = 0.39$).

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



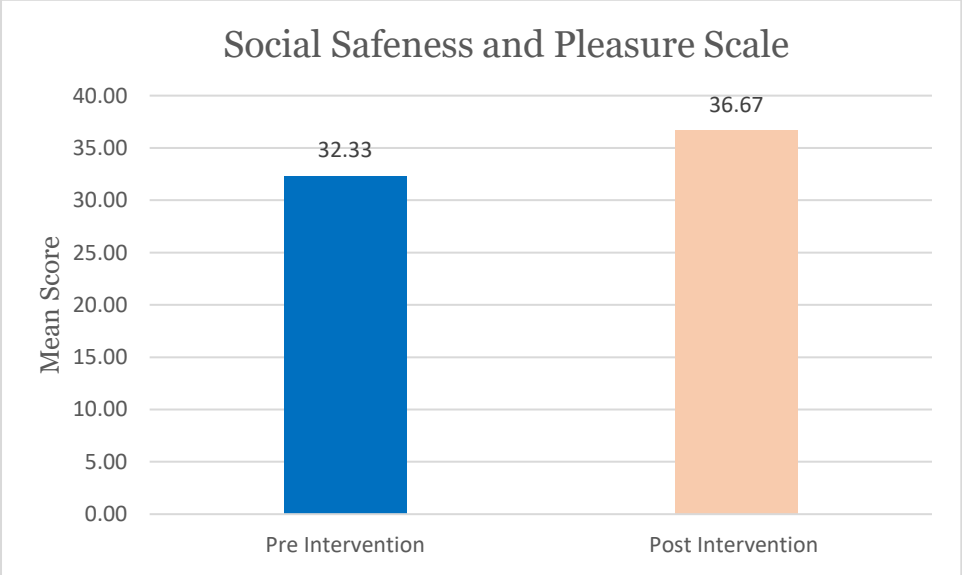
Total symptom scores on the Fear Questionnaire were found to have dropped from a mean score of 17.94 (*SD* = 9.72) to 13.89 (*SD* = 9.45) following statistical analysis using a pairwise t-test at level 2 of the Anxiety Disorder Programme. This reduction

is statistical significant, $t(17) = 2.220$, $p < 0.05$. A small effect size was observed (Cohen's $d = 0.42$).

The Social Safeness and Pleasure Scale

Service users scores on the Social Safeness and Pleasure Scale showed a change from a mean of 32.33 (*SD*= 11.10) pre-intervention to 36.67 (*SD*=10.10) post-intervention. A pairwise t-test was used to analyse the sample. This increase was statistically significant $t(17) = -7.657$, $p < .001$, with a small effect size (Cohen's $d = 0.28$).

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



4.6.4. Summary

Level 1: Outcomes for the service users who completed Level 1 of the Anxiety Programme between January and December 2021 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

	Effect Size		
Instrument	**2019**	**2020**	**2021**
Fear Questionnaire	-0.70(r)	0.18(r)	0.54 (Cohen's *d)*
Y-BOCS (Global Score)	1.19(Cohen's *d*)	1.06(Cohen's *d)*	1.43 (Cohen's *d)*
Penn State Worry Questionnaire	-0.71(r)	0.48(r)	0.96(Cohen's *d)*
Social Phobia Inventory	0.85(Cohen's *d*)	0.31(r)	0.43(Cohen's *d)*
Agoraphobia Scale	0.67(Cohen's *d*)	-	0.47(Cohen's *d)*
Social Work and Leisure Questionnaire	0.77(Cohen's *d*)	0.83(Cohen's *d*)	0.67(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 2021 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.

4.7. 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 SPMHS in 2014 and is facilitated by the psychology department. In 2021, the CFT team piloted a 6-week psychoeducation CFT group, which is presented below. The shorter nature of this CFT group allowed the team to offer intervention to a larger number of service users, and enabled the clinicians to conduct a more accurate assessment of client needs', in terms of whether they would benefit from a longer-term group based psychological intervention following completion of the psychoeducation group. Qualitative results highlighted extremely positive feedback of this pilot programme. The CFT programme will implement this new format in 2022, offering several 6-week

introductory psychoeducational CFT group cycles throughout 2022. Several 16 session CFT therapy group cycles will also be offered in 2022 for those who have completed the 6-week group and are suitable for the longer-term intervention.

4.7.1. Descriptors

57 individuals completed the CFT programme at either SPUH or SEH in 2021. Pre and post data was available for 36 individuals, representing 63% return rate of both pre and post measures. 72.2% of these were female (N = 26) and 27.8% were male (N = 10). Programme attendees ranged in age from 20 to 73 years with a mean age of 42.5 years. Missing Value Analysis (MVA) was carried out to examine the type of missingness within the data. Where data was found to be Missing Completely at Random by Little's test (Li, 2013), the Expectation Maximisation method was applied before any total scores were computed or analyses carried out.

4.7.2. 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 2021.

All service users attending the CFT Programme in SPMHS 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, 2014). 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 2021. Groups continued to be delivered online, via MS Teams, due to national public health restrictions.

- **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.

- **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.

- **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., 2017). Each scale consists of 13 items which generate an engagement (i.e. motivation to care for wellbeing, attention/sensitivity to suffering, sympathy, distress tolerance, empathy, being

accepting and non-judgmental) and an action sub-scale (i.e. directing attention to what is helpful, thinking and reasoning about what is likely to be helpful, taking helpful actions and creating inner feelings of support, kindness, helpfulness and encouragement to deal with distress). Responses are given on a 10-point Likert scale; one – never, to 10 – always. High scores indicate high compassion. This measure was introduced in April 2017.

4.7.3. Results

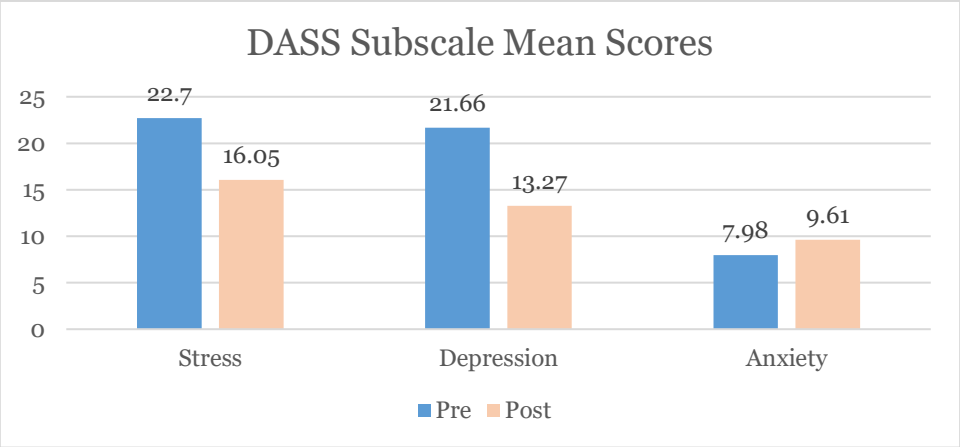
Depression Anxiety and Stress Scales (DASS)

Analysis of the DASS stress scores from the CFT programme indicated that there was a significant decrease in reported stress, $z = -3.41$, $p < 0.05$, representing a moderate effect size ($r = -0.56$). Participants mean scores decreased from 22.7 (*SD* = 9.09) at pre-intervention to 16.05 (*SD* = 9.94) after completing the programme.

Analysis of the DASS depression scores from the CFT programme indicated that there was a significant decrease in reported depressive symptoms, $z = -3.67$, $p < 0.001$, representing a moderate effect size ($r = -0.61$). Participants mean scores decreased from 21.66 (*SD* = 11.21) at pre-intervention to 13.27 (*SD* = 9.46) after completing the programme.

Wilcoxon signed ranks test revealed the DASS anxiety subscale mean scores increased slightly following engagement in the group from 7.98 (*SD* = 4.61) at pre-intervention to 9.61 (*SD* = 9.14) at post-intervention, however this change was not statistically significant, $z = -1.08$, $p > 0.05$. CFT facilitators wondered whether this slight, nonsignificant, increase in anxiety post intervention might represent fears regarding the ending of a therapeutic input which several group members had spoken to during final sessions of the group.

Graph: Depression Anxiety and Stress Scores



The Fears of Compassion Scale (FCS)

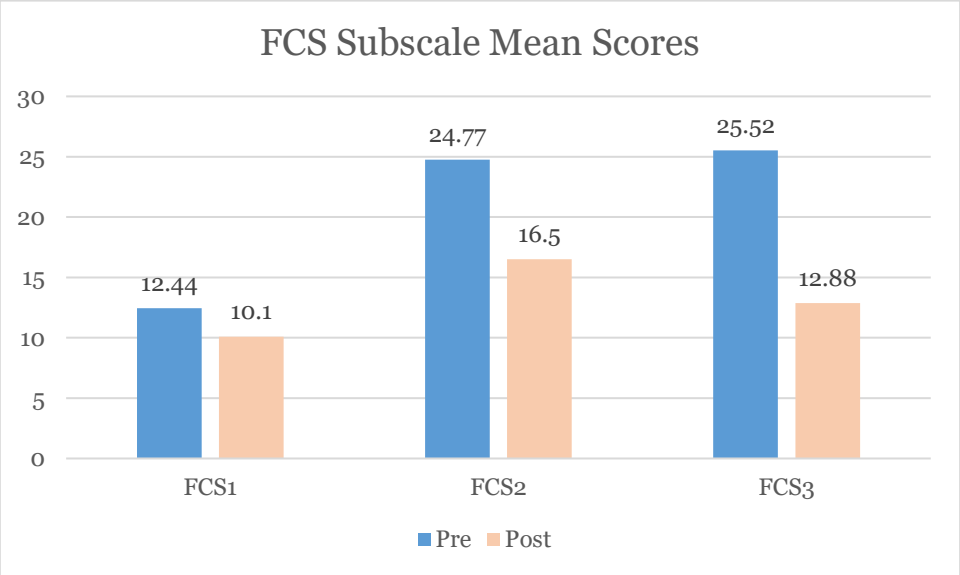
The FCS is divided into three scales; fear of expressing compassion for others, fear of responding to compassion from others and fear of expressing kindness and compassion towards self. Mean scores on the subscales are presented below.

A paired samples t-test revealed a significant reduction in reported fear of expressing compassion for others, $t(36) = 2.70$, $p < 0.05$, representing a medium effect size (Cohen's $d = 0.45$). Mean scores fell from 12.44 ($SD = 8.09$) at pre-intervention to 10.16 ($SD = 6.5$) at post-intervention.

A paired samples t-test revealed a significant reduction in reported fear of responding to compassion from others, $t(36) = 5.10$, $p < 0.001$, representing a robust effect size (Cohen's $d = 0.85$). Mean scores fell from 24.77 ($SD = 11.68$) at pre-intervention to 16.58 ($SD = 11$) at post intervention.

A Wilcoxon Signed Ranks Tests demonstrated a statistically significant reduction in fears of expressing kindness and compassion towards self, $z = -4.7$, $p < 0.001$. At pre-intervention, participants mean scores were 25.52 ($SD = 13.11$), compared to 12.88 ($SD = 10.42$) at post-intervention, with a robust effect size ($r = -0.78$).

Graph: The Fears of Compassion Subscales



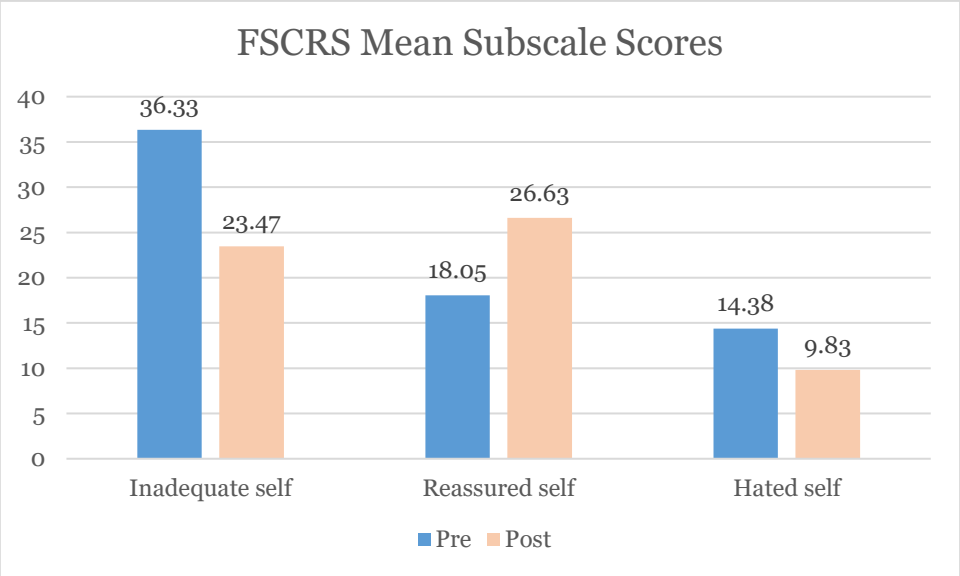
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

Mean scores on the FSCRS 'inadequate self' subscale showed a significant decrease following engagement with the programme z = -5.23, p < 0.05. Mean scores fell from 36.33 (SD = 5.58) at pre-intervention to 23.47 (SD = 7.12) at post-intervention, demonstrating a robust effect size, (r = -0.84). Decreases in scores indicate reduced feelings of inadequacy.

Mean scores on the FSCRS 'reassured self' subscale showed a significant increase following engagement with the programme z = -4.97, p < 0.05. Mean scores rose from 18.05 (SD = 5.02) at pre-intervention to 26.63 (SD = 7.00) at post-intervention, demonstrating a robust effect size, (r = -0.82). Increases in scores indicate increased feelings of reassurance in self.

Mean scores on the FSCRS 'hated self' subscale showed a significant decrease following engagement with the programme z = -4.68, p < 0.05. Mean scores fell from 14.38 (SD = 4.96) at pre-intervention to 9.83 (SD = 4.09) at post-intervention, demonstrating a robust effect size, (r = -0.78). Decreases in scores indicate reduced feelings of self-hatred.

Graph: FSCRS Subscale Scores



Compassionate Engagement and Action Scale (CEAS) 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.

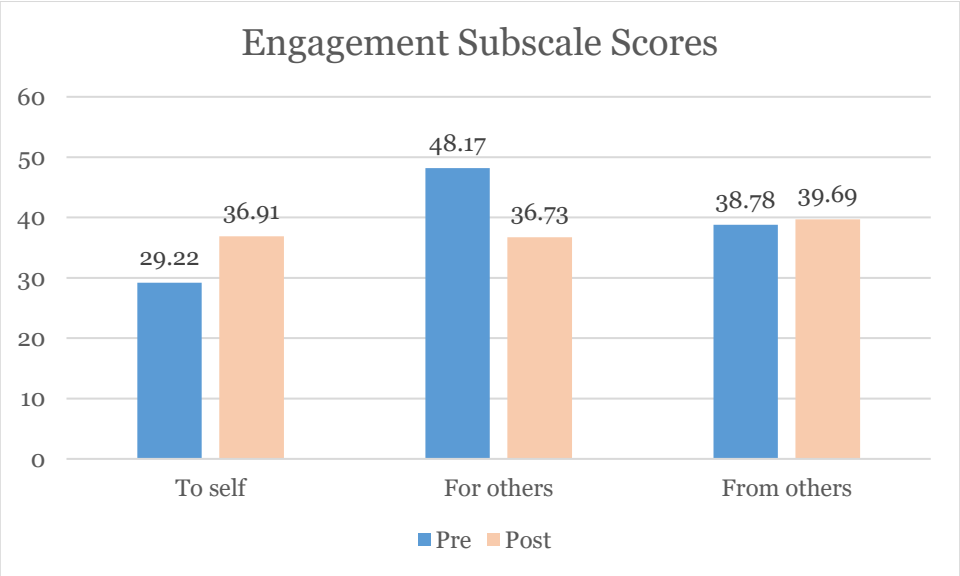
Significant increases were reported on the overall Compassion to Self-Scale from pre-intervention (*M* = 29.22, *SD* = 10.30) to post-intervention (*M* = 36.91, *SD* = 9.28), $t(36) = -4.48$, $p < 0.05$, with a strong effect size (Cohen's $d = -0.74$). These findings illustrate that participants' self-directed compassion increased from pre- to post-intervention.

Significant decreases were reported on the overall Compassion to Others-Scale from pre-intervention (*M* = 48.17, *SD* = 8.47) to post-intervention (*M* = 36.73, *SD* = 9.36), $t(36) = 6.59$, $p < 0.05$, with a strong effect size (Cohen's $d = 1.09$). These findings illustrate that participants' compassion for others decreased from pre- to post-intervention. A potential explanation for this might be that individuals attending CFT typically report high levels of compassion to others prior to commencing CFT and that this can often mean sacrificing own needs and solely focussing on compassion to others rather than to self. Also, prior to commencing CFT many people misinterpret compassion to others as appeasement or submissive behaviours. The CFT team

wondered whether this finding might represent group member's increased understanding of compassion and ability to allow for flow of compassion to self rather than only to others.

Mean scores on the Compassion from Others Scale showed a slight increase from pre-intervention (M = 38.78, SD = 10.93) to post-intervention (M = 39.69, SD = 10.72), $t(36)$ = -0.65, $p > 0.05$ which was not statistically significant.

Graph: Compassionate Engagement Subscale Scores



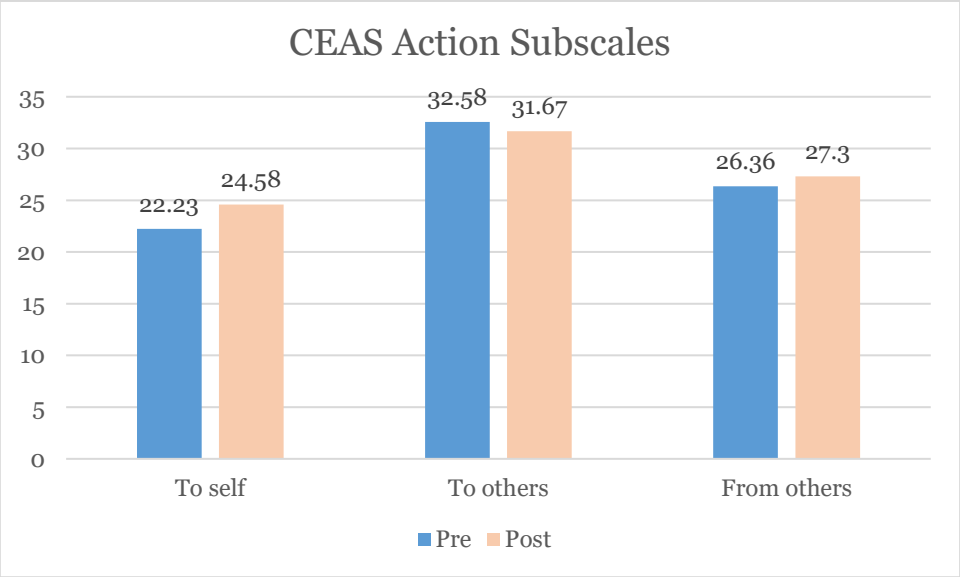
Within the Compassionate Action sub-scales, a statistically significant increase in mean scores can be observed on the Compassion to Self subscale. Participant mean scores increased from pre-intervention (M = 22.23, SD = 7.95) to post-intervention (M = 24.58, SD = 5.14), $t(36)$ = -2.12, $p < 0.05$, with a medium effect size (r = -0.35).

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

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

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

Graph: Compassionate Action sub-scales



4.7.4. CFT Psychoeducation

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).

In addition to the CFT programme outlined in the wider CFT outcomes report, the CFT team offered one cycle of a psycho-educational introductory 6 session group in 2021. This is a new addition to the CFT programme and reflects plans we have to implement a new structure to the CFT group programme in 2022 which incorporates brief (6 session) introductory psychoeducational groups followed by longer term (16 session) CFT therapy groups for those who have attended the psychoeducational groups and are suitable for the CFT therapy. The CFT team piloted an introductory 6 session psychoeducational group, which was extremely well received by group members, before offering this in 2021.

The CFT Psychoeducation Group provides group members with an introduction to the CFT model and practices. It also serves to support collaborative assessment and

formulation of group readiness and suitability for CFT therapy with the service user. Group members also have the opportunity to get an experience of how working with others in a CFT group feels and whether or not this is the right fit of intervention and approach for them.

4.7.5. Descriptors

Data was available for 5 participants who attended the level 1 CFT Psychoeducation group in 2021. 60% (n = 3) were female and 40% (n =2) were male. The mean age was 45.6 years (SD = 14.2) with a range of 29 to 62 years.

4.7.6. CFT Psychoeducation Outcome Measures

- **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 injure 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.

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

The Functions of Self-Criticising/Attacking Scale (FSCS) was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004) to measure the functions of self-criticism; why people think they self-criticise and self-attack. Factor analysis suggests two very different functions for being self-critical; one is to try and improve the self and stop the self from making mistakes (self-correction) and the other involves expressing anger and wanting to harm the self (self-persecution). It is a 21-item scale measuring both these factors. The responses are given on a five-point Likert scale ranging from 0

– ‘not at all like me’, to four – ‘extremely like me’. Cronbach alphas were .92 for correcting and persecuting respectively.

- **Depression Anxiety and Stress Scale (DASS-21)**

The 21-item Depression, Anxiety and Stress Scale (DASS-21) is a set of three self-report scales designed to measure 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. 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. 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.

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

This scale was developed to measure the extent to which people experience their social worlds as safe, warm and soothing. The items relate feelings of belonging, acceptance and feelings of warmth from others (e.g. “I feel content within my relationships”, “I feel secure and wanted”, “I feel a sense of warmth in my relationships with people”). Respondents rate on a 5 point Likert scale the extent to which they agree with each of the 12 statements ranging from 0 (almost never) to 4 (almost all the time). In developing this scale, a list of 14 adjectives indicative of safeness/soothing such as ‘soothed’, ‘peaceful’, ‘warm’, ‘serene’, ‘safe’, ‘secure’, were first selected by three of the researchers. Each of these were then ranked on a scale of 1-3 by five researchers (1= low soothing; 3= high soothing). The scores on each of the adjectives were then summed and 12 statements related to everyday situations were

devised to capture the sense of safeness such as 'contented', 'soothed', 'secure', 'calm.' Social Safeness and Pleasure Scale has a high Cronbach alpha of .92.

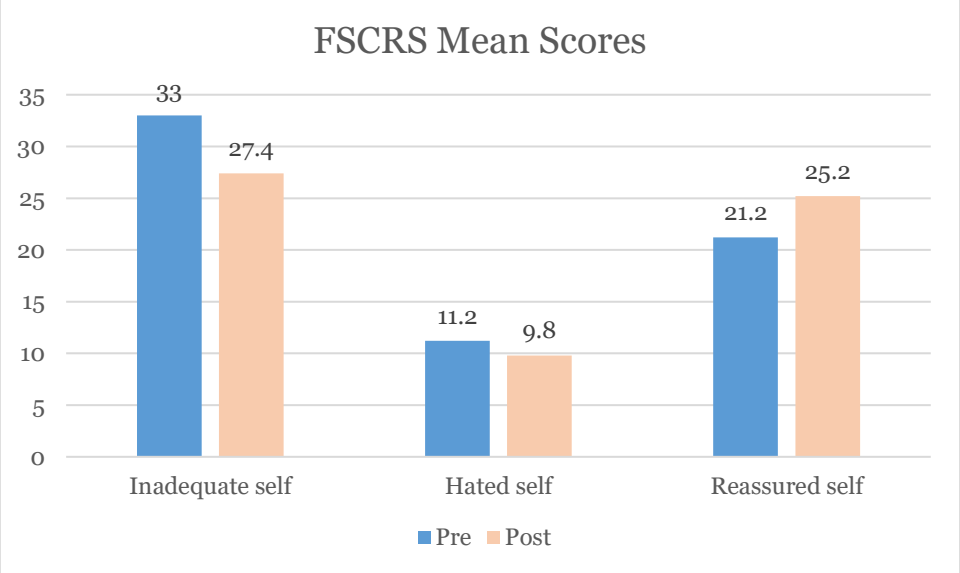
4.7.7. Results

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

Mean scores on the FSCRS 'inadequate self' subscale decreased from pre-intervention (M = 33, SD = 6.08) to post-intervention (M = 27.4, SD = 9.2).

Mean scores on the FSCRS 'hated self' subscale decreased from pre-intervention (M = 11.2, SD = 3.96) to post-intervention (M = 9.8, SD = 3.42).

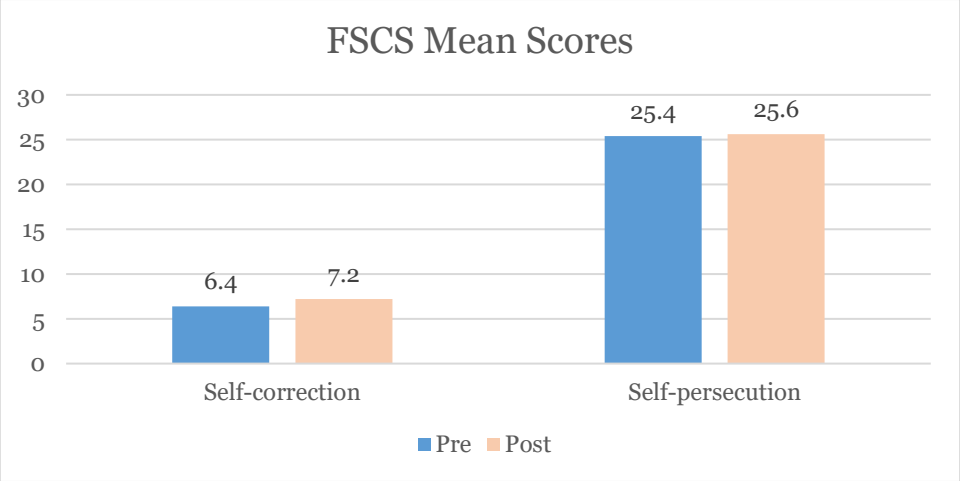
Mean scores on the FSCRS 'reassured self' subscale increased from pre-intervention (M = 21.2, SD = 4.65) to post-intervention (M = 25.2, SD = 7.79).



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

Mean scores on the FSCS 'self-persecution' subscale increased marginally from pre-intervention (M = 25.4, SD = 16.4) to post-intervention (M = 25.6, SD = 16.8).

Mean scores on the FSCS 'self-correction' subscale increased marginally from pre-intervention (M = 6.4, SD = 5.59) to post-intervention (M = 7.2, SD = 4.43).

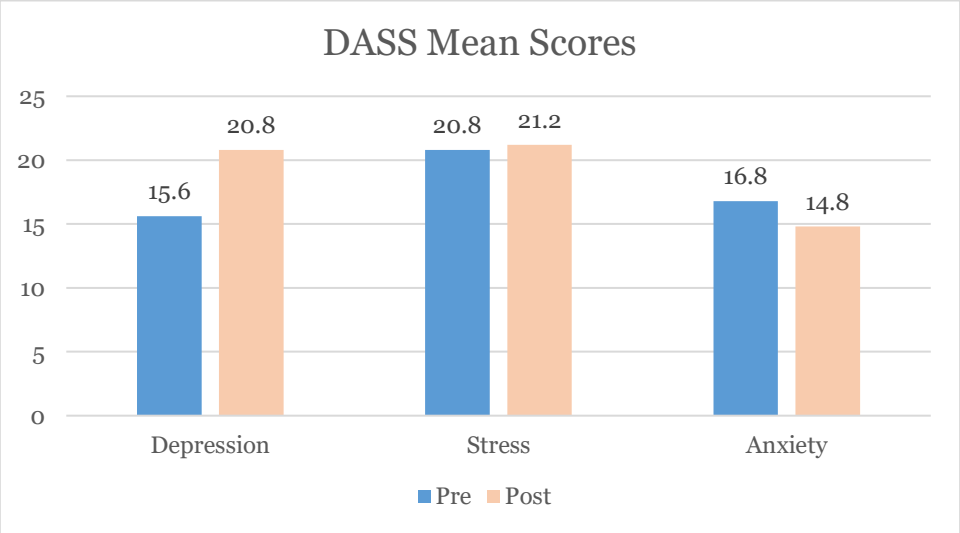


Depression Anxiety and Stress Scale (DASS)

Mean scores on the DASS depression subscale increased slightly from pre-intervention (*M* = 15.6, *SD* = 7.92) to post-intervention (*M* =20.8, *SD* = 17.92).

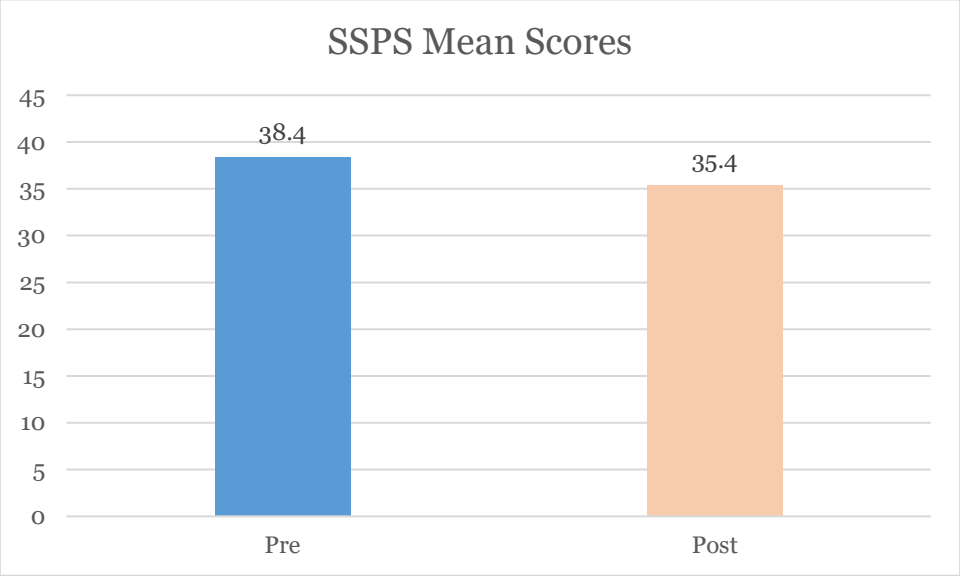
Mean scores on the DASS stress subscale increased slightly from pre-intervention (*M* = 20.8, *SD* = 13.75) to post-intervention (*M* = 21.2, *SD* = 13.08).

Mean scores on the DASS anxiety subscale decreased from pre-intervention (*M* = 16.8, *SD* = 9.23) to post-intervention (*M* = 14.8, *SD* = 7.15).



Social Safety and Pleasure Scale (SSPS)

Mean scores on the social safety and pleasure scale decreased from 38.40 (*SD* = 10.92) to 35.80 (*SD* = 11.69) following engagement in the programme.



4.7.8. Summary

The Compassion-Focused Therapy Programme started in SPMHS in 2014. Since then, 32 cycles of the group have been facilitated. The programme has received considerable interest within the hospital. Anecdotal feedback from clients who attended these groups has been 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 waiting times are often an issue. To address this, increased staff resource has allowed for increased number of group cycles offered in 2021. In 2022 there will be a change to the format of the CFT group programme which we hope will result in greater access to the CFT programme with reduced wait times.

The CFT Level 1 psychoeducation group is an extremely new addition to the CFT programme in the hospital delivered by the Psychology Department, the above results are for the programme's first cycle. The programme aspires to address psychological distress associated with self-criticism and feelings of shame which can

underpin many mental health difficulties. The level 1 psychoeducational component of the group aims to provide an introduction to the model and practices while also providing a space to consider where longer term CFT therapeutic work is appropriate and would be helpful to service users. Unfortunately, due to the small sample size, statistical analysis of the outcome measures was not possible. Nonetheless, the analysis of mean scores overall demonstrated some promising positive results.

Qualitative feedback from group members was overwhelmingly positive about this group. The CFT team will continue to evaluate and monitor outcomes for the CFT Level 1 psychoeducation group in 2022 when several cycles will be completed.

4.8. Compassion-Focused Therapy for Eating Disorders

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

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

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

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

CFT categorises emotions by their functions for:

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

These have been named the threat, drive and soothing systems respectively. The CFT-E model suggests that people who experience eating disorders have learned to regulate their experience of threat through their drive system, with little access to their healthy soothing system (Allan & Goss, 2012). For example, experiences of threat such as shame and self-criticism can be managed through the drive of goal-directed food restriction or accessing soothing through food. Research indicates that food restriction stems from experiences of threat which are overly responded to by the drive system through excessive dieting which becomes reinforced through feelings of pride (Kelly & Tasca, 2016). Bingeing behaviour is regulated by the soothing system through dissociation from negative emotions and an increase in pleasurable sensation and soothing affect (Allan & Goss, 2012).

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

CFT-E incorporates education for both clients and their family members; skill building and therapeutic elements.

The format of the programme. incorporates psychoeducation for service users and their family members; skill building and therapeutic elements. Currently it is staffed by three psychologists and one assistant psychologist. In total, there are 30 half day group sessions for group participants and one evening session for family and friends. The programme continues to be delivered online via Microsoft teams due to public health restrictions.

4.8.1. Descriptors

Fifteen participants competed the programme comprising 7 participants in cycle 8 and 8 participants in cycle 9. Eleven participants returned outcome measures post intervention. The programme welcomes participants with a range of eating disorder

symptoms and diagnoses. All 11 individuals who returned measures in 2021 were female. Participants ranged in age from 22 to 52 years with a mean age of 35.81. Pre- and post-outcome data was available for 10 participants on all measures. One participant completed only one measure at the pre-and post-interval and their data will be included in analyses of this measure only. Missing Value Analysis (MVA) was carried out to examine the type of missingness within the data. Where data was found to be Missing Completely at Random by Little's test (Li, 2013) the Expectation Maximisation method was applied before any total scores were computed or analyses carried out

4.8.2. Compassion-Focused Therapy for Eating Disorders outcome measures

The following section presents a summary of the routine clinical outcome measures used for the 2 CFT-E cycles that finished in 2021. All service users attending the CFT-E programme are invited to complete the following measures at assessment for the programme and again upon completion.

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

The Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) is a 34-item self-report questionnaire developed to monitor clinically significant change in outpatients. The client is asked to respond to 34 questions about how they have been feeling over the last week using a five-point Likert scale ranging from 'not at all', to 'most or all the time'. The 34 items of the measure cover four dimensions: subjective wellbeing, problems/symptoms, life functioning and risk/harm.

The responses are designed to be averaged by the practitioner to produce a mean score to indicate the level of current psychological global distress (from healthy to severe). The scoring range of the CORE-OM is between 0 and 4, with 4 being the highest level of severity. The CORE Outcome Measure (CORE-OM) was conceived as a non-proprietary measure of psychological distress. Crucially, it was informed by feedback from practitioners as to what they considered to be important to include (Barkham et al., 2010). Since its development, the CORE-OM has been validated with samples from the general population, NHS primary and secondary care and in older adults. Furthermore, analyses of over 2,000 responses show good reliability and convergent

validity against longer and less general measures; small gender effects, large clinical/non-clinical differences and good sensitivity to change (Evans et al., 2009).

- **Eating Disorder Examination Questionnaire (EDE-Q)**

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

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

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

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

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

The Functions of Self-Criticising/Attacking Scale (FSCS) was developed by Gilbert, Clarke, Hempel, Miles and Irons (2004) to measure the functions of self-criticism; why people think they self-criticise and self-attack. Factor analysis suggests two very

different functions for being self-critical; one is to try and improve the self and stop the self from making mistakes (self-correction) and the other involves expressing anger and wanting to harm the self (self-persecution). It is a 21-item scale measuring both these factors. The responses are given on a five-point Likert scale ranging from 0 - not at all like me, to four - extremely like me. Cronbach alphas were .92 for correcting and persecuting respectively.

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

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

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

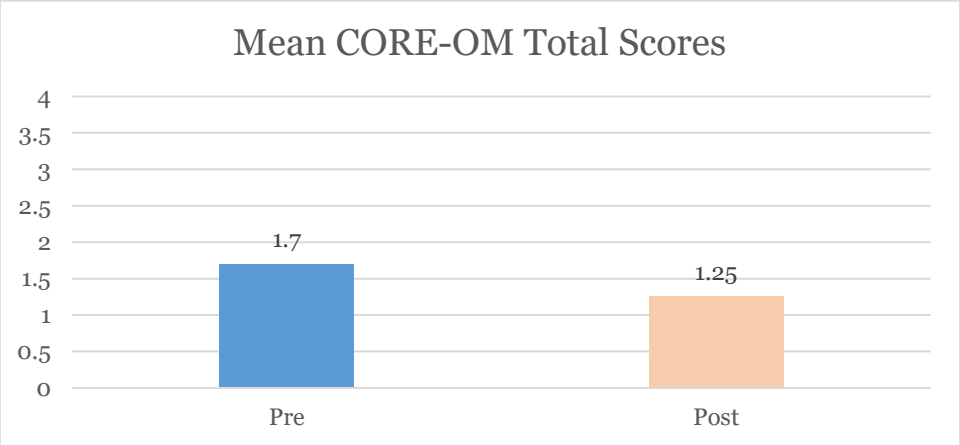
The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to the self, compassion to the other and compassion experienced from the other (Gilbert et al., 2017). Each scale consists of 13 items which generate an engagement (i.e. motivation to care for wellbeing,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

4.8.3. Results

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

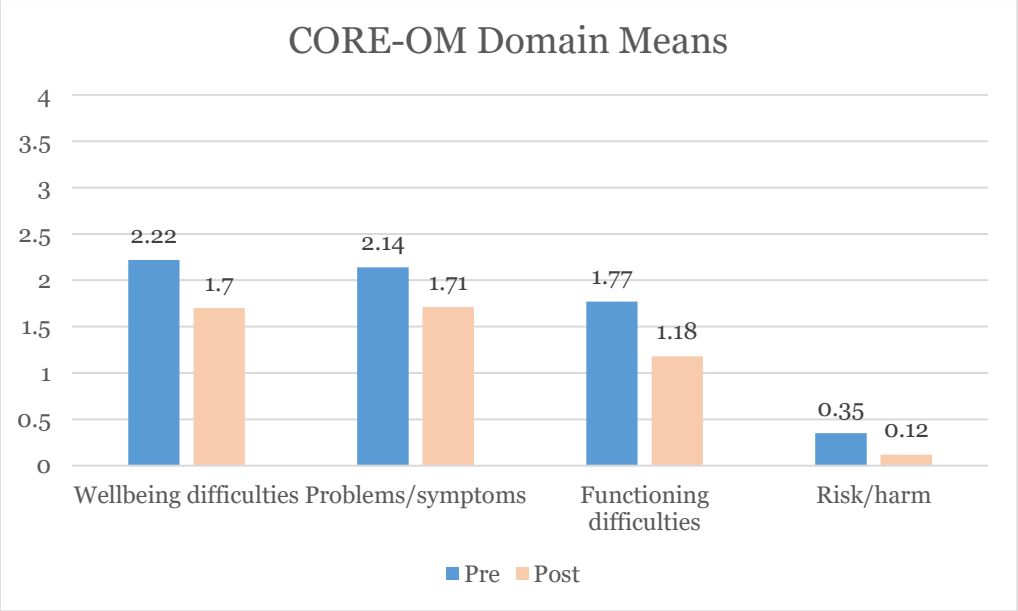
A Wilcoxon Signed Ranks Test revealed that participants experienced a decrease in psychological distress, moving from a mean total score of 1.70 (*SD* = 0.54) on the CORE-OM at pre-intervention to 1.25 (*SD* = 0.45) following completion of the programme, $z = -2.40$, $p < 0.05$, representing a robust effect size (Cohen's $d = 1.15$).

Graph: CORE-OM Total Mean Score



Analysis of the subscales revealed statistically significant decreases in three of the four domains ($p < 0.05$). This indicates improvement in these domains. The risk/harm subscale decreased, but this change was not statistically significant.

Mean scores on the subjective wellbeing subscale decreased from 2.22 (0.63) at pre-intervention to 1.70 (*SD* = 0.61) at post-intervention. Mean scores on the problems/symptoms domain decreased from 2.14 (*SD* = 0.59) at pre-intervention to 1.71 (*SD* = 0.70) at post-intervention. Mean scores on the functioning subscale decreased from 1.77 (*SD* = 0.68) at pre-intervention to 1.18 (*SD* = 0.44) at post-intervention. Mean scores on the risk/harm subscale decreased from 0.35 (*SD* = 0.34) at pre-intervention to 0.12 (*SD* = 0.23) at post-intervention. These changes indicate that participants level of current psychological global distress improved following engagement with the programme.



Eating Disorder Examination Questionnaire (EDE-Q)

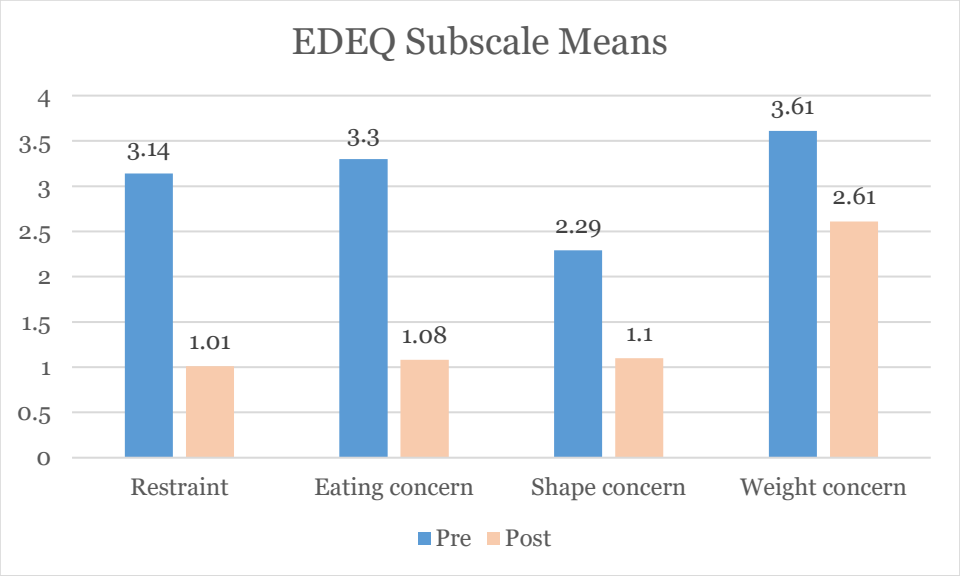
Participants reported a reduction of eating disorder symptomatology as measured by scores on the EDE-Q. The global score on the EDE-Q reflected decreased symptomatology between pre-intervention (M = 2.77, SD = 1.69) and post-intervention (M = 1.22, SD = 1.45). This change was not statistically significant however, when each subscale was looked at separately there was positive statistically significant change in all subscales with the exception of the weight concern subscale.

There are four sub-scales measured within the EDE-Q are restraint, eating concern, shape concern and weight concern. A series of Wilcoxon Signed Ranks Tests were carried out and the pre and post-intervention scores are depicted in the table below. Statistically significant reductions in eating disorder symptoms and behaviours are observed across each of the four sub-scales, excluding 'weight concern' which was not statistically significant, from pre-intervention to post-intervention, reflecting a large effect size.

EDE-Q Subscale	Mean(SD) Pre	Mean(SD) Post	Z	p-value	R
Restraint	3.14(2.20)	1.01(1.24)	-2.31	0.02	-0.73
Eating concern	3.30(2.41)	0.78(0.65)	-2.36	0.01	-0.83
Shape concern	2.29(1.29)	1.10(0.96)	-2.25	0.02	-0.75

Weight concern	3.61(3.11)	2.61(5.21)	-1.60	0.10	N/A

Graph: EDEQ Subscale Means

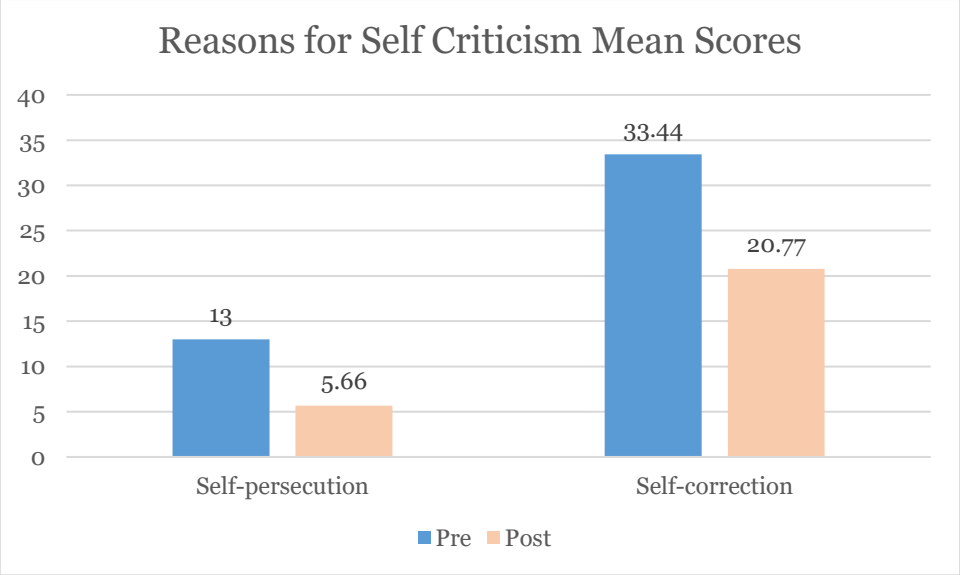


The Functions of Self-Criticizing/Attacking Scale (FSCS)

The FSCS is divided into two sub-scales, measuring the function of self-criticising/attacking in terms of self-correction and self-persecution. A statistically significant reduction was revealed on the self-persecution sub-scale, with participants' self-criticising/attacking scores transitioning from 13 (*SD* = 8.44) pre-intervention to 5.66 (*SD* = 6.2) at post-intervention, $t(9) = 3.51$, $p < 0.05$, representing a robust effect size (*Cohen's d* = 1.17).

On the self-correction subscale, participant's self-criticising/attacking scores reduced significantly from 33.44 (*SD* = 10.38) at pre-intervention to 20.77 (*SD* = 14.2) at post-intervention, $t(9) = 4.17$, $p < 0.05$, representing a robust effect size (*Cohen's d* = 1.39).

Graph: FSCS Total and sub-scale scores



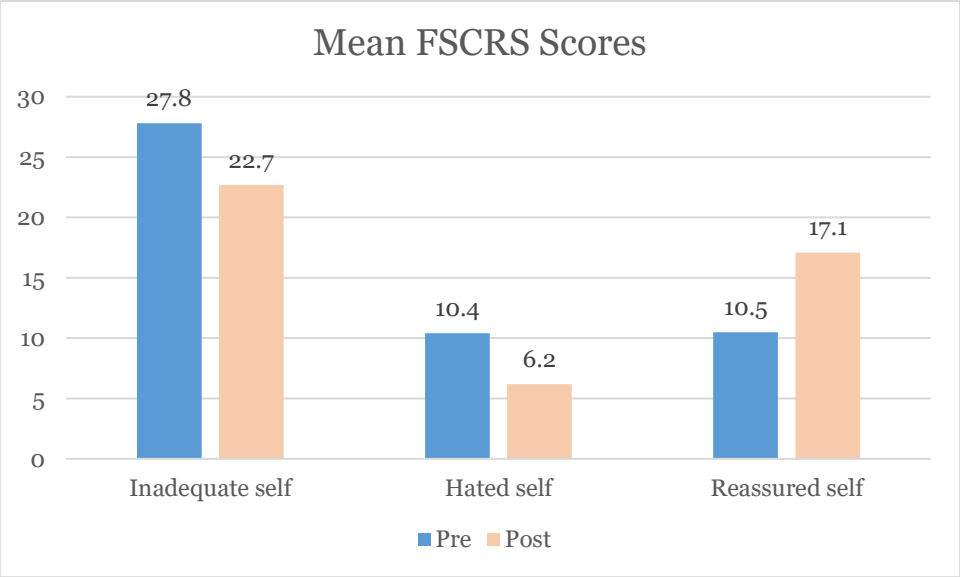
The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS) Results

A paired samples t-test demonstrated a significant decrease in mean scores on the FSCRS 'inadequate self' sub-scale from pre (M = 27.80, SD = 5.13) to post-intervention (M = 22.70, SD = 7.11), $t(9) = 2.51$, $p < 0.05$, demonstrating a strong effect size (*Cohen's d* = 0.79). This suggests that post-completion of the programme participants experienced reduced feelings of inadequacy.

A significant reduction in mean scores on the 'hated self' sub-scale was also observed from pre (M = 10.40, SD = 4.52) to post-intervention (M = 6.20, SD = 3.67), $t(9) = 3.09$, $p < 0.05$, demonstrating a strong effect size (*Cohen's d* = 0.96). These scores suggest that participant levels of self-directed hostility decreased upon completion of the programme.

A significant increase in mean scores on the 'reassured self' sub-scale was achieved from pre-intervention (M = 10.50, SD = 7.59) to post-intervention (M = 17.10, SD = 5.95), $t(9) = -3.71$, $p < 0.05$, demonstrating a medium effect size (*Cohen's d* = -1.17). These results indicate that participants' ability to cope and reassure themselves increased following engagement with the CFT-E programme.

Graph: FSCRS Reassured Self sub-scale scores



Compassionate Engagement and Action Scale (CEAS)

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.

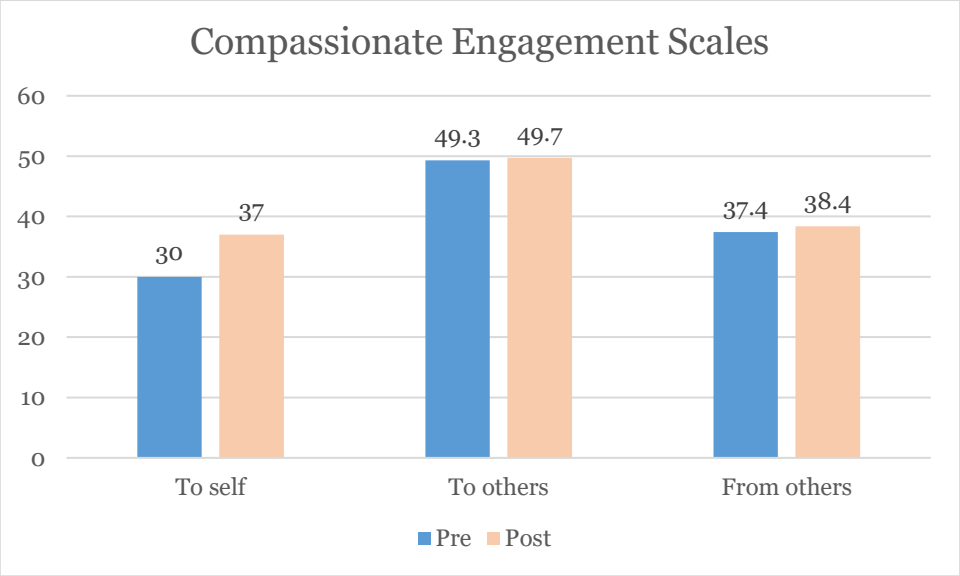
Mean scores on the Compassion to Self engagement scale increased were reported from pre-intervention (*M* = 30, *SD* = 11.36) to post-intervention (*M* = 37, *SD* = 7.64), however this difference was not statistically significant. There was a significant increase in the Compassion to-Self Action scale, with mean scores increasing from 19 (*SD* = 8.44) at pre-intervention to 25 (*SD* = 3.12) at post-intervention, $t(9) = -2.97$, $p < 0.05$. this represents a robust effect size (Cohen's $d = -0.99$).

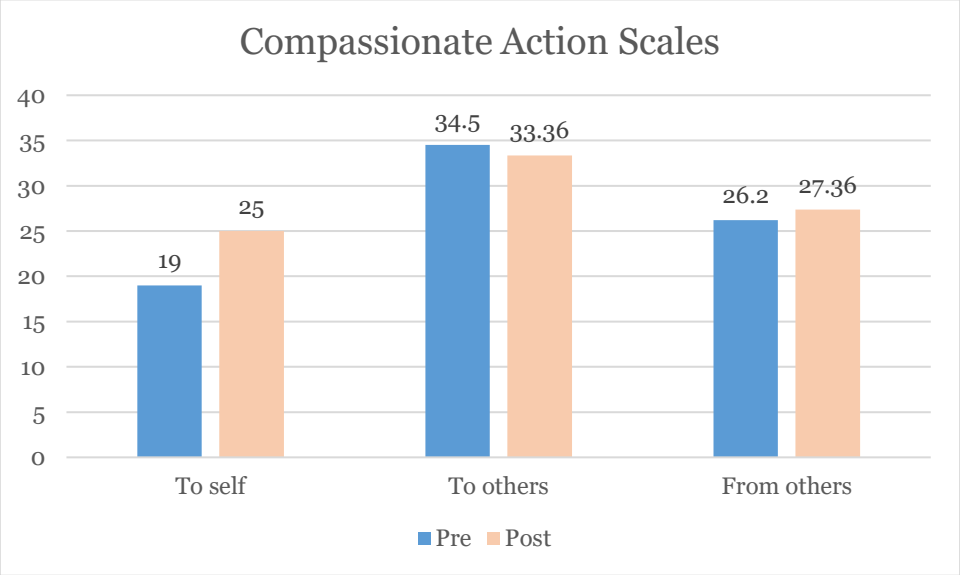
Mean scores on the Compassion to Others engagement scale increased slightly from pre-intervention (*M* = 49.30, *SD* = 6.01) to post-intervention (*M*= 49.73, *SD* = 7.86), however this difference was not statistically significant. Mean scores on the Compassion to Others action scale decreased non-significantly from pre-intervention (*M* = 34.5, *SD* = 3.02) to post-intervention (*M* = 33.36, *SD* = 4.36). Note scores on both the compassion to others engagement and compassion to others action scales were high for participants pre and post the group.

Mean scores on the Compassion from Others engagement scale showed a non-significant increase from pre-intervention (*M* = 37.4, *SD* = 7.51) to post-intervention

(*M* = 38.4, *SD* = 7.98). Mean scores on the Compassion from Others action scale also increased from pre-intervention (*M* = 26.2, *SD* = 4.77) to post-intervention (*M* = 27.36, *SD* = 5.31), however this change was not statistically significant.

Graph: CEAS Engagement and Action Mean Scores





4.8.4. Summary

Since CFT-E began in SPMHS in 2015, nine cycles have been facilitated and the most recent two cycles completed in 2021 were delivered online. The programme receives referrals from within the hospital and from external referrers. Qualitative research from group members has been largely positive, with group members reporting a reduction in

their eating disorder symptoms and an increase in their ability to give and receive compassion, which is statistically supported in the findings presented (Mullen, Dowling, Doyle, & O'Reilly, 2019) as well as in our more recent audit for online CFT-E. Quantitative research reported above further substantiates the efficacy of the CFT-E programme, with participants demonstrating less psychological distress pre and post intervention, a reduction in eating disorder symptoms, a reduction in self -criticism and an increase in self -reassuring and self -compassion. The programme is meetings its aims in reducing eating disorder symptoms and improving service users' relationship with themselves.

4.9. Coping with Covid-19 for Older Adults (COCOA) and Coping for Older Adults Psychology Group (COAP)

COCOA is a psychological 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 fosters 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 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, Group Radical Openness and trauma-informed approaches. Five cycles of the programme were run in 2021 between January and September. In late 2021 the programme was re-launched as the Coping for Older Adults Psychology (COAP) programme. This was as a result of the waning level of concern about COVID-19 expressed amongst older adult service users and an apparent improvement in the pandemic situation overall, together with the positive feedback from service users about the COCOA programme. One of the original aims of the COCOA programme had been to increase accessibility to psychological interventions for older people and given positive feedback from service users, in particular about the accessibility and brevity of the programme it was felt that a brief intervention, focused on psychological approaches to coping should remain on offer. The specific focus on

COVID-19 was removed from the programme with most of the content and the structure remaining unchanged otherwise. The first cycle of the newly revised COAP programme was launched in October 2021.
The new programme is detailed in a later section of this report.

4.9.1. Descriptors

Pre and post data were available for 24 service users who completed the programme in 2021. Of these, 17 were female (70.8%) and 7 were male (29.2%). Programme attendees ranged in age from 57 to 88 years (*M* = 73.29, *SD* = 6.99).

4.9.2. Coping with COVID-19 for Older Adults (COCOA) programme outcome measures

- **Depression Anxiety Stress Scale (DASS-21)**

The Depression Anxiety Stress Scale (DASS; Lovibond & Lovibond, 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. The DASS has a score range of 0-60, with higher scores indicative of worse psychological difficulties. Each scale is made up of seven items divided into sub-scales.
Research has found it to have adequate reliability and internal consistency, with a Cronbach α of 0.761 (Le, Tran, Holton, Nguyen, Wolfe & Fisher, 2017).

4.9.3. Results

Depression Anxiety Stress Scale (DASS-21)

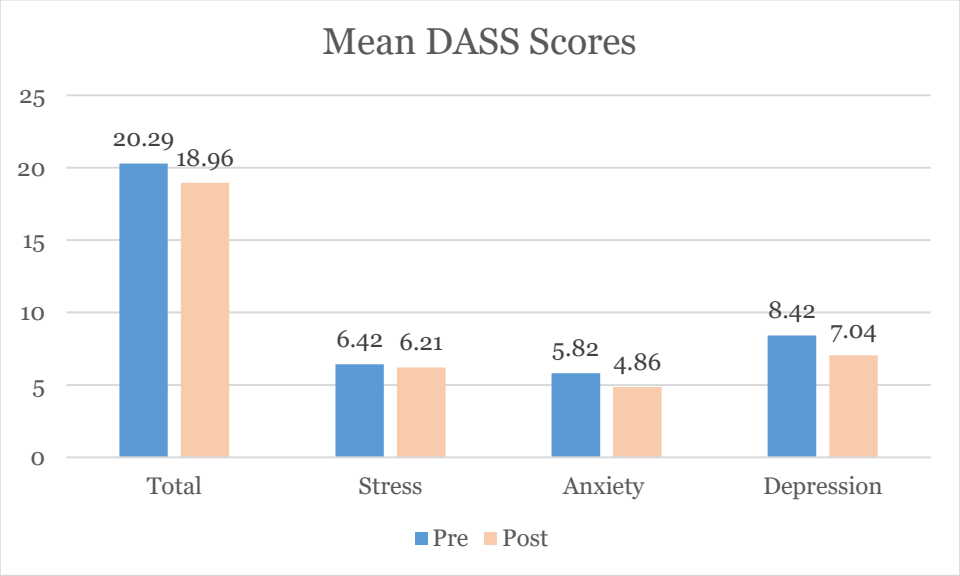
Analysis of the three sub-scales, which make up the DASS-21 - stress, anxiety and depression – showed a numerical decrease on two of three domains from pre to post intervention.
Mean scores on the stress subscale decreased from 6.42(*SD* = 5.85) at pre-intervention to 6.21(*SD* = 4.91) at post-intervention. However, a Wilcoxon-Signed ranked test revealed that this difference was not statistically significant.
Mean scores on the anxiety subscale decreased from 5.82 (*SD* = 4.62) at pre-intervention to 4.86 (*SD* = 3.83) at post-intervention. Paired samples t-test revealed that this difference was not statistically significant.

Mean scores on the depression subscale decreased from 8.42(*SD* = 7.02) at pre-intervention to 7.04(*SD* = 5.76) at post-intervention. However, a paired samples t-test revealed this difference was not statistically significant.

There was a decrease in DASS-21 total scores from pre-intervention (*M* = 20.29, *SD* = 15.79) to post-intervention (*M* = 18.96, *SD* = 13.63). However, a paired samples t-test revealed this difference was not statistically significant.

This is a small data set (*n*=24) and is therefore sensitive to scores which are somewhat atypical. Two participants scores in particular were quite atypical which, although they do not fulfil statistical criteria as outliers, have likely had an effect on what might have been greater levels of significant change for the whole sample otherwise. The small sample size is also sensitive to the situational nature of the measure which asks about distress for a period of 1 week prior to completing the measure.

Graphs: Mean COCOA DASS Total Score and Subscale Scores



4.9.4. COAP (Coping for Older Adults Psychology Programme)

In later summer and early autumn 2021 the pandemic crisis appeared to be abating with less need being voiced by older adult service users for support in managing the health crisis. Given the positive feedback from service users about the content, length and accessibility of the programme, and in line with our aim to reduce barriers to

older adults engaging in psychological therapies, the programme was re-launched as the Coping for Older Adults Psychology (COAP) programme. Content was largely the same as in the COCOA programme, but with the goal of reaching a broader range of older adult service users who might be open to engaging with a psychological approach to their difficulties.

Two cycles of the COAP programme were completed in 2021.

4.9.5. Descriptors

Pre and post data was available for 5 individuals who engaged in the COAP programme in 2021. Participants ranged in age from 69 to 82 years. The mean age was 76.60 years (*SD* = 5.12). Three of the participants were male and two of the participants were female.

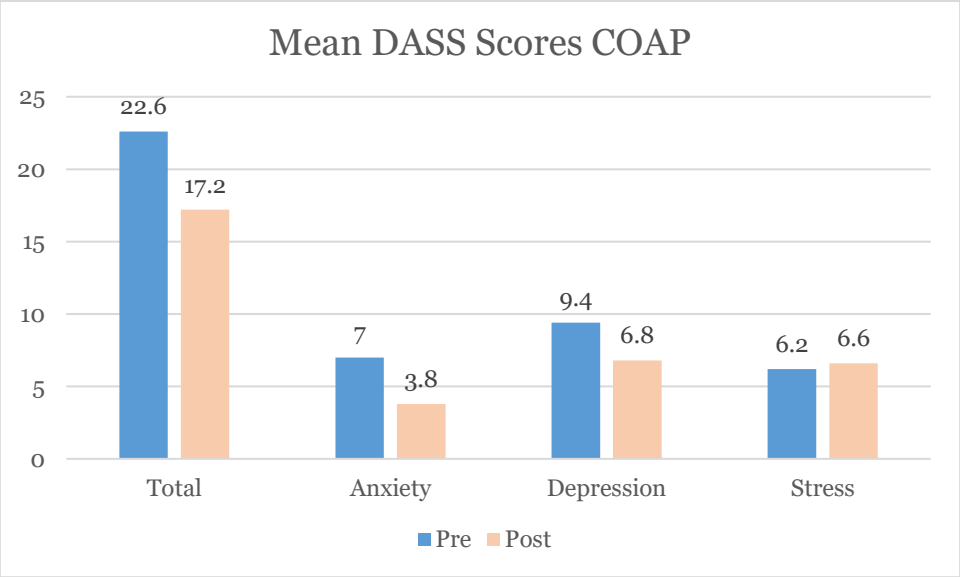
4.9.6. Results

Depression, Anxiety and Stress Scale (DASS)

The mean total score on the DASS fell from 22.60 (*SD* = 11.92) to 17.20 (*SD* = 8.16) following engagement in the programme. Numerically these results suggest an improvement in psychological difficulties. However, this difference was not statistically significant. Scores on the anxiety and depression subscales decreased from 7.00(*SD* = 3.87) and 9.40 SD = 5.72) to 3.80 (*SD* = 3.11) and 6.80 (*SD* = 2.77) respectively (see graph below), however neither of these differences were statistically significant. The stress subscale score increased slightly following the intervention, from 6.20 (*SD* = 2.22) to 6.60 (*SD* = 2.73) however this difference was not statistically significant.

This is a very small data set (*n*=5), hence statistically significant levels of change is unlikely.

Graph: Mean DASS Scores COAP



4.9.7. Summary

The COCOA programme began in 2020 in response to COVID-19. Four cycles were completed in 2020 and five cycles were completed in 2021.

The quantitative research indicates that participants experienced less psychological distress after completing the programme and reported decreases in levels of depression and stress. This suggests that this novel programme has been a useful support for older adults in coping with the challenges of COVID-19 with a high degree of positive qualitative feedback from participants.

In response to changes in the pandemic and positive feedback from service users and with a view to removing barriers to engaging in psychological therapy which can exist for older adults the COCOA programme was re-launched in autumn 2021 as the COAP Programme (Coping for Older Adult Psychology programme).

4.10. Depression Recovery Programme

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

4.10.1. The Depression Programme

The Depression Programme is an 11 week day programme for people with Moderately Severe Depression, consisting of one full day per week (6 hours clinical contact) of group-based CBT consistent with NICE guidelines. It has capacity for 12 attendees on each cycle. People waiting on a cycle are encouraged to attend the Access to Recovery Programme. The Depression Programme is facilitated by Cognitive Psychotherapists and incorporates CBT, Mindfulness and Compassion Focused Therapy. CBT therapists in training will at times co-facilitate groups.
In the first 4 weeks groups are of a workshop format to facilitate the application of core CBT and compassion focused maintenance models in development of personal formulation. It also encourages the development of skills such as mindfulness.
In weeks 5 through to 11, workshops aim to facilitate the application of core CBT longitudinal models in development of personal formulation. It encourages further development of skills such as mindfulness and Affiliative focused emotional regulation consistent with Compassion Focused Therapy teachings.

4.10.2. Aftercare

This programme consists of one half day a month for up to 1 year. This programme is open to service users who have completed the Depression Programme. It is facilitated by cognitive psychotherapists and focuses on relapse prevention utilizing CBT, compassion focused therapy and mindfulness. It promotes the development of further self-awareness and self-management which are key to identifying risks of relapse and maintaining recovery.

4.10.3. Descriptors

Paired data were available for 44 service users who completed the programme in 2021; 28 females (63.6%) and 16 males (36.4%). The age profile of participants ranged from 21 to 78 years, with the average age being 47 years.

4.10.4. Depression Recovery Programme outcome measures

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

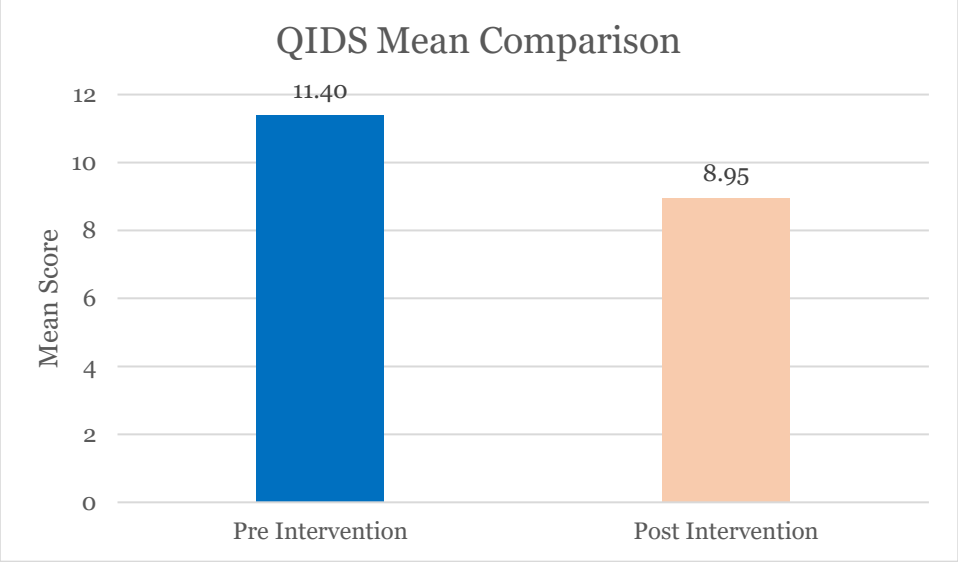
The Quick Inventory of Depression Symptomatology (Rush AJ, Gullion CM, Basco MR, Jarrett RB, Trivedi MH, 2003) is a 16-item measure used to assess the severity of depression symptoms. The items cover the nine diagnostic domains of depression as identified in the DSMS-IV: sad mood, concentration, self-criticism, 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).

4.10.5. Results

Quick Inventory of Depression Symptomatology

Comparison of service user scores on the QIDS indicated a reduction of depression severity scores from pre-intervention (M = 11.40, SD = 4.93) to post-intervention (M = 8.95, SD = 5.58). This reduction in mean scores is statistically significant. A paired samples t-test revealed $t(43)= 3.477$, $p< .001$, with a small effect size (Cohen's d = .47).

Graph: Pre and post intervention



4.10.6. Summary

This is the seventh year the Depression Programme has been included in the SPMHS *Outcomes Report*. This is the third 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 the programme experience a significant reduction in symptoms associated with depression.

4.11. Eating Disorders Programme

The Eating Disorders Programme (EDP) is a service specifically oriented to meet the needs of people with anorexia nervosa, bulimia nervosa, binge eating disorder and Other Specified Feeding and Eating Disorders (OSFED). The objective of the programme is to address the physical, psychological and social issues arising as a result of an eating disorder in an attempt to resolve and overcome many of the struggles associated with it. The programme is a multidisciplinary programme with an emphasis on a CBT treatment model which is applied throughout inpatient, day care and outpatient treatment stages, as needed by the service user. 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 service user 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 supervision 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.

4.11.1 Descriptors

Data was available for a total of 28 service users attending the EDP as an inpatient in 2021.

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 day service users. However, the public health restrictions resulting from the COVID-19 pandemic impacted on the collection of data for day service users and therefore we did not have enough data to complete analysis for the day service.

4.11.2. EDP outcome measures

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

- **Eating Disorder Examination – Questionnaire**

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

  27 items contribute to global score and four sub-scales including restraint, eating concern, weight concern and shape concern. Items from each sub-scale are summed and averaged with the global score generated by summing and averaging the sub-scale

scores (resulting scores range from 0 to six for each sub-scale and the global score). Higher scores suggest greater psychopathology. Evidence in support of the reliability and validity of the measure comes from a number of studies (eg. Beaumont, Kopec-Schrader, Talbot, & Toyouz, 1993; Cooper, Cooper, & Fairburn, 1989; Luce and Crowther, 1999; Mond, Hay, Rodgers, Owen, & Beaumonth, 2004). Normative data on the EDE-Q sub-scales have been provided in three key studies and are shown in the table below (Wilfley et al, 1997; Carter et al, 2001 and Passi et al, 2003 as cited in Garety et al, 2005).

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

  The State Self-Esteem Scale is a 20-item scale that measures a participant's self-esteem at a given point in time. The 20 items are subdivided into three components of self-esteem: performance self-esteem, social self-esteem and appearance self-esteem. All items are answered using a five-point scale (one = not at all, two = a little bit, three = somewhat, four = very much, five = extremely).

  Higher scores indicate higher levels of self-esteem.

4.11.3. 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 = 3.41) and post-treatment (M = 2.10). A pairwise sample t-test indicated this was a statistically significant change $t(26)$= 6.536, p<.001, with a large effect size d=1.24

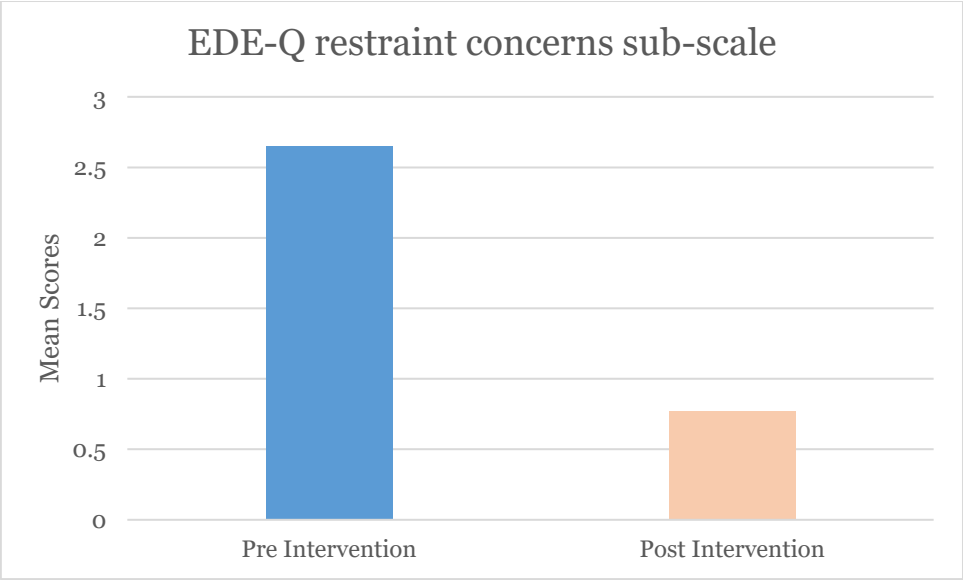
All sub-scales of the EDE-Q showed statistically significant decreases in symptomatology by time point. Symptomatology on the restraint sub-scale significantly decreased from pre-treatment (M= 2.65) to post-treatment (M = 0.77), $t(26)$= 5.641, p<.001, with a large effect size d=1.477.

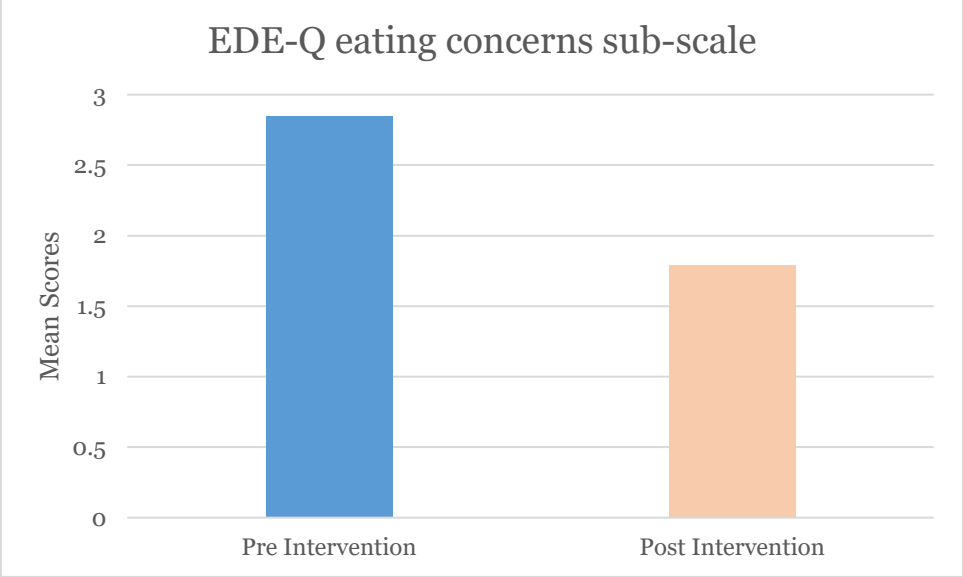
Secondly, symptomatology on the eating concern sub-scale significantly decreased from pre-treatment (M= 2.85) to post-treatment (M = 1.79), $t(26)$= 4.600, p<.001, with a large effect size d=1.00.

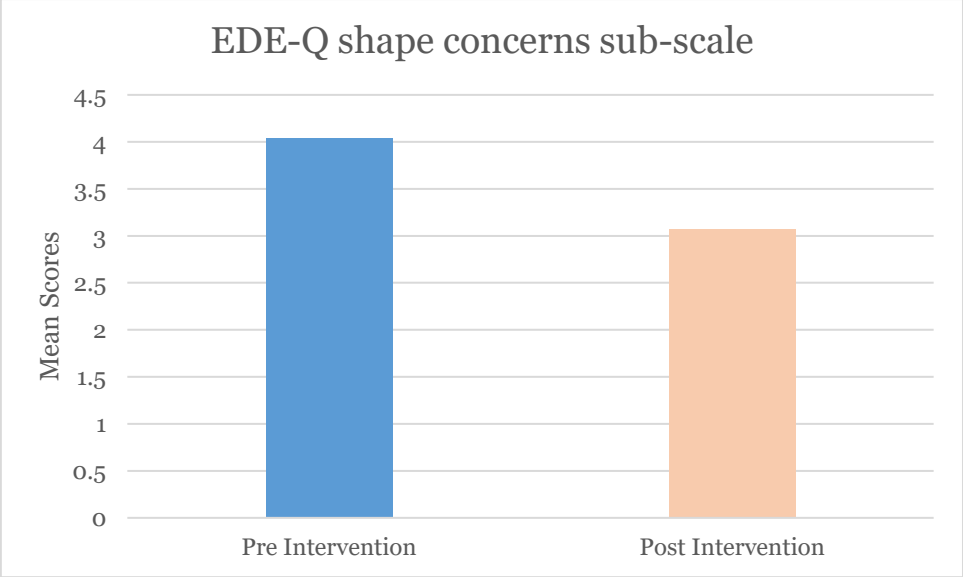
Additionally, symptomatology on the shape concern sub-scale significantly decreased from pre-treatment (M= 4.04) to post-treatment (M = 3.07), $t(26)$= 4.375, p<.001, with a medium effect size d=.67

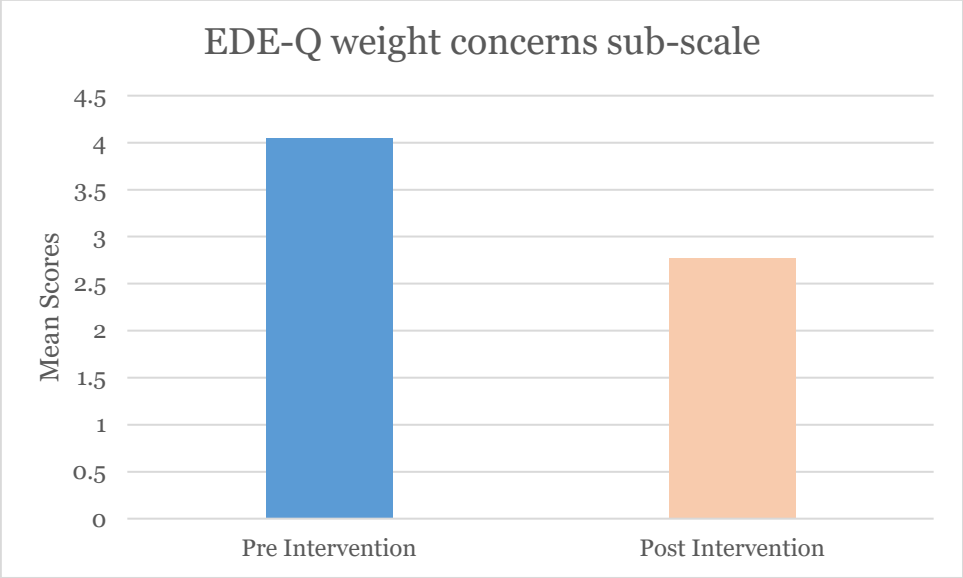
Finally, symptomatology on the weight concern sub-scale significantly decreased from pre-treatment (M= 4.05) to post-treatment (M = 2.77), $t(26)$= 5.128, p<.001, with a large effect size d=.87

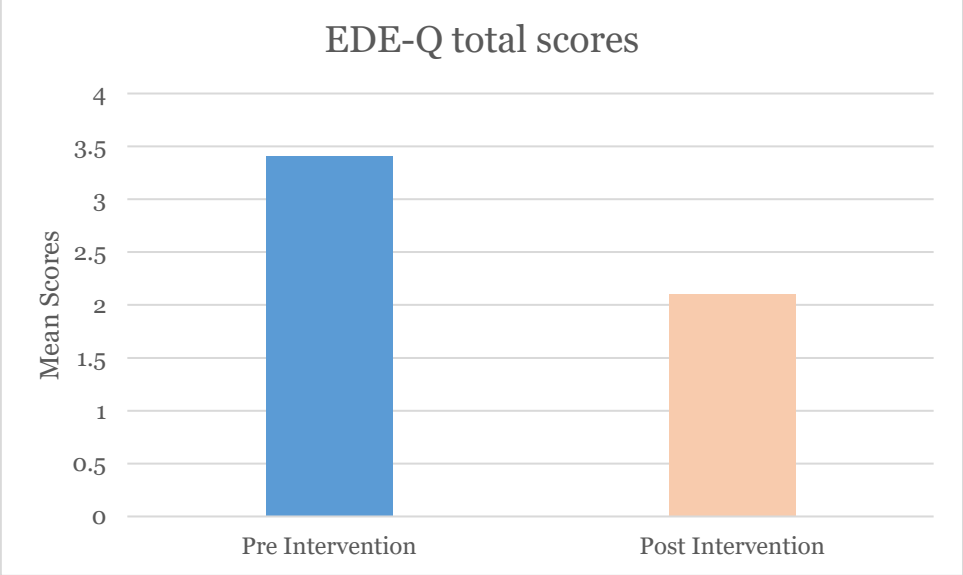
Graph: EDE-Q Global and sub-scale scores pre and post intervention






EDE-Q shape concerns sub-scale
Mean Scores
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Pre Intervention
Post Intervention


EDE-Q weight concerns sub-scale
Mean Scores
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Pre Intervention
Post Intervention


EDE-Q total scores
Mean Scores
4
3.5
3
2.5
2
1.5
1
0.5
0
Pre Intervention
Post Intervention

State Self-Esteem Scale (SSES)

On the SSES, service users 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. Mean score across all scales had increased suggesting improvements across all domains. Data was collected from 27 attendees.

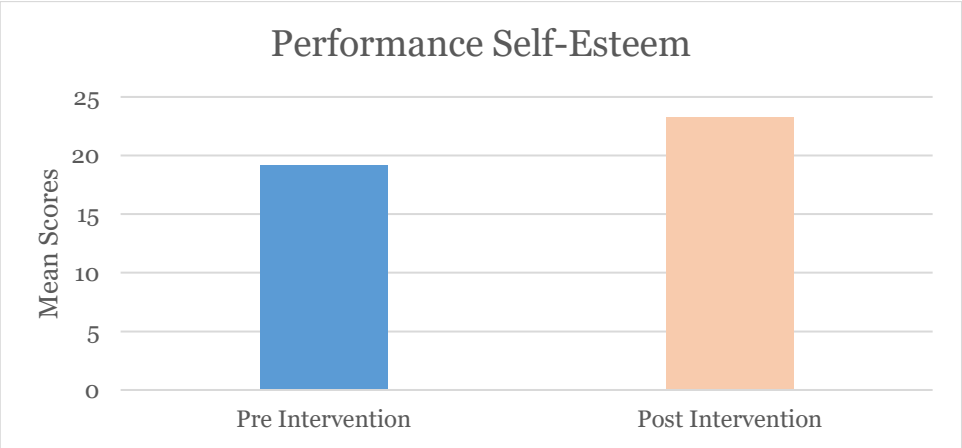
The total score on the SESS showed an increase between pre-treatment (M=50.44) and post-treatment (M=59.33). A pair wise sample t-test indicated this was a statistically significant change, $t(26)$= 2.545, p<.05, with a medium effect size d=.57

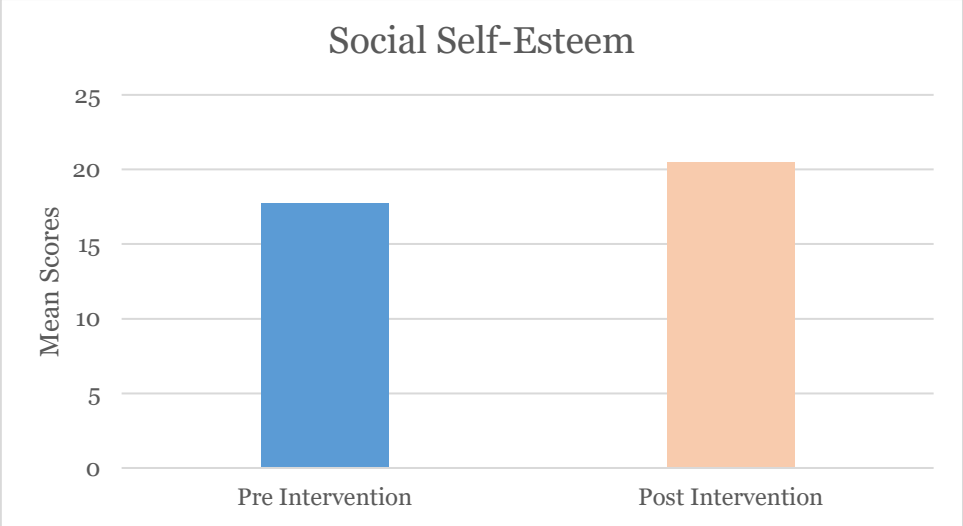
The performance self-esteem score on the SESS showed an increase between pre-treatment (M=19.14) and post-treatment (M=23.22). A pair wise sample t-test indicated this was a statistically significant change, $t(26)$= 3.217, p<.05, with a medium effect size d=.71

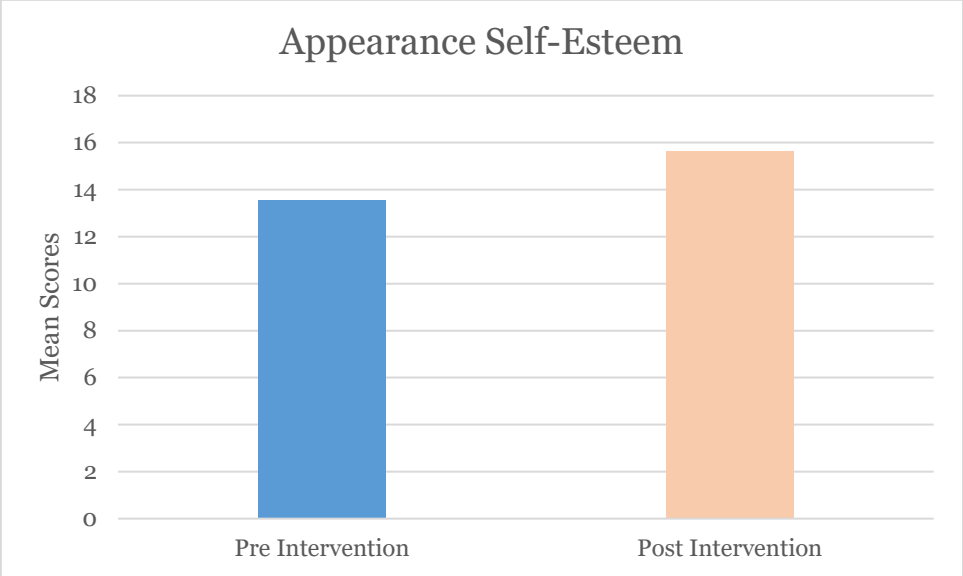
The social self-esteem score on the SESS showed an increase between pre-treatment (M=17.74) and post-treatment (M=20.48). A pair wise sample t-test indicated this was not a statistically significant change, $t(26)$= 2.074, p>.05.

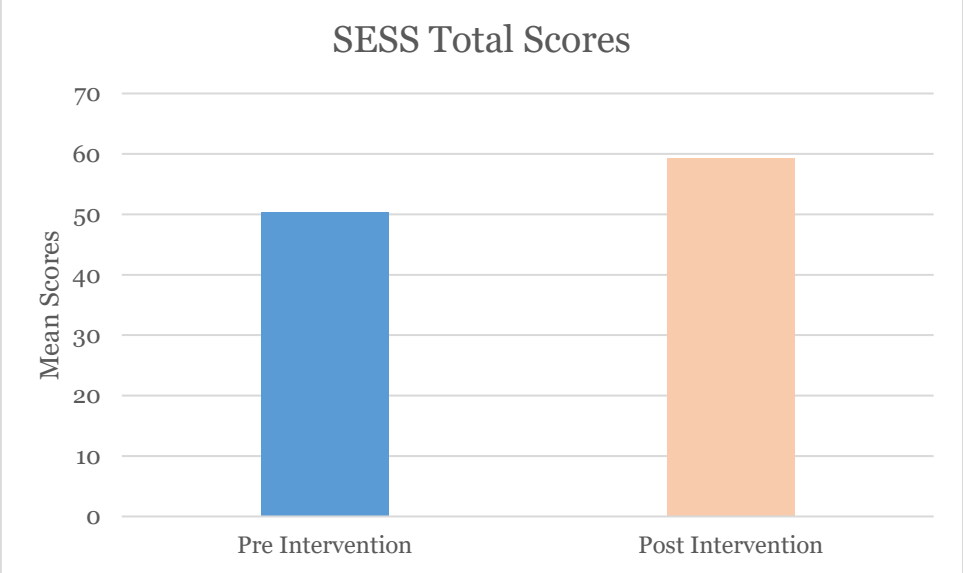
The appearance self-esteem score on the SESS showed an increase between pre-treatment (M=13.55) and post-treatment (M=15.62). A pair wise sample t-test indicated this was a statistically significant change, $t(26)$= 3.217, p<.05, with a small effect size d=.49.

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




Social Self-Esteem
Mean Scores
25
20
15
10
5
0
Pre Intervention
Post Intervention


Appearance Self-Esteem
Mean Scores
18
16
14
12
10
8
6
4
2
0
Pre Intervention
Post Intervention


SESS Total Scores
Mean Scores
70
60
50
40
30
20
10
0
Pre Intervention
Post Intervention

4.11.4. 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

4.12. Dialectical Behaviour Therapy (DBT) Programme

The DBT programme (formerly named Living Through Distress) 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. Towards the end of 2021 the LTD team made the decision to rename the programme Dialectical Behavioural Therapy (DBT). This is to reflect that fact that, while LTD has always been based on the DBT model, in the last two years the programme moved towards delivering an intervention that is very much adherent to the DBT approach, although in a more intensive format. It is hoped this name change will help MDT's referring to the program to be clear on the nature of the intervention and who is likely to benefit from it. It is also hoped that name will ensure prospective clients are more clearly informed on the nature of the programme they will engage with.

DBT is a multimodal staged psychotherapeutic approach. The DBT programme in St Patrick's University Hospital is a stage 1 DBT programme "focusing 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 reports of diagnostic status). DBT Stage 1 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 availability of a DBT consultation team. In addition to the Comprehensive DBT streams, in 2021 a DBT skills group was established. Based on these changes, the programme delivers the following services:

1) Comprehensive DBT: Comprehensive DBT consists of 4 DBT modes (skills training, one to one therapy, phone coaching and weekly therapist consultation team meetings). 24 group sessions occur in a 3-month period, and 8 one to one sessions are offered across the 12 weeks. Six comprehensive groups take place each year. Groups are closed, meaning that no new members join once the group has commenced.
2) DBT Skills Group: DBT skills group consist of group skills training and weekly therapist consultation team meetings. 24 group sessions occur in a 3 month period. This group is offered to service users who have not displayed pervasive patterns of self-harm or suicidal behaviour in the past 6 months but do experience emotional dysregulation and impulsive attempts to regulate emotion. Three skills groups take place each year. Groups are closed, meaning no new members join once the group has commenced.

Linehan (1993a) proposed that emotional dysregulation underlies many types of maladaptive coping behaviour. Research suggests that behaviours such as deliberate self-harm (DSH) function as emotion regulation strategies (Chapman et al., 2006), and 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 in transaction with certain dysfunctional environments, as well as from the interaction between them over time (Linehan, 1993a). Skills that aid individuals to regulate their emotions are at the core of DBT. DBT focuses on both change and acceptance skills in order to help participants develop new solutions to the problems in their lives.

Efficacy/ Effectiveness of DBT

Multiple randomised controlled trials have evaluated the efficacy of the standard 12-month version of DBT (e.g. Linehan, et al, 1991; Linehan et al; 2006; Priebe et al, 2012). Two Cochrane Reviews have shown DBT to be superior to treatment as usual in reducing BPD symptom severity, self-harm and psychosocial functioning (Storebø et al., 2020). DBT is an empirically supported treatment in its 12-month format and has been adherently rolled out in treatment centres across the world. DBT also has an emerging evidence base for effectiveness in treating other psychological disorders, such as eating disorders (Telch et al., 2001), addiction (Linehan et al., 1999;2002) and PTSD (Harned, Korslund, & Linehan, 2014).

DBT informed interventions are described in a Cochrane review (2009) as effective evidence-based interventions for deliberate self-harm (DSH) behaviours, emotional under-control difficulties and Borderline Personality Disorder.

DBT in St Patrick's Hospital is delivered in a more intensive fashion, with group skills teaching occurring twice weekly over a three-month period. 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 DBT 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 DBT showed greater improvements in DSH, anxiety, mindfulness and aspects of emotion regulation than people receiving treatment as usual.

Data from cycles 64 - 78 are described below, all of which finished in 2021. Data analysis of Comprehensive DBT and DBT skills group are reported separately. Groups continued to be delivered via MS Teams due to national public health restrictions.

4.12.1. Descriptors

Pre and post programme data were available for 24 participants who completed the DBT Comprehensive programme in 2021. Missing Value Analysis (MVA) was carried out to account for any missing data. As the data was determined as Missing Completely at Random by Little's test (Li, 2013) the Expectation Maximisation method was applied to the dataset before any total scores were computed or analyses carried out.
Of the 24 participants, 99% were female and 1% were male. DBT attendees ranged in age from 19 to 49 years, with an average age of 31.04 years (SD = 9.85). Their highest level of educational attainment ranged from leaving certificate qualification (4.2%) to third level non-degree qualification (37.5%) to third level degree (33.3%) to postgraduate qualification (20.8%).

Attendees' current employment status was also recorded. 8.3% were in part-time employment, 33.3% were in full-time employment, 12.5% worked in the home, 12.9% were unemployed, 25% were students and 8.3% chose other.

4.12.2. DBT 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. There are four components to the DTS model: an individual's (1) ability to tolerate emotions (tolerance); (2) assessment of the emotional situation as acceptable (appraisal); (3) level of attention absorbed by the negative emotion and relevant interference with functioning (absorption); and (4) ability to regulate emotion (regulation). 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. Scores can range from 15-75.

- **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). The possible score range is from 12-60.

- **Ways of Coping Checklist**

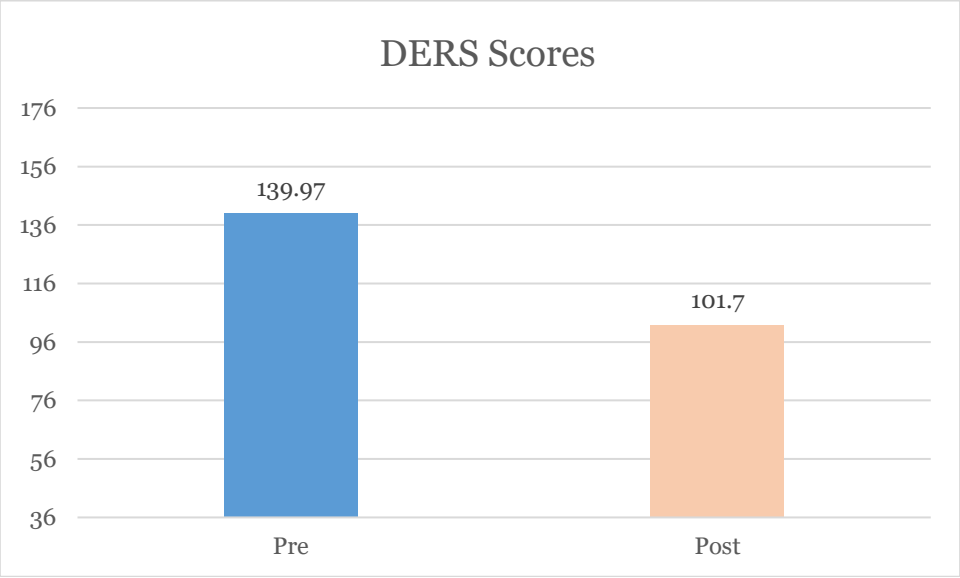
The Ways of Coping Checklist (WCCL) is a measure of coping based on Lazarus and Folkman's (1984) stress and coping theory. The WCCL contains 66 items that describe thoughts and acts that people use to deal with the internal and/or external demands of specific stressful encounters. Participants respond 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. Scores can range from 0-198.

4.12.3. 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 139.97 (*SD* = 16.42) on the DERS at pre-intervention to 101.70 (*SD* = 19.35) post-completion of the programme; $t(24) = 8.51$, $p < 0.05$. This change represented a large effect size (Cohen's $d = -1.73$). See graph below for visual representation.

Graph: Difficulties in Emotion Regulation Scale Total Scores 2021

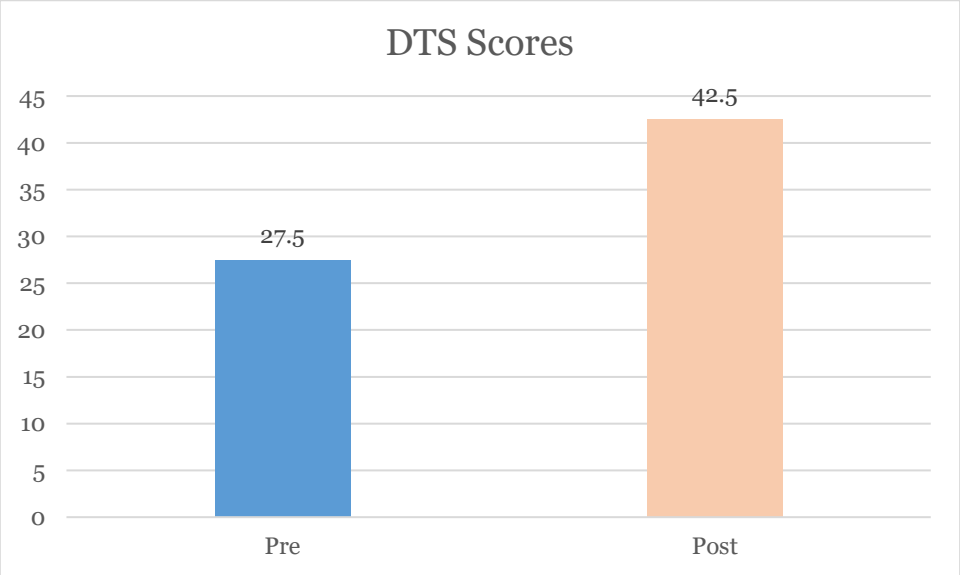


Note: Higher scores indicate greater difficulties with emotion regulation

Distress Tolerance Scale (DTS)

Participants also experienced a significant increase in distress tolerance moving from a mean total score of 27.50 (*SD* = 10.46) before the programme on the DTS to 42.50 (*SD* = 11.18) after completing the programme, $z = -3.67$, $p = .001$. representing a strong effect size ($r = -0.75$).

Graph: Distress Tolerance Scale Total Scores 2021

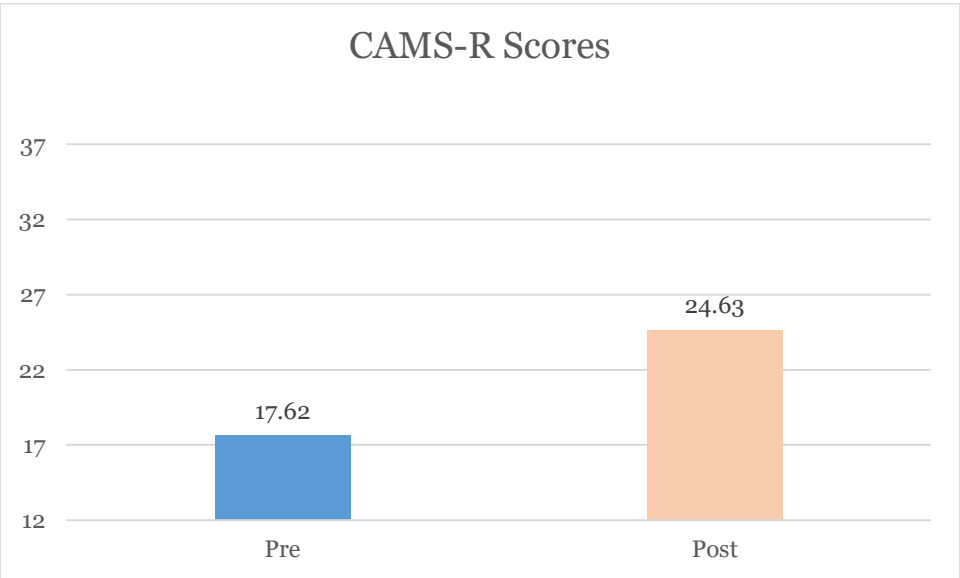


Note: Higher scores indicate increased ability to tolerate distress

Cognitive and Affective Mindfulness Scale Revised (CAMS-R)

Participants also had greater mindful qualities after completing the programme. Mean scores of 17.62 (*SD* = 2.82) at pre-intervention increased to 24.63 (*SD* = 3.84) at post-intervention. This was a statistically significant change; $t(24) = -8.11$, $p = 0.001$, and represents a large effect size ($d = -1.65$).

Graph: Mean CAMS-R Scores for Comprehensive Group

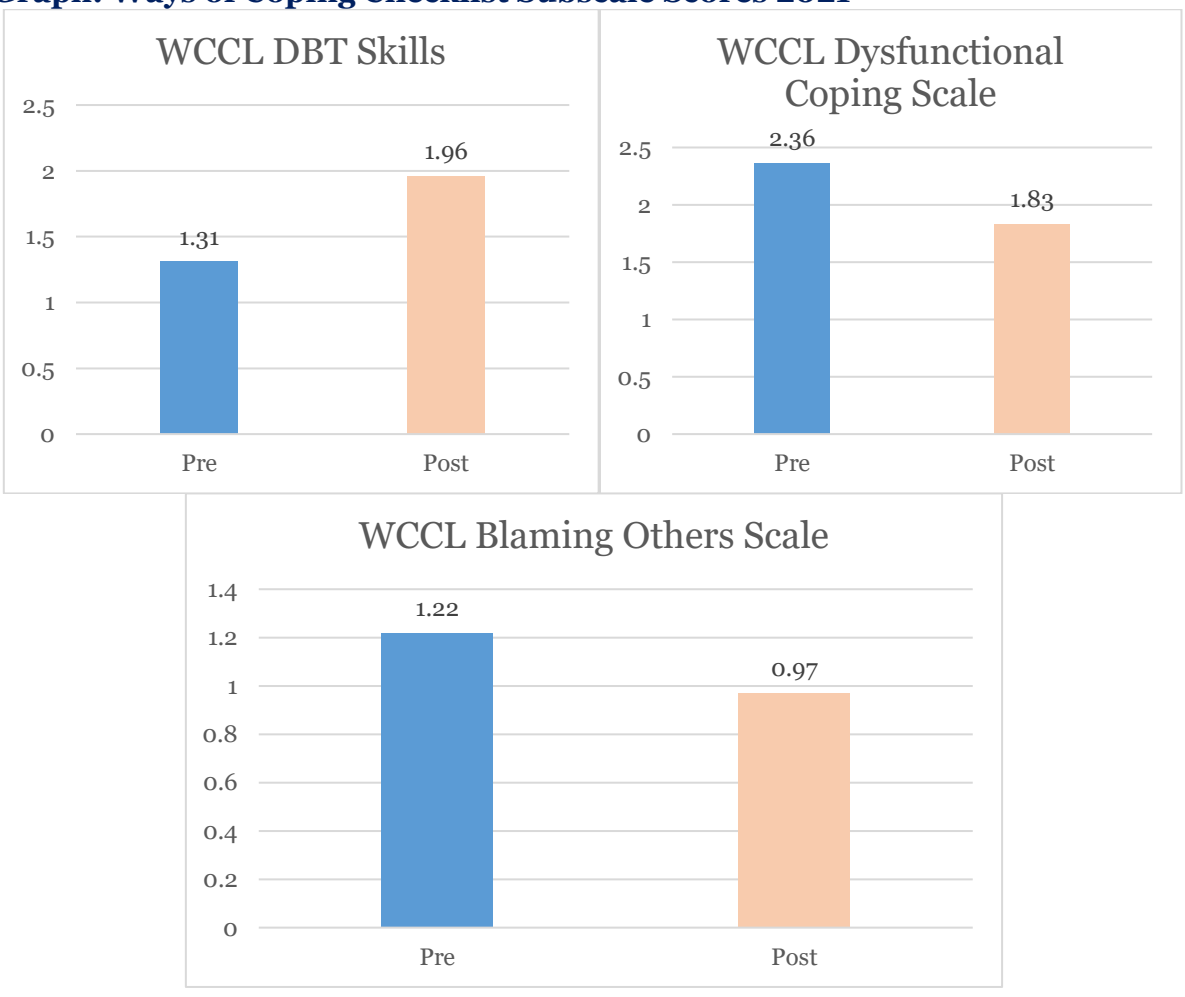


Ways of Coping Checklist (WCCL)

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 Subscale increased from 1.31 (*SD* = 0.45) at pre-intervention to 1.96 (*SD* = 0.37) at post-intervention, $t(24)= -7.03$, $p < 0.05$, with a large effect size ($d = -1.43$).

Mean scores on the General Dysfunctional Coping Subscale significantly decreased from 2.36 (*SD* = 0.30) at pre-intervention to 1.83 (*SD* = 0.47) at post-intervention, $t(24) = 4.48$, $p < 0.05$. This represented a medium effect size ($d = 0.91$). 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 1.22 (*SD* = 0.73) to 0.97 (*SD*= 0.5) post-intervention, however this result was not statistically significant. See graphs below for visual representation.

Graph: Ways of Coping Checklist Subscale Scores 2021



4.12.4. DBT Skills Only

DBT Skills Only is 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 6 months). This consists of 24 group sessions. 3 cycles ran and completed in 2021, as presented below. DBT Skills Only uses the same outcome measures as the comprehensive strand.

4.12.5. Descriptors

Complete pre and post data was available for 19 participants who completed the DBT Skills Only group in 2021. Missing Value Analysis (MVA) was carried out to account for any missing data. As the data was determined as Missing Completely at Random by Little's test (Cheng & Evanston, 2013) the Expectation Maximisation method was applied to the dataset before any total scores were computed or analyses carried out. Of these 19, 19 (100%) were female. The mean age of participants was 31.83 (SD = 10.10), ranging from 19 to 49 years. Their highest level of educational attainment ranged from junior certificate qualification (10.5%), to leaving certificate (26,.3%), to third level non-degree qualification (26.3%) to third level degree (21.1%) to postgraduate qualification (15.8%).

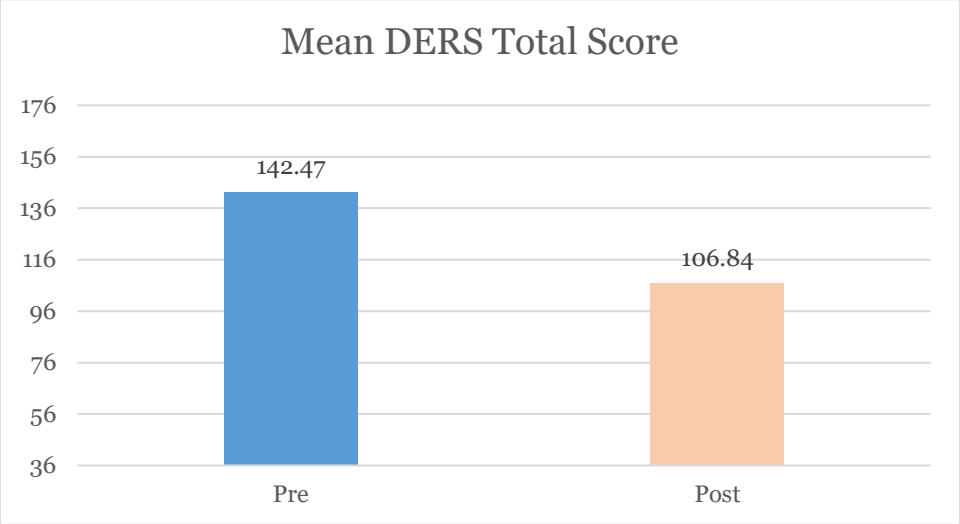
Attendees' current employment status was also recorded. 15.8% were in part-time employment, 31.6% were in full-time employment, 5.3% worked in the home, 10.5% were unemployed, 31.6% were students and 5.3% chose not to answer.

4.12.6. 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 142.47 (*SD* = 18.33) on the DERS at pre-intervention to 106.84 (*SD* = 25.22) post-completion of the programme; $z = -3.56$, $p < 0.05$. This change represented a large effect size ($r = 0.81$). See graph below for visual representation.

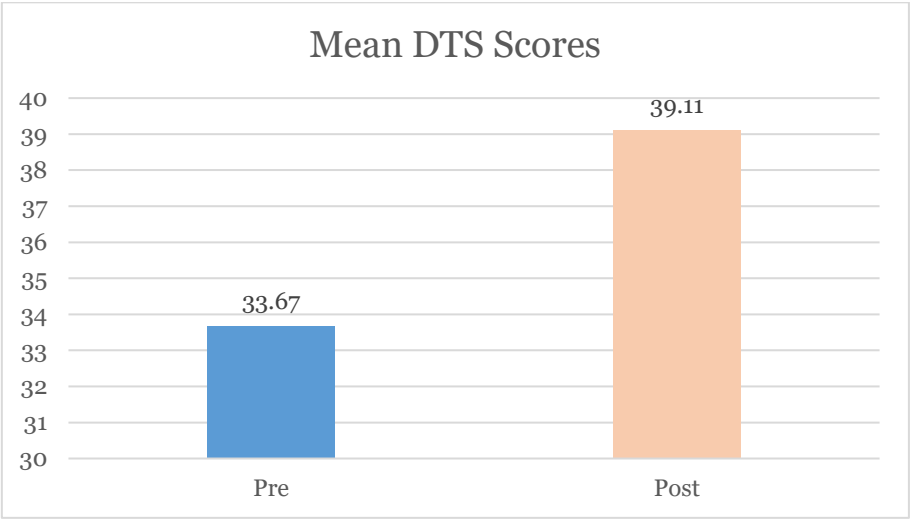
Graph: Mean DERS Scores for Skills Only Group



Distress Tolerance Scale (DTS)

Mean scores on the DTS increased following engagement in the group, from 33.67 (*SD* = 15.67) at pre-intervention to 39.11 (*SD* = 11.37) at post-intervention. However, this difference was not statistically significant, $t(19) = -1.32$, $p > 0.05$.

Graph: Mean DTS Scores for Skills Only Group

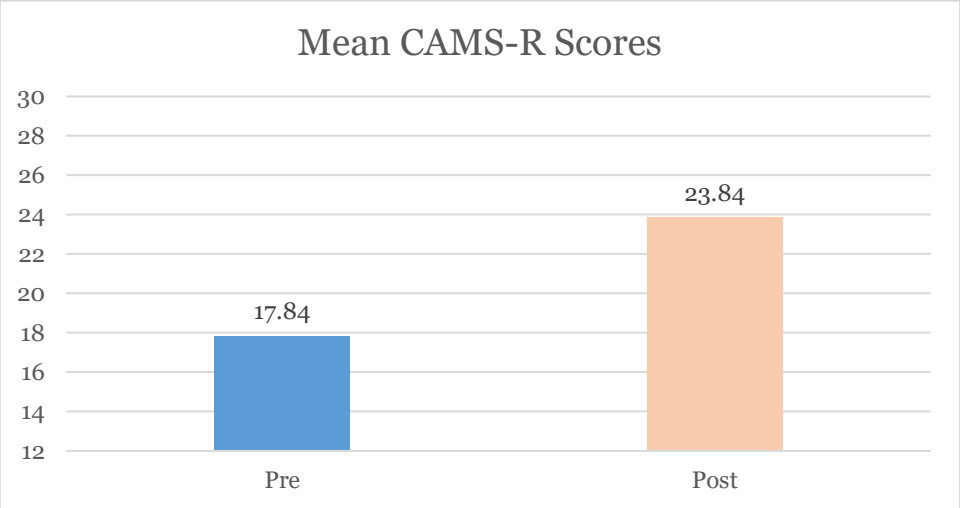


Note: higher scores indicate increased ability to tolerate distress

Cognitive and Affective Mindfulness Scores

Participants also had greater mindful qualities after completing the skills only programme. Mean scores of 17.84 (*SD* = 3.23) at pre-intervention increased to 23.84 (*SD* = 4.00) at post-intervention. This was a statistically significant change; $t(19) = -7.10$, $p < 0.001$, and represents a large effect size ($d = -1.62$).

Graph: Mean CAMS-R Scores for Skills Only



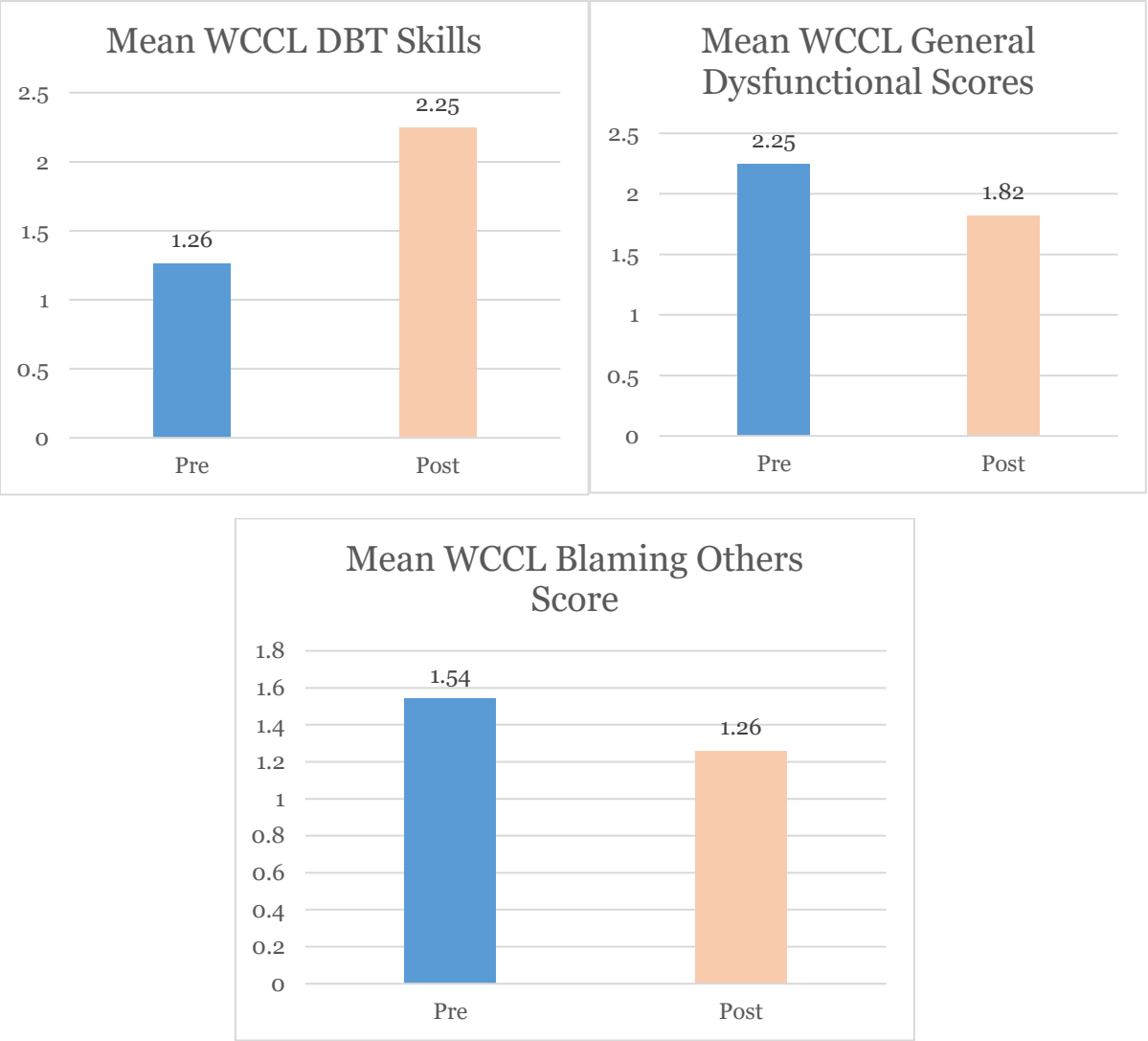
DBT Ways of Coping Checklist (WCCL)

Wilcoxon signed rank tests revealed a significant increase in the use of DBT skills ways of coping following the intervention as measured by the WCCL. The mean score for DBT skill use was 1.26 (*SD* = 0.37) pre-intervention, which rose to 2.25 (*SD* = 0.37) at post-intervention; $z = -3.70$, $p < 0.05$. This represents a large effect size ($r = -0.84$).

Mean scores on the General Dysfunctional Coping subscale decreased following the intervention, from 2.25 (*SD* = 0.37) to 1.82 (0.46); $z = -3.09$, $p < 0.05$. This represents a large effect size ($r = -0.70$).

Mean scores on the Blaming Others Subscale decreased slightly from 1.54 (*SD* = 0.88) pre-intervention to 1.26 (*SD* = 0.50) post-intervention. However, a paired samples t-test revealed this was not a statistically significant change; $t(19) = 1.30$, $p > 0.05$.

Graph: DBT Ways of Coping Checklist Scores Skills Only 2021



4.12.7. Summary

For participants with pre and post data, significant improvements were observed in use of mindfulness, coping styles, distress tolerance and emotion regulation in both the comprehensive and skills only groups. Effect size calculations demonstrated medium to large effect sizes for significant results.

The Living Through Distress Programme has now been renamed as Dialectical Behaviour Therapy (DBT). While Living Through Distress was always based on the DBT model, the name change is to reflect that the DBT program in SPMHS is delivering an intervention that is adherent to the DBT model, albeit in a shortened format.

4.13. 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 recovering from or living with psychosis. In 2021, the programme focused on offering its Level 1 group intervention, which involves ten weekly group sessions as well as a mid-way individual check-in session focused on supporting engagement and application of skills. The group is informed predominantly by CFT for psychosis (CFT; Gilbert, 2014; Heriot-Maitland et al., 2019). Service users attend an individual screening session prior to the group, which focuses on providing information about the group, assessing fit with service user needs, building rapport and identifying hopes or goals for the group.

Areas of focus in the Level 1 group include: i) developing a psychological understanding of psychosis; ii) having a safe space to connect with others about challenges associated with having experienced psychosis; iii) exploring what it means to be self-compassionate, and working on ways to develop more self-compassion, and iv) learning some new skills to cope with difficult emotions and to feel more calm/soothed. It is hoped that through addressing these areas, service users will experience a reduction in self-judgment, shame and distress relating to their experiences. Results from outcome analysis on the LTP Level 1 group are described below for the three cycles of LTP that finished in 2021. Groups continued to be delivered remotely via MS Teams in 2021 due to national public health restrictions.

4.13.1. Descriptors

19 individuals completed the LTP programme in 2021, across 3 cycles. Pre and post self-report data were available for 10 out of those 19 (53% rate of return). Programme attendees ranged in age from 20 to 65 years, with a mean age of 38.8 (SD = 15.69). 5 participants were male and 5 participants were female. Missing Value Analysis (MVA) was carried out to account for any missing data. As the data was determined as Missing Completely at Random by Little's test (Cheng & Evanston, 2013) the Expectation Maximisation method was applied to the dataset before any total scores were computed or statistical analyses carried out.

4.13.2. Living Through Psychosis Programme Outcome Measures

Data were collected on a set of measures that were identified as aligning with the above aims of the group.

- **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.

- **The Brief Symptom Inventory (BSI; Derogatis, L. R., & Savitz, K. L. (1999))**

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.

- **The Personal Beliefs about Experience Questionnaire (PBEQ) (Taylor, Pyle, Schwannauer, Hutton, & Morrison, 2015)**

The PBEQ is a 13-item self-report measure of appraisals of psychotic-like experiences, in the domains of negative appraisal of experience, external shame, and internal shame/defectiveness. Items are rated on a four-point scale (1 = strongly disagree to 4 = strongly agree). Although the measure has three scales, they have variable internal consistency so for the purpose of this report we use only the total score, range 13-52 (higher scores representing less negative appraisals of psychotic-like experiences).

- **Compassionate Motivation and Action Scale(CMAS) (Steindl, Tellegen, Filus, Seppala, Doty & Kirby, 2020)**

The CMAS offers a brief and user-friendly measure of compassionate and self-compassionate motivation and action. It encompasses two subscales, a Compassion Scale (12 items) and a Self-Compassion Scale (18 items). Within each scale, there are three subscales: compassionate intention, distress tolerance, and compassionate action.

Items are rated on a seven-point scale (1= strongly disagree to 7 strongly agree), with higher scores indicate higher levels of self-compassion.

Data was collected on the CMAS Self-Compassion Scale as part of LTP outcomes.

Qualitative feedback

A qualitative feedback form was used in 2021 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 across each of the three cycles in 2021:

- *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?*

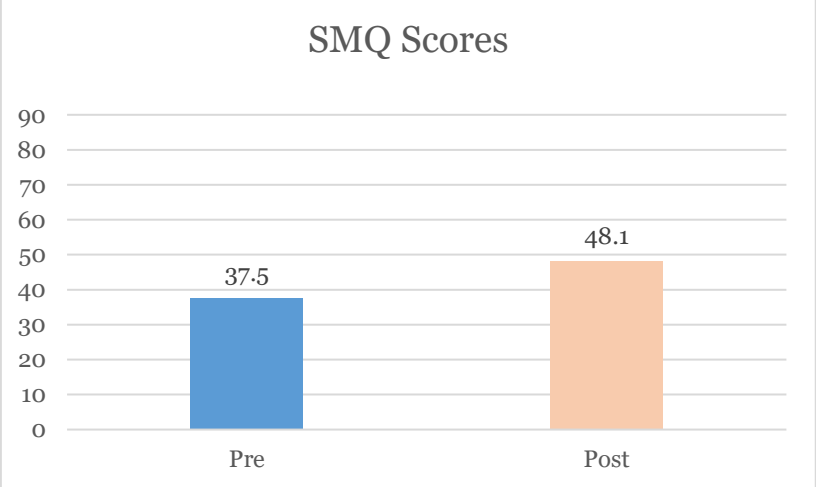
- *Is there anything that you think we could do to improve the LTP programme?*
- *Is there anything else that you would like to say about your experience of the LTP programme?*

4.13.3. Results

Southampton Mindfulness Questionnaire (SMQ)

Analysis of the SMQ indicated that individuals' tendency to mindfully respond to distressing thoughts and images significantly increased post-intervention. The mean score of 37.50 (*SD* = 4.86) increased to 48.10 (*SD* = 3.75) following the intervention; $t(10) = -2.28$, $p < 0.05$. Higher scores on this measure indicate greater mindful awareness.

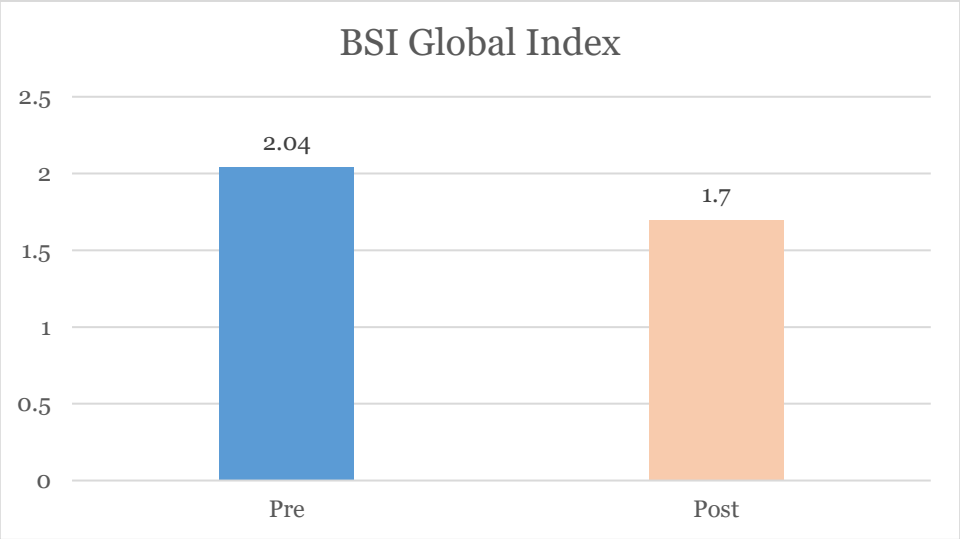
Graph: Southampton Mindfulness Questionnaire Scores



The Brief Symptom Inventory (BSI)

Global distress levels as measured by the BSI Global Index score decreased following the intervention. The mean score of 2.04 (*SD* = 0.65) pre-intervention fell to 1.70 (*SD* = 0.53) post-intervention. However, this difference was not statistically significant; $z = -1.36$, $p > 0.05$.

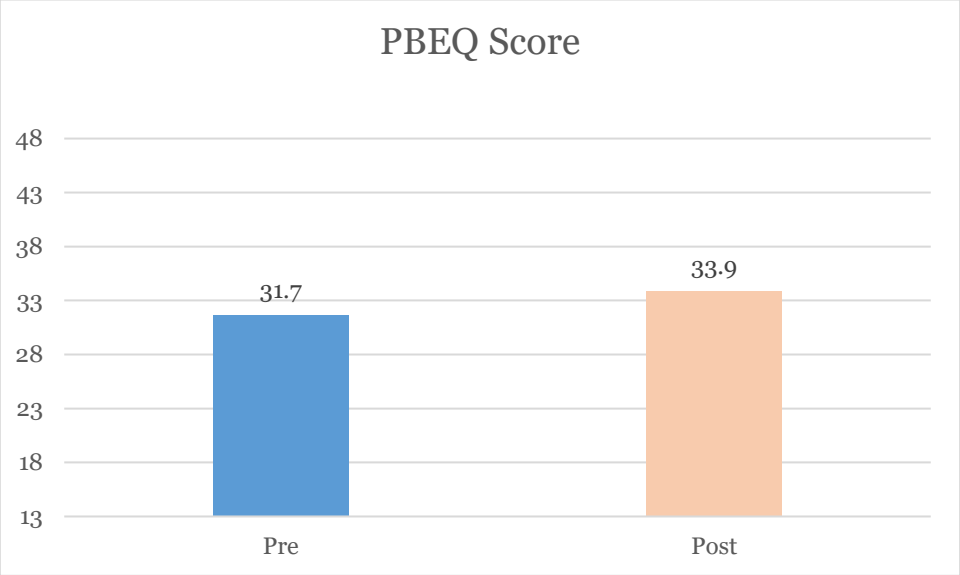
Graph: Brief Symptom Inventory (BSI) Scores



The Personal Beliefs about Experiences Questionnaire (PBEQ)

Mean scores on the PBEQ increased slightly following engagement with the programme. The mean score beforehand was 31.70 (*SD* = 4.96), this increased to 33.90 (*SD* = 7.09) at post-intervention. This increase in score reflects a reduction in negative appraisals of psychotic like experiences, however, this increase was not statistically significant; $t(10) = -1.23$, $p > 0.05$.

Graph: Personal Beliefs about Experiences Questionnaire Scores

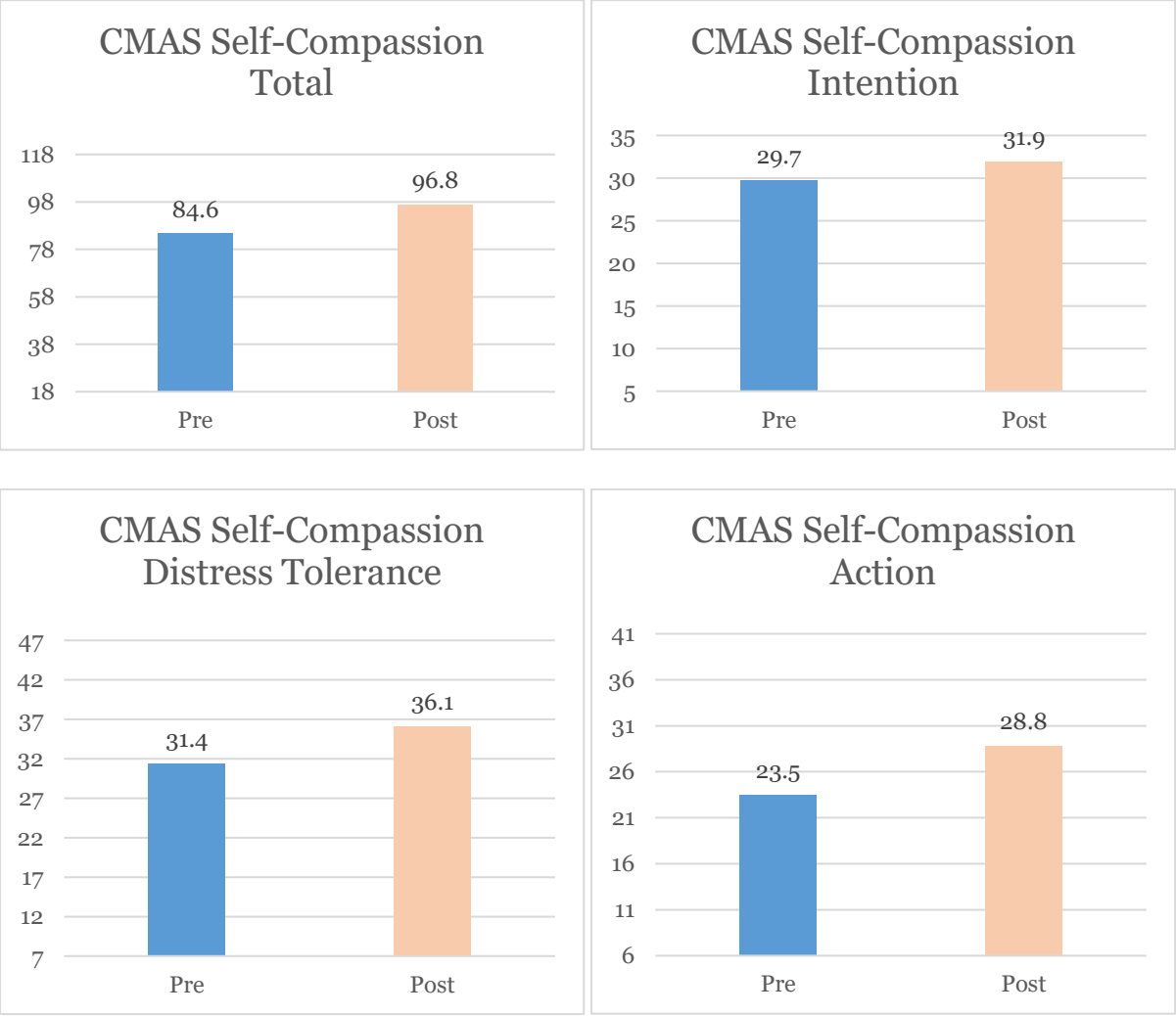


Compassionate Motivation and Action Scales (CMAS) – Self Compassion Scale

Mean scores on the CMAS Self Compassion Scale increased from 84.60 (SD = 16.08) to 96.80 (*SD* = 14.29) following engagement in the programme. However, this increase was not statistically significant; $t(10) = -1.67$, $p > 0.05$.

The three subscales within the Self Compassion Scale were analysed. The compassionate intention subscale mean score also increased from 29.70 (*SD* = 1.29) to 31.90 (*SD* = 0.98), the distress tolerance subscale mean score also increased from 31.40 (*SD* = 2.13) to 36.10 (*SD* = 2.28) and the compassionate action subscale mean score increased from 23.50 (*SD* = 2.91) to 28.80 (*SD* = 2.48), however these results were not statistically significant.

Graph: CMAS Total Scores and Subscales



Qualitative Feedback

Is there anything that you found *helpful* about attending the LTP programme?

Several services users reported finding the tools and skills taught in LTP to be helpful. These included practices focused on grounding and noticing emotional states, on developing a capacity for mindful awareness, and on accessing a felt sense of compassion for oneself.

> *I found it helpful that the course has equipped me with some valuable tools which may aid me when I'm distressed or in a "threat" zone.*
>
> *The tools and exercises really helped to accept that I may have tricky feelings in the future but I'm more prepared to deal with them.*

Some services users also named the CFT three systems emotion regulation model ("*threat, drive or soothe*") as helpful, including one who explained that it allowed her to notice and bring understanding to her own internal emotional state.

Some described connecting with other people as helpful as it offered a chance to connect with others who had similar experiences. Others spoke of the value of gaining insight into different perspectives.

One services user spoke of valuing a psychological perspective on psychosis:

> *A psychologist's explanation of what psychosis is has helped me to finally accept that I have a mental health problem. I am more aware of it now and know how to keep well now and in the future. This helped me a lot.*

Some noted feeling as though LTP provided "*a safe place to speak*" and open up about their feelings. For some service users, learning to respond to themselves with more compassion was identified as helpful. For example, one spoke of "*changing my reactions/beliefs and conclusions I draw about myself to be more kind, accepting and compassionate*".

Is there anything that you found *unhelpful* about attending the LTP programme?

One service user reported difficulties with emotional processing during LTP. They stated that "*It can be hard interpreting your own feelings as well as other people's feelings*".

Another person described the online format of the group to be challenging:

> *In terms of cohesiveness the course would not be at its optimum level because it was carried out fully on a remote basis. In addition, there were intermittently some minor problems with the technology we used.*

Some service users named finding the "*slow pace*" of group difficult at times, however one reported that "*by the end [they] found the pace helped in accessing the soothing compassionate side of [their] self*".

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

Overall, service users suggested that more taught skills and tools could be helpful for them, as well as the possibility of extending the group to run for a longer period of time,

> *In my experience, it took me a few weeks to feel comfortable and open up, so if the programme was to run for longer or there was a follow up every few weeks to touch base that could help.*

The majority of service users informed us that they would be open to attending a longer Level 2 Living Through Psychosis therapy group.

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

Service users described engaging with LTP as a valuable experience which would be highly recommended to other service users:

> *It was tough at the start but I really value the experience and highly recommend it to continue for other service users. Reflecting on my stay in St Pat's I really feel this course was most helpful and beneficial.*

Some advised that the taught skills in LTP have been helpful in managing symptoms associated with experiences of psychosis and further elaborated on a wider positive impact on coping with comorbid difficulties, such as addiction.

One person reported that LTP was "*a very helpful program that I got huge value from and will miss very much as time went on it become more of a help to me as I learned to understand practicing compassion more*".

4.13.4. 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 and living with psychosis. The results of this analysis indicate that group members appear to be developing their capacity for mindful, non-judgmental awareness of distressing thoughts and images in particular. It is important to consider the impact of the small sample size when measuring significant change. Qualitative feedback suggests that overall, service users attending LTP in 2021 found the group helpful. Aspects that appear to be most helpful include the development of new ideas about psychosis as well as new practices and coping skills, connecting with others who have had similar experiences, and learning about self-compassion. The qualitative feedback also provides helpful steer in terms of improving and developing the programme for future service users. The LTP team will continue to develop the programme offering during 2022 in order to address the psychological needs of service users with psychosis.

4.14. Mindfulness Programme

The Mindfulness Programme provides eight weekly group training sessions in mindful awareness in SEH. The course is offered in the evening in order to accommodate service users. The group is facilitated by staff trained with Level 1 Teacher Training in Mindfulness from Bangor University, Wales. The programme aims to introduce service users to the practice of mindfulness for stress reduction through group discussion and experiential practices. The programme aims to help service users develop the ability to pay attention to the moment and to be more aware of thoughts, feelings and sensations in a non-judgemental way. Developing and practising this non-judgemental awareness has been found to reduce psychological distress and prevent relapse of some mental ill-health experiences (see Piet & Hougaard, 2011).

4.14.1 Descriptors

Data was collected on 37 participants; 12 males (32.4%) and 25 females (67.6%). Pre and post data were available for 23 participants. Participants' age ranged from 18 to 69 years old (*M*= 47 years).

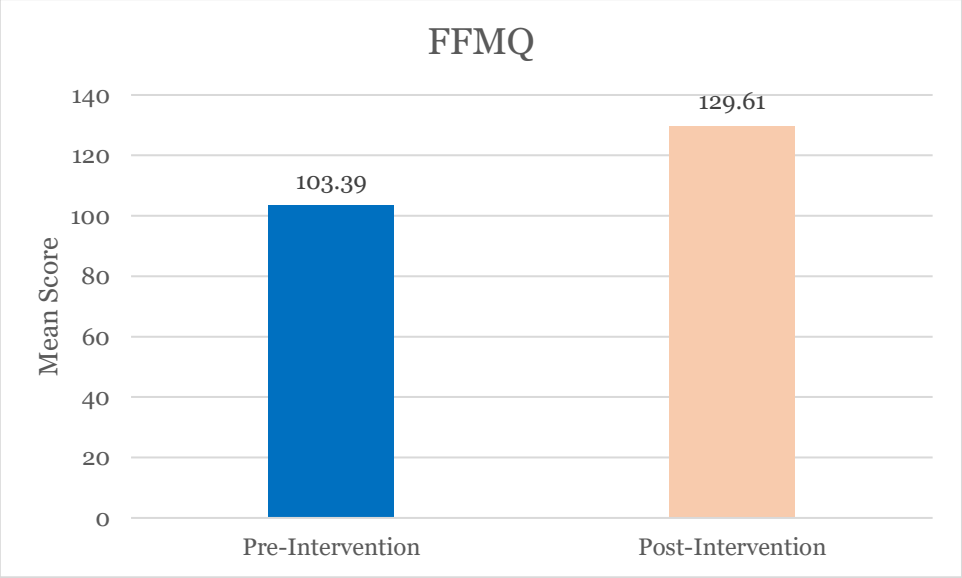
4.14.2. Mindfulness Programme outcome measures

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).

4.14.3 Results

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=103.39; SD=21.614) to post-intervention (M=129.61; SD=19.26). A t-test revealed a statistically significant increase in FFMQ total scores following participation in the programme, t (22) = -6.932, p<.001, with a large effect size (Cohen's d = 1.28). 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. 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	23.48 (5.4)	29.60 (4.0)	-6.103	22	**.001***	1.28
Describe	24.43 (6.7)	29.60 (5.60)	-4.519	22	**.001***	0.83
Awareness	18.60 (5.3)	23.70 (6.0)	-4.357	22	**.001***	0.49
Non-Judgement	19.91 (7.9)	25.09 (7.6)	-4.346	22	**.001***	0.45
Non-Reactivity	16.96 (4.8)	21.60 (4.2)	-4.665	22	**.001***	1.06

4.14.4. Summary

In line with the 2020 report, results for 2021 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 large effect size apparent for changes on the measure overall.

4.15. 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 Dialectical Behaviour Therapy Adolescence (DBT-A), Radically Open Dialectical Behaviour Therapy (RO-DBT), and Group Radical Openness (GRO). 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, Managing Emotions, Distress Tolerance, Relationships (Interpersonal Effectiveness), and Walk the Middle Path. Modules vary in length between one and six sessions.

4.15.1. Descriptors

In 2021, 11 families participated in PSG-A. Of these 11, 3 families withdrew from the programme and their data has been excluded due to the absence of time 2 measures. Their demographic data will be included here for descriptive analyses. Pre and post data were available for 8 families. The average age of young people attending was 16 years. 9 of the young people were female, 1 was male and 1 was transgender. 4 of the parents were male and 9 of the parents were female.

4.15.2. Psychology Skills Group for Adolescents Outcome Measures

The Psychology Skills Group for Adolescents outcome measures were revised in August 2020 to better reflect the areas of skills development and change targeted in the programme. The Difficulties with Emotion Regulation Scale (DERS) and DBT Ways of Coping Checklist (DBT-WCCL) were retained as they reflect core constructs of interest in the programme. The Brief Reasons for Living Scale – Adolescents (BRFL-A) was added as a means of examining the meaningfulness of protective factors present in the young people's lives. The Parent-Adolescent Communication Scale (PACS) was also introduced given that interpersonal effectiveness is a key area of skills development targeted in the group and parents play an active role in the group process. Lastly, the Over and Undercontrolled Traits Measure for Adolescents (OUT-Ma) was added in order to evaluate both domains of control which present to

varying degrees in the young people attending the programme. The Borderline Symptom List – 23 Items (BSL-23), Child Behaviour Checklist (CBCL), and Adolescent Psychopathology Questionnaire (APS) were discontinued.

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

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) was completed by young people at pre and post intervention. This DERS assesses emotion dysregulation and comprises six subscales: Non-Acceptance of Emotional Responses (NONACCEPT), Difficulties Engaging in Goal-Directed Behaviour (GOALS); Difficulty with Impulse Control (IMPULSE); Lack of Emotional Awareness (AWARE); Limited Access to Emotion Regulation Strategies (STRATEGIES), and Lack of Emotional Clarity (CLARITY). The measure consists of 36 items scored on a five-point Likert scale (1 = almost never; 5 = almost always). Total scale scores range from 36 to 180 with higher total scores indicating greater difficulties in emotion regulation. The DERS demonstrates good internal consistency (α = .93), construct and predictive validity, and test-retest reliability (Gratz & Roemer, 2004).

- **DBT Ways of Coping Checklist (DBT-WCCL)**

The DBT Ways of Coping Checklist (DBT-WCCL; Neacsiu, Rizvi, Vitaliano, Lynch, & Linehan, 2010) was completed by young people and parents at pre- and post-intervention. The DBT-WCCL assesses use of DBT skills and comprises of two subscales: the DBT Skills Subscale (DSS) and the Dysfunctional Coping Subscale (DCS). The measure consists of 59 items scored on a four-point Likert scale (0 = never used; 3 = regularly used). Higher mean scores on the DSS indicate greater use of DBT skills while higher mean scores on the DCS indicate greater use of unhelpful coping behaviours. This measure has shown good to excellent internal consistency, test-retest reliability, and content validity (Neacsiu et al., 2010).

- **Brief Reasons for Living Scale – Adolescents (BRFL-A)**

The Brief Reasons for Living Inventory – Adolescents (BRFL-A; Osman et al., 1996) was completed by young people at pre and post intervention. The BRFL-A assesses factors protecting against suicidal behaviour in adolescents and is comprised of five subscales: Family Alliance (FA), Suicide-Related Concerns (SRC), Self-Acceptance (SA), Peer-Acceptances and Support (PAS), and Future Optimism (FO). In the BRFL-

A, specific reasons that people might have for not ending their life are presented and participants are asked to rate how important each reason is to them for staying alive. The measure consists of 32 items scored on a six-point Likert scale (1 = not at all important; 6 = extremely important). Higher mean scores on subscales indicate greater perceived importance of factors protecting against suicide. The BRFL-A demonstrates good internal consistency and good construct, convergent, predictive, and discriminant validity (Osman et al., 1996).

- **Parent-Adolescent Communication Scale**

The Parent-Adolescent Communication Scale (PACS; Barnes & Olson, 1985) was completed by young people at pre and post intervention. The PACS assesses the quality of communication between parents and adolescents and is comprised of two subscales, Open Family Communication and Problems in Family Communication, which are combined to provide an overall estimate of parent-adolescent communication. The measure consists of 20 items scored using a five-point Likert scale (1 = strongly disagree; 5 = strongly agree). Total scale scores range from 20 to 100 and higher scores are indicative of better parent-adolescent communication. The PACS demonstrates good internal consistency and test-retest reliability (Barnes & Olsen, 1985).

- **Over and Under Controlled Traits Measure for Adolescents (OUT-Ma)**

The Over and Under Controlled Traits Measure for Adolescents (OUT-Ma; James et al., in preparation) was completed by young people at pre and post intervention. The OUT-Ma assesses traits of over and under control in adolescents and is comprised of two subscales: Over control (OC) and Under control (UC). In the OUT-Ma, traits of over and under control are presented and participants are asked to rate how characteristic each trait is of them. The measure consists of 25 items scored on a seven-point Likert scale (0 = not at all; 6 = extremely). Higher mean scores on the OC and UC subscales are indicative of higher levels over and under controlled traits, respectively. The OUT-Ma is currently undergoing validation in the adolescent community population.

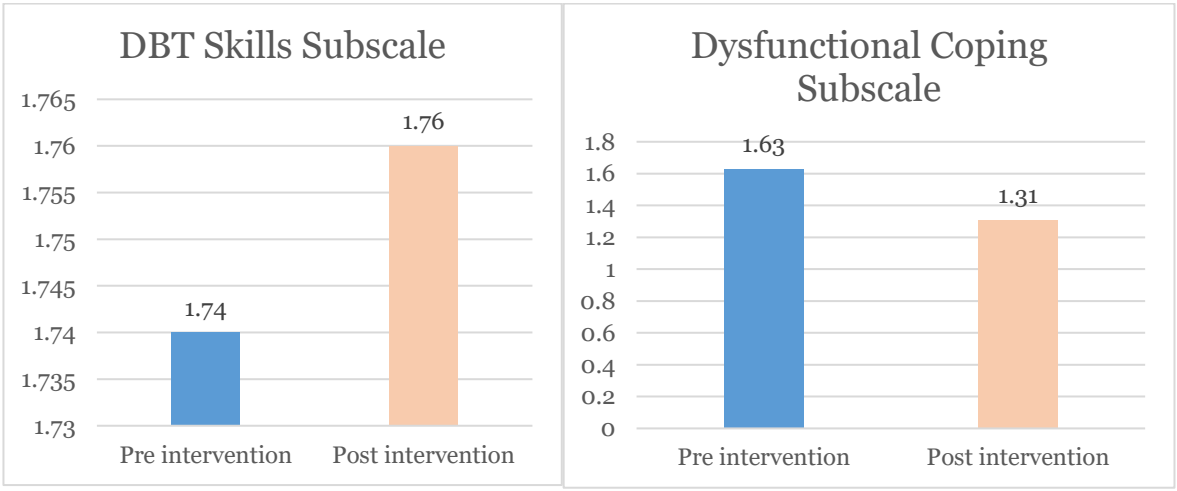
4.15.3. Results

DBT Ways of Coping Checklist (DBTWCCL)

The DBTWCCL is completed by parents and young people. Scores obtained demonstrate that DBT skill use (DSS) increased slightly from pre-intervention to post-intervention. At pre-intervention, parents and young people had a mean DSS score of 1.74. Post-intervention, parents and young people achieved a mean DSS score of 1.76. Paired sample t-tests indicated that this was not a statistically significant change, whereby t (16) = -0.175, $p > 0.05$.

Scores on the Dysfunctional Coping Skills subscale (DCS) decreased from pre-intervention to post-intervention amongst parents and young people. At pre-intervention, parents and young people had a mean score of 1.63 on the DCS. At post-intervention, this decreased to 1.31. Paired sample t-tests indicated that this was a statistically significant change, whereby t (16) = 2.61, $p < 0.05$.

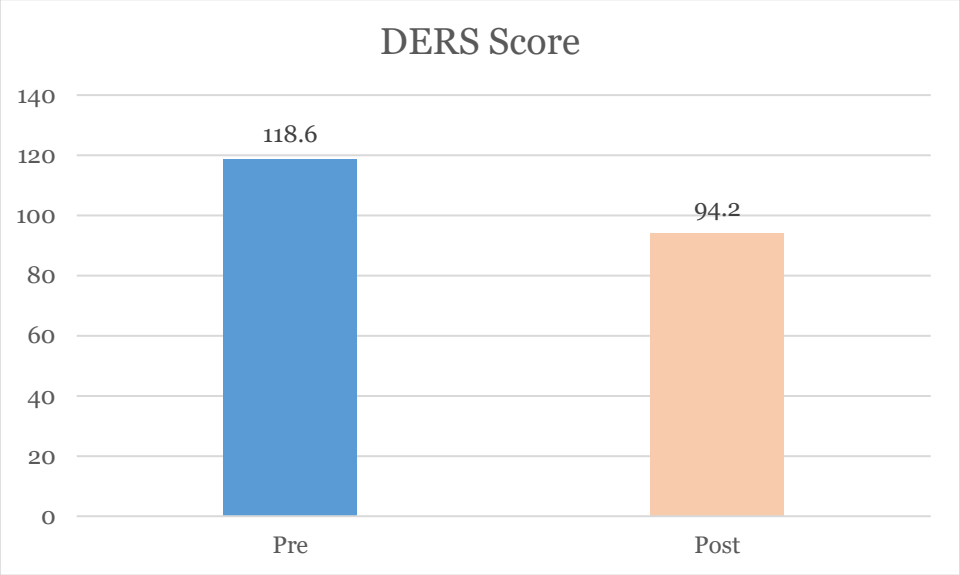
Graph: DBT Ways of Coping Checklist Scores



Difficulties in Emotion Regulation Scale (DERS)

This measure is completed by young people only. Pre and post intervention data were available for N=8. Analysis showed total difficulties in regulating emotions decreased from pre-intervention (M=118.6, SD = 28.2) to post-intervention (M=94.2, SD = 20.8). Paired sample t-tests indicated that this was a statistically significant change, whereby $t(8) = 3.95$, $p < 0.05$, reflecting a large effect size (d = 1.39).

Graph: DERS Scores

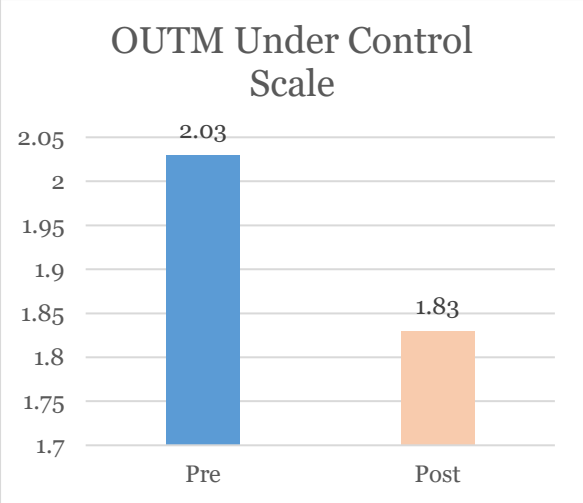


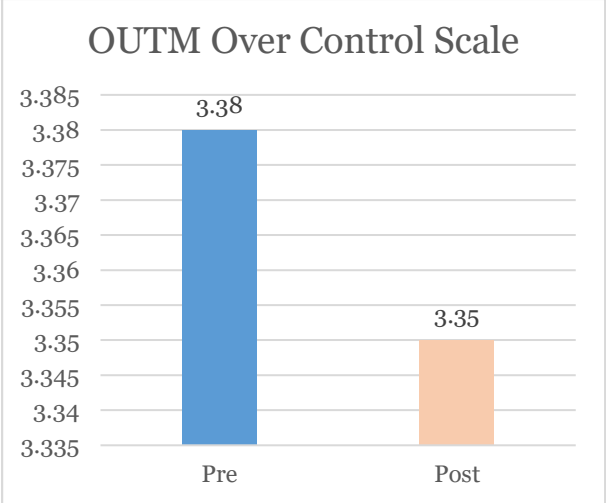
**note: lower scores indicate decreased difficulty in regulating emotions*

Adolescent Over and Under Control Trait Measure (OUTM)

The Adolescent Over and Under Control Trait Measure (OUTM) is comprised of two subscales, one measuring one measuring under control traits and one measuring over control traits. Pre-intervention, the mean under control subscale score was 2.03 (*SD* = 1.24). Post intervention, this fell to 1.83 (*SD* = 1.14). however, this difference was not statistically significant $t(8) = 1.93$, $p > 0.05$.

Pre-intervention, the mean over control score was 3.38 (*SD* = 0.94). Post intervention, this fell 3.35 (*SD* = 0.88). However, this difference was not statistically significant; $t(8) = 0.23$, $p > 0.05$. Numerically, these findings suggest over control and under control traits decreased following engagement in the intervention, however this did not prove to be statistically significant.

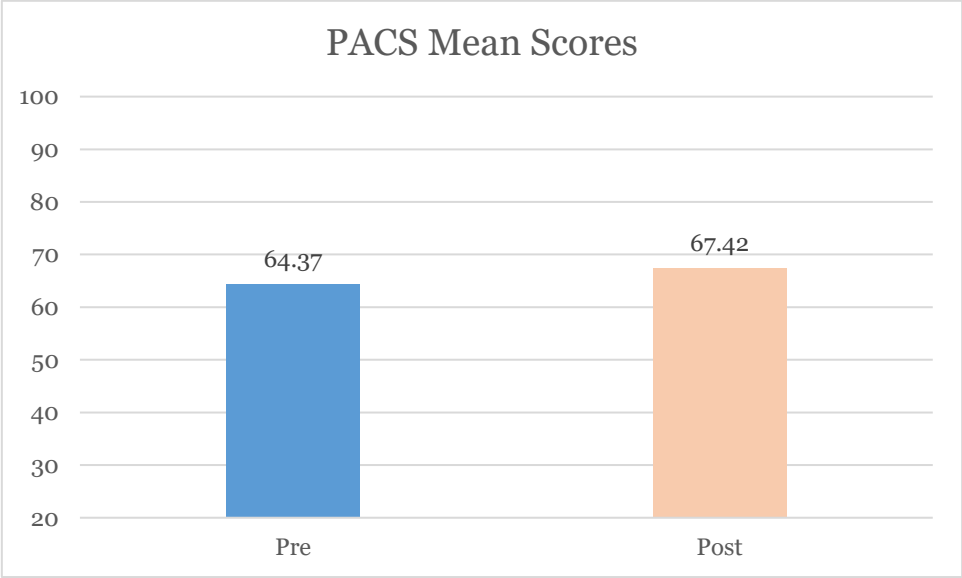




Parent Adolescent Communication Scale (PACS)

Pre-intervention, the mean PACS score was 64.37 (*SD* = 12.36). Post-intervention, this increased to 67.42 (*SD* = 7.97). However, this difference was not statistically significant; z = -0.67, $p > 0.05$. Numerically, these findings suggest communication between young people and their parents improved following engagement in the intervention, however this did not prove to be statistically significant.

Graph: Mean PACS scores



Brief Reasons for Living Inventory – Adolescent (BRFL-A)

Pre-intervention, the mean BRFLA score was 3.76 (SD = 0.24). Post-intervention, this increased to 4.47 (SD = 0.18). A paired samples t-test revealed this difference to be statistically significant; $t(8) = -5.44$, $p < 0.05$. These findings suggest that young people experienced an increase in the protective factors present in their lives, suggesting that following engagement in the intervention, participants had increased reasons to live.

4.15.4. Summary

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

The findings presented provide a meaningful insight into the effectiveness of the programme. The results indicate that by attending the group, young people developed an increased capacity to regulate their emotions. Young people who completed the group also evidenced an increase in the use of DBT skills when coping with difficulty and a decrease in use of dysfunctional or harmful coping mechanisms. Young people also reported less over control and under control traits following the programme and increased reasons to live. Their endorsement in protective factors against harm to themselves also increased following attendance.

4.16. (Group) Radical Openness Programme

Group Radical Openness (GRO) is a transdiagnostic group therapy intervention for individuals who are overcontrolled. GRO was developed in St Patrick's Mental Health Services. It is a distinct group therapy approach where the clients become the main agent of change. Difficulties associated with overcontrol fall under three core themes that are explicitly addressed in GRO; Distance in Relationships, Rigidity, and Inhibited Emotion.

Difficulties in all three themes are seen as key protective mechanisms that are important and needed at different points in the individual's life, but are having a

negative impact. Thus, the core aim of GRO is to *experience* change within the group, with peers, which can then be generalised to life outside group. Although treatment resistant depression, certain eating disorders, and a variety of avoidant personality styles may seem very different, we have found that targeting the underlying mechanism (i.e. the overcontrol), leads to much better outcomes for our service users. GRO is offered over a five-month period, twice a week for 11 weeks and then once a week for four weeks.

4.16.1. Descriptors

A total of 42 people completed the GRO programme in 2021. Pre and post outcome data were available for 35 people, representing an 83% return rate. 54% of the participants were female and 46% were male. Participant's ages ranged from 20 years to 64 years (M=40.29, SD=13.62).

4.16.2. Group Radical Openness Programme outcome measures

The GRO programme has five outcome measures that explore change in the key areas targeted by the programme. These are; the Five Factor Obsessive Compulsive Inventory (Short Form) (FFOCI-SF), the Brief Symptom Inventory (BSI), the Revised Adult Attachment Scale (RAAS), the Personal Need for Structure Scale (PNS), and the Emotion Regulation Questionnaire (ERQ).

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

The FFOCI-SF (Griffin et al., 2018) is a 48-item self-report questionnaire that explores traits of obsessive-compulsive personality disorder (OCDP) that are associated with overcontrol. The FFOCI-SF is based on the conceptual framework of the five-factor model of personality. The questionnaire is made up of 12 sub-scales: excessive worry, detached coldness, risk-aversion, constricted, inflexibility, dogmatism, perfectionism, fastidiousness, punctiliousness, workaholism, doggedness, and ruminative deliberation. Each item is rated on a five-point Likert scale from one (strongly disagree) to five (strongly agree). Higher scores indicate greater identification with OCPD traits.

Research has found that the FFOCI-SF has good psychometric properties with strong internal and external validity, and strong reliability with a Cronbach's alpha ranging

from .77 to .87 (Griffin et al., 2018). 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). This report focuses on total scores of the FFOCI to determine overall levels of overcontrol.

- **Brief symptom Inventory (BSI)**

The BSI (Derogatis & Melisartos, 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.

- **Revised Adult Attachment Scale – Close Relationships Version (RAAS)**

The RAAS (Collins, 1996) is an 18-item measure of relationship attachment. It contains three sub-scales: Close, Depend, 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 Close and Depend sub-scales indicate greater comfort with closeness and intimacy (depending on others) 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).

- **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). Higher scores indicate greater desire for structure and a dislike for unstructured and unpredictable situations (inflexibility). 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).

- **Emotion Regulation Questionnaire (ERQ)**

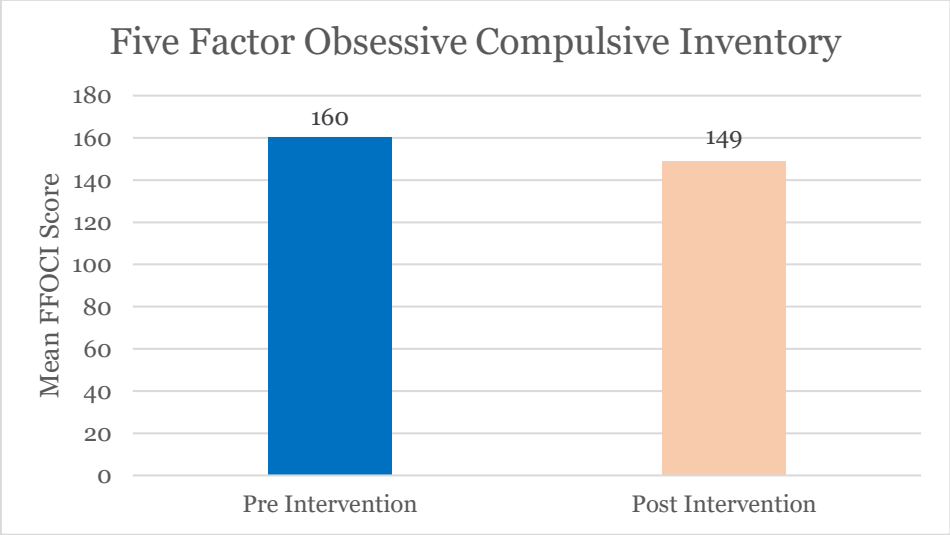
The ERQ (Gross & John, 2003) is a 10-item self-report measure of two emotion regulation strategies: Cognitive Reappraisal and Expressive Suppression. Cognitive Reappraisal describes the process of confronting automatic thoughts and assumptions and reframing them in a more helpful way. Expressive Suppression describes the ability to control or suppress responding to emotional experiences. Participants 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, and convergent and discriminant validity (Preece, Becerra, Robincon et al. 2019).

4.16.3. Results

Five Factor Obsessive Compulsive Inventory (Short Form)

A significant change was observed on the FFOCI-SF, whereby t (34) = 4.975, p< .001, reflecting a small effect size (Cohen's d = 0.47). This suggests that after completing the programme participants were experiencing a reduction in overcontrolled traits associated with OCPD.

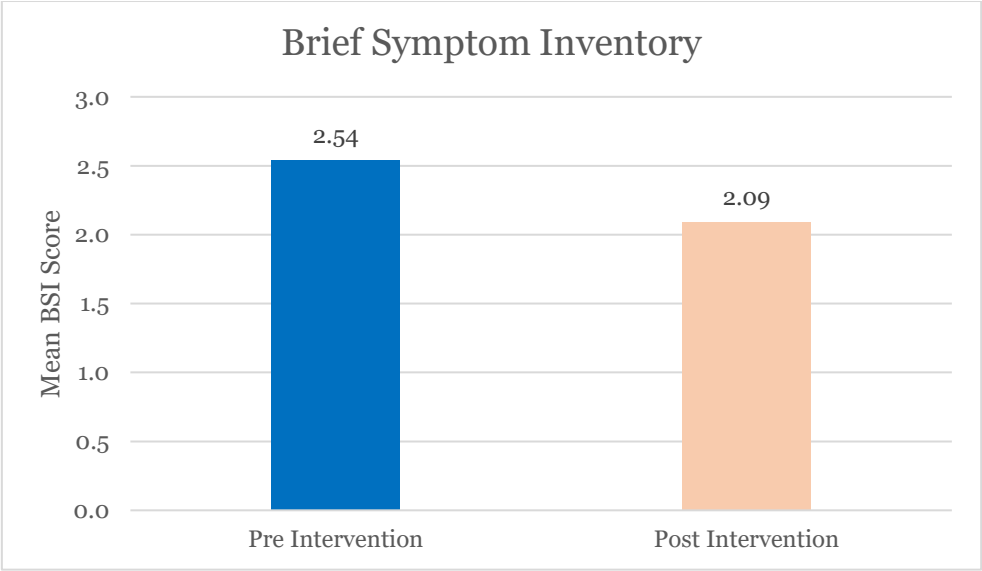
Graph: Five Factor Obsessive Compulsive Inventory – Short Form. Mean Total Scores Pre and Post Intervention



Brief Symptom Inventory

A significant reduction in service users' psychological distress was also observed after completing the programme. This was shown by a reduction in mean scores on the Global Severity Scale of the BSI, whereby t (34) = 4.474, p<.001, reflecting a medium effect size (*Cohen's d*= 0.79).

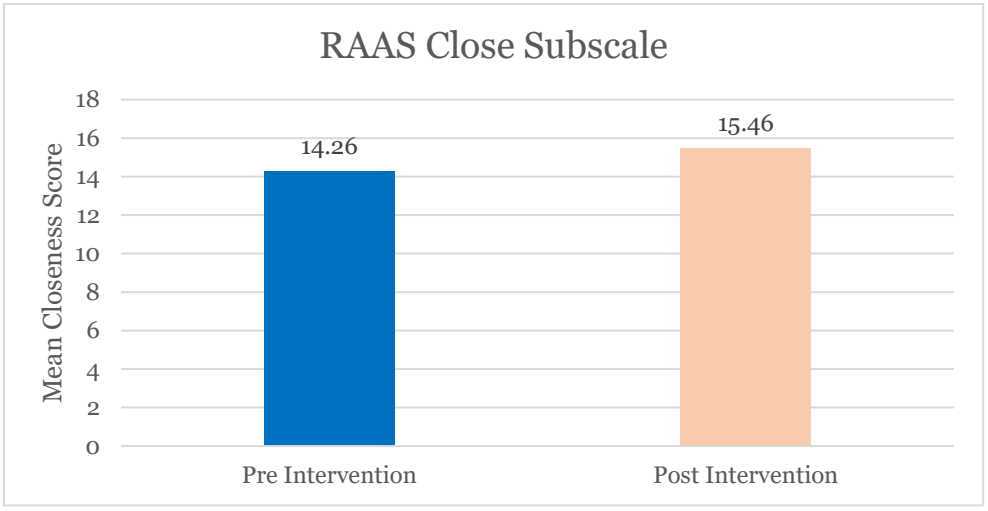
Graph: Brief Symptom Inventory, Global Severity Index (GSI) Pre and Post Intervention Mean Comparison

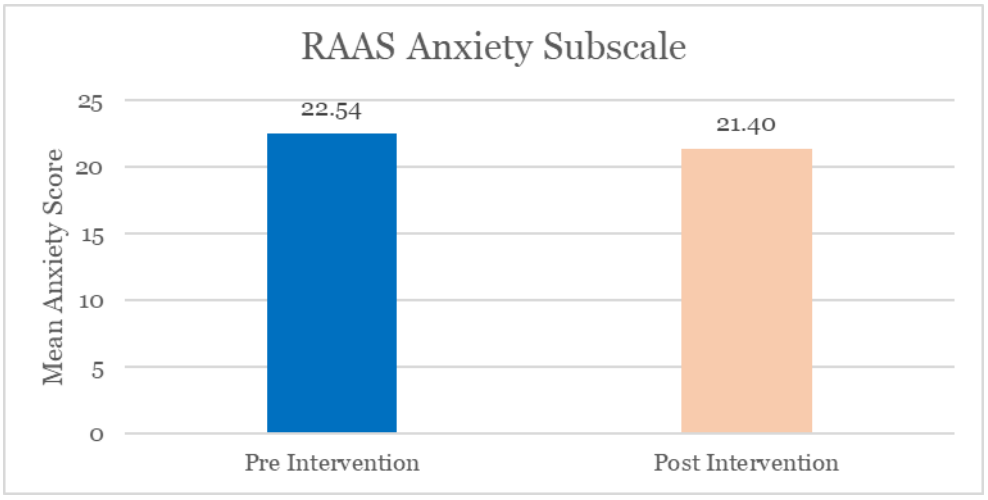


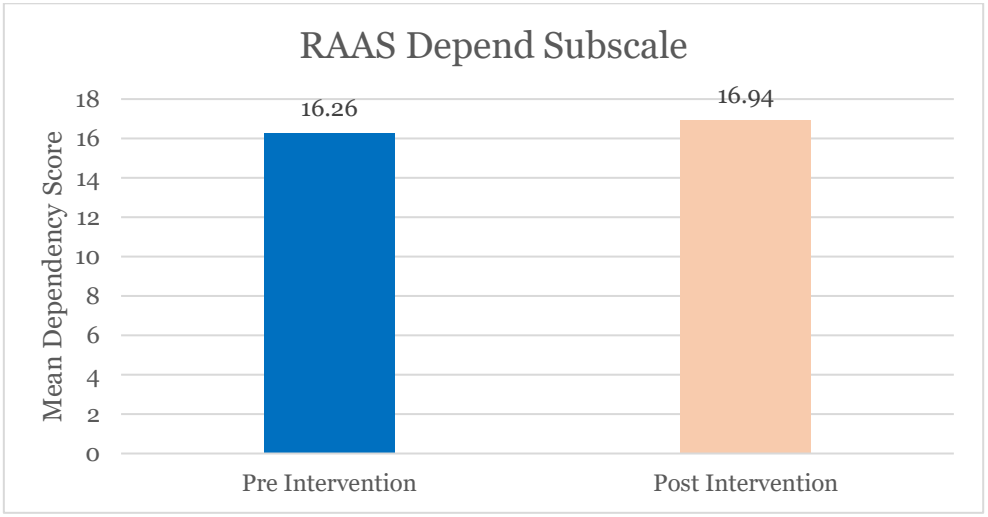
Revised Adult Attachment Scale – Close Relationships Version

There was no statistically significant difference on the Close, Anxiety, or Depend sub-scales pre and post intervention. Results indicate that participants' comfort with closeness and the extent to which they feel they can depend on others, and their anxiety levels with regards to fears of being rejected did not significantly change after completing the programme. However, there is a trend towards an improvement on all three subscales post intervention.

Graph: Revised Adult Attachment Subscales Mean Total Score Pre and Post Intervention



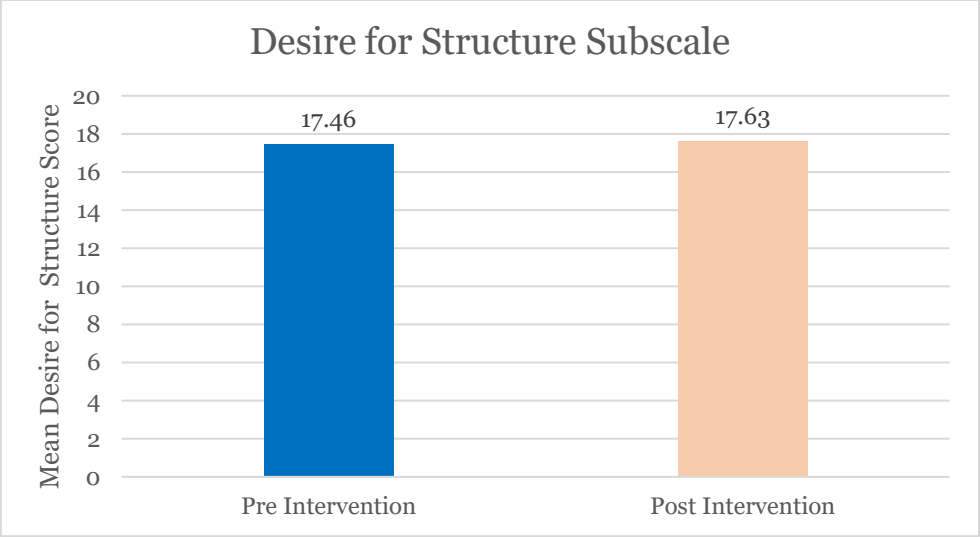


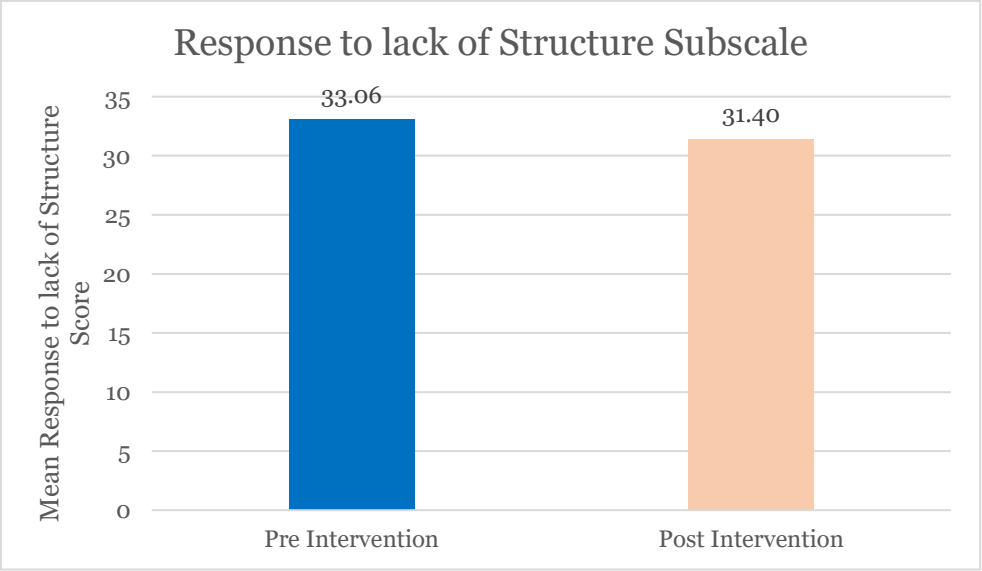


Personal Need for Structure

Significant change was observed on one of the two subscales of the PNS, Response to Lack of Structure, where t (34) = 2.090, $p < .05$, reflecting a small effect size (Cohen's d=0.31). 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 Score Pre and Post Intervention

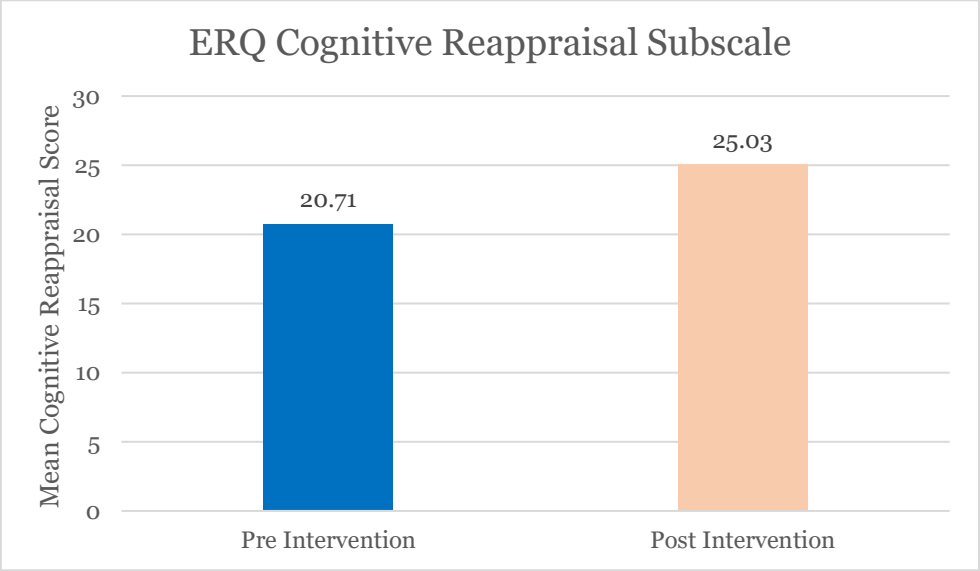


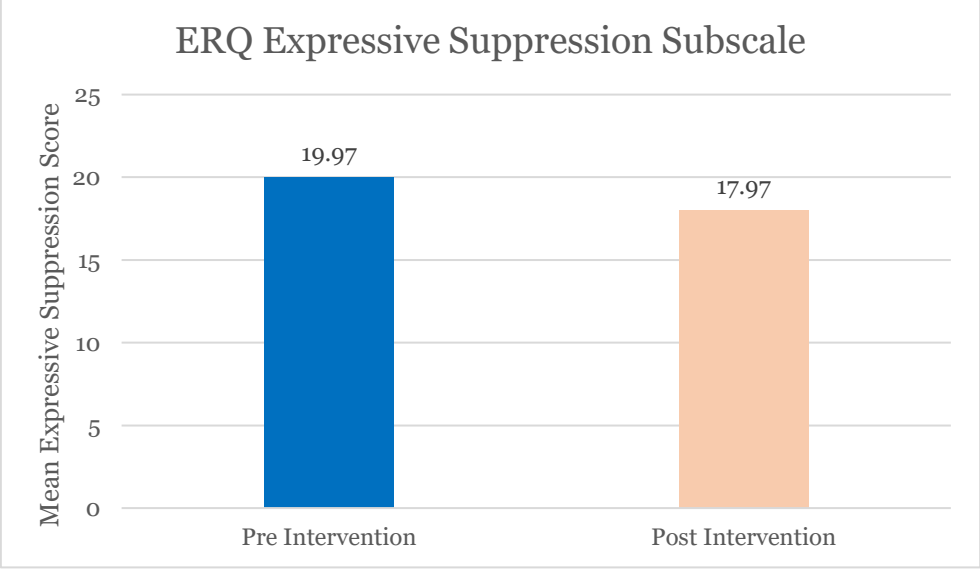


Emotion Regulation Questionnaire

Significant change was observed in the Expressive Suppression subscale whereby t (34) = 3.104, p < .001, with a medium effect size (Cohen's d=0.57). This suggests that participants reported less suppression of their emotions following completion of the programme. There was also a statistically significant difference on the Cognitive Reappraisal subscale t (34) = 2.412, p < .05, with a small effect size (Cohen's d=0.39). This suggests that participants demonstrated statistically significant improvements in their ability to reappraise unhelpful cognitions regarding emotions following completion of the programme.

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





4.16.4. Summary

The Group Radical Openness (GRO) programme helps individuals develop understanding and awareness of their overcontrol. The programme targets and encourages new ways of coping that are less costly and less harmful.

In 2021, service users who completed the GRO programme showed reductions in overcontrolled traits associated with OCPD and reductions in overall psychological distress. Service users also reported an increase in flexibility when responding to changes in their environment. Finally, service users showed a decrease in suppressing the expression of their emotions and an improved ability in their cognitive appraisal of emotions. Analysis of outcome measures of the GRO Programme indicates that this intervention 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 the COVID-19 pandemic, the programme was adapted and changed to online delivery in 2020 and continued online for 2021.

4.16. Psychosis Recovery Programme

The Psychosis Recovery Programme is an intensive three-week programme catering for both inpatients and day service users. 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 and input from a social work student at specified periods. Of note, art therapy input was available for part of 2021 from a student art therapist who was on work placement. Groups were conducted face to face as service users found it difficult to engage online due to the nature of their illness. All groups were conducted in adherence with COVID-19 protocols and guidance.

4.17.1. Descriptors

In 2021, complete pre and post programme RAS scores were available for 16 participants. Demographic data is presented for the 32 people who engaged in the programme in 2021. The average age of Psychosis Programme participants was 40.84 (*SD* = 15.91) years (ranging from 18 - 81 years). 40.6% were female (*n* = 13) and 59.4% were male (*n*= 19). 75% were single, 18.8% married, 3.1% were separated and 3.1% were cohabiting with a partner. 34.4% were in employment, 6.3% worked

4.17.2. 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, with a possible score range of 0-120. 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.

4.17.3. Results

In 2021, complete pre and post-RAS scores were available for 16 participants. Demographic data is presented for the 32 people who engaged in the programme in 2021. The average age of Psychosis Programme participants was 40.84 (SD = 15.91) years (ranging from 18 - 81 years). 40.6% were female (n = 13) and 59.4% were male (n= 19). 75% were single, 18.8% married, 3.1% were separated and 3.1% were cohabiting with a partner. 34.4% were in employment, 6.3% worked in the home, 12.5% were unemployed, 12.5% were students, 18.8% were receiving disability allowance, 12.5% were retired and a further 3.1% were either in supported training employment.

84.4% were living with family and 15.6% were living alone.

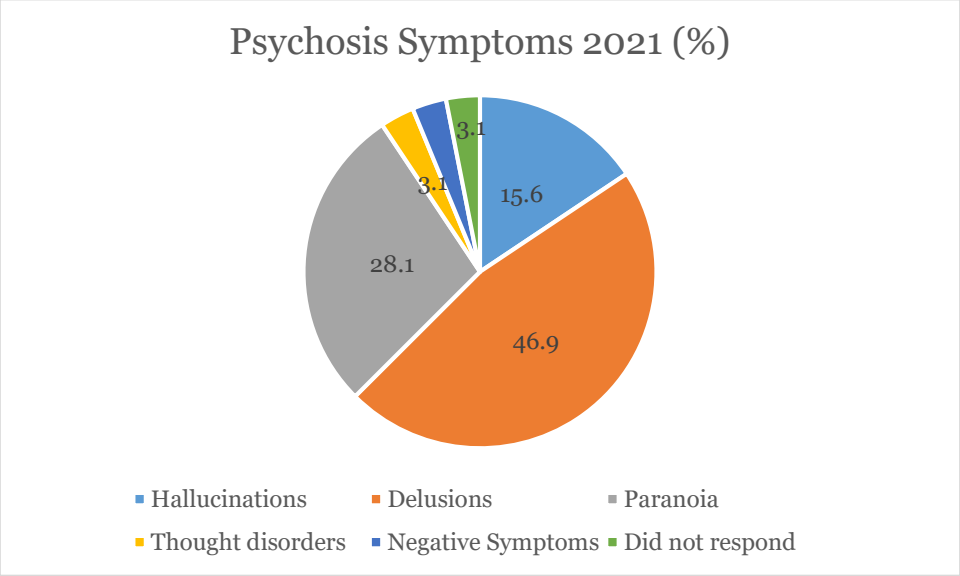
Regards highest level of education attained, 15.6% had completed the Junior Certificate, 40.6% had completed the Leaving Certificate, 12.5% had a non-degree third level qualification and 31.3% had a third level degree. 100% of service users reported their ethnicity as white Irish. Comparing 2020 to 2021, service users, for whom we have data, appear relatively similar in terms of age, gender, marital status and employment.

In 2020, there was an increase in service users reporting that delusions were the primary psychosis experience. This has increased again in 2021. However, there has been a decrease in the reported primary experience of paranoia and a decrease in hallucinations. 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%).

In 2021, primary reported symptoms data was available for 31 service users. The primary reported symptoms were delusions (46.9%), paranoia (28.1%), hallucinations (15.6%), thought disorders (3.1%) and negative symptoms (3.1%). 3.1% of participants did not provide an answer on primary symptoms, see graph below for reported primary psychosis symptoms in 2021. The average attendance at

sessions per client in 2021 was 8.33 (*SD* = 4.67). Participants are permitted to attend multiple cycles of the programme.

Figure: Primary Psychosis Symptoms 2021



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* = 3.98; *SD* = 1.21) to post-intervention (*M* = 4.33; SD = 0.85), $z = -2.41$, $p < 0.05$ with a moderate effect size ($r = -0.60$). This indicates that overall, service users experienced an increase in coping ability and quality of life following completion of the programme.

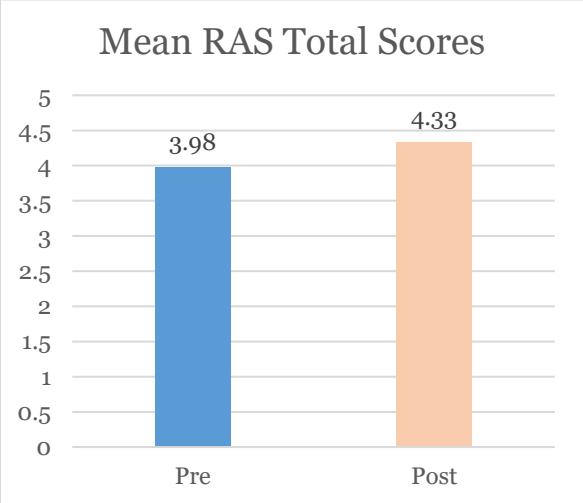
Significantly higher mean scores were identified post-intervention for services users on all RAS sub-scales. This indicates that participants had increased confidence and hope, had greater abilities to ask for help and rely on others, could be goal directed and the table below outlines test statistics and figures for differences in pre and post intervention means and graphs on the following page for visual representations.

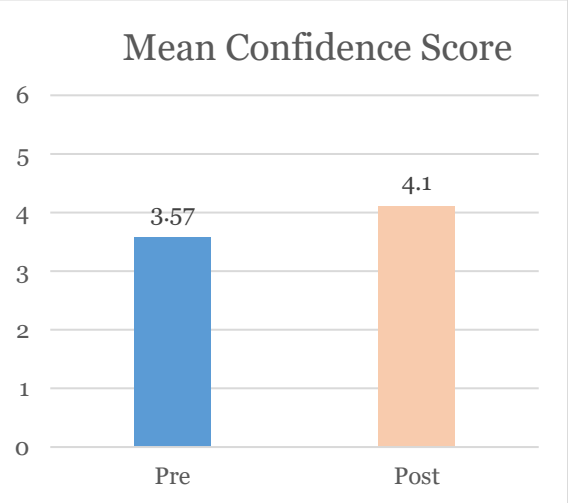
Table: Results from Wilcoxon Signed Rank tests for the RAS pre and post scores

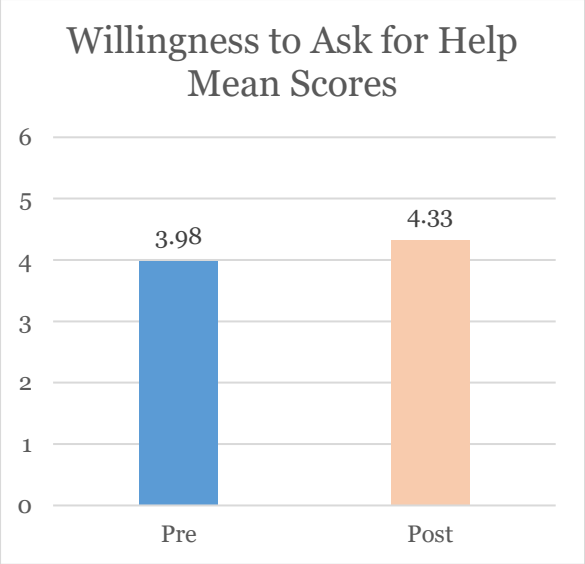
RAS	Pre mean	Post mean	*z*	*p*	*r*
Mean total	3.98	4.33	-2.41	0.016	-0.60
Confidence and hope	3.57	4.10	-2.44	0.014	-0.61
Willingness to ask for help	3.98	4.33	-2.00	0.045	-0.50
Goal/success orientation	3.90	4.40	-3.06	0.002	-0.76
Ability to rely on others	3.91	4.43	-2.54	0.011	-0.63
Not dominated by symptoms	3.03	3.66	-2.63	0.008	-0.65

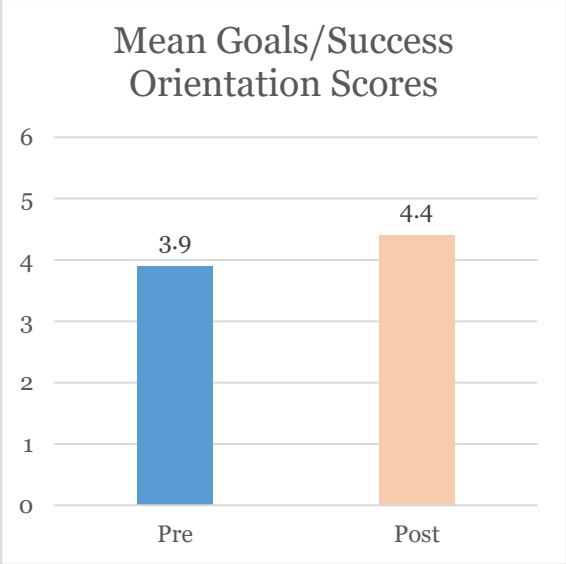
RAS = Recovery Assessment Scale

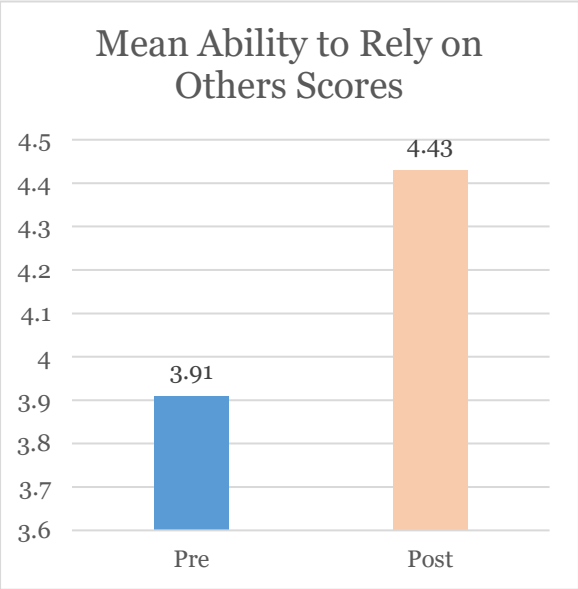
Graphs: Mean Total and subscale scores for the RAS

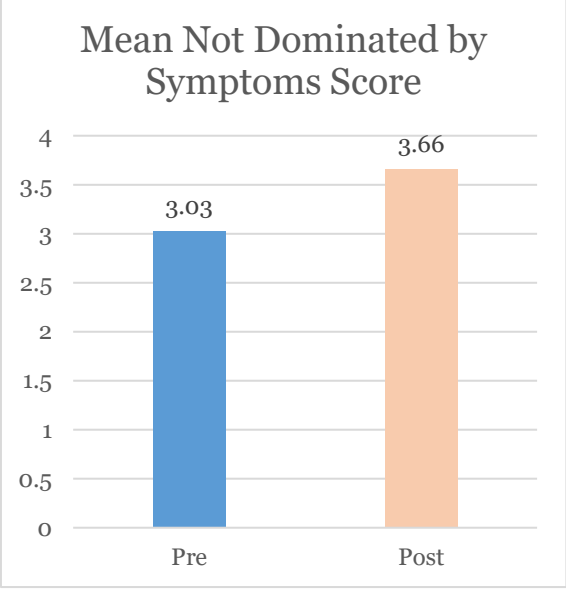








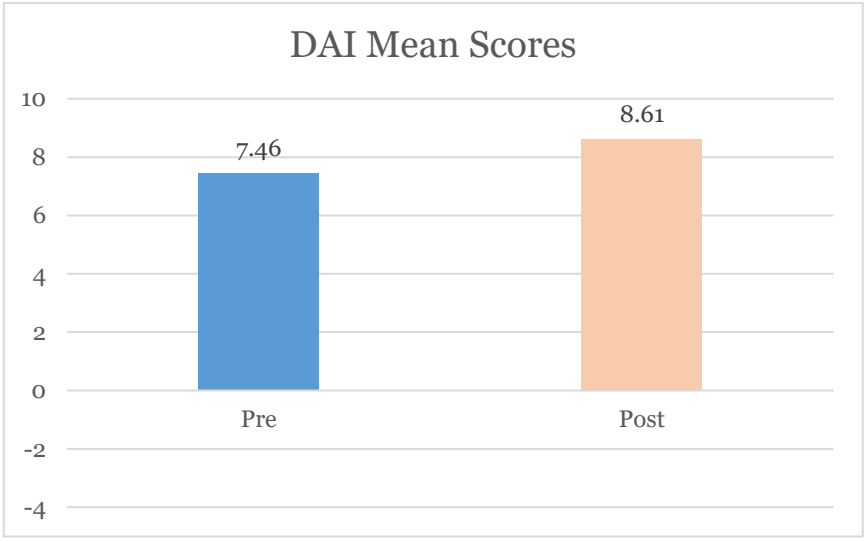




Drug Attitude Inventory (DAI)

Pre and post DAI scores were available for 20 service users. A Wilcoxon Signed Rank test identified an increase in mean scores on the DAI-10 from pre-intervention (M = 7.46, SD= 1.93), to post-intervention (M = 8.61; SD = 1.68); z = -2.90, $p < 0.05$, demonstrating a medium effect size (r = -0.64). The mean scores indicate that some service users who completed the measures reported more positive views towards medication after completing the programme.

Graph: Mean DAI Scores Pre and Post Intervention



4.17.4. 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 numbers of completed pre and post measures were low due to the programme being delivered online which may have caused difficulties for return rate, and due to the small sample statistically significant results must be interpreted with caution. As only a small sample of those who engaged returned complete measures, 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.

4.18. Recovery programme

The Recovery Programme is a structured 12-day programme based on the Wellness and Recovery Action Plan (WRAP) approach designed by Mary Ellen Copeland of the Copeland Centre (1992). The WRAP approach focuses on assisting service users who

have experienced mental health difficulties to regain hope, personal responsibility through education, self-advocacy and support. The recovery model emphasises the centrality of the personal experience of the individual and the importance of mobilising the person's own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. The Recovery Programme at SPMHS is delivered through the Wellness and Recovery Centre for day service users.

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

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

4.18.1. Descriptors

Pre and post data were available for 29 participants who attended in 2021. The average age of participants was 55 years, ranging from 27-81 with a standard deviation of 13.73. Of those who completed the Recovery Programme 27.6% were male and 72.4% were female.

4.18.2. 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).

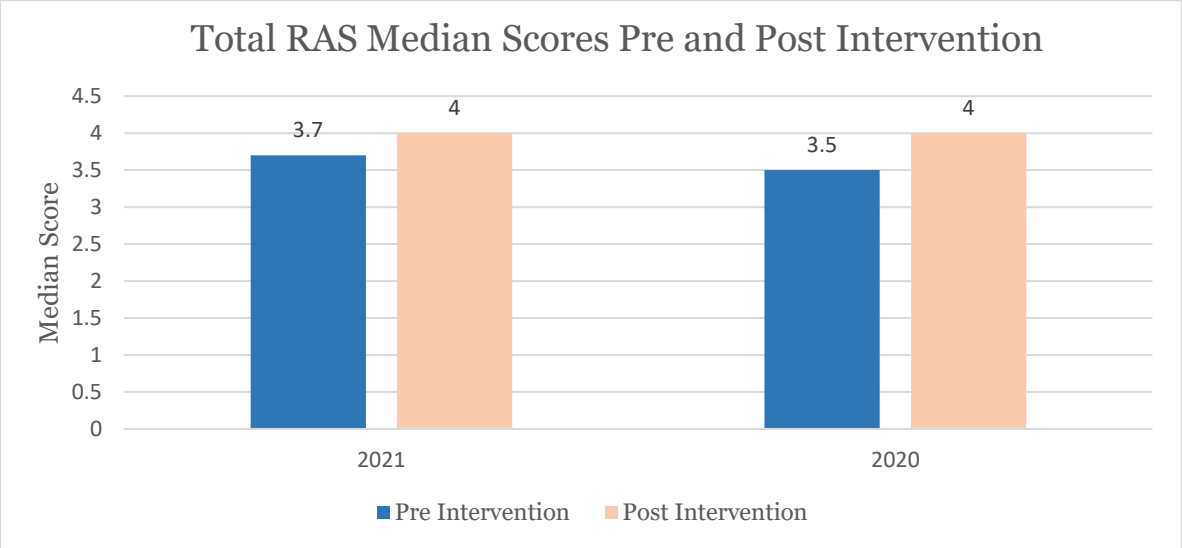
In 2015, it was decided to make a minor adjustment to the reporting of the RAS figures in this Outcomes Report. The change involved moving from reporting total scores to reporting mean scores, which makes the data more meaningful to the reader, whereby it is easier to draw comparisons across the subscales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

4.18.3. Results

Recovery Assessment Scale

Total Median RAS scores increased from pre-measurement (*Mdn* = 3.7) to post-measurement (*Mdn* = 4.0) indicating greater overall recovery. A Wilcoxon Signed Rank Test revealed this increase was statistically significant, $z = -4.577$, $p < 0.001$, with a large effect size, $r = 0.84$.

Graph: Recovery Assessment Scale, median scores pre and post intervention 2020 and 2021



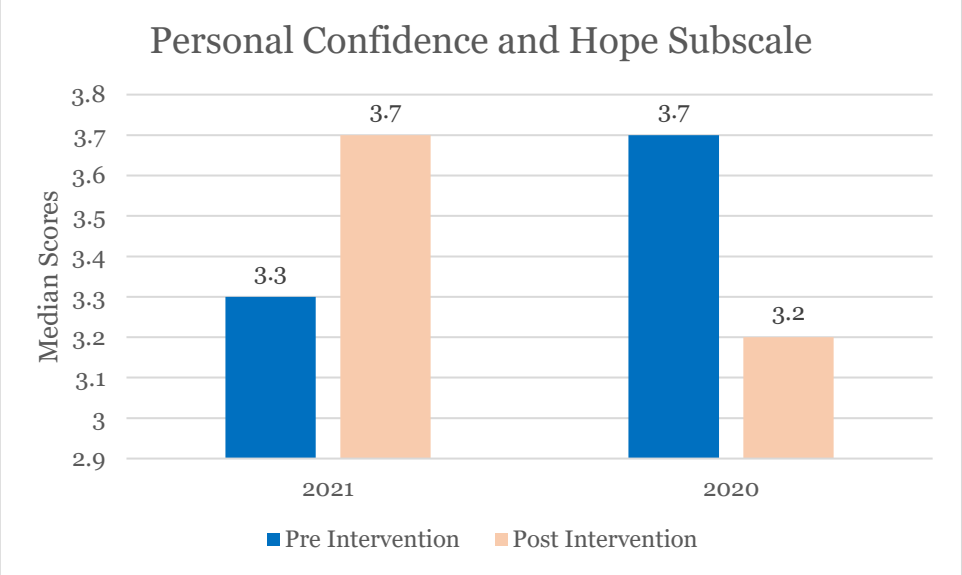
The figures below show pre and post scores on each of the five sub-scales: 'willingness to ask for help', 'personal confidence and hope', 'ability to rely on others', 'not dominated by symptoms' and 'goal and success orientation'. A series of Wilcoxon Signed Rank tests were run in order to compare pre 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.

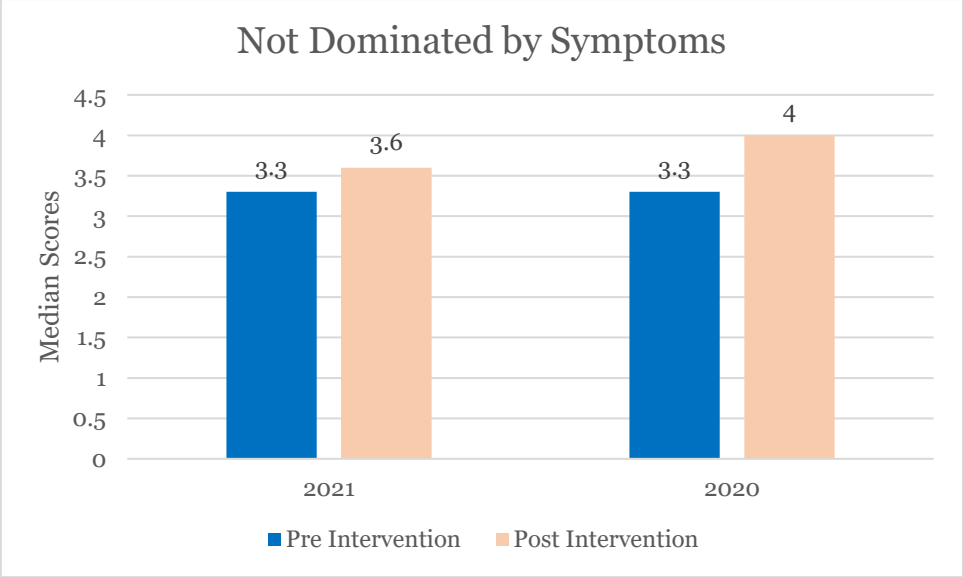
Scores on all five sub-scales improved significantly from pre to post-measurement (see the graphs below).

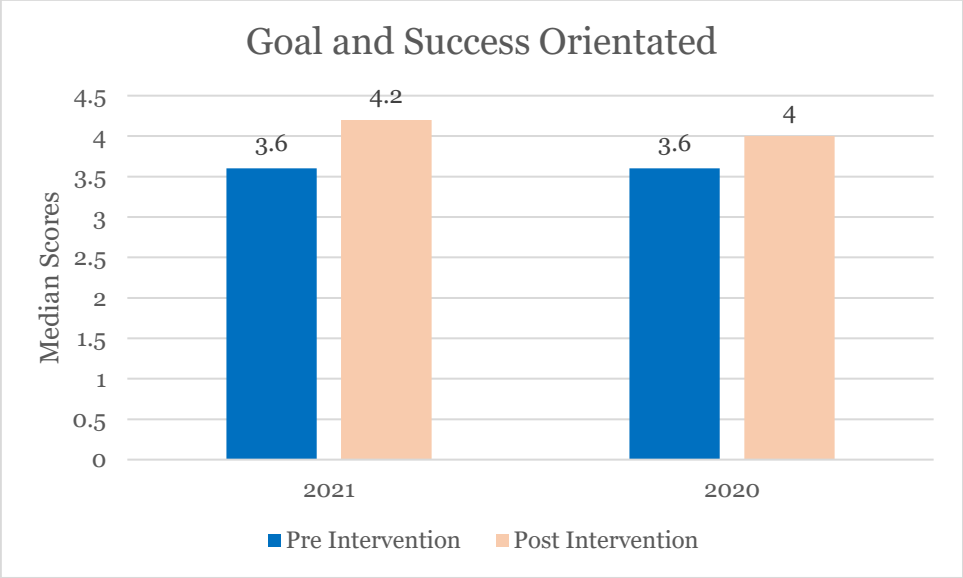
Table 2: Median scores on RAS (Wilcoxon Signed Rank tests)

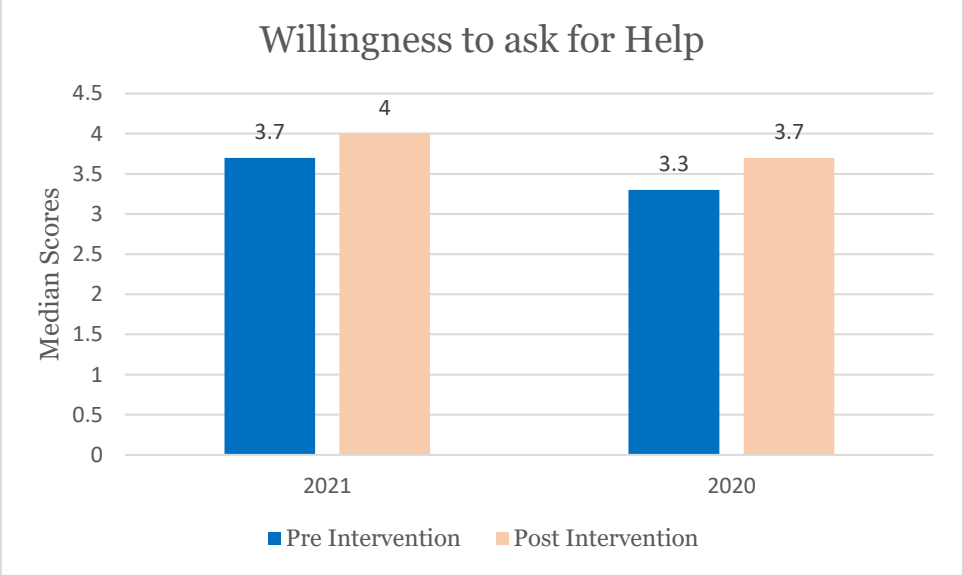
RAS Subscales	Pre *Median*	Post *Median*	*Z-value*	*P-Value*	*Rosenthal's r*
Willingness to Ask For Help	3.7	4.0	-2.95	.003*	0.54
Personal Confidence	3.3	3.7	-4.57	.001*	0.84
Ability to Rely on Others	4.0	4.3	-2.76	.006*	0.51
Not Dominated By Symptoms	3.3	3.6	-2.71	.007*	0.50
Goal and Success Orientation	3.6	4.2	-4.25	.001*	0.78

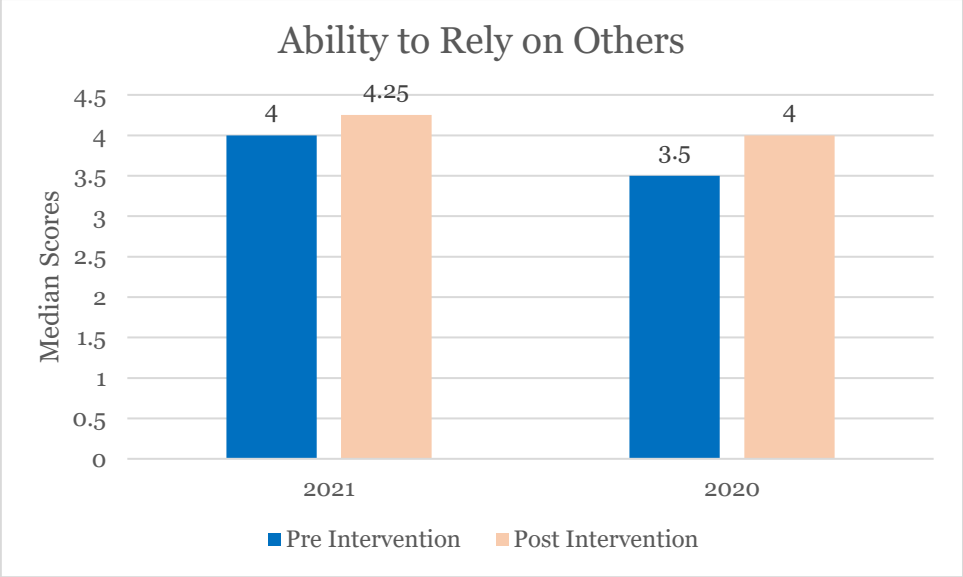
Graphs: Recovery Assessment Scale sub-scale median total scores pre and post intervention 2020 and 2021




Not Dominated by Symptoms
Median Scores
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.3
3.6
3.3
4
2021
2020
Pre Intervention
Post Intervention


Goal and Success Orientated
Median Scores
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.6
4.2
3.6
4
2021
2020
Pre Intervention
Post Intervention

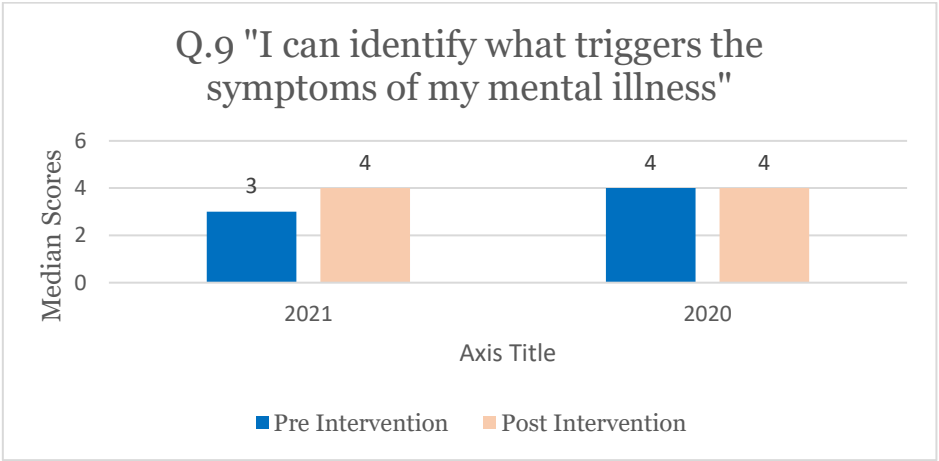

Willingness to ask for Help
Median Scores
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
3.7
4
3.3
3.7
2021
2020
Pre Intervention
Post Intervention

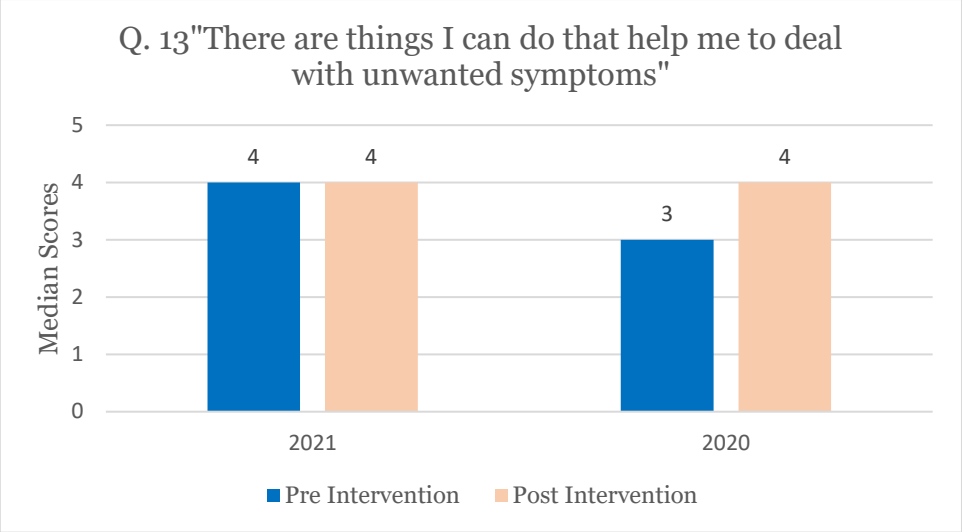


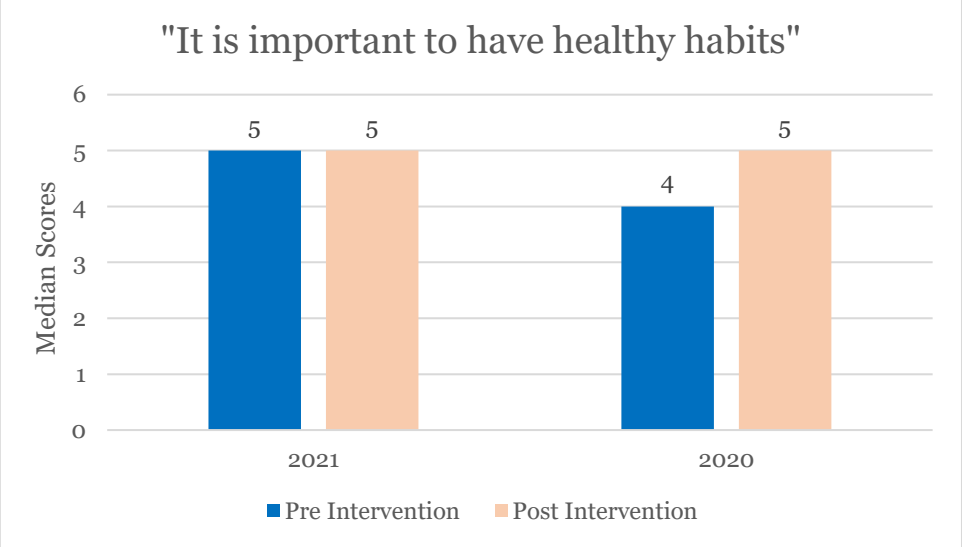
From clinician reflection, it was recommended to examine certain individual items not include in the sub-scale scores that reflect elements of the programme. These included item nine – 'I can identify what triggers the symptoms of my mental illness'; item 13 – 'There are things I can do that help me 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 9, 13 and 41 to identify any significant changes in scores. Pre to post measurement for item 9 (z = -3.720, p = 0.001) and item 13 (z = -2.676, p < 0.007) both showed statistically significant change in scores with a medium effect size respectively (r=.69, r=.50). Item 41 did not indicate significant improvements.

Graph: Recovery Assessment Scale items 9, 13, 41 median total scores pre and post-intervention 2020 and 2021







4.18.4. 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 several 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. Two of the three items clinicians indicated as capturing specific therapeutic targets of the programme showed significant improvements at post-intervention.

4.19. SAGE Programme

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 (Lynch, 2018; Booth et al, 2018), and how these can contribute to recurrent mental health difficulties. The programme is currently under review, however in 2021 the programme was comprised of 16 group sessions and two individual sessions. Themes addressed in the programme are difficulties with emotional inhibition, interpersonal aloofness, psychological rigidity and the role they play in maintaining mental health issues.

Data is described below for two cycles of this programme, which ended in 2021. Due to national public health restrictions, the programme was delivered via Microsoft Teams.

4.19.1. Descriptors

Complete data was available for 10 people who completed the programme in 2021. Programme attendees ranged in age from 66 to 85 years of age, with a mean age of 71.80 (*SD* = 5.66).

4.19.2. SAGE outcome measures

- **Depression Anxiety and Stress Scale (DASS-21)**

The 21-item Depression, Anxiety and Stress Scale (DASS-21) is a set of three self-report scales designed to measure 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 3 - applied to me very much, or most of the time. 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. 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.

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

The Personal Need for Structure Questionnaire aims to measure how people respond to new or uncertain situations. In this context it is used as a measure of rigidity/flexibility and it's brevity makes it an appropriate measure for use with older adults.

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, which in this context is interpreted as evidence of greater flexibility.

- **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. In this context it was used as a measure of intimacy/aloofness. 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).

- **The Emotional Control Questionnaire-Emotional Inhibition (ECQ-EI) (Roger & Najarian, 1989)**

The ECQ-EI (Roger & Najarian, 1989) 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 1 - strongly disagree, to 7 - strongly agree. The ECQ-EI has been found to have high internal validity, convergent and discriminant validity (Preece, Becerra, Robincon et al. 2019). In the context of the Sage Programme it is used as a measure of emotional inhibition/expression.

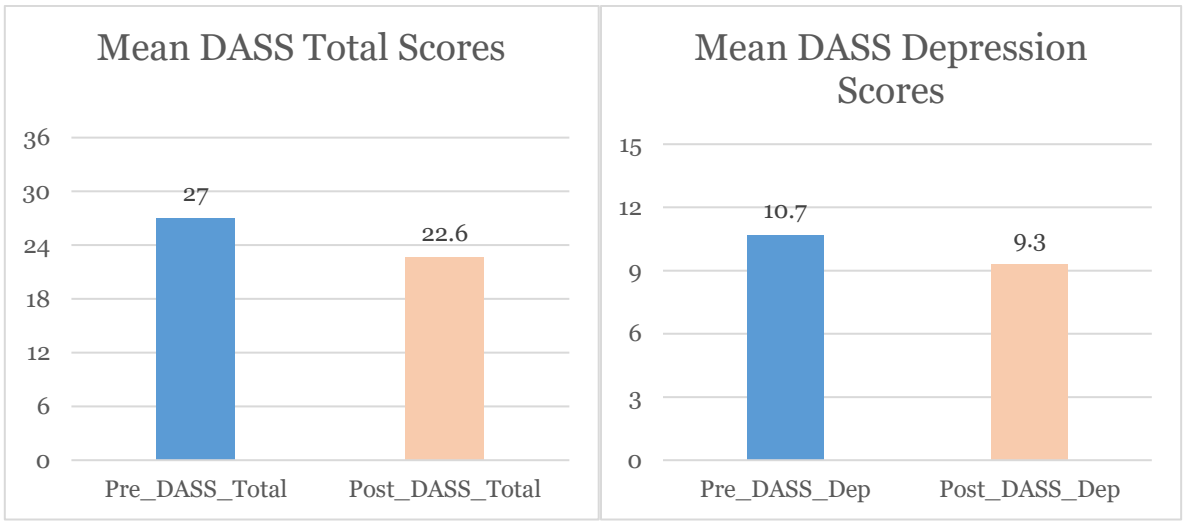
4.19.3. Results

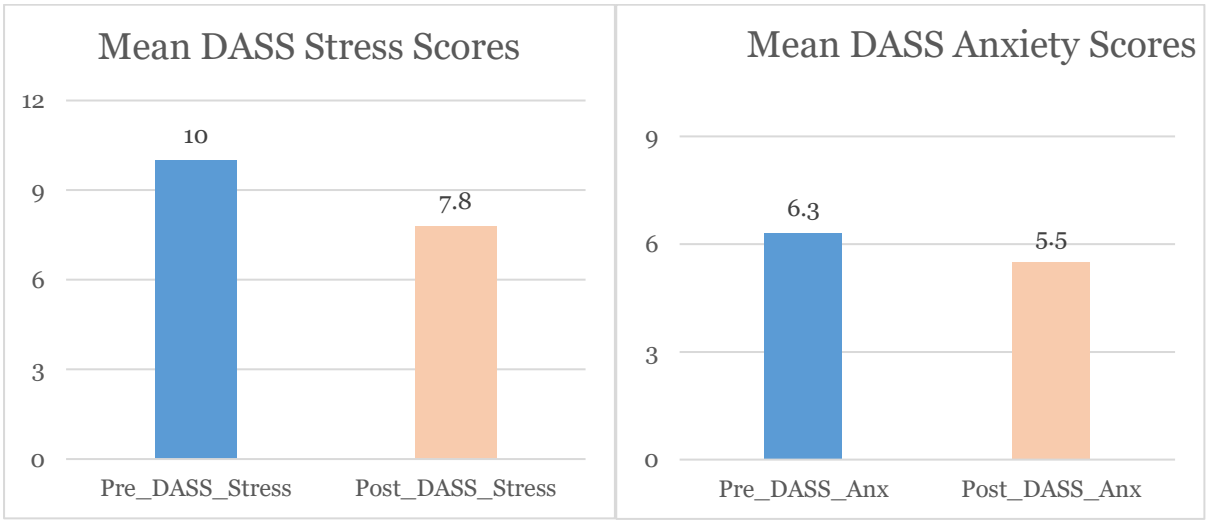
Depression Anxiety and Stress Scale (DASS)

Analysis of the three sub-scales, which make up the DASS - stress, anxiety and depression – using a paired samples t-test showed a numerical decrease in psychological difficulties between pre (M = 27.00, SD = 10.67) and post intervention (M = 22.60, SD = 2.60), however this was not statistically significant; $t(9) = 1.01$, $p > 0.05$.

Scores on the stress, anxiety and depression subscales all decreased, suggesting overall increases in mental health among participants. Mean scores on the depression subscale fell from 10.70 (SD = 4.00) at pre-intervention to 9.30 (SD = 4.73) at post-intervention. Scores on the anxiety subscale fell from 6.30(SD = 4.16) to 5.50 (SD = 3.95) after the programme. Mean stress scores fell from 10 (SD = 4.83) at pre-intervention to 7.80 (SD = 3.15) at post-intervention. None of these differences were statistically significant, however.

Graphs: Mean Scores on the DASS Total Score and Subscales

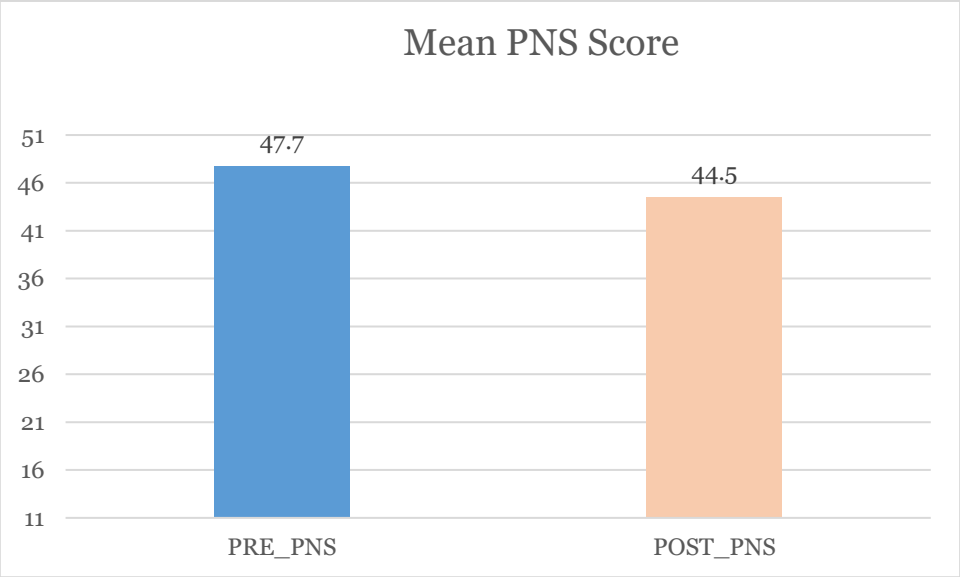




Personal Need for Structure (PNS)

Mean scores on the PNS decreased from 47.70 (*SD* = 7.39) at pre-intervention to 44.50 (*SD* = 6.88) at post-intervention, which was statistically significant; (t (9) = 2.24, $p < 0.05$). Reduction in mean scores was interpreted as indicating increased flexibility.

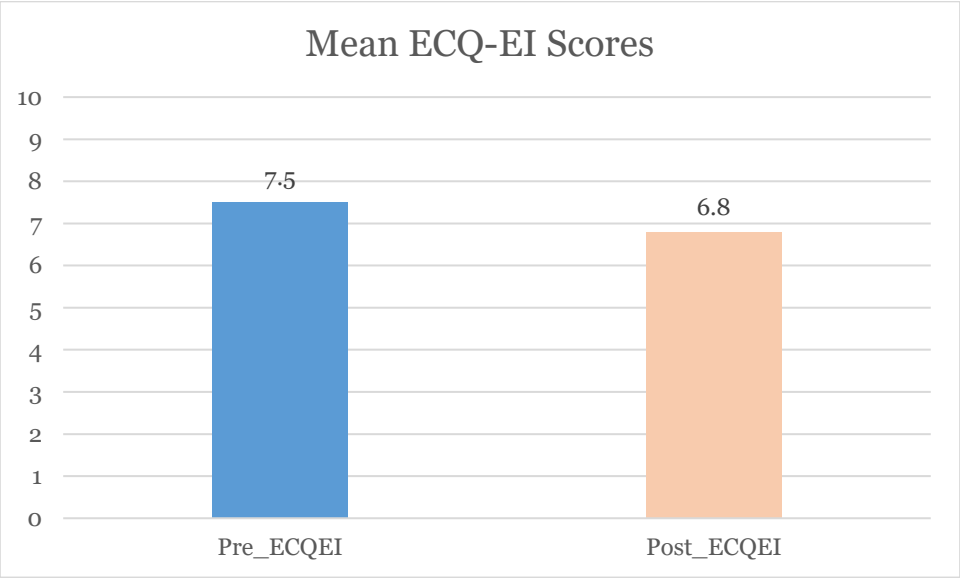
Graph: Personal Need for Structure Mean Score



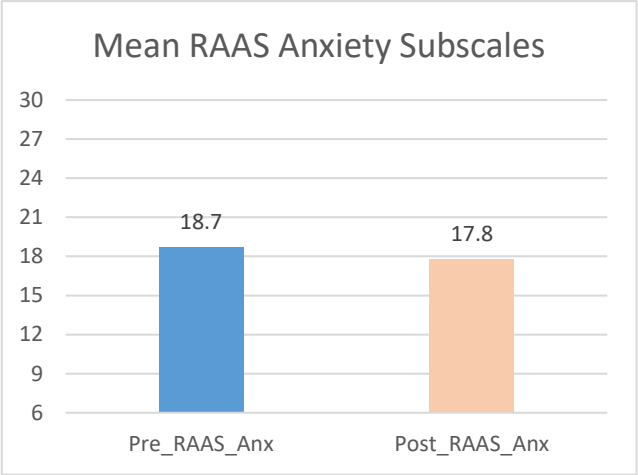
Emotion Control Questionnaire-Emotional Inhibition (ECQ-EI)

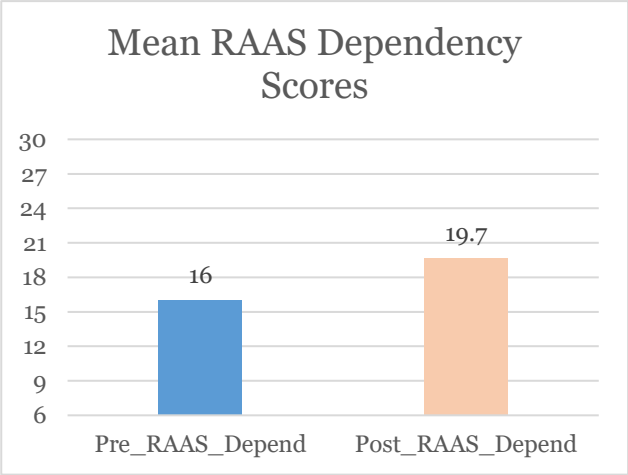
The total mean score on the ECQ-EI decreased from 7.50 (*SD* = 2.84) at pre-intervention to 6.80 (*SD* = 1.98) at post-intervention, however this difference was non-significant. Decreases in ECQ-EI scores was interpreted as indicating that participants are reporting less suppression of their emotions and have an improved ability to reappraise unhelpful cognitions regarding emotion.

Graph: Emotion Control Questionnaire - Emotional Inhibition (ECQ-EI) mean scores



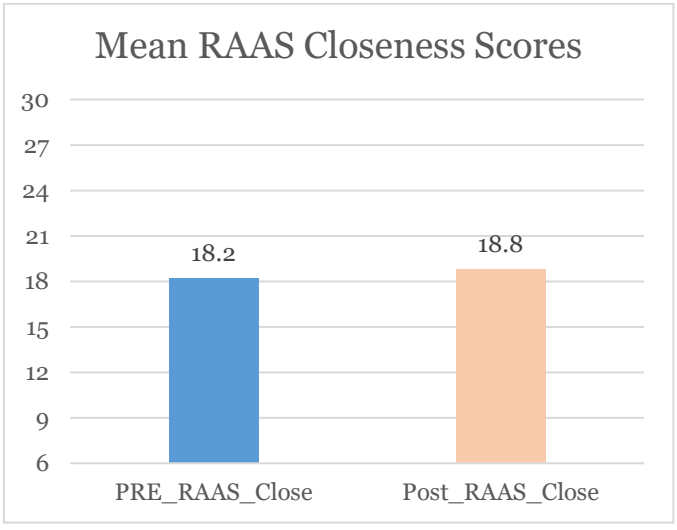
Revised Adult Attachment Scale (RASS)





Mean scores on the closeness and dependent subscales did increase at post-intervention from 18.20 (*SD* = 5.49) and 16.00 (*SD* = 6.20) at pre-intervention to 18.80 (*SD* = 5.82) and 19.70 (*SD* = 5.33) at post-intervention respectively. This change was not statistically significant. Numerically however, 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 from 18.70 (*SD* = 5.39) to 17.78 (*SD* 6.14) following the programme, however this was not statistically significant. This result indicates that participants' anxiety levels (with regards to close relationships) reduced slightly after completing the programme.

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



4.19.4. Summary

Two cycles of the Sage Programme were completed in 2021. Participants who completed the programme and both pre- and post-group outcome measures were included in the analysis. Out of 14 participants who completed pre-group measures, 10 participants completed the programme and post-group measures. The remaining four participants did not complete the programme or post-group group measures and were therefore excluded from the analysis. The data collected indicate positive gains in participant scores, in terms of overall improvements in mental health, increases in flexibility and relational intimacy and decreases in emotional suppression, consistent with the therapeutic aims of the programme.

With the exception of data regarding increases in psychological flexibility (Personal Need for Structure Questionaire) changes detected from pre to post measures did not reach statistical significance. The small sample size (n = 10) may have impacted the power to detect meaningful differences on the majority of measures and it is important to hold this in mind when interpreting the results.

4.20. Trauma Group Programme

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

4.20.1. Descriptors

A total of nine people who were referred completed the third Trauma programme cycle in 2021. All 9 participants returned pre and post outcome data. Five of the participants were female and four were male. Participant's ages ranged from 41 years to 68 years (M=56.67, SD=10.37). Pre-treatment completion of the Adverse Childhood Experience (ACEs) indicated that seven of nine returned ACEs measures scored above four, with one participant scoring four; three participants scoring five; one participant scoring six; and two participants 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.

4.20.2. Trauma Group Programme Outcome Measures

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

The PTSD Checklist is a 20-item self-report checklist of post-traumatic stress disorder (PTSD) symptoms based closely on the DSM-5 criteria (PCL-5; Lang & Stein, 2005). Service users rate each item from 0 – not at all, to four – extremely, to indicate the degree to which they have been impacted by that symptom over the past month. The PCL has demonstrated strong psychometric properties. Estimates of internal consistency (Cronbach's alpha) range between 0.94 (Blanchard et al, 1996) to 0.97 (Weathers et al. 1993). Test-retest reliability has been reported as .96 at two to three days and 0.88 at one week (Blanchard et al.,1996; Ruggiero et al.,2003). Higher scores indicate higher experiencing of PTSD symptoms. 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 1 – totally disagree, to 7 - totally agree. The measure consists of three subscales 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 3 categories of individuals; a non-traumatised population, a traumatised population without PTSD and a traumatised population with PTSD. The median score for the non-traumatized group was 45.5, for the traumatized group without PTSD was 49 and for the traumatized group with PTSD the median score was 133.

- **Compassionate Engagement and Action Scales**

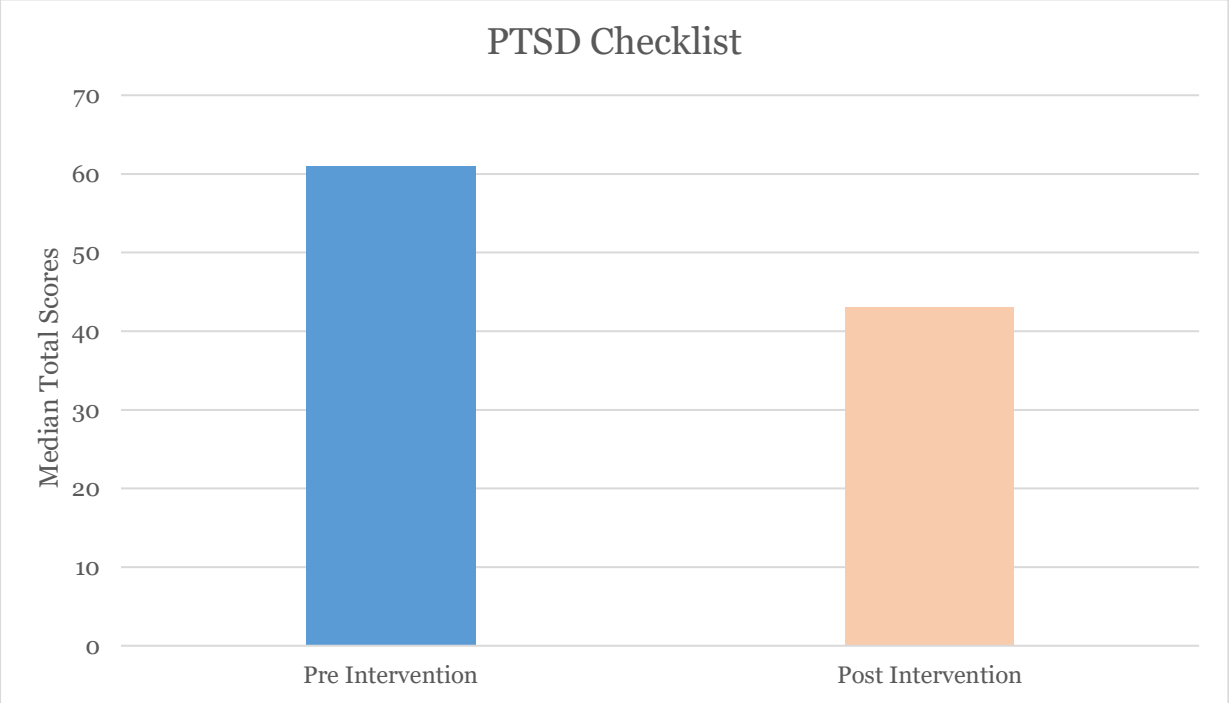
  The Compassionate Engagement and Action Scales (CEAS) are three separate scales measuring compassion to the self, compassion to the other and compassion experienced from the other (Gilbert et al., 2017). Each scale consists of 13 items, which generate an engagement subscale (motivation to care for wellbeing, 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.

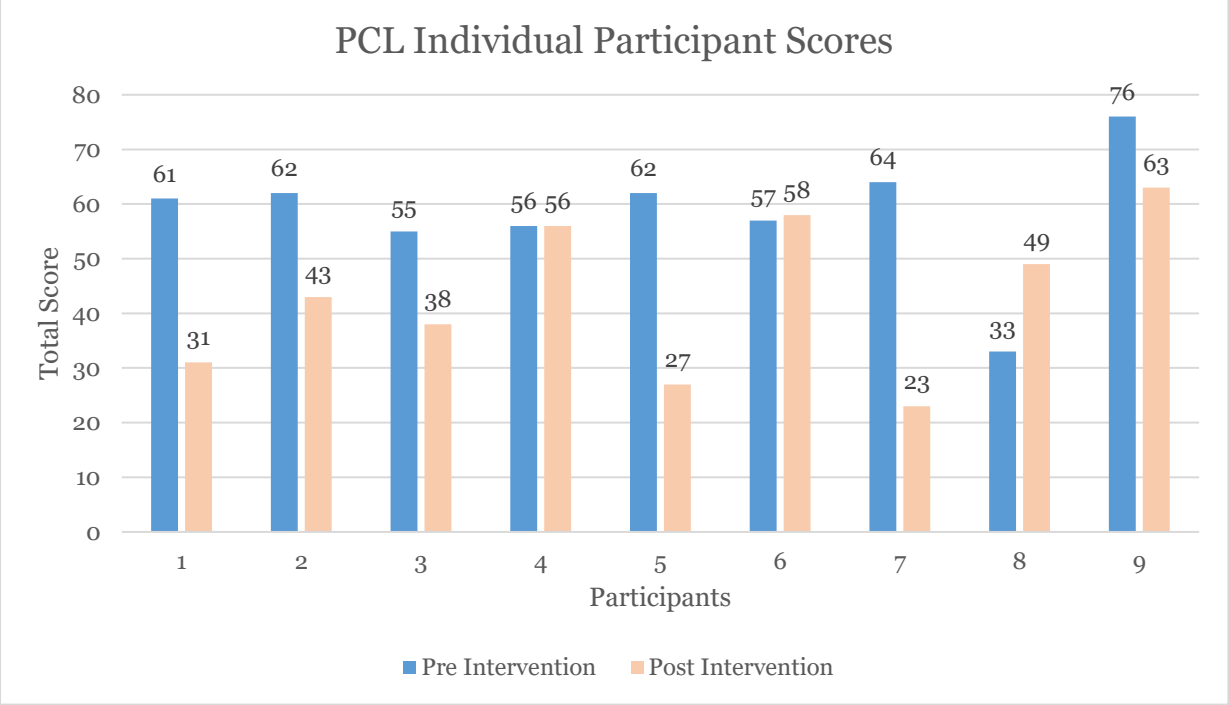
4.20.3. Results

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 9 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



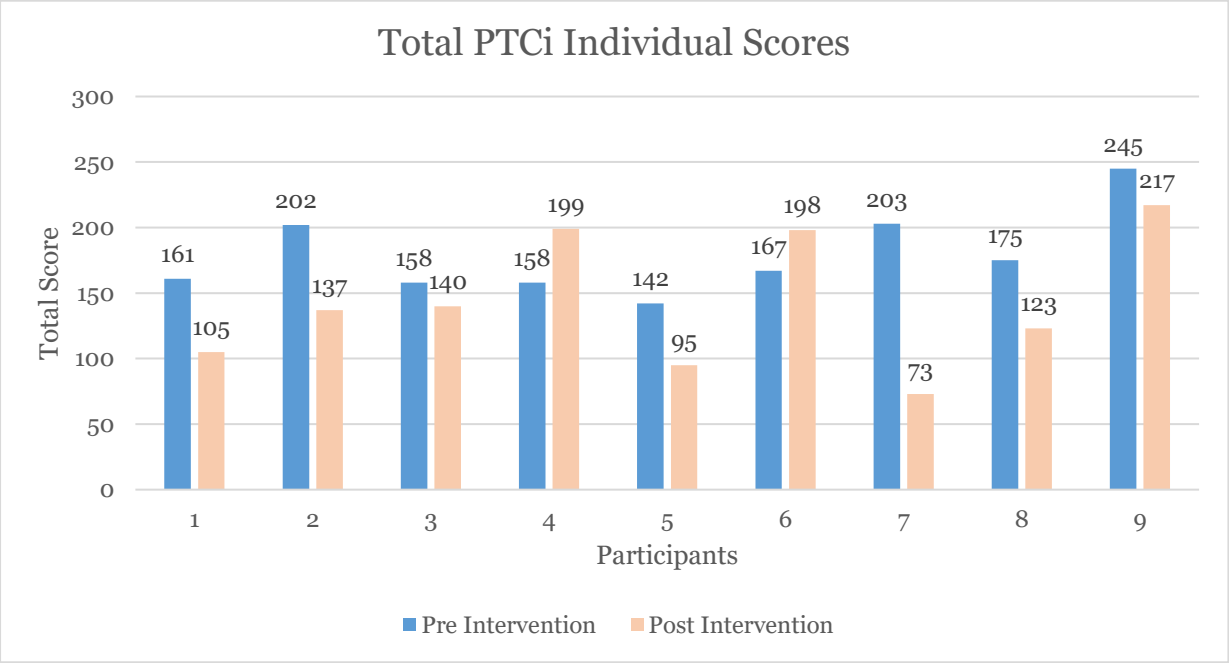


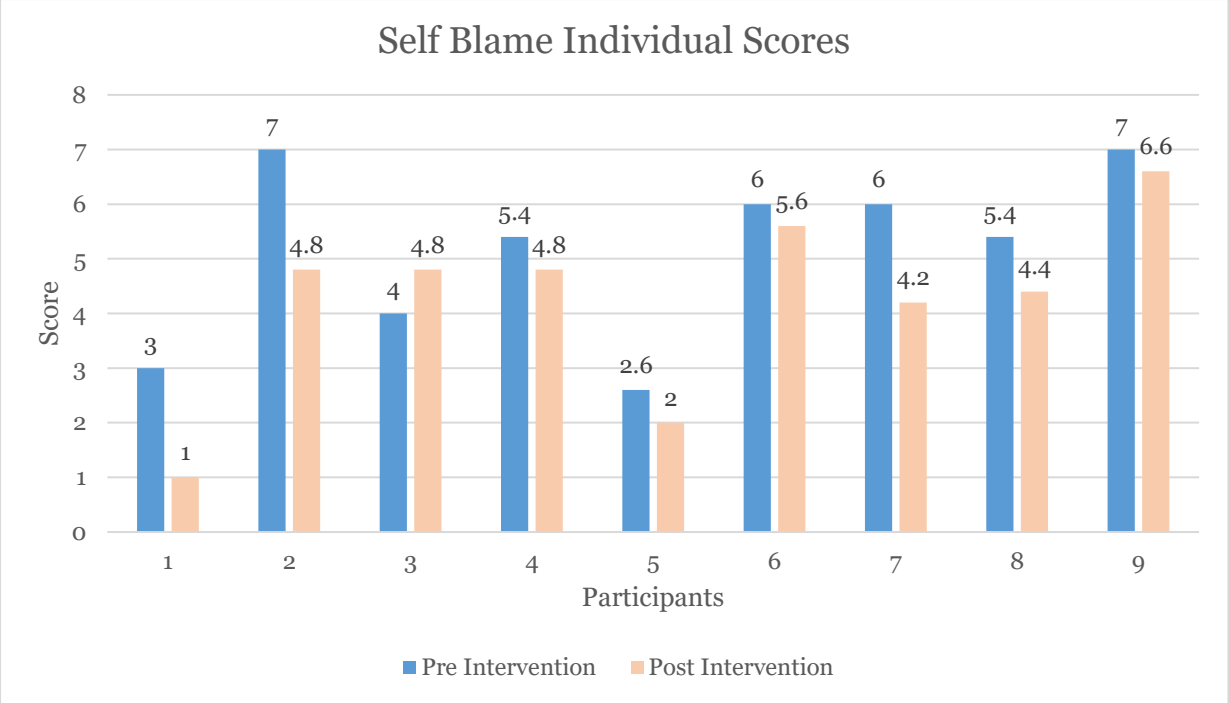
As can be seen from the above graph, 6 out of 9 participants (66.6%) demonstrated a clinically significant reduction in PCL scores from pre intervention to post

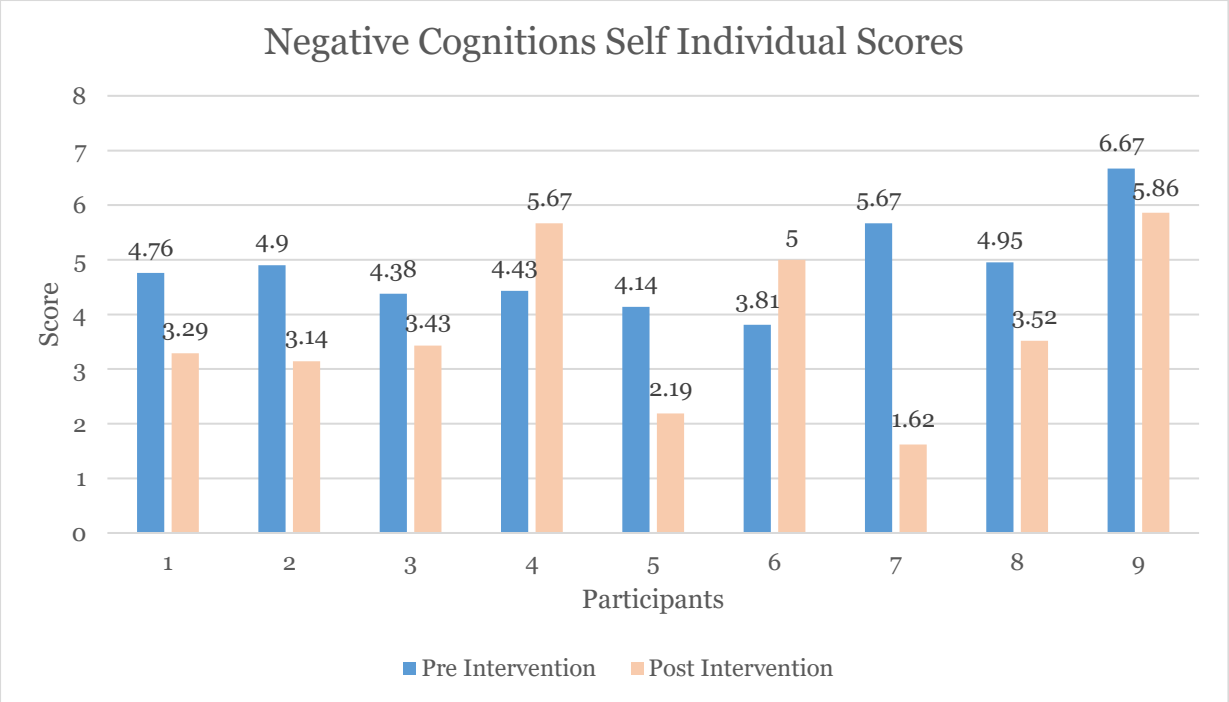
intervention (10 points or greater). 1 participant demonstrated a clinically signficant increase in PCL scores. In addition, 3 participants (33.3%) have moved from meeting criteria for a provisional diagnosis of PTSD pre intervention (cut off score of 38 or higher) to no longer meeting criteria post intervention.

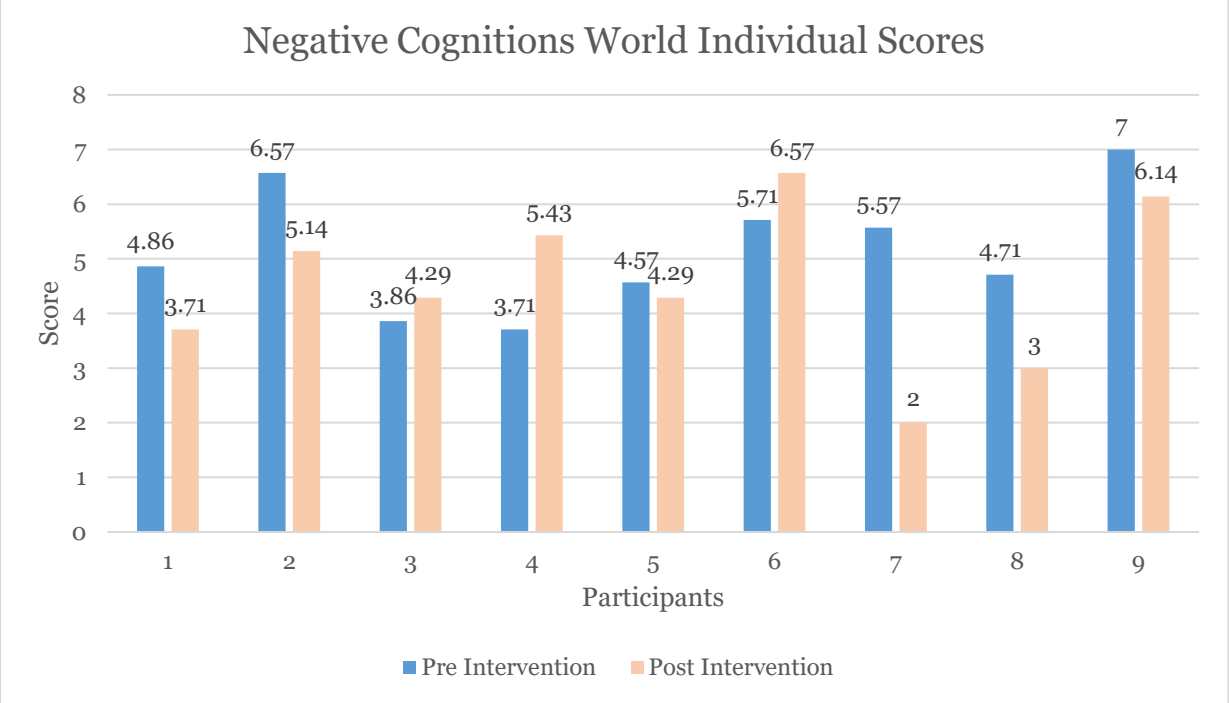
The Post Traumatic Cognitions Inventory (PTCI)

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




Self Blame Individual Scores
Score
Participants
Pre Intervention
Post Intervention
3
1
7
4.8
4
4.8
5.4
4.8
2.6
2
6
5.6
6
4.2
5.4
4.4
7
6.6

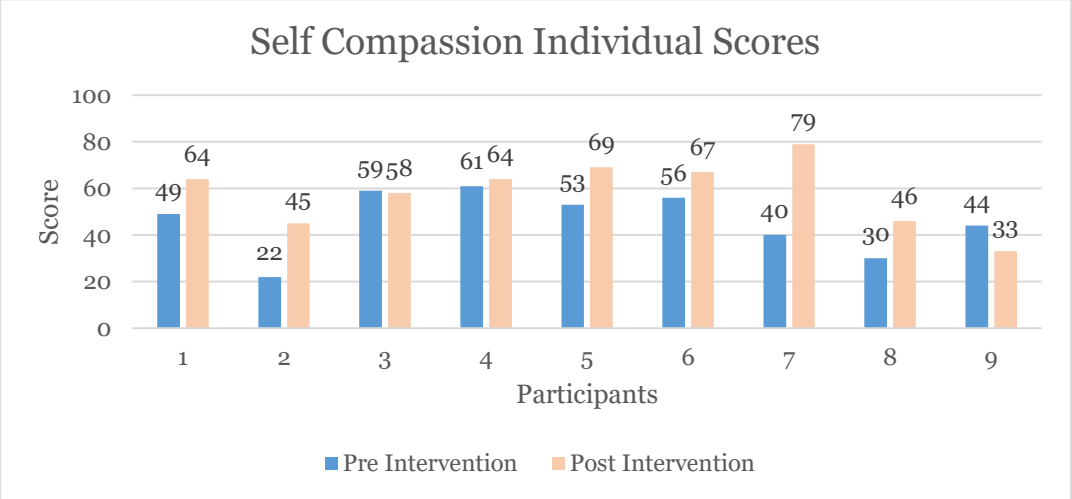

Negative Cognitions Self Individual Scores
Score
Participants
Pre Intervention
Post Intervention
4.76
3.29
4.9
3.14
4.38
3.43
4.43
5.67
4.14
2.19
3.81
5
5.67
1.62
4.95
3.52
6.67
5.86

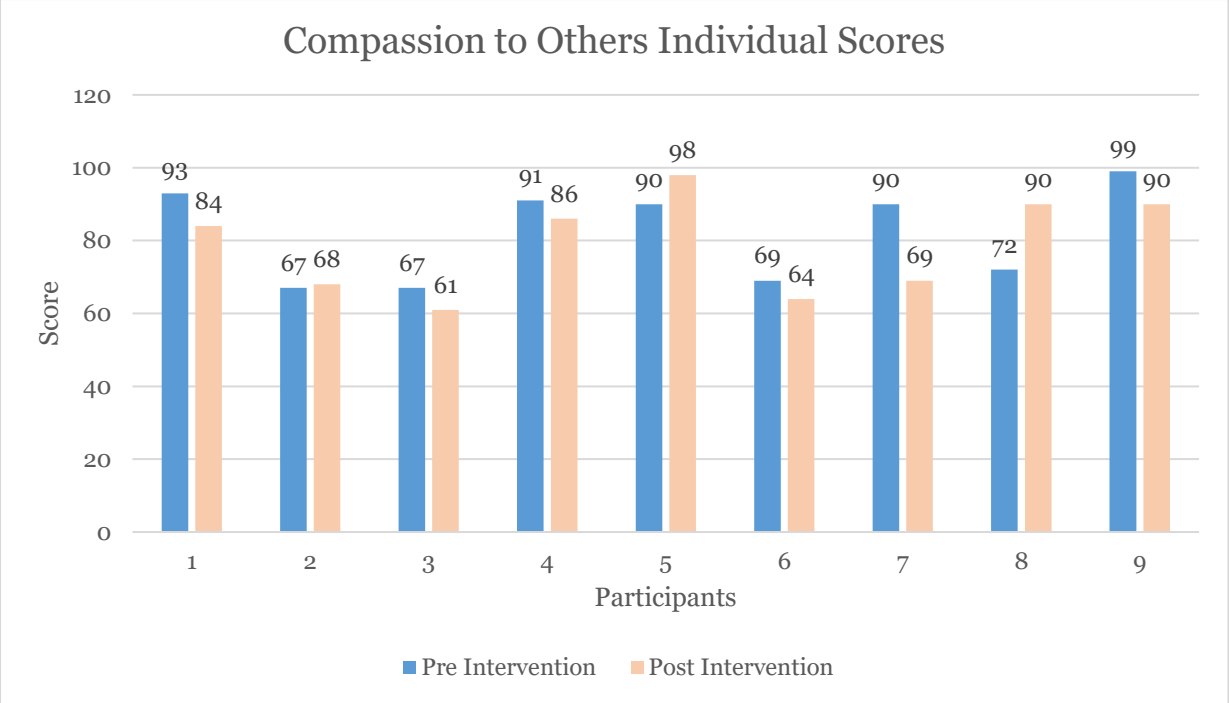


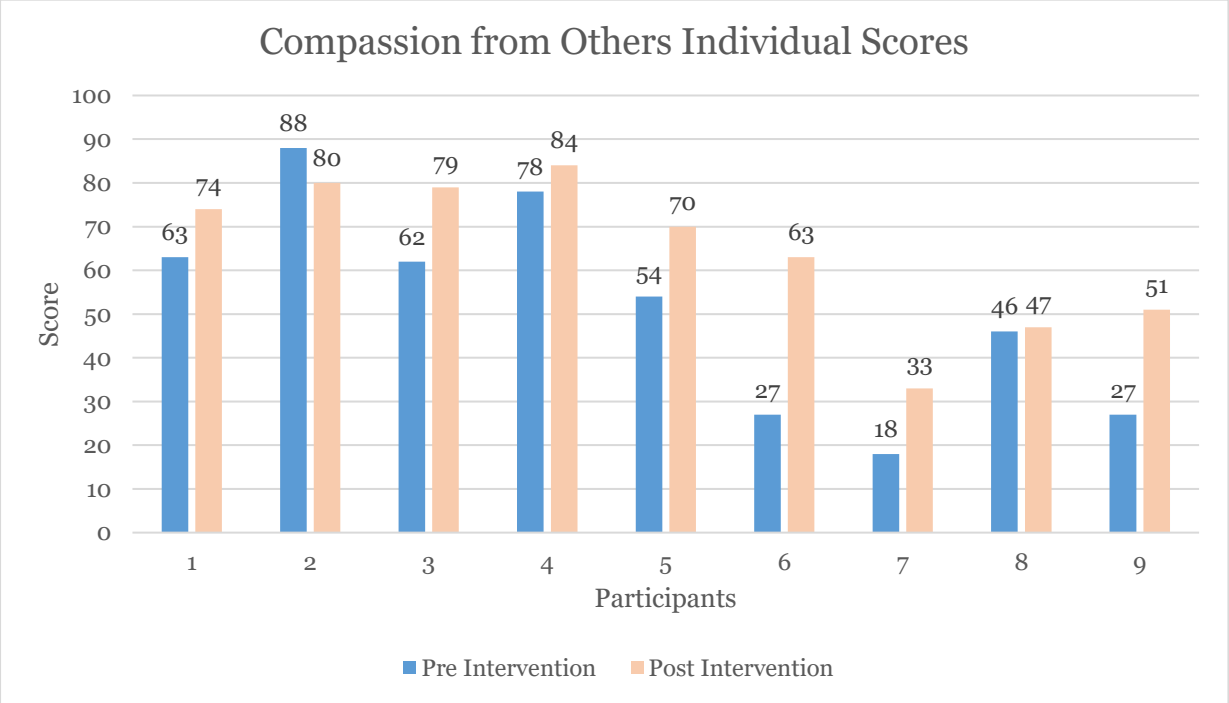
As can be seen on the Total PTCi Individual Scores graph, all participants scored 133 or above at pre-intervention, indicating a similar level of distress as experienced by traumatised subjects with PTSD. Four of these participants demonstrated a significant reduction in scores, no longer meeting this criteria post intervention. Six out of nine participants (66.6%) 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, 7 out of 9 participants (77.7%) demonstrated an improvement on the self-compassion subscale, 3 out of 9 participants (33.3%) indicated an increased compassion to others. Additionally, 8 out of 9 participants (88.8%) scores on the compassion from others increased.

4.20.4. Summary

The Trauma Programme is still a relatively new programme in the hospital delivered by the Psychology Department, the above results are for the programme's third cycle. The programme aspires to reduce 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. Nonetheless, the analysis of individual scores overall demonstrated promising positive results. These results indicate that the Trauma Programme is effective in delivering its aims. Two participants PCL-5 scores increased following the programme. Recent research comparing face to face groups to online groups and a hybrid group indicated that over all the group has statistically significant positive results. However online versus face to face preferences may impact outcomes for participants.

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. 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	22.91 SD = 8.73	15.66 SD = 8.85	5.561	58	.000	.82
Clinician Rated	16.66 SD = 5.85	11.00 SD = 1.73	2.357	3	.142	1.31
Parent Rated	20.98 SD = 8.54	16.34 SD = 9.20	3.553	52	.001	0.52

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 2021. Analysis was therefore run on pre and post data received.

As illustrated in the table above, a significant decrease in total scores for the client self-rated HoNOSCA was apparent at the post-intervention time point (t (58) = 5.561, p<.001), reflecting a large effect size (Cohen's d =.82).

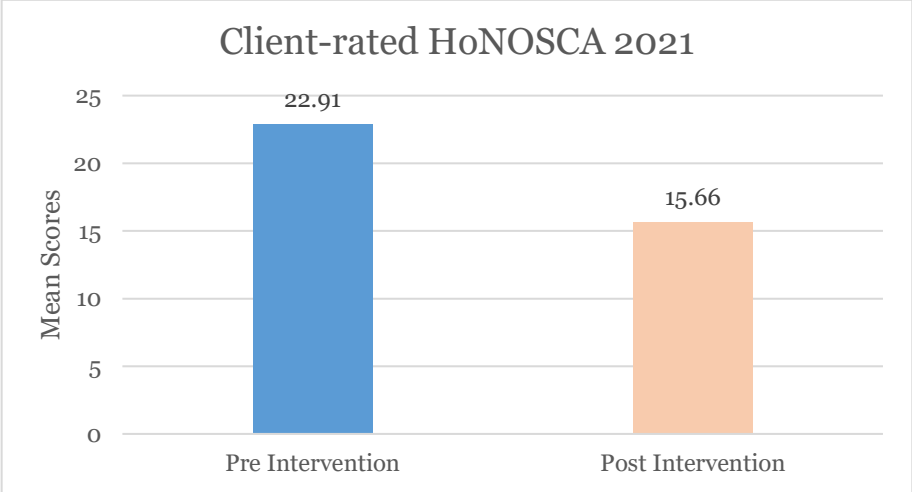
A significant decrease in total scores was also identified post-intervention on the parent-rated HoNOSCA, (t (52) = 3.553, p<.001), demonstrating a medium effect size (Cohen's d =.52).

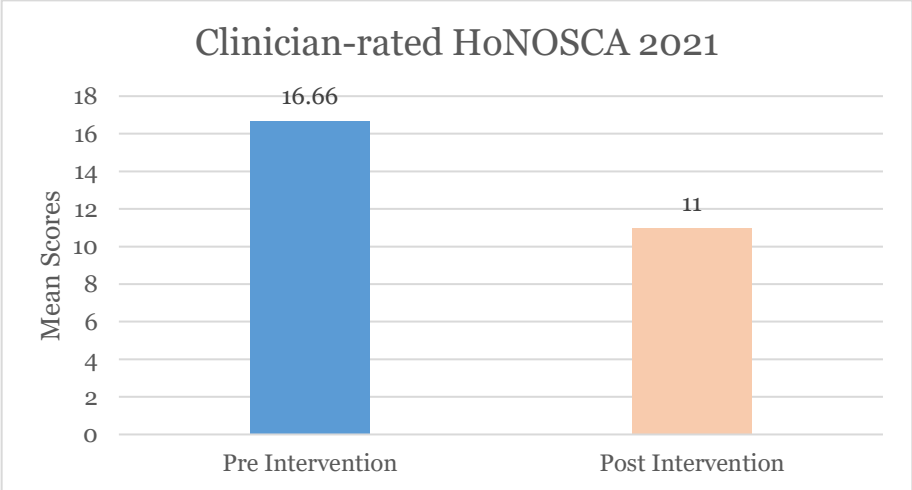
On the clinician-rated HoNOSCA, a no significant decrease in total scores were observed at post-intervention, (t (3) = 2.357, p>.142).

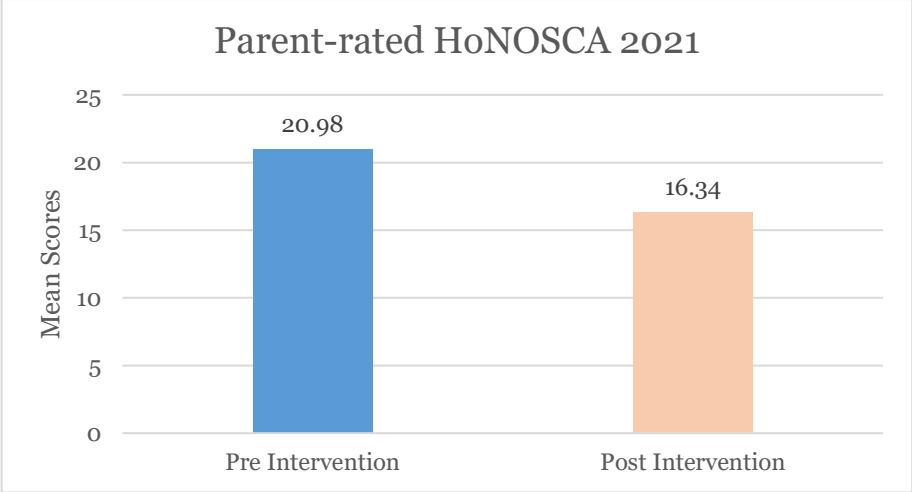
For the parent-rated measure separate forms were given to both Mom and Dad to complete at each time point, where appropriate. In the instances where both Mom and Dad returned data at a single time point, the average score was calculated to provide a unitary parent score.

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







4.21.3. Summary

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

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

The MDT is actively working on improving data collection at discharge with the aim of improving response rates in 2022, including exploring methods to better engage young people in this process.

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 2022.

SECTION FIVE
Measures of service user satisfaction

5. Service user satisfaction questionnaires

5.1. Introduction

SPMHS is committed to listening to, and acting upon, the views of those who use and engage with its service. To enhance communication between service users and providers, a service user satisfaction survey was developed and is distributed to service users who attend inpatient care, Dean Clinics and day programme services. This report outlines the views of a portion of inpatient, Dean Clinic and day programme service users from January to December 2021. The results of the service user satisfaction survey are collated for the first six months of each year and for each full year, to provide management and the Board of Governors with valuable measures of the services provided. Standards of performance are set for measures throughout the survey and failure to achieve defined average scores results in actions being apportioned to the appropriate staff. This approach is in keeping with continuous quality improvement.

5.1.2. Survey design

The report is structured to reflect the design of the survey, whereby responses of each survey question are depicted in graph and/or table form. The inpatient survey was initially created based on the Picker Institute National Inpatient Survey for Mental Health Services in the UK. Subsequent adaptations were made to include topics which appear to be of importance to service users (as identified by previous service user feedback and complaints) and to service providers (e.g. 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.

Some of the surveys detailed in this report invited respondents to answer open-ended qualitative questions in order to identify any points of interest not contained within the closed statements and to give further voice to the service users' experiences. The responses to these opened ended questions are reviewed by SPMHS management and form part of continuous quality improvement processes. However, these responses are not presented in this report as they have the potential to breach confidentiality and they are not representative, as these open-ended questions are often not completed.

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

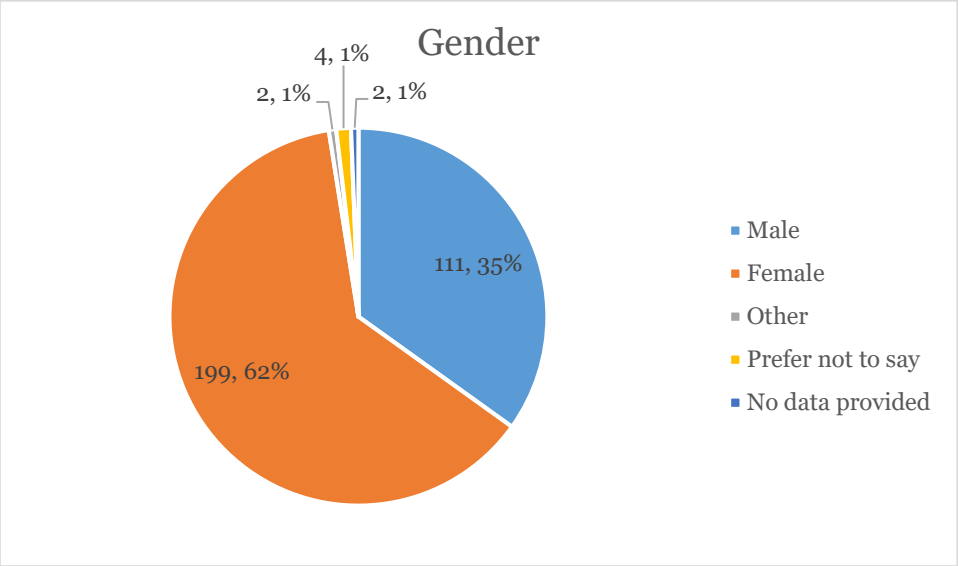
5.1.3. Data collection

The three surveys for the Dean Clinics, inpatient and day programmes were continually distributed from January to December 2021 to gather information about service users' journeys through SPMHS, thus engaging a system in which service users can offer feedback and take an active role in the provision of their care. Since March 2016, the service user satisfaction surveys for the Dean Clinics, inpatient and day programmes are also available online to increase accessibility. The employment of the service users' satisfaction survey is part of a larger quality improvement process undertaken by SPMHS. Data collection across SPMHS is continually facilitated as a key strategic objective to improve services.

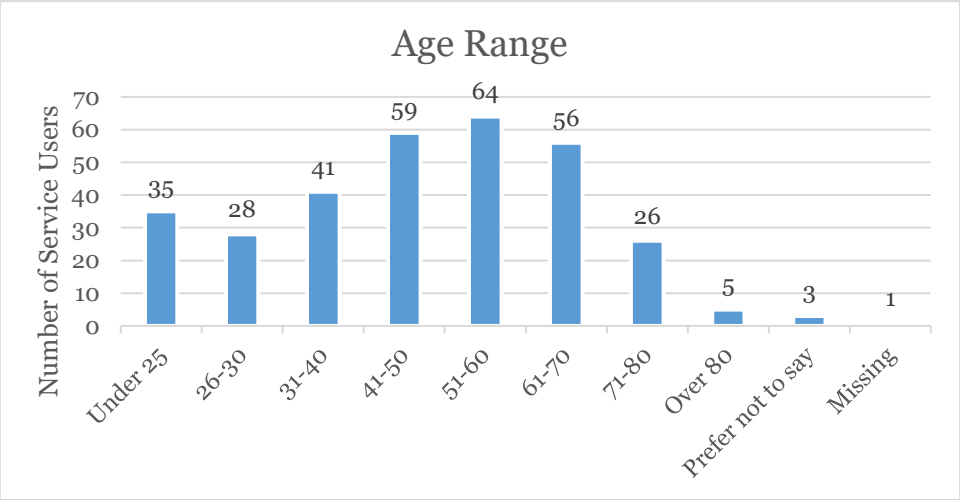
5.2. Dean Clinics

Dean Clinic administration staff gave all attendees an opportunity to complete the questionnaire and return it in person or by post to SPMHS or to complete the survey online. All service users were given an opportunity to complete the questionnaire except for those attending a first appointment or assessment and those whom Dean Clinic administration staff felt may have been too unwell to complete the questionnaire. There has been a notable increase in the number of service users completing survey's this year from 75 in 2020 to 318 in 2021. This is due to the successful implementation of an awareness by all clinics participating, informing service users that there is an avenue for feedback and the successful use of technology for the completion of surveys. 11 service users availed of the Dean Clinic services in person and 307 attended remotely.

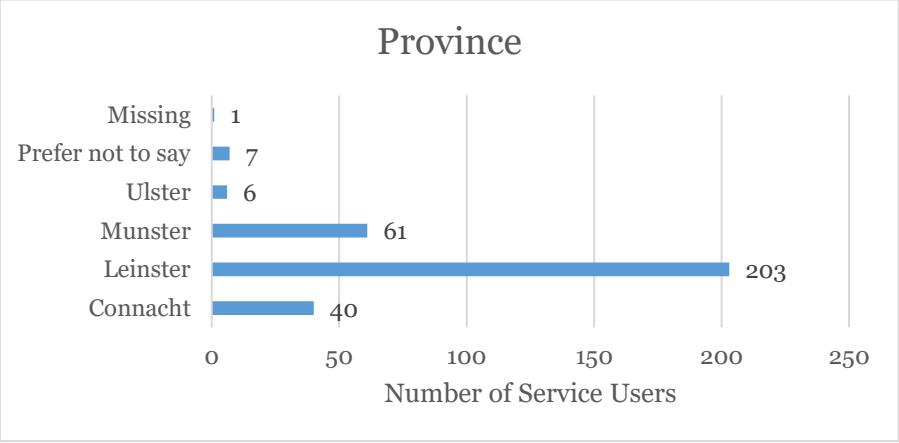
Graph: Service user gender



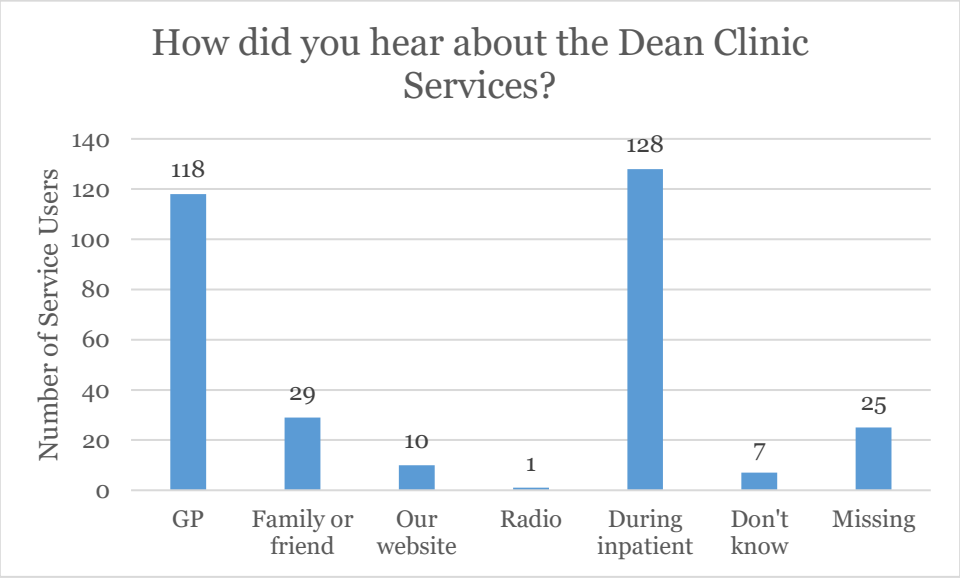
Graph: Service user age range



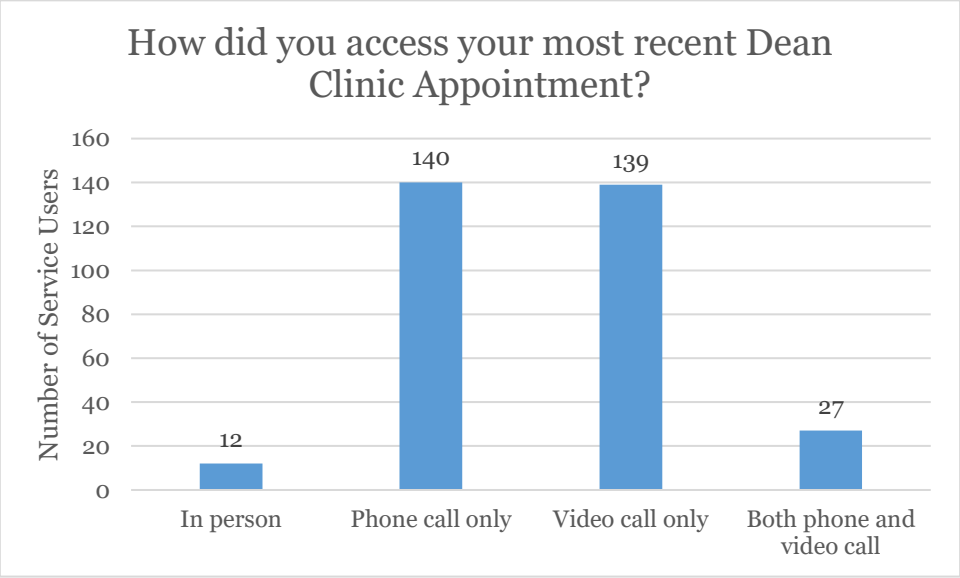
Graph: Service user province



Graph: How did service user hear about Dean Clinic service



Graph: How did service user access Dean Clinic service



In Person

Tell us about your experience of in person assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

Experience of Care & Treatment following your assessment?	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
It was convenient for me to access the Dean Clinic	6	54.5	5	45.5	0	0	0	0	0	0
I was welcomed in a friendly and professional manner by the Dean Clinic staff	9	81.8	2	18.2	0	0	0	0	0	0
I was shown where the facilities were in the Dean Clinic, such as the bathroom and waiting room	6	54.5	4	36.4	0	0	1	9.1	0	0
I was treated with dignity and respect	8	80	2	20	0	0	0	0	0	0
My confidentiality was protected	8	80	2	20	0	0	0	0	0	0
My privacy was respected	7	70	3	30	0	0	0	0	0	0
Dean Clinic staff were courteous	8	80	2	20	0	0	0	0	0	0
I felt included in decisions about my treatment	7	70	3	30	0	0	0	0	0	0
I trusted my doctor or therapist or nurse	8	80	2	20	0	0	0	0	0	0

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

Service users who attended in person completed and returned the service user satisfaction survey between January and December 2021 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 9.36 (N=11; SD=0.92). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 9.36 (N=11; SD=0.92).

Table: In person 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	0	0	0	0
2	0	0	0	0
3	0	0	0	0
4	0	0	0	0

5	0	0	0	0
6	0	0	0	0
7	0	0	0	0
8	3	27.3	3	27.3
9	1	9.1	1	9.1
10	7	63.6	7	63.6
No Answer	0	0	0	0
1-5	0	0	0	0
6-10	11	100	11	100
Total	11	100	11	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	11	9.36	0.92
Overall, the Dean Clinic	11	9.36	0.92

Remote

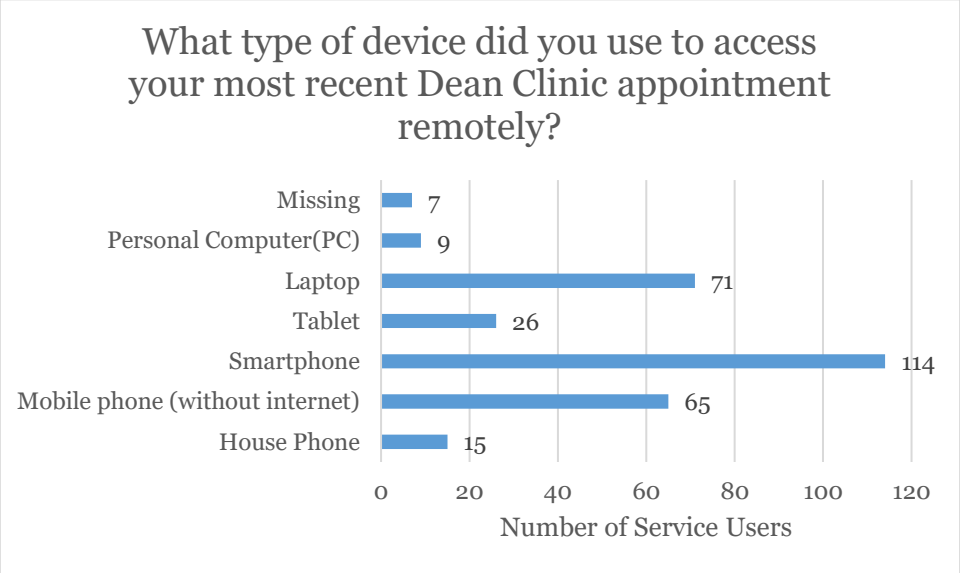
Tell us about your experience of remote assessment/therapy/review

Respondents experience of assessment/therapy/review appointment

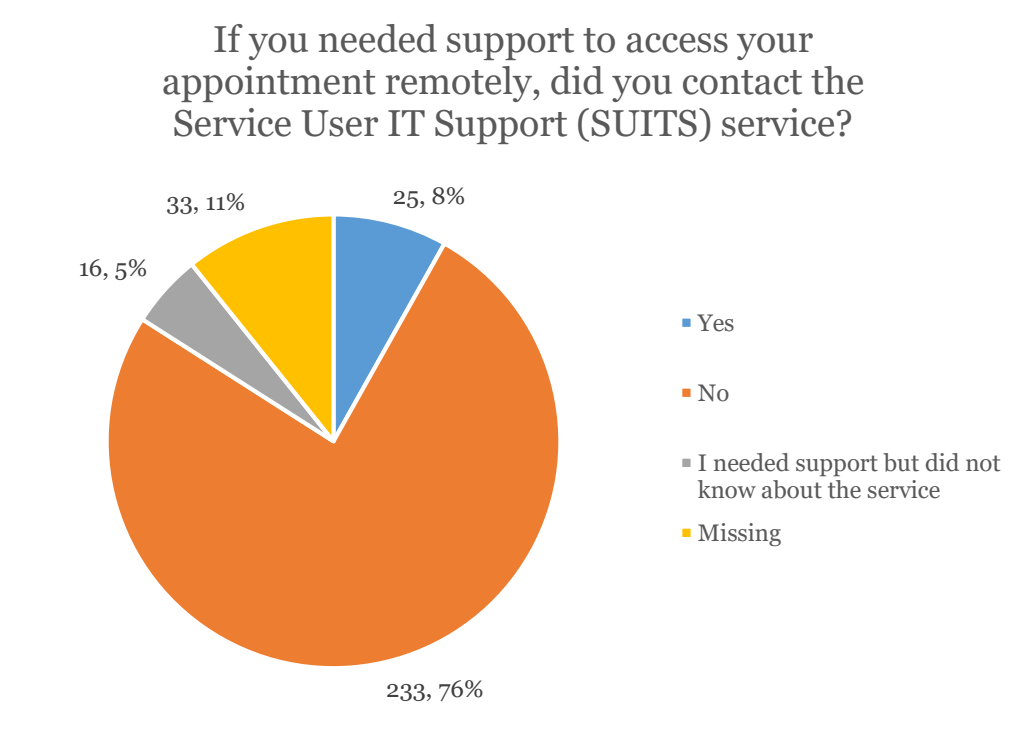
Experience of Care & Treatment following your assessment?	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		No Answer
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
It was convenient for me to access my appointment remotely	117	45.9	88	34.5	27	10.6	16	6.3	7	2.7	52
It was clearly explained to me how to access my appointment using either phone or video	107	41.6	101	39.3	26	10.1	18	7	5	2	50
I felt using technology did not negatively impact on my care and treatment	79	30.7	76	29.6	49	19.1	38	14.8	15	5.8	50
I would consider the option of attending Dean Clinic appointments by phone or video in the future	78	30.2	79	30.6	37	14.3	38	14.7	26	10.2	49
I was treated with dignity and respect	167	65	71	27.6	11	4.3	3	1.2	5	1.9	50

My confidentiality was protected	159	63.1	72	28.5	15	6	4	1.6	2	0.8	55
My privacy was respected	165	64.7	70	27.4	17	6.7	2	0.8	1	0.4	52
Dean Clinic staff were courteous	174	68.8	66	26	7	2.8	3	1.2	3	1.2	54
I felt included in decisions about my treatment	141	55.1	77	30	22	8.6	12	4.7	4	1.6	51
I trusted my doctor or therapist or nurse	158	61.5	67	26.1	15	5.8	12	4.7	5	1.9	50

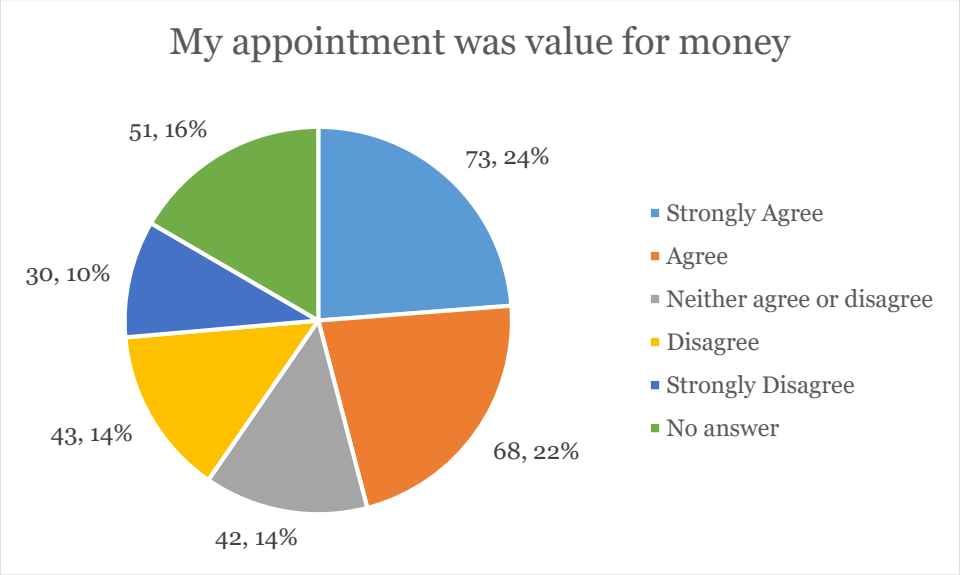
Graph: What type of device did you use to access your most recent Dean Clinic appointment remotely?



Graph: 'If you needed support to access your appointment remotely, did you contact the Service User IT Support (SUITS) service?



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



How would you rate your remote care and treatment at the Dean Clinic?
Service users who completed and returned the Service User Satisfaction Survey between January and December demonstrated a relatively high level of satisfaction with the care they received. Service users rated their care and treatment at the Dean Clinic on a scale of one to 10, showing a mean score of 8.11 (N=307; SD=2.36). Respondents also indicated a relatively high level of satisfaction with the overall Dean Clinic service, with a mean also of 7.92 (N=307; SD=2.42).

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	2.3	7	2.3
2	4	1.3	3	1
3	4	1.3	6	2
4	9	2.9	13	4.2
5	18	5.9	24	7.8
6	9	2.9	5	1.6
7	17	5.5	19	6.2
8	37	12.1	34	11.1
9	44	14.3	49	16
10	102	33.2	91	29.6
No Answer	56	18.3	56	18.2

	1-5	42	13.7	53	17.3
	6-10	209	68	198	64.5
Total		307	100	307	100

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

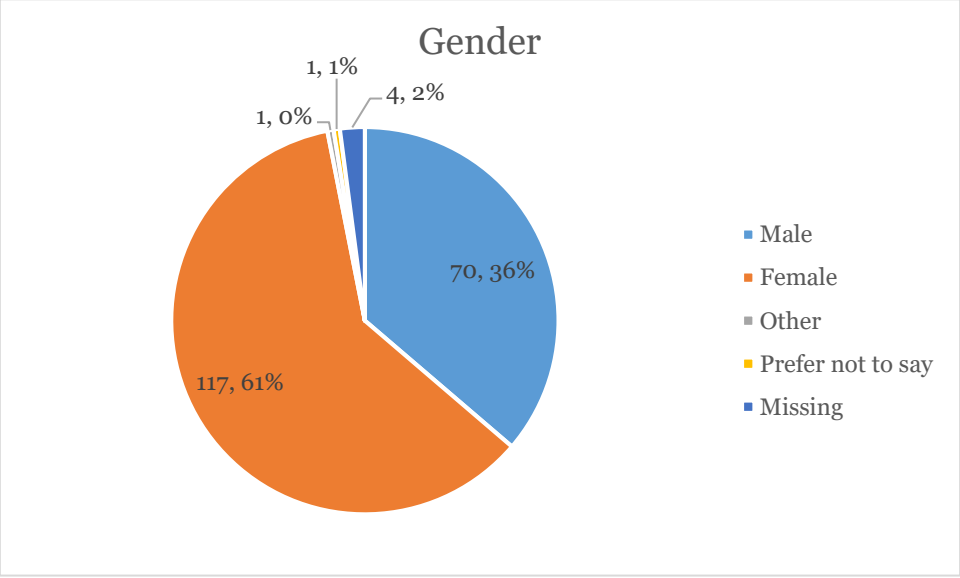
How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment at the Dean Clinic	307	8.11	2.36
Overall, the Dean Clinic	307	7.92	2.42

5.3. Adult inpatient services

5.3.1. Demographics

Service users discharged between January and December 2021 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. 193 surveys were returned to SPMHS adult inpatient services.

Graph: Inpatient gender



Graph: Home province

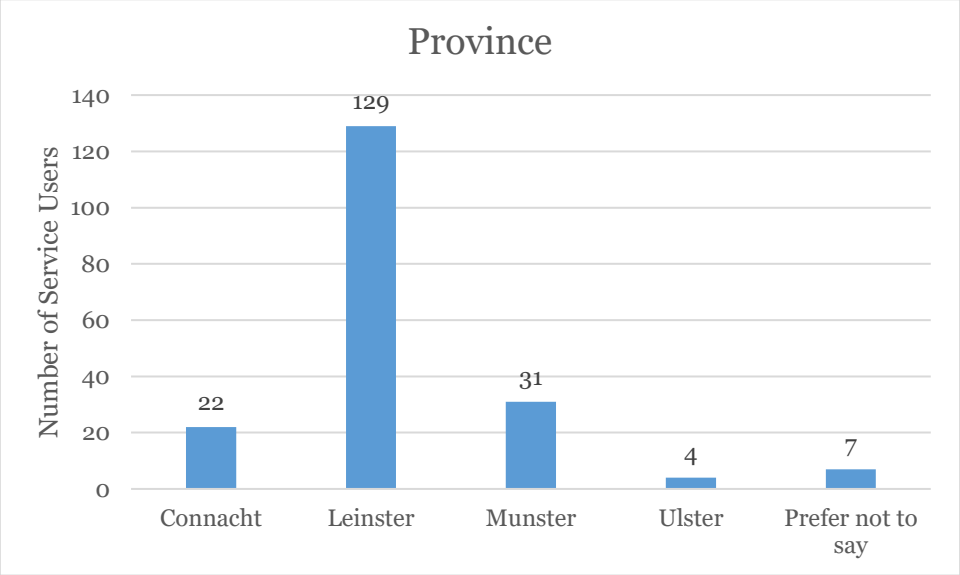


Table: Respondents' opinions regarding their experience of admission to hospital

Tell us about your experience of admission.	Strongly Agree		Agree		Disagree		Neither Agree or Disagree		Strongly Disagree		No answer	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
A member of staff explained what was happening	87	45.1	69	35.8	15	7.8	8	4.1	10	5.2	4	2.1
A member of staff explained the ward routine such as mealtimes and visiting arrangements	86	44.6	64	33.2	10	5.2	20	10.4	8	4.1	5	2.6
A member of staff explained about activities available	54	28	59	30.6	25	13	36	18.7	13	6.7	6	3.1

Table: Question 5 "Overall, what was your experience of how the hospital staff looked after you while you were an inpatient in St Patrick's Hospital?"

	Poor		Good		Excellent		Not Applicable		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Nursing staff	11	5.7	47	24.4	134	69.4	1	0.5	0	0
Consultant Psychiatrist	29	15	47	24.4	111	57.4	3	1.6	3	1.6
Registrar	20	10.4	57	29.5	105	54.4	9	4.7	2	1
Key Worker	34	17.6	36	18.7	88	45.6	26	13.4	9	4.7
Psychologist	12	6.2	28	14.6	92	47.6	48	24.9	13	6.7
Occupational Therapist	13	6.7	24	12.4	76	39.4	66	34.2	14	7.3
Social Worker	15	7.8	14	7.3	48	24.9	99	51.3	17	8.7
Pharmacist	5	2.6	43	22.3	84	43.5	54	28	7	3.6
Healthcare Assistant	3	1.6	21	10.9	97	50.2	63	32.6	9	4.7
Household Staff	4	2.1	27	14	130	67.3	25	13	7	3.6
Other	8	4.1	27	14	66	34.2	76	39.4	16	8.3

Table: Question 6: "Overall, can you tell us about your experience of the following while you were an inpatient in St Patrick's Hospital"

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
The quality of food available was of a high standard	51	26.4	52	26.9	15	7.8	34	17.7	33	17.1	8	4.1
There was a good selection of food available	47	24.2	55	28.6	21	10.9	34	17.7	29	15	7	3.6
The daily activities provided were interesting and helpful	42	21.8	63	32.6	28	14.5	32	16.6	19	9.8	9	4.7
The weekend activities were interesting and helpful	27	14	54	28	43	22.3	41	21.2	18	9.3	10	5.2
The cleanliness in the hospital was of a high standard	80	41.5	48	24.9	10	5.1	21	10.9	26	13.5	8	4.1

Table: Respondents' experiences of leaving the hospital

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I was given notice of my discharge	72	37.3	48	24.9	17	8.8	13	6.7	33	17.1	10	5.2
I felt ready to go home	60	31.1	52	26.9	23	11.9	20	10.4	28	14.5	10	5.2
I was provided with details of the SPMHS Support and Information Service	52	26.9	47	24.4	20	10.4	35	18.1	26	13.5	13	6.7
I was provided with details about the SPMHS Day Services available	46	23.7	38	19.7	26	13.5	42	21.8	27	14	14	7.3
I was provided with details of my follow up appointments	55	28.5	51	26.4	11	5.7	31	16.1	30	15.5	15	7.8
I know what to do in the event of a further mental health crisis	64	33.1	44	22.8	22	11.4	25	13	27	14	11	5.7

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. Over half respondents felt they had more positive views towards mental health difficulties in general (54.9%) and felt that they would share with others that they received support from SPMHS (50.7%).

Table: Respondents' perceived involvement in discharge

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I feel that my views and perceptions regarding my own mental health difficulties and mental health in general are more positive than they were	51	26.4	55	28.4	31	16.1	22	11.4	25	13	9	4.7
I will tell people that I was admitted to St Patrick's Hospital	47	24.4	51	26.4	24	12.4	34	17.7	29	15	8	4.1
I would recommend St Patrick's Hospital to others	82	42.5	36	18.6	14	7.3	22	11.4	31	16.1	8	4.1

Overall views of SPMHS

Service users who completed and returned the service user satisfaction survey demonstrated a high level of satisfaction with the care they received, rating their care and treatment in hospital on a scale of one to 10, with a mean of 7.65 (N=193; SD=2.60). Respondents also demonstrated a high level of satisfaction with the hospital overall, rating the hospital on a scale of 1 to 10, with a mean of 7.68 (N=193; SD=2.64)

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

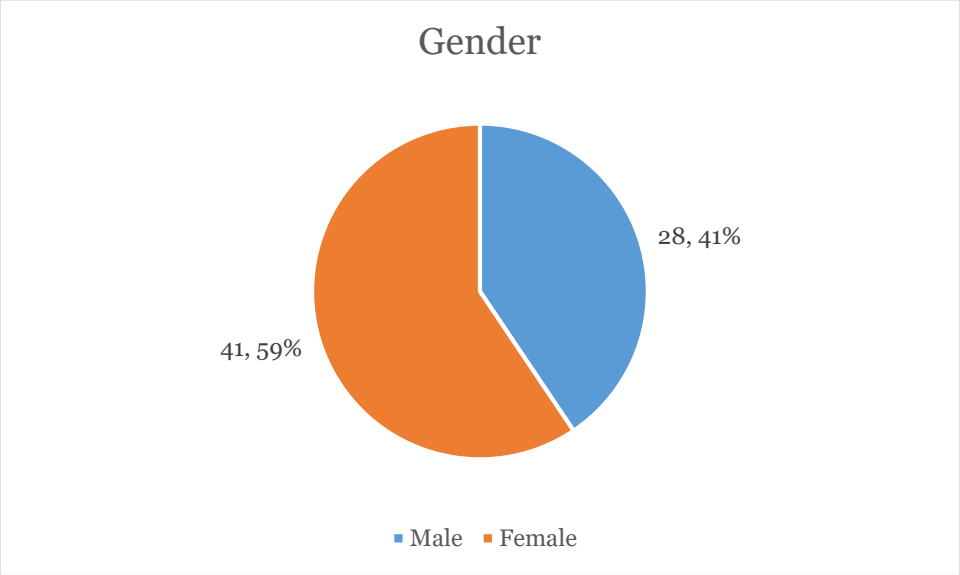
How would you rate...?	...your care & treatment		...the hospital overall	
	n	%	n	%
1	7	3.6	6	3.1
2	3	1.6	7	3.6
3	8	4.1	7	3.6
4	14	7.3	10	5.2
5	8	4.1	10	5.2
6	9	4.7	8	4.3
7	15	7.8	18	9.3
8	31	16.1	27	14.0
9	28	14.5	27	14.0
10	64	33.2	68	35.2
No Answer	6	3.1	5	2.6
0-5	40	20.7	40	20.7
6+	147	76.2	148	76.7
Total	193	100	193	100

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

How would you rate...?	N	Mean (μ)	Standard Deviation (∂)
Your care and treatment in hospital	193	7.65	2.60
The hospital	193	7.68	2.64

5.4. Homecare Service User Experience Survey

Graph: Service User gender



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

A total of 69 responses were received (N = 69).

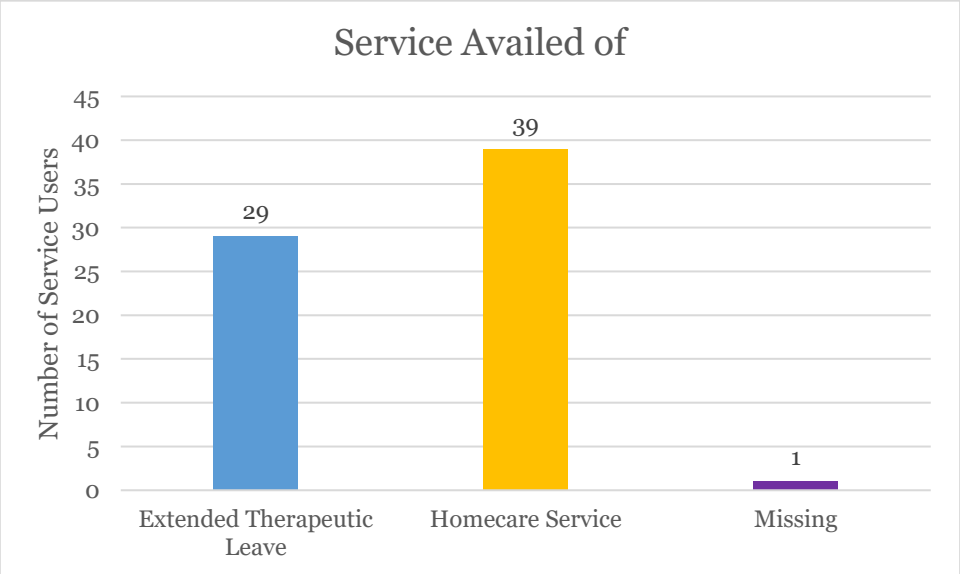


Table: Tell us about your experience of using phone and video calls to access our services?

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.

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
It was clearly explained to me how I would access the services provided as part of the Homecare service	36	52.3	20	29	1	1.4	4	5.8	3	4.3	5	7.2
I found it was easy to access my care and treatment video communications or phone	35	50.8	19	27.5	4	5.8	4	5.8	3	4.3	4	5.8
The quality of sound on phone calls or video calls was generally good	25	36.3	34	49.3	4	5.8	3	4.3	0	0	3	4.3
The quality of video was generally good	28	40.6	28	40.6	4	5.8	2	2.9	1	1.4	6	8.7
The internet connection was generally good	27	39.1	27	39.1	6	8.8	4	5.8	1	1.4	4	5.8
I found using technology to access services to be convenient	35	50.9	17	24.6	5	7.2	4	5.8	3	4.3	5	7.2
I felt using technology did not negatively impact on my care and treatment	26	37.7	16	23.2	10	14.5	9	13	3	4.3	5	7.2
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	29	42	18	26.1	6	8.7	8	11.6	3	4.3	5	7.2
I am comfortable using technology and regularly use video calls to stay in touch with friends and family	30	43.5	15	21.7	9	13	8	11.6	3	4.3	4	5.7

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

	Poor		Good		Excellent		Not Applicable		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Nursing staff	4	5.8	12	17.4	46	66.7	4	5.8	3	4.3
Consultant Psychiatrist	6	8.7	10	14.5	47	68.2	3	4.3	3	4.3
Registrar	2	2.9	17	24.7	40	58	7	10.1	3	4.3
Key Worker	6	8.7	9	13	32	46.4	16	23.2	6	8.7
Psychologist	4	5.8	8	11.6	35	50.7	17	24.7	5	7.2
Occupational Therapist	2	2.9	9	13	34	49.3	21	30.5	3	4.3
Social Worker	4	5.8	8	11.6	15	21.7	38	55.1	4	5.8
Pharmacist	2	2.9	12	17.4	31	44.9	19	27.6	5	7.2
Healthcare Assistant	2	2.9	4	5.8	17	24.6	38	55.1	8	11.6
Other	1	1.4	2	2.9	22	32	35	50.7	9	13

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

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I felt using video and/or telephone calls did not stop me from being able to express myself when talking to my team	28	40.7	19	27.5	11	16	5	7.2	3	4.3	3	4.3
I felt using video and/or telephone calls did not stop me from feeling understood by my team	30	43.6	17	24.6	10	14.5	6	8.7	3	4.3	3	4.3
I felt using video and/or telephone calls did not stop me from understanding what was being said to me by team	30	43.6	24	34.8	9	13	2	2.9	1	1.4	3	4.3
I felt using video and/or telephone	32	46.4	18	26.1	14	20.3	0	0	0	0	5	7.2

calls did not stop me from understanding if changes were made to my medication												
I had access to my medication	31	44.9	23	33.4	8	11.6	2	2.9	0	0	5	7.2
I received regular calls from my consultant	29	42.1	19	27.5	9	13	7	10.2	2	2.9	3	4.3
I received regular calls from nursing staff	40	58	18	26.1	4	5.8	4	5.8			3	4.3
I received regular calls from my key worker	20	29	14	20.3	18	26.1	7	10.1	6	8.7	4	5.8
I felt any issues I had were understood by my team	30	43.6	22	31.9	5	7.2	5	7.2	3	4.3	4	5.8
I felt any issues I had were addressed by my team	29	42.1	24	34.8	7	10.1	4	5.8	2	2.9	3	4.3

Table: Q. Please tell us about your experience of completing your Homecare treatment

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I was given notice of my discharge	31	44.9	25	36.4	5	7.2	3	4.3	1	1.4	4	5.8
I felt ready to go home	21	30.5	28	40.5	8	11.6	6	8.7	2	2.9	4	5.8
I was provided with details of SPMHS Support and Information Services	24	34.9	23	33.3	11	15.9	6	8.7	1	1.4	4	5.8
I was provided with details about the SPMHS day services available	22	32	20	29	14	20.3	7	10.1	1	1.4	5	7.2
I was provided with details of my follow up appointments	31	44.9	22	32	6	8.7	4	5.8	1	1.4	5	7.2
I know what to do in the event of a further mental health crisis	31	44.9	19	27.6	9	13	2	2.9	4	5.8	4	5.8

Q. Please tell us about your experience of stigma having completed your Homecare treatment

	Strongly Agree		Agree		Neither Agree or Disagree		Disagree		Strongly Disagree		Missing	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
I feel that my views and perceptions regarding my own mental health difficulties and mental health in general are more positive than they were	25	36.3	25	36.3	11	15.9	1	1.4	3	4.3	4	5.8
I will tell people that I was admitted to SPMHS	22	31.9	23	33.3	8	11.6	8	11.6	4	5.8	4	5.8
I would recommend SPMHS to others	41	59.4	18	26.1	0	0	2	2.9	4	5.8	4	5.8

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 7.65 (N=193; SD=2.60). Respondents also demonstrated a high level of satisfaction with the hospital overall, rating the hospital on a scale of 1 to 10, with a mean of 7.68 (N=193; SD=2.64)

How would you rate...?	...your care & treatment		...the Hospital overall	
	n	**%**	**n**	**%**
1	2	2.9	2	2.9
2	1	1.4	1	1.4
3	2	2.9	2	2.9
4	2	2.9	2	2.9
5	0	0	0	0
6	2	2.9	3	4.3
7	6	8.7	6	8.7
8	12	17.4	13	18.8
9	13	18.8	11	15.9
10	26	37.7	26	37.7
No Answer	3	4.3	3	4.3
0-5	7	10.2	7	10.2
6+	59	85.5	59	85.5
Total	69	100	69	100

5.5. Day programme services

Programme coordinators in SPMHS invited all service users finishing a programme to complete a copy of the questionnaire and return it in person, by post to SPMHS or to complete the survey online.

5.5.1. 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 2021 was 192.

Day service programmes attended by survey respondents

Programme	Number of respondents attending (N = 192)	Percentage of respondents attending
Access to Recovery	6	3.1%
Addiction and Chemical Dependence Programme	3	1.6%
ACT	56	29.2%
Aftercare	5	2.6%
Anxiety Programme	8	4.2%
Bipolar Programme	6	3.1%
Compassion-Focused Therapy	7	3.6%
CFT-Eating Disorders	3	1.6%
Depression	10	5.2%
Dual Diagnosis	6	3.1%
Eating Disorder Programme	6	3.1%
FACTS	2	1.0%
Formulation	3	1.5%
Group Radical Openness	4	2.1%
Living Through Distress	5	2.6%
Living Through Psychosis	1	0.5%
Mindfulness Based Stress Reduction	3	1.6%
Mindfulness	4	2.1%
Pathways to Wellness	1	0.5%

Regaining Recovery	2	1.0%
SAGE	1	0.5%
Schema	1	0.5%
Self-esteem	5	2.6%
Stepdown	3	1.6%
Temple Formulation Group	1	0.5%
Unknown	21	10.9%
Wellness in Recovery	2	1.0%
WRAP	16	8.6%
Young Adult Programme	1	0.5%
TOTAL	192	100%

The respondents by province is presented in the table below

Province	N	Percentage
Connaught	9	4.7%
Leinster	160	83.3%
Munster	17	8.9%
Ulster	3	1.6%
Prefer not to say	1	0.5%
Missing	2	1.0%
TOTAL	192	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/nor disagree		No answer	
	n	%	n	%	n	%	n	%
A member of day services clearly explained what was happening	171	89.1%	3	1.6%	8	4.2%	10	5.2 %
A member of staff explained the timetable	171	89.1%	5	2.6%	6	3.1%	10	5.2 %

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. 73.4% (n = 141) strongly agreed that they trusted the members of their day programme team. 77.6% (n = 149) strongly agreed that they were always treated with dignity and respected as an individual. 78.1% (n = 150) also strongly agreed that their team were courteous and respectful. 72.9% (n = 140) strongly agreed that members of the team were knowledgeable and easy to understand.

	Agree		Disagree		Neither agree/nor disagree		No answer	
	N	%	n	%	n	%	n	%
I trusted the members of my programme team	170	88.5%	3	1.6%	9	4.7%	10	5.2%
I was always treated with dignity and respect	174	90.6%	4	2.1%	4	2.1%	10	5.2%
Members of my programme team were courteous and respected me as an individual	177	92.2	2	1.0	3	1.6	10	5.2
Members of my team were knowledgeable and easy to understand	176	91.7%	2	1.0%	4	2.1%	10	5.2%

Tell us about your experience of finishing the programme

Respondents also generally reported an informed ending to the programme, with 77.6% (n = 149) agreeing that they knew when the programme was to end. 75.5% (n = 145) of respondents felt that the programme met their expectations. 76.1% (n = 146) felt that they know what to do in the event of a further mental health crisis. 66.7% (n = 128) 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.

	Agree	Disagree	Neither agree/nor disagree	No answer
I knew in advance when the programme was due to finish	149 (77.6)	10 (5.2)	16 (8.3)	17 (8.8)
The programme met all of my expectations	145 (75.5)	13 (6.8)	18 (9.3)	16 (8.3)
I know how to get help in the event of a further mental health crisis	146 (76.1)	12 (6.3)	16 (8.3)	18 (9.3)
I have been given details of St Patrick's Mental Health Services Support and Information Services	128 (66.7)	22 (11.5)	24 (12.5)	18 (9.3)

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

	Agree		Disagree		Neither agree/nor disagree		No answer	
	n	%	n	%	n	%	n	%
I feel my views and perceptions regarding my own mental health difficulties and mental health in general are more positive than they were	106	55.2%	46	23.9%	36	18.8%	14	7.3%
I will tell people that I have attended a day programme in St Patrick's Mental Health Services	84	43.8%	58	30.2%	36	18.8%	14	7.3%
I would recommend St Patrick's Mental Health Services day services to other	119	61.9%	50	26.0%	9	4.7%	14	7.3%

Experience of using technology

Respondents were asked to rate their experience of using technology to access day programme services as these are being delivered online due to public health guidelines. 89.6% of respondents (N = 172) agreed that it was clearly explained to them how to access their programme using telephone or video call. 81.3% (N = 156) agreed that they found using telephone or video call to be convenient. 61.5% (N = 118) agreed that they felt using technology did not negatively impact on their experience of attending the programme. 73.5% (N = 141) respondents agreed that they would consider the option of attending future programmes by video or telephone call in the future. See table below for more information.

	Agree	Disagree	Neither agree/nor disagree	No answer
It was clearly explained to me how to access my programme using telephone or video call	172(89.6%)	1(0.5%)	9(4.7%)	10 (5.2%)
I found using telephone or video calls to be convenient	156 (81.3%)	10(5.2%)	15(7.8%)	11(5.7%)
I felt technology did not negatively impact on my experience of attending the programme	118 (61.5%)	33(17.2%)	31(16.1%)	10(5.2%)
I would consider the option of attending programmes in the future using video or telephone call	141 (73.5%)	25(13.1%)	17(8.9%)	9(4.7%)

Respondents were asked about their contact with the Service User IT Support Services (SUITS).

If you needed support to access your programme remotely, did you contact the Service User IT Support (SUITS) service?	Yes	No	Needed support but did not know about the service	No answer
n (%)	57(29.7%)	97(50.5%)	11(5.7%)	27(14.1%)

Those who accessed support from SUITS were asked to rate their satisfaction with the service. A total of 55 people rated the support received. 81.8% (N = 45) of respondents rated the support as 6 or above.

If you accessed SUITS for support, how would you rate the support?		
	n	**%**
1 (Poor)	1	0.5
2	1	0.5
3	1	0.5
4	2	1.0
5 (Good)	5	2.6
6	1	0.5
7	2	1.0
8	5	2.6
9	8	4.2
10 (Excellent)	29	15.1
Missing	137	71.4
1-5	10	5.1
6-10	45	81.8
Total	192	100

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. 84.8% of respondents (n = 163) rated their care and treatment a score of 6 or above. Respondents were also asked to rate the Wellness and Recovery Centre overall. 82.8% of respondents (n = 159) rated the Wellness and Recovery Centre overall a score of 6 or above. See the table below for further information.

How would you rate your...	... care and treatment?		... overall experience of the Wellness and Recovery centre?	
	n	%	n	%
1	1	0.5	2	1.0
2	0	0	2	1.0
3	4	2.1	2	1.0
4	3	1.6	2	1.0
5	6	3.1	9	4.7
6	2	1.0	1	.5
7	11	5.7	16	8.3
8	29	15.1	24	12.5
9	20	10.4	25	13.0
10	101	52.6	93	48.4
Missing	15	7.8	16	8.3
1-5	29	15.2	17	8.9
6-10	163	84.8	159	82.8
Total	192	100	192	100

5.6. Willow Grove Adolescent Unit Service User Satisfaction Survey 2021

Willow Grove is the inpatient adolescent unit of SPMHS (previously described in this document). The unit has an associated outpatient Dean Clinic located in St Patricks University Hospital, 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 2021.

5.6.1. 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.

5.6.2. Respondents

Parents and young people were asked to complete this measure on the day of discharge. 35 young people and 48 parents/carers completed the questionnaire. Response rates for service users was 31.53%. 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 decreased by 51.47% and increased by 11.62% for parents/carers in 2021 compared with 2020, where responses were provided from 68 young people and 43 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.

5.6.3. 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 1 - very poor, to 5 - very good, printed with corresponding smiley faces to help young people to understand the response options.

5.6.4. Results

Quantitative responses

The median response (i.e. the most common response) for each question is listed in the table below. In order to be concise, the median response for the young people and their parents/carers are presented in a single table. 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 who answered the survey reported that they were happy or very happy with their experience of the care and treatment provided. The majority of responses for young people were a four - 'happy' (40%), followed by five - 'very happy' (40%) and three - 'mixed' (17.1%). 2.9% of young people reported that they were unhappy with the care and treatment provided. For the parents/carers, the majority of responses on their experience of the care and treatment provided were five - 'very happy' (60.4%), followed by four - 'happy (27.1%) and three 'mixed' (10.4%).

The least positive answer given by service users was in relation to access to visiting arrangements. 20% were 'very unhappy' with visiting arrangements, 20% were unhappy with visiting arrangements, 28.6% were mixed, 20% were happy and 2.9% were very happy.

Service users most commonly rated five – 'very happy' for their access to keyworkers/allocated nurse and the opportunity to attend the discharge planning meeting.

Service users rated four – 'happy' for the items including: their overall care and treatment, the waiting time prior to admission, information received from St Patrick's website, process of assessment and admission, information received prior to admission, the environment and facilities, the atmosphere on the unit, the cleanliness of the unit, the meals provided, safety on the unit, their access to group therapy, their access to individual therapy, access to professionals, access to educational support, information received about their treatment plan, the level of involvement in their treatment plan, the opportunity to provide feedback, feeling they were listened to and respected, confidentiality of the service, preparation for discharge, information about discharge, having a service identified for follow up, provision of support, provision of an advocacy group and that their admission provided them with skills to help address their mental health difficulties.

Parents most commonly rated five – 'very happy' for the experience of accessing the service, process of assessment and admission, the information received prior to admission, the overall experience of care and treatment, the cleanliness of the unit, the safety of the unit, their child's access to individual therapy, their child's access to group therapy, their access to a range of professionals, their child's access to keyworkers and nurses, their child's access to educational support, their access to an independent advocacy group, their access to the treatment team, feeling they were listened to and respected, the confidentiality of the service, the information received prior to discharge, the identification of service for follow up care, opportunity to attend discharge planning meeting and how well they felt the admission addressed their child's mental health difficulties.

The public health restrictions implemented in response to COVID-19 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 Surveys

Please tell us how satisfied you were with aspects of our service	Parents	Young people
Experience of accessing the service	5	4
Information received prior to admission	5	3
Information provided by St Patrick's website	4	4
The information given on admission	5	4
The environment and facilities	4.5	4
The overall atmosphere or feel of the unit	4	4
The cleanliness of the unit	5	4
The meals provided	4	4
Visiting arrangements	4	3
Safety arrangements on the unit	5	4

Experience of care and treatment	5	4
Access to group therapy	5	4
Access to individual therapy	5	4
Access to leisure activities and outings	4	3
Access to a range of professionals	5	4
Access to key workers/allocated nurses	5	5
Access to educational supports	5	4
Access to an independent advocacy group	5	4
Your level of contact with the treatment team	5	4
Information received on treatment plan	4	4
Your involvement (young person)/your collaboration (parent) in treatment plan	4	4
Your opportunity to give feedback to the treatment team	4.5	4
How you felt you were listened to/respected	5	4
Confidentiality of the service	5	4.5
Opportunity to attend discharge planning meeting	5	5
Information given to you to prepare for discharge	5	4
Having a service identified for follow up care	5	4
Provision of family support	4	4
Opportunity to attend parents support group	3	N/A
Opportunity to attend Positive Parenting Course	3	N/A

Was your child's stay helpful in addressing mental health difficulty?	5	N/A
Providing you with Skills to manage your mental health	N/A	4

SECTION SIX

CONCLUSIONS

6.1. Conclusions

1. The SPMHS eleventh *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. These attributes have been even more invaluable throughout the COVID-19 pandemic and have ensured that outcome measurement has continued to be central to ensuring quality clinical services.

2. Service user experience survey results indicate the service user experience of SPMHS services continued to be positive. The surveys have helped SPMHS to identify and address any areas for improvement.

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 2021, 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. 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. SPMHS staff have continued to effectively report outcome measures in 2021, despite the continued challenges posed by the COVID-19 public health restrictions. Technology mediated care continues as an effective option for clinical service delivery and providing access and convenience to service users.

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, but in inceaesed focus on technology mediated surveys to improve response rates did show inceased response rates in 2021.

SECTION SEVEN

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